



**Commonwealth of Pennsylvania
Department of Human Services
Children’s Health Insurance Program**

**2021 External Quality Review Report
Independence Blue Cross**

Final Report
June 2022



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realized.

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Introduction

Purpose and Background

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

The Pennsylvania (PA) Department of Human Services (DHS) Children’s Health Insurance Program (CHIP) provides free or low-cost health insurance to uninsured children and teens that are not eligible for or enrolled in Medical Assistance (MA) via the PA DHS HealthChoices Medicaid managed care program. PA CHIP contracted with IPRO as its EQRO to conduct the 2021 EQRs (Review Period: 1/1/2020 – 12/31/2020) for the CHIP MCOs and to prepare the technical reports.

The mandatory EQR-related activities that must be included in detailed technical reports, per 42 CFR §438.358 (crosswalked to §457.1250 for CHIP), are as follows:

- validation of performance improvement projects,
- validation of MCO performance measures, and
- review of compliance with Medicaid and CHIP managed care regulations.

It should be noted that a fourth mandatory activity, validation of network adequacy, was named in the CMS *External Quality Review (EQR) Protocols* published in October 2019. However, CMS has not published an official protocol for this activity, and this activity is conducted at the state’s discretion. Each managed care program agreement entered into by DHS identifies network adequacy standards for those programs. For CHIP MCOs, DHS has published provider network standards through CHIP Sole Source Amendments and the CHIP Procedures Handbook, Chapter 21.

The report includes six core sections:

- I. Performance Improvement Projects
- II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
- III. Performance Improvement Projects
- IV. 2020 Opportunities for Improvement – MCO Response
- V. 2021 Strengths and Opportunities for Improvement
- VI. Summary of Activities

Information for **Section I** of this report is derived from IPRO’s validation of each CHIP MCO’s Performance Improvement Projects (PIPs) for a new validation cycle, including review of the PIP design and implementation using documents provided by the MCO.

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

Historically for the CHIP MCOs, the information for the compliance with Structure and Operations Standards in **Section III** of the report was derived from the results of on-site reviews conducted by PA CHIP staff, with findings entered into the department’s on-site monitoring tool, and follow up materials provided as needed or requested. Beginning in 2020, compliance data were collected from the commonwealth’s monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from CHIP’s contract agreements with the plans, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO. Standards presented in the on-site tool

are those currently reviewed and utilized by PA CHIP staff to conduct reviews; these standards may be applicable to other subparts, and will be crosswalked to reflect regulations as applicable.

Section IV, 2020 Opportunities for Improvement – MCO Response, includes the MCO’s responses to the 2020 EQR Technical Report’s opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

Section V has a summary of the MCO’s strengths and opportunities for improvement for this review period as determined by IPRO. This section will highlight performance measures across HEDIS and Pennsylvania-specific performance measures where the MCO has performed highest and lowest.

Section VI contains a summary of findings across all sections of the EQR Technical Reports, including Structure and Operations Standards, Performance Improvement Projects, Performance Measures, 2020 Opportunities for Improvement MCO Responses, and Strengths and Opportunities for Improvement found for 2021.

I. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCO/MCPs 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/MCP.

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each CHIP MCO. For the purposes of the EQR, CHIP MCOs were required to participate in studies selected by DHS CHIP for validation by IPRO in 2017 for 2021 activities. Under the applicable Agreement with DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement in 2018. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

As part of the new EQR PIP cycle that was initiated for all CHIP MCOs in 2017, IPRO adopted the Lean methodology, following the CMS recommendation that Quality Improvement Organizations (QIOs) and other healthcare stakeholders embrace Lean in order to promote continuous quality improvement in healthcare. MCOs were provided with the most current Lean PIP submission and validation templates at the initiation of the PIP.

2021 is the thirteenth year to include validation of PIPs. For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

CHIP MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, the two topics selected were “Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years” and “Improving Blood Lead Screening Rate in Children 2 Years of Age”.

“Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years” was selected after review of the CMS Child Core Set Developmental Screening in the First Three Years measure, as well as a number of additional developmental measures. The performance of these measures across Pennsylvania CHIP Contractors has been flat, and in some cases has not improved across years. Available data indicates that fewer than half of Pennsylvania children from birth to 3 years enrolled in CHIP and Medicaid in 2014 were receiving recommended screenings. Taking into account that approximately 1 in 10 Pennsylvania children may experience a delay in one or more aspects of development, this topic was selected with the aim of all children at risk are reached. The Aim Statement for the topic is “By the end of 2020 the MCO aims to increase developmental screening rates for children ages one, two and three years old.” Contractors were asked to create objectives that support this Aim Statement.

For this PIP, DHS CHIP is requiring all CHIP Contractors to submit rates at the baseline, interims, and final measurement years for “Developmental Screening the in First Three Years of Life”. Additionally, Contractors are encouraged to consider other performance measures such as:

- Proportion of children identified at-risk for developmental, behavioral, and social delays who were referred to early intervention
- Percentage of children and adolescents with access to primary care practitioners
- Percentage of children with well-child visits in the first 15 months of life

“Improving Blood Lead Screening Rates in Children 2 Years of Age” was selected as the result of a number of observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages 3 through 6 years without a prior lead blood test have blood levels screened consistent with current Department of Health

and CDC standards. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2016 was 66.5%, while the Pennsylvania CHIP average was 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the previous few years, rates by Contractor and weighted average fell below the national average. In addition to the HEDIS lead screening rate, Contractors have been encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors were identified,
- Total number of children successfully identified with elevated blood lead levels,
- Percent of the population under the age of 5 years suffering from elevated blood lead levels, or
- Percent of individuals employed in the agriculture, forestry, mining, and construction industries.

The PIPs extend from January 2017 through December 2020; with research beginning in 2017, initial PIP proposals developed and submitted in second quarter 2017, and a final report submitted by MCOs in June 2021. The non-intervention baseline period was January 2017 to December 2017. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in 2019 and 2020, as well as a final report in June 2021. In adherence with this timeline, all MCOs submitted their final reports in July 2021, with review and findings administered by IPRO in Winter 2021.

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

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

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. Throughout the course of the PIPs, IPRO provides technical assistance to each MCO/MCP. The technical assistance includes feedback.

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

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO/MCP'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/MCP's enrollment and generalizable to the MCO/MCP'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 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/MCP 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.

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. Measurement Year (MY 2017) is the baseline year, and during the 2021 review year, elements were reviewed

and scored at multiple points during the year once final reports were submitted in July 2021. All MCOs received some level of guidance towards improving their proposals in these findings, and MCOs will respond accordingly with resubmission to correct specific areas.

For each review element, the assessment of compliance is determined through the responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. The overall score is expressed in terms of levels of compliance. The elements are not formally scored beyond the full/partial/non-compliant determination.

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

Table 1.1: Element Designation

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

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of “Met”, “Partially Met”, or “Not Met”. Elements receiving a “Met” will receive 100% of the points assigned to the element, “Partially Met” elements will receive 50% of the assigned points, and “Not Met” elements will receive 0%.

Findings

To encourage MCOs to focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year.

Subsequent to MCO proposal submissions that were provided in early 2018, several levels of feedback were provided to MCOs. This feedback included:

- MCO-specific review findings for each PIP.
- Conference calls with each MCO to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic.
- Information to assist MCOs in preparing their next full PIP submission for the Interim Year 2 Update, such as additional instructions regarding collection of the core required measures.

Similar types of feedback were provided for each submission throughout the cycle. MCOs were requested to revise and resubmit their documents to address the feedback and to be reviewed again. PIP-specific calls were held with each MCO that experienced continued difficulty. Additionally, as needed, PA CHIP discussed ongoing issues with MCOs as part of their regularly scheduled monitoring calls. As discussed earlier, final reports were submitted in July 2021. Review of these submissions began in October 2021 and ran through February 2022. Upon review of the submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary. MCOs requiring additional discussion and potential modification were contacted and advised via email of any necessary or optional changes that IPRO determined would improve the quality of their overall projects.

Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years

Independence Blue Cross (IBC) provided a discussion of topic rationale in 2018, which included the potential for meaningful impact on member health, functional status, and satisfaction. The topic selection impacts the maximum proportion of members that is feasible, while still reflecting high-volume and high-risk conditions. The discussion at baseline also included support of the topic rationale with MCO-specific data and trends, which were utilized to compare to statewide and nationwide benchmarks in assessing reasonability of the topic of Developmental Screening. It was noted that sign-off and acknowledgement from key MCO staff should be provided to assure involvement and approval throughout the course of the PIP, and these were included in the plan's 2019 interim report.

IBC was encouraged to develop an aim and goals that are feasible and bold at baseline. It was noted that the goals developed to achieve this aim do not match the final goal rate, and the plan was encouraged to revisit and adjust accordingly at that time. Furthermore, it was suggested that the second indicator developed by the plan be revisited and redeveloped, as it is a restatement of the first indicator (increasing number of developmental screenings). The plan was encouraged to choose a separate measure of health care to track throughout the PIP. In IBC's 2019 interim report, the plan's goal was restated to match the final goal included in the report. It was noted during review that the plan targeted a modest goal that could benefit from examination; the plan responded in 2019 with a revised goal which was bold, yet attainable.

Methodologically, IBC developed indicators in 2018 that measure changes in health status, functional status, and processes of care with strong associations with improved outcomes. The indicators were noted to be defined clearly and have been demonstrated to be measurable, as they are PA-specific and HEDIS performance measures. Additional information regarding the name of the second indicator was requested at baseline review, as well as information regarding differentiating between the first and second indicators by choosing an alternative. Both of these items were addressed and explained in the plan's interim report from 2019. In 2020, it was noted during review that there was an update for one of the plan's indicators, the developmental screening measure, in 2020. The numerator now only encompasses children who had a claim with CPT code 96110 by their first, second, or third birthday and only one rate was reported. IPRO recommended that the plan incorporate this update in a revised report and the plan addressed this in their revised December 2020 submission. The study design at baseline specified data collection methods that are valid and data analysis procedures which are logical, and no significant changes were made through the course of either interim reporting period.

Barrier analysis was performed in 2018, primarily through the means of review of claims information. These barriers were identified at the member, plan, and provider level. It was noted at baseline review that additional information regarding the conclusions regarding provider level barriers should be provided, including confirmation that these barriers were discovered via claims analysis. Additionally, member level barriers seemed to have been identified utilizing claims analysis as well, but it is unclear how many of the barriers identified can be identified through this method. More information was requested at baseline, and IBC provided additional background and rationale in their 2019 interim report. In 2020, it was noted that no descriptions were included for any of the interventions developed by the plan and IPRO recommended that descriptions be included in a revised report. The plan added these in their revised submission in 2020, but did not follow convention. It was recommended by IPRO for consistency that they include the descriptions in the correct section of the report in their final 2021 report.

IBC developed interventions at baseline to follow barriers throughout the study that are informed by their barrier analysis. Actions in these interventions attempt to address members, providers, and MCO. It was noted during baseline review that tracking measures should be developed for each intervention, in order to assist in determining how effectively the interventions have been implemented.

IBC was asked to provide updated finalized rates for all performance indicators at baseline review. Additionally, final goals and target rates were requested to be included in the results section to track progress towards goals over time. The plan provided all requested rates in their 2019 interim report for this project.

Discussion of the success of the PIP to date was included in 2019, with relevant analyses included to note changes in performance indicators, as well as lessons learned from this stage of the project. During interim review, it was

recommended that IBC provide a summary of any follow up activities in discussion or planned at this stage of the project, which was addressed and included in their final submission. In 2020, the plan initially only included minimal discussion and updates in their Lessons Learned section, and IPRO recommended a more comprehensive and detailed discussion be included by the plan. IBC further elaborated and included discussion of the COVID-19 pandemic on their project in their December 2020 revision. This guidance provided by IPRO, combined with the compliance designations provided in **Table 1.2**, serves as IPRO's validation and recommendations to the plan regarding this project.

In the plan's final report submission, IBC provided final data for all indicators and tracking measures. For Indicator 1, the target was exceeded, and performance improvement was demonstrated. The MCO noted that Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) measures were combined into Child and Adolescent Well-Care Visits (WCV). At the implementation of the project, plans were required to define a second indicator, for which IBC selected W34. Although modified for HEDIS, there does not appear to be an attempt to collect data using similar parameters to the W34 measure for the purposes of continuing the measurement defined for the PIP. Without any comparable measurement of the indicator defined by the MCO at the beginning of the project, a required indicator is not measured consistently over time and performance improvement could not be evaluated.

Minimal additional updates were included in the Lessons Learned and Follow Up sections. In the 2020 interim report, it was noted that a more thorough discussion of findings would better highlight what the MCO is taking away from this project in terms of development screening in their CHIP population. This section was revised to include additional explanation and a discussion of COVID-19 in relation to interventions for the year. For the final report, however, aside from noting the impact of the change in the HEDIS W34 measure on trending and advising that member postcards are produced in Spanish, much of the information remained the same. While the plan noted again that findings were discussed with staff, there were no substantive changes to the activities noted from the prior year. **Table A.1.1** of the MCO's interventions for the project can be found in the **Appendix** of this report.

The following recommendations were identified during the Final Report review process:

- It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.
- It is recommended that IBC include numerator and denominator descriptions for all intervention tracking measures.
- It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.

Improving Blood Lead Screening Rate in Children 2 Years of Age

IBC provided a discussion of topic rationale in 2018 which included the potential for meaningful impact on member health, functional status, and satisfaction. The topic selection, developed at baseline, impacts the maximum proportion of members that is feasible, while still reflecting high-volume and high-risk conditions. The discussion at baseline submission also included support of the topic rationale with MCO-specific data and trends, which were utilized to compare to statewide and nationwide benchmarks in assessing reasonability of the topic of Lead Screening. It was noted that sign-off and acknowledgement from key MCO staff should be provided to assure involvement and approval throughout the course of the PIP, and these were included in the plan's 2019 interim report.

At baseline review, IBC was encouraged to develop an aim and goals that are feasible and bold and to streamline the aim that was developed to include fewer statements regarding the measure. It was noted that the goals developed to achieve this aim do not match the final goal rate, and the plan was encouraged to revisit and adjust accordingly. Furthermore, it was suggested that the second indicator developed by the plan be revisited and redeveloped, as it is a restatement of the first indicator (increasing number of lead screenings). The plan was encouraged to choose a separate measure of health care to track throughout the PIP. These baseline requests were addressed during the 2019 interim report reviews.

