



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

**2020 External Quality Review Report
United Healthcare Community Plan**

Final Report
April 2021



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realized.

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Introduction

Purpose and Background

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

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

- validation of performance improvement projects
- review to determine MCO compliance with structure and operations standards established by the State
- 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) via the PA DHS HealthChoices Medicaid managed care program. PA CHIP has contracted with IPRO as its EQRO to conduct the 2020 EQRs for the CHIP MCOs and to prepare the technical reports. This is the third year of PA CHIP technical reports. The report includes six core sections:

- I. Performance Improvement Projects
- II. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- III. Performance Improvement Projects
- IV. 2019 Opportunities for Improvement MCO Response
- V. 2020 Strengths and Opportunities for Improvement
- VI. Summary of Activities

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

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

Historically for the CHIP MCOs, the information for the compliance with Structure and Operations Standards in Section III of the report was derived from the results of on-site reviews conducted by PA CHIP staff, with findings entered into the department's on-site monitoring tool, and follow up materials provided as needed or requested. Beginning in 2020, compliance data were collected from the commonwealth's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from CHIP's contract agreements with the plans, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO. Standards presented in the on-site tool are those currently reviewed and utilized by PA CHIP staff to conduct reviews; these standards may be applicable to other subparts, and will be crosswalked to reflect regulations as applicable.

Section IV, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2019 EQR Technical Report's opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

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

Section VI contains a summary of findings across all sections of the EQR Technical Reports, including Structure and Operations Standards, Performance Improvement Projects, Performance Measures, 2019 Opportunities for Improvement MCO Responses, and Strengths and Opportunities for Improvement found for 2020.

I: 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 2017 for 2020 activities. Under the applicable Agreement with DHS in effect during this review period, CHIP MCOs are required to conduct focused studies each year. For all CHIP MCOs, two new PIPs were initiated as part of this requirement in 2018. For all PIPs, CHIP MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

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

2020 is the twelfth year to include validation of PIPs. For each PIP, all CHIP MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS CHIP provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

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

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

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

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

“Improving Blood Lead Screening Rates in Children 2 Years of Age” was selected as the result of a number of observations. Despite an overall decrease over the last 30 years in children with elevated blood lead levels in the United States, children from low-income families in specific states, including Pennsylvania, have seen decreased rates of screening of blood lead levels. Current CHIP policy requires that all children ages one and two years old and all children ages 3 through 6 years without a prior lead blood test have blood levels screened consistent with current Department of Health and CDC standards. Using the HEDIS Lead Screening measure, the average national lead screening rate in 2016 was 66.5%, while the Pennsylvania CHIP average was 53.2%. Despite an overall improvement in lead screening rates for Pennsylvania CHIP Contractors over the previous few years, rates by Contractor and weighted average fell below the national average. In addition to the HEDIS lead screening rate, Contractors have been encouraged to consider these measures as optional initiatives:

- Percentage of home investigations where lead exposure risk hazards/factors were identified,
- Total number of children successfully identified with elevated blood lead levels,

- Percent of the population under the age of 5 years suffering from elevated blood lead levels, or
- Percent of individuals employed in the agriculture, forestry, mining, and construction industries.

The PIPs extend from January 2017 through December 2020; with research beginning in 2017, initial PIP proposals developed and submitted in second quarter 2017, and a final report 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 second round of interim reports in July 2020, with review and findings administered by IPRO in Fall 2020.

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 summarizing information surrounding the PIP and assessing sustained improvement from the baseline measurement, including whether significant sustained improvement over the lifetime of the project occurred.

Review Element Designation/Weighting

This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods. Measurement Year (MY 2017) is the baseline year, and during the 2020 review year, elements were reviewed and scored at multiple points during the year once interim reports were submitted in July 2020. All MCOs received some level of guidance towards improving their proposals 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 responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. The overall score is expressed in terms of levels of compliance. The elements are not formally scored beyond the full/partial/non-compliant determination.

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

Table 1.1: Element Designation

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

Scoring Matrix

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

Findings

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

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

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

As discussed earlier, the second interim reports were submitted in July 2020. Review of these submissions began in September 2020 and ran through November 2020. 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

United Healthcare Community Plan (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.

In 2020, it was noted during review that key signatures and other information were missing from the plan’s interim report due to formatting issues. IPRO recommended that this be addressed, and signatures provided in a revised report. The plan addressed this and provided all required information in their revised 2020 interim report. Additionally, it was noted that the plan had included excessive information and materials in their initial report, making the report unreasonably large with significantly expanded scope. IPRO noted that this excessive information was contrary to the aim and goals of utilizing the LEAN methodology and recommended that the plan use as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project. The plan also addressed this in their resubmission, including only information that promotes increased value and fully covers all updates and changes to the project

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 difficulty in measuring effect. In 2020, three tracking measures had overall 2019 rates included but not quarterly data. There were also questions regarding the validity of the approach for calculation; the plan summed quarterly numerator values but kept denominator values static, or reported rates greater than 100% in some cases. IPRO recommended that the plan address these questions in a revised report. In their December 2020 resubmission, United included ample discussion and logic for their processes and inclusion of annual rates.

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. In 2020, the plan continued developing their discussion section and supplemented it with discussion surrounding the impacts of the COVID-19 pandemic and its effects on interventions. Guidance provided by IPRO, combined with the compliance designations provided in Table 1.2, serves as IPRO's validation and recommendations to the plan regarding this project.

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.

As with Developmental Screening, in 2020, it was noted during review that key signatures and other information were missing from the plan's interim report due to formatting issues. IPRO recommended that this be addressed, and signatures provided in a revised report. The plan addressed this and provided all required information in their revised 2020 interim report. Additionally, it was noted that the plan had included excessive information and materials in their initial report, making the report unreasonably large with significantly expanded scope. IPRO noted that this excessive information was contrary to the aim and goals of utilizing the LEAN methodology and recommended that the plan use as little documentation and extended explanations as possible while still providing a report that promotes increased value and fully covers all updates and changes to the project. The plan also addressed this in their resubmission, including only information that promotes increased value and fully covers all updates and changes to the project.

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. In 2020, several tracking measures had overall 2019 rates included but not quarterly data. There were also questions regarding the validity of the approach for calculation; the plan summed quarterly numerator values but kept denominator values static, or reported rates greater than 100% in some cases. IPRO recommended that the plan address these questions in a revised report. In their December 2020 resubmission, United included ample discussion and logic for their processes and inclusion of annual rates.

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. In 2020, the plan continued developing their discussion section and supplemented it with discussion surrounding the impacts of the COVID-19 pandemic and its effects on interventions. Guidance provided by IPRO, combined with the compliance designations provided in Table 1.2, serves as IPRO's validation and recommendations to the plan regarding this project.

Table 2.3: UHC PIP Compliance Assessments – 2020 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

II: 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 2020. Source code, raw data, and rate sheets were submitted by the MCOs to IPRO for review in 2020. 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 validation code against these data to validate that the final reported rates were accurate. Additionally, MCOs were provided with comparisons to the previous year's rates and were requested to provide explanations for highlighted differences. Differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates.

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

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

Table 2.1: Performance Measure Groupings

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

Source	Measures
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents —Physical Activity (Age 12–17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents —Physical Activity (Total)
HEDIS	Childhood Immunization Status by Age 2 —DTaP
HEDIS	Childhood Immunization Status by Age 2 —IPV
HEDIS	Childhood Immunization Status by Age 2 —MMR
HEDIS	Childhood Immunization Status by Age 2 —Hib
HEDIS	Childhood Immunization Status by Age 2 —Hepatitis B
HEDIS	Childhood Immunization Status by Age 2 —VZV
HEDIS	Childhood Immunization Status by Age 2 —Pneumococcal Conjugate
HEDIS	Childhood Immunization Status by Age 2 —Hepatitis A
HEDIS	Childhood Immunization Status by Age 2 —Rotavirus
HEDIS	Childhood Immunization Status by Age 2 —Influenza
HEDIS	Childhood Immunizations Status by Age 2 —Combo 2
HEDIS	Childhood Immunizations Status by Age 2 —Combo 3
HEDIS	Childhood Immunizations Status by Age 2 —Combo 4
HEDIS	Childhood Immunizations Status by Age 2 —Combo 5
HEDIS	Childhood Immunizations Status by Age 2 —Combo 6
HEDIS	Childhood Immunizations Status by Age 2 —Combo 7
HEDIS	Childhood Immunizations Status by Age 2 —Combo 8
HEDIS	Childhood Immunizations Status by Age 2 —Combo 9
HEDIS	Childhood Immunizations Status by Age 2 —Combo 10
HEDIS	Immunizations for Adolescents—Meningococcal
HEDIS	Immunizations for Adolescents—Tdap
HEDIS	Immunizations for Adolescents—HPV
HEDIS	Immunizations for Adolescents—Combination 1
HEDIS	Immunizations for Adolescents—Combination 2
HEDIS	Well-Child Visits in the First 15 Months of Life (0 Visits)
HEDIS	Well-Child Visits in the First 15 Months of Life (1 Visit)
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
Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Screenings and Follow-up	
HEDIS	Lead Screening in Children (Age 2 years)
HEDIS	Chlamydia Screening in Women (16–20 years)
HEDIS	Chlamydia Screening in Women—Total
PA EQR	Developmental Screening in the First Three Years of Life—Total
PA EQR	Developmental Screening in the First Three Years of Life—1 year
PA EQR	Developmental Screening in the First Three Years of Life—2 years
PA EQR	Developmental Screening in the First Three Years of Life—3 years
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) —Initiation Phase
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase
HEDIS	Follow-up Care After Hospitalization for Mental Illness—7 Days
HEDIS	Follow-up Care After Hospitalization for Mental Illness—30 Days
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (13–17 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (18–19 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (Total)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (13–17 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (18–19 years)
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (Total)

Source	Measures
Dental Care for Children	
HEDIS	Annual Dental Visit (2–3 Years)
HEDIS	Annual Dental Visit (4–6 Years)
HEDIS	Annual Dental Visit (7–10 Years)
HEDIS	Annual Dental Visit (11–14 Years)
HEDIS	Annual Dental Visit (15–18 Years)
HEDIS	Annual Dental Visit (19–20 Years)
HEDIS	Annual Dental Visit (Total)
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 (Ages 3–17 years)
HEDIS	Appropriate Testing for Children with Pharyngitis (Ages 18 years)
HEDIS	Appropriate Testing for Children with Pharyngitis (Total)
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (3–17 years)
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (18 years)
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection (Total)
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 (Total)
HEDIS	Medication Management for People with Asthma — Medication Compliance 75% (5–11 years)
HEDIS	Medication Management for People with Asthma — Medication Compliance 75% (12–18 years)
HEDIS	Medication Management for People with Asthma — Medication Compliance 75% (Total)
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2–19 years)
HEDIS	Asthma Medication Ratio (5–11 years)
HEDIS	Asthma Medication Ratio (12–18 years)
HEDIS	Asthma Medication Ratio (19 years)
HEDIS	Asthma Medication Ratio (Total)
Behavioral Health	
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose (Total)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Cholesterol (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Cholesterol (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Cholesterol (Total)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose & Cholesterol (1–11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose & Cholesterol (12–17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics — Blood Glucose & Cholesterol (Total)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1–11 years)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12–17 years)
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)
Utilization	
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages < 1 year)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages 1–9 years)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages 10–19 years)
HEDIS	Ambulatory Care: Outpatient Visits/1000 Member Months (Ages < 1 year)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages < 1 years)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages 1–9 years)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages 10–19 years)
HEDIS	Ambulatory Care: Emergency Department Visits/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization — General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization — General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization — General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization — General Hospital/Acute Care: Total Discharges/1000 Member Months (Ages < 1–19 years) Total Rate

Source	Measures
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Discharges/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Surgery Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Discharges/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages < 1 year)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages 1–9 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Medicine Average Length of Stay/1000 Member Months (Ages < 1–19 years) Total Rate
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Maternity/1000 Member Months (Ages 10–19 years)
HEDIS	Inpatient Utilization—General Hospital/Acute Care: Maternity Average Length of Stay/1000 Member Months (Ages 10–19 years) Total Rate
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Any Services (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Any Services (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Inpatient (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Inpatient (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 0–12 years)—Total Rate
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Male
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Female
HEDIS	Mental Health Utilization: Intensive Outpatient/Partial Hospitalization (Ages 13–17 years)—Total Rate
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Male
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Female
HEDIS	Mental Health Utilization: Outpatient (Ages 0–12 years)—Total Rate

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

Source	Measures
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 13–17 years)—Female
HEDIS	Identification of Alcohol and Other Drug Services: Telehealth (Ages 13–17 years)—Total Rate

PA-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 Affordable Care Act (ACA). In 2020, 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. PA-specific performance measure rates were calculated administratively, which uses only the MCOs data systems to identify numerator positives. The hybrid methodology, which uses a combination of administrative data and medical record review (MRR) to identify numerator “hits” for rate calculation, was not used for the PA-specific performance measures.

