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**Commonwealth of Pennsylvania**

**Department of Human Services**

**Children’s Health Insurance Program**

**2022 External Quality Review Report**

**Capital Blue Cross**

Final Report

April 2023

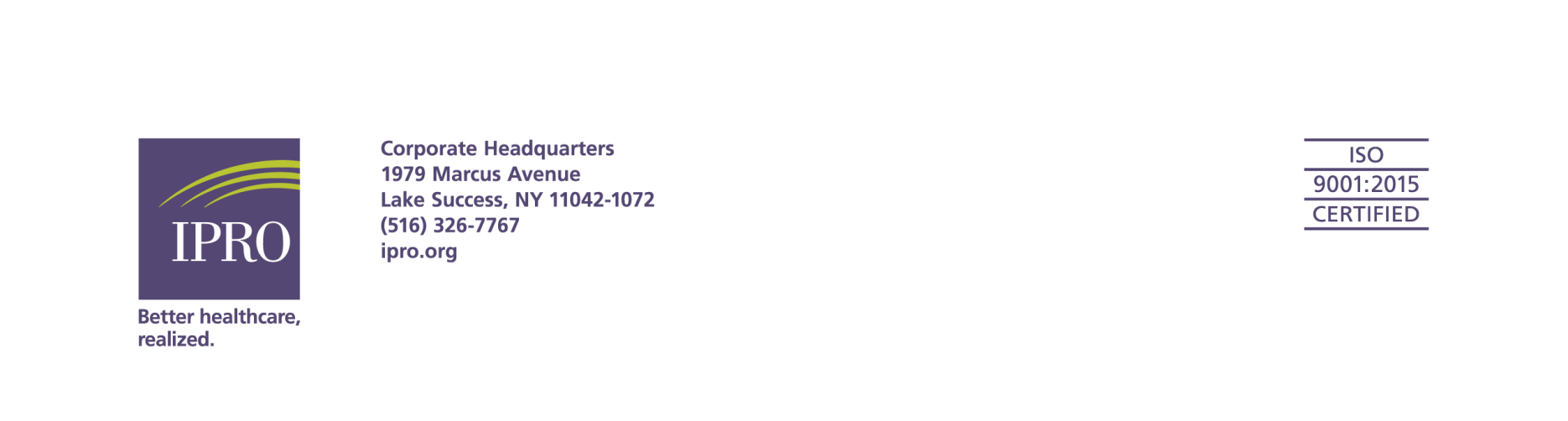


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# Introduction

## 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 2022 EQRs (Review Period: 1/1/2021–12/31/2021) for the CHIP MCOs and to prepare the technical reports.

The mandatory EQR-related activities that must be included in detailed technical reports, per *Title 42 Code of Federal Regulations (CFR) Section (§) 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:

1. Validation of Performance Improvement Projects
2. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
4. MCO Responses to the Previous EQR Recommendations
5. Strengths, Opportunities for Improvement, and EQR Recommendations
6. 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 Medicaid and CHIP managed care regulations 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** includes the MCO’s responses to the 2021 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, 2021 Opportunities for Improvement MCO Reponses, and Strengths and Opportunities for Improvement found for 2022.

# I. Validation of Performance Improvement Projects

**Objectives**

*Title 42 CFR § 438.330(d)* establishes that state agencies require contracted MCOs to conduct PIPs that focus on both clinical and non-clinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO.

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 2022 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 2022. 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.

The PIPs extend from January 2021 through December 2024. The non-intervention baseline period is January 2021 to December 2021, with research beginning in 2022. Initial PIP proposals were developed and submitted in first quarter 2022, and baseline reports including any proposal updates were submitted by MCOs in August 2022. Following the formal PIP proposal and baseline measurement reports, the timeline defined for the PIPs requires an interim report in 2023, as well as a final report in August 2024.

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.

As part of the new EQR PIP cycle that was initiated for all CHIP MCOs in 2022, 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.

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

As part of the EQR PIP cycle that was initiated for all CHIP MCOs in 2022, 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 Access to Pediatric Preventive Dental Care” and “Improving Blood Lead Screening Rate in Children.

**“Improving Access to Pediatric Preventive Dental Care”** was selected after review showed that several dental metrics have consistently fallen below comparable populations or have not steadily improved across years. For the HEDIS®Annual Dental Visit (ADV) measure, while CHIP Managed Care averages have been higher than Medicaid Managed Care (MMC) averages for most age cohorts since 2015, the CHIP averages have been consistently lower than Medicaid for the youngest cohort (ages 2–3) during the same time period. Additionally, from HEDIS 2018 to HEDIS 2020, year-to-year trends in CHIP averages across age cohorts have fluctuated, with no steady improvement for any age cohort. Preventive dental measures also indicated room for improvement. Prior to CMS’ replacement of the Dental Sealants In 6–9-Year-Old Children at Elevated Caries Risk measure for MY 2020, CHIP rates varied from roughly 19% to roughly 25% since 2015. At the time of topic development, trends were not available for the new CMS sealant measure, Sealant Receipt on Permanent 1st Molars (SFM-CH), but MCOs have been encouraged to target this measure for examination. Further, CMS reporting of Federal Fiscal Year (FFY) 2014 data from the CMS-416 Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report followed trends from previous years, indicating that the percentage of Pennsylvania children ages 1–20 who received any preventive dental service for FFY 2014 (42.5%), was below the National rate of 45.6%.

Given the research that early childhood caries can lead to the presence of many poor health factors and that early preventive dental visits are effective in reducing the need of restorative and emergency care, it became apparent that examination of this research and how it might be applicable to CHIP is warranted, particularly given that metrics indicate there is room for improvement.

For this PIP, DHS CHIP is requiring all CHIP MCOs to submit the following measures on an annual basis:

* Annual Dental Visits (ADV – HEDIS). MCOs will report on the measure collected and submitted for HEDIS.
* Total Eligible Members Receiving Preventive Dental Services. For this measure, each MCO will define all parameters that will be used to collect and report a rate for this measure using its claims system.
* MCO-defined. Each MCO is required to identify and define at least one additional topic-related performance measure to collect and study for this PIP based on the data for its population.

**“Improving Blood Lead Screening Rates in Children”** was selected again due to several factors. A 2021 look at national trends regarding lead screening and blood lead levels (BLLs) showed that Pennsylvania was among the states with the highest number of children with elevated BLLs, with most samples coming from the Philadelphia and Pittsburgh metropolitan areas[[1]](#footnote-1). The National Surveillance Data table, utilizing NHANES data, supported this finding, citing percentages ranging from 6 to 9% for children with BLLs at least 5 ug/dL, and around 1.5% for children with at least 10 ug/dL in Pennsylvania[[2]](#footnote-2). Current CHIP policy requires that all children ages 1 and 2 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. Between 2012 and 2018, Pennsylvania has seen fluctuating lead screening rates for children younger than 72 months old, with 17.8% screened in both 2012 and again in 2018. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2019 was 70.0%, while the Pennsylvania CHIP average was 66.2%. This rate fell between the 25th and 33rd percentile for HEDIS® Quality Compass benchmarks. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the previous few years, rates by MCO and weighted average continued to be below the national average. Additionally, when comparing Pennsylvania Medicaid and CHIP rates, Medicaid’s weighted average rate for 2019 was 81.6%, 15.5 points higher than CHIP. However, regarding population, it was noted that children less than 1 year of age typically receive Medicaid benefits until they reach 1 year. At this point, many children move over to CHIP, provided their families are eligible. MCOs were advised that this can affect overall CHIP rates across all MCOs, since the < 1 year age group will have disproportionately fewer members than older age groups.

Given the inconsistent improvement and rates that continue to fall below national averages, DHS CHIP determined that it has become apparent that continued intervention in this area of healthcare for the CHIP population is necessary.

For this PIP, DHS CHIP is requiring all CHIP MCOs to submit the following measures on an annual basis:

* Lead Screening in Children (LSC – HEDIS). MCOs will report on the measure collected and submitted for HEDIS.
* Total Number of Children Successfully Identified with Elevated Blood Lead Levels. For this measure, each MCO will define all parameters that will be used to collect and report a rate for this measure using its claims system.
* MCO-defined. Each MCO is required to identify and define at least one additional topic-related performance measure to collect and study for this PIP based on the data for its population.

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

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

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. Measurement Year (MY) 2021 is the baseline year, and during the 2022 review year, elements were reviewed and scored at multiple points during the year, when initial proposals were submitted in March 2022 and proposal update/baseline reports were submitted in August 2022. For Review Year 2022, the latest applicable findings are the proposal update/baseline report review findings; these are the findings included in each MCO’s report. All MCOs received some level of guidance towards improving their projects in these findings, and as requested, 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 compliance (met), partial compliance (partially met), and non-compliance (not met). The elements are not formally scored beyond the met/partially met/not met 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** |
| Met | Met or exceeded the element requirements | 100% |
| Partially Met | Met essential requirements but is deficient in some areas | 50% |
| Not Met | Has not met the essential requirements of the element | 0% |

When the PIPs are reviewed, all projects are evaluated 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.

