Commonwealth Pennsylvania Department of Human Services Children's Health Insurance Program

2019 External Quality Review Report
United Healthcare Community Plan

Final Report
August 2020

IPRO
Better healthcare,
realized.

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Introduction

Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted CHIP 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 CHIP Managed Care recipients.

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

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

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). PA CHIP has contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2019 EQRs for the CHIP MCOs and to prepare the technical reports. This is the second year of separate PA CHIP technical reports. The report includes six core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
IV. 2018 Opportunities for Improvement – MCO Response
V. 2019 Strengths and Opportunities for Improvement
VI. Summary of Activities

For the CHIP MCOs, the information for the compliance with Structure and Operations Standards section of the report is 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. 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.

Information for Section II of this report is derived from activities conducted with and on behalf of DHS to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. Information for Section I 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®[1]) measures for each CHIP MCO. Within Section II, CAHPS Survey results follow the performance measures.

Section IV, 2018 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2018 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 peformance measures across HEDIS® and Pennsylvania-specfic performance measures where the MCO has performed highest and lowest. Section V provides a summary of EQR activities for the CHIP MCO for this review period.

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

I: Structure and Operations Standards

This section of the EQR report presents a review of the CHIP MCOs compliance with structure and operations standards. The review is based on information derived from the most recent reviews of the MCO. On site reviews are conducted by CHIP annually.

The format for this section of the report was developed to be consistent with the subparts prescribed by the BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol.* Under each subpart heading are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three BBA regulations subparts as explained in the Protocol, i.e., Subpart C: Enrollee Rights and Protections; Subpart D: Quality Assessment And Performance Improvement (including access, structure and operation and measurement and improvement standards); and Subpart H: Certifications and Program Integrity. As PA CHIP continues to move forward with alignment of the EQR provisions to the CHIP population, re-assessment of the review items and crosswalks may be warranted.

Methodology and Format

Prior to the audit which is performed on-site at the MCO, documents are provided to CHIP by the MCO, which address various areas of compliance. This includes training materials, provider manuals, MCO organization charts, policies and procedures manuals, and geo access maps. These documents are reviewed prior to the onsite audit and are used to address areas of compliance which include Quality of Care, Medical Services, Provider Adequacy, Applications and Eligibility, Customer Service, Marketing Outreach, Audits, and IT Reports. These items are 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.

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. Table 1.1 showcases each of the items and subcategories.

IPRO reviewed the most recent elements in the areas that CHIP audits and created a crosswalk to pertinent BBA regulations. A total of 31 unique items were identified that were relevant to evaluation of CHIP-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semi-annually, quarterly, monthly and as needed. The items from Review Year (RY) 2019 provide the information necessary for this assessment. For RY 2019, Pennsylvania is designated a Cycle 1 state for CMS Payment Error Rate Measurement (PERM). The Cycle 1 review had not been completed at the time of the onsite review. PERM results and any Corrective Action Plan will be presented to CHIP MCOs in the future.

Table 1.1: Compliance Items and Subcategories

Subpart C: Enrollee Rights and Protections
Medical Services
PH-95
Bright Futures
Case Management
Utilization Management
Quality Improvement Plans
Quality of Care
Provider Network and Adequacy
Provider Credentialing
Appointment Standards
Communication to Providers and Members
Provider Enrollment

Application and Eligibility
Application Timeliness and Renewal Rates
UFI Random Sample
Transfers In/ Out of Enrollment
Subpart D: Quality Assessment and Performance Improvement Regulations
Customer Service
CHIP Dedicated Customer Service Staff
CHIP Information
Application Input
General Website and Online Manuals
Blue and Green Sheets
Marketing and Outreach
Community Outreach
Programmatic Change Requests
Subpart H: Certifications and Program Integrity
Audits and Reports
ERP Logs and Resolution
Fraud and Abuse
Precluded Provider Report
HIPAA Breaches
PPS Reporting
A-133
Information Technology Files and Reports
Ad Hoc
TMSIS/Encounter Data
Provider Files
Testing

Determination of Compliance

Information necessary for the review is provided through an on-site review that is conducted by DHS CHIP. Throughout the duration of this on-site, each area highlighted above is reviewed and a rating scale is utilized to determine compliance. The MCO can be rated either "non-compliant", "partially compliant", or "compliant" in each area based on the findings of the audit. Following each rating scale, a comprehensive description of identified strengths and weaknesses are provided to the MCO. 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.

Subsections under parts C, D and H are based on the items that were reviewed during the most recent review year. This focuses the current year's technical reports on results that were found during the current year for compliance review. As items are required to be reviewed during a three year time period, it is possible that an MCO has been evaluated for an item but was not reviewed this year. In these instances, an N/A is notated for the MCO in the report. There is no corresponding non-compliance penalty for an MCO in this case.

Subpart C: Enrollee Rights and Protections

31 items were evaluated for the MCO in Review Year (RY) 2019.

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

Table 1.2: MCO Compliance with Subpart C: Enrollee Rights and Protections Regulations

Subpart C: Categories	Compliance	Comments
PH-95	N/A	
Bright Futures	Compliant	United Healthcare Community Plan (UHC) has provided multiple ways of their compliancy with Bright Futures. Clinical Practice Consultants provide face to face provider education in offices which is tracked and noted the number of offices who has received the training. The Quality team works with UHC' s Core providers and ACO practices to provide education and resources during monthly and quarterly meeting. Providers also received information via fax and email.
Case Management	Compliant	
Utilization Management	Compliant	
Quality Improvement Plans	N/A	
Provider Network and Adequacy	Compliant	
Provider Credentialing	Compliant	
Appointment Standards	Compliant	
Communication to Providers and Members	Compliant	Clinical Practice Consultants provide face to face provider education in offices which is tracked and noted the number of offices who has received the training. Providers also received information via fax and email. There is a provider online portal that is used to give bulletin and new information
Provider Enrollment	Compliant	
Application Timeliness and Renewal Rates	Compliant	UHC had adequate timeliness on processing applications, but there was a dip in the fifteen-day processing of apps between December 2018 and January 2019; UHC stated that this was because of open enrollment's increased application amount. UHC stated that to combat the spike in the upcoming open enrollment, they have hired new staff.
UFI Random Sample	Compliant	
Transfers In/ Out of Enrollment	N/A	

Subpart D: Quality Assessment and Performance Improvement Regulations

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 CHIP enrollees. [42 C.F.R. § 438.206 (a)]

Table 1.3: MCO Compliance with Subpart D: Quality Assessment and Performance Improvement Regulations

Subpart D: Categories	Compliance	Comments
CHIP Dedicated Customer Service Staff	Compliant	
CHIP Information	N/A	
Application Input	Compliant	
General Website and Online Manuals	Compliant	
Blue and Green Sheets	Compliant	
Community Outreach	N/A	
Programmatic Change Requests	Compliant	

Subpart H: Certifications and Program Integrity

The general purpose of the Subpart H regulations is to ensure the promotion of program integrity through programs which prevent fraud and abuse through means of misspent program funds and to promote quality health care services for CHIP enrollees. These safeguards require that the CHIP MCO make a commitment to a formal and effective fraud and abuse program. [42 C.F.R. § 438.600 (a)]

Table 1.4: MCO Compliance with Subpart H: Certifications and Program Integrity

Subpart H: Categories	Compliance	Comments
ERP Logs and Resolution	Compliant	
Fraud and Abuse	Compliant	
Precluded Provider Report	N/A	
HIPAA Breaches	Compliant	
PPS Reporting	Compliant	

Subpart H: Categories	Compliance	Comments
A-133	Compliant	
Ad Hoc	Compliant	
TMSIS/Encounter Data	Compliant	
Provider Files	Compliant	
Testing	Compliant	

II. Performance Improvement Projects

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 2019 for 2018 activities. Under the applicable Agreement with the DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two PIPs were implemented as part of this requirement. 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 for each proposal.

As part of the EQR PIP cycle that was initiated for all CHIP MCOs in 2017, IPRO adopted the LEAN methodology, following the CMS recommendation that Quality Improvement Organizations (QIOs) and other healthcare stakeholders embrace LEAN in order to promote continuous quality improvement in healthcare.

2019 is the eleventh year to include validation of PIPs. For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

In 2018, CHIP MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, the two topics selected were "Improving Developmental Screening Rate in Children Ages 1, 2, and 3 Years" and "Improving Blood Lead Screening Rate in Children 2 Years of Age". Interim results included in the following section were provided by plans for both of these PIPs in 2019.

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

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

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

"Improving Blood Lead Screening Rates in Children 2 Years of Age" was selected as the result of a number of observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages three through six without a prior lead blood test have blood levels screened consistent with current Department of Health and CDC standards. The average national lead screening rate in 2016 is 66.5%, while the Pennsylvania CHIP average is 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the past few years, rates by Contractor and weighted average fall below the national average. In addition to the lead screening rate, Contractors have been encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors are identified,

- Total number of children successfully identified with elevated blood lead levels,
- Percent of the population under the age of five suffering from elevated blood lead levels, or
- Percent of individuals employed in the agriculture, forestry, mining, and construction industries.

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

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

Validation Methodology

IPRO's review evaluates each project against seven review elements:

Element 1. Project Topic/Rationale
Element 2. Aim
Element 3. Methodology
Element 4. Barrier Analysis
Element 5. Robust Interventions
Element 6. Results Table
Element 7. Discussion and Validity of Reported Improvement

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

Review Element Designation/Weighting

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. MY 2017 is the baseline year, and during the 2019 review year, due to the several levels of feedback required, elements were reviewed and scored at multiple points during the year once interim reports were submitted in July 2019. Some MCOs received guidance towards improving their submissions in these findings, and MCOs responded accordingly with resubmission to correct specific areas.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. The elements are not formally scored beyond the full/partial/non-compliant determination.

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

Table 2.1: Element Designation

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

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have 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. Some elements will be re-reviewed as applicable with each submission. 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 focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the CHIP MCOs, and IPRO continued and progressed throughout the review year.

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

- MCO-specific review findings for each PIP.
- Conference calls with each MCO as needed to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic.
- Information to assist MCOs in preparing their next full PIP submission for the Interim Year 1 Update, such as additional instructions regarding collection of the core required measures.

As discussed earlier, interim documents were submitted in July 2019. Review of these submissions began in August 2019 and ran through October 2019. Upon initial review of the submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary. MCOs requiring additional discussion and potential modification were contacted and advised via email of any necessary or optional changes that IPRO determined would improve the quality of their overall projects.

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

UHC provided a discussion of topic rationale in 2018, which included the potential for meaningful impact on member health, functional status, and satisfaction. The topic selection, noted at baseline, impacts the maximum proportion of members that is feasible, while still reflecting high-volume and high-risk conditions. The discussion also included support of the topic rationale with MCO-specific data and trends, which were utilized to compare to statewide and nationwide benchmarks in assessing reasonability of the topic of Developmental Screening.

The aim statement was included at baseline, and specified performance indicators for improvement, which also included corresponding goals. These goals target improvement rates in the population that are bold and feasible, and based upon baseline data and trends. It was noted during baseline review that improvement goals over time should also be included. UHC has developed objectives in 2018 that align the aim and goals with corresponding interventions. It was noted during baseline review that one of the performance indicators, percentage of PCPs educated by Clinical Practice Consultants on developmental screening importance, falls into the category of tracking measure, and is better suited to be developed as a measure to track an intervention born out of the plan's barrier analysis. Per the baseline findings, this was removed from the project by the plan in their 2019 interim report. It was noted during this 2019 review that Indicators 1-3 describe individual components of the CHIP-defined measure: Developmental Screening in the First Three

Years of Life and do not represent a contractor-defined indicator, and a contractor defined indicator is required for this project. The plan replaced indicator 4 with another measure of health care that aligned with the goal of the project and is distinct from the developmental screening measure in their final interim report submission in 2019.

Methodologically, UHC developed indicators at baseline which measure changes in health status, functional status, and processes of care with strong associations with improved outcomes. It was noted at baseline review that the indicators themselves are defined clearly and have been demonstrated to be measurable, as they are PA-specific and HEDIS performance measures. The study design specified data collection methods that are valid and data analysis procedures which are logical.

UHC performed a barrier analysis in 2018 which utilized feedback from providers, ad hoc reviews of medical records, and claims analysis to identify susceptible subpopulations, stratified by clinical characteristics. Provider input was utilized at baseline to identify barriers, and subsequently informed the development of robust interventions. These interventions included provider and member education and outreach. It was noted that the interventions and their tracking measures could benefit from additional information in the proposal, including detailed information on provider and member educational approaches and refining of tracking measures to best follow the success of the implemented interventions. In their 2019 interim report, the plan's mailing intervention was removed due to its passive nature and difficultly in measuring effect.

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

Discussion of the success of the PIP to date was included in 2019, with relevant analyses included to note changes in performance indicators, as well as follow up activities that are planned and lessons learned from this stage of the project.

Improving Blood Lead Screening Rate in Children 2 Years of Age

UHC provided a discussion of topic rationale at baseline which included the potential for meaningful impact on member health, functional status, and satisfaction. It was noted in 2018 that the topic selection impacts the maximum proportion of members that is feasible, while still reflecting high-volume and high-risk conditions. At baseline, UHC was encouraged to provide additional information with regards to a discussion in their project topic section that focused on cities with confirmed elevated blood levels. It was not evident from the baseline proposal if these were cities in the UHC coverage area, or what the impact of the issue is for UHC specifically. These concerns were addressed in the plan's 2019 interim report submission.