PA-Specific 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. Two rates are reported:

- CHIPRA—which utilized CHIPRA provider inclusion criteria.
- 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, 2 years of age through 19 years of age, with an asthma diagnosis who have ≥ 1 emergency department (ED) visit during the measurement year.

Contraceptive Care for All Women—CHIPRA Core Set

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

Contraceptive Care for Postpartum Women—CHIPRA Core Set

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

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2020. 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 2020, Volume 2 Narrative. The measurement year for HEDIS 2020 measures is 2019, as well as prior years for selected measures. Each year, DHS updates its requirements for the MCOs to be consistent with NCQA’s requirement for the reporting year. MCOs are required to report the complete

set of CHIP measures, as specified in the HEDIS Technical Specifications, Volume 2, which includes using the Medicaid measure specifications. 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; and
- 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 assesses 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 assesses 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 assesses the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (Hib); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Adolescent Well-Care Visits

This measure assesses 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

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

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

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

Immunization for Adolescents

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

- Combination 1: Meningococcal and Tdap; and
- Combination 2: Meningococcal, Tdap, and HPV.

Lead Screening in Children

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

Follow-up Care for Children Prescribed ADHD Medication

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

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

Follow Up After Hospitalization for Mental Illness

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

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

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

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

Annual Dental Visit

This measure assesses the percentage of children and adolescents between the ages of 2 and 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 assesses 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 Pharyngitis

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

Appropriate Treatment for Upper Respiratory Infection

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

Medication Management for People with Asthma — 75% Compliance

This measure assesses the percentage of members 5–19 years of age during the measurement year who were identified as having persistent asthma, 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

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

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

This measure assesses the percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications. For this measure a lower rate indicates better performance.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

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

Follow-up After High-Intensity Care for Substance Use Disorder—New in 2020

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

Pharmacotherapy for Opioid Use Disorder—New in 2020

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

Ambulatory Care

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

Inpatient Utilization

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Maternity;
- Surgery;
- Medicine; and
- Total inpatient (the sum of Maternity, Surgery, and Medicine).

Mental Health Utilization

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

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

Identification of Alcohol and Other Drug Services

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

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

CAHPS Survey

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

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2020 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures.

The Contraceptive Care for All Women and Contraceptive Care for Postpartum Women (CCW; CCP) were first-year measures in 2018 for all CHIP MCOs. As in prior reporting years, CHIP MCOs saw very small denominators for the Contraceptive Care for Postpartum Women (CCP) measure; thus, rates are not reported for this measure across the plans. In 2019, clarification was added to note that to remain aligned with CMS specifications, the look-back period to search for exclusions is limited to the measurement year. In 2020, this clarification was continued for both Contraceptive Care measures.

The Dental Sealants for 6- to 9-Year-Old Children at Elevated Caries Risk (SEAL-CH) measure underwent some modifications in 2020. 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 comparison to the 2016 rates and are aligned with the CMS guidance. In 2020, these changes were continued and applicable CDT codes used for numerator compliance were updated and/or added. In addition, schools were added as allowed places of service for this measure.

The Developmental Screening in the First Three Years of Life measure was modified in 2018 in order to clarify the age cohorts that are used when reporting for this measure. This clarification noted that children can be screened in the 12 months preceding or on their first, second, or third birthday. 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 first birthday;
- Age Cohort 2: member must be screened anytime between 1 day after first birthday to day of second birthday; and
- Age Cohort 3: member must be screened anytime between 1 day after second birthday to day of third birthday.

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

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

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

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

Findings

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

Rates for both the measurement year and the previous year are presented, as available (i.e., 2020 [MY 2019] and 2019 [MY 2018]). In addition, statistical comparisons are made between the 2020 and 2019 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the Z ratio. A Z ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of 2020 rates to 2019 rates, statistically significant increases are indicated by “+,” statistically significant decreases by “-,” and no statistically significant change by “n.s.”

In addition to each individual MCO rate, the CHIP Medicaid Managed Care (MMC) average for 2020 (MY 2019) 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 2020 rates to MMC rates, the “+” denotes that the plan rate exceeds the MMC rate, the “-” denotes that the MMC rate exceeds the plan rate, and “n.s.” denotes no statistically significant difference between the two rates. 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 are not highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, “NA” (Not Applicable) appears in the corresponding cells. However, “NA” (Not Available) also appears in the cells under the HEDIS 2020 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

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

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

As part of IPRO’s validation of UHC’s Performance Measures and CAHPS Survey results, the following are recommended areas of focus for the plan moving into the next reporting year:

- It is recommended that UHC focus efforts on improving access to dental care in their population. In 2020, the Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk measure performed below the reported weighted average in 2020. This was similarly an opportunity for improvement for UHC in 2019.

- It is recommended that UHC improve outpatient visits for ambulatory care, as the AMBA: Outpatient Visits/1000 MM measure performed below the reported weighted average in 2020. Outpatient Visit was similarly an opportunity for improvement for UHC in 2019.

Access to/Availability of Care

No strengths are identified for 2020 (MY 2019) Access to/Availability of Care performance measure.

Opportunities for improvement are identified for the following Access to/Availability of Care performance measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
 - Contraceptive Care for All Women (Age 15–20 years): Most or Moderately Effective.

Table 2.2: Access to/Availability of Care

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12–24 months)	430	418	97.2%	95.5%	98.9%	98.3%	n.s.	98.5%	n.s.	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months–6 years)	5,275	4,899	92.9%	92.2%	93.6%	93.5%	n.s.	94.9%	-	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7–11 years)	5,908	5,671	96.0%	95.5%	96.5%	96.4%	n.s.	96.4%	n.s.	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12–19 years)	7,996	7,597	95.0%	94.5%	95.5%	96.1%	-	96.3%	-	≥ 75th and < 90th percentile
PA EQR	Contraceptive Care for All Women (Age 15–20 years): Most or Moderately Effective	2,827	728	25.8%	24.1%	27.4%	25.5%	n.s.	28.9%	-	NA
PA EQR	Contraceptive Care for All Women (Age 15–20 years): LARC	2,827	66	2.3%	1.8%	2.9%	1.9%	n.s.	2.2%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most or moderately effective contraception—3 days	6	1	NA	NA	NA	NA	NA	0.0%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): Most or moderately effective contraception—60 days	6	3	NA	NA	NA	NA	NA	0.0%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—3 days	6	1	NA	NA	NA	NA	NA	0.0%	NA	NA
PA EQR	Contraceptive Care for Postpartum Women (Age 15–20 years): LARC—60 days	6	1	NA	NA	NA	NA	NA	0.0%	NA	NA
HEDIS	Pharmacotherapy for Opioid Use Disorder (16–19 years)	0	0	NA	NA	NA	0.0%	NA	NA	NA	NA

Well-Care Visits and Immunizations

Strengths are identified for the following 2020 (MY 2019) Well-Care Visits and Immunizations performance measures:

- The following rates are statistically significantly above/better than the 2020 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);
 - Childhood Immunization Status—Influenza;
 - Childhood Immunization Status—Combo 6;
 - Childhood Immunization Status—Combo 8;
 - Childhood Immunization Status—Combo 9;
 - Childhood Immunization Status—Combo 10; and
 - Well-Child Visits in the First 15 Months of Life (6 or more visits).

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

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
 - Well-Child Visits in the First 15 Months of Life (5 visits).

Table 2.3: Well-Care Visits and Immunizations

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (3–11 years)	11,043	215	91.1%	90.6%	91.6%	88.6%	+	84.3%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (12–17 years)	7,552	156	89.1%	88.4%	89.9%	88.0%	+	83.4%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile (Total)	18,595	371	90.3%	89.8%	90.7%	88.4%	+	83.9%	+	≥ 75th and < 90th percentile

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (3–11 years)	11,043	201	85.2%	84.5%	85.8%	83.5%	+	79.0%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (12–17 years)	7,552	148	84.6%	83.8%	85.4%	80.4%	+	77.0%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition (Total)	18,595	349	84.9%	84.4%	85.4%	82.4%	+	78.2%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (3–11 years)	11,043	187	79.2%	78.5%	80.0%	79.7%	-	73.3%	+	≥ 75th and < 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (12–17 years)	7,552	151	86.3%	85.5%	87.1%	83.7%	+	78.9%	+	≥ 90th percentile
HEDIS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity (Total)	18,595	338	82.2%	81.7%	82.8%	81.2%	+	75.6%	+	≥ 90th percentile
HEDIS	Childhood Immunization Status— DTaP	566	363	88.3%	85.6%	91.1%	89.5%	n.s.	87.7%	n.s.	≥ 90th percentile
HEDIS	Childhood Immunization Status— IPV	566	389	94.6%	92.7%	96.6%	95.1%	n.s.	93.1%	n.s.	≥ 90th percentile
HEDIS	Childhood Immunization Status— MMR	566	385	93.7%	91.6%	95.8%	92.7%	n.s.	92.7%	n.s.	≥ 90th percentile
HEDIS	Childhood Immunization Status— Hib	566	388	94.4%	92.4%	96.4%	94.6%	n.s.	92.9%	n.s.	≥ 90th percentile
HEDIS	Childhood Immunization Status— Hepatitis B	566	383	93.2%	91.0%	95.4%	94.6%	n.s.	91.8%	n.s.	≥ 75th and < 90th percentile

Indicator		2020 (MY 2019)					Rate Comparison					
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile	
HEDIS	Childhood Immunization Status—VZV	566	384	93.4%	91.3%	95.6%	93.2%	n.s.	92.0%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Pneumococcal Conjugate	566	364	88.6%	85.9%	91.3%	90.5%	n.s.	87.9%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Hepatitis A	566	370	90.0%	87.5%	92.6%	89.3%	n.s.	89.2%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Childhood Immunization Status—Rotavirus	566	342	83.2%	80.0%	86.4%	82.2%	n.s.	80.9%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Influenza	566	283	68.9%	65.0%	72.8%	58.9%	+	62.2%	+	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 2	566	352	85.6%	82.7%	88.6%	85.4%	n.s.	84.0%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 3	566	344	83.7%	80.6%	86.8%	83.7%	n.s.	81.9%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 4	566	337	82.0%	78.7%	85.2%	80.8%	n.s.	79.2%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 5	566	314	76.4%	72.8%	80.0%	73.0%	n.s.	73.6%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 6	566	264	64.2%	60.2%	68.3%	54.3%	+	57.1%	+	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 7	566	309	75.2%	71.5%	78.8%	71.8%	n.s.	71.8%	n.s.	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 8	566	259	63.0%	59.0%	67.1%	53.8%	+	56.0%	+	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 9	566	243	59.1%	55.0%	63.3%	50.6%	+	53.0%	+	≥ 90th percentile	
HEDIS	Childhood Immunization Status—Combo 10	566	239	58.2%	54.0%	62.3%	50.1%	+	52.1%	+	≥ 90th percentile	
HEDIS	Immunizations for Adolescents—Meningococcal	1,650	389	94.6%	93.5%	95.8%	92.7%	n.s.	92.9%	n.s.	≥ 90th percentile	
HEDIS	Immunizations for Adolescents—Tdap	1,650	394	95.9%	94.9%	96.9%	93.7%	n.s.	93.5%	n.s.	≥ 90th percentile	
HEDIS	Immunizations for Adolescents—HPV	1,650	162	39.4%	37.0%	41.8%	38.7%	n.s.	37.3%	+	≥ 50th and < 75th percentile	
HEDIS	Immunizations for Adolescents—Combination 1	1,650	383	93.2%	91.9%	94.4%	91.5%	n.s.	91.5%	n.s.	≥ 90th percentile	
HEDIS	Immunizations for Adolescents—Combination 2	1,650	156	38.0%	35.6%	40.3%	37.5%	n.s.	36.2%	n.s.	≥ 50th and < 75th percentile	

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (0 visits)	293	1	0.3%	0.0%	1.2%	0.0%	n.s.	0.3%	n.s.	≥ 10th and < 25th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (1 visit)	293	2	0.7%	0.0%	1.8%	0.0%	n.s.	0.4%	n.s.	≥ 10th and < 25th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (2 visits)	293	1	0.3%	0.0%	1.2%	0.0%	n.s.	0.5%	n.s.	< 10th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (3 visits)	293	5	1.7%	0.1%	3.4%	1.8%	n.s.	1.1%	n.s.	< 10th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (4 visits)	293	6	2.0%	0.3%	3.8%	2.7%	n.s.	2.3%	n.s.	< 10th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (5 visits)	293	21	7.2%	4.0%	10.3%	7.3%	n.s.	13.0%	-	< 10th percentile
HEDIS	Well-Child Visits in the First 15 Months of Life (6 or more visits)	293	257	87.7%	83.8%	91.6%	88.1%	n.s.	82.3%	+	≥ 90th percentile
HEDIS	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	4,581	348	84.7%	83.6%	85.7%	83.1%	+	85.0%	-	≥ 90th percentile
HEDIS	Adolescent Well-Care Visits	10,576	304	74.0%	73.1%	74.8%	73.8%	n.s.	71.3%	-	≥ 90th percentile

EPSDT: Screenings and Follow-up

No strengths are identified for 2020 (MY 2019) EPSDT: Screenings and Follow-up performance measures.