Methodologically, IBC developed indicators in 2018 that measure changes in health status, functional status, and processes of care with strong associations with improved outcomes. As discussed above, baseline review noted that the

second indicator itself needed further development in order to accurately measure success as the proposal goes onward. The study design specified data collection methods that are valid and data analysis procedures which are logical.

IBC performed a barrier analysis at baseline which utilized discussions with pediatric providers, analysis of provider feedback and focus group outreach to parents and guardians of CHIP members to identify susceptible subpopulations, stratified by clinical characteristics. It was noted during baseline review that many barriers identified were very similar in nature, and IBC was encouraged to pare down barriers into high level, cohesive points from which interventions can be developed. Interventions were developed that are largely passive in nature, including educational mailings and newsletters. It was noted that these types of passive interventions are difficult to track in terms of success rate. Additional information was requested to showcase how provider level interventions will be piloted, as well as a request for further development of the tracking measures for this particular intervention. In their 2019 interim report, these concerns were addressed through a comprehensive overhaul of their interventions and clarification included for their barrier identification. It was noted that final target rates are required for their new second indicator. These were included in their 2020 interim report. In 2020, it was noted that no descriptions were included for any of the interventions developed by the plan and IPRO recommended that the plan include these in a revised report. The plan added these in their revised submission in 2020, but did not follow convention. It was recommended by IPRO for consistency that they include the descriptions in the correct section of the report in their final 2021 report.

As with Developmental Screening, IBC was asked to provide updated finalized rates for all performance indicators during baseline review. Additionally, final goals and target rates were requested to be included in the results section to track progress towards goals over time. The plan provided all requested rates in their 2019 interim report for this project.

Discussion of the success of the PIP to date was included in 2019, with relevant analyses included to note changes in performance indicators, as well as lessons learned from this stage of the project. During interim review, it was requested that IBC provide a summary of any follow up activities in discussion or planned at this stage of the project, which was addressed and included in their final submission. In 2020, the plan initially only included minimal discussion and updates in their Lessons Learned section, and IPRO recommended a more comprehensive and detailed discussion be included by the plan. IBC further elaborated and included discussion of the COVID-19 pandemic on their project in their December 2020 revision. This guidance provided by IPRO, combined with the compliance designations provided in **Table 1.2**, serves as IPRO's validation and recommendations to the plan regarding this project.

In the plan's final report submission, IBC provided final data for all indicators and tracking measures. For indicator 1, the target was not met, and performance decline was demonstrated. For indicator 2, using the administrative methodology, the target was met, and performance improvement was demonstrated. Some additional updates were included in the Lessons Learned and Follow Up sections. In 2020 interim report, it was noted that MCOs are encouraged to consider the effects of the ongoing COVID-19 health crisis on continued implementation of existing interventions and the impact on indicators through the final stages of this project. This section was revised in the MCO's final submission to include additional explanation and a discussion of COVID-19 in relation to interventions for the year, and the determination was updated from Partially Met to Met. For the final report, the plan noted that external collaboration is needed to develop more aggressive testing initiatives, and the importance of addressing health disparities aggressively. The plan noted movement towards these goals by collaborating with another MCO and revamping its member, provider, and plan initiatives. **Table A.1.1** of the MCO's interventions for the project can be found in the **Appendix** of this report.

The following recommendations were identified during the Final Report review process:

- It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.
- It is recommended that IBC include numerator and denominator descriptions for all intervention tracking measures.
- It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.

Table 1.2: IBC PIP Compliance Assessments – Final Reports

Review Element	Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	Improving Blood Lead Screening Rate in Children 2 Years of Age
Element 1. Project Topic/Rationale	Met	Met
Element 2. Aim	Met	Met
Element 3. Methodology	Partially Met	Met
Element 4. Barrier Analysis	Met	Met
Element 5. Robust Interventions	Partially Met	Partially Met
Element 6. Results Table	Met	Met
Element 7. Discussion and Validity of Reported Improvement	Partially Met	Met

PIP: performance improvement project.

II: Performance Measures and CAHPS Survey

Objectives

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

The MCOs were provided with final specifications for the PA Performance Measures in May 2021. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2021. 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 validation 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. Differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates.

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

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

Table 2.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
PA EQR	Contraceptive Care for All Women (Age 15–20 years): Most/Moderately Effective
PA EQR	Contraceptive Care for All Women (Age 15–20 years): LARC
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most/Moderately Effective—3 days
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most/Moderately Effective—60 days
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—3 days
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—60 days
HEDIS	Pharmacotherapy for Opioid Use Disorder (16–19 years)
Well-Care Visits and Immunizations	
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Percentile (Age 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Percentile (Age 12–17 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Percentile (Total)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Age 3–11 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Age 12–17 years)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Total)
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity (Age 3–11 years)

Source	Measures
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity (Age 12–17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity (Total)
HEDIS	Childhood Immunization Status by Age 2—DTaP
HEDIS	Childhood Immunization Status by Age 2—IPV
HEDIS	Childhood Immunization Status by Age 2—MMR
HEDIS	Childhood Immunization Status by Age 2—HiB
HEDIS	Childhood Immunization Status by Age 2—Hepatitis B
HEDIS	Childhood Immunization Status by Age 2—VZV
HEDIS	Childhood Immunization Status by Age 2—Pneumococcal Conjugate
HEDIS	Childhood Immunization Status by Age 2—Hepatitis A
HEDIS	Childhood Immunization Status by Age 2—Rotavirus
HEDIS	Childhood Immunization Status by Age 2—Influenza
HEDIS	Childhood Immunizations Status by Age 2—Combo 2
HEDIS	Childhood Immunizations Status by Age 2—Combo 3
HEDIS	Childhood Immunizations Status by Age 2—Combo 4
HEDIS	Childhood Immunizations Status by Age 2—Combo 5
HEDIS	Childhood Immunizations Status by Age 2—Combo 6
HEDIS	Childhood Immunizations Status by Age 2—Combo 7
HEDIS	Childhood Immunizations Status by Age 2—Combo 8
HEDIS	Childhood Immunizations Status by Age 2—Combo 9
HEDIS	Childhood Immunizations Status by Age 2—Combo 10
HEDIS	Immunizations for Adolescents—Meningococcal
HEDIS	Immunizations for Adolescents—Tdap
HEDIS	Immunizations for Adolescents—HPV
HEDIS	Immunizations for Adolescents—Combination 1
HEDIS	Immunizations for Adolescents—Combination 2
HEDIS	Well-Child Visits in the First 15 Months of Life (≥ 6 Visits)
HEDIS	Well-Child Visits in the First 30 Months of Life (≥ 2 visits)
HEDIS	Child and Adolescent Well-Care Visits (3-11 years)
HEDIS	Child and Adolescent Well-Care Visits (12-17 years)
HEDIS	Child and Adolescent Well-Care Visits (18-19 years)
HEDIS	Child and Adolescent Well-Care Visits (3-19 years)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Screenings and Follow-up	
HEDIS	Lead Screening in Children (Age 2 years)
HEDIS	Chlamydia Screening in Women (16–20 years)
PA EQR	Developmental Screening in the First Three Years of Life—Total
PA EQR	Developmental Screening in the First Three Years of Life—1 year
PA EQR	Developmental Screening in the First Three Years of Life—2 years
PA EQR	Developmental Screening in the First Three Years of Life—3 years
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD)—Initiation Phase
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase
HEDIS	Follow-up Care After Hospitalization for Mental Illness—7 Days
HEDIS	Follow-up Care After Hospitalization for Mental Illness—30 Days
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (13–17 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (18–19 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (Total)

Source	Measures
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (13–17 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (18–19 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (Total)
Dental Care for Children	
HEDIS	Annual Dental Visit (2–3 Years)
HEDIS	Annual Dental Visit (4–6 Years)
HEDIS	Annual Dental Visit (7–10 Years)
HEDIS	Annual Dental Visit (11–14 Years)
HEDIS	Annual Dental Visit (15–18 Years)
HEDIS	Annual Dental Visit (19 Years)
HEDIS	Annual Dental Visit (Total)
PA EQR	Sealant Receipt on Permanent First Molars (≥ 1 molar)
PA EQR	Sealant Receipt on Permanent First Molars (All 4 molars)
Respiratory Conditions	
HEDIS	Appropriate Testing for Pharyngitis (Ages 3–17 years)
HEDIS	Appropriate Testing for Pharyngitis (Ages 18 years)
HEDIS	Appropriate Testing for Pharyngitis (Total)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (3–17 years)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (18 years)
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total)
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2–19 years)
HEDIS	Asthma Medication Ratio (5–11 years)
HEDIS	Asthma Medication Ratio (12–18 years)
HEDIS	Asthma Medication Ratio (19 years)
HEDIS	Asthma Medication Ratio (Total)
Behavioral Health	
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Total)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (Total)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (Total)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1–11 years)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12–17 years)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)
Utilization	
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages < 1 year)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages 1–9 years)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages 10–19 years)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages < 1-19 years) Total Rate
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages < 1 years)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages 1–9 years)

Source	Measures
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages 10–19 years)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate

Source	Measures
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Maternity/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Maternity Average Length of Stay/1000 Member Months (Ages 10–19 years) Total Rate
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Outpatient (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Outpatient (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Outpatient (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Emergency Department (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Emergency Department (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Emergency Department (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Emergency Department (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Emergency Department (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Emergency Department (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Telehealth (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Telehealth (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Telehealth (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Telehealth (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Telehealth (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Telehealth (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 13–17 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Any Services (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 13–17 years)—Male

Source	Measures
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Inpatient (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 13–17 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Outpatient (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 13–17 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Emergency Department (Ages 13–17 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 0–12 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 0–12 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 0–12 years)—Total Rate
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 13–17 years)—Male
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 13–17 years)—Total Rate

PA: Pennsylvania; EQR: external quality review; HEDIS: Healthcare Effectiveness Data and Information Set.

PA-Specific and CMS Core Set Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS specifications. Measures previously developed and added, as mandated by CMS for children in accordance with the Children’s Health Insurance Program Reauthorization Act (CHIPRA), were continued as applicable to revised CMS specifications. New measures were developed and added in 2021 as mandated in accordance with the Act and with CMS specifications. In 2021, the Sealant Receipt on Permanent First Molars was added. For each indicator, the criteria that were specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed. PA-specific performance measure rates were calculated administratively, which uses only the MCOs data systems to identify numerator positives. The hybrid methodology, which uses a combination of administrative data and medical record review (MRR) to identify numerator “hits” for rate calculation, was not used for the PA-specific performance measures.

PA-Specific and CMS Core Set Administrative Measures

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

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

Sealant Receipt on Permanent First Year Molars —CHIPRA Core Set—New for 2021

This performance measure assesses the percentage of enrolled children who have ever received sealants on permanent first molar teeth and turned 10 years old during the measurement year. Two rates are reported:

- The percentage of enrolled children who received a sealant on at least one permanent first molar in the 48 months prior to their 10th birthday; and
- The percentage of unduplicated enrolled children who received sealants on all four permanent first molars in the 48 months prior to their 10th birthday.

Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits—PA-specific

This performance measure assesses the percentage of children and adolescents, 2 years of age through 19 years of age, with an asthma diagnosis who have ≥ 1 emergency department (ED) visit during the measurement year.

Contraceptive Care for All Women—CHIPRA Core Set

This performance measure assesses the percentage of women ages 15 through 20 years at risk of unintended pregnancy and were provided a most effective/moderately effective contraception method or a long-acting reversible contraception (LARC) method. For the CMS Core measures, two rates are reported: one each for (1) the provision of most/moderately effective contraception, and for (2) the provision of LARC.

Contraceptive Care for Postpartum Women—CHIPRA Core Set

This performance measure assesses the percentage of women ages 15 through 20 years who had a live birth and were provided a most effective/moderately effective contraception method or a long-acting reversible contraception (LARC) method within 3 days and within 60 days of delivery. For the CMS Core measures, four rates are reported: (1) most or moderately effective contraception—3 days, (2) most or moderately effective contraception—60 days, (3) LARC—3 days, and (4) LARC—60 days.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2021. As indicated previously, performance on selected HEDIS measures is included in this year's EQR report. Development of HEDIS measures and the clinical rationale for their inclusion in the HEDIS measurement set can be found in HEDIS MY 2020, Volume 2 Narrative. The measurement year for the HEDIS measures is 2020, as well as prior years for selected measures. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA's requirement for the reporting year. MCOs are required to report the complete set of CHIP measures, as specified in the HEDIS Technical Specifications, Volume 2, which includes using the Medicaid measure specifications. Because CHIP enrollment only includes members up to 19 years old, for each of the required measures, CHIP MCOs report based only on all eligible members up to age 19 as applicable. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.1.H—Child Survey.

Well-Child Visits in the First 30 Months of Life – New for 2021

This measure assesses the percentage of enrollees who turned 30 months old during the measurement year, who were continuously enrolled from 31 days of age through 30 months of age, and who:

- Received six or more well-child visits with a PCP during their first 15 months of life; and
- Received two or more well-child visits with a PCP for age 15 months-30 months of life.

Child and Adolescent Well-Care Visits – New for 2021

This measure assesses the percentage of members 3–19 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Childhood Immunization Status

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 nine separate combination rates.

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

This measure assesses the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN practitioner, and who had evidence of the following during the measurement year:

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

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

Immunization for Adolescents

This measure assessed the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, 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: Meningococcal and Tdap; and
- Combination 2: Meningococcal, Tdap, and HPV.

Lead Screening in Children

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

Follow-up Care for Children Prescribed ADHD Medication

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

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

Follow Up After Hospitalization for Mental Illness

This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within 30 days after discharge; and
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

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

Annual Dental Visit

This measure assesses the percentage of children and adolescents between the ages of 2 and 19 years of age who were continuously enrolled in the MCO for the measurement year who had a dental visit during the measurement year.

Chlamydia Screening in Women

This measure assesses the percentage of women 16–20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Appropriate Testing for Pharyngitis

This measure assesses the percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Appropriate Treatment for Upper Respiratory Infection

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

Asthma Medication Ratio

This measure assesses the percentage of members 5–19 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assesses the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Follow-up After High-Intensity Care for Substance Use Disorder

This measure assesses the percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder.

