MaineCare Summary of Child Core Set Measures

Summary of Pediatric Quality Measures for Children Enrolled in MaineCare

Calendar Years 2012 – 2016

October 2018
About this Report

This report was written by Mary Lindsey Smith, PhD, MSW, Katie Rosingana and Mark Richards of the Cutler Institute for Health and Social Policy, Muskie School of Public Service at the University of Southern Maine. We would like to acknowledge our colleagues at the Muskie School of Public Service, Tina Gressani and Apsara Kumarage who conducted the measure programming and calculations for the child health quality measures presented in this report. We would also like to thank Dr. Amy Belisle, Director of Child Health Quality Improvement at Maine Quality Counts, Dr. Kevin Flanigan, former Medical Director of MaineCare Services, Maine Department of Health and Human Services (DHHS), Amy Dix, former Director of Value Based Purchasing Unit and Ginger Roberts-Scott, former Policy and Children’s Services Program Manager at MaineCare Services, Maine DHHS, for their feedback and support throughout the development of this report.

This report presents the results of the 17 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to the Centers for Medicare and Medicaid Services (CMS) for CY 2012 – CY2016. Also included in this report are several retired CHIPRA Core Measures and three measures from the Improving Health Outcomes for Children (IHOC) project’s Master List of Pediatric Measures. In addition to presenting results in graphs and narrative, this report also provides measure definitions and background information about each measure topic.

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The views expressed are those of the author’s and do not necessarily represent the views of either the Department or the School. For further information regarding this report, please contact Mary Lindsey Smith at m.lindsey.smith@maine.edu.
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In February 2010, Maine and Vermont were awarded a five-year demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to improve the quality of health care for children insured by Medicaid and the Children’s Health Insurance Program (CHIP). Maine’s Department of Health and Human Services’ (DHHS) Office of MaineCare Services (OMS) received the Improving Health Outcomes for Children (IHOC) grant in partnership with the Maine Center for Disease Control, the Muskie School of Public Service at the University of Southern Maine, Vermont’s Medicaid Program, and the University of Vermont.

In Maine, a key objective of the IHOC grant was to collect and report on the Initial Core Set of Children’s Health Care Quality Measures (referred to as the “CHIPRA Core Measures”), a set of 27 standardized, evidence-based measures identified by CMS for use by State Medicaid and CHIP programs. States submit results of the CHIPRA Core Measures to CMS once each year as a component of the CHIP Annual Report, a web-based reporting system (MACPro) that CMS and its contractors use to monitor the operations of Medicaid and CHIP programs.

Although reporting of the Core Measures is currently not required by CMS, MaineCare reported results for 17 of the measures in the Calendar Year 2016 (CY2016). Of the core set of measures MaineCare is currently reporting through the Medicaid and CHIP Program (MACPro) portal, thirteen are claims-based, three are registry-based, and one is based on consumer surveys.

This document presents the results of the 17 CHIPRA Core Measures that were collected using MaineCare claims, Vital Statistics or survey data and reported to CMS. These measures include:

- Well-child visits (3 measures)
- Access to primary care providers
- Chlamydia screening
- Dental sealants
- Preventative dental services
- Emergency Department (ED) visits
- Follow-up care for children with ADHD medication
- Use of multiple concurrent antipsychotics
- Follow-up after hospitalization for mental illness
- Prenatal care (2 measures)
- Live births weighing less than 2,500 grams
- Developmental screening

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Medication management for people with asthma
Patient experience of care

Maine continues to report on the following CHIPRA Core Measures that have been retired:

- Appropriate testing for children with pharyngitis
- Annual pediatric hemoglobin A1c testing
- Dental treatment services
- Asthma ED visits

In addition to the CHIPRA Core Measures, Maine providers collaborating with the IHOC project identified other quality measures to support quality improvement at the practice-level. Through a stakeholder feedback process, measures drawn from Bright Futures guidelines, Meaningful Use, and other sources were added to the CHIPRA Core Measures to create the Maine Master List of Pediatric Measures, totaling 52 pediatric quality measures.