Throughout 2022, there were different levels of communication provided to MCOs in preparation for and after their Project Proposal submissions in early 2022, including:

* Responses to questions or requested clarifications, via both a Q&A document for issues impacting all MCOs and individual responses to MCO-specific questions.
* MCO-specific review findings for each PIP, including a combined comprehensive review of the proposal submissions and the updated proposal/baseline report submissions.
* Information to assist MCOs in preparing their next PIP submission, the proposal update/baseline report, such as additional instructions regarding collection and analysis of the core required measures.

Similar and additional types of feedback will continue to be provided for each submission throughout the cycle. MCOs are requested to revise and resubmit their documents to address the feedback and to be reviewed again. PIP-specific calls are held with MCOs that experience continued difficulty or as requested. Additionally, as needed, PA CHIP discusses ongoing issues with MCOs as part of their regularly scheduled monitoring calls. As discussed earlier, initial proposals were submitted in March 2022 and proposal update/baseline reports were submitted in August 2022. Review of the initial submissions occurred in June 2022; review of the updates and baseline reports began in October 2022 and ran through December 2022. Upon review of the most recent 2022 submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary, which was due outside of the current EQR review period. Reviews of the resubmissions are therefore not included in these 2022 reports.

**Improving Access to Pediatric Preventive Dental Care**

Capital Blue Cross’s (CBC’s) baseline proposal demonstrated the topic has potential to impact the maximum proportion of members that is feasible. The goal set by the MCO targets an improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with the rationale for target rate provided.

Regarding the aim statements and objectives provided by CBC, reviewers designated this element as partially met, as the aim statements should address what will be improved, by how much, among whom, and over what time frame. Reviewers advised that the aim statement should include each Performance Indicator (PI).

CBC created clearly defined and measurable indicators, which measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes. Additionally, CBC indicated a plan to measure the indicators consistently over time, including data collection procedures to ensure that data are valid, reliable, and representative of the entire eligible population. CBC’s data analysis procedures indicate that the plan will interpret improvement in terms of achieving target rates and the plan will monitor intervention tracking measures (ITMs) so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions. Reviewers noted that CBC should provide more detail regarding individual ITM data collection and monitoring, such as how “touchpoints available” and “touchpoints delivered” are recorded and collected.

Reviewers noted that the plan identified barriers for improvement through data analysis and quality improvement processes, however reviewers requested that additional information be provided in the PIP regarding the data sources that informed some of the barriers. CBC included several member and provider interventions (e.g., reminders to incoming callers, birthday cards with QR codes for dental education, and HEDIS scorecards for providers) to address identified causes/barriers. **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 Proposal and Baseline Report review process:

* Regarding the project topic, it was recommended that the MCO describe how PIP Topic addresses your member needs and why it is important to your members.
* Regarding the project topic, it was recommended that the MCO describe high-volume or high-risk conditions addressed.
* Regarding the project topic, it was recommended that the MCO include MCO data to demonstrate the opportunity for improvement among CBC CHIP membership.
* Regarding the project topic, it was recommended that the MCO add an aim statement. The aim statement must address what will be improved, by how much, among whom, and over what time frame, and ensure the aim statement(s) includes each Performance Indicator.
* For data analysis, it was recommended that the MCO provide more detail regarding individual ITM data collection and monitoring (e.g., how “touchpoints available” and “touchpoints delivered” are recorded and collected).
* For barrier analysis, it was recommended that the MCO list the data sources that informed “Lack of parental awareness” and “Lack of provider awareness.” Include whether these barriers were identified through conversations with members and providers.
* It was recommended that the MCO include target rates in their Results Table.

**Improving Blood Lead Screening Rate in Children**

CBC’s baseline proposal demonstrated that the topic reflects high-volume or high-risk conditions for the population under review with the potential for meaningful impact on member health, functional status, and satisfaction for the population. The goal set by the MCO targets an improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with the rationale for target rate provided.

Regarding the aim statements and objectives provided by CBC, reviewers determined this element as met. CBC included baseline rates and indicated goals for all four indicators, with rationales and bold target improvement rates.

Upon review of CBC’s methodology for data collection and analysis, multiple questions were raised. Reviewers noted that it is difficult to identify how the data will be collected and analyzed, and by whom, especially data being reviewed in the areas of case management outreach. It is also unclear how often the data will be analyzed. The MCO should include in their report whether there will be any data analysis during the year, how ongoing quality improvement will be monitored, and how stagnation or worsening rates will be identified and/or addressed. Reviewers also noted that N/A was indicated for sampling, but references are made to hybrid data, which should be clarified in the report. In addition, CBC should describe who will be collecting data including titles and qualifications, including for HEDIS. Generally, reviewers noted that discussion of data collection addressing ITM’s is not specific enough. The MCO should provide more detail regarding individual ITM data collection and monitoring.

CBC listed barriers in their report, however the source of where/how a barrier was identified was not included. Reviewers requested clarification for ITM 1a. The MCO should include the definition of a “touchpoint,” and whether both the number of calls made by parent/guardians and the number of topics discussed by member services should be clarified. Reviewers noted that CBC should dedicate narrative in the report to how this data will be collected and analyzed, and whether this is a new system being implemented or if member services is already doing this (prior to 2022). The method of barrier identification states member education; therefore, the MCO should include how a member service representative is educating a parent/guardian during a touchpoint on the need for lead screening. In addition, the MCO should add barriers and ITMs for Indicator 3. **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 Proposal and Baseline Report review process:

* It was recommended that CBC develop the following section: Describe how PIP Topic addresses your member needs and why it is important to your members.
* It was recommended that CBC include MCO data to demonstrate the opportunity for improvement among CBC CHIP membership.
* It was recommended that CBC include an explanation in the Project Topic regarding well-child visits and/or data disparities to tie in Indicator 3 to the overall Lead PIP topic.
* It was recommended that CBC add an aim statement. The aim statement must address what will be improved, by how much, among whom, and over what time frame. Please ensure the aim statement(s) includes each Performance Indicator. The aims and objectives identify “improve lead screen rates” as the goal. It was also recommended that it is updated to include Indicator 3.
* It was recommended that CBC expand the Objectives to detail each intervention.
* It was recommended that CBC explain in their methodology why Indicator 2 is identifying children with blood levels greater than or equal to 5mg/dL when the value was updated to 3.5 µg/dL by the CDC in 2021.
* N/A is indicated for sampling, but reference is made to hybrid data. It is recommended that CBC clarify if a hybrid methodology is being used and, if so, include a discussion of the sampling methodology.
* It was recommended that CBC describe who will be collecting data including titles and qualifications, including for HEDIS. Define “throughout the measurement year” and how often rates are updated.
* It is not clear how often data will be reviewed and who will be responsible for this. It is recommended that CBC include data collection/review at least quarterly. Additionally, there is no indication that barriers/root cause analysis will be performed for stagnation or worsening ITM data.
* At the end of the section Data Collection and Analysis Procedures, it is recommended that CBC provide more detail regarding individual ITM data collection and monitoring.
* Barriers are identified but the source of where/how a barrier was identified is not present. It is recommended that CBC include discussion of this in their report.
* It is recommended that CBC include clarification for ITM 1a. For example, what is a “touchpoint”? Is this the number of calls made by parent/guardians, or the number of topics discussed by member services? How will this data be collected and analyzed? Is this a new system being implemented or is member services already doing this (prior to 2022)? The method of barrier identification states member education; how is a member service representative educating a parent/guardian during a touchpoint on the need for lead screening?
* Numerator and Denominator definitions for ITM 5b are unclear and appear to be measuring the same thing. It is recommended that CBC revise, so it is clear what is being measured and provide some actions to specifically address these rates.
* There are no associated barriers and ITMs addressing Indicator 3, which CBC should add to their report.

Table 1.2: CBC PIP Compliance Assessments – 2022 Proposal and Baseline Report

| **Review Element** | **Improving Access to Pediatric Preventive Dental Care** | **Improving Blood Lead Screening Rate in Children** |
| --- | --- | --- |
| Element 1. Project Topic/Rationale | Partially Met | Partially Met |
| Element 2. Aim | Partially Met | Partially Met |
| Element 3. Methodology | Partially Met | Partially Met |
| Element 4. Barrier Analysis | Partially Met | Partially Met |
| Element 5. Robust Interventions | Partially Met | Partially Met |
| Element 6. Results Table | N/A | N/A |
| Element 7. Discussion and Validity of Reported Improvement | N/A | N/A |

PIP: performance improvement project; N/A: not applicable.