Pharmacotherapy for Opioid Use Disorder

This measure assessed the percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 years and older with a diagnosis of OUD.

Ambulatory Care

This measure summarizes utilization of ambulatory care in both the Outpatient Visits and Emergency Department Visits categories. Outpatient Visits includes telehealth visits.

Inpatient Utilization

This 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).

Mental Health Utilization

This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year:

- Inpatient;
- Intensive outpatient or partial hospitalization;
- Outpatient;
- Emergency Department;
- Telehealth; and
- Any service.

Identification of Alcohol and Other Drug Services

This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

- Inpatient;
- Intensive outpatient or partial hospitalization;
- Outpatient or medication treatment;
- Emergency Department;
- Telehealth; and
- Any service.

CAHPS Survey

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

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2021 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures.

The Contraceptive Care for All Women and Contraceptive Care for Postpartum Women (CCW; CCP) were first-year measures in 2018 for all CHIP MCOs. In 2021, clarification was added to both specifications to include all paid and suspended claims when reporting these measures. As in prior reporting years, CHIP MCOs saw very small denominators for the Contraceptive Care for Postpartum Women (CCP) measure; thus, rates are not reported for this measure across the plans. In 2019, clarification was added to note that to remain aligned with CMS specifications, the look-back period to search for exclusions is limited to the measurement year. In 2020, this clarification was continued for both Contraceptive Care measures. In 2021, a clarification was included in the CCP specifications that when calculating the number of days postpartum, date of delivery should be used as Day 0.

The Sealant Receipt on Permanent First Year Molars was new for 2021, and replaced the Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk measures, which was retired in 2020. The primary differences between the two measures were: 1) the denominator no longer requires a multiple year lookback to assess risk for any child regardless of Medicaid or CHIP (which required pooling data sources), and 2) the denominator now includes children enrolled with the MCO for 12 months preceding their 10th birthday, with allowable exclusions and numerator hits to be checked for the previous 48 months.

The Developmental Screening in the First Three Years of Life measure was modified in 2018 in order to clarify the age cohorts that are used when reporting for this measure. This clarification noted that children can be screened in the 12 months preceding or on their first, second, or third birthday. Specific timeframes were provided for each age cohort. In

2019, additional clarification was added regarding the time period to be used for each age cohort. Specifically, the member's birthday should fall in one of the following cohorts for each numerator:

- Age Cohort 1: Children who had a claim with a relevant CPT code before or on their first birthday;
- Age Cohort 2: Children who had a claim with a relevant CPT code after their first birthday and before or on their second birthday; and
- Age Cohort 3: Children who had a claim with a relevant CPT code after their second birthday and before or on their third birthday.

In 2020, these changes were continued, and additional change occurred in the reporting of a single numerator for each age cohort using CPT code 96110. The CPT code 96111, used in reporting for the previously reported numerators B and C, was retired in MY 2019. As of 2020, only claims with a 96110 CPT code are counted for this measure.

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

Conclusions and Comparative Findings

MCO results are presented in **Table 2.2** through **Table 2.8**. For each measure, the denominator, numerator, and measurement year rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% confidence interval indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the confidence interval 95 times, or 95% of the time.

Rates for both the measurement year and the previous year are presented, as available (i.e., 2021 [MY 2020] and 2020 [MY 2019]). In addition, statistical comparisons are made between the MY 2020 and MY 2019 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the Z ratio. A Z ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by "+," statistically significant decreases by "-", and no statistically significant change by "n.s."

In addition to each individual MCO rate, the CHIP Medicaid Managed Care (MMC) average for 2021 (MY 2020) is presented. The CHIP MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of difference between the plan's measurement year rate and the CHIP MMC average for the same year. For comparison of MY 2020 rates to CHIP MMC rates, the "+" denotes that the plan rate exceeds the CHIP MMC rate, the "-" denotes that the MMC rate exceeds the plan rate, and "n.s." denotes no statistically significant difference between the two rates. Rates for the CHIP HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

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

Table 2.2 to Table 2.7 show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between the rates as presented in the table.

Graphical representation of findings is provided for a subset of measures with sufficient data to provide informative illustrations to the tables in this section. These graphical representations can be found in the **Appendix**.

As part of IPRO's validation of IBC's Performance Measures and CAHPS Survey results, the following are recommended areas of focus for the plan moving into the next reporting year. Particular attention has been paid to measures that are not only identified as opportunities for the current 2022 review year but were also identified as opportunities or did not show an improvement in rates in 2021.

- It is recommended that IBC improve counseling and assessment of nutrition and physical activity for its members. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity was an opportunity in 2020 for all age cohorts. In 2021, the 12—17 years old group and the Total were again identified as opportunities.
- It is recommended that IBC improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for all age cohorts was an opportunity in 2020 and has been identified as an opportunity again in 2021.
- It is recommended that IBC work to improve satisfaction with their members' healthcare. IBC scored below the MMC weighted average for all four CAHPS elements that assess satisfaction with the child's doctor, specialist, health plan, and health care coverage.

Access to/Availability of Care

No strengths are identified for the 2021 (MY 2020) Access to/Availability of Care performance measures.

Opportunities for improvement are identified for the following 2021 (MY 2020) Access to/Availability of Care performance measures.

- The following rates are statistically significantly below/worse than the 2021 MMC weighted average:
 - Contraceptive Care for All Women (15–20 years): Most or Moderately Effective.

Table 2.2: Access to/Availability of Care

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
PA EQR	Contraceptive Care for All Women (Age 15–20 years): Most or Moderately Effective	2,335	463	19.8%	18.2%	21.5%	22.7%	-	25.4%	-	NA
PA EQR	Contraceptive Care for All Women (Age 15–20 years): LARC	2,335	22	0.9%	0.5%	1.4%	1.4%	n.s.	1.9%	-	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most or moderately effective contraception—3 days	6	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most or moderately effective contraception—60 days	6	5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—3 days	6	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—60 days	6	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (16–19 years)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Well-Care Visits and Immunizations

No strengths are identified for the 2021 (MY 2020) Well-Care Visits and Immunizations performance measures.

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

- The following rates are statistically significantly below/worse than the 2021 MMC weighted average:
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total);
 - Childhood Immunization Status—VZV;
 - Childhood Immunization Status—Pneumococcal Conjugate; and
 - Well-Child Visits in the First 30 Months of Life (15 months ≥ 6 Visits).

Table 2.3: Well-Care Visits and Immunizations

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (3–11 years)	6,092	171	81.4%	80.4%	82.4%	78.8%	+	83.4%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (12–17 years)	5,271	118	75.6%	74.5%	76.8%	78.1%	-	80.7%	-	>= 25th and < 50th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total)	11,363	289	79.0%	78.2%	79.7%	78.5%	+	82.2%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (3–11 years)	6,092	165	78.6%	77.5%	79.6%	71.9%	+	79.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (12–17 years)	5,271	108	69.2%	68.0%	70.5%	75.5%	-	75.4%	-	>= 50th and < 75th percentile

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (Total)	11,363	273	74.6%	73.8%	75.4%	73.4%	+	77.5%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (3–11 years)	6,092	155	73.8%	72.7%	74.9%	62.1%	+	76.1%	-	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (12–17 years)	5,271	106	68.0%	66.7%	69.2%	74.8%	-	75.2%	-	>= 50th and < 75th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (Total)	11,363	261	71.3%	70.5%	72.1%	67.5%	+	75.8%	-	>= 50th and < 75th percentile
HEDIS	Childhood Immunization Status—DTaP	180	148	82.7%	76.9%	88.5%	85.8%	n.s.	87.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status—IPV	180	160	89.4%	84.6%	94.2%	90.8%	n.s.	93.3%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunization Status—MMR	180	159	88.8%	84.0%	93.7%	92.1%	n.s.	92.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunization Status—HiB	180	161	89.9%	85.3%	94.6%	92.5%	n.s.	93.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunization Status—Hepatitis B	180	154	86.0%	80.7%	91.4%	87.9%	n.s.	92.4%	n.s.	>= 25th and < 50th percentile
HEDIS	Childhood Immunization Status—VZV	180	152	84.9%	79.4%	90.4%	91.3%	-	91.9%	-	>= 25th and < 50th percentile
HEDIS	Childhood Immunization Status— Pneumococcal Conjugate	180	146	81.6%	75.6%	87.5%	84.6%	n.s.	88.8%	-	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status—Hepatitis A	180	153	85.5%	80.0%	90.9%	90.0%	n.s.	89.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunization Status—Rotavirus	180	137	76.5%	70.1%	83.0%	77.1%	n.s.	81.8%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status—Influenza	180	119	66.5%	59.3%	73.7%	68.8%	n.s.	64.1%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status— Combination 2	180	142	79.3%	73.1%	85.5%	82.5%	n.s.	83.7%	n.s.	>= 90th percentile

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Childhood Immunization Status—Combination 3	180	136	76.0%	69.5%	82.5%	79.2%	n.s.	82.1%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status—Combination 4	180	135	75.4%	68.9%	82.0%	78.3%	n.s.	79.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status—Combination 5	180	125	69.8%	62.8%	76.8%	69.6%	n.s.	74.6%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status—Combination 6	180	110	61.5%	54.1%	68.8%	62.5%	n.s.	59.0%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status—Combination 7	180	124	69.3%	62.3%	76.3%	68.8%	n.s.	73.0%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status—Combination 8	180	110	61.5%	54.1%	68.8%	61.7%	n.s.	58.0%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status—Combination 9	180	100	55.9%	48.3%	63.4%	55.4%	n.s.	54.0%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status—Combination 10	180	100	55.9%	48.3%	63.4%	54.6%	n.s.	53.3%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents—Meningococcal	1,070	378	92.0%	90.3%	93.6%	94.2%	n.s.	90.9%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents—Tdap	1,070	375	91.2%	89.5%	93.0%	93.9%	n.s.	91.5%	n.s.	>= 75th and < 90th percentile
HEDIS	Immunizations for Adolescents—HPV	1,070	153	37.2%	34.3%	40.2%	39.2%	n.s.	38.4%	n.s.	>= 25th and < 50th percentile
HEDIS	Immunizations for Adolescents—Combination 1	1,070	371	90.3%	88.4%	92.1%	92.7%	n.s.	89.9%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents—Combination 2	1,070	149	36.3%	33.3%	39.2%	36.7%	n.s.	37.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (15 months ≥ 6 Visits)	84	39	46.4%	35.2%	57.7%	72.5%	-	60.3%	-	>= 25th and < 50th percentile
HEDIS	Well-Child Visits in the First 30 Months of Life (15-30 months ≥ 2 Visits)	242	212	87.6%	83.2%	92.0%	N/A	N/A	89.5%	n.s.	>= 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (3—11 years)	7,720	5,224	67.7%	66.6%	68.7%	N/A	N/A	65.8%	+	>= 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (12—17 years)	7,063	4,490	63.6%	62.4%	64.7%	N/A	N/A	62.5%	n.s.	>= 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (18—19 years)	1,145	619	54.1%	51.1%	57.0%	N/A	N/A	51.1%	n.s.	>= 90th percentile
HEDIS	Child and Adolescent Well-Care Visits (Total)	15,928	10,333	64.9%	64.1%	65.6%	N/A	N/A	63.5%	+	>= 90th percentile

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; N/A: not applicable.

EPSDT: Screenings and Follow-up

Strengths are identified for the following 2021 (MY 2020) EPSDT: Screenings and Follow-up performance measures.

- The following rates are statistically significantly above/better than the 2021 MMC weighted average:
 - Chlamydia Screening in Women (16–20 years).

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

- The following rates are statistically significantly below/worse than the 2021 MMC weighted average:
 - Lead Screening in Children (2 years); and
 - Follow Up Care for Children Prescribed ADHD Medication— Initiation Phase.

Table 2.4: EPSDT: Screenings and Follow-up

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Lead Screening in Children (2 years)	180	103	57.5%	50.0%	65.0%	67.5%	-	74.7%	-	>= 10th and < 25th percentile
HEDIS	Chlamydia Screening in Women (16–20 years)	645	289	44.8%	40.9%	48.7%	50.3%	n.s.	37.8%	+	>= 25th and < 50th percentile
PA EQR	Developmental Screening in the First Three Years of Life— Total	696	474	68.1%	64.6%	71.6%	67.8%	n.s.	66.1%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life— 1 year	70	37	52.9%	40.5%	65.3%	58.6%	n.s.	64.6%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life—2 years	187	137	73.3%	66.6%	79.9%	76.8%	n.s.	69.1%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life—3 years	439	300	68.3%	63.9%	72.8%	64.8%	n.s.	64.9%	n.s.	NA
HEDIS	Follow Up Care for Children Prescribed ADHD Medication— Initiation Phase	104	30	28.9%	19.7%	38.0%	43.5%	-	49.0%	-	< 10th percentile
HEDIS	Follow Up Care for Children Prescribed ADHD Medication— Continuation & Maintenance Phase	24	5	N/A	N/A	N/A	54.8%	N/A	71.8%	N/A	< 10th percentile

Indicator		2021 (MY 2020)					Rate Comparison ¹					
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile	
HEDIS	Follow Up After Hospitalization For Mental Illness—7 days	64	37	58.3%	45.5%	71.2%	36.5%	+	55.6%	n.s.	>= 75th and < 90th percentile	
HEDIS	Follow Up After Hospitalization For Mental Illness—30 days	64	43	68.3%	56.2%	80.5%	51.4%	+	75.4%	n.s.	>= 25th and < 50th percentile	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—30 days (13—17 years)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—30 days (18—19 years)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—30 days (Total)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days (13—17 years)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days (18—19 years)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	
HEDIS	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days (Total)	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Dental Care for Children

Strengths are identified for the following 2021 (MY 2020) Dental Care for Children performance measures.

- The following rates are statistically significantly above/better than the 2021 MMC weighted average:
 - Annual Dental Visit (2–3 years);
 - Annual Dental Visit (7–10 years);
 - Annual Dental Visit (11–14 years); and
 - Annual Dental Visit (15–18 years).

No opportunities for improvement are identified for the 2021 (MY 2020) Dental Care for Children performance measures.