No opportunities for improvement are identified for 2020 (MY 2019) EPSDT: Screenings and Follow-up performance measures.

Table 2.4: EPSDT: Screenings and Follow-up

Indicator		2020 (MY 2019)					Rate Comparison					
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile	
HEDIS	Lead Screening in Children (Age 2 years)	566	308	74.9%	71.3%	78.6%	67.9%	+	72.7%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Chlamydia Screening in Women (16–20 years)	933	408	43.7%	40.5%	47.0%	45.2%	n.s.	40.8%	n.s.	≥ 10th and < 25th percentile	
HEDIS	Chlamydia Screening in Women—Total	933	408	43.7%	40.5%	47.0%	45.2%	n.s.	40.8%	n.s.	≥ 10th and < 25th percentile	
PA EQR	Developmental Screening in the First Three Years of Life—Total	1,611	1,030	63.9%	61.6%	66.3%	56.1%	+	64.6%	n.s.	NA	
PA EQR	Developmental Screening in the First Three Years of Life—1 year	113	77	68.1%	59.1%	77.2%	54.7%	+	66.6%	n.s.	NA	
PA EQR	Developmental Screening in the First Three Years of Life—2 years	566	385	68.0%	64.1%	72.0%	58.6%	+	69.5%	n.s.	NA	
PA EQR	Developmental Screening in the First Three Years of Life—3 years	932	568	60.9%	57.8%	64.1%	54.4%	+	61.7%	n.s.	NA	
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase	198	106	53.5%	46.3%	60.7%	51.2%	n.s.	52.2%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Follow-up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	51	30	58.8%	44.3%	73.3%	67.4%	n.s.	63.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Follow-up After Hospitalization For Mental Illness—7 days	82	39	47.6%	36.1%	59.0%	48.0%	n.s.	49.0%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Follow-up After Hospitalization For Mental Illness—30 days	82	58	70.7%	60.3%	81.2%	69.6%	n.s.	71.3%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (13–17 years)	3	1	NA	NA	NA	0.0%	NA	0.0%	NA	NA	
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (18–19 years)	1	1	NA	NA	NA	0.0%	NA	0.0%	NA	NA	

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—30 days (Total)	4	2	NA	NA	NA	0.0%	NA	0.0%	NA	NA
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (13–17 years)	3	1	NA	NA	NA	0.0%	NA	0.0%	NA	NA
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (18–19 years)	1	1	NA	NA	NA	0.0%	NA	0.0%	NA	NA
HEDIS	Follow-up After High-Intensity Care for Substance Use Disorder—7 days (Total)	4	2	NA	NA	NA	0.0%	NA	0.0%	NA	NA

Dental Care for Children

No strengths are identified for 2020 (MY 2019) Dental Care for Children performance measures.

Opportunities for improvement are identified for the following Respiratory Conditions performance measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
 - Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk; and
 - Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (Dental-Enhanced).

Table 2.5: Dental Care for Children

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Annual Dental Visit (2–3 years)	1,692	827	48.9%	46.5%	51.3%	49.8%	n.s.	49.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Annual Dental Visit (4–6 years)	3,630	2,749	75.7%	74.3%	77.1%	75.1%	n.s.	76.1%	n.s.	≥ 75th and < 90th percentile
HEDIS	Annual Dental Visit (7–10 years)	6,423	5,041	78.5%	77.5%	79.5%	77.7%	n.s.	79.0%	n.s.	≥ 90th percentile
HEDIS	Annual Dental Visit (11–14 years)	6,478	4,833	74.6%	73.5%	75.7%	73.1%	n.s.	75.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	Annual Dental Visit (15–18 years)	5,647	3,611	63.9%	62.7%	65.2%	62.6%	n.s.	65.7%	-	≥ 75th and < 90th percentile
HEDIS	Annual Dental Visit (19–20 years)	113	55	48.7%	39.0%	58.3%	55.9%	n.s.	54.5%	n.s.	≥ 75th and < 90th percentile
HEDIS	Annual Dental Visit (Total)	23,983	17,116	71.4%	70.8%	71.9%	70.3%	+	72.2%	-	≥ 90th percentile
PA EQR	Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (CHIPRA)	4,005	0	0.0%	0.0%	0.0%	1.2%	-	18.1%	-	NA
PA EQR	Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)	4,085	17	0.4%	0.2%	0.6%	2.9%	-	18.8%	-	NA

Respiratory Conditions

No strengths are identified for 2020 (MY 2019) Respiratory Conditions performance measures.

No opportunities for improvement are identified for 2020 (MY 2019) Respiratory Conditions performance measures.

Table 2.6: Respiratory Conditions

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 3–17 years)	2,741	2,377	86.7%	85.4%	88.0%	NA	NA	87.8%	n.s.	≥ 75th and < 90th percentile
HEDIS	Appropriate Testing for Pharyngitis (Ages 18 years)	83	63	75.9%	66.1%	85.7%	NA	NA	81.3%	n.s.	≥ 75th and < 90th percentile
HEDIS	Appropriate Testing for Pharyngitis (Total)	2,824	2,440	86.4%	85.1%	87.7%	86.1%	n.s.	87.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (3–17 years)	4,646	341	92.7%	91.9%	93.4%	NA	NA	92.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (18 years)	109	9	91.7%	86.1%	97.4%	NA	NA	85.1%	n.s.	≥ 90th percentile
HEDIS	Appropriate Treatment for Upper Respiratory Infection (Total)	4,755	350	92.6%	91.9%	93.4%	90.5%	n.s.	92.0%	n.s.	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma—50% Compliance (Age 5–11 years)	183	108	59.0%	51.6%	66.4%	60.8%	n.s.	62.3%	n.s.	NA
HEDIS	Medication Management for People with Asthma—50% Compliance (Age 12–18 years)	160	98	61.3%	53.4%	69.1%	54.3%	n.s.	61.2%	n.s.	NA
HEDIS	Medication Management for People with Asthma—50% Compliance (Total)	344	206	59.9%	54.6%	65.2%	58.1%	n.s.	62.1%	n.s.	NA
HEDIS	Medication Management for People With Asthma—Medication Compliance 75% (5–11)	183	60	32.8%	25.7%	39.9%	31.1%	n.s.	37.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	Medication Management for People With Asthma—Medication Compliance 75% (12–18)	160	51	31.9%	24.3%	39.4%	27.8%	n.s.	36.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	Medication Management for People With Asthma—Medication Compliance 75% (Total)	344	111	32.3%	27.2%	37.4%	29.6%	n.s.	37.2%	n.s.	≥ 10th and < 25th percentile
PA EQR	Annual Number of Asthma Patients with One or More Asthma-Related Emergency Room Visits (Age 2–19)	2,691	217	8.1%	7.0%	9.1%	9.6%	-	7.8%	n.s.	NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
	years)										
HEDIS	Asthma Medication Ratio—5–11 years	192	152	79.2%	73.2%	85.2%	78.9%	n.s.	77.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Asthma Medication Ratio—12–18 years	177	118	66.7%	59.4%	73.9%	69.6%	n.s.	68.0%	n.s.	≥ 50th and < 75th percentile
HEDIS	Asthma Medication Ratio—19 years	2	1	NA	NA	NA	50.0%	NA	0.0%	NA	≥ 25th and < 50th percentile
HEDIS	Asthma Medication Ratio—Total	371	271	73.0%	68.4%	77.7%	74.8%	n.s.	73.1%	n.s.	≥ 75th and < 90th percentile

Behavioral Health

Strengths are identified for the following 2020 (MY 2019) Behavioral Health performance measures:

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (12–17 Years);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose (Total);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (12–17 Years);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol (Total);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (12–17 Years); and
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose & Cholesterol (Total).

No opportunities for improvement are identified for 2020 (MY 2019) Behavioral Health performance measures.

Table 2.7: Behavioral Health

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (6–11 years)	2	1	NA	NA	NA	0.0%	NA	NA	NA	≥ 50th and < 75th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (1–5 Years)	32	21	65.6%	47.6%	83.6%	0.0%	NA	0.0%	+	≥ 75th and < 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (12–17 years)	34	22	64.7%	47.2%	82.2%	0.0%	NA	0.0%	+	≥ 75th and < 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	2	1	NA	NA	NA	0.0%	NA	NA	NA	≥ 75th and < 90th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1–5 Years)	32	15	46.9%	28.0%	65.7%	0.0%	NA	0.0%	+	≥ 50th and < 75th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6–11 years)	34	16	47.1%	28.8%	65.3%	0.0%	NA	0.0%	+	≥ 75th and < 90th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12–17 years)	2	1	NA	NA	NA	0.0%	NA	NA	NA	≥ 90th percentile
HEDIS	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	32	15	46.9%	28.0%	65.7%	0.0%	NA	0.0%	+	≥ 75th and < 90th percentile

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1–5 Years)	34	16	47.1%	28.8%	65.3%	0.0%	NA	0.0%	+	≥ 75th and < 90th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6–11 years)	3	0	NA	NA	NA	0.0%	NA	0.0%	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12–17 years)	18	9	NA	NA	NA	52.4%	NA	0.0%	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	21	9	NA	NA	NA	53.8%	NA	0.0%	NA	NA

Utilization

Strengths are identified for the following 2020 (MY 2019) Utilization performance measures:

- The following rates are statistically significantly above/better than the 2020 MMC weighted average:
 - AMBA: Emergency Department Visits/1000 MM Ages 1–9 years; and
 - AMBA: Emergency Department Visits/1000 MM Ages < 1–19 years Total Rate.

Opportunities for improvement are identified for the following 2020 (MY 2019) Utilization measures:

- The following rates are statistically significantly below/worse than the 2020 MMC weighted average:
 - AMBA: Outpatient Visits/1000 MM Ages < 1 year;
 - AMBA: Outpatient Visits/1000 MM Ages 1–9 years;
 - AMBA: Outpatient Visits/1000 MM Ages 10–19 years; and
 - AMBA: Outpatient Visits/1000 MM Ages < 1–19 years Total Rate.