# 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 April 2022. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2022. 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 2021 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 2021 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 (Ages 15–20 years): Most/Moderately Effective |
| PA EQR | Contraceptive Care for All Women (Ages 15–20 years): LARC |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): Most/Moderately Effective—3 days |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): Most/Moderately Effective—60 days |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): LARC—3 days |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): LARC—60 days |
| Well-Care Visits and Immunizations | |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Percentile (Ages 3–11 years) |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Percentile (Ages 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 (Ages 3–11 years) |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 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 (Ages 3–11 years) |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity (Ages 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—Combination 3 |
| HEDIS | Childhood Immunizations Status by Age 2—Combination 7 |
| HEDIS | Childhood Immunizations Status by Age 2—Combination 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 (Ages 3-11 years) |
| HEDIS | Child and Adolescent Well-Care Visits (Ages 12-17 years) |
| HEDIS | Child and Adolescent Well-Care Visits (Ages 18-19 years) |
| HEDIS | Child and Adolescent Well-Care Visits (Ages 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 (Ages 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 |
| Dental Care for Children | |
| HEDIS | Annual Dental Visit (Ages 2–3 Years) |
| HEDIS | Annual Dental Visit (Ages 4–6 Years) |
| HEDIS | Annual Dental Visit (Ages 7–10 Years) |
| HEDIS | Annual Dental Visit (Ages 11–14 Years) |
| HEDIS | Annual Dental Visit (Ages 15–18 Years) |
| HEDIS | Annual Dental Visit (Age 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 (Age 18 years) |
| HEDIS | Appropriate Testing for Pharyngitis (Total) |
| HEDIS | Appropriate Treatment for Upper Respiratory Infection (Ages 3–17 years) |
| HEDIS | Appropriate Treatment for Upper Respiratory Infection (Age 18 years) |
| HEDIS | Appropriate Treatment for Upper Respiratory Infection (Total) |
| PA EQR | Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2–19 years) |
| HEDIS | Asthma Medication Ratio (Ages 5–11 years) |
| HEDIS | Asthma Medication Ratio (Ages 12–18 years) |
| HEDIS | Asthma Medication Ratio (Age 19 years) |
| HEDIS | Asthma Medication Ratio (Total) |
| Behavioral Health | |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Ages 1–11 years) |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Ages 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 (Ages 1–11 years) |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (Ages 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 (Ages 1–11 years) |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (Ages 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 (Ages 1–11 years) |
| HEDIS | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12–17 years) |
| HEDIS | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total) |
| Utilization | |
| HEDIS | Ambulatory Care: Outpatient Visits/1,000 Member Months (Ages < 1 year) |
| HEDIS | Ambulatory Care: Outpatient Visits/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Ambulatory Care: Outpatient Visits/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Ambulatory Care: Outpatient Visits/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Ambulatory Care: Emergency Department Visits/1,000 Member Months (Ages < 1 years) |
| HEDIS | Ambulatory Care: Emergency Department Visits/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Ambulatory Care: Emergency Department Visits/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Ambulatory Care: Emergency Department Visits/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Total Discharges/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1,000 Member Months (Ages < 1 year) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1,000 Member Months (Ages 1–9 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1,000 Member Months (Ages < 1–19 years) Total Rate |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Maternity Discharges/1,000 Member Months (Ages 10–19 years) |
| HEDIS | Inpatient Utilization—General Hospital/Acute Care: Maternity Average Length of Stay/1,000 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 |
| 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. In 2022, Childhood Immunization Status retired six of the nine combination rates that were previously reported. The remaining combinations three, seven, and ten continued to be reported. 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**

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 Percentage 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 2022. 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 & MY 2021, Volume 2 Narrative*. The measurement year for the HEDIS measures is 2021, 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**

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 primary care provider (PCP) during their first 15 months of life; and
* Received two or more well-child visits with a PCP for ages 15 months–30 months of life.

**Child and Adolescent Well-Care Visits**

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 three 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.

**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 2022 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. 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 in 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 time frames 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. 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., 2022 [MY 2021] and 2021 [MY 2020]). In addition, statistical comparisons are made between the MY 2021 and MY 2020 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 2021 rates to MY 2020 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 2022 (MY 2021) 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 2021 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 2021 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 CBC’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 CBC focus efforts on improving weight assessment and counseling for nutrition for their members. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition and Counseling for Physical Activity were opportunities in 2021 and again in 2022.
* It is recommended that CBC focus efforts on developmental screenings for their members younger than 3 years old. Developmental Screening in the First Three Years of Life was an opportunity in 2021 and again in 2022.
* It is recommended that CBC focus efforts on improving dental care for its members. The Annual Dental Visits measure for members 2–3 years old and 4–6 years old was identified as an opportunity in 2022.
* It is recommended that CBC focus efforts on improving utilization of ambulatory outpatient visits. The AMBA: Outpatient Visits measure was identified as an opportunity across all age cohorts (< 1 year old to 19 years old) in 2021 and again in 2022.

### Access to/Availability of Care

Strengths are identified for the following 2022 (MY 2021) Access to/Availability of Care performance measures:

* The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  + Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective – 3.3 percentage points.

No opportunities for improvement are identified for the 2022 (MY 2021) Access to/Availability of Care performance measures.

Table 2.2: Access to/Availability of Care

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| PA EQR | Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective | 1,592 | 435 | **27.3%** | 25.1% | 29.5% | 27.6% | n.s. | 24.1% | + | NA |
| PA EQR | Contraceptive Care for All Women (Ages 15–20 years): LARC | 1,592 | 37 | **2.3%** | 1.5% | 3.1% | 1.7% | n.s. | 2.0% | n.s. | NA |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): Most or moderately effective contraception—3 days | 5 | 1 | **N/A** | N/A | N/A | N/A | N/A | N/A | N/A | NA |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): Most or moderately effective contraception—60 days | 5 | 5 | **N/A** | N/A | N/A | N/A | N/A | N/A | N/A | NA |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): LARC—3 days | 5 | 1 | **N/A** | N/A | N/A | N/A | N/A | N/A | N/A | NA |
| PA EQR | Contraceptive Care for Postpartum Women (Ages 15–20 years): LARC—60 days | 5 | 3 | **N/A** | N/A | N/A | N/A | N/A | N/A | N/A | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable, as denominator is less than 30.

### Well-Care Visits and Immunizations

No strengths are identified for the 2022 (MY 2021) Well-Care Visits and Immunizations performance measures.

Opportunities for improvement are identified for the following 2022 (MY 2021) Well-Care Visits and Immunizations performance measures:

* The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 3–11 years) – 6.7 percentage points;
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 3–11 years) – 9.9 percentage points;
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total) – 6.5 percentage points;
  + Immunizations for Adolescents—HPV – 6.3 percentage points; and
  + Immunizations for Adolescents—Combination 2 – 6.7 percentage points.

Table 2.3: Well-Care Visits and Immunizations

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI percentile (Ages 3–11 years) | 200 | 166 | **83.0%** | 77.5% | 88.5% | 85.3% | n.s. | 84.5% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI percentile (Ages 12–17 years) | 180 | 142 | **78.9%** | 72.7% | 85.1% | 77.9% | n.s. | 81.2% | n.s. | ≥ 25th and < 50th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI percentile (Total) | 380 | 308 | **81.1%** | 77.0% | 85.1% | 81.9% | n.s. | 83.0% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (Ages 3–11 years) | 200 | 144 | **72.0%** | 65.5% | 78.5% | 69.6% | n.s. | 78.7% | - | ≥ 25th and < 50th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (Ages 12–17 years) | 180 | 131 | **72.8%** | 66.0% | 79.6% | 64.4% | n.s. | 74.3% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (Total) | 380 | 275 | **72.4%** | 67.7% | 77.0% | 67.2% | n.s. | 76.7% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (Ages 3–11 years) | 200 | 130 | **65.0%** | 58.1% | 71.9% | 67.5% | n.s. | 74.9% | - | ≥ 25th and < 50th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (Ages 12–17 years) | 180 | 129 | **71.7%** | 64.8% | 78.5% | 65.0% | n.s. | 74.3% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (Total) | 380 | 259 | **68.2%** | 63.3% | 73.0% | 66.4% | n.s. | 74.7% | - | ≥ 25th and < 50th percentile |
| HEDIS | Childhood Immunization Status—DTaP | 120 | 95 | **79.2%** | 71.5% | 86.9% | 86.4% | n.s. | 83.7% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—IPV | 120 | 104 | **86.7%** | 80.2% | 93.2% | 94.4% | - | 90.5% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Childhood Immunization Status—MMR | 120 | 107 | **89.2%** | 83.2% | 95.1% | 94.4% | n.s. | 89.3% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—HiB | 120 | 105 | **87.5%** | 81.2% | 93.8% | 92.0% | n.s. | 90.5% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—Hepatitis B | 120 | 103 | **85.8%** | 79.2% | 92.5% | 93.2% | - | 89.1% | n.s. | ≥ 25th and < 50th percentile |
| HEDIS | Childhood Immunization Status—VZV | 120 | 104 | **86.7%** | 80.2% | 93.2% | 92.0% | n.s. | 89.5% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—Pneumococcal Conjugate | 120 | 97 | **80.8%** | 73.4% | 88.3% | 87.0% | n.s. | 85.1% | n.s. | ≥ 90th percentile |
| HEDIS | Childhood Immunization Status—Hepatitis A | 120 | 101 | **84.2%** | 77.2% | 91.1% | 88.3% | n.s. | 86.2% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Childhood Immunization Status—Rotavirus | 120 | 91 | **75.8%** | 67.8% | 83.9% | 72.2% | n.s. | 80.8% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—Influenza | 120 | 76 | **63.3%** | 54.3% | 72.4% | 57.4% | n.s. | 65.7% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Childhood Immunization Status—Combination 3 | 120 | 94 | **78.3%** | 70.5% | 86.1% | 80.3% | n.s. | 79.5% | n.s. | ≥ 90th percentile |
| HEDIS | Childhood Immunization Status—Combination 7 | 120 | 84 | **70.0%** | 61.4% | 78.6% | 64.8% | n.s. | 73.3% | n.s. | ≥ 90th percentile |
| HEDIS | Childhood Immunization Status—Combination 10 | 120 | 69 | **57.5%** | 48.2% | 66.8% | 43.8% | + | 57.0% | n.s. | ≥ 90th percentile |
| HEDIS | Immunizations for Adolescents— Meningococcal | 411 | 375 | **91.2%** | 88.4% | 94.1% | 89.5% | n.s. | 89.1% | n.s. | ≥ 90th percentile |
| HEDIS | Immunizations for Adolescents—Tdap | 411 | 378 | **92.0%** | 89.2% | 94.7% | 91.5% | n.s. | 89.8% | n.s. | ≥ 90th percentile |
| HEDIS | Immunizations for Adolescents—HPV | 411 | 134 | **32.6%** | 27.9% | 37.3% | 38.2% | n.s. | 38.9% | - | ≥ 25th and < 50th percentile |
| HEDIS | Immunizations for Adolescents— Combination 1 | 411 | 370 | **90.0%** | 87.0% | 93.0% | 88.8% | n.s. | 88.5% | n.s. | ≥ 90th percentile |
| HEDIS | Immunizations for Adolescents— Combination 2 | 411 | 131 | **31.9%** | 27.2% | 36.5% | 36.7% | n.s. | 38.6% | - | ≥ 25th and < 50th percentile |
| HEDIS | Well-Child Visits in the First 30 Months of Life (Age 15 months ≥ 6 Visits) | 59 | 41 | **69.5%** | 56.9% | 82.1% | 62.3% | n.s. | 59.3% | n.s. | ≥ 90th percentile |
| HEDIS | Well-Child Visits in the First 30 Months of Life (Ages 15–30 months ≥ 2 Visits) | 169 | 144 | **85.2%** | 79.6% | 90.9% | 89.5% | n.s. | 85.8% | n.s. | ≥ 90th percentile |
| HEDIS | Child and Adolescent Well-Care Visits (Ages 3–11 years) | 5,145 | 3,307 | **64.3%** | 63.0% | 65.6% | 64.7% | n.s. | 67.1% | - | ≥ 75th and < 90th percentile |
| HEDIS | Child and Adolescent Well-Care Visits  (Ages 12–17 years) | 4,746 | 2,953 | **62.2%** | 60.8% | 63.6% | 63.3% | n.s. | 63.4% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Child and Adolescent Well-Care Visits (Ages 18–19 years) | 752 | 352 | **46.8%** | 43.2% | 50.4% | 48.6% | n.s. | 50.1% | n.s. | NA |
| HEDIS | Child and Adolescent Well-Care Visits (Total) | 10,643 | 6,612 | **62.1%** | 61.2% | 63.1% | 62.9% | n.s. | 64.2% | - | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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, as denominator is less than 30.