Table 2.5: Dental Care for Children

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Annual Dental Visit (2–3 years)	880	431	49.0%	45.6%	52.3%	60.4%	-	35.8%	+	>= 90th percentile
HEDIS	Annual Dental Visit (4–6 years)	1,984	1,382	69.7%	67.6%	71.7%	82.4%	-	61.3%	+	>= 90th percentile
HEDIS	Annual Dental Visit (7–10 years)	4,032	2,802	69.5%	68.1%	70.9%	84.8%	-	62.7%	+	>= 90th percentile
HEDIS	Annual Dental Visit (11–14 years)	4,746	3,115	65.6%	64.3%	67.0%	81.8%	-	60.0%	+	>= 90th percentile
HEDIS	Annual Dental Visit (15–18 years)	4,459	2,462	55.2%	53.7%	56.7%	70.3%	-	51.0%	+	>= 75th and < 90th percentile
HEDIS	Annual Dental Visit (19 years)	84	37	44.1%	32.8%	55.3%	61.2%	-	38.3%	n.s.	>= 90th percentile
HEDIS	Annual Dental Visit (Total)	16,185	10,229	63.2%	62.5%	63.9%	78.3%	-	56.9%	+	>= 90th percentile
PA EQR	Sealant Receipt on Permanent First Molars (≥ 1 Molar)	748	394	52.7%	49.0%	56.3%	N/A	N/A	38.7%	+	NA
PA EQR	Sealant Receipt on Permanent First Molars (All 4 Molars)	748	295	39.4%	35.9%	43.0%	N/A	N/A	26.7%	+	NA

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP 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; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable; PA: Pennsylvania; EQR: external quality review.

Respiratory Conditions

No strengths are identified for the 2021 (MY 2020) Respiratory Conditions performance measures.

Opportunities for improvement are identified for the following 2021 (MY 2020) Respiratory Conditions performance measures.

- The following rates are statistically significantly below/worse than the 2021 MMC weighted average:
 - Asthma Medication Ratio (5–11 years); and
 - Asthma Medication Ratio (Total).

Table 2.6: Respiratory Conditions

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis (3–17 years)	910	793	87.1%	84.9%	89.4%	91.0%	n.s.	86.7%	n.s.	>= 75th and < 90th percentile

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis (18 years)	36	28	77.8%	62.8%	92.7%	74.0%	n.s.	72.9%	n.s.	>= 90th percentile
HEDIS	Appropriate Testing for Children with Pharyngitis (Total)	946	821	86.8%	84.6%	89.0%	90.3%	n.s.	86.2%	n.s.	>= 90th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (3–17 years)	2,008	103	94.9%	93.9%	95.9%	95.0%	n.s.	93.5%	+	>= 75th and < 90th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (18 years)	56	7	87.5%	77.9%	97.1%	81.1%	n.s.	87.5%	n.s.	>= 75th and < 90th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (Total)	2,064	110	94.7%	93.7%	95.7%	94.7%	n.s.	93.3%	+	>= 90th percentile
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2–19 years)	989	85	8.6%	6.8%	10.4%	9.4%	n.s.	7.1%	n.s.	NA
HEDIS	Asthma Medication Ratio (5–11 years)	124	80	64.5%	55.7%	73.3%	56.9%	n.s.	81.3%	-	< 10th percentile
HEDIS	Asthma Medication Ratio (12–18 years)	151	99	65.6%	57.6%	73.5%	57.5%	n.s.	71.2%	n.s.	>= 25th and < 50th percentile
HEDIS	Asthma Medication Ratio (19 years)	1	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	>= 90th percentile
HEDIS	Asthma Medication Ratio (Total)	276	180	65.2%	59.4%	71.0%	57.2%	+	76.1%	-	>= 50th and < 75th percentile

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Behavioral Health

No strengths are identified for 2021 (MY 2020) Behavioral Health performance measures.

No opportunities for improvement are identified for 2021 (MY 2020) Behavioral Health performance measures.

Table 2.7: Behavioral Health

Indicator		2021 (MY 2020)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (1—11 years)	5	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	>= 50th and < 75th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (12—17 years)	16	8	N/A	N/A	N/A	N/A	N/A	53.7%	N/A	>= 25th and < 50th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Total)	21	10	N/A	N/A	N/A	N/A	N/A	57.4%	N/A	>= 25th and < 50th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics— Cholesterol (1—11 years)	5	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	>= 75th and < 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics— Cholesterol (12—17 years)	16	4	N/A	N/A	N/A	N/A	N/A	24.1%	N/A	>= 10th and < 25th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Cholesterol (Total)	21	6	N/A	N/A	N/A	N/A	N/A	34.9%	N/A	>= 25th and < 50th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics— Blood Glucose & Cholesterol (1—11 years)	5	2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	>= 75th and < 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose & Cholesterol (12-17 Years)	16	4	N/A	N/A	N/A	33.3%	N/A	22.2%	N/A	>= 10th and < 25th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (Total)	21	6	N/A	N/A	N/A	30.8%	N/A	31.8%	N/A	>= 25th and < 50th percentile

Indicator		2021 (MY 2020)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1—11 years)	3	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	>= 10th and < 25th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12—17 years)	10	6	N/A	N/A	N/A	N/A	N/A	71.7%	N/A	>= 25th and < 50th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	13	7	N/A	N/A	N/A	N/A	N/A	67.3%	N/A	>= 25th and < 50th percentile

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; 2021 Rate N/A: not applicable, as denominator is less than 30; N/A: not applicable.

Utilization

No strengths are identified for the 2021 (MY 2020) Utilization performance measures.

Opportunities for improvement are identified for the following Utilization measures:

- The following rates are statistically significantly below/worse than the 2021 MMC weighted average:
 - AMBA: Outpatient Visits/1000 MM Ages <1 year;
 - AMBA: Outpatient Visits/1000 MM Ages 1— 9 years;
 - AMBA: Outpatient Visits/1000 MM Ages 10—19 years;
 - AMBA: Outpatient Visits/1000 MM Ages <1—19 years Total Rate; and
 - AMBA: Emergency Department Visits/1000 MM Ages <1 year.

Table 2.8: Utilization

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages <1 year	1,744	997	571.67	N/A	N/A	669.78	-	613.82	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 1— 9 years	105,370	16,519	156.77	N/A	N/A	209.83	-	198.85	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 10—19 years	155,268	22,190	142.91	N/A	N/A	177.85	-	187.19	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages <1—19 years Total Rate	262,394	39,708	151.33	N/A	N/A	193.87	-	195.78	-	>= 90th percentile

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages <1 year	1,744	28	16.06	N/A	N/A	36.02	-	23.50	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 1—9 years	105,370	1,658	15.74	N/A	N/A	27.37	-	16.36	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 10—19 years	155,268	2,076	13.37	N/A	N/A	22.37	-	15.35	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages <1—19 years Total Rate	262,394	3,764	14.34	N/A	N/A	24.52	-	15.85	-	>= 90th percentile
HEDIS	IPIUA: Total Discharges/1000 MM Ages <1 year	1,744	0	0.00	0.0%	0.0%	2.67	-			NA
HEDIS	IPIUA: Total Discharges/1000 MM Ages 1—9 years	105,370	64	0.61	60.7%	61.3%	1.14	-			NA
HEDIS	IPIUA: Total Discharges/1000 MM Ages 10—19 years	155,268	142	0.91	90.9%	91.1%	0.92	-			NA
HEDIS	IPIUA: Total Discharges/1000 MM Ages <1—19 years Total Rate	262,394	206	0.79	78.8%	79.2%	1.02	-			NA
HEDIS	IPIUA: Total Inpatient ALOS Ages <1 year	0	0	-	N/A	N/A	1.75	N/A			NA
HEDIS	IPIUA: Total Inpatient ALOS Ages 1—9 Years	64	179	2.80	N/A	N/A	2.53	N/A			NA
HEDIS	IPIUA: Total Inpatient ALOS Ages 10—19 years	142	413	2.91	N/A	N/A	3.06	N/A			NA
HEDIS	IPIUA: Total Inpatient ALOS Ages <1—19 years Total Rate	206	592	2.87	N/A	N/A	2.80	N/A			NA
HEDIS	IPIUA: Surgery Discharges/1000 MM Ages <1 year	1,744	0	0.00	0.0%	0.0%	0.67	-			NA
HEDIS	IPIUA: Surgery Discharges/1000 MM Ages 1—9 years	105,370	13	0.12	11.8%	12.2%	0.29	-			NA
HEDIS	IPIUA: Surgery Discharges/1000 MM Ages 10—19 years	155,268	40	0.26	25.8%	26.2%	0.32	-			NA
HEDIS	IPIUA: Surgery Discharges/1000 MM Ages <1—19 years Total Rate	262,394	53	0.20	19.8%	20.2%	0.31	-			NA
HEDIS	IPIUA: Surgery ALOS Ages <1 year	0	0	-	N/A	N/A	3.00	N/A			NA
HEDIS	IPIUA: Surgery ALOS Ages 1—9 years	13	55	4.23	N/A	N/A	4.06	N/A			NA
HEDIS	IPIUA: Surgery ALOS Ages 10—19 years	40	125	3.13	N/A	N/A	3.98	N/A			NA

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	IPIUA: Surgery ALOS Ages <1—19 years Total Rate	53	180	3.40	N/A	N/A	4.00	N/A			NA
HEDIS	IPIUA: Medicine Discharges/1000 MM Ages <1 year	1,744	0	0.00	0.0%	0.0%	2.00	-			NA
HEDIS	IPIUA: Medicine Discharges/1000 MM Ages 1—9 years	105,370	51	0.48	47.7%	48.3%	0.85	-			NA
HEDIS	IPIUA: Medicine Discharges/1000 MM Ages 10—19 years	155,268	93	0.60	59.8%	60.2%	0.54	-			NA
HEDIS	IPIUA: Medicine Discharges/1000 MM Ages <1—19 years Total Rate	262,394	144	0.55	54.8%	55.2%	0.67	-			NA
HEDIS	IPIUA: Medicine ALOS Ages <1 year	0	0	-	N/A	N/A	1.33	N/A			NA
HEDIS	IPIUA: Medicine ALOS Ages 1—9 years	51	124	2.43	N/A	N/A	2.01	N/A			NA
HEDIS	IPIUA: Medicine ALOS Ages 10—19 years	93	268	2.88	N/A	N/A	2.58	N/A			NA
HEDIS	IPIUA: Medicine ALOS Ages <1—19 years Total Rate	144	392	2.72	N/A	N/A	2.26	N/A			NA
HEDIS	IPIUA: Maternity/1000 MM Ages 10—19 years	155,268	9	0.06	5.9%	6.1%	0.06	-			NA
HEDIS	IPIUA: Maternity ALOS Ages 10—19 years Total Rate	9	20	2.22	N/A	N/A	2.60	N/A			NA
HEDIS	MPT: Any Services Ages 0—12 years—Male	81,114	270	3.99%	3.9%	4.1%	6.43%	-			NA
HEDIS	MPT: Any Services MM Ages 0—12 years—Female	79,026	208	3.16%	3.0%	3.3%	4.36%	-			NA
HEDIS	MPT: Any Services Ages 0—12 years—Total Rate	160,140	478	3.58%	3.5%	3.7%	5.41%	-			NA
HEDIS	MPT: Any Services Ages 13—17 years—Male	42,777	228	6.40%	6.2%	6.6%	7.99%	-			NA
HEDIS	MPT: Any Services Ages 13—17 years—Female	44,303	398	10.78%	10.5%	11.1%	11.92%	-			NA
HEDIS	MPT: Any Services Ages 13—17 years—Total Rate	87,080	626	8.63%	8.4%	8.8%	9.99%	-			NA
HEDIS	MPT: Inpatient Ages 0—12 years—Male	81,114	2	0.03%	0.0%	0.0%	0.11%	-			NA
HEDIS	MPT: Inpatient Ages 0—12 years—Female	79,026	7	0.11%	0.1%	0.1%	0.09%	-			NA

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	MPT: Inpatient Ages 0—12 years—Total Rate	160,140	9	0.07%	0.1%	0.1%	0.10%	-			NA
HEDIS	MPT: Inpatient Ages 13—17 years—Male	42,777	16	0.45%	0.4%	0.5%	0.63%	-			NA
HEDIS	MPT: Inpatient Ages 13—17 years—Female	44,303	40	1.08%	1.0%	1.2%	1.16%	-			NA
HEDIS	MPT: Inpatient Ages 13—17 years—Total Rate	87,080	56	0.77%	0.7%	0.8%	0.90%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Male	81,114	5	0.07%	0.1%	0.1%	0.27%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Female	79,026	12	0.18%	0.1%	0.2%	0.06%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Total Rate	160,140	17	0.13%	0.1%	0.1%	0.17%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Male	42,777	14	0.39%	0.3%	0.5%	0.69%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Female	44,303	31	0.84%	0.8%	0.9%	1.46%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Total Rate	87,080	45	0.62%	0.6%	0.7%	1.08%	-			NA
HEDIS	MPT: Outpatient Ages 0—12 years—Male	81,114	212	3.14%	3.0%	3.3%	6.30%	-			NA
HEDIS	MPT: Outpatient Ages 0—12 years—Female	79,026	140	2.13%	2.0%	2.2%	4.30%	-			NA
HEDIS	MPT: Outpatient Ages 0—12 years—Total Rate	160,140	352	2.64%	2.6%	2.7%	5.32%	-			NA
HEDIS	MPT: Outpatient Ages 13—17 years—Male	42,777	172	4.83%	4.6%	5.0%	7.64%	-			NA
HEDIS	MPT: Outpatient Ages 13—17 years—Female	44,303	281	7.61%	7.4%	7.9%	11.40%	-			NA
HEDIS	MPT: Outpatient Ages 13—17 years—Total Rate	87,080	453	6.24%	6.1%	6.4%	9.56%	-			NA