The aim, developed in 2018, specified performance indicators for improvement with corresponding goals. These goals set a target improvement rate that is feasible and bold, and based upon baseline data and strength of interventions, including rationale. The objectives outlined by the plan align the aim of the proposal and the goals with MCO-specific interventions.

Methodologically, UHC developed indicators at baseline which measure changes in health status, functional status, and processes of care with strong associations with improved outcomes. Most indicators themselves were defined clearly and have been demonstrated to be measurable, as they are PA-specific and HEDIS performance measures. At baseline, it was noted that the second indicator selected, which focuses on practitioner office education, is better suited to be a tracking measure, and should be replaced with a measure that focuses on health care status. In UHC's 2019 interim report, their second indicator was removed as a performance indicator, and per the guidelines an additional contractor-defined indicator was developed for this project. The study design specified data collection methods that are valid and data analysis procedures which are logical.

UHC performed a barrier analysis in 2018, which utilized feedback from providers and office staff to identify susceptible subpopulations, stratified by clinical characteristics. Provider input was utilized to identify barriers, and subsequently

informed the development of robust interventions. These interventions include provider and member education and outreach. It was noted that the interventions and their tracking measures could benefit from additional information in the proposal, including detailed information on provider and member educational approaches and refining of tracking measures to best follow the success of the implemented interventions. These concerns were addressed in the plan's 2019 interim report for this project.

As with Developmental Screening, UHC was asked to provide updated finalized rates for all performance indicators at baseline review. Additionally, final goals and target rates were requested to be included in the results section to track progress towards goals over time. These rates were included in the MCO's 2019 interim report.

Discussion of the success of the PIP to date was included in 2019, with relevant analyses included to note changes in performance indicators, as well as follow up activities that are planned and lessons learned from this stage of the project. This included discussion of how activities may be adjusted in response to the interim findings for this project.

Table 2.1: UHC PIP Compliance Assessments – Interim Reports

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

III. Performance Measures and CAHPS® Survey

Methodology

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 2019. Source code, raw data and rate sheets were submitted by the MCOs to IPRO for review in 2019. 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. Source code was reviewed by IPRO. Raw data were also reviewed for reasonability and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. Differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates.

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

Table 3.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS®	Children and Adolescents' Access to PCPs (Age 12 - 24 months)
HEDIS®	Children and Adolescents' Access to PCPs (Age 25 months - 6 years)
HEDIS®	Children and Adolescents' Access to PCPs (Age 7-11 years)
HEDIS®	Children and Adolescents' Access to PCPs (Age 12-19 years)
Well-Care Visits and Immunizations	
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Total)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Total)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 3-11 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 12-17 years)
HEDIS®	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical Activity: (Total)
HEDIS®	Childhood Immunization Status by Age 2 (DtaP)
HEDIS®	Childhood Immunization Status by Age 2 (IPV)
HEDIS®	Childhood Immunization Status by Age 2 (MMR)
HEDIS®	Childhood Immunization Status by Age 2 (HiB)
HEDIS®	Childhood Immunization Status by Age 2 (Hepatitis B)
HEDIS®	Childhood Immunization Status by Age 2 (VZV)
HEDIS®	Childhood Immunization Status by Age 2 (Pneumococcal Conjugate)
HEDIS®	Childhood Immunization Status by Age 2 (Hepatitis A)
HEDIS®	Childhood Immunization Status by Age 2 (Rotavirus)
HEDIS®	Childhood Immunization Status by Age 2 (Influenza)

Source	Measures
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 2)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 3)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 4)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 5)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 6)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 7)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 8)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 9)
HEDIS®	Childhood Immunizations Status by Age 2 (Combination 10)
HEDIS®	Immunizations for Adolescents (Meningococcal)
HEDIS®	Immunizations for Adolescents (Tdap/Td)
HEDIS®	Immunizations for Adolescents (HPV)
HEDIS®	Immunizations for Adolescents (Combination 1)
HEDIS®	Immunizations for Adolescents (Combination 2)
EPSDT: Screenings and Follow-up	
HEDIS®	Lead Screening in Children (Age 2 years)
HEDIS®	Chlamydia Screening in Women (Age 16-19 years)
PA EQR	Developmental Screening in the First Three Years of Life – 1 year
PA EQR	Developmental Screening in the First Three Years of Life – 2 years
PA EQR	Developmental Screening in the First Three Years of Life – 3 years
PA EQR	Developmental Screening in the First Three Years of Life – Total
PA EQR	Contraceptive Care for All Women Most/Moderately Effective (Age 15 months – 2 years)
PA EQR	Contraceptive Care for All Women LARC (Age 15 months – 2 years)
PA EQR	Contraceptive Care for Postpartum Women Most/Moderately Effective – 3 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women Most/Moderately Effective – 60 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women LARC – 3 days (Age 15 months – 20 years)
PA EQR	Contraceptive Care for Postpartum Women LARC – 60 days (Age 15 months – 20 years)
Dental Care for Children	
HEDIS®	Annual Dental Visit (Age 2-20 years)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
Respiratory Conditions	
HEDIS®	Appropriate Testing for Children with Pharyngitis
HEDIS®	Appropriate Treatment for Children with Upper Respiratory Infection
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 5-11 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 12-18 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Age 19 years)
HEDIS®	Medication Management for People with Asthma - 50% Compliance (Total)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Age 19 years)
HEDIS®	Medication Management for People with Asthma - 75% Compliance (Total)
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2 – 19 years)
HEDIS®	Asthma Medication Ratio (Age 5-11 years)
HEDIS®	Asthma Medication Ratio (Age 12-18 years)
HEDIS®	Asthma Medication Ratio (Age 19 years)
HEDIS®	Asthma Medication Ratio (Total)
Behavioral Health	
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)

Source	Measures
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 1 – 5 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 6 – 11 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 12 – 17 years)
HEDIS®	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 1 – 5 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 6 – 11 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Age 12 – 17 years)
HEDIS®	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 1 – 5 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 6 – 11 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 12 – 17 years)
HEDIS®	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)
Utilization	
HEDIS®	Well-Child Visits in the First 15 Months of Life (0 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (1Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (2 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (3 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (4 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (5 Visits)
HEDIS®	Well-Child Visits in the First 15 Months of Life (>= 6 Visits)
HEDIS®	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 – 6 years)
HEDIS®	Adolescent Well-Care Visits (Age 12 – 19 years)
HEDIS®	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages <1 - 19 years)
HEDIS®	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Surgery Discharges /1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Surgery Average Length of Stay /1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Medicine Discharges /1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Medicine Average Length of Stay /1000 Member Months (Ages <1 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Maternity /1000 Member Months (Ages 10 - 19 years)
HEDIS®	Inpatient Utilization - General Hospital/Acute Care: Maternity Average Length of Stay /1000 Member Months (Ages 10 - 19 years)
HEDIS®	Mental Health Utilization: Any Services (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Any Services (Ages 13 – 17 years Male and Female)
HEDIS®	Mental Health Utilization: Inpatient (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Inpatient (Ages 13 – 17 years Male and Female)
HEDIS®	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13 – 17 years Male and Female)
HEDIS®	Mental Health Utilization: Outpatient (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Outpatient (Ages 13 – 17 years Male and Female)
HEDIS®	Mental Health Utilization: Emergency Department (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Emergency Department (Ages 13 – 17 years Male and Female)
HEDIS®	Mental Health Utilization: Telehealth (Ages 0 – 12 years Male and Female)
HEDIS®	Mental Health Utilization: Telehealth (Ages 13 – 17 years Male and Female)
HEDIS®	Identification of Alcohol and Other Drug Services: Any Services (Ages 0 – 12 years Male and Female)
HEDIS®	Identification of Alcohol and Other Drug Services: Any Services (Ages 13 – 17 years Male and Female)
HEDIS®	Identification of Alcohol and Other Drug Services: Inpatient (Ages 0 – 12 years Male and Female)
HEDIS®	Identification of Alcohol and Other Drug Services: Inpatient (Ages 13 – 17 years Male and Female)

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

Pennsylvania (PA)-Specific Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS® specifications. Measures previously developed and added as mandated by CMS for children in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) were continued as applicable to revised CMS specifications. New measures were developed and added in 2018 as mandated in accordance with the ACA. In 2019, no new measures were added. For each indicator, the criteria that were specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed. Indicator rates were calculated through one of two methods: (1) administrative, which uses only the MCOs data systems to identify numerator positives and (2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator "hits" for rate calculation.

PA Specific Administrative Measures

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.

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

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

Additionally, to be more closely aligned to the CHIPRA Core Set Measure specifications, this measure is enhanced for the state with additional available dental data (Dental-enhanced).

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

This performance measure assesses the percentage of children and adolescents, two 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 at risk of unintended pregnancy and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC). 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 who had a live birth and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC), within 3 days and within 60 days of delivery. For the CMS Core measures, four rates are reported in total (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 2019. 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® 2019, Volume 2 Narrative. The measurement year for HEDIS® 2019 measures is 2018, 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. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.0 – Child Survey.

Children and Adolescents' Access to Primary Care Practitioners

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

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

Well-Child Visits in the First 15 Months of Life

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

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

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

Childhood Immunization Status

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

Adolescent Well-Care Visits

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

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

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

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

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

Immunization for Adolescents

This measure assessed the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

- Combination 1: Meningococcal and Tdap
- 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 assessed the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

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

Follow Up After Hospitalization for Mental Illness

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.
- 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

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

Chlamydia Screening in Women

This measure assessed the percentage of women 16–19 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 Children with Pharyngitis

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

Appropriate Treatment for Children with Upper Respiratory Infection

This measure assessed the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Medication Management for People with Asthma - 75% Compliance

This measure assessed the percentage of members 5–19 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period and remained on an asthma controller medication for at least 75% of their treatment period.

Asthma Medication Ratio – New for 2019

This measure assessed the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

This measure assessed the percentage of children and adolescents 1–17 years of age who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

For this measure a lower rate indicates better performance.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

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

Additional HEDIS® Measures

Ambulatory Care, Inpatient Utilization, Mental Health Utilization, and Identification of Alcohol and Other Drug Services measures, due to differences in reporting metrics compared to the above measures, are included in Tables A1 through A4 in Appendix A of this report.

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 2019 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 new in 2018 for all CHIP MCOs. As in 2018, in 2019 CHIP MCOs saw very small denominators for the Contraceptive Care for Postpartum Women (CCP) measure, and 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.

The Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH) measure underwent some modifications in 2018. This measure was new in 2016 and several issues were discovered during the 2016 validation process. Feedback received from MCOs regarding the 2016 implementation was highlighted for discussion and led to modifications to the measure specifications for the 2017 validation process. One issue in particular was that many MCOs noted that there were providers other than the ones specified by CMS potentially applying the sealants. Based on the issues, a second numerator was developed in addition to the CMS numerator. Cases included in this numerator are cases that would not have been accepted per the CMS guidance because the provider type could not be crosswalked to an acceptable CMS provider. The second numerator was created to quantify these cases, and to provide additional information for DHS about whether sealants were being applied by providers other than those outlined by CMS, for potential future consideration when discussing the measure. There was a wide range of other providers identified across MCOs for the second numerator. Because the second numerator and the total created by adding both numerators deviate from CMS guidance, they were provided to DHS for informational purposes but are not included for reporting. The SEAL-CH and enhanced SEAL-CH rates reported in this section for are comparable to the 2016 rates and are aligned with the CMS guidance. In 2019, these changes were continued, and applicable CDT codes used for numerator compliance were updated and/or added.

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 1st, 2nd, or 3rd birthday. Specifically, the member must be screened in the following timeframes in order to be compliant for their age cohort:

- Age Cohort 1: member must be screened anytime between birth to 1st birthday
- Age Cohort 2: member must be screened anytime between 1 day after 1st birthday to day of 2nd birthday
- Age Cohort 3: member must be screened anytime between 1 day after 2nd birthday to day of 3rd birthday

In 2019, these clarifications were continued forward, and 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.
- Age Cohort 3: Children who had a claim with a relevant CPT code after their second birthday and before or on their third birthday

Findings

MCO results are presented in Tables 3.2 through 3.8. 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., 2019 (MY 2018) and 2018 (MY 2017)]. In addition, statistical comparisons are made between the 2019 and 2018 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 2019 rates to 2018 rates, statistically significant increases are indicated by "+", statistically significant decreases by "–" and no statistically significant change by "n.s.".

In addition to each individual MCOs rate, the MMC average for 2019 (MY 2018) is presented. The MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of difference between the plan's measurement year rate and the MMC average for the same year. For comparison of 2019 rates to MMC rates, the "+" symbol denotes that the plan rate exceeds the MMC rate; the "–" symbol denotes that the MMC rate exceeds the plan rate and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS® measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS® measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a **3**-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "NA" (Not Applicable) appears in the corresponding cells. However, "NA" (Not Available) also appears in the cells under the HEDIS® 2019 percentile column for PA-specific measures that do not have HEDIS® percentiles to compare.

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

Graphical representation of findings is provided for a subset of measures with sufficient data to provide informative illustration to the tables provided below. These can be found in the appendix.

Access to/Availability of Care

No strengths are identified for 2019 (MY 2018) Access/Availability of Care performance measures.

No opportunities for improvement are identified for 2019 (MY 2018) Access/Availability of Care performance measures.