### EPSDT: Screenings and Follow-up

No strengths are identified for the 2022 (MY 2021) EPSDT: Screenings and Follow-up performance measures.

Opportunities for improvement are identified for the following 2022 (MY 2021) EPSDT: Screenings and Follow-up performance measures.

* The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  + Lead Screening in Children (Age 2 years) – 12.6 percentage points;
  + Chlamydia Screening in Women (Ages 16–20 years) – 7.5 percentage points;
  + Developmental Screening in the First Three Years of Life—Total – 14.5 percentage points;
  + Developmental Screening in the First Three Years of Life—1 year – 24.2 percentage points;
  + Developmental Screening in the First Three Years of Life—2 years – 20.0 percentage points; and
  + Developmental Screening in the First Three Years of Life—3 years – 10.9 percentage points.

Table 2.4: EPSDT: Screenings and Follow-up

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | Lead Screening in Children (Age 2 years) | 120 | 66 | **55.0%** | 45.7% | 64.3% | 45.7% | n.s. | 67.6% | - | ≥ 25th and < 50th percentile |
| HEDIS | Chlamydia Screening in Women (Ages 16–20 years) | 486 | 141 | **29.0%** | 24.9% | 33.1% | 31.0% | n.s. | 36.5% | - | < 10th percentile |
| PA EQR | Developmental Screening in the First Three Years of Life—Total | 466 | 240 | **51.5%** | 46.9% | 56.1% | 51.9% | n.s. | 66.0% | - | NA |
| PA EQR | Developmental Screening in the First Three Years of Life— 1 year | 51 | 22 | **43.1%** | 28.6% | 57.7% | 53.2% | n.s. | 67.3% | - | NA |
| PA EQR | Developmental Screening in the First Three Years of Life— 2 years | 119 | 62 | **52.1%** | 42.7% | 61.5% | 53.2% | n.s. | 72.1% | - | NA |
| PA EQR | Developmental Screening in the First Three Years of Life— 3 years | 296 | 156 | **52.7%** | 46.8% | 58.6% | 51.1% | n.s. | 63.6% | - | NA |
| HEDIS | Follow Up Care for Children Prescribed ADHD Medication— Initiation Phase | 117 | 43 | **36.8%** | 27.6% | 45.9% | 39.4% | n.s. | 41.7% | n.s. | ≥ 25th and < 50th percentile |
| HEDIS | Follow Up Care for Children Prescribed ADHD Medication— Continuation & Maintenance Phase | 31 | 13 | **41.9%** | 23.0% | 60.9% | NA | n.s. | 58.3% | n.s. | ≥ 10th and < 25th percentile |
| HEDIS | Follow Up After Hospitalization For Mental Illness— 7 days | 54 | 27 | **50.0%** | 35.7% | 64.3% | 60.0% | n.s. | 49.8% | n.s. | NA |
| HEDIS | Follow Up After Hospitalization For Mental Illness— 30 days | 54 | 43 | **79.6%** | 68.0% | 91.3% | 90.0% | n.s. | 74.7% | n.s. | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable, as denominator is less than 30.

### Dental Care for Children

Strengths are identified for the following 2022 (MY 2021) Dental Care for Children performance measures:

* The following rates are statistically significantly above/better than the 2022 (MY 2021) MMC weighted average:
  + Sealant Receipt on Permanent First Molars (≥ 1 Molar) – 9.6 percentage points; and
  + Sealant Receipt on Permanent First Molars (All 4 Molars) – 8.4 percentage points.

Opportunities for improvement are identified for the following Dental Care for Children performance measures.

* The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  + Annual Dental Visit (Ages 2–3 years) – 12.1 percentage points; and
  + Annual Dental Visit (Ages 4–6 years) – 3.5 percentage points.

Table 2.5: Dental Care for Children

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | Annual Dental Visit (Ages 2–3 years) | 417 | 114 | **27.3%** | 22.9% | 31.7% | 30.9% | n.s. | 39.5% | - | ≥ 10th and < 25th percentile |
| HEDIS | Annual Dental Visit (Ages 4–6 years) | 1,330 | 815 | **61.3%** | 58.6% | 63.9% | 59.6% | n.s. | 64.8% | - | ≥ 50th and < 75th percentile |
| HEDIS | Annual Dental Visit (Ages 7–10 years) | 2,776 | 1,943 | **70.0%** | 68.3% | 71.7% | 63.6% | + | 68.7% | n.s. | ≥ 90th percentile |
| HEDIS | Annual Dental Visit (Ages 11–14 years) | 3,063 | 2,000 | **65.3%** | 63.6% | 67.0% | 62.7% | + | 64.3% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Annual Dental Visit (Ages 15–18 years) | 3,093 | 1,717 | **55.5%** | 53.7% | 57.3% | 54.6% | n.s. | 54.4% | n.s. | ≥ 75th and < 90th percentile |
| HEDIS | Annual Dental Visit (Age 19 years) | 48 | 20 | **41.7%** | 26.7% | 56.7% | 29.0% | n.s. | 38.4% | n.s. | NA |
| HEDIS | Annual Dental Visit (Total) | 10,727 | 6,609 | **61.6%** | 60.7% | 62.5% | 58.3% | + | 61.5% | n.s. | NA |
| PA EQR | Sealant Receipt on Permanent First Molars (≥ 1 Molar) | 823 | 397 | **48.2%** | 44.8% | 51.7% | 51.3% | n.s. | 38.6% | + | NA |
| PA EQR | Sealant Receipt on Permanent First Molars (All 4 Molars) | 823 | 289 | **35.1%** | 31.8% | 38.4% | 39.4% | n.s. | 26.8% | + | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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, as denominator is less than 30; PA: Pennsylvania; EQR: external quality review.

### Respiratory Conditions

No strengths are identified for the 2022 (MY 2021) Respiratory Conditions performance measures.

No opportunities for improvement are identified for the 2022 (MY 2021) Respiratory Conditions performance measures.