The document also presents results of measures from the Maine list not included among the CHIPRA Core Measures. The following Maine Pediatric measures were calculated using MaineCare claims:

- Well-child visits between 15 months and 3 years of age (Maine Pediatric Measures #32), and between 7 and 11 years of age (Maine Pediatric Measures #34).
- Asthma controller medication (Maine Pediatric Measures #25)
- Fluoride treatment

The goal of this document is to present the claims-based CHIPRA and Maine Pediatric measure results in a user-friendly format for the Maine DHHS and other key stakeholders. Measures are grouped by topic. For each topic, a Background section provides a brief description and rationale for collection. Next, we provide a general description of how each measure is defined, followed by the results.

Most of the measures use a 12-month measurement period. To fulfill requirements of the CHIP Annual Report we used measurement periods that correspond to Calendar Years (CY). This aligns with last year’s report and is a change from previous reports that were based on the Federal Fiscal year (FFY).

Where available, we also include national 2016 HEDIS averages from Medicaid managed care plans along with Maine’s results. The Health Plan Employer Data and Information Set (HEDIS) is a set of performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS measures are widely used by employers, consumers, and Medicaid agencies to compare and monitor performance of health plans. Many of the CHIPRA Core Measures are HEDIS measures, and the NCQA publishes average results for selected measures each year. HEDIS averages are included to provide a point of comparison for the Maine results.

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2 The background discussion for CHIPRA Core Measures is drawn from the Background Report for the Initial, Recommended Core Set of Children’s Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs. Available at: [http://archive.ahrq.gov/policymakers/chipra/coreset/coreset.pdf](http://archive.ahrq.gov/policymakers/chipra/coreset/coreset.pdf)

3 FFY runs from October 1- September 30; CY runs from January 1 – December 31.

Background

Current American Academy of Pediatrics (AAP) *Bright Futures* guidelines suggest that all children receive a well-child visit (WCV) at specific intervals depending on age. Well-child visits are the gateway to immunizations and early identification of problems. They provide opportunities to discuss developmental issues with parents and deliver evidence-based and other recommended specific preventive services. The CHIPRA Core measures include three well-child visit measures currently specified by National Committee for Quality Assurance (NCQA): 1) WCVs in the first 15 months of life; 2) WCVs in the 3rd, 4th, 5th, and 6th years of life; 3) WCVs in adolescence (ages 12 – 21).

Stakeholders in Maine noted the importance of measuring WCVs for two additional age ranges that are not included in the CHIPRA measures: WCVs between 15 months and 3 years of age (Maine Pediatric Measure #32), and WCVs between 7 and 11 years of age (Maine Pediatric Measure #34).

Measure Definition

These measures assess, for each age group, the number of children who received a well-child or preventive care visit from a primary care provider (including, for adolescents, an obstetrician-gynecologist) during the measurement year.

For the youngest group, children who turn 15 months during the measurement year and are continuously enrolled from 31 days after birth to 15 months of age are in the measure denominator. The number of visits is counted (0, 1, 2, 3, 4, 5, 6 or more visits) for this age group.

For children between 15 months and 3 years of age, children who turn 3 years old during the measurement year and are continuously enrolled between 15 months and 3 years of age are in the measure denominator. The number of visits is counted (0, 1, 2, 3) for this age group.

For 3-6 year olds, 7-11 year olds, and adolescents (12-21 years old) the criterion is at least one well-child visit with a primary care provider during the measurement year. The denominator population for each of these measures is defined by the age of the child at the end of the measurement year, and requires that the child be continuously enrolled during the year.

Results

The results of the WCV measures for CY2012 through CY2016 are shown in Figures 1 – 3 and Table 1. Rates of well-child visits remained relatively constant over the 4-year measurement period.

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5 Throughout this document, much of the background information for each measure is drawn from the Background Report for the Initial, Recommended Core Set of Children’s Healthcare Quality Measures for Voluntary Use by Medicaid and CHIP Programs. Available at [http://www.ahrq.gov/policymakers/chipra/overview/background/index.html](http://www.ahrq.gov/policymakers/chipra/overview/background/index.html)

6 “Continuously enrolled” means the child missed no more than one month of MaineCare eligibility in the measurement period. For 12 month measurement periods, the child must be enrolled for at least 11 months to be included in the denominator.
Figure 1 shows the percentage of children enrolled in MaineCare with 0-1, 2-4, 5 or 6 or more total WCVs in the first 15 months of life. In CY2016, over two-thirds of enrolled children (71%) had at least six visits in the first 15 months, and 84% had five or more visits. MaineCare’s rates for children having six or more WCVs in the first 15 months of life were higher than the 2016 HEDIS national average of 62%.