Table 3.2: Access to Care

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Children and Adolescents' Access To PCP (12-24 Months)	483	475	98.3%	97.1%	99.6%	98.5%	n.s.	97.9%	n.s.	>= 90th percentile
HEDIS	Children and Adolescents' Access To PCP (25 Months-6 Yrs)	5,594	5,232	93.5%	92.9%	94.2%	94.3%	n.s.	94.1%	n.s.	>= 90th percentile
HEDIS	Children and Adolescents' Access To PCP (7-11 Yrs)	5,870	5,656	96.4%	95.9%	96.8%	96.9%	n.s.	96.6%	n.s.	>= 90th percentile
HEDIS	Children and Adolescents' Access To PCP (12-19 Yrs)	7,946	7,639	96.1%	95.7%	96.6%	96.2%	n.s.	96.3%	n.s.	>= 90th percentile

Well-Care Visits and Immunizations

Strengths are identified for the following 2019 (MY 2018) Well-Care Visits and Immunizations performance measures.

- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)
    - Immunizations for Adolescents – HPV
    - Immunizations for Adolescents - Combination 2

No opportunities for improvement are identified for 2019 (MY 2018) Well-Care Visits and Immunizations performance measures.

Table 3.3: Well-Care Visits and Immunizations

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2018 Rate Compared to 2017	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years)	11,327	140	88.6%	88.0%	89.2%	85.8%	+	84.4%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years)	7,640	81	88.0%	87.3%	88.8%	89.5%	-	82.2%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)	18,967	221	88.4%	87.9%	88.9%	87.3%	+	83.5%	+	>= 75th and < 90th percentile

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2018 Rate Compared to 2017	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years)	11,327	132	83.5%	82.9%	84.2%	84.9%	-	78.9%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years)	7,640	74	80.4%	79.5%	81.3%	89.0%	-	75.6%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	18,967	206	82.4%	81.9%	82.9%	86.6%	-	77.5%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years)	11,327	126	79.7%	79.0%	80.5%	76.2%	+	73.4%	+	>= 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years)	7,640	77	83.7%	82.9%	84.5%	90.7%	-	76.4%	+	>= 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	18,967	203	81.2%	80.6%	81.8%	82.2%	-	74.6%	+	>= 90th percentile
HEDIS	Childhood Immunization Status - DTaP	725	368	89.5%	87.2%	91.8%	85.9%	n.s.	86.7%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - IPV	725	391	95.1%	93.5%	96.8%	92.7%	n.s.	92.6%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - MMR	725	381	92.7%	90.7%	94.7%	92.2%	n.s.	91.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status - HiB	725	389	94.6%	92.9%	96.4%	93.7%	n.s.	92.2%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Hepatitis B	725	389	94.6%	92.9%	96.4%	93.2%	n.s.	91.6%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - VZV	725	383	93.2%	91.3%	95.1%	93.2%	n.s.	91.1%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Pneumococcal Conjugate	725	372	90.5%	88.3%	92.7%	86.4%	n.s.	87.2%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Hepatitis A	725	367	89.3%	87.0%	91.6%	90.8%	n.s.	87.4%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status - Rotavirus	725	338	82.2%	79.4%	85.1%	80.0%	n.s.	79.1%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Influenza	725	242	58.9%	55.2%	62.5%	63.0%	n.s.	58.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Childhood Immunization Status - Combo 2	725	351	85.4%	82.8%	88.0%	82.2%	n.s.	82.2%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 3	725	344	83.7%	80.9%	86.5%	79.6%	n.s.	80.1%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 4	725	332	80.8%	77.8%	83.7%	78.3%	n.s.	77.1%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 5	725	300	73.0%	69.7%	76.3%	68.4%	n.s.	70.5%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 6	725	223	54.3%	50.6%	58.0%	56.7%	n.s.	53.5%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 7	725	295	71.8%	68.4%	75.1%	67.4%	n.s.	68.6%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 8	725	221	53.8%	50.1%	57.5%	56.7%	n.s.	52.7%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 9	725	208	50.6%	46.9%	54.3%	50.9%	n.s.	49.0%	n.s.	>= 90th percentile
HEDIS	Childhood Immunization Status - Combo 10	725	206	50.1%	46.4%	53.8%	50.9%	n.s.	48.2%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents - Meningococcal	1,546	381	92.7%	91.4%	94.0%	91.2%	n.s.	92.7%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents - Tdap	1,546	385	93.7%	92.4%	94.9%	91.0%	n.s.	93.8%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents - HPV	1,546	159	38.7%	36.2%	41.1%	39.7%	n.s.	35.6%	+	>= 50th and < 75th percentile
HEDIS	Immunizations for Adolescents - Combination 1	1,546	376	91.5%	90.1%	92.9%	88.6%	n.s.	91.4%	n.s.	>= 90th percentile
HEDIS	Immunizations for Adolescents - Combination 2	1,546	154	37.5%	35.0%	39.9%	38.2%	n.s.	34.2%	+	>= 50th and < 75th percentile

EPSDT/Bright Futures: Screenings and Follow-up

No strengths are identified for the 2019 (MY 2018) EPSDT: Screenings and Follow-up performance measures.

No opportunities for improvement are identified for the 2019 (MY 2018) EPSDT: Screenings and Follow-up performance measures.

Table 3.4: EPSDT/Bright Futures: Screenings and Follow-up

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Lead Screening in Children	725	279	67.9%	64.4%	71.4%	66.2%	n.s.	66.1%	n.s.	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (16-20)	930	420	45.2%	41.9%	48.4%	42.2%	n.s.	42.6%	n.s.	>= 10th and < 25th percentile
HEDIS	Chlamydia Screening in Women - Total	930	420	45.2%	41.9%	48.4%	42.2%	n.s.	42.6%	n.s.	>= 10th and < 25th percentile
PA EQR	Developmental Screening in the First Three Years of Life – 1 year	1,812	1,017	56.1%	53.8%	58.4%	53.7%	n.s.	56.0%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life – 2 years	106	58	54.7%	44.8%	64.7%	50.0%	n.s.	50.3%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life – 3 years	725	425	58.6%	55.0%	62.3%	56.7%	n.s.	58.3%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life – Total	981	534	54.4%	51.3%	57.6%	52.0%	n.s.	55.1%	n.s.	NA
PA EQR	Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective	2,811	718	25.5%	23.9%	27.2%	18.5%	+	28.2%	-	NA
PA EQR	Contraceptive Care for All Women (Age 15 – 20 years): LARC	2,811	53	1.9%	1.4%	2.4%	2.4%	n.s.	1.9%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): Most or moderately effective contraception – 3 days	19	1	NA	NA	NA	NA	NA	5.9%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): Most or moderately effective contraception – 60 days	19	7	NA	NA	NA	NA	NA	43.1%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): LARC – 3 days	19	0	NA	NA	NA	NA	NA	3.9%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15 – 20 years): LARC – 60 days	19	2	NA	NA	NA	NA	NA	19.6%	NA	NA

Dental Care for Children

No strengths are identified for the 2019 (MY 2018) Dental Care for Children performance measures.

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

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Annual Dental Visit (15-18 Years)
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk
  - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced)

Table 3.5: Dental Care for Children

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Annual Dental Visit (2-3 Yrs)	1,907	949	49.8%	47.5%	52.0%	47.6%	n.s.	48.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Annual Dental Visit (4-6 Yrs)	3,754	2,820	75.1%	73.7%	76.5%	74.0%	n.s.	75.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Annual Dental Visit (7-10 Yrs)	6,508	5,055	77.7%	76.7%	78.7%	76.4%	n.s.	78.7%	n.s.	>= 75th and < 90th percentile

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Annual Dental Visit (11-14 Yrs)	6,437	4,705	73.1%	72.0%	74.2%	72.6%	n.s.	75.2%	-	>= 90th percentile
HEDIS	Annual Dental Visit (15-18 Yrs)	5,632	3,523	62.6%	61.3%	63.8%	62.2%	n.s.	66.0%	-	>= 75th and < 90th percentile
HEDIS	Annual Dental Visit (19-20 Yrs)	102	57	55.9%	45.8%	66.0%	46.0%	n.s.	54.3%	n.s.	>= 90th percentile
HEDIS	Annual Dental Visit (Total)	24,340	17,109	70.3%	69.7%	70.9%	69.1%	+	71.8%	-	>= 90th percentile
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)	4,267	51	1.2%	0.9%	1.5%	22.1%	-	18.9%	-	NA
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)	4,361	128	2.9%	2.4%	3.5%	22.3%	-	19.2%	-	NA

Note: The ADV 19-20 year old age cohort is reported here as only 19 year olds, in order to include only members that are CHIP eligible.

Respiratory Conditions

No strengths are identified for the 2019 (MY 2018) Respiratory Conditions performance measures.

Opportunities for improvement are identified for the following Respiratory measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
    - Medication Management for People With Asthma - Medication Compliance 75% (Total)

Table 3.6: Respiratory Conditions

Indicator		2019 (MY 2018)						Rate Comparison			
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Appropriate Testing for Children With Pharyngitis	1,650	1,420	86.1%	84.4%	87.8%	83.5%	+	87.3%	n.s.	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children With Upper Respiratory Infection[1]	1,768	168	90.5%	89.1%	91.9%	90.7%	n.s.	90.4%	n.s.	>= 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma - 50% Compliance (Age 5-11 years)	212	129	60.8%	54.0%	67.7%	59.4%	n.s.	61.9%	n.s.	NA
HEDIS	Medication Management for People with Asthma - 50% Compliance (Age 12-18 years)	151	82	54.3%	46.0%	62.6%	52.1%	n.s.	58.8%	n.s.	NA
HEDIS	Medication Management for People with Asthma - 50% Compliance (Total)	365	212	58.1%	52.9%	63.3%	56.7%	n.s.	60.4%	n.s.	NA
HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (5-11)	212	66	31.1%	24.7%	37.6%	32.0%	n.s.	37.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (12-18)	151	42	27.8%	20.3%	35.3%	34.7%	n.s.	35.3%	n.s.	>= 25th and < 50th percentile
HEDIS	Medication Management for People With Asthma - Medication Compliance 75% (Total)	365	108	29.6%	24.8%	34.4%	33.0%	n.s.	36.4%	-	>= 10th and < 25th percentile
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2 – 19 years)	3,079	294	9.6%	8.5%	10.6%	8.8%	n.s.	10.0%	n.s.	NA
HEDIS	Asthma Medication Ratio - 5 - 11 years	227	179	78.9%	73.3%	84.4%	NA	NA	77.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio - 12 - 18 years	168	117	69.6%	62.4%	76.9%	NA	NA	70.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio - 19 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Asthma Medication Ratio - Total	397	297	74.8%	70.4%	79.2%	NA	NA	73.9%	n.s.	>= 90th percentile

[1] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
Note: Although reporting for age cohort 19 - 50 year olds for the MMA measure, it is not included in CHIP reporting as most members in this cohort are not eligible for CHIP based on age.

Behavioral Health

No strengths are identified for 2019 (MY 2018) Behavioral Health performance measures.

No opportunities for improvement are identified for 2019 (MY 2018) Behavioral Health performance measures.

Table 3.7: Behavioral Health

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	201	103	51.2%	44.1%	58.4%	54.0%	n.s.	49.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	43	29	67.4%	52.3%	82.6%	56.7%	n.s.	63.7%	n.s.	>= 75th and < 90th percentile
HEDIS	Follow Up After Hospitalization For Mental Illness - 7 days	92	43	46.7%	36.0%	57.5%	51.7%	n.s.	46.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Follow Up After Hospitalization For Mental Illness - 30 days	92	62	67.4%	57.3%	77.5%	78.0%	n.s.	69.9%	n.s.	>= 25th and < 50th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (6-11 years)	0	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5 Years)	6	3	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (12-17 years)	36	15	41.7%	24.2%	59.2%	NA	NA	37.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	42	18	42.9%	26.7%	59.0%	38.9%	n.s.	42.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-5 Years)	0	-	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6-11 years)	5	1	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 years)	21	1	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	26	1	NA	NA	NA	NA	NA	68.6%	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1-5 Years)	0	-	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6-11 years)	5	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12-17 years)	23	0	NA	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	28	0	NA	NA	NA	NA	NA	NA	NA	NA

Utilization

No strengths are identified for the 2019 (MY 2018) Utilization performance measures.