Table 2.6: Respiratory Conditions

| **Indicator** | | **2022 (MY 2021)** | | | | | | **Rate Comparison1** | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | Appropriate Testing for Children with Pharyngitis (Ages 3–17 years) | 209 | 164 | **78.5%** | 72.7% | 84.3% | 85.6% | - | 79.1% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Appropriate Testing for Children with Pharyngitis (Age 18 years) | 13 | 9 | **N/A** | N/A | N/A | 64.7% | N/A | 81.5% | N/A | NA |
| HEDIS | Appropriate Testing for Children with Pharyngitis (Total) | 222 | 173 | **77.9%** | 72.2% | 83.6% | 84.8% | - | 79.1% | n.s. | NA |
| HEDIS | Appropriate Treatment for Children with Upper Respiratory Infection (Ages 3–17 years) | 692 | 27 | **96.1%** | 94.6% | 97.6% | 94.0% | + | 95.6% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Appropriate Treatment for Children with Upper Respiratory Infection  (Age 18 years) | 30 | 3 | **90.0%** | 77.6% | 100.0% | 89.3% | n.s. | 96.0% | n.s. | NA |
| HEDIS | Appropriate Treatment for Children with Upper Respiratory Infection (Total) | 722 | 30 | **95.8%** | 94.3% | 97.4% | 93.9% | n.s. | 95.5% | n.s. | NA |
| PA EQR | Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Ages 2–19 years) | 489 | 31 | **6.3%** | 4.1% | 8.6% | 2.9% | + | 9.1% | - | NA |
| HEDIS | Asthma Medication Ratio (Ages 5–11 years) | 66 | 53 | **80.3%** | 69.9% | 90.7% | 90.7% | n.s. | 79.3% | n.s. | ≥ 50th and < 75th percentile |
| HEDIS | Asthma Medication Ratio (Ages 12–18 years) | 89 | 74 | **83.2%** | 74.8% | 91.5% | 71.8% | n.s. | 73.8% | n.s. | ≥ 90th percentile |
| HEDIS | Asthma Medication Ratio (Age 19 years) | 1 | 1 | **N/A** | N/A | N/A | N/A | N/A | 0.0% | N/A | NA |
| HEDIS | Asthma Medication Ratio (Total) | 156 | 128 | **82.1%** | 75.7% | 88.4% | 80.5% | n.s. | 76.4% | n.s. | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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; PA: Pennsylvania; EQR: external quality review; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable, as denominator is less than 30.

### Behavioral Health

No strengths are identified for 2022 (MY 2021) Behavioral Health performance measures.

No opportunities for improvement are identified for 2022 (MY 2021) Behavioral Health performance measures.

Table 2.7: Behavioral Health

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Ages 1—11 years) | 6 | 3 | **N/A** | N/A | N/A | N/A | N/A | 0.0% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Ages 12—17 years) | 23 | 16 | **N/A** | N/A | N/A | N/A | N/A | 70.3% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Total) | 29 | 19 | **N/A** | N/A | N/A | N/A | N/A | 68.9% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics— Cholesterol (Ages 1—11 years) | 6 | 4 | **N/A** | N/A | N/A | N/A | N/A | 0.0% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics— Cholesterol (Ages 12—17 years) | 23 | 9 | **N/A** | N/A | N/A | N/A | N/A | 46.9% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics — Cholesterol (Total) | 29 | 13 | **N/A** | N/A | N/A | N/A | N/A | 50.0% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics— Blood Glucose & Cholesterol (Ages 1—11 years) | 6 | 3 | **N/A** | N/A | N/A | N/A | N/A | 0.0% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose & Cholesterol (Ages 12–17 Years) | 23 | 9 | **N/A** | N/A | N/A | N/A | N/A | 46.9% | N/A | NA |
| HEDIS | Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (Total) | 29 | 12 | **N/A** | N/A | N/A | N/A | N/A | 48.7% | N/A | NA |
| HEDIS | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1—11 years) | 2 | 1 | **N/A** | N/A | N/A | N/A | N/A | 0.0% | N/A | NA |
| HEDIS | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12—17 years) | 15 | 10 | **N/A** | N/A | N/A | N/A | N/A | 68.8% | N/A | NA |
| HEDIS | Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total) | 17 | 11 | **N/A** | N/A | N/A | N/A | N/A | 66.0% | N/A | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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; N/A: not applicable, as denominator is less than 30.

### Utilization

No strengths are identified for the 2022 (MY 2021) Utilization performance measures.

Opportunities for improvement are identified for the following 2022 (MY 2021) Utilization measures:

* The following rates are statistically significantly below/worse than the 2022 (MY 2021) MMC weighted average:
  + AMBA: Outpatient Visits/1,000 Member Months (MM) Ages < 1 year – 56.4 points;
  + AMBA: Outpatient Visits/1,000 MM Ages 1—9 years – 25.2 points;
  + AMBA: Outpatient Visits/1,000 MM Ages 10—19 years – 3.5 points;
  + AMBA: Outpatient Visits/1,000 MM Ages < 1—19 years Total Rate – 13.7 points; and
  + AMBA: Emergency Department Visits/1,000 MM Ages < 1 year – 14.4 points.