Table 2.8: Utilization

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages < 1 year	3,238	2,138	660.28	NA	NA	652.14	+	728.35	-	≥ 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 1–9 years	198,930	51,363	258.20	NA	NA	257.92	+	269.28	-	≥ 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages 10–19 years	235,652	53,455	226.84	NA	NA	222.77	+	234.08	-	≥ 90th percentile
HEDIS	AMBA: Outpatient Visits/1000 MM Ages < 1–19 years Total Rate	437,820	106,956	244.29	NA	NA	242.43	+	253.18	-	≥ 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages < 1 year	3,238	119	36.75	NA	NA	35.35	+	39.05	n.s.	≥ 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 1–9 years	198,930	6,240	31.37	NA	NA	31.96	-	29.15	+	≥ 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages 10–19 years	235,652	5,805	24.63	NA	NA	25.88	-	24.38	n.s.	≥ 90th percentile
HEDIS	AMBA: Emergency Department Visits/1000 MM Ages < 1–19 years Total Rate	437,820	12,164	27.78	NA	NA	28.77	-	26.59	+	≥ 90th percentile
HEDIS	IPIUA: Total Discharges/1000 MM Ages < 1 year	3,238	8	2.47	NA	NA	2.36	-			NA
HEDIS	IPIUA: Total Discharges/1000 MM Ages 1–9 years	198,930	113	0.57	56.6%	57.0%	0.59	-			NA
HEDIS	IPIUA: Total Discharges/1000 MM Ages 10–19 years	235,652	125	0.53	52.8%	53.2%	0.71	-			NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	IPIA: Total Discharges/1000 MM Ages < 1–19 years Total Rate	437,820	246	0.56	56.0%	56.3%	0.66	-			NA
HEDIS	IPIA: Total Inpatient ALOS Ages < 1 year	8	19	2.38	NA	NA	3.25	NA			NA
HEDIS	IPIA: Total Inpatient ALOS Ages 1–9 Years	113	538	4.76	NA	NA	2.79	NA			NA
HEDIS	IPIA: Total Inpatient ALOS Ages 10–19 years	125	427	3.42	NA	NA	3.07	NA			NA
HEDIS	IPIA: Total Inpatient ALOS Ages < 1–19 years Total Rate	246	984	4.00	NA	NA	2.97	NA			NA
HEDIS	IPIA: Surgery Discharges/1000 MM Ages < 1 year	3,238	0	0.00	0.0%	0.0%	0.00	NA			NA
HEDIS	IPIA: Surgery Discharges/1000 MM Ages 1–9 years	198,930	32	0.16	15.9%	16.2%	0.07	-			NA
HEDIS	IPIA: Surgery Discharges/1000 MM Ages 10–19 years	235,652	54	0.23	22.7%	23.1%	0.15	-			NA
HEDIS	IPIA: Surgery Discharges/1000 MM Ages < 1–19 years Total Rate	437,820	86	0.20	19.5%	19.8%	0.11	-			NA
HEDIS	IPIA: Surgery ALOS Ages < 1 year	0	0	-	NA	NA	-	NA			NA
HEDIS	IPIA: Surgery ALOS Ages 1–9 years	32	229	7.16	NA	NA	3.50	NA			NA
HEDIS	IPIA: Surgery ALOS Ages 10–19 years	54	221	4.09	NA	NA	4.65	NA			NA
HEDIS	IPIA: Surgery ALOS Ages < 1–19 years Total Rate	86	450	5.23	NA	NA	4.31	NA			NA
HEDIS	IPIA: Medicine Discharges/1000 MM Ages < 1 year	3,238	8	2.47	NA	NA	2.36	-			NA
HEDIS	IPIA: Medicine Discharges/1000 MM Ages 1–9 years	198,930	81	0.41	40.5%	40.9%	0.52	-			NA
HEDIS	IPIA: Medicine Discharges/1000 MM Ages 10–19 years	235,652	61	0.26	25.7%	26.1%	0.44	-			NA
HEDIS	IPIA: Medicine Discharges/1000 MM Ages < 1–19 years Total Rate	437,820	150	0.34	34.1%	34.4%	0.49	-			NA
HEDIS	IPIA: Medicine ALOS Ages < 1 year	8	19	2.38	NA	NA	3.25	NA			NA
HEDIS	IPIA: Medicine ALOS Ages 1–9 years	81	309	3.81	NA	NA	2.70	NA			NA
HEDIS	IPIA: Medicine ALOS Ages 10–19 years	61	182	2.98	NA	NA	2.67	NA			NA
HEDIS	IPIA: Medicine ALOS Ages < 1–19 years Total Rate	150	510	3.40	NA	NA	2.71	NA			NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	IPUA: Maternity/1000MM Ages 10–19 years	235,652	10	0.04	4.2%	4.3%	0.11	-			NA
HEDIS	IPUA: Maternity ALOS Ages 10–19 years Total Rate	10	24	2.40	NA	NA	2.58	NA			NA
HEDIS	MPT: Any Services Ages 0–12 years— Male	143,433	710	5.94%	5.8%	6.1%	6.1%	-			NA
HEDIS	MPT: Any Services MM Ages 0–12 years— Female	142,287	479	4.04%	3.9%	4.1%	4.0%	-			NA
HEDIS	MPT: Any Services Ages 0–12 years— Total Rate	285,720	1,189	4.99%	4.9%	5.1%	5.0%	-			NA
HEDIS	MPT: Any Services Ages 13–17 years— Male	63,988	402	7.54%	7.3%	7.7%	7.5%	-			NA
HEDIS	MPT: Any Services Ages 13–17 years— Female	63,421	708	13.40%	13.1%	13.7%	12.1%	-			NA
HEDIS	MPT: Any Services Ages 13–17 years— Total Rate	127,409	1,110	10.45%	10.3%	10.6%	9.8%	-			NA
HEDIS	MPT: Inpatient Ages 0–12 years— Male	143,433	8	0.07%	0.1%	0.1%	0.1%	-			NA
HEDIS	MPT: Inpatient Ages 0–12 years— Female	142,287	10	0.08%	0.1%	0.1%	0.2%	-			NA
HEDIS	MPT: Inpatient Ages 0–12 years— Total Rate	285,720	18	0.08%	0.1%	0.1%	0.1%	-			NA
HEDIS	MPT: Inpatient Ages 13–17 years— Male	63,988	28	0.53%	0.5%	0.6%	0.4%	-			NA
HEDIS	MPT: Inpatient Ages 13–17 years— Female	63,421	54	1.02%	0.9%	1.1%	1.1%	-			NA
HEDIS	MPT: Inpatient Ages 13–17 years— Total Rate	127,409	82	0.77%	0.7%	0.8%	0.8%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0–12 years— Male	143,433	19	0.16%	0.1%	0.2%	0.1%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0–12 years— Female	142,287	14	0.12%	0.1%	0.1%	0.1%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 0–12 years— Total Rate	285,720	33	0.14%	0.1%	0.2%	0.1%	-			NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Male	63,988	10	0.19%	0.2%	0.2%	0.2%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Female	63,421	34	0.64%	0.6%	0.7%	0.6%	-			NA
HEDIS	MPT: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Total Rate	127,409	44	0.41%	0.4%	0.5%	0.4%	-			NA
HEDIS	MPT: Outpatient Ages 0–12 years—Male	143,433	695	5.81%	5.7%	5.9%	6.0%	-			NA
HEDIS	MPT: Outpatient Ages 0–12 years—Female	142,287	470	3.96%	3.9%	4.1%	3.9%	-			NA
HEDIS	MPT: Outpatient Ages 0–12 years—Total Rate	285,720	1,165	4.89%	4.8%	5.0%	5.0%	-			NA
HEDIS	MPT: Outpatient Ages 13–17 years—Male	63,988	395	7.41%	7.2%	7.6%	7.3%	-			NA
HEDIS	MPT: Outpatient Ages 13–17 years—Female	63,421	677	12.81%	12.5%	13.1%	11.7%	-			NA
HEDIS	MPT: Outpatient Ages 13–17 years—Total Rate	127,409	1,072	10.10%	9.9%	10.3%	9.4%	-			NA
HEDIS	MPT: ED Ages 0–12 years—Male	143,433	2	0.02%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: ED Ages 0–12 years—Female	142,287	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: ED Ages 0–12 years—Total Rate	285,720	2	0.01%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: ED Ages 13–17 years—Male	63,988	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: ED Ages 13–17 years—Female	63,421	5	0.09%	0.1%	0.1%	0.0%	-			NA
HEDIS	MPT: ED Ages 13–17 years—Total Rate	127,409	5	0.05%	0.0%	0.1%	0.0%	-			NA
HEDIS	MPT: Telehealth Ages 0–12 years—Male	143,433	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: Telehealth Ages 0–12 years—Female	142,287	2	0.02%	0.0%	0.0%	0.0%	n.s.			NA
HEDIS	MPT: Telehealth Ages 0–12 years—Total Rate	285,720	2	0.01%	0.0%	0.0%	0.0%	-			NA
HEDIS	MPT: Telehealth Ages 13–17 years—Male	63,988	2	0.04%	0.0%	0.1%	0.0%	n.s.			NA
HEDIS	MPT: Telehealth Ages 13–17 years—Female	63,421	1	0.02%	0.0%	0.0%	0.0%	-			NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	MPT: Telehealth Ages 13–17 years—Total Rate	127,409	3	0.03%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Any Services Ages 0–12 years—Male	143,433	2	0.02%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Any Services Ages 0–12 years—Female	142,287	1	0.01%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Any Services Ages 0–12 years—Total Rate	285,720	3	0.01%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Any Services Ages 13–17 years—Male	63,988	56	1.05%	1.0%	1.1%	0.7%	-			NA
HEDIS	IAD: Any Services Ages 13–17 years—Female	63,421	44	0.83%	0.8%	0.9%	0.9%	-			NA
HEDIS	IAD: Any Services Ages 13–17 years—Total Rate	127,409	100	0.94%	0.9%	1.0%	0.8%	-			NA
HEDIS	IAD: Inpatient Ages 0–12 years—Male	143,433	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Inpatient Ages 0–12 years—Female	142,287	1	0.01%	0.0%	0.0%	0.0%	n.s.			NA
HEDIS	IAD: Inpatient Ages 0–12 years—Total Rate	285,720	1	0.00%	0.0%	0.0%	0.0%	n.s.			NA
HEDIS	IAD: Inpatient Ages 13–17 years—Male	63,988	8	0.15%	0.1%	0.2%	0.1%	-			NA
HEDIS	IAD: Inpatient Ages 13–17 years—Female	63,421	11	0.21%	0.2%	0.2%	0.2%	-			NA
HEDIS	IAD: Inpatient Ages 13–17 years—Total Rate	127,409	19	0.18%	0.2%	0.2%	0.2%	-			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0–12 years—Male	143,433	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0–12 years—Female	142,287	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 0–12 years—Total Rate	285,720	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Male	63,988	3	0.06%	0.0%	0.1%	0.1%	-			NA

Indicator		2020 (MY 2019)					Rate Comparison				
Source	Name	Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2019 (MY 2018) Rate	2020 Rate Compared to 2019	MMC	2020 Rate Compared to MMC	HEDIS 2020 Percentile
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Female	63,421	1	0.02%	0.0%	0.0%	0.1%	-			NA
HEDIS	IAD: Intensive Outpatient/Partial Hospitalization Ages 13–17 years—Total Rate	127,409	4	0.04%	0.0%	0.0%	0.1%	-			NA
HEDIS	IAD: Outpatient Ages 0–12 years—Male	143,433	2	0.02%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Outpatient Ages 0–12 years—Female	142,287	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Outpatient Ages 0–12 years—Total Rate	285,720	2	0.01%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: Outpatient Ages 13–17 years—Male	63,988	33	0.62%	0.6%	0.7%	0.4%	-			NA
HEDIS	IAD: Outpatient Ages 13–17 years—Female	63,421	17	0.32%	0.3%	0.4%	0.5%	-			NA
HEDIS	IAD: Outpatient Ages 13–17 years—Total Rate	127,409	50	0.47%	0.4%	0.5%	0.4%	-			NA
HEDIS	IAD: ED Ages 0–12 years—Male	143,433	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: ED Ages 0–12 years—Female	142,287	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: ED Ages 0–12 years—Total Rate	285,720	0	0.00%	0.0%	0.0%	0.0%	-			NA
HEDIS	IAD: ED Ages 13–17 years—Male	63,988	13	0.36%	0.3%	0.4%	0.2%	-			NA
HEDIS	IAD: ED Ages 13–17 years—Female	63,421	14	0.40%	0.3%	0.4%	0.2%	-			NA
HEDIS	IAD: ED Ages 13–17 years—Total Rate	127,409	27	0.38%	0.3%	0.4%	0.2%	-			NA
HEDIS	IAD: Telehealth Ages 0–12 years—Male	143,433	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Telehealth Ages 0–12 years—Female	142,287	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Telehealth Ages 0–12 years—Total Rate	285,720	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Telehealth Ages 13–17 years—Male	63,988	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Telehealth Ages 13–17 years—Female	63,421	0	0.00%	0.0%	0.0%	0.0%	NA			NA
HEDIS	IAD: Telehealth Ages 13–17 years—Total Rate	127,409	0	0.00%	0.0%	0.0%	0.0%	NA			NA