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	MPT: ED Ages 0—12 years—Male	81,114	1	0.01%	0.0%	0.0%	0.00%	n.s.			NA
HEDIS	MPT: ED Ages 0—12 years—Female	79,026	0	0.00%	0.0%	0.0%	0.01%	-			NA
HEDIS	MPT: ED Ages 0—12 years—Total Rate	160,140	1	0.01%	0.0%	0.0%	0.01%	-			NA
HEDIS	MPT: ED Ages 13—17 years—Male	42,777	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	MPT: ED Ages 13—17 years—Female	44,303	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	MPT: ED Ages 13—17 years—Total Rate	87,080	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	MPT: Telehealth Ages 0—12 years—Male	81,114	142	2.10%	2.0%	2.2%	0.00%	+			NA
HEDIS	MPT: Telehealth Ages 0—12 years—Female	79,026	125	1.90%	1.8%	2.0%	0.00%	+			NA
HEDIS	MPT: Telehealth Ages 0—12 years—Total Rate	160,140	267	2.00%	1.9%	2.1%	0.00%	+			NA
HEDIS	MPT: Telehealth Ages 13—17 years—Male	42,777	131	3.67%	3.5%	3.8%	0.00%	+			NA
HEDIS	MPT: Telehealth Ages 13—17 years—Female	44,303	248	6.72%	6.5%	7.0%	0.00%	+			NA
HEDIS	MPT: Telehealth Ages 13—17 years—Total Rate	87,080	379	5.22%	5.1%	5.4%	0.00%	+			NA
HEDIS	IAD: Any Services Ages 0—12 years—Male	81,114	2	0.03%	0.0%	0.0%	0.00%	n.s.			NA
HEDIS	IAD: Any Services Ages 0—12 years—Female	79,026	3	0.05%	0.0%	0.1%	0.01%	-			NA
HEDIS	IAD: Any Services Ages 0—12 years—Total Rate	160,140	5	0.04%	0.0%	0.1%	0.01%	-			NA
HEDIS	IAD: Any Services Ages 13—17 years—Male	42,777	33	0.93%	0.8%	1.0%	1.15%	-			NA
HEDIS	IAD: Any Services Ages 13—17 years—Female	44,303	25	0.68%	0.6%	0.8%	0.69%	-			NA
HEDIS	IAD: Any Services Ages 13—17 years—Total Rate	87,080	58	0.80%	0.7%	0.9%	0.91%	-			NA
HEDIS	IAD: Inpatient Ages 0—12 years—Male	81,114	1	0.01%	0.0%	0.0%	0.00%	n.s.			NA
HEDIS	IAD: Inpatient Ages 0—12 years—Female	79,026	1	0.02%	0.0%	0.0%	0.00%	n.s.			NA

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	IAD: Inpatient Ages 0—12 years—Total Rate	160,140	2	0.01%	0.0%	0.0%	0.00%	n.s.			NA
HEDIS	IAD: Inpatient Ages 13—17 years—Male	42,777	6	0.17%	0.1%	0.2%	0.20%	-			NA
HEDIS	IAD: Inpatient Ages 13—17 years—Female	44,303	5	0.14%	0.1%	0.2%	0.17%	-			NA
HEDIS	IAD: Inpatient Ages 13—17 years—Total Rate	87,080	11	0.15%	0.1%	0.2%	0.18%	-			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Male	81,114	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Female	79,026	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Total Rate	160,140	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Male	42,777	4	0.11%	0.1%	0.1%	0.11%	-			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Female	44,303	1	0.03%	0.0%	0.0%	0.11%	-			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Total Rate	87,080	5	0.07%	0.1%	0.1%	0.11%	-			NA
HEDIS	IAD: Outpatient Ages 0—12 years—Male	81,114	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Outpatient Ages 0—12 years—Female	79,026	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Outpatient Ages 0—12 years—Total Rate	160,140	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Outpatient Ages 13—17 years—Male	42,777	18	0.50%	0.4%	0.6%	0.60%	-			NA
HEDIS	IAD: Outpatient Ages 13—17 years—Female	44,303	5	0.14%	0.1%	0.2%	0.28%	-			NA
HEDIS	IAD: Outpatient Ages 13—17 years—Total Rate	87,080	23	0.03%	0.0%	0.0%	0.44%	-			NA

Indicator		2021 (MY 2020)					Rate Comparison ¹				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2020 (MY 2019) Rate	2021 Rate Compared to 2020	MMC	2021 Rate Compared to MMC	HEDIS 2021 Percentile
HEDIS	IAD: ED Ages 0—12 years—Male	81,114	1	0.01%	0.0%	0.0%	0.00%	n.s.			NA
HEDIS	IAD: ED Ages 0—12 years—Female	79,026	2	0.03%	0.0%	0.0%	0.01%	-			NA
HEDIS	IAD: ED Ages 0—12 years—Total Rate	160,140	3	0.02%	0.0%	0.0%	0.01%	-			NA
HEDIS	IAD: ED Ages 13—17 years—Male	42,777	10	0.28%	0.2%	0.3%	0.54%	-			NA
HEDIS	IAD: ED Ages 13—17 years—Female	44,303	13	0.35%	0.3%	0.4%	0.28%	-			NA
HEDIS	IAD: ED Ages 13—17 years—Total Rate	87,080	23	0.32%	0.3%	0.4%	0.41%	-			NA
HEDIS	IAD: Telehealth Ages 0—12 years—Male	81,114	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Telehealth Ages 0—12 years—Female	79,026	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Telehealth Ages 0—12 years—Total Rate	160,140	0	0.00%	0.0%	0.0%	0.00%	N/A			NA
HEDIS	IAD: Telehealth Ages 13—17 years—Male	42,777	4	0.11%	0.1%	0.1%	0.00%	+			NA
HEDIS	IAD: Telehealth Ages 13—17 years—Female	44,303	5	0.14%	0.1%	0.2%	0.00%	+			NA
HEDIS	IAD: Telehealth Ages 13—17 years—Total Rate	87,080	9	0.12%	0.1%	0.1%	0.00%	+			NA

¹ For comparison of MY 2020 rates to MY 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.” For comparison of MY 2020 rates to CHIP MMC rates, the “+” denotes that the plan rate exceeds the CHIP MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates. Gray shading indicates IPRO does not provide or calculate these rates. Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

Table 2.9 provides the survey results of four composite questions by two specific categories for the MCO across the last 3 measurement years, as available. The composite questions target the MCO's performance strengths as well as opportunities for improvement.

Indicators from the survey chosen for reporting here include those that measure satisfaction as well as those that highlight the supplemental questions in the survey that cover mental health.

Due to differences in the CAHPS submissions from year to year, direct comparisons of results are not always available. Questions that are not included in the most recent survey version are not presented in **Table 2.9**.

MY 2020 Child CAHPS 5.1H Survey Results

Table 2.9: CAHPS MY 2020 Child Survey Results

Survey Section/Measure	2021 (MY 2020)	2021 Rate Compared to 2020	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2021 MMC Weighted Average
Satisfaction with Child's Care						
Satisfaction with your child's current personal doctor (Rating of 8–10)	87.80%	▼	94.74%	▲	90.46%	91.09%
Satisfaction with specialist (Rating of 8–10)	86.00%	▼	88.61%	▲	82.43%	88.22%
Satisfaction with health plan (Rating of 8–10) (Satisfaction with child's plan)	85.44%	▼	89.34%	▲	88.12%	87.29%
Satisfaction with child's health care (Rating of 8–10)	83.75%	▼	91.27%	▲	89.34%	90.78%
Quality of Mental Health Care						
Received care for child's mental health from any provider? (Usually or Always)	8.62%	▼	14.52%	▲	6.42%	11.23%
Easy to get needed mental health care? (Usually or Always)	8.01%	▼	11.82%	▲	8.64%	9.15%
Provider you would contact for mental health services? (PCP)	59.63%	▼	64.98%	▼	66.56%	65.87%
Child's overall mental or emotional health? (Very good or Excellent)	77.05%	▼	83.69%	▲	82.76%	76.42%

▲ ▼ = Performance increased (▲) or decreased (▼) compared to prior year's rate.

Gray shaded boxes reflect rates above the MY 2020 MMC Weighted Average.

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; MMC: Medicaid Managed Care; PCP: primary care provider.

III: Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

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

The SMART items are a comprehensive set of monitoring items that have been developed by PA DHS from the managed care regulations. PA CHIP staff reviews SMART items on an ongoing basis for each CHIP MCO as part of their compliance review. These items vary in review periodicity as determined by CHIP and reviews typically occur annually or as needed.

Prior to the audit, CHIP MCOs provide documents to CHIP for review, which address various areas of compliance. This includes training materials, provider manuals, MCO organization charts, policy and procedure manuals, and geo access maps. These items are also used to assess the MCOs overall operational, fiscal, and programmatic activities to ensure compliance with contractual obligations. Federal and state law require that CHIP conduct monitoring and oversight of its MCOs. For the current review year, reviews were performed virtually due to the public health emergency.

Throughout the audit, these areas of compliance are discussed with the MCO and clarifying information is provided, where possible. Discussions that occur are compiled along with the reviewed documentation to provide a final determination of compliance, partial compliance, or non-compliance for each section.

Description of Data Obtained

The documents used by IPRO for the current review include the SMART database findings completed by PA CHIP staff as of December 31, 2020 for Review Year (RY) 2020. Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on CHIP's on-site review findings. Beginning in 2020, findings are reported by IPRO using the SMART database completed by PA CHIP staff. The SMART items provide the information necessary for this review. The SMART items and their associated review findings for this year are maintained in a database. The SMART database has been maintained internally at DHS CHIP since Review Year (RY) 2019 and will continue going forward for future review years. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 44 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations.

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 that were updated in 2016 and finalized in late 2019. These requirements are described in the CMS EQR Protocol: *Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the subparts in the BBA regulations explained in the Protocol, i.e., Subpart D – MCO, Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) Standards and Subpart E – Quality Measurement and Improvement.

The crosswalk links SMART items to specific provisions of the regulations, where possible. **Table 3.1** provides a count of items linked to each standard designated in the protocols as subject to compliance review. The **Appendix** lists all standards that can be included in compliance review, either directly through one of the 11 required standards below or indirectly through interaction with Subparts D and E.

Table 3.1: SMART Items Count per Regulation

BBA Regulation	CHIP Citation	SMART Items
Subpart D: MCO, PIHP and PAHP Standards		
Availability of services	457.1230(a)	3
Assurances of adequate capacity and services	457.1230(b)	1
Coordination and continuity of care	457.1230(c)	2
Coverage and authorization of services	457.1230(d)	2
Provider selection	457.1233(a)	2
Confidentiality	457.1230(c)	1
Grievance systems	457.1260	23
Subcontractual relationships and delegation	457.1233(b)	2
Practice guidelines	457.1233(c)	2
Health information systems	457.1233(d)	1
Subpart E: Quality Measurement and Improvement		
Quality assessment and performance improvement program	457.1240(b)	5

¹ Per CMS guidelines and protocols, this regulation is typically referred to as “Grievance and appeals systems.” However, to better align with the CHIP reference for 457.1260, it is referred to in this report as “Grievance systems.”

SMART: Systematic Monitoring, Access and Retrieval Technology; BBA: Balanced Budget Act; CHIP: Children’s Health Insurance Program; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.

Determination of Compliance

As mentioned above, historically the information necessary for the review was provided through an on-site review that was conducted by DHS CHIP. Beginning with CHIP’s adoption of the SMART database in 2020, this database is now used to determine an MCO’s compliance on individual provisions. This process was done by referring to CMS’s “Regulations for Compliance Review”, where specific CHIP citations are noted as required for review and corresponding sections are identified and described for each Subpart, particularly D and E. IPRO then grouped the monitoring standards by provision and evaluated the MCO’s compliance status with regard to the SMART Items. For example, all provisions relating to availability of services are summarized under Availability of Service 457.1230(a).

Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS CHIP. If an item was not evaluated for a particular MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all items were Compliant, the MCO was evaluated as Compliant. If some were Compliant and some were non-Compliant, the MCO was evaluated as partially-Compliant. If all items were non-Compliant, the MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

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

Findings

A total of 44 items were directly associated with a regulation subject to compliance review and 42 were evaluated for the MCO in Review Year (RY) 2020.

Subpart D: MCO, PIHP and PAHP Standards

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

Table 3.2: MCO Compliance with Enrollee Rights and Protections Regulations

MCO, PIHP AND PAHP STANDARDS		
Subpart D: Categories	Compliance	Comments
Availability of services	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2020.
Assurances of adequate capacity and services	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Coordination and continuity of care	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Coverage and authorization of services	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Provider selection	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Confidentiality	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Grievance systems	Compliant	23 items were crosswalked to this category. The MCO was evaluated against 23 items and was compliant on 23 items based on RY 2020.
Subcontractual relationships and delegation	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.
Practice guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2020.
Health information systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2020.

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

Subpart E: Quality Measurement and Improvement

The general purpose of the regulations included under this heading is to ensure that each contracting MCO implements and maintains a quality assessment and performance improvement program as required by the State. This includes implementing an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.

Table 3.3: MCO Compliance with Quality Assessment and Performance Improvement Regulations

QUALITY MEASUREMENT AND IMPROVEMENT		
Subpart E: Categories	Compliance	Comments
Quality assessment and performance improvement program (QAPI)	Compliant	5 items were crosswalked to this category. The MCO was evaluated against 5 items and was compliant on 5 items based on RY 2020.

MCO: managed care organization; RY: reporting year.

IV: MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include “an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year’s EQR.” **Table 4.1** displays the MCO’s opportunities as well as IPRO’s assessment of their responses. The detailed responses are included in the embedded Word document. In addition to the opportunities identified from the EQR, DHS also required MCOs to develop a root cause analysis around select P4P indicators.

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each CHIP MCO has addressed the opportunities for improvement made by IPRO in the 2020 EQR Technical Reports, which were distributed May 2021. The 2021 EQR is the third to include descriptions of current and proposed interventions from each CHIP MCO that address the prior year reports’ recommendations.

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

- Follow-up actions that the MCO has taken through June 30, 2021 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 2021, as well as any additional relevant documentation provided by IBC.

The embedded Word document presents IBC’s responses to opportunities for improvement cited by IPRO in the 2020 EQR Technical Report, detailing current and proposed interventions.



IBC 2020 Opps
Response Request F

IBC Response to Previous EQR Recommendations

Table 4.1 displays IBC’s progress related to the *2020 External Quality Review Report*, as well as IPRO’s assessment of IBC’s response.