![Figure 1](https://example.com/figure1.png)

**Figure 1**
Number of Well-Child Visits in the First 15 Months

Source: MaineCare Claims Data

Figure 2 shows the percentage of children age 15 months to 3 years with 0, 1, 2, or 3 or more total WCVs. The 3+ age rate has increased slightly since CY2012. Over the past four years the number of children between the ages of 15 months and 3 years receiving the recommended number of well-child visits (3+) has maintained a steady rate, yet 10% of the children in this age range had no WCVs which is consistent with national averages.7

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Figure 3 shows the percentage of children who had at least one WCV in the measurement year, by three different age ranges: ages 3–6, ages 7–11, and ages 12–21; although rates have remained fairly stable over the past four years, in 2016 there were slight increases in rates for all age ranges compared to 2015. Notably, WCV rates decline considerably as children get older (Figure 3, Table 1). For 3 to 6 year olds, about 69% had at least one visit during the measurement year. For 7 to 11 year olds, the rate falls to 55%, and for adolescents, it falls further still to 47%. The percentage of adolescents with at least one WCV increased two percentage points from the previous year. Note that MaineCare rates are lower than the HEDIS national average for 2016: 3% lower for both 3-6 year olds and adolescents.\(^8\)

\(^8\) HEDIS did not measure visits for ages 7-11.
**Table 1**

Number of Children Who Had at Least One Well Child Visit, by Age Cohort

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>CY2012 At least 1 visit</th>
<th>CY2012 Total</th>
<th>CY2013 At least 1 visit</th>
<th>CY2013 Total</th>
<th>CY2014 At least 1 visit</th>
<th>CY2014 Total</th>
<th>CY2015 At least 1 visit</th>
<th>CY2015 Total</th>
<th>CY2016 At least 1 visit</th>
<th>CY2016 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCVs, 3-6 Years</td>
<td>16,681</td>
<td>26,187</td>
<td>16,593</td>
<td>25,430</td>
<td>15,891</td>
<td>24,129</td>
<td>15,158</td>
<td>22,614</td>
<td>14,599</td>
<td>21,253</td>
</tr>
<tr>
<td>WCVs, 7-11 Years</td>
<td>14,878</td>
<td>30,543</td>
<td>15,370</td>
<td>30,340</td>
<td>15,578</td>
<td>30,142</td>
<td>15,592</td>
<td>29,321</td>
<td>15,592</td>
<td>28,256</td>
</tr>
<tr>
<td>WCVs, 12-21 Years</td>
<td>18,787</td>
<td>47,145</td>
<td>19,116</td>
<td>45,583</td>
<td>18,929</td>
<td>44,604</td>
<td>19,324</td>
<td>42,952</td>
<td>19,349</td>
<td>41,106</td>
</tr>
</tbody>
</table>

*Source: MaineCare Claims Data*
Background

The CHIPRA legislation specified that measures of availability of services be included in the CHIPRA Core measure set. Availability of services is an important topic, given the many reports from national studies on the lack of providers and some providers’ unwillingness to serve Medicaid patients. The expert panel convened by the federal Agency for Healthcare Research and Quality (AHRQ) and CMS to review and make recommendations for the CHIPRA Core measures noted that “…realized access to care (e.g., utilization of primary care providers) [is an] incomplete measure of availability because the reasons for lack of utilization could go well beyond lack of availability (e.g., parents don't perceive a need for the service). However, realized access is a piece of availability and a way to measure access under capitated primary care arrangements.”

The panel also noted that the Access to PCP measure is only a proxy measure for availability of services; it cannot be considered a true measure of availability because it deals with only primary care, and because the reasons for non-use of primary care services may vary, from lack of availability, to lack of time, to lack of perceived need, and other factors.

This measure can be considered important from two perspectives. From a payer perspective, it is good to know whether enrolled children are getting any care. Access to primary care providers is essential for children to have well-child visits and the opportunity for social and developmental screening, two measures also included in the CHIPRA Core measure set.