Table 2.8: Utilization

| **Indicator** | | **2022 (MY 2021)** | | | | | **Rate Comparison1** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source** | **Name** | **Denom** | **Num** | **Rate** | **Lower 95% Confidence Limit** | **Upper 95% Confidence Limit** | **2021 (MY 2020) Rate** | **2022 Rate Compared to 2021** | **MMC** | **2022 Rate Compared to MMC** | **HEDIS 2022 Percentile** |
| HEDIS | AMBA: Outpatient Visits/1,000 MM Ages < 1 year | 1,087 | 648 | **596.14** | N/A | N/A | 582.30 | + | 652.55 | - | NA |
| HEDIS | AMBA: Outpatient Visits/1,000 MM Ages 1—9 years | 59,516 | 11,519 | **193.54** | N/A | N/A | 187.36 | + | 218.78 | - | NA |
| HEDIS | AMBA: Outpatient Visits/1,000 MM Ages 10—19 years | 94,044 | 19,912 | **211.73** | N/A | N/A | 190.67 | + | 215.21 | - | NA |
| HEDIS | AMBA: Outpatient Visits/1,000 MM Ages < 1—19 years Total Rate | 154,655 | 32,080 | **207.43** | N/A | N/A | 191.70 | + | 221.18 | - | NA |
| HEDIS | AMBA: Emergency Department Visits/1,000 MM Ages < 1 year | 1,087 | 19 | **17.48** | N/A | N/A | 37.17 | - | 31.92 | - | NA |
| HEDIS | AMBA: Emergency Department Visits/1,000 MM Ages 1—9 years | 59,516 | 810 | **13.61** | N/A | N/A | 13.31 | + | 16.58 | - | NA |
| HEDIS | AMBA: Emergency Department Visits/1,000 MM Ages 10—19 years | 94,044 | 1,323 | **14.07** | N/A | N/A | 13.25 | + | 16.69 | - | NA |
| HEDIS | AMBA: Emergency Department Visits/1,000 MM Ages < 1—19 years Total Rate | 154,655 | 2,152 | **13.91** | N/A | N/A | 13.42 | + | 16.80 | - | NA |
| HEDIS | IPUA: Total Discharges/1,000 MM Ages < 1 year | 1,087 |  | **0.92** | 90.3% | 93.7% | 0.00 | N/A |  |  | NA |
| HEDIS | IPUA: Total Discharges/1,000 MM Ages 1—9 years | 59,516 |  | **0.40** | 39.6% | 40.4% | 0.29 | - |  |  | NA |
| HEDIS | IPUA: Total Discharges/1,000 MM Ages 10—19 years | 94,044 |  | **0.56** | 55.7% | 56.3% | 0.51 | - |  |  | NA |
| HEDIS | IPUA: Total Discharges/1,000 MM Ages < 1—19 years Total Rate | 154,655 |  | **0.50** | 49.8% | 50.2% | 0.41 | - |  |  | NA |
| HEDIS | IPUA: Total Inpatient ALOS Ages < 1 year |  |  | **5.00** | N/A | N/A | N/A | N/A |  |  | NA |
| HEDIS | IPUA: Total Inpatient ALOS Ages 1—9 Years |  |  | **2.38** | N/A | N/A | 4.18 | N/A |  |  | NA |
| HEDIS | IPUA: Total Inpatient ALOS Ages 10—19 years |  |  | **3.51** | N/A | N/A | 4.08 | N/A |  |  | NA |
| HEDIS | IPUA: Total Inpatient ALOS Ages < 1—19 years Total Rate |  |  | **3.18** | N/A | N/A | 4.11 | N/A |  |  | NA |
| HEDIS | IPUA: Surgery Discharges/1,000 MM Ages < 1 year | 1,087 |  | **NA** | N/A | N/A | 0.00 | N/A |  |  | NA |
| HEDIS | IPUA: Surgery Discharges/1,000 MM Ages 1—9 years | 59,516 |  | **0.12** | 11.7% | 12.3% | 0.10 | - |  |  | NA |
| HEDIS | IPUA: Surgery Discharges/1,000 MM Ages 10—19 years | 94,044 |  | **0.22** | 21.7% | 22.3% | 0.18 | - |  |  | NA |
| HEDIS | IPUA: Surgery Discharges/1,000 MM Ages < 1—19 years Total Rate | 154,655 |  | **0.18** | 17.8% | 18.2% | 0.15 | - |  |  | NA |
| HEDIS | IPUA: Surgery ALOS Ages < 1 year |  |  | **0.00** | N/A | N/A | N/A | N/A |  |  | NA |
| HEDIS | IPUA: Surgery ALOS Ages 1—9 years |  |  | **3.86** | N/A | N/A | 6.13 | N/A |  |  | NA |
| HEDIS | IPUA: Surgery ALOS Ages 10—19 years |  |  | **3.10** | N/A | N/A | 5.37 | N/A |  |  | NA |
| HEDIS | IPUA: Surgery ALOS Ages < 1—19 years Total Rate |  |  | **3.29** | N/A | N/A | 5.59 | N/A |  |  | NA |
| HEDIS | IPUA: Medicine Discharges/1,000 MM Ages < 1 year | 1,087 |  | **0.92** | 90.3% | 93.7% | 0.00 | N/A |  |  | NA |
| HEDIS | IPUA: Medicine Discharges/  1,000 MM Ages 1—9 years | 59,516 |  | **0.29** | 28.6% | 29.4% | 0.18 | - |  |  | NA |
| HEDIS | IPUA: Medicine Discharges/  1,000 MM Ages 10—19 years | 94,044 |  | **0.27** | 26.7% | 27.3% | 0.22 | - |  |  | NA |
| HEDIS | IPUA: Medicine Discharges/  1,000 MM Ages < 1—19 years Total Rate | 154,655 |  | **0.28** | 27.8% | 28.2% | 0.20 | - |  |  | NA |
| HEDIS | IPUA: Medicine ALOS Ages < 1 year |  |  | **5.00** | N/A | N/A | N/A | N/A |  |  | NA |
| HEDIS | IPUA: Medicine ALOS Ages 1—9 years |  |  | **1.76** | N/A | N/A | 3.07 | N/A |  |  | NA |
| HEDIS | IPUA: Medicine ALOS Ages 10—19 years |  |  | **4.16** | N/A | N/A | 3.91 | N/A |  |  | NA |
| HEDIS | IPUA: Medicine ALOS Ages < 1—19 years Total Rate |  |  | **3.23** | N/A | N/A | 3.59 | N/A |  |  | NA |
| HEDIS | IPUA: Maternity Discharges/1,000 MM Ages 10—19 years | 94,044 |  | **0.07** | 6.8% | 7.2% | 0.11 | - |  |  | NA |
| HEDIS | IPUA: Maternity ALOS Ages 10—19 years Total Rate |  |  | **2.43** | N/A | N/A | 2.18 | N/A |  |  | NA |
| HEDIS | MPT: Any Services Ages 0—12 years—Male | 45,972 | 212 | **5.53%** | 5.3% | 5.7% | 6.12% | - |  |  | NA |
| HEDIS | MPT: Any Services Ages 0—12 years—Female | 45,305 | 188 | **4.98%** | 4.8% | 5.2% | 4.79% | - |  |  | NA |
| HEDIS | MPT: Any Services Ages 0—12 years—Total Rate | 91,277 | 400 | **5.26%** | 5.1% | 5.4% | 5.46% | - |  |  | NA |
| HEDIS | MPT: Any Services Ages 13—17 years—Male | 26,457 | 173 | **7.85%** | 7.5% | 8.2% | 6.95% | - |  |  | NA |
| HEDIS | MPT: Any Services Ages 13—17 years—Female | 27,375 | 390 | **17.10%** | 16.7% | 17.5% | 13.21% | - |  |  | NA |
| HEDIS | MPT: Any Services Ages 13—17 years—Total Rate | 53,832 | 563 | **12.55%** | 12.3% | 12.8% | 10.12% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 0—12 years—Male | 45,972 | 2 | **0.05%** | 0.0% | 0.1% | 0.08% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 0—12 years—Female | 45,305 | 4 | **0.11%** | 0.1% | 0.1% | 0.19% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 0—12 years—Total Rate | 91,277 | 6 | **0.08%** | 0.1% | 0.1% | 0.14% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 13—17 years—Male | 26,457 | 9 | **0.41%** | 0.3% | 0.5% | 0.29% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 13—17 years—Female | 27,375 | 41 | **1.80%** | 1.6% | 2.0% | 0.85% | - |  |  | NA |
| HEDIS | MPT: Inpatient Ages 13—17 years—Total Rate | 53,832 | 50 | **1.11%** | 1.0% | 1.2% | 0.58% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Male | 45,972 | 4 | **0.10%** | 0.1% | 0.1% | 0.04% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Female | 45,305 | 6 | **0.16%** | 0.1% | 0.2% | 0.13% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Total Rate | 91,277 | 10 | **0.13%** | 0.1% | 0.2% | 0.08% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Male | 26,457 | 7 | **0.32%** | 0.3% | 0.4% | 0.25% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Female | 27,375 | 26 | **1.14%** | 1.0% | 1.3% | 0.85% | - |  |  | NA |
| HEDIS | MPT: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Total Rate | 53,832 | 33 | **0.74%** | 0.7% | 0.8% | 0.56% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 0—12 years—Male | 45,972 | 161 | **4.20%** | 4.0% | 4.4% | 5.26% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 0—12 years—Female | 45,305 | 154 | **4.08%** | 3.9% | 4.3% | 3.85% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 0—12 years—Total Rate | 91,277 | 315 | **4.14%** | 4.0% | 4.3% | 4.55% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 13—17 years—Male | 26,457 | 134 | **6.08%** | 5.8% | 6.4% | 6.20% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 13—17 years—Female | 27,375 | 299 | **13.11%** | 12.7% | 13.5% | 10.45% | - |  |  | NA |
| HEDIS | MPT: Outpatient Ages 13—17 years—Total Rate | 53,832 | 433 | **9.65%** | 9.4% | 9.9% | 8.35% | - |  |  | NA |
| HEDIS | MPT: ED Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | MPT: ED Ages 0—12 years—Female | 45,305 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | MPT: ED Ages 0—12 years—Total Rate | 91,277 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | MPT: ED Ages 13—17 years—Male | 26,457 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | MPT: ED Ages 13—17 years—Female | 27,375 | 1 | **0.04%** | 0.0% | 0.1% | 0.00% | n.s. |  |  | NA |
| HEDIS | MPT: ED Ages 13—17 years—Total Rate | 53,832 | 1 | **0.02%** | 0.0% | 0.0% | 0.00% | n.s. |  |  | NA |
| HEDIS | MPT: Telehealth Ages 0—12 years—Male | 45,972 | 111 | **2.90%** | 2.7% | 3.1% | 2.59% | - |  |  | NA |
| HEDIS | MPT: Telehealth Ages 0—12 years—Female | 45,305 | 85 | **2.25%** | 2.1% | 2.4% | 2.35% | - |  |  | NA |
| HEDIS | MPT: Telehealth Ages 0—12 years—Total Rate | 91,277 | 196 | **2.58%** | 2.5% | 2.7% | 2.47% | - |  |  | NA |
| HEDIS | MPT: Telehealth Ages 13—17 years—Male | 26,457 | 78 | **3.54%** | 3.3% | 3.8% | 3.00% | - |  |  | NA |
| HEDIS | MPT: Telehealth Ages 13—17 years—Female | 27,375 | 213 | **9.34%** | 9.0% | 9.7% | 7.56% | - |  |  | NA |
| HEDIS | MPT: Telehealth Ages 13—17 years—Total Rate | 53,832 | 291 | **6.49%** | 6.3% | 6.7% | 5.31% | - |  |  | NA |
| HEDIS | IAD: Any Services Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Any Services Ages 0—12 years—Female | 45,305 | 1 | **0.03%** | 0.0% | 0.0% | 0.02% | - |  |  | NA |
| HEDIS | IAD: Any Services Ages 0—12 years—Total Rate | 91,277 | 1 | **0.01%** | 0.0% | 0.0% | 0.01% | - |  |  | NA |
| HEDIS | IAD: Any Services Ages 13—17 years—Male | 26,457 | 17 | **0.77%** | 0.7% | 0.9% | 0.83% | - |  |  | NA |
| HEDIS | IAD: Any Services Ages 13—17 years—Female | 27,375 | 17 | **0.75%** | 0.6% | 0.9% | 0.45% | - |  |  | NA |
| HEDIS | IAD: Any Services Ages 13—17 years—Total Rate | 53,832 | 34 | **0.76%** | 0.7% | 0.8% | 0.64% | - |  |  | NA |
| HEDIS | IAD: Inpatient Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Inpatient Ages 0—12 years—Female | 45,305 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Inpatient Ages 0—12 years—Total Rate | 91,277 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Inpatient Ages 13—17 years—Male | 26,457 | 3 | **0.14%** | 0.1% | 0.2% | 0.29% | - |  |  | NA |
| HEDIS | IAD: Inpatient Ages 13—17 years—Female | 27,375 | 7 | **0.31%** | 0.2% | 0.4% | 0.08% | - |  |  | NA |
| HEDIS | IAD: Inpatient Ages 13—17 years—Total Rate | 53,832 | 10 | **0.22%** | 0.2% | 0.3% | 0.19% | - |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Female | 45,305 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 0—12 years—Total Rate | 91,277 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Male | 26,457 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Female | 27,375 | 1 | **0.04%** | 0.0% | 0.1% | 0.08% | - |  |  | NA |
| HEDIS | IAD: Intensive Outpatient/Partial Hospitalization Ages 13—17 years—Total Rate | 53,832 | 1 | **0.02%** | 0.0% | 0.0% | 0.04% | - |  |  | NA |
| HEDIS | IAD: Outpatient Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Outpatient Ages 0—12 years—Female | 45,305 | 1 | **0.03%** | 0.0% | 0.0% | 0.02% | - |  |  | NA |
| HEDIS | IAD: Outpatient Ages 0—12 years—Total Rate | 91,277 | 1 | **0.01%** | 0.0% | 0.0% | 0.01% | - |  |  | NA |
| HEDIS | IAD: Outpatient Ages 13—17 years—Male | 26,457 | 7 | **0.32%** | 0.3% | 0.4% | 0.29% | - |  |  | NA |
| HEDIS | IAD: Outpatient Ages 13—17 years—Female | 27,375 | 8 | **0.35%** | 0.3% | 0.4% | 0.20% | - |  |  | NA |
| HEDIS | IAD: Outpatient Ages 13—17 years—Total Rate | 53,832 | 15 | **0.33%** | 0.3% | 0.4% | 0.25% | - |  |  | NA |
| HEDIS | IAD: ED Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: ED Ages 0—12 years—Female | 45,305 | 1 | **0.03%** | 0.0% | 0.0% | 0.00% | n.s. |  |  | NA |
| HEDIS | IAD: ED Ages 0—12 years—Total Rate | 91,277 | 1 | **0.01%** | 0.0% | 0.0% | 0.00% | n.s. |  |  | NA |
| HEDIS | IAD: ED Ages 13—17 years—Male | 26,457 | 7 | **0.32%** | 0.3% | 0.4% | 0.42% | - |  |  | NA |
| HEDIS | IAD: ED Ages 13—17 years—Female | 27,375 | 5 | **0.22%** | 0.2% | 0.3% | 0.12% | - |  |  | NA |
| HEDIS | IAD: ED Ages 13—17 years—Total Rate | 53,832 | 12 | **0.27%** | 0.2% | 0.3% | 0.27% | - |  |  | NA |
| HEDIS | IAD: Telehealth Ages 0—12 years—Male | 45,972 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Telehealth Ages 0—12 years—Female | 45,305 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Telehealth Ages 0—12 years—Total Rate | 91,277 | 0 | **0.00%** | 0.0% | 0.0% | 0.00% | N/A |  |  | NA |
| HEDIS | IAD: Telehealth Ages 13—17 years—Male | 26,457 | 5 | **0.23%** | 0.2% | 0.3% | 0.17% | - |  |  | NA |
| HEDIS | IAD: Telehealth Ages 13—17 years—Female | 27,375 | 2 | **0.09%** | 0.1% | 0.1% | 0.12% | - |  |  | NA |
| HEDIS | IAD: Telehealth Ages 13—17 years—Total Rate | 53,832 | 7 | **0.16%** | 0.1% | 0.2% | 0.14% | - |  |  | NA |