Table 4.1: IBC Response to Previous EQR Recommendations

Recommendation for IBC	IPRO Assessment of MCO Response ¹
Improve Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective	Remains an opportunity for improvement
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (12–17 years)	Remains an opportunity for improvement

Recommendation for IBC	IPRO Assessment of MCO Response ¹
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total)	Partially addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Total)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (3–11 years)	Addressed
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (12–17 years)	Remains an opportunity for improvement
Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total)	Partially addressed
Improve Well–Child Visits in the first 15 Months of Life (6 or more visits)	Measure retired
Improve Follow Up After Hospitalization For Mental Illness – 7 days	Addressed
Improve Follow Up After Hospitalization For Mental Illness – 30 days	Addressed
Improve Asthma Medication Ratio – 5 – 11 years	Partially addressed
Improve Asthma Medication Ratio – 12 – 18 years	Addressed
Improve Asthma Medication Ratio – Total	Partially addressed
Improve AMBA: Outpatient Visits/1000 MM Ages <1 year	Remains an opportunity for improvement
Improve AMBA: Outpatient Visits/1000 MM Ages 1 – 9 years	Remains an opportunity for improvement
Improve AMBA: Outpatient Visits/1000 MM Ages 10 – 19 years	Remains an opportunity for improvement
Improve AMBA: Outpatient Visits/1000 MM Ages <1 – 19 years Total Rate	Remains an opportunity for improvement
Improve AMBA: Emergency Department Visits/1000 MM Ages 1 – 9 years	Partially addressed
Improve AMBA: Emergency Department Visits/1000 MM Ages 10 – 19 years	Partially addressed
Improve AMBA: Emergency Department Visits/1000 MM Ages <1 – 19 years Total Rate	Partially addressed

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

V: MCO Strengths and Opportunities for Improvement and EQR Recommendations

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

Strengths

- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2021 (MY 2020) on the following measures:
 - Chlamydia Screening in Women (16–20 years);
 - Annual Dental Visit (2–3 years);
 - Annual Dental Visit (7–10 years);
 - Annual Dental Visit (11–14 years); and
 - Annual Dental Visit (15–18 years).
- IBC was found to be fully compliant on all contracts and with state and federal managed care regulations reviewed.

Opportunities for Improvement

- IBC was found to be partially compliant on three elements reviewed for the Developmental Screening PIP: Element 3. Methodology, Element 5. Robust Interventions, and Element 7. Discussion and Validity of Reported Improvement. IBC was found to be partially compliant on one element reviewed for the Lead Screening PIP: Element 5. Robust Interventions.
- The MCO's performance was statistically significantly below/worse than the MMC rate in 2021 (MY 2020) as indicated by the following measures:
 - Contraceptive Care for All Women (15–20 years): Most or Moderately Effective;
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (12–17 years);
 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total);
 - Childhood Immunization Status—VZV;
 - Childhood Immunization Status—Pneumococcal Conjugate;
 - Well-Child Visits in the First 30 Months of Life (15 months \geq 6 Visits);
 - Lead Screening in Children (2 years);
 - Follow Up Care for Children Prescribed ADHD Medication— Initiation Phase;
 - Asthma Medication Ratio (5–11 years);
 - Asthma Medication Ratio (Total);
 - AMBA: Outpatient Visits/1000 MM Ages <1 year;
 - AMBA: Outpatient Visits/1000 MM Ages 1– 9 years;
 - AMBA: Outpatient Visits/1000 MM Ages 10–19 years;
 - AMBA: Outpatient Visits/1000 MM Ages <1–19 years Total Rate; and
 - AMBA: Emergency Department Visits/1000 MM Ages <1 year.

Table 5.1: EQR Recommendations

Measure/Project	IPRO's Recommendation	Standards
Performance Improvement Projects (PIPs)		
Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years	It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.	Quality
	It is recommended that the MCO include numerator and denominator descriptions for all intervention tracking measures.	Quality
	It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.	Quality
Improving Blood Lead Screening Rate in Children 2 Years of Age	It is recommended that the MCO utilize as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project for the given year.	Quality
	It is recommended that the MCO include numerator and denominator descriptions for all intervention tracking measures.	Quality
	It is recommended that the MCO include confirmation that no additional changes were planned at the conclusion of the PIP, as none were included in their final Discussion and Next Steps sections.	Quality
Performance Measures and CAHPS Survey		
Weight Assessment and Counseling	It is recommended that the MCO improve counseling and assessment of nutrition and physical activity for its members. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity was an opportunity in 2020 for all age cohorts. In 2021, the 12—17 years old group and the Total were again identified as opportunities.	Timeliness
Ambulatory Care Outpatient Visits	It is recommended that the MCO improve outpatient visits related to ambulatory care for their population. Ambulatory Care: Outpatient Visits for all age cohorts was an opportunity in 2020 and has been identified as an opportunity again in 2021.	Quality
Healthcare Satisfaction	It is recommended that the MCO work to improve satisfaction with their members' healthcare. IBC scored below the MMC weighted average for all four CAHPS elements that assess satisfaction with the child's doctor, specialist, health plan, and health care coverage.	Quality
Compliance with Medicaid and CHIP Managed Care Regulations		
There are no recommendations related to compliance with Medicaid and CHIP Managed Care Regulations for the MCO for the current review year.		N/A

EQR: external quality review; PIP: performance improvement project; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; N/A: not applicable.

VI: Summary of Activities

Performance Improvement Projects

- IBC's Lead Screening and Developmental Screening PIP 2021 Final Reports were both validated. The MCO received feedback and subsequent information related to these activities from IPRO and CHIP in 2022.

Performance Measures

- IBC reported all HEDIS, PA-Specific, and CAHPS Survey performance measures in 2021 for which the MCO had a sufficient denominator.

Structure and Operations Standards

- IBC was found to be fully compliant on all subparts. Items that were not reviewed for 2021 will be reviewed during the 2022 review cycle. Compliance review findings from the RY 2021 SMART database populated by PA CHIP were used to make the determinations for IBC.

2020 Opportunities for Improvement MCO Response

- IBC provided a response to the opportunities for improvement issued in the 2020 annual technical report for those measures that were identified as statistically significantly below or worse than the MMC weighted average.

2021 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for IBC in 2021. A response will be required by the MCO for the noted opportunities for improvement in 2022.

Appendix

A.1.1. Performance Improvement Project Interventions

As referenced in **Section I: Validation of Performance Improvement Projects**, **Table A.1.1** lists all of the interventions outlined in the MCO's most recent PIP submission for the review year.

Table A.1.1: PIP Interventions

Summary of Interventions
Independence Blue Cross (IBC) – Developmental Screening
1. Increase the percent of members who receive developmental screening by age 3 by 5 percentage points
2. Increase the percent of members who receive Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) by 3 percentage points
3. Increase the percent of members who receive developmental screening by age 3 by 5 percentage points
4. Increase the percent of members who receive Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) by 3 percentage points
5. Increase the percent of members who receive Child and Adolescent Well-Care Visits (WCV). This newly combined HEDIS measure of 2020 will serve as baseline
Independence Blue Cross (IBC) – Lead Screening
1. Provide gap list to KHPE practitioners with Keystone HMO CHIP members aged 2 with no claims evidence of a lead test
2. Provide gap list to KHPE practitioners with Keystone HMO CHIP members who have no claims evidence for this service (reports provided electronically on a monthly basis)

PIP: performance improvement project.

A.2.1. Comprehensive Compliance Standards List

Revised CMS protocols include updates to the structure and compliance standards, including which standards are required for compliance review. Under the most recent protocols, there are 11 standards that CMS has now 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. **Table A.2.1** lists the standards in the updated protocol, designated as one of the 11 required standards or one of those deemed as a related standard.

Table A.2.1: Required and Related Structure and Compliance Standards

BBA Regulation	Required	Related
Subpart C: Enrollee Rights and Protections		
Enrollee Rights		✓
Provider-Enrollee Communication		✓
Marketing Activities		✓
Emergency and Post-Stabilization Services – Definition		✓
Emergency Services: Coverage and Payment		✓
Subpart D: MCO, PIHP and PAHP Standards		
Availability of Services	✓	
Assurances of adequate capacity and services	✓	
Coordination and Continuity of Care	✓	
Coverage and Authorization of Services	✓	
Provider Selection	✓	
Provider Discrimination Prohibited		✓

BBA Regulation	Required	Related
Confidentiality	✓	
Enrollment and Disenrollment		✓
Grievance and appeal Systems	✓	
Subcontractual Relationships and Delegations	✓	
Practice Guidelines	✓	
Health Information Systems	✓	
Subpart E: Quality Measurement and Improvement; External Quality Review		
Quality assessment and performance improvement program (QAPI)	✓	
Subpart F: Grievance and Appeal System		
General Requirements		✓
Notice of Action		✓
Handling of Grievances and Appeals		✓
Resolution and Notification		✓
Expedited Resolution		✓
Information to Providers and Subcontractors		✓
Recordkeeping and Recording		✓
Continuation of Benefits Pending Appeal and State Fair Hearings		✓
Effectuation of Reversed Resolutions		✓

BBA: Balanced Budget Act; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan.