Measure Definition

For children aged 12-24 months, and 25 months-6 years, this measure assesses the receipt of one or more visits with a primary care provider during the measurement year. For children aged 7-11 and 12-19 years, the measure assesses the receipt of one or more visits with a primary care provider during the measurement year or the year prior to the measurement year. Continuous enrollment for the younger two age groups is required for the measurement year. For the two older age groups, continuous enrollment is required for both sequential measurement years.

Figure 4 shows the percentage of children in each age group who had at least one visit with their PCP in the five measurement years. MaineCare’s performance on this measure is excellent across all age categories. Realized access among the youngest children is nearly universal, at 97% and rates of access to PCPs average around 90% for the other three age groups as well. These rates are above the FFY 2015 rates reported by states in the 2016 Annual Report on the Quality of Care for Children in Medicaid and CHIP, and are also above the 2016 HEDIS Averages.

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Background

Screening to identify health conditions for early intervention with effective treatments is a primary purpose of preventive (well-care) visits. Screening for chlamydia, a sexually transmitted infection, of sexually active females ages 16-20 was identified as an important screening because, if left untreated, it can cause pelvic inflammatory disease in women, a condition that can result in sterility. Chlamydia is easy-to-treat, but widespread. In 2016, 1,598,354 cases of chlamydia infection were reported to the Centers for Disease Control (CDC), making it the most common notifiable condition in the United States.\(^{12}\) This corresponds to a rate of 497.3 cases per 100,000 population, an increase of

\(^{12}\)Information gathered from the Center for Disease Control, National Overview of Sexually Transmitted Diseases (STDs), 2016 at: https://www.cdc.gov/std/stats16/natoverview.htm
4.7% since 2015.\textsuperscript{13} Although Maine ranks 48\textsuperscript{th} in reported chlamydia cases (4,156 in 2016), screening is essential to ensure that cases are not being missed and going untreated.\textsuperscript{14}

**Measure Definition**

This measure assesses the extent to which at least one chlamydia test is given during the measurement year to women 16-20 years of age who were identified as sexually active and were enrolled in MaineCare for at least 11 out of the 12 months during the measurement year.

**Results**

Figure 5 shows that 40% of sexually active women age 16 – 20 years enrolled in MaineCare had a chlamydia screening in CY2016. Screening rates were very similar from 2012-2016, and did not change in 2016. Each year screening rates in Maine have fallen below the HEDIS average rates, which have consistently topped 50% since 2009.

\textbf{Figure 5}

Chlamydia Screening for Women (Ages 16-20)

\begin{center}
\begin{tabular}{|c|c|c|c|c|}
\hline
\hline
Percentage of Women & 41\% & 40\% & 40\% & 40\% \\
(n=8,106) & (n=7,681) & (n=7,050) & (n=6,562) \\
\hline
\end{tabular}
\end{center}

\textit{Source: MaineCare Claims Data}

\textsuperscript{13}Information gathered from the Center for Disease Control, National Overview of Sexually Transmitted Diseases (STDs), 2015 at: http://www.cdc.gov/std/stats15/std-trends-508.pdf

\textsuperscript{14}Information gathered from the Kaiser Family Foundation, State Health Facts.org at: http://kff.org/other/state-indicator/chlamydia-cases/#
Dental Preventive and Treatment Services

CHIPRA Measures PDENT-CH, SEAL-CH

Maine Pediatric Measures 16, 38, 39, 59

Background

Oral health problems are common, painful, and preventable. According to the CDC Oral Health Division, tooth decay affects 20% of U.S. children aged 5–11 years and 13% of those aged 12–19 years. Rates of tooth decay among children ages 5–19 years from lower-income families is twice as high compared to children in higher income families. Ongoing dental services are essential to improve children’s oral health.

Dental services are a required benefit for most Medicaid-eligible individuals under the age of 21, as a component of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, and with the advent of CHIPRA, dental services are also a required benefit for CHIP enrollees. Historically, two dental measures reported through CMS-416 (a required report submitted by all EPSDT programs to CMS each year) are were included in the CHIPRA core set: children receiving preventive dental services and children receiving dental treatment services. (CHIPRA dental treatment measure was retired in March of 2015 but, is still calculated as part of the Maine Pediatric Measures. All dental measures were calculated using MaineCare claims data.