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

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

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

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

2020 Child CAHPS 5.0H Survey Results

Table 2.9: CAHPS 2020 Child Survey Results

Survey Section/Measure	2020 (MY 2019)	2020 Rate Compared to 2019	2019 (MY 2018)	2019 Rate Compared to 2018	2018 (MY 2017)	2020 MMC Weighted Average
Satisfaction with Child's Care						
Satisfaction with your child's current personal doctor (Rating of 8–10)	91.08%	▲	88.76%	▼	90.28%	92.83%
Satisfaction with specialist (Rating of 8–10)	84.91%	▼	87.39%	▲	86.05%	84.67%
Satisfaction with health plan (Rating of 8–10) (Satisfaction with child's plan)	81.24%	▲	79.83%	▼	82.64%	85.77%
Satisfaction with child's health care (Rating of 8–10)	90.33%	▲	88.02%	▲	84.52%	88.80%
Quality of Mental Health Care						
Received care for child's mental health from any provider? (Usually or Always)	14.92%	▲	8.76%	▲	6.76%	14.31%
Easy to get needed mental health care? (Usually or Always)	11.16%	▲	9.01%	▼	33.73%	11.61%
Provider you would contact for mental health services?(PCP)	66.74%	▼	69.66%	▲	68.98%	66.66%
Child's overall mental or emotional health? (Very good or Excellent)	84.32%	▲	79.66%	▼	82.89%	82.33%

▲ ▼ = Performance compared to prior year's rate.

Shaded boxes reflect rates above the 2020 MMC Weighted Average.

III: Structure and Operations Standards

This section of the EQR report presents a review of the CHIP MCO’s compliance with structure and operations standards. The review is based on information derived from the most recent reviews of the MCO. The review is based on information derived from reviews of the MCO that were conducted within the past three years, most typically within the immediately preceding year. Compliance reviews are conducted by CHIP on a recurring basis.

Methodology and Format

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

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 3.1 showcases each of the items and subcategories.

Historically, regulatory requirements were grouped to corresponding BBA regulation subparts based on CHIP’s on-site review findings. Beginning in 2020, findings are reported by IPRO using the SMART database completed by PA CHIP staff as of December 31, 2020 for Review Year (RY) 2019. The SMART items provide the information necessary for this review. The SMART items are a comprehensive set of monitoring items that PA CHIP staff will review on an ongoing basis for each CHIP MCO. The SMART items and their associated review findings for this year are maintained in a database. The SMART database has been maintained internally at DHS CHIP since Review Year (RY) 2019 and will continue going forward for future review years. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 25 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS CHIP.

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the subparts set out in the BBA regulations that were updated in 2016 and finalized in late 2019. These requirements are described in the CMS EQR Protocol: *Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO’s findings are presented in a manner consistent with the subparts in the BBA regulations explained in the Protocol, i.e., Subpart D – MCO, Prepaid Inpatient Health Plan (PIHP) and Prepaid Ambulatory Health Plan (PAHP) Standards and Subpart E – Quality Measurement and Improvement.

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

Table 3.1: SMART Items Count per Regulation

BBA Regulation	CHIP Citation	SMART Items
Subpart D: MCO, PIHP and PAHP Standards		
Availability of services	457.1230(a)	3
Assurances of adequate capacity and services	457.1230(b)	1
Coordination and continuity of care	457.1230(c)	2
Coverage and authorization of services	457.1230(d)	2
Provider selection	457.1233(a)	2
Confidentiality	457.1230(c)	1

BBA Regulation	CHIP Citation	SMART Items
Grievance systems ¹	457.1260	8
Subcontractual relationships and delegation	457.1233(b)	2
Practice guidelines	457.1233(c)	2
Health information systems	457.1233(d)	1
Subpart E: Quality Measurement and Improvement		
Quality assessment and performance improvement program	457.1240(b)	1

Determination of Compliance

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

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

25 items were directly associated with a regulation subject to compliance review and were evaluated for the MCO in Review Year (RY) 2019.

Subpart D: MCO, PIHP and PAHP Standards

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

Table 3.2: MCO Compliance with Enrollee Rights and Protections Regulations

MCO, PIHP AND PAHP STANDARDS		
Subpart D: Categories	Compliance	Comments
Availability of services	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2019.
Assurances of adequate capacity and services	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Coordination and continuity of care	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.

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

MCO, PIHP AND PAHP STANDARDS		
Subpart D: Categories	Compliance	Comments
Coverage and authorization of services	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Provider selection	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Confidentiality	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Grievance systems	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 8 items and was compliant on 8 items based on RY 2019.
Subcontractual relationships and delegation	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.
Practice guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2019.
Health information systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2019.

Subpart E: Quality Measurement and Improvement

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

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

QUALITY MEASUREMENT AND IMPROVEMENT		
Subpart E: Categories	Compliance	Comments
Quality assessment and performance improvement program (QAPI)	Not determined	1 item was crosswalked to this category. The MCO was not evaluated against any items in RY 2019 and no determination was made. This category will be reviewed for this plan during the 2021 review cycle.

IV: 2019 Opportunities for Improvement MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each CHIP MCO has addressed the opportunities for improvement made by IPRO in the 2019 CHIP EQR Technical Reports, which were distributed in April 2020 and re-distributed in August 2020.

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, 2020 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 2020, as well as any additional relevant documentation provided by UHC. While IPRO publishes each MCO's responses as they are received, clarifications made by DHS CHIP to the responses to improve understanding are denoted using square brackets.

The embedded Word document presents UHC's responses to opportunities for improvement cited by IPRO in the 2019 EQR Technical Report, detailing current and proposed interventions. The measures that required responses include the following:

- Annual Dental Visit (15-18 years)
- Dental Sealants for 6-9 Year Old Children At Elevated Caries Risk
- Dental Sealants for 6-9 Year Old 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



UHCP 2019 Opps
Response Request Fc

V: 2020 Strengths and Opportunities for Improvement

The review of the MCO's 2020 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.

For 2020, in light of the COVID-19 global health crisis, NCQA allowed plans to rotate HEDIS measures that are collected using the hybrid methodology. Plans were allowed to report their audited HEDIS 2019 hybrid rate for an applicable measure if it was better than their HEDIS 2020 hybrid rate as a result of low chart retrieval. Due to this, some strengths and opportunities that were identified in 2019 may be identified for the MCO again for 2020, and may again require review and response.

Strengths

- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2020 (MY 2019) 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);
 - Childhood Immunization Status – Influenza;
 - Childhood Immunization Status – Combo 6;
 - Childhood Immunization Status – Combo 8;
 - Childhood Immunization Status – Combo 9;
 - Childhood Immunization Status – Combo 10;
 - Well-Child Visits in the first 15 Months of Life (6 or more visits);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose (12–17 Years);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose (Total);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol (12–17 Years);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Cholesterol (Total);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose & Cholesterol (12–17 Years);
 - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose & Cholesterol (Total);
 - AMBA: Emergency Department Visits/1000 MM Ages 1 – 9 years; and
 - AMBA: Emergency Department Visits/1000 MM Ages <1 – 19 years Total Rate.

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2020 (MY 2019) as indicated by the following measures:

- Contraceptive Care for All Women (Age 15 – 20 years): Most or Moderately Effective;
- Well-Child Visits in the first 15 Months of Life (5 visits);
- Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk;
- Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk (Dental-Enhanced);
- AMBA: Outpatient Visits/1000 MM Ages <1 year;
- AMBA: Outpatient Visits/1000 MM Ages 1 – 9 years;
- AMBA: Outpatient Visits/1000 MM Ages 10 – 19 years; and
- AMBA: Outpatient Visits/1000 MM Ages <1 – 19 years Total Rate.

VI: Summary of Activities

Performance Improvement Projects

- UHC's Lead Screening and Developmental Screening PIP 2020 Interim Reports were both validated. The MCO received feedback and subsequent information related to these activities from IPRO and CHIP in 2020.

Performance Measures

- UHC reported all HEDIS, PA Performance Measures, and CAHPS Survey performance measures in 2020 for which the MCO had a sufficient denominator.

Structure and Operations Standards

- UHC was found to be fully compliant on all items reviewed for Subpart D. UHC was not reviewed for the one required item for Subpart E but this category will be reviewed during the 2021 review cycle. Compliance review findings from the RY 2020 SMART database populated by PA CHIP were used to make the determinations for UHC.

2019 Opportunities for Improvement MCO Response

- UHC provided a response to the opportunities for improvement issued in the 2019 annual technical report for those measures that were identified as statistically significantly below or worse than the MMC weighted average.

2020 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for UHC in 2020. A response will be required by the MCO for the noted opportunities for improvement in 2021.

Appendix

Comprehensive Compliance Standards List

Revised CMS protocols include updates to the structure and compliance standards, including which standards are required for compliance review. Under the new protocols, there are 11 standards that CMS has now designated as required to be subject to compliance review. Several previously required standards have now been deemed by CMS as incorporated into the compliance review through interaction with the new required standards, and appear to assess items that are related to the required standards. **Table A.1.1** lists the standards in the updated protocol, designated as one of the 11 required standards or one of those now deemed as a related standard.

Table A.1.1: Required and Related Structure and Compliance Standards

BBA Regulation	Required	Related
Subpart C: Enrollee Rights and Protections		
Enrollee Rights		✓
Provider-Enrollee Communication		✓
Marketing Activities		✓
Emergency and Post-Stabilization Services – Definition		✓
Emergency Services: Coverage and Payment		✓
Subpart D: MCO, PIHP and PAHP Standards		
Availability of Services	✓	
Assurances of adequate capacity and services	✓	
Coordination and Continuity of Care	✓	
Coverage and Authorization of Services	✓	
Provider Selection	✓	
Provider Discrimination Prohibited		✓
Confidentiality	✓	
Enrollment and Disenrollment		✓
Grievance and appeal Systems	✓	
Subcontractual Relationships and Delegations	✓	
Practice Guidelines	✓	
Health Information Systems	✓	
Subpart E: Quality Measurement and Improvement; External Quality Review		
Quality assessment and performance improvement program (QAPI)	✓	
Subpart F: Grievance and Appeal System		
General Requirements		✓
Notice of Action		✓
Handling of Grievances and Appeals		✓
Resolution and Notification		✓
Expedited Resolution		✓
Information to Providers and Subcontractors		✓
Recordkeeping and Recording		✓
Continuation of Benefits Pending Appeal and State Fair Hearings		✓
Effectuation of Reversed Resolutions		✓