1 For comparison of MY 2021 rates to MY 2020 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “−,” and no statistically significant change by “n.s.” For comparison of MY 2021 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.

Where cells are blank in the above table, this reflects that there are missing data in the MCO’s Interactive Data Submission System (IDSS) file. Cells are reported as blank to reflect this.

Denom: denominator; Num: numerator; MY: measurement year; MMC: Medicaid Managed Care; HEDIS: Healthcare Effectiveness Data and Information Set; MM: member months; NA: not available, as no HEDIS percentile is available to compare; N/A: not applicable; ALOS: average length of stay; ED: emergency department.

## 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 2021 Child CAHPS 5.1H Survey Results

Table 2.9: CAHPS MY 2021 Child Survey Results

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Survey Section/Measure** | **2022**  **(MY 2021)** | **2022 Rate Compared to 2021** | **2021 (MY 2020)** | **2021 Rate Compared to 2020** | **2020 (MY 2019)** | **2022 MMC Weighted Average** |
| Satisfaction with Child’s Care | | | | | | |
| Satisfaction with your child's current personal doctor (Rating of 8–10) | 90.27% | ▼ | 94.50% | ▼ | 95.09% | 90.74% |
| Satisfaction with specialist (Rating of 8–10) | 88.52% | ▼ | 88.89% | ▲ | 88.31% | 88.22% |
| Satisfaction with health plan (Rating of 8–10) (Satisfaction with child's plan) | 88.03% | ▼ | 88.13% | ▼ | 90.88% | 87.29% |
| Satisfaction with child's health care (Rating of 8–10) | 86.50% | ▼ | 93.37% | ▲ | 92.65% | 90.78% |
| Quality of Mental Health Care | | | | | | |
| Received care for child's mental health from any provider? (Usually or Always) | 16.53% | ▲ | 11.80% | ▼ | 13.03% | 13.86% |
| Easy to get needed mental health care? (Usually or Always) | 14.29% | ▲ | 8.95% | ▼ | 10.36% | 11.51% |
| Provider you would contact for mental health services? (PCP) | 63.52% | ▼ | 72.43% | ▲ | 64.39% | 65.86% |
| Child's overall mental or emotional health? (Very good or Excellent) | 74.42% | ▼ | 78.24% | ▼ | 83.87% | 76.08% |

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

Gray shaded boxes reflect rates above the MY 2021 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, 2021, for Review Year (RY) 2021. 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 beginning in Review Year (RY) 2019 and has continued for subsequent review years. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 56 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) | 6 |
| Coordination and continuity of care | 457.1230(c) | 5 |
| Coverage and authorization of services | 457.1230(d) | 3 |
| Provider selection | 457.1233(a) | 2 |
| Confidentiality | 457.1230(c) | 1 |
| Grievance systems1 | 457.1260 | 24 |
| Subcontractual relationships and delegation | 457.1233(b) | 1 |
| Practice guidelines | 457.1233(c) | 2 |
| Health information systems | 457.1233(d) | 2 |
| **Subpart E: Quality Measurement and Improvement** | |  |
| Quality assessment and performance improvement program | 457.1240(b) | 7 |

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)*.

In 2022, not all MCOs underwent compliance review and therefore some MCOs’ findings were retained from their 2021 review. In these cases, a footnote will be provided to denote where 2021 findings are included in the below tables.

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 CBC, a review was not completed during 2022. Findings below from their review completed in 2021 have been included as they are the most updated findings available for each category. **CBC was compliant in all categories in 2021, therefore there are no recommendations related to compliance with structure and operations standards for CBC.**

## 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 CFR § 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: review 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: review 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 pay-for-performance (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 2021 EQR Technical Reports, which were distributed May 2022. The 2022 EQR is the fourth 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, 2022, 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 2022, as well as any additional relevant documentation provided by CBC.

The embedded Word document presents CBC’s responses to opportunities for improvement cited by IPRO in the 2021 EQR Technical Report, detailing current and proposed interventions.



## CBC Response to Previous EQR Recommendations

**Table 4.1** displays CBC’s progress related to the *2021 External Quality Review Report,* as well as IPRO’s assessment of CBC’s response.

Table 4.1: CBC Response to Previous EQR Recommendations

| **Recommendation for CBC** | **IPRO Assessment of MCO Response1** |
| --- | --- |
| Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 3–11 years) | Partially addressed |
| Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 12–17 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 (Ages 3–11 years) | Remains an opportunity for improvement |
| Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 12–17 years) | Addressed |
| Improve Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total) | Partially addressed |
| Improve Childhood Immunization Status—Rotavirus | Addressed |
| Improve Childhood Immunization Status—Combination 5 | Measure retired |
| Improve Childhood Immunization Status—Combination 7 | Addressed |
| Improve Childhood Immunization Status—Combination 9 | Measure retired |
| Improve Childhood Immunization Status—Combination 10 | Addressed |
| Improve Lead Screening in Children (Age 2 years) | Partially addressed |
| Improve Chlamydia Screening in Women (Ages 16–20 years) | Remains an opportunity for improvement |
| Improve Developmental Screening in the First Three Years of Life— Total | Remains an opportunity for improvement |
| Improve Developmental Screening in the First Three Years of Life—2 years | Remains an opportunity for improvement |
| Improve Developmental Screening in the First Three Years of Life—3 years | Partially addressed |
| Improve AMBA: Outpatient Visits/1,000 MM Ages < 1 year | Not addressed |
| Improve AMBA: Outpatient Visits/1,000 MM Ages 1—9 years | Not addressed |
| Improve AMBA: Outpatient Visits/1,000 MM Ages < 1—19 years Total Rate | Not addressed |
| Improve AMBA: Emergency Department Visits/1,000 MM Ages 1—9 years | 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.

MCO: managed care organization; EQR: external quality review; MM: member months.

# V: Strengths, Opportunities for Improvement, and EQR Recommendations

The review of the MCO’s MY 2021 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 2022 (MY 2021) on the following measures:
  + Contraceptive Care for All Women (Ages 15–20 years): Most or Moderately Effective;
  + Sealant Receipt on Permanent First Molars (≥ 1 Molar); and
  + Sealant Receipt on Permanent First Molars (All 4 Molars).
* CBC was found to be fully compliant on all contracts and with state and federal managed care regulations reviewed.