Two claims-based measures were added to this report in 2015: fluoride varnish services and dental sealants. Research indicates dental sealants on the back teeth (molars) could prevent up to 80% of cavities in school-age children. In October 2016, the Centers for Disease Control released a report on the importance of dental sealants for school-aged children, of which only 43% of children ages 6-11 have been treated with sealants. According to the CDC, "school-age children without sealants have almost three times more cavities than children with sealants." Children should get sealants on their permanent molars as soon as the teeth come in (ages 5-7 in most children). This measure is for children ages 6-9 who are deemed at elevated risk for tooth decay. Children who get at least four treatments of fluoride varnish before their fourth birthday are less likely to have cavities, and those who get fluoride varnish at earlier ages benefit even more. MaineCare covers fluoride varnish for children twice a year.

Measure Definition

Receipt of Preventive Dental Services and Dental Treatment Services assess the percent of children ages 1 to 20 who received dental services as a function of the number of children eligible for EPSDT. Children are counted as eligible for EPSDT services if they were enrolled in MaineCare for at least 3 consecutive months during the measurement year.

Sealants for children ages 6-9 years is the percentage of enrolled children with “elevated risk” (i.e., moderate or high) who received a sealant on a permanent first molar tooth as a dental or oral health service within the reporting year.

Fluoride varnish is assessed as the total number of children age one to twenty years who are eligible for Medicaid and/or CHIP and enrolled for 90 continuous days who received Fluoride Dental Treatment.

15 http://www.cdc.gov/oralhealth/children_adults/child.htm
16 The dental treatment measure (TDENT) was part of the CMS Child Core Set during the previous reporting periods but was retired in March 2015.
17 Centers for Disease Control and Prevention, Vital Signs. https://www.cdc.gov/vitalsigns/
18 “Dental Services” are identified using CDT or HCPCS codes D0100 – D9999. “Preventive Dental” are codes D1000 – D1999, and “Dental Treatment” are codes D2000 – D9999.
**Results**

Figure 6 shows results for the two measures related to dental services for children ages 1-20 that are eligible for EPSDT services. In CY2016, the rate for dental preventive services remained stable as it has over the last four years. Over 52% of eligible children received preventive dental services in CY2016, up from 49% in CY2012. Over the past 4 years, the provision of dental treatment services has remained stable at 14%.

![Figure 6](image)

As seen below in Figure 7, the largest percentage of children at elevated risk receiving dental sealants in each year from 2014-2016 were 7-year olds, with over a quarter of children receiving them at that age (28% and 27%).

![Figure 7](image)
Figure 8 shows the rate of fluoride treatment services for children ages 6 months to 4 years, which has increased significantly from 22% in 2012 to 34% in 2016.

**Figure 8**
Children who Received Flouride Services

Source: MaineCare Claims Data

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2012</td>
<td>22%</td>
</tr>
<tr>
<td>CY2013</td>
<td>25%</td>
</tr>
<tr>
<td>CY2014</td>
<td>27%</td>
</tr>
<tr>
<td>CY2015</td>
<td>32%</td>
</tr>
<tr>
<td>CY2016</td>
<td>34%</td>
</tr>
</tbody>
</table>

**Appropriate Testing for Children with Pharyngitis and Prescribed an Antibiotic**

CHIPRA Measure CWP (Retired)

Maine Pediatric Measure 30

**Background**
Upper respiratory infections (URIs), including pharyngitis (inflammation of the throat), are among the most common reasons for children’s acute care encounters with health care providers. URIs often present opportunities for the overuse of antibiotics even though most URIs are time-limited and, if viral, cannot be cured with antibiotics. The purpose of the measure is to monitor and help reduce the unnecessary use of antibiotics by ensuring that antibiotics were not given without a diagnosis of streptococcal (strep) bacteria. Pharyngitis is measured because it was determined to be the leading diagnosis for 6.4 million visits to physician offices and hospital outpatient departments for all children under age 15 in 2006 nationally, providing many opportunities for inappropriate antibiotic use.19

**Measure Definition**
This measure assesses whether a strep test was administered for children 2-18 years in the 7-day period from 3 days prior through 3 days after the first eligible episode date. An eligible episode is an outpatient visit with a diagnosis of pharyngitis at which an antibiotic was dispensed. The measure counts children who were continuously enrolled 30 days prior to the episode date through 3 days after the episode date.