Opportunities for improvement are identified for the following Utilization measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Well-Child Visits in the first 15 Months of Life (5 visits)
  - Ambulatory Care: Outpatient Visits/1000 MM Ages <1 year
  - Ambulatory Care: Outpatient Visits/1000 MM Ages 1 - 9 years
  - Ambulatory Care: Outpatient Visits/1000 MM Ages 10 - 19 years
  - Ambulatory Care: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate
  - Ambulatory Care: Emergency Department Visits/1000 MM Ages <1 year

Table 3.8: Utilization

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (0 visits)	310	0	0.0%	0.0%	0.2%	0.3%	n.s.	0.2%	n.s.	NA
HEDIS	Well-Child Visits in the first 15 Months of Life (1 visit)	310	0	0.0%	0.0%	0.2%	0.3%	n.s.	0.0%	NA	NA
HEDIS	Well-Child Visits in the first 15 Months of Life (2 visits)	310	0	0.0%	0.0%	0.2%	0.6%	n.s.	0.4%	n.s.	NA

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (3 visits)	310	4	1.8%	0.2%	3.5%	1.3%	n.s.	1.1%	n.s.	< 10th percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (4 visits)	310	6	2.7%	0.8%	4.7%	2.8%	n.s.	2.9%	n.s.	< 10th percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (5 visits)	310	16	7.3%	4.2%	10.4%	9.1%	n.s.	13.7%	-	< 10th percentile
HEDIS	Well-Child Visits in the first 15 Months of Life (6 or more visits)	310	193	88.1%	84.4%	91.9%	85.6%	-	81.7%	-	>= 90th percentile
HEDIS	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	4,755	182	83.1%	82.0%	84.2%	85.9%	-	84.0%	-	>= 75th and < 90th percentile
HEDIS	Adolescent Well-Care Visits	10,544	242	73.8%	72.9%	74.6%	73.7%	-	70.2%	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages <1 year	3,395	2,214	652.14	NA	NA	697.03	-	727.44	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 1 - 9 years	199,635	51,489	257.92	NA	NA	255.11	-	273.40	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 10 - 19 years	227,881	50,764	222.77	NA	NA	225.73	-	237.76	-	>= 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate	430,911	104,467	242.43	NA	NA	243.23	-	257.32	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages <1 year	3,395	120	35.35	NA	NA	38.35	-	40.21	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 1 - 9 years	199,635	6,381	31.96	NA	NA	32.72	-	30.21	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 10 - 19 years	227,881	5,898	25.88	NA	NA	27.61	-	25.12	-	>= 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages <1 - 19 years Total Rate	430,911	12,399	28.77	NA	NA	30.13	-	27.52	-	>= 90th percentile
HEDIS	IPUA: Total Discharges/1000 MM Ages <1 year	3,395	8	2.36	NA	NA	3.20	-		NA	NA
HEDIS	IPUA: Total Discharges/1000 MM Ages 1 - 9 years	199,635	117	0.59	58.4%	58.8%	0.81	-		NA	NA
HEDIS	IPUA: Total Discharges/1000 MM Ages 10 - 19 years	227,881	161	0.71	70.5%	70.8%	0.92	-		NA	NA
HEDIS	IPUA: Total Discharges/1000 MM Ages <1 - 19 years Total Rate	430,911	286	0.66	66.2%	66.5%	0.89	-		NA	NA
HEDIS	IPUA: Total Inpatient ALOS Ages <1 year	8	26	3.25	NA	NA	6.40	NA		NA	NA
HEDIS	IPUA: Total Inpatient ALOS Ages 1 - 9 Years	117	327	2.79	NA	NA	2.74	NA		NA	NA
HEDIS	IPUA: Total Inpatient ALOS Ages 10 - 19 years	161	495	3.07	NA	NA	4.69	NA		NA	NA
HEDIS	IPUA: Total Inpatient ALOS Ages <1 - 19 years Total Rate	286	848	2.97	NA	NA	3.88	NA		NA	NA
HEDIS	IPUA: Surgery Discharges/1000 MM Ages <1 year	3,395	0	0.00	0.0%	0.0%	0.00	NA		NA	NA
HEDIS	IPUA: Surgery Discharges/1000 MM Ages 1 - 9 years	199,635	14	0.07	6.9%	7.1%	0.07	-		NA	NA
HEDIS	IPUA: Surgery Discharges/1000 MM Ages 10 - 19 years	227,881	34	0.15	14.8%	15.1%	0.21	-		NA	NA
HEDIS	IPUA: Surgery Discharges/1000 MM Ages <1 - 19 years Total Rate	430,911	48	0.11	11.0%	11.2%	0.14	-		NA	NA
HEDIS	IPUA: Surgery ALOS Ages <1 year	0	0	NA	NA	NA	-	NA		NA	NA
HEDIS	IPUA: Surgery ALOS Ages 1 - 9 years	14	49	3.50	NA	NA	5.57	NA		NA	NA
HEDIS	IPUA: Surgery ALOS Ages 10 - 19 years	34	158	4.65	NA	NA	6.93	NA		NA	NA
HEDIS	IPUA: Surgery ALOS Ages <1 - 19 years Total Rate	48	207	4.31	NA	NA	6.62	NA		NA	NA
HEDIS	IPUA: Medicine Discharges/1000 MM Ages <1 year	3,395	8	2.36	NA	NA	3.20	-		NA	NA
HEDIS	IPUA: Medicine Discharges/1000 MM Ages 1 - 9 years	199,635	103	0.52	51.4%	51.8%	0.75	-		NA	NA
HEDIS	IPUA: Medicine Discharges/1000 MM Ages 10 - 19 years	227,881	101	0.44	44.1%	44.5%	0.64	-		NA	NA
HEDIS	IPUA: Medicine Discharges/1000 MM Ages <1 - 19 years Total Rate	430,911	212	0.49	49.0%	49.3%	0.71	-		NA	NA
HEDIS	IPUA: Medicine ALOS Ages <1 year	8	26	3.25	NA	NA	6.40	NA		NA	NA
HEDIS	IPUA: Medicine ALOS Ages 1 - 9 years	103	278	2.70	NA	NA	2.48	NA		NA	NA
HEDIS	IPUA: Medicine ALOS Ages 10 - 19 years	101	270	2.67	NA	NA	4.16	NA		NA	NA
HEDIS	IPUA: Medicine ALOS Ages <1 - 19 years Total Rate	212	574	2.71	NA	NA	3.39	NA		NA	NA
HEDIS	IPUA: Maternity/1000 MM Ages 10 - 19 years	227,881	26	0.11	11.3%	11.5%	0.08	-		NA	NA
HEDIS	IPUA: Maternity ALOS Ages 10 - 19 years Total Rate	26	67	2.58	NA	NA	2.94	NA		NA	NA
HEDIS	MPT: Any Services Ages 0 - 12 years - Male	143,403	726	6.08%	6.0%	6.2%	6.31%	-		NA	NA
HEDIS	MPT: Any Services MM Ages 0 - 12 years - Female	141,342	470	3.99%	3.9%	4.1%	4.21%	-		NA	NA
HEDIS	MPT: Any Services Ages 0 - 12 years - Total Rate	284,745	1,196	5.04%	5.0%	5.1%	5.27%	-		NA	NA
HEDIS	MPT: Any Services Ages 13 - 17 years - Male	62,261	387	7.46%	7.3%	7.7%	7.37%	-		NA	NA
HEDIS	MPT: Any Services Ages 13 - 17 years - Female	61,348	618	12.09 %	11.8%	12.3%	12.52%	-		NA	NA

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	MPT: Any Services Ages 13 - 17 years - Total Rate	123,609	1,005	9.76%	9.6%	9.9%	9.91%	-		NA	NA
HEDIS	MPT: Inpatient Ages 0 - 12 years - Male	143,403	11	0.09%	0.1%	0.1%	0.04%	-		NA	NA
HEDIS	MPT: Inpatient Ages 0 - 12 years - Female	141,342	18	0.15%	0.1%	0.2%	0.03%	-		NA	NA
HEDIS	MPT: Inpatient Ages 0 - 12 years - Total Rate	284,745	29	0.12%	0.1%	0.1%	0.04%	-		NA	NA
HEDIS	MPT: Inpatient Ages 13 - 17 years - Male	62,261	23	0.44%	0.4%	0.5%	0.20%	-		NA	NA
HEDIS	MPT: Inpatient Ages 13 - 17 years - Female	61,348	57	1.11%	1.0%	1.2%	0.83%	-		NA	NA
HEDIS	MPT: Inpatient Ages 13 - 17 years - Total Rate	123,609	80	0.78%	0.7%	0.8%	0.51%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	143,403	17	0.14%	0.1%	0.2%	0.10%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	141,342	8	0.07%	0.1%	0.1%	0.04%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	284,745	25	0.11%	0.1%	0.1%	0.07%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	62,261	9	0.17%	0.1%	0.2%	0.06%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	61,348	31	0.61%	0.5%	0.7%	0.14%	-		NA	NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	123,609	40	0.39%	0.4%	0.4%	0.10%	-		NA	NA
HEDIS	MPT: Outpatient Ages 0 - 12 years - Male	143,403	712	5.96%	5.8%	6.1%	6.15%	-		NA	NA
HEDIS	MPT: Outpatient Ages 0 - 12 years - Female	141,342	464	3.94%	3.8%	4.0%	4.12%	-		NA	NA
HEDIS	MPT: Outpatient Ages 0 - 12 years - Total Rate	284,745	1,176	4.96%	4.9%	5.0%	5.14%	-		NA	NA
HEDIS	MPT: Outpatient Ages 13 - 17 years - Male	62,261	377	7.27%	7.1%	7.5%	7.06%	-		NA	NA
HEDIS	MPT: Outpatient Ages 13 - 17 years - Female	61,348	596	11.66 %	11.4%	11.9%	11.40%	-		NA	NA
HEDIS	MPT: Outpatient Ages 13 - 17 years - Total Rate	123,609	973	9.45%	9.3%	9.6%	9.20%	-		NA	NA
HEDIS	MPT: ED Ages 0 - 12 years - Male	143,403	4	0.03%	0.0%	0.0%	0.02%	-		NA	NA
HEDIS	MPT: ED Ages 0 - 12 years - Female	141,342	2	0.02%	0.0%	0.0%	0.01%	-		NA	NA
HEDIS	MPT: ED Ages 0 - 12 years - Total Rate	284,745	6	0.03%	0.0%	0.0%	0.02%	-		NA	NA
HEDIS	MPT: ED Ages 13 - 17 years - Male	62,261	2	0.04%	0.0%	0.1%	0.06%	-		NA	NA
HEDIS	MPT: ED Ages 13 - 17 years - Female	61,348	2	0.04%	0.0%	0.1%	0.22%	-		NA	NA
HEDIS	MPT: ED Ages 13 - 17 years - Total Rate	123,609	4	0.04%	0.0%	0.1%	0.14%	-		NA	NA
HEDIS	MPT: Telehealth Ages 0 - 12 years - Male	143,403	1	0.01%	0.0%	0.0%	0.00%	n.s.		NA	NA
HEDIS	MPT: Telehealth Ages 0 - 12 years - Female	141,342	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	MPT: Telehealth Ages 0 - 12 years - Total Rate	284,745	1	0.00%	0.0%	0.0%	0.00%	n.s.		NA	NA
HEDIS	MPT: Telehealth Ages 13 - 17 years - Male	62,261	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	MPT: Telehealth Ages 13 - 17 years - Female	61,348	2	0.04%	0.0%	0.1%	0.00%	n.s.		NA	NA
HEDIS	MPT: Telehealth Ages 13 - 17 years - Total Rate	123,609	2	0.02%	0.0%	0.0%	0.00%	n.s.		NA	NA
HEDIS	IAD: Any Services Ages 0 - 12 years - Male	143,403	2	0.02%	0.0%	0.0%	0.02%	-		NA	NA
HEDIS	IAD: Any Services Ages 0 - 12 years - Female	141,342	5	0.04%	0.0%	0.1%	0.01%	-		NA	NA
HEDIS	IAD: Any Services Ages 0 - 12 years - Total Rate	284,745	7	0.03%	0.0%	0.0%	0.01%	-		NA	NA
HEDIS	IAD: Any Services Ages 13 - 17 years - Male	62,261	36	0.69%	0.6%	0.8%	1.10%	-		NA	NA
HEDIS	IAD: Any Services Ages 13 - 17 years - Female	61,348	44	0.86%	0.8%	0.9%	0.69%	-		NA	NA
HEDIS	IAD: Any Services Ages 13 - 17 years - Total Rate	123,609	80	0.78%	0.7%	0.8%	0.90%	-		NA	NA
HEDIS	IAD: Inpatient Ages 0 - 12 years - Male	143,403	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Inpatient Ages 0 - 12 years - Female	141,342	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Inpatient Ages 0 - 12 years - Total Rate	284,745	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Inpatient Ages 13 - 17 years - Male	62,261	6	0.12%	0.1%	0.1%	0.12%	-		NA	NA
HEDIS	IAD: Inpatient Ages 13 - 17 years - Female	61,348	12	0.23%	0.2%	0.3%	0.20%	-		NA	NA
HEDIS	IAD: Inpatient Ages 13 - 17 years - Total Rate	123,609	18	0.17%	0.2%	0.2%	0.16%	-		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Male	143,403	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Female	141,342	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0 - 12 years - Total Rate	284,745	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Male	62,261	3	0.06%	0.0%	0.1%	0.00%	n.s.		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Female	61,348	3	0.06%	0.0%	0.1%	0.00%	n.s.		NA	NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13 - 17 years - Total Rate	123,609	6	0.06%	0.0%	0.1%	0.00%	+		NA	NA
HEDIS	IAD: Outpatient Ages 0 - 12 years - Male	143,403	1	0.01%	0.0%	0.0%	0.01%	-		NA	NA

Indicator		2019 (MY 2018)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2018 (MY2017) Rate	2019 Rate Compared to 2018	MMC	2019 Rate Compared to MMC	HEDIS 2019 percentile
HEDIS	IAD: Outpatient Ages 0 - 12 years - Female	141,342	1	0.01%	0.0%	0.0%	0.01%	-		NA	NA
HEDIS	IAD: Outpatient Ages 0 - 12 years - Total Rate	284,745	2	0.01%	0.0%	0.0%	0.01%	-		NA	NA
HEDIS	IAD: Outpatient Ages 13 - 17 years - Male	62,261	20	0.39%	0.3%	0.4%	0.61%	-		NA	NA
HEDIS	IAD: Outpatient Ages 13 - 17 years - Female	61,348	26	0.51%	0.5%	0.6%	0.34%	-		NA	NA
HEDIS	IAD: Outpatient Ages 13 - 17 years - Total Rate	123,609	46	0.45%	0.4%	0.5%	0.48%	-		NA	NA
HEDIS	IAD: ED Ages 0 - 12 years - Male	143,403	1	0.01%	0.0%	0.0%	0.01%	-		NA	NA
HEDIS	IAD: ED Ages 0 - 12 years - Female	141,342	3	0.03%	0.0%	0.0%	0.00%	n.s.		NA	NA
HEDIS	IAD: ED Ages 0 - 12 years - Total Rate	284,745	4	0.02%	0.0%	0.0%	0.00%	-		NA	NA
HEDIS	IAD: ED Ages 13 - 17 years - Male	62,261	8	0.21%	0.2%	0.2%	0.37%	-		NA	NA
HEDIS	IAD: ED Ages 13 - 17 years - Female	61,348	6	0.18%	0.1%	0.2%	0.14%	-		NA	NA
HEDIS	IAD: ED Ages 13 - 17 years - Total Rate	123,609	14	0.19%	0.2%	0.2%	0.26%	-		NA	NA
HEDIS	IAD: Telehealth Ages 0 - 12 years - Male	143,403	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Telehealth Ages 0 - 12 years - Female	141,342	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Telehealth Ages 0 - 12 years - Total Rate	284,745	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Telehealth Ages 13 - 17 years - Male	62,261	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Telehealth Ages 13 - 17 years - Female	61,348	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA
HEDIS	IAD: Telehealth Ages 13 - 17 years - Total Rate	123,609	0	0.00%	0.0%	0.0%	0.00%	NA		NA	NA

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey

Satisfaction with the Experience of Care

The following tables provide the survey results of four composite questions by two specific categories for the MCO across the last three measurement years, as available. The composite questions will target the MCOs 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, which 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 the tables.