## Opportunities for Improvement

* CBC was found to be partially compliant on all elements reviewed for the Dental PIP.
* CBC was found to be partially compliant on all elements reviewed for the Lead Screening PIP
* The MCO’s performance was statistically significantly below/worse than the MMC rate in 2022 (MY 2021) as indicated by the following measures:
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Ages 3–11 years);
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Ages 3–11 years);
  + Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity (Total);
  + Immunizations for Adolescents—HPV;
  + Immunizations for Adolescents—Combination 2;
  + Lead Screening in Children (Age 2 years);
  + Chlamydia Screening in Women (Ages 16–20 years);
  + Developmental Screening in the First Three Years of Life— Total;
  + Developmental Screening in the First Three Years of Life—1 year;
  + Developmental Screening in the First Three Years of Life—2 years;
  + Developmental Screening in the First Three Years of Life—3 years;
  + Annual Dental Visit (Ages 2–3 years);
  + Annual Dental Visit (Ages 4–6 years);
  + AMBA: Outpatient Visits/1,000 MM Ages < 1 year;
  + AMBA: Outpatient Visits/1,000 MM Ages 1—9 years;
  + AMBA: Outpatient Visits/1,000 MM Ages 10—19 years;
  + AMBA: Outpatient Visits/1,000 MM Ages < 1—19 years Total Rate; and
  + AMBA: Emergency Department Visits/1,000 MM Ages < 1 year.

## EQR Recommendations

**Table 5.1** includes IPRO’s recommendations and the type of standard for selected PIPs and performance measures.

Table 5.1: EQR Recommendations

| **Measure/Project** | **IPRO’s Recommendation** | **Standard** |
| --- | --- | --- |
| **Performance Improvement Projects (PIPs)** | |  |
| Improving Access to Pediatric Preventive Dental Care | Regarding the project topic, it was recommended that the MCO describe how PIP Topic addresses your member needs and why it is important to your members. | Quality |
| Regarding the project topic, it was recommended that the MCO describe high-volume or high-risk conditions addressed. | Quality |
| Regarding the project topic, it was recommended that the MCO include MCO data to demonstrate the opportunity for improvement among CBC CHIP membership. | Quality |
| Regarding the project topic, it was recommended that the MCO add an Aim Statement. The Aim Statement must address what will be improved, by how much, among whom, and over what timeframe, and ensure the Aim statement(s) includes each Performance Indicator. | Quality |
| For data analysis, if was recommended that the MCO provide more detail regarding individual intervention tracking measure (ITM) data collection and monitoring (e.g., how are “touchpoints available” and “touchpoints delivered” recorded and collected). | Quality |
| For barrier analysis, it was recommended that the MCO list the data sources that informed “Lack of parental awareness” and “Lack of provider awareness.” Include whether these barriers are identified through conversations with members and providers. | Quality |
| It was recommended that the MCO include target rates in their Results Table. | Quality |
| Improving Blood Lead Screening Rate in Children | It was recommended that CBC develop the following section: Describe how PIP Topic addresses your member needs and why it is important to your members. | Quality |
| It was recommended that CBC include MCO data to demonstrate the opportunity for improvement among CBC CHIP membership. | Quality |
| It was recommended that CBC include an explanation in the Project Topic regarding well-child visits and/or data disparities to tie in Indicator 3 to the overall Lead PIP topic. | Quality |
| It was recommended that CBC add an Aim Statement. The Aim Statement must address what will be improved, by how much, among whom, and over what timeframe. Please ensure the Aim statement(s) includes each Performance Indicator. The aims and objectives identify “improve lead screen rates” as the goal. It was also recommended that it is updated to include indicator 3. | Quality |
| It was recommended that CBC expand the Objectives to detail each intervention. | Quality |
| It was recommended that CBC explain in their methodology why Indicator 2 is identifying children with blood levels greater than or equal to 5mg/dL when the value has been updated to 3.5 µg/dL by the CDC in 2021. | Quality |
| N/A is indicated for sampling, but reference is made to hybrid data. It is recommended that CBC clarify if a hybrid methodology is being used and if so, include a discussion of the sampling methodology. | Quality |
| It was recommended that CBC describe who will be collecting data including titles and qualifications, including for HEDIS. Define “throughout the measurement year” and how often rates are updated. | Quality |
| It is not clear how often data will be reviewed and who will be responsible for this. It is recommended that CBC include data collection/review at least quarterly. Additionally, there is no indication that barriers/root cause analysis will be performed for stagnation or worsening ITM data. | Quality |
| At the end of the section Data Collection and Analysis Procedures, it is recommended that CBC provide more detail regarding individual ITM data collection and monitoring. | Quality |
| Barriers are identified but the source of where/how this barrier was identified is not present. It is recommended that CBC include discussion of this in their report. | Quality |
| It is recommended that CBC include clarification for ITM 1a. For example, what is a “touchpoint”? Is this the number of calls made by parent/guardians, or the number of topics discussed by member services? How will this data be collected and analyzed? Is this a new system being implemented or is member services already doing this (prior to 2022)? The method of barrier identification states member education, how is a member service representative educating a parent/guardian during a touchpoint on the need for lead screening? | Quality |
| Numerator and Denominator definitions for ITM 5b are unclear and appear to be measuring the same thing. It is recommended that CBC revise, so it is clear what is being measured and provide some actions to specifically address these rates. | Quality |
| There are no associated barriers and ITMs addressing Indicator 3, which CBC should add to their report. | Quality |
| **Performance Measures and CAHPS Survey** | |  |
| Weight Management and Counseling | It is recommended that CBC focus efforts on improving weight assessment and counseling for nutrition for their members. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition and Counseling for Physical Activity were opportunities in 2021 and again in 2022. | Access |
| Developmental Screening | It is recommended that CBC focus efforts on developmental screenings for their members younger than 3 years old. Developmental Screening in the First Three Years of Life was an opportunity in 2021 and again in 2022. | Access, Timeliness |
| Dental Care | It is recommended that CBC focus efforts on improving dental care for its members. The Annual Dental Visits measure for members 2-3 years old and 4-6 years old was identified as an opportunity in 2022. | Access, Quality |
| Ambulatory Care Outpatient Visits | It is recommended that CBC focus efforts on improving utilization of ambulatory outpatient visits. The AMBA: Outpatient Visits measure was identified as an opportunity across all age cohorts (< 1 year old to 19 years old) was identified as an opportunity in 2021 and again in 2022. | Access |
| **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; ED: emergency department; N/A: not applicable.

# VI: Summary of Activities

## Performance Improvement Projects

* CBC’s Lead Screening and Dental PIP 2022 Baseline Reports were both validated. The MCO received feedback and subsequent information related to these activities from IPRO and CHIP in 2022.

## Performance Measures

* CBC reported all HEDIS, PA-Specific, and CAHPS Survey performance measures in 2022 for which the MCO had a sufficient denominator.

## Structure and Operations Standards

* CBC was found to be fully compliant on all subparts. Items that were not reviewed for 2022 will be reviewed during the 2023 review cycle. Compliance review findings from the RY 2021 SMART database populated by PA CHIP were used to make the determinations for CBC.

## 2021 Opportunities for Improvement MCO Response

* CBC provided a response to the opportunities for improvement issued in the 2021 annual technical report for those measures that were identified as statistically significantly below or worse than the MMC weighted average.

## 2022 Strengths and Opportunities for Improvement

* Both strengths and opportunities for improvement have been noted for CBC in 2022. A response will be required by the MCO for the noted opportunities for improvement in 2023.

# 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** |
| --- |
| **Capital Blue Cross (CBC) – Preventive Dental** |
| 1. Best Next Action: When a member’s parent/guardian places a call to member services, the representative is notified whether an open gap exists for the member and the representative reminds the caller to have the screening performed. |
| 2. Send annual birthday cards to members which include QR code for parent/guardian to scan; landing page provides resources where they can learn about the importance of dental health. |
| 3. Share HEDIS scoreboard data with CHIP high volume providers in a value-based relationship on either monthly or quarterly clinical quality meetings. |
| **Capital Blue Cross (CBC) – Lead Screening** |
| 1. Best Next Action: When a member’s parent/guardian places a call to member services, the representative is notified whether an open gap exists for the member and the representative reminds the caller to have the screening performed. |
| 2. Send annual birthday cards to members which include QR code for parent/guardian to scan; landing page provides resources where they can learn about the importance of screening for lead exposure. |
| 3. Share HEDIS scoreboard data with CHIP high volume provider groups in a value-based relationship on either monthly or quarterly clinical quality meetings. |
| 4. To establish access to blood lead level (BLL) data for tracking and reporting. |

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 |  | ✓ |
| 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.: 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

1. https://jamanetwork.com/journals/jamapediatrics/article-abstract/2784260 [↑](#footnote-ref-1)
2. https://www.cdc.gov/nceh/lead/docs/cbls-national-data-table-508.pdf [↑](#footnote-ref-2)