A.3.1. Performance Measure Graphs

Figure A.3.1: Access to Care

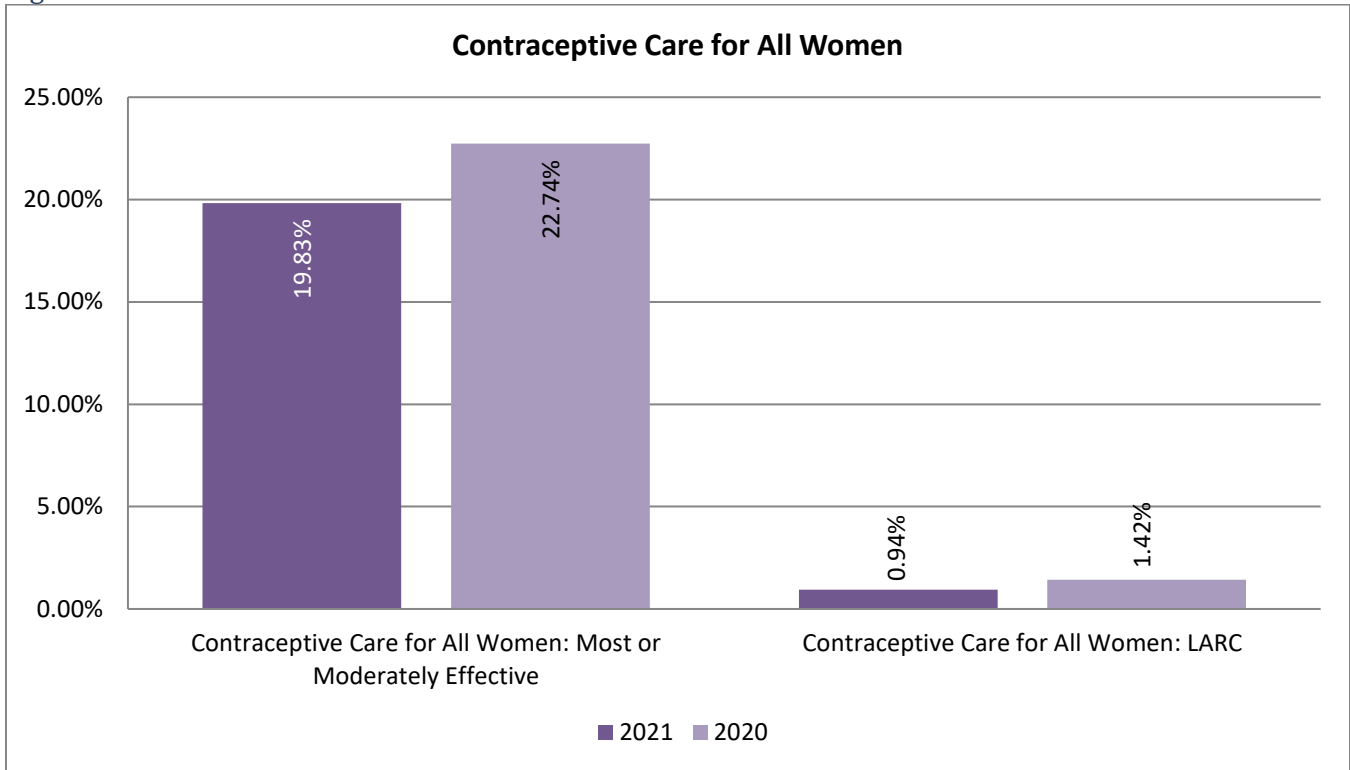


Figure A.3.2: Dental Care for Children I

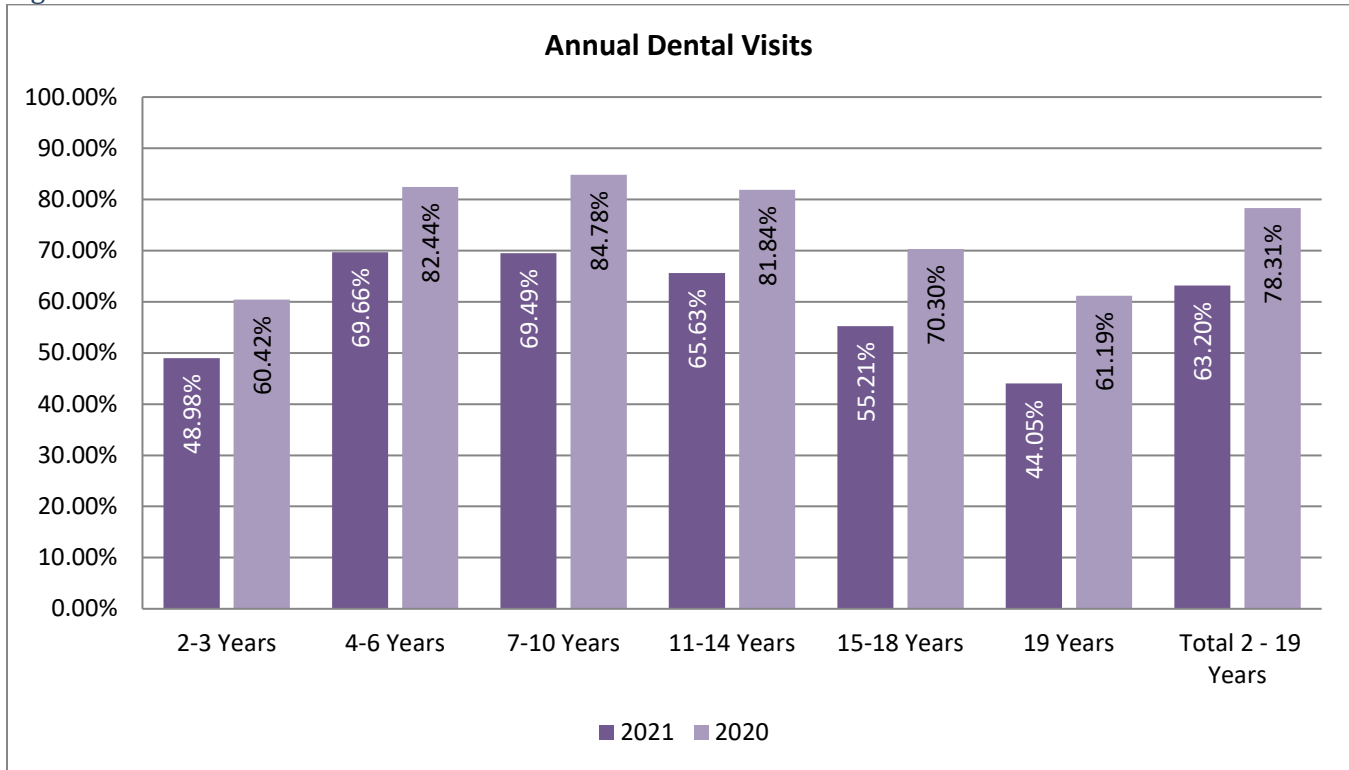


Figure A.3.3: Dental Care for Children II

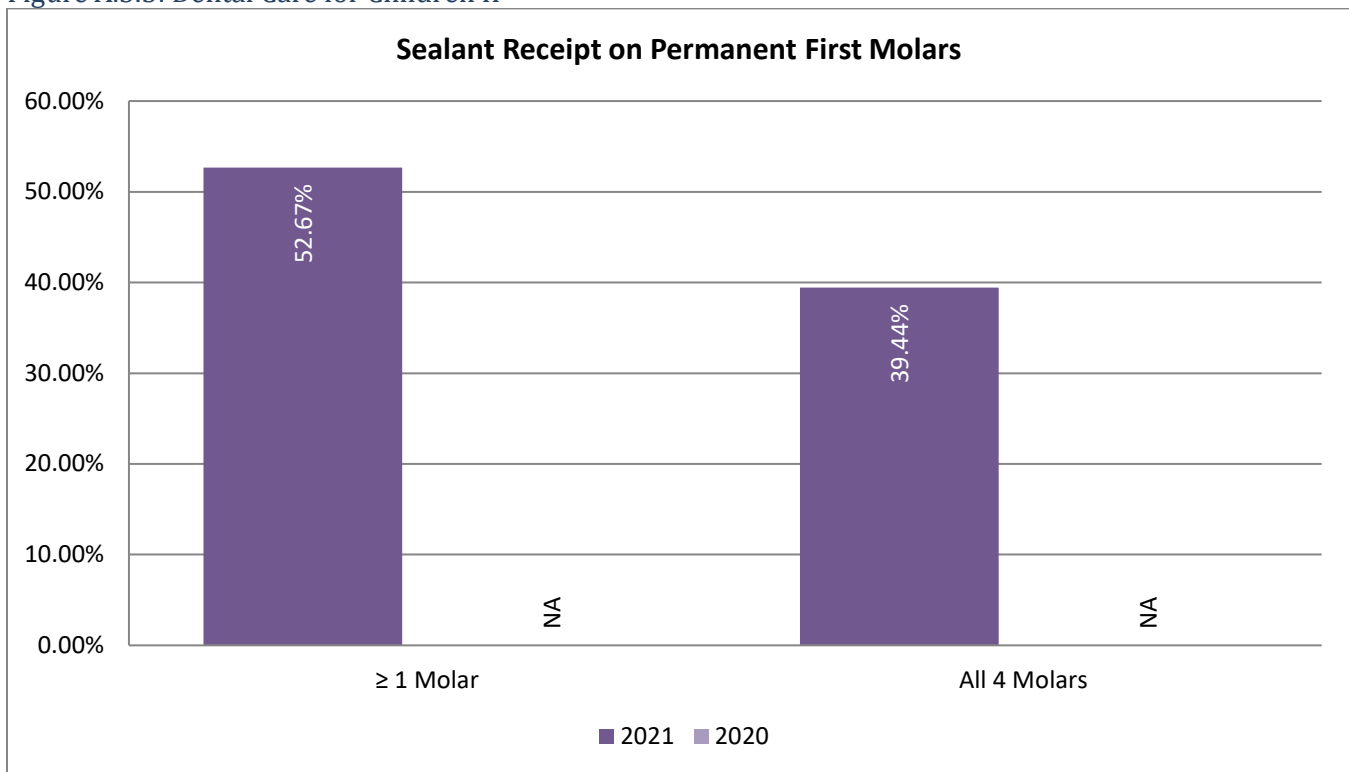


Figure A.3.4: EPSDT: Screenings and Follow-Up I

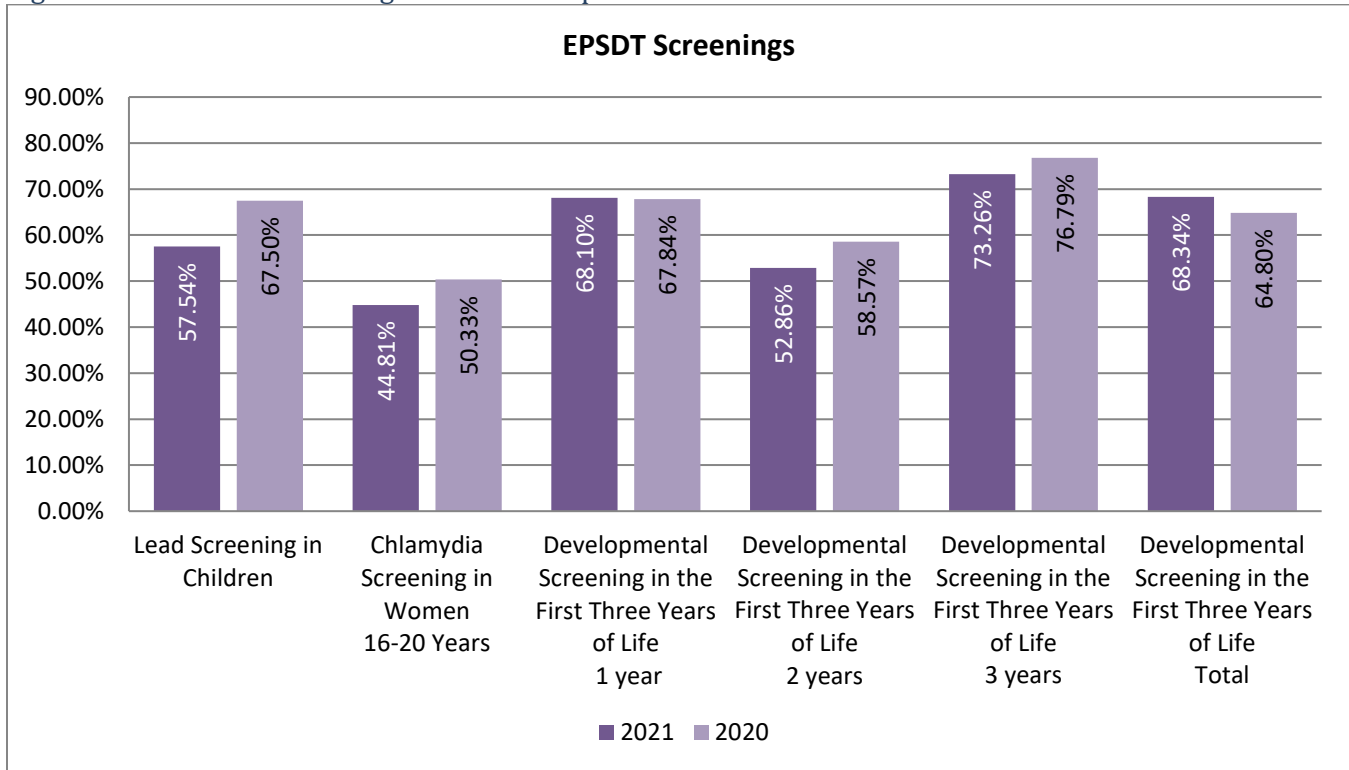


Figure A.3.5: EPSDT: Screenings and Follow-Up II