2019 Child CAHPS® 5.0H Survey Results

Table 3.9: CAHPS® 2019 Child Survey Results

Satisfaction with Child's Care	2019 (MY 2018)	2019 Rate Compared to 2018	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2019 MMC Weighted Average
Satisfaction with your child's current personal doctor (rating of 8 to 10)	88.76%	▼	90.28%	▲	85.03%	90.42%
Satisfaction with specialist (rating of 8 to 10)	87.39%	▲	86.05%	▲	81.25%	84.67%
Satisfaction with health plan (rating of 8 to 10) (satisfaction with child's plan)	79.83%	▼	82.64%	▲	77.29%	85.77%
Satisfaction with child's health care (rating of 8 to 10)	88.02%	▲	84.52%	▲	83.60%	88.80%
Quality of Mental Health Care						
Received care for child's mental health from any provider? (usually or always)	8.76%	▲	6.76%	▼	9.97%	10.29%
Easy to get needed mental health care? (usually or always)	9.01%	▼	33.73%	▼	41.14%	18.96%
Provider you would contact for mental health services? (PCP)	69.66%	▲	68.98%	▼	71.43%	67.10%
Child's overall mental or emotional health? (very good or excellent)	79.66%	▼	82.89%	▲	80.08%	81.32%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2019 CHIP Weighted Average.

IV: 2018 Opportunities for Improvement MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each PH MCO has addressed the opportunities for improvement made by IPRO in the 2018 CHIP EQR Technical Reports, which were distributed April 2019. The 2019 EQR is the first to include descriptions of current and proposed interventions from each CHIP MCO that address the 2018 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 July 31, 2019 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 2019, as well as any additional relevant documentation provided by UHC.

Table 4.1 presents UHC's responses to opportunities for improvement cited by IPRO in the 2018 CHIP EQR Technical Report, detailing current and proposed interventions.

Table 4.1: Current and Proposed Interventions

Reference Number: [UHCP] 2018.01: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Annual Dental Visit (11-14 Yrs.).
Follow Up Actions Taken Through 07/31/19: **Public Health Dental Hygiene Practitioner (PHDHP) Program (Ongoing)** • UnitedHealthcare has continued its partnership with Cornerstone Health for a Public Health Dental Hygiene Practitioner (PHDHP) program. The PHDHP meets with members that are seen in a primary care setting and provides oral health instruction to the member and their parent/guardian and helps to coordinate a dental visit for that child. If time permits, the PHDHP will provide a cleaning or topical fluoride varnish. The PHDHP also provides follow-up telephone calls to ensure that the member follows through on their dental visit. In June 2019 UnitedHealthcare expanded the PHDHP program to the South East Zone with Greater Philadelphia Health Action. This FQHC will also see members in the primary care setting to help increase ADV compliance with one of our largest providers. **Topical Fluoride Varnish (Ongoing)** • In an attempt to increase primary care provider support of members establishing a dental home, UnitedHealthcare put together a Topical Fluoride Varnish educational training/slides for Pediatric Primary Care Providers. Additionally, a list of General Dentists that see pediatric members was provided to Pediatric Practices in an attempt to create more referral opportunities for dental care. **UHC Dental Advisory Committee (started Q2 2019)** • UnitedHealthcare also established a Dental Advisory Committee made up of General and Pediatric Dentists, Orthodontists, Oral Surgeons, Dental Schools and a Public Policy Expert. The purpose of the group is to improve dental care and expand dental coverage for UnitedHealthcare members. There have been two Dental Advisory Committee Meetings in 2019. In addition, UnitedHealthcare has held two Dental Provider Town Hall meetings, in which all dental providers (participating and non-participating) are invited to discuss Pennsylvania Government Dental Programs and Dental Quality Initiatives.

Broken Appointment Pilot (started Q2 2019)

- UnitedHealthcare has developed a pilot program with a provider in South West Pennsylvania to provide outreach to UnitedHealthcare members that have at least two broken appointments. Thus far, only one member has been reached and the provider will be sharing an updated list of members to be contacted regarding their broken appointments.

Mobile Dental Events (Ongoing)

- UnitedHealthcare has partnered with Miracle Dental's mobile dental events in South West Pennsylvania to create an opportunity to close gaps in care for members in need of an annual dental visit. Members will be contacted by telephone to inform them of mobile dental events in their area. Members that are interested in participating in the mobile dental event will have an appointment scheduled for the mobile dental event in their area.

Future Actions Planned:

Dental Advisory Committee and Provider Town Halls (Q3 2019)

Dental Advisory Committee meetings will continue to take place Quarterly and Provider Town Halls will occur semi-annually. These meetings will focus on quality initiatives around Annual Dental Visits.

Future Actions Planned:

The plan will be continuing all follow up actions listed above.

Expected outcome or goals of the actions that were taken or will be taken:

An increase in utilization and completion of contraceptive care by members is our expected outcome/goals. The plan expects higher percentage of members accessing services through our ongoing outreach efforts with these initiatives.

Process for monitoring the actions to determine the effectiveness of the actions taken:

The effectiveness of these activities will be measured and evaluated to determine as to whether revisions need to be made to current actions by monthly Quality meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to develop new initiatives to improve rates, and monitor HEDIS rates month over month.

Reference Number: [UHCP] 2018.02: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Annual Dental Visit (15-18 Yrs.)

Follow Up Actions Taken Through 07/31/19:

Please see section **[UHCP] 2018.01:**

Future Actions Planned:

Please see section **[UHCP] 2018.01:**

Reference Number: [UHCP] 2018.03: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Annual Dental Visit (Total).

Follow Up Actions Taken Through 07/31/19:

Please see section **[UHCP] 2018.01:**

Future Actions Planned:

Please see section **[UHCP] 2018.01:**

Reference Number: [UHCP] 2018.04: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA).

Follow Up Actions Taken Through 07/31/19:

Provider Education (Ongoing)

- UnitedHealthcare promoted the use of dental sealants with dental providers by educating providers on clinical guidelines

and opportunities to provide this valuable service to children. This promotion was done via fax blasts and leave-behinds from Provider Advocates.

Provider Incentive (Q4 2018 and Q4 2019)

- UnitedHealthcare offered a sealant incentive for the month of October as a way to promote dental sealants. There were 60 providers that met the incentive in 2018 and this incentive will run again in October 2019.

Future Actions Planned:

Promotion of Dental Sealant (Planned in October 2019)

UnitedHealthcare will continue to promote the use of dental sealants with dental providers through provider education and an incentive for the month of October.

Focus Groups (Planned for Q3 2019)

UnitedHealthcare will have a Dental Sealant focus group ("Sealant Summit") with the largest dental providers to obtain feedback on strategies to increase sealant utilization, barriers to utilization and ideas on the incentive.

Future Actions Planned:

The plan will be continuing all follow up actions listed above.

Expected outcome or goals of the actions that were taken or will be taken:

An increase in utilization and completion of contraceptive care by members is our expected outcome/goals. The plan expects higher percentage of members accessing services through our ongoing outreach efforts with these initiatives.

Process for monitoring the actions to determine the effectiveness of the actions taken:

The effectiveness of these activities will be measured and evaluated to determine as to whether revisions need to be made to current actions by monthly Quality meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to develop new initiatives to improve rates, and monitor HEDIS rates month over month.

Reference Number: [UHCP] 2018.05: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Appropriate Testing for Children With Pharyngitis.

Follow Up Actions Taken Through 07/31/19:

Clinical Practice Consultant (CPCs) (Ongoing)

- CPC's educate providers with quick reference guide on rapid streps with Pharyngitis diagnosis from Pediatric Reference Guides
- CPC's distribute Quick Reference Guide for Adult HEDIS measures and Pediatric HEDIS measures to the providers. Educate not only Pediatricians but Family Practitioners as well

Provider Education in Newsletter (Ongoing)

- Created and published a newsletter article regarding pharyngitis testing

Future Actions Planned:

The plan will be continuing all follow up actions listed above.

Expected outcome or goals of the actions that were taken or will be taken:

An increase in utilization and completion of contraceptive care by members is our expected outcome/goals. The plan expects higher percentage of members accessing services through our ongoing outreach efforts with these initiatives.

Process for monitoring the actions to determine the effectiveness of the actions taken:

The effectiveness of these activities will be measured and evaluated to determine as to whether revisions need to be made to current actions by monthly Quality meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to develop new initiatives to improve rates, and monitor HEDIS rates month over month.

Reference Number: [UHCP] 2018.06: The MCO's rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Well-Child Visits in the first 15 Months of Life (5 visits).

Follow Up Actions Taken Through 07/31/19:

One Year Birthday Mailing (Ongoing)

- Educational mailing on well visits and preventive care to parents/caregivers during the month of member's first birthday. This mailing also includes a reminder card and tracker for visits and immunizations

Clinical Practice Consultants (CPCs) Activities (Ongoing)

- CPC's provide ongoing education to billing agents on proper CPT codes for BRIGHT FUTURES screenings.
- Educating providers and their staff on well child visits and providing gap in care listing to each respective practice

Auto Call Education Campaign (Ongoing)

- Interactive Voice Recognition (IVR) Child Health Prevention: Auto messaging to educate/ encourage parents of children with care gaps to complete their well child visits

Developmental Education Member Mailing (Ongoing)

- Developmental screening educational mailing sent to parent/caregivers
- CPC's are working with the Philadelphia Department of Public Health to distribute informational packet to providers around developmental assessments and screenings

Online Provider Education (Ongoing)

- Web Based provider learning through UHC OnAir which delivers education regarding BRIGHT FUTURES. This resource continues to be discussed with providers by the CPCs and the link to the UHC OnAir provider site.

Live Outreach Calls (Ongoing)

- Telephonic outreach calls conducted to education parents/guardians on the importance of well child visits. In addition, assistance with appointment scheduling and reminders calls are completed

Advocate for Me Model(Ongoing)

- Connects the member to the Service Advocate that will best to support the call and/or care the member is requiring: provides provider information, appointment scheduling, assists with PCP and provider searches, completing a health assessment

Future Actions Planned:

The plan will be continuing all Follow up actions listed above.

Expected outcome or goals of the actions that were taken or will be taken:

An increase in utilization and completion of contraceptive care by members is our expected outcome/goals. The plan expects higher percentage of members accessing services through our ongoing outreach efforts with these initiatives.

Process for monitoring the actions to determine the effectiveness of the actions taken:

The effectiveness of these activities will be measured and evaluated to determine as to whether revisions need to be made to current actions by monthly Quality meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to develop new initiatives to improve rates, and monitor HEDIS rates month over month.

V. 2019 Strengths and Opportunities for Improvement

The review of MCO's 2019 performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for CHIP members served by this MCO.

Strengths

- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2019 (MY 2018) on the following measures:
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years)
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)
    - Immunizations for Adolescents - HPV
    - Immunizations for Adolescents - Combination 2

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2019 (MY 2018) as indicated by the following measures:
    - Annual Dental Visit (15-18 Yrs)
    - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk
    - Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced)
    - Medication Management for People With Asthma - Medication Compliance 75% (Total)
    - Well-Child Visits in the first 15 Months of Life (5 visits)
    - Ambulatory Care: Outpatient Visits/1000 MM Ages <1 year
    - Ambulatory Care: Outpatient Visits/1000 MM Ages 1 - 9 years
    - Ambulatory Care: Outpatient Visits/1000 MM Ages 10 - 19 years
    - Ambulatory Care: Outpatient Visits/1000 MM Ages <1 - 19 years Total Rate
    - Ambulatory Care: Emergency Department Visits/1000 MM Ages <1 year

VI. Summary of Activities

Structure and Operations Standards

- UHC was found to be fully compliant on Subparts C, D and H. Compliance review findings for ABH from RY 2019 were used to make the determinations.

Performance Improvement Projects

- UHC's Lead Screening and Developmental Screening PIP Interim Reports were both validated. The MCO received feedback and subsequent information related to these activities from IPRO and CHIP in 2019.