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Results

Figure 9 shows the rates of appropriate testing for children diagnosed with pharyngitis has varied slightly over the last four years, with the rate decreasing from last year by four percent. In CY2016, 81% of children enrolled in MaineCare who were diagnosed with pharyngitis and prescribed an antibiotic had received a strep test. MaineCare’s rates for appropriate testing for children with pharyngitis have continually exceeded national HEDIS averages for testing; in 2016 MaineCare’s rates were 14% higher than the HEDIS average of 67%.

![Figure 9: Appropriate Testing for Children Diagnosed with Pharyngitis who are Prescribed an Antibiotic (Ages 2-18)](source: MaineCare Claims Data)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2012</td>
<td>81%</td>
</tr>
<tr>
<td>CY2013</td>
<td>82%</td>
</tr>
<tr>
<td>CY2014</td>
<td>84%</td>
</tr>
<tr>
<td>CY2015</td>
<td>80%</td>
</tr>
<tr>
<td>CY2016</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Source:** MaineCare Claims Data

Emergency Department (ED) Visits

*CHIPRA Measure AMB-CH*

*Maine Pediatric Measure 41*

Background

Emergency departments are a critical feature of the U.S. health care delivery system. However, their availability and convenience compared to other care settings means that they may be used when traditional care settings would be more appropriate and less costly. The intent of using this measure is to reduce unnecessary ED visits.
The measure is potentially important to MaineCare, given that in 2006, Medicaid paid for 62% of all ED visits of children less than age 1 and they paid for 42% of all ED visits of children 1-17 years.20

**Measure Definition**

This measure assesses the average number of ED visits per 1,000 member months (rather than individual members). The measure breaks out the results by age: less than 1 year, 1-9 years, 10-19 years and the total of all ages.

**Results**

The results in Figure 10 show that in CY2016 and each measurement year, children under the age of one report the most ED visits. This age group saw a decrease over the last four years, from 71 ED visits per 1,000 member months in 2012 to 62 ED visits in 2016. Overall, the rates have dropped for all age categories. Between 2012 and 2016 rates for individuals in the various age cohorts have dropped between 7% and 9%; in 2016 the overall average number of ED visits for all age cohorts was 42.

![Figure 10](image-url)

**Figure 10**

Emergency Department Visits Per 1,000 Member Months

Source: MaineCare Claims Data

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Asthma is the most prevalent chronic physical condition among children. In 2016, 6.1 million children in the U.S. had asthma, which is equal to 8.3% of the population under the age of 18.\(^{21}\) As of 2016, 10% of children covered by Medicaid reported currently having asthma.\(^{22}\) In 2015, the CDC reported that 11.2% of Maine children currently had asthma.\(^{23}\)

Children with asthma have higher rates of healthcare utilization and costs, in 2009 the average yearly cost of care for a child with asthma was $1,039\(^{24}\). In the same year, one in five children with asthma went to an emergency department for an asthma related incident.\(^{25}\) Between 2000 and 2010, the average cost for an asthma related stay for a child was $3,600.\(^{26}\) Emergency department visits for asthma are important to measure because they are expensive and provide a gateway to hospitalization.

Asthma controller medicines are also important to measure because they help prevent asthma symptoms when taken every day as prescribed. The asthma controller measure (Maine Pediatric Measure #25) is not part of the CHIPRA core set, but is included in Meaningful Use.

**Measure Definition**

The medication management for people with asthma measure (MMA-CH), assesses the percentage of adolescents, 11-20 years of age during the measurement year, who were identified as having persistent asthma and were dispensed appropriate asthma controller medications and that they remained on the medication for at least 50% or 75% of their treatment period. Results are presented for all those children with a diagnosis of asthma at the 50\(^{th}\) and 75\(^{th}\) percentage points and further broken down into three age categories: 5 to 11, 12 to 18, and 19 to 20.

The asthma ED visit measure assesses the percentage of children in MaineCare ages 2 through 20 diagnosed with asthma during the measurement year with one or more asthma-related ED visits. The measure does not require that a child be continuously enrolled in MaineCare to be included; the eligible population is defined by the age of the child and diagnosis of asthma, identified using ICD-9 codes in the claims.