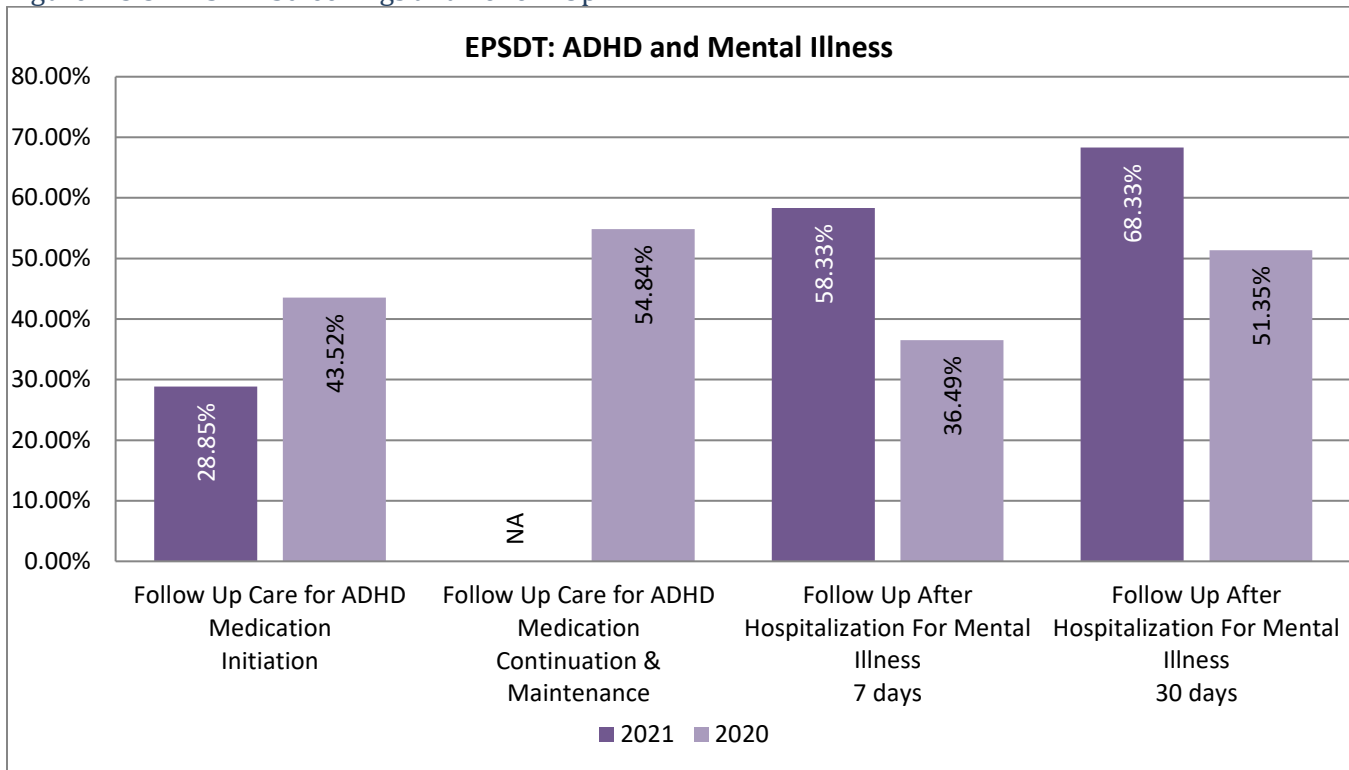


Figure A.3.6: Respiratory Conditions

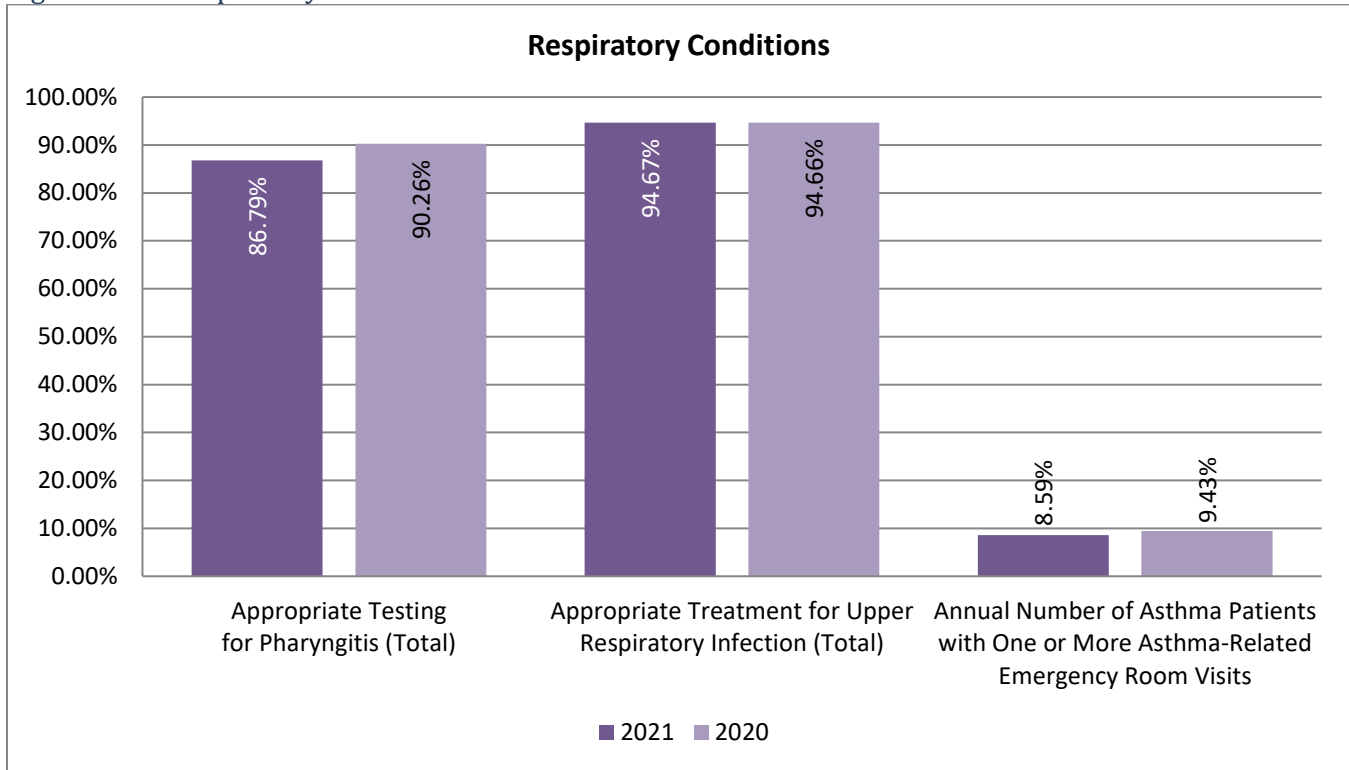


Figure A.3.7: Well Care I

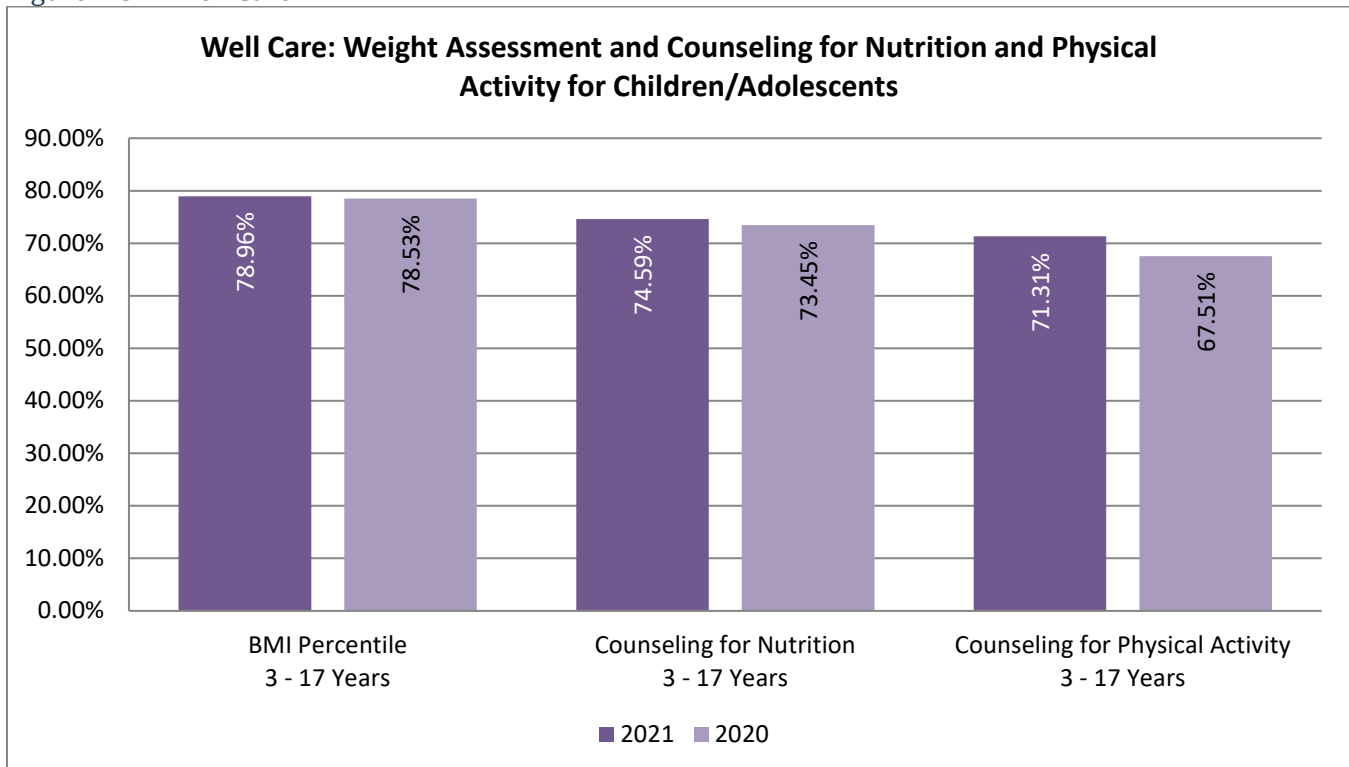


Figure A.3.8: Well Care II

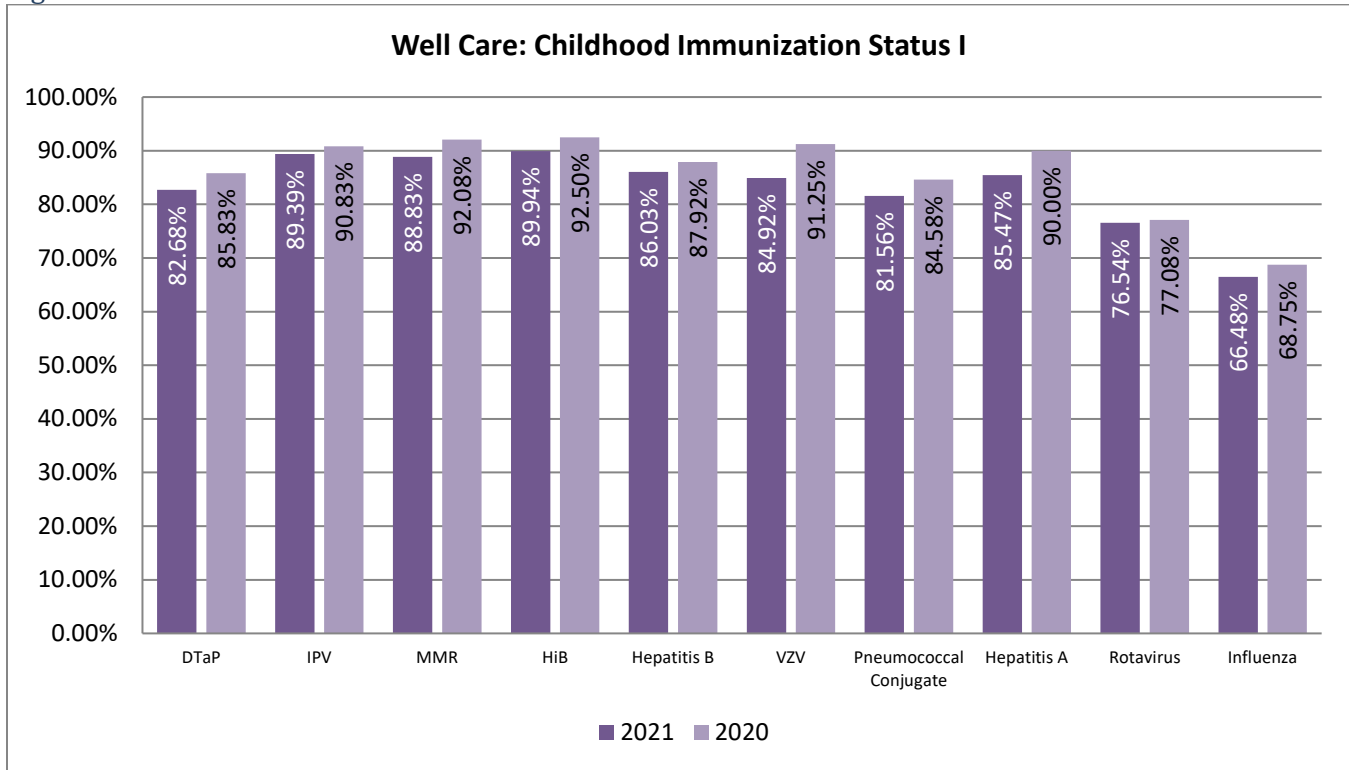


Figure A.3.9: Well Care III

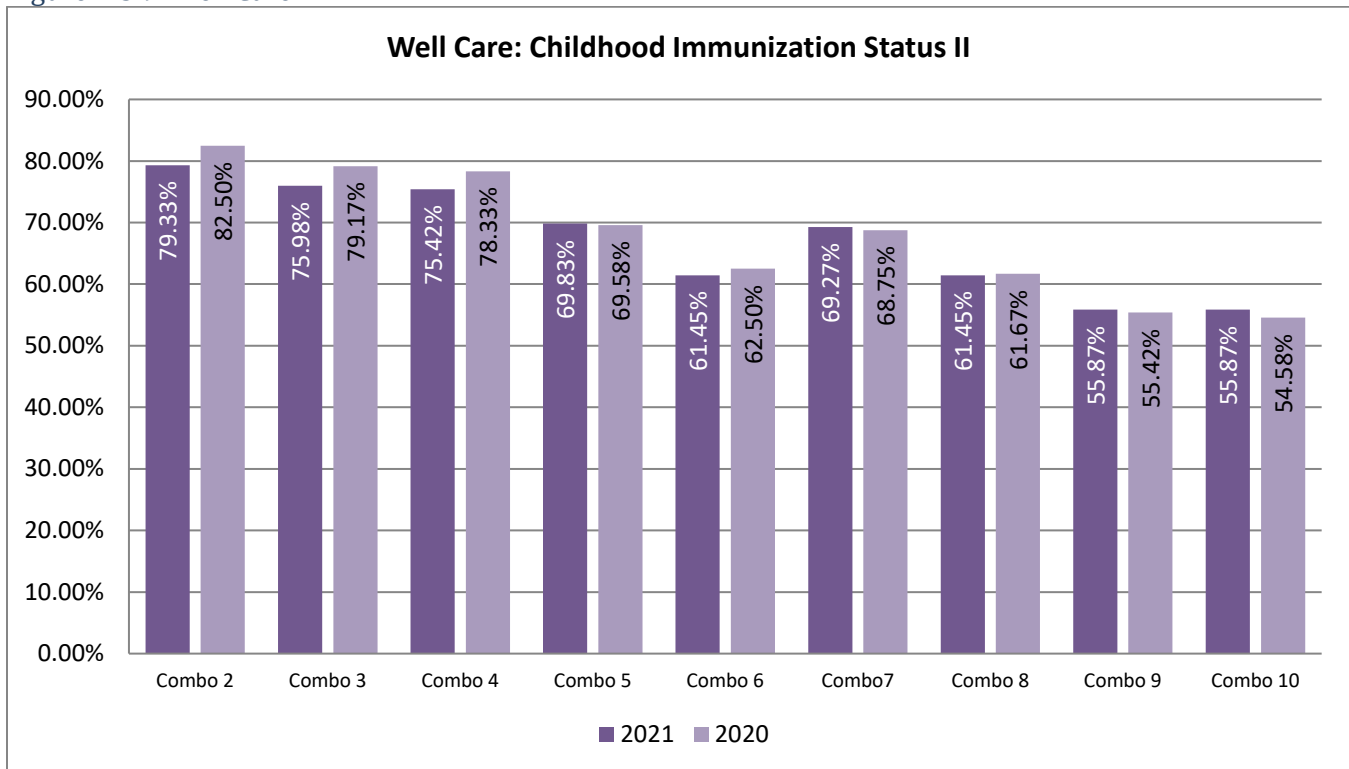


Figure A.3.10: Well Care IV

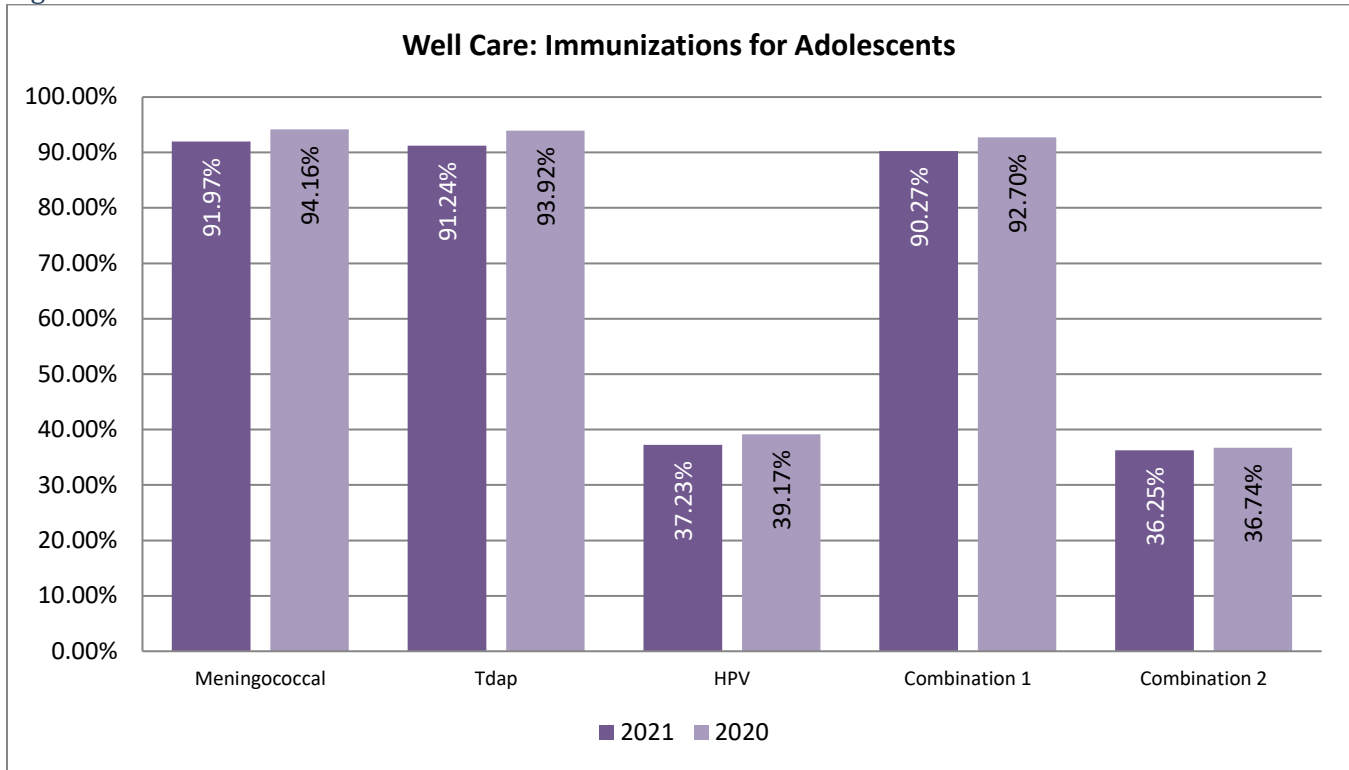


Figure A.3.11: Well Care V