Performance Measures

- UHC reported all HEDIS, PA Performance Measures, and CAHPS Survey performance measures in 2019 for which the MCO had a sufficient denominator.

2018 Opportunities for Improvement MCO Response

- UHC provided a response to the opportunities for improvement issued in the 2018 annual technical report for those measures on that were identified as statistically significantly below or worse the MMC.

2019 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for UHC in 2019. A response will be required by the MCO for the noted opportunities for improvement in 2020.

Appendix

Figure 1: Access to Care

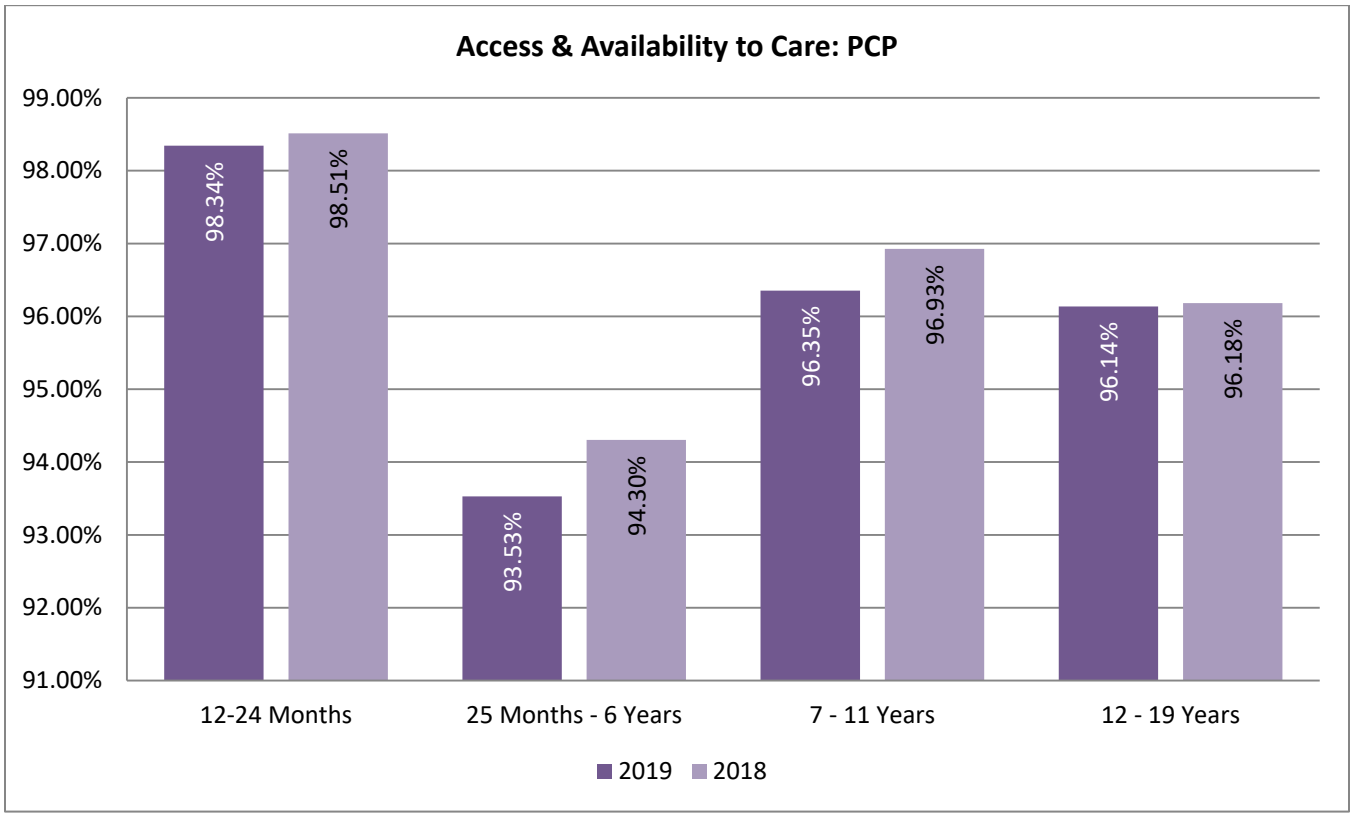

Figure 2: Well Care I

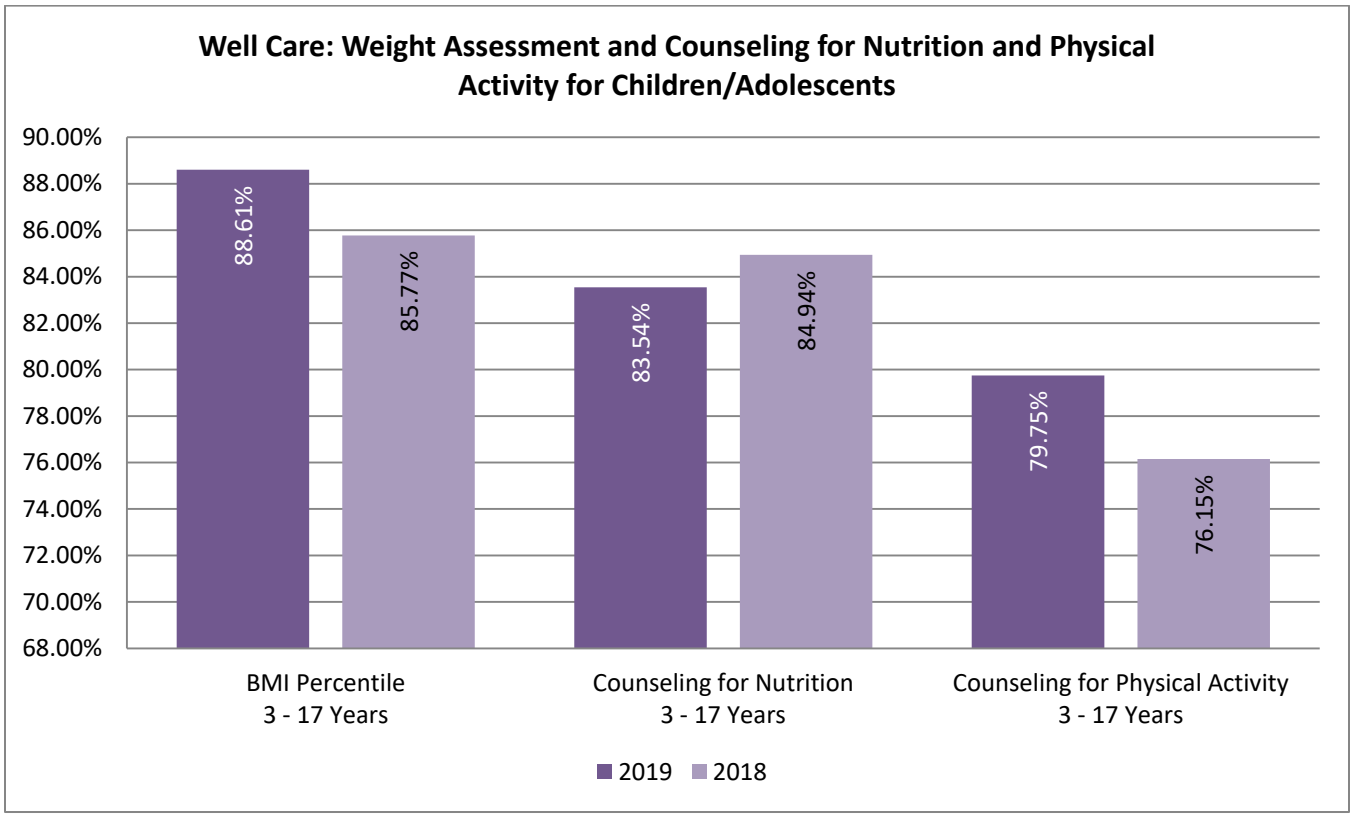

Figure 3: Well Care II

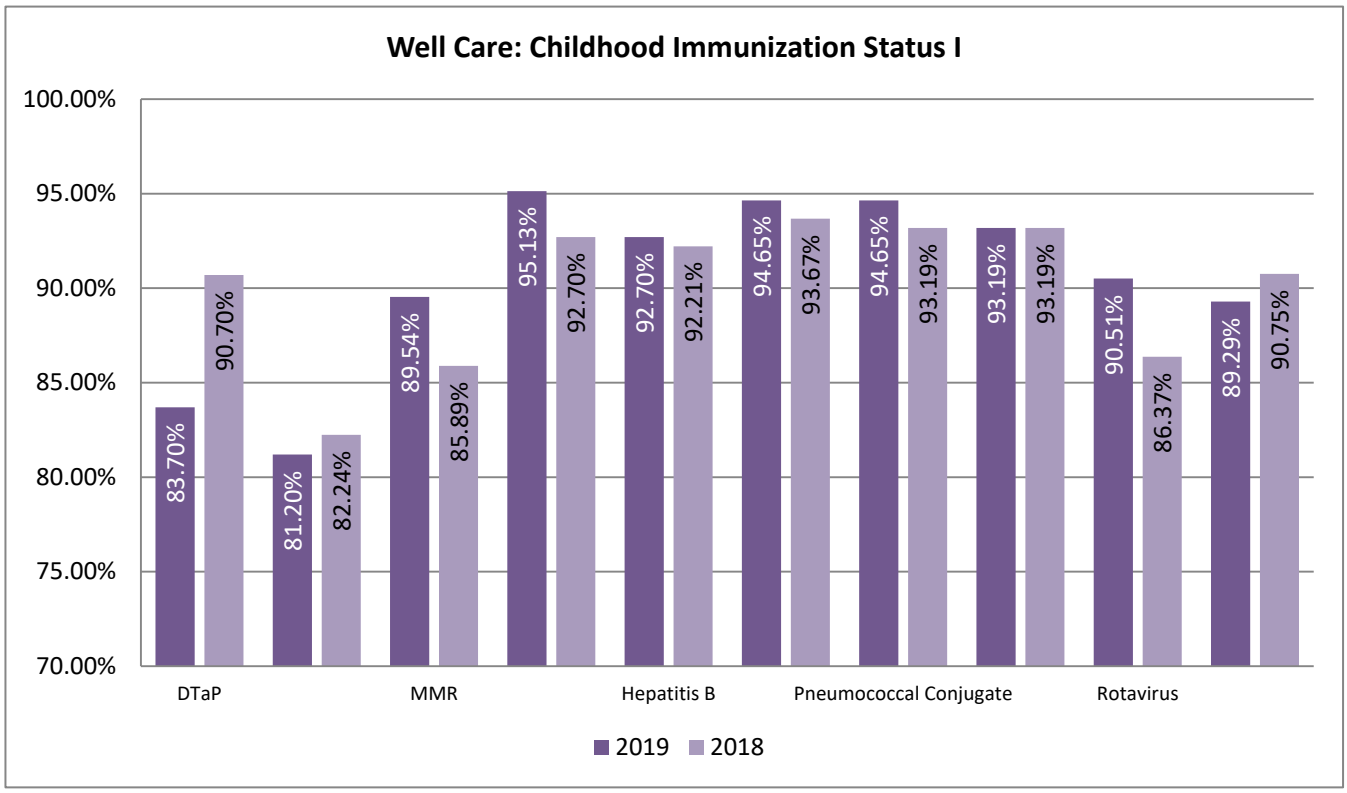

Figure 4: Well Care III

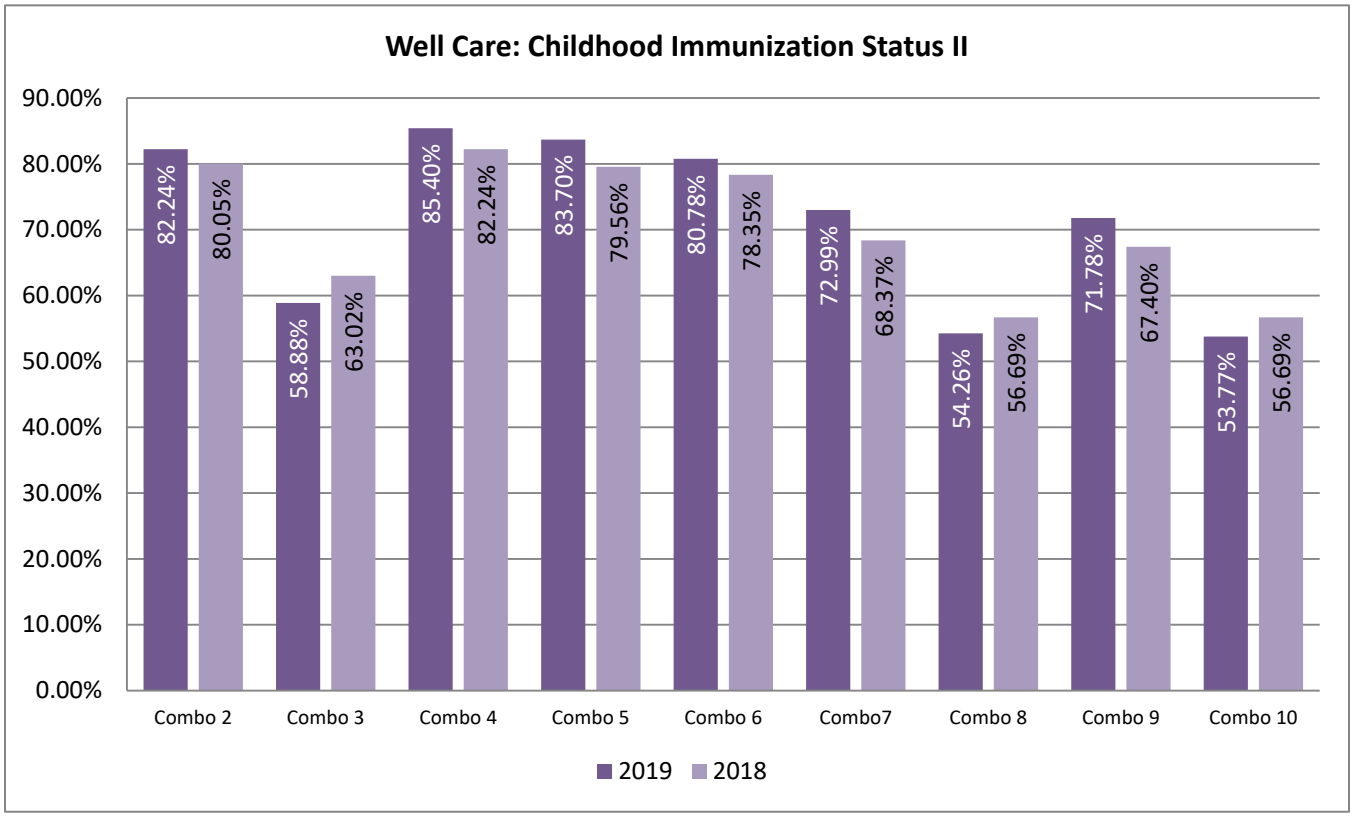

Figure 5: Well Care IV

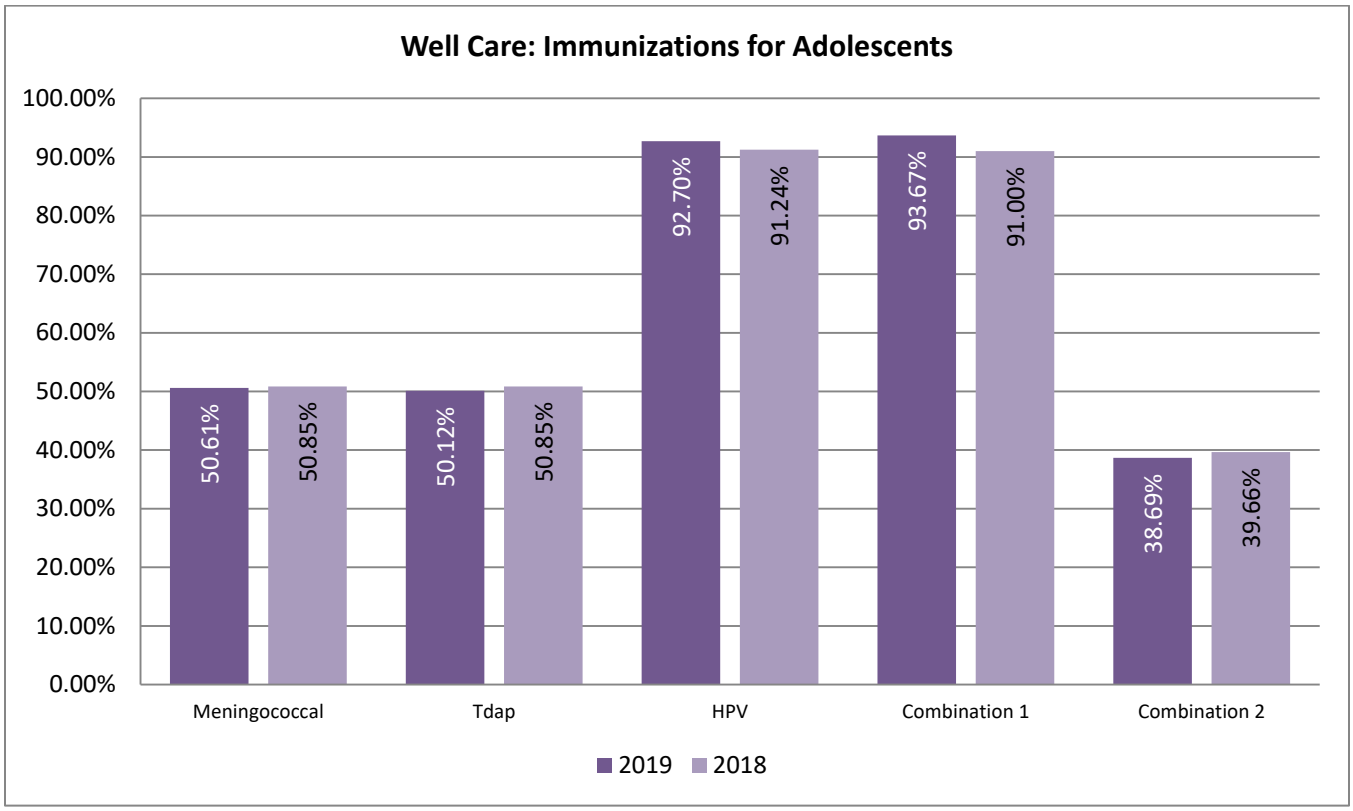