2020 Performance Measure Graphs

Figure A.2.1: Access to Care I

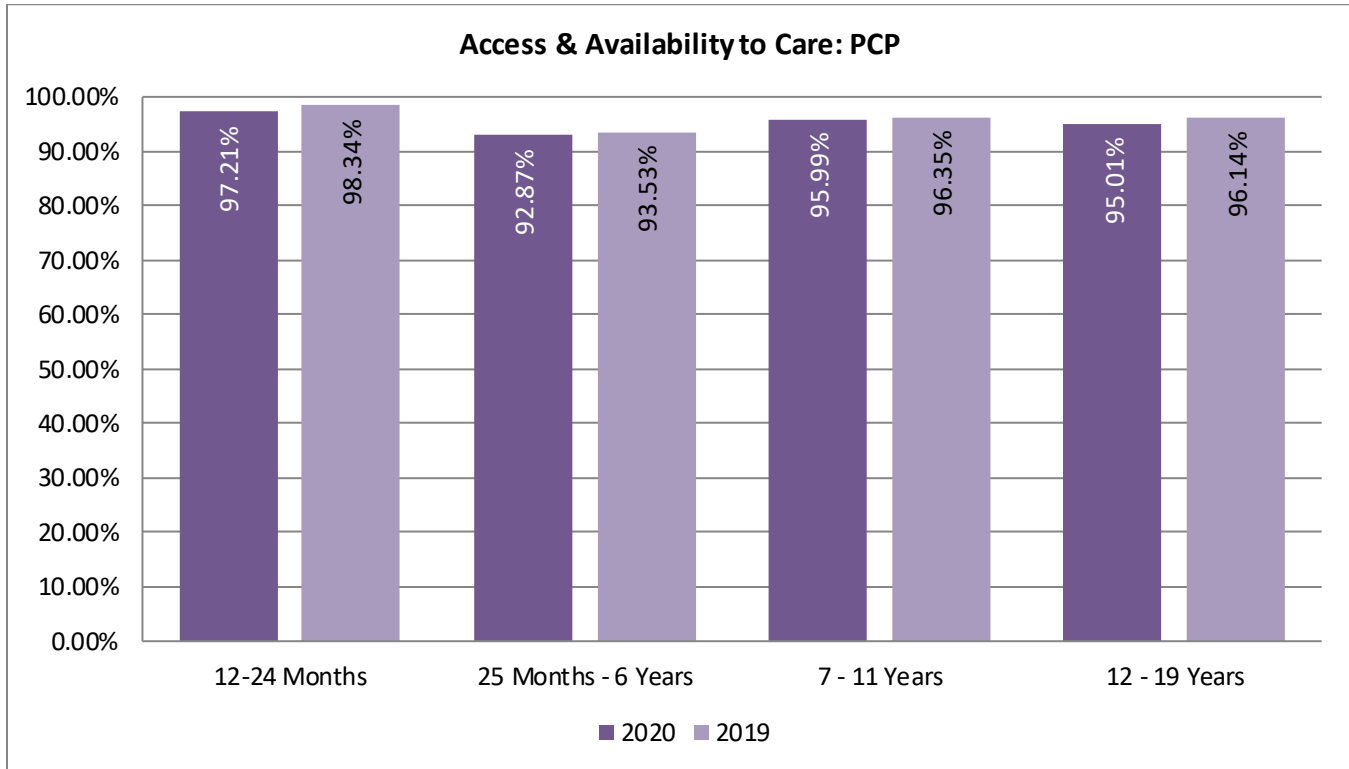


Figure A.2.2: Access to Care II

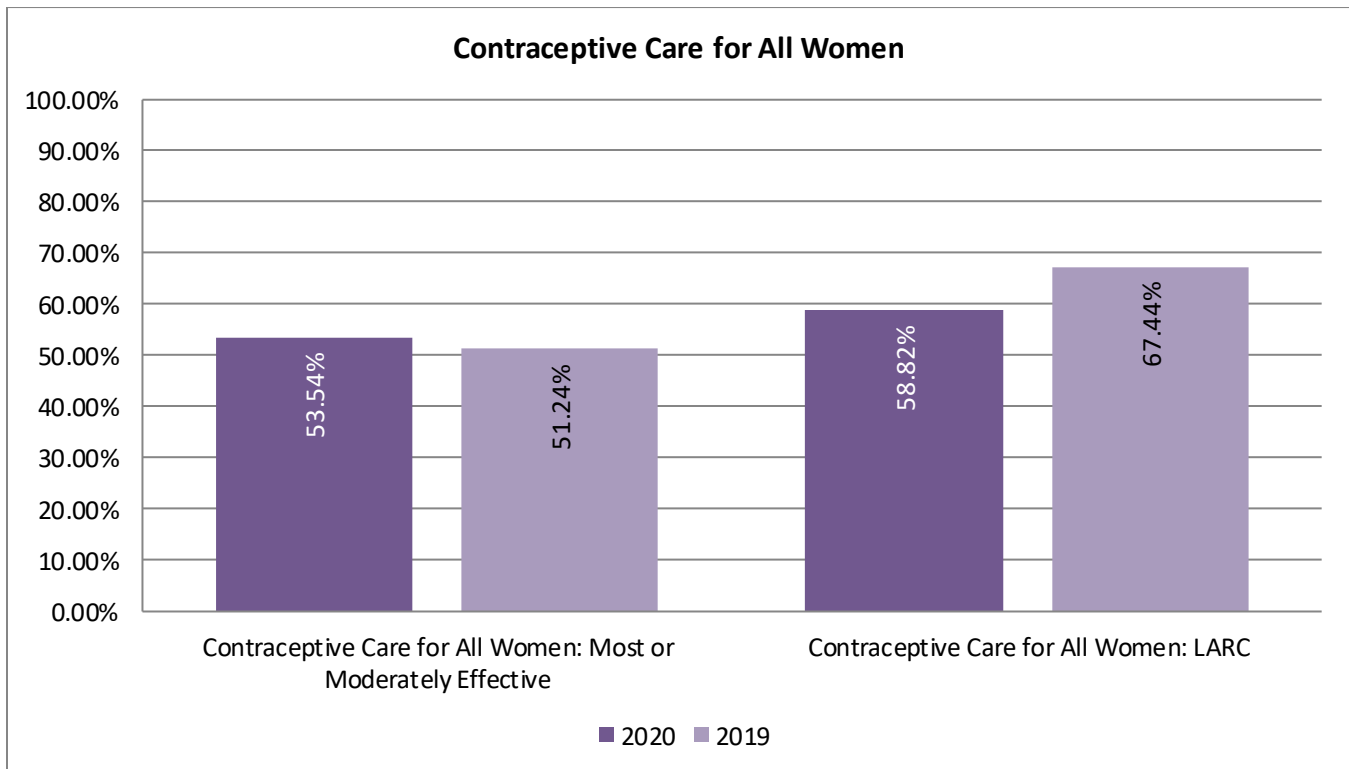


Figure A.2.3: Dental Care for Children I

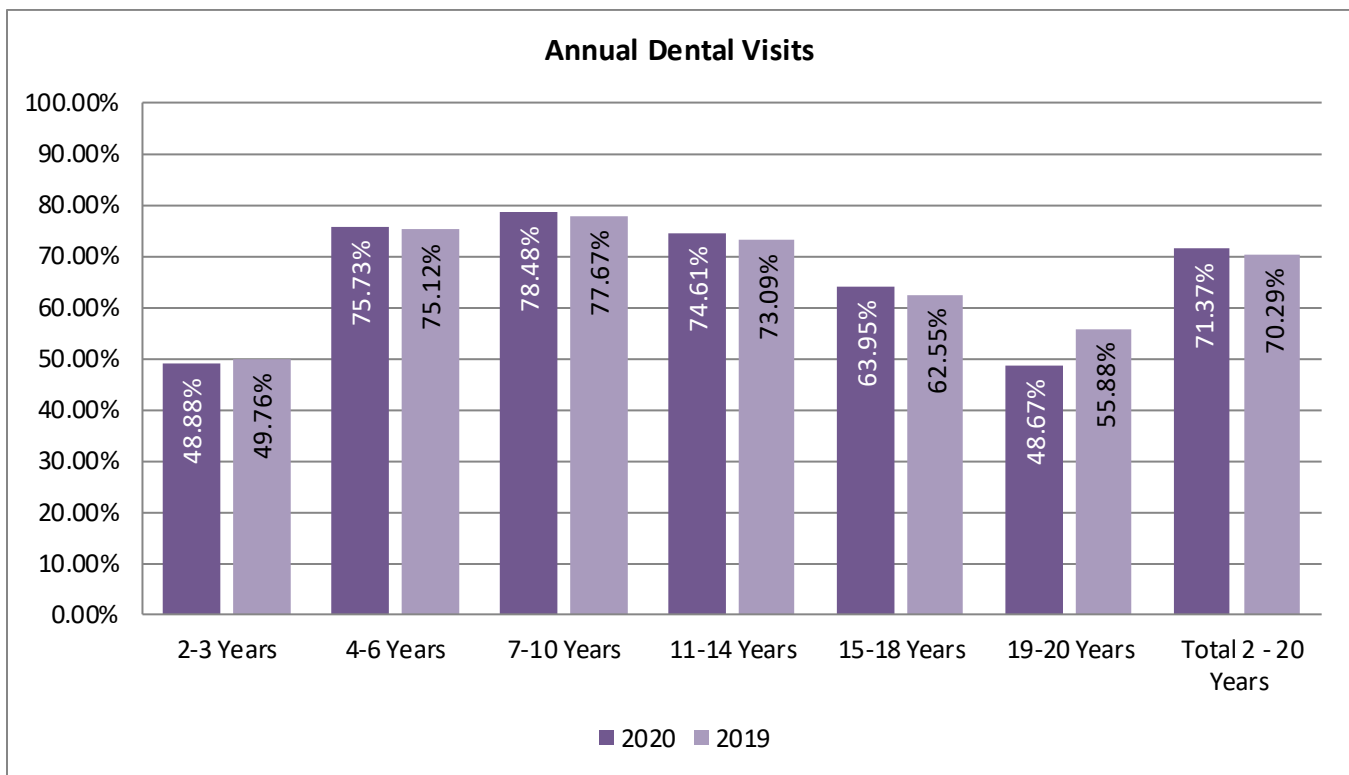


Figure A.2.4: Dental Care for Children II