Figure 6: EPSDT/Bright Futures I

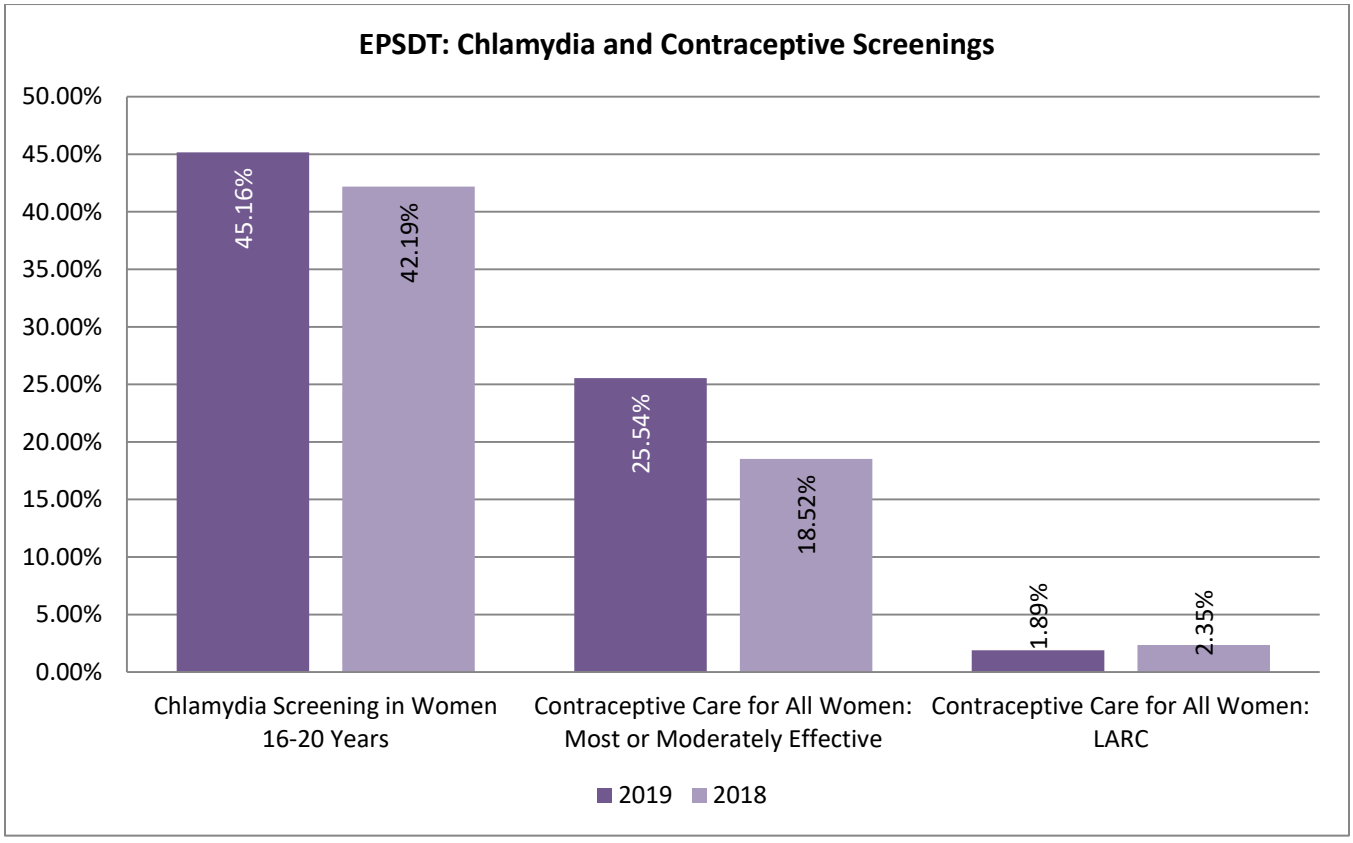

Figure 7: EPSDT/Bright Futures II

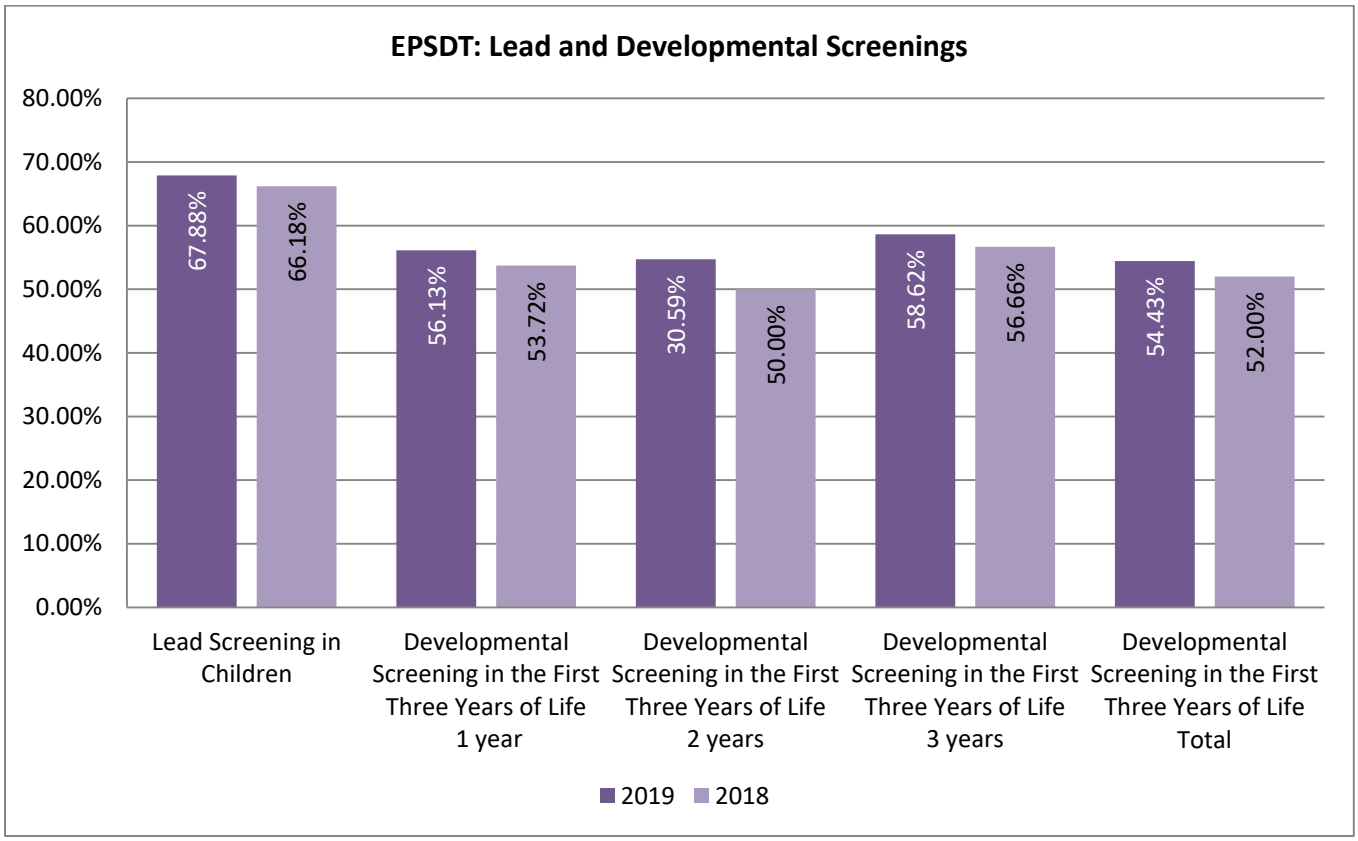

Figure 8: Dental Care for Children I

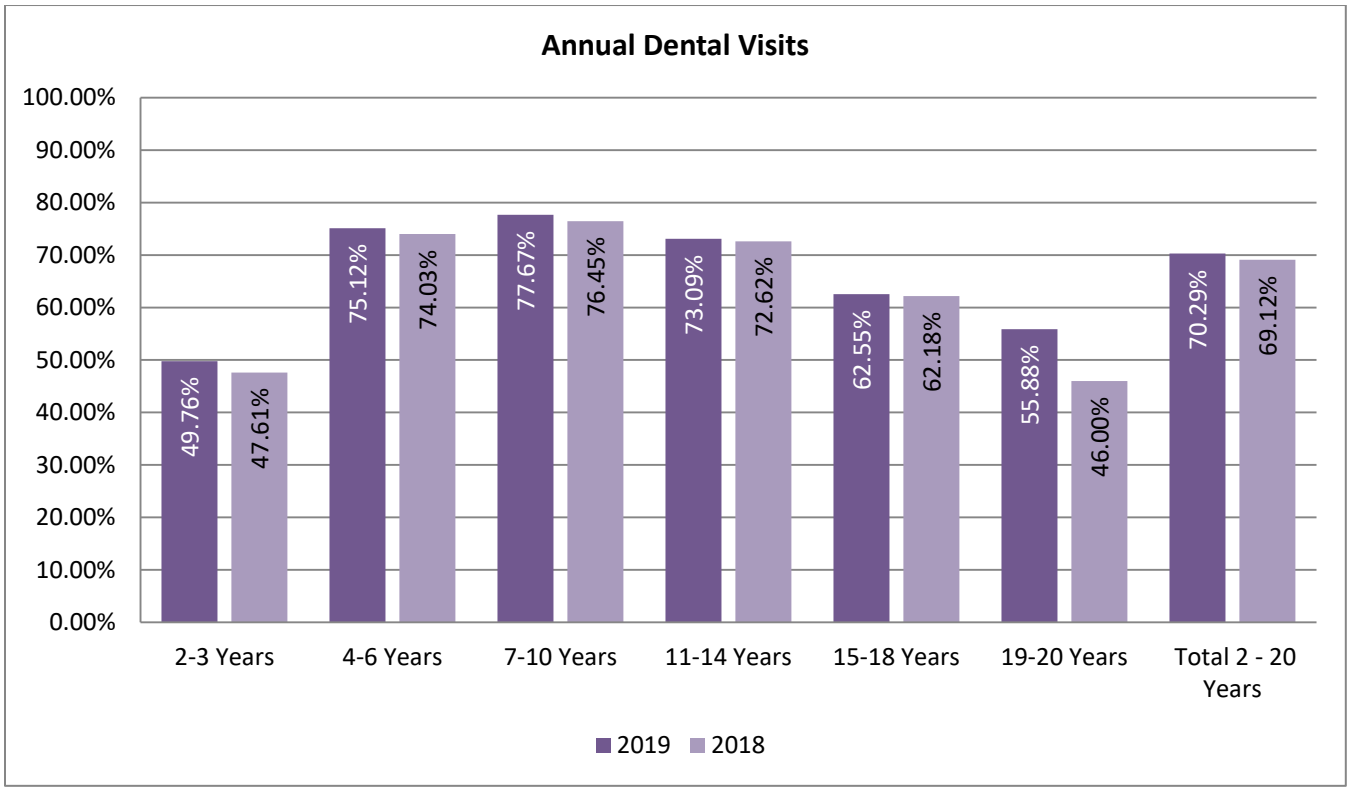

Figure 9: Dental Care for Children II

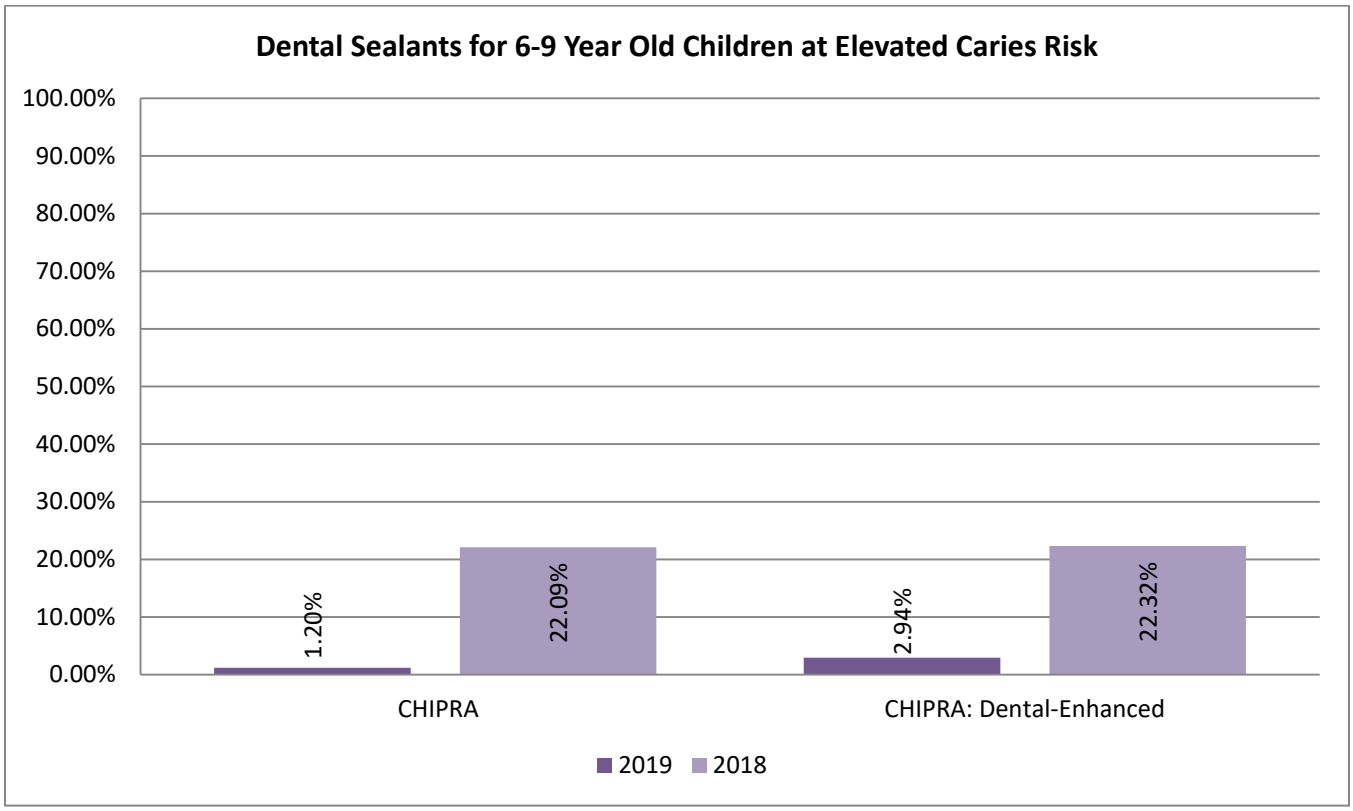

Figure 10: Respiratory Conditions

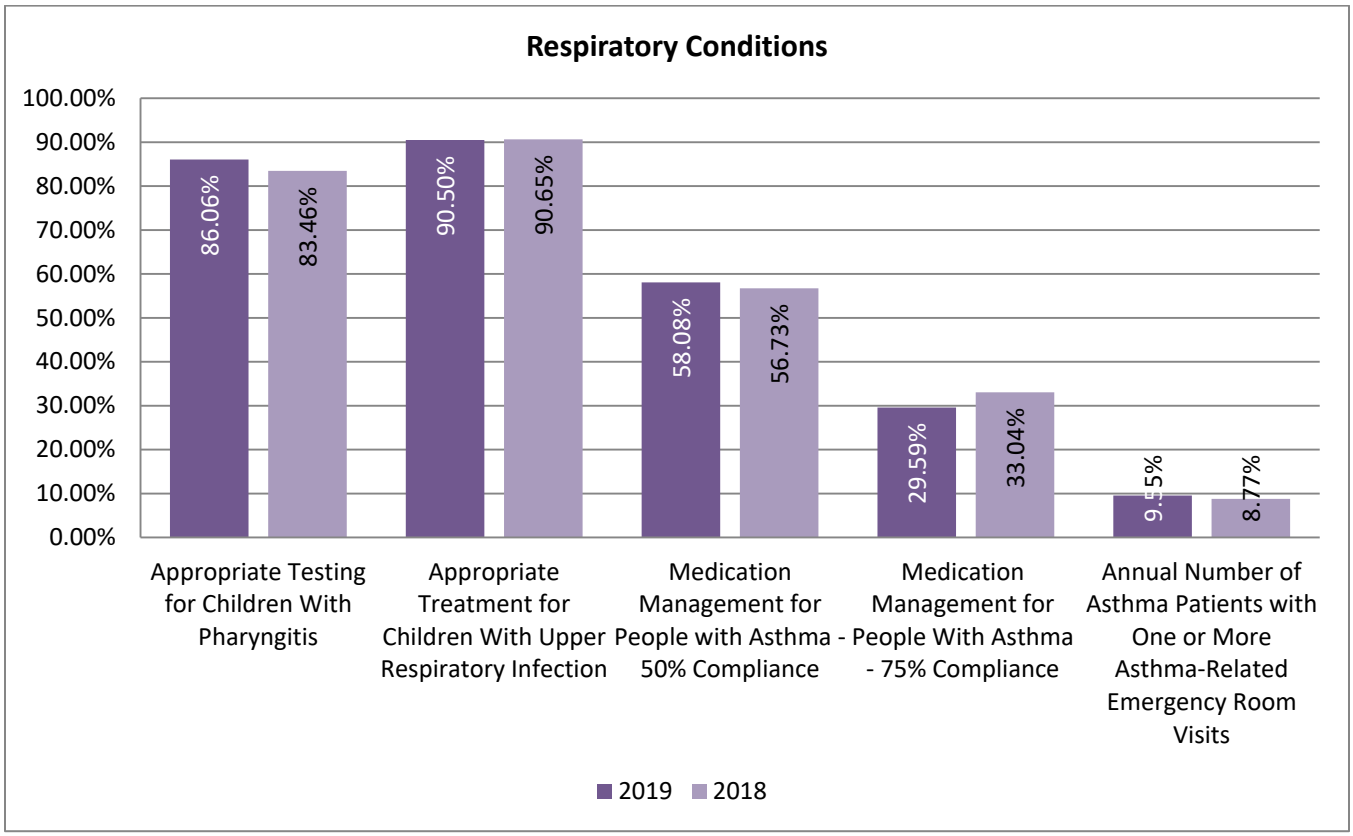

Figure 11: Behavioral Health

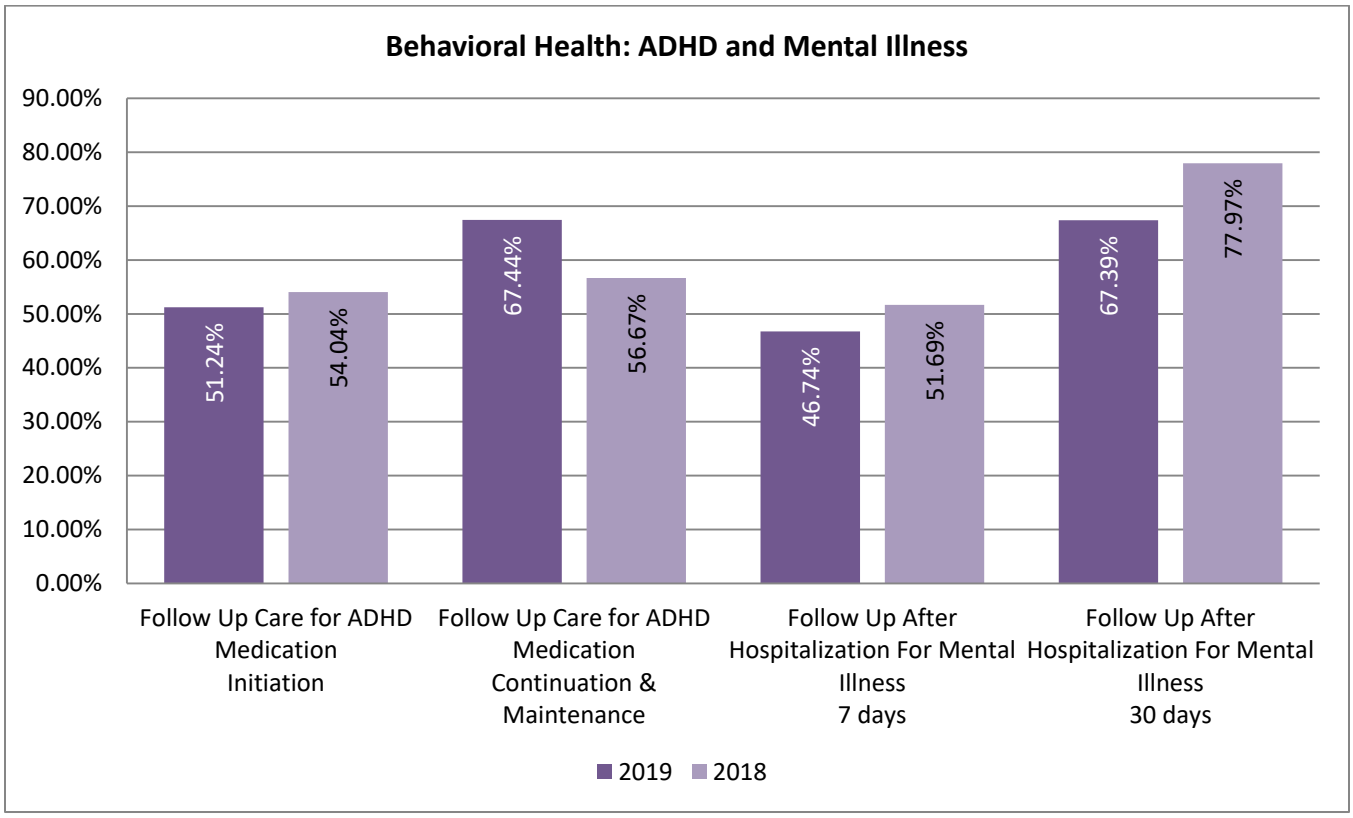

Figure 12: Utilization