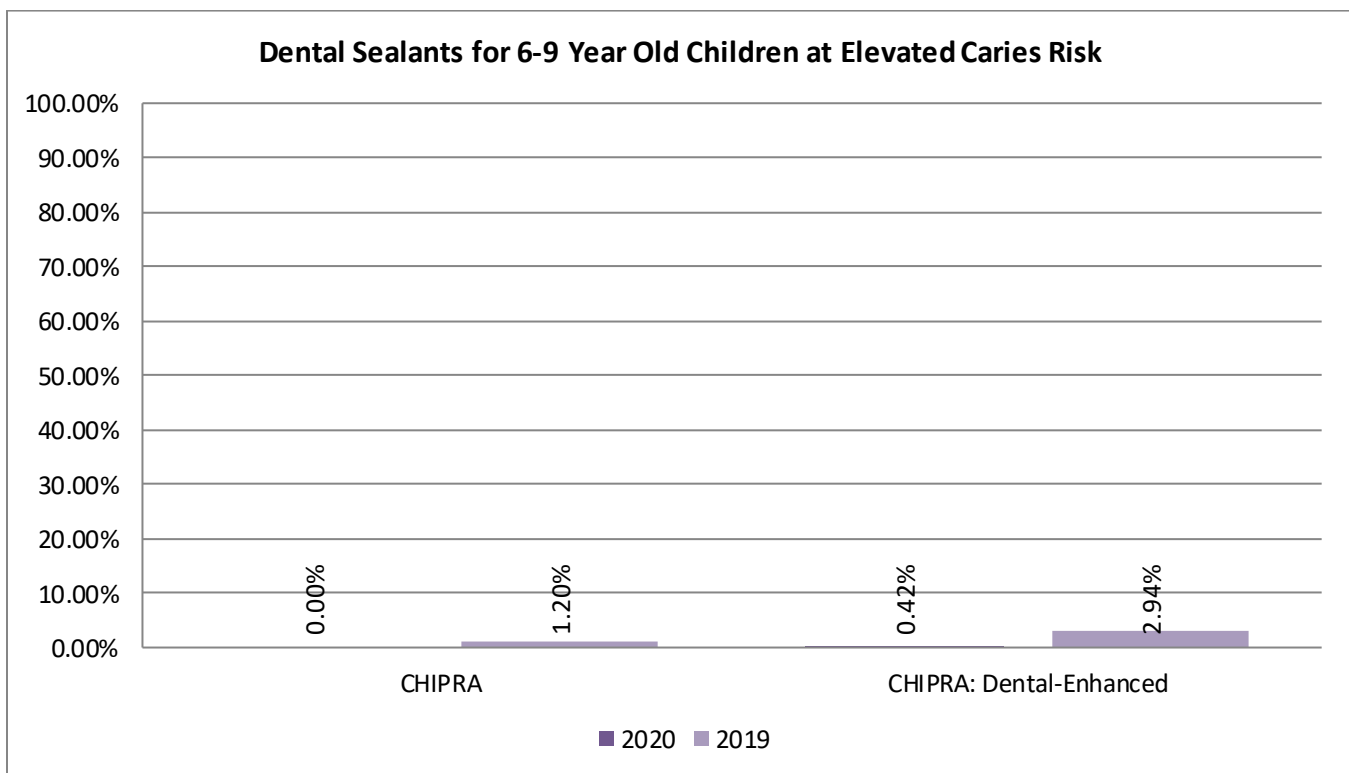


Figure A.2.5: EPSDT: Screenings and Follow-up I

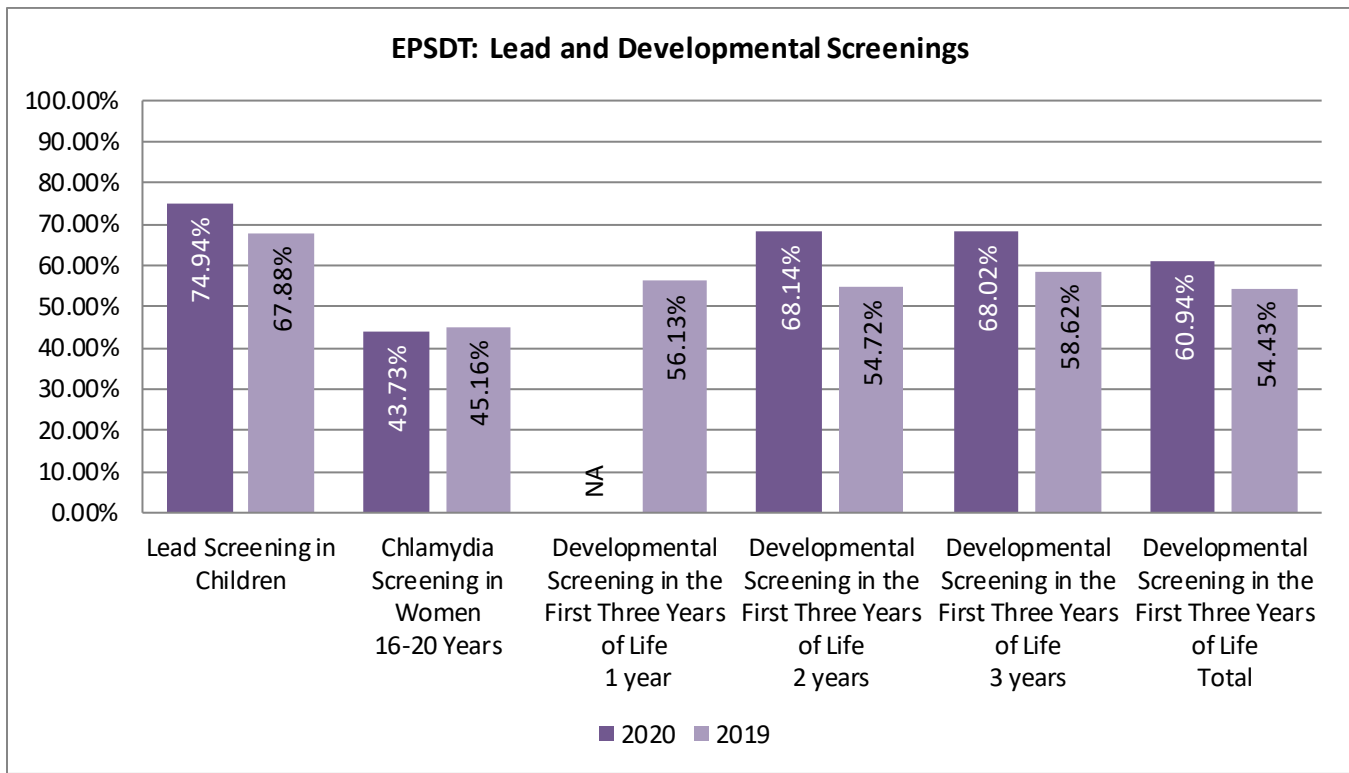


Figure A.2.6: EPSDT: Screenings and Follow-up II

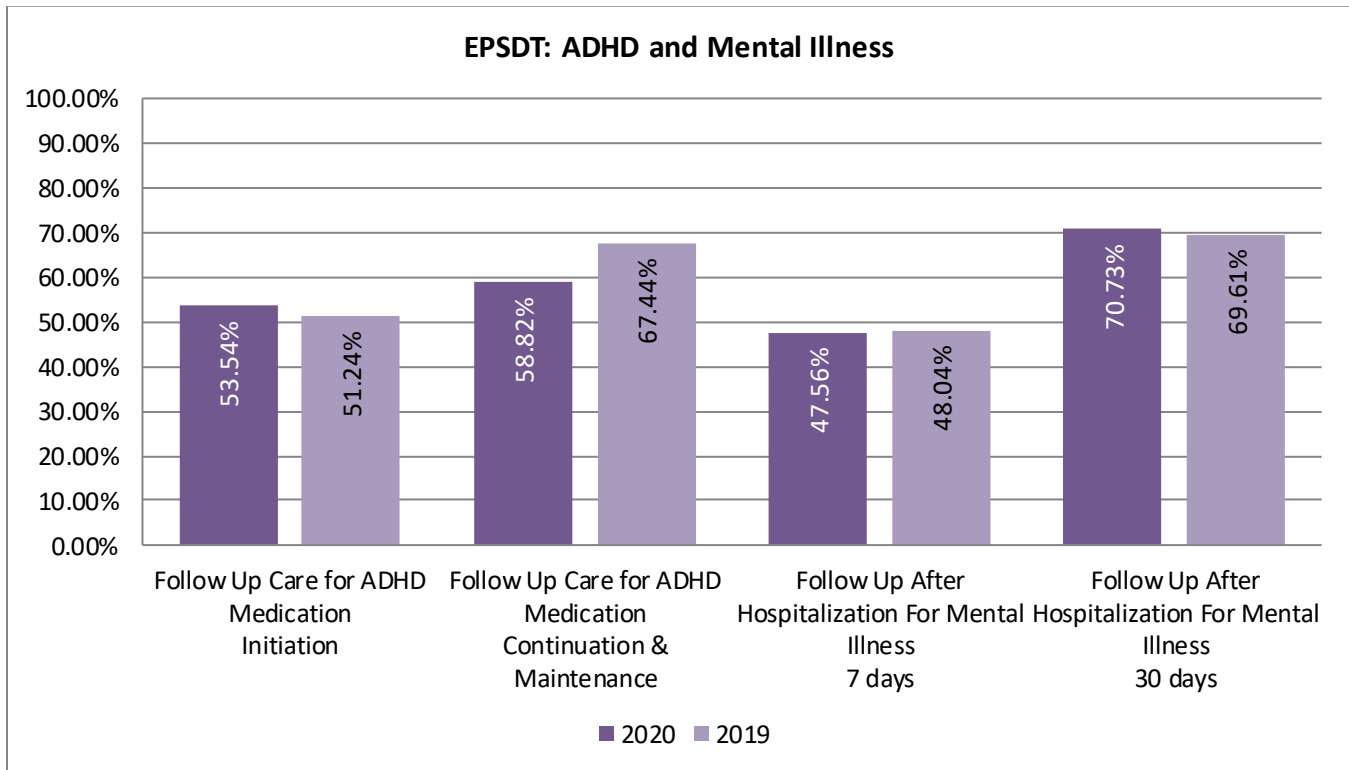


Figure A.2.7: Respiratory Conditions

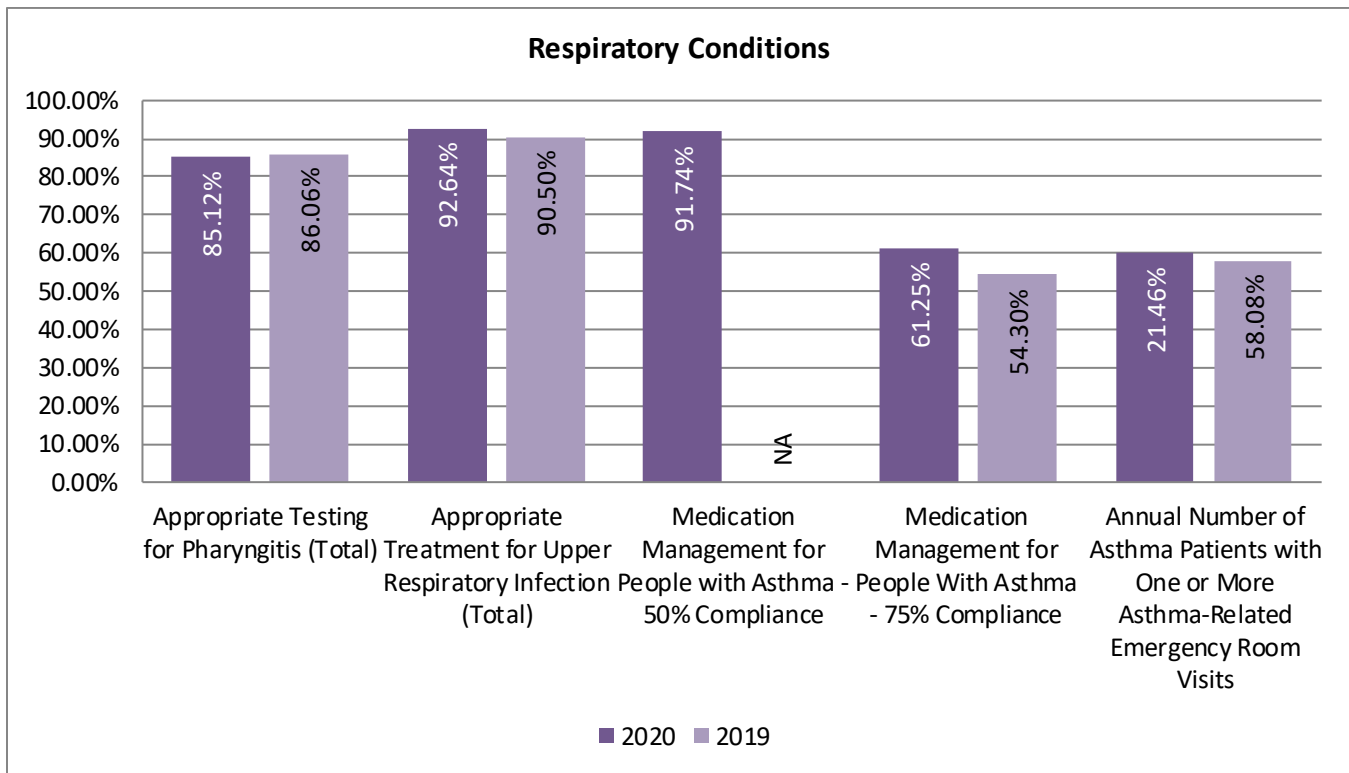


Figure A.2.8: Well Care I

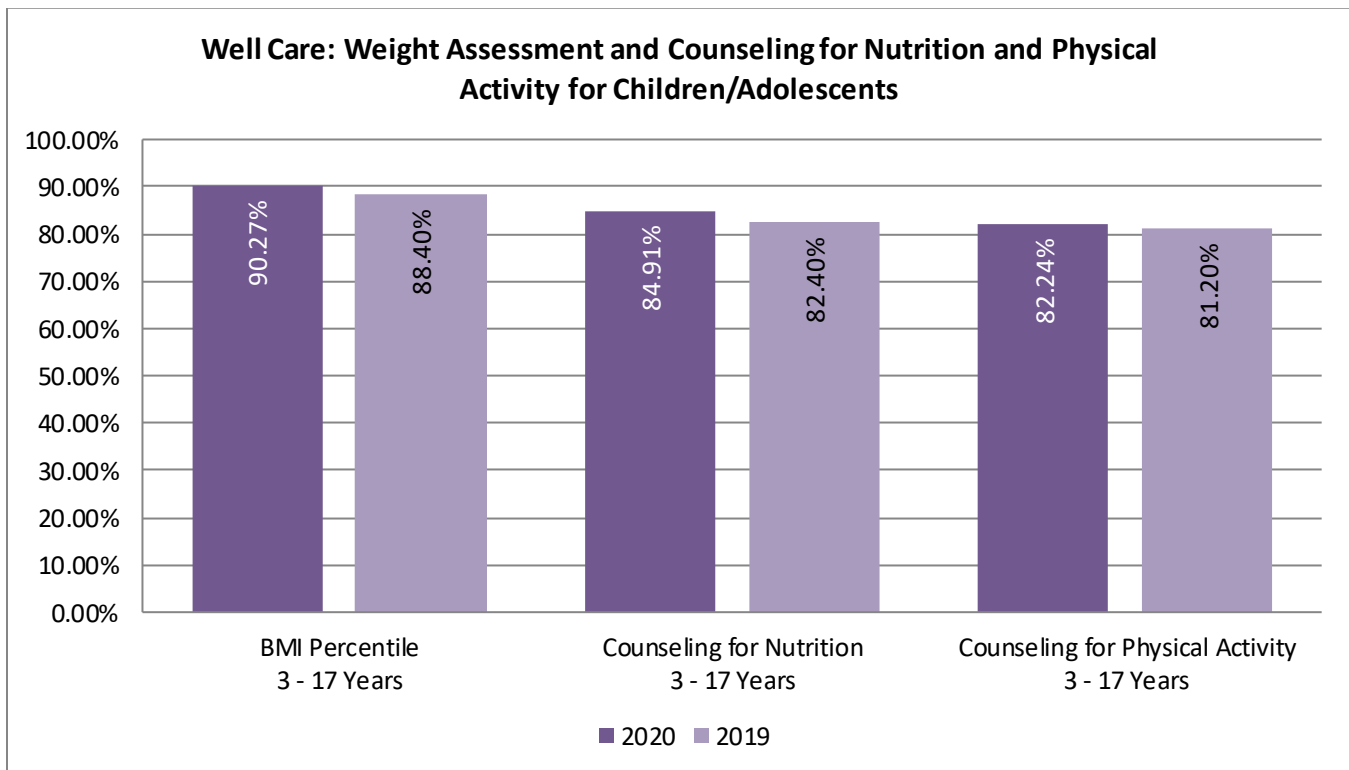


Figure A.2.9: Well Care II

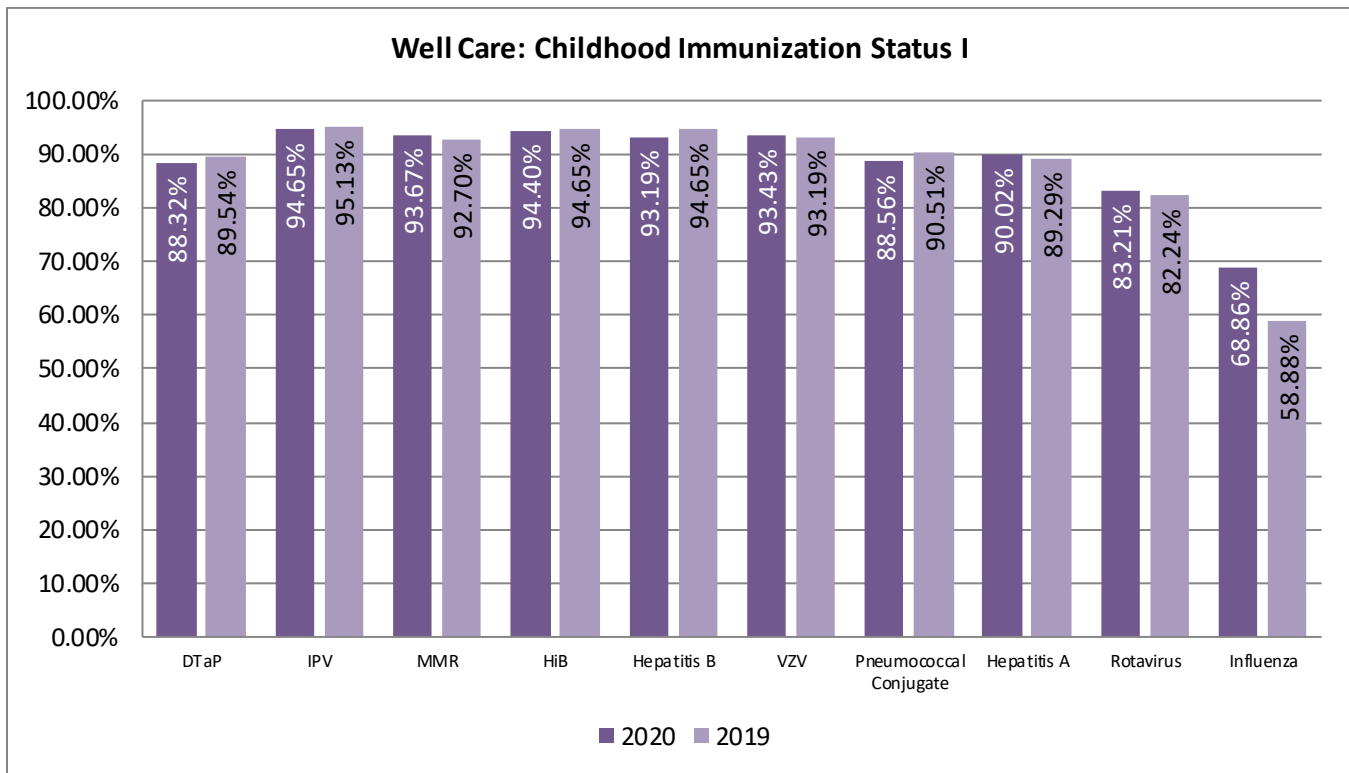


Figure A.2.10: Well Care III

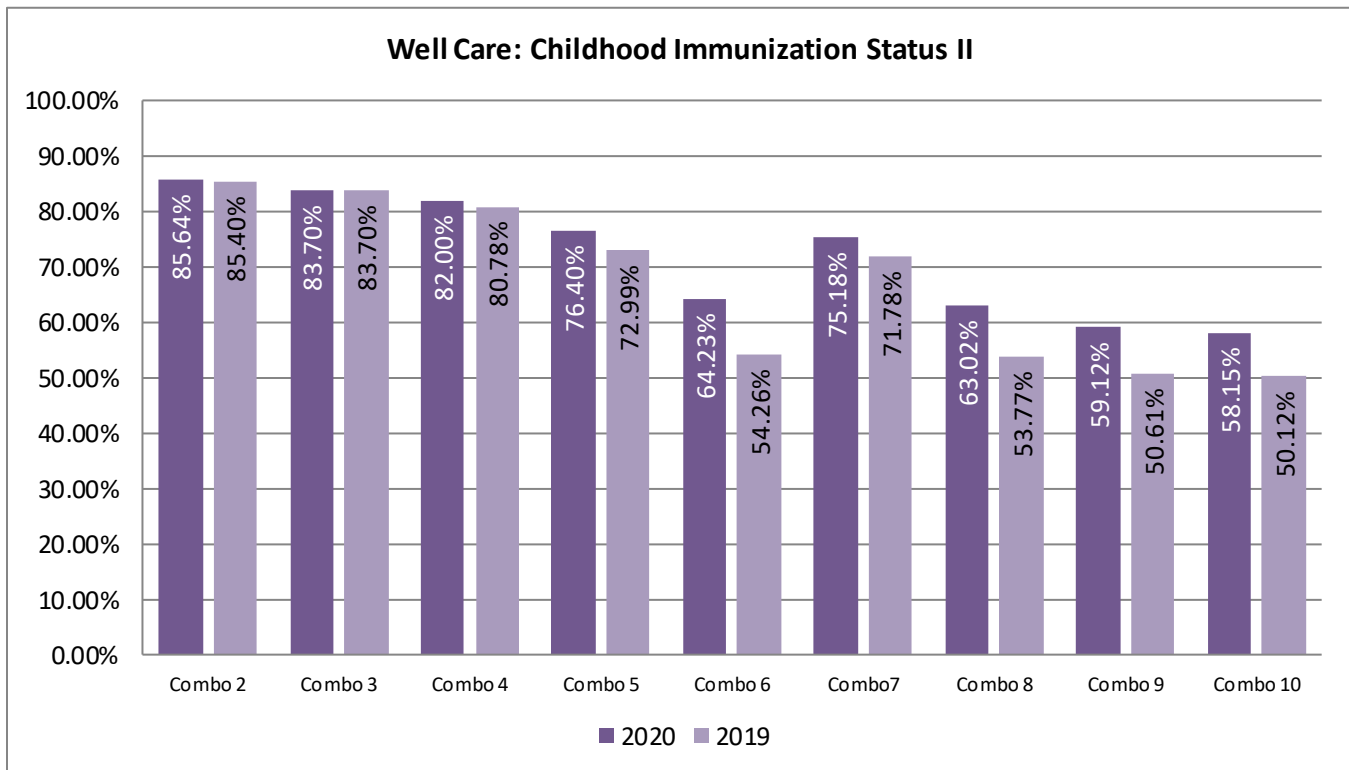


Figure A.2.11: Well Care IV

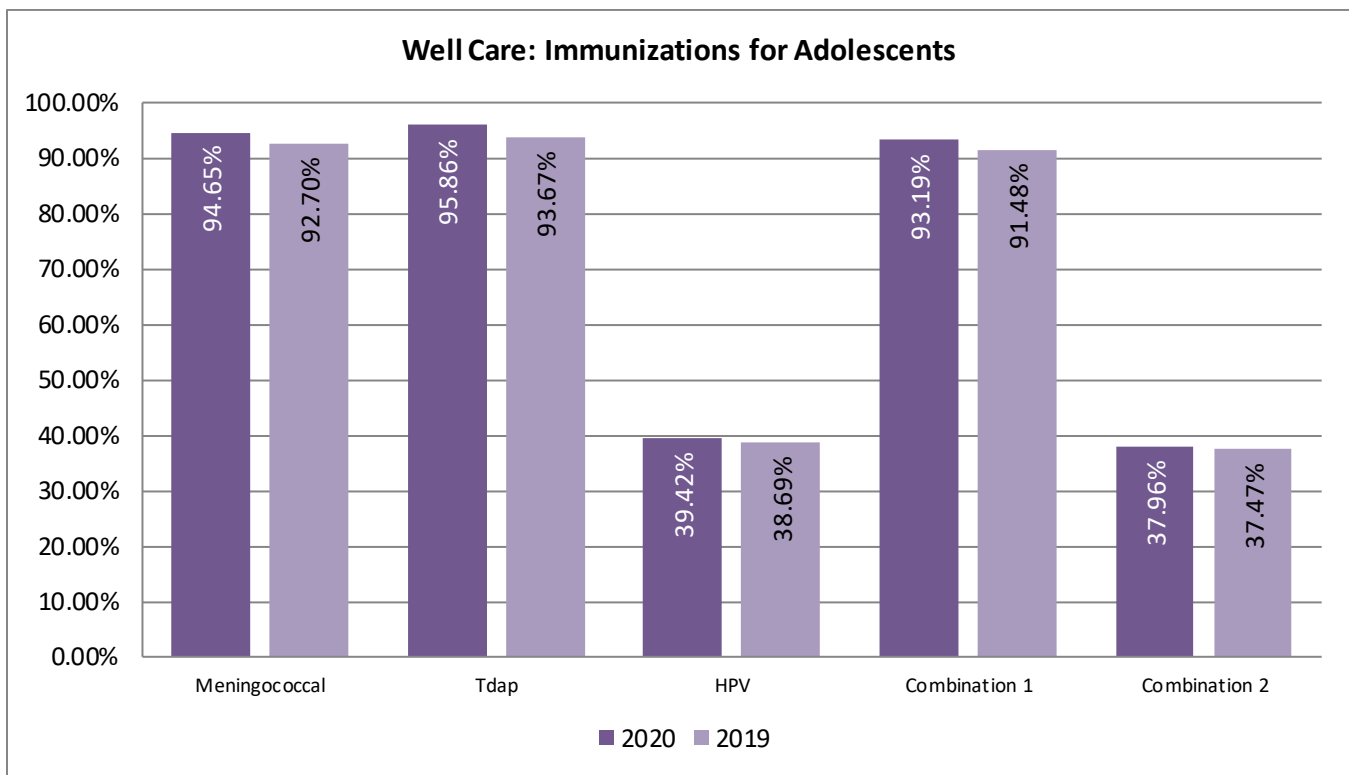


Figure A.2.12: Well Care V