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\(^{21}\) Information gathered from the Center for Disease Control, National Health Interview Survey, 2016, Table C-1b available at: [https://ftp.cdc.gov/pub/Health_statistics/NCHs/NHIS/SHS/2016_SHS_Table_C-1.pdf](https://ftp.cdc.gov/pub/Health_statistics/NCHs/NHIS/SHS/2016_SHS_Table_C-1.pdf)

\(^{22}\) Information gathered from the Center for Disease Control, National Health Interview Survey, 2016, Table C-1b available at: [https://ftp.cdc.gov/pub/Health_statistics/NCHs/NHIS/SHS/2016_SHS_Table_C-1.pdf](https://ftp.cdc.gov/pub/Health_statistics/NCHs/NHIS/SHS/2016_SHS_Table_C-1.pdf)

\(^{23}\) Information gathered from the Center for Disease Control, Adult Current Asthma Prevalence by State available at: [https://www.cdc.gov/asthma/archivedata/2015/2015_data_states.html](https://www.cdc.gov/asthma/archivedata/2015/2015_data_states.html)

\(^{24}\) Information gathered from the Center for Disease Control, Asthma’s Impact on the Nation: Data from the CDC National Asthma Control Program available at: [http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf](http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf)

\(^{25}\) Information gathered from the Center for Disease Control, Asthma’s Impact on the Nation: Data from the CDC National Asthma Control Program available at: [http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf](http://www.cdc.gov/asthma/impacts_nation/asthmafactsheet.pdf)

The asthma controller medication measure assesses the percentage of children enrolled in MaineCare ages 5 through 21 years who were identified as having persistent asthma who were appropriately prescribed controller medication during the measurement year.

**Results**

As shown in Figure 11, of children ages 5-20 enrolled in MaineCare with a diagnosis of asthma and prescribed asthma medication, more than half have the desired ratio of controller medication to other asthma medications (equal to or more than .50). For the age groups that have comparable HEDIS measurement (5-11 years and 12-18 years), MaineCare children are below the HEDIS average for 5-11 year olds (65% vs 73%), and are below the HEDIS average (61% vs 63%) for 12-18 year olds. MaineCare children do better than the HEDIS average where applicable for the medication management piece of this measure. The percentage of MaineCare children ages 5-11 that were given asthma controller medications and remained on the medication for at least 75% of their treatment period was 39% compared to HEDIS national average of 30%; MaineCare children ages 12-18 were at 37% for this medication management component compared to 29% national HEDIS average.

**Figure 11**  
Use of Appropriate Medications & Medication Management

Figure 12 shows that in CY2016, there were 9,051 children ages 2 – 20 enrolled in MaineCare who were identified as having asthma; of those, just under 7% had one or more visits to the ED because of their asthma during the year. Rates for asthma-related ED visits have ranged between 6.7% and 7.8% since CY2012, when rates were over 8%.
Figure 13 shows the number of active asthma patients who were appropriately prescribed controller medications during the measurement year. Two age groups were measured, children ages 5-11 years and 12-20 years. Over 90% of 5-11 year old children with asthma were prescribed controller medications in all five measurement years. Among the older age group (12-20 years) controller medication rates were slightly lower ranging from 89% in CY2013 to 85% in CY2016. These rates were comparable to 2014 HEDIS Rates which were 91% for children ages 5 – 11 and 86% for children 12 - 18.27 (Note: 2015, 2016 HEDIS rates not available, as NCQA retired this measure.)

Figure 12
Asthma Patients with at Least 1 Asthma-Related Emergency Department Visit

Source: MaineCare Claims Data

Figure 13
Children with Asthma Prescribed Contoller Medication

Source: MaineCare Claims Data

Note: 2015, 2016 HEDIS rates not available, as NCQA retired this measure.

Background

Health care providers and others are raising concerns about the rising rate of diabetes among children and adolescents. In a 2017 report, the CDC reported that about 132,000 people younger than 18 years of age are diagnosed with diabetes (type 1 or type 2) living in the U.S. in 2015. This represents 0.18% of all people in this age group.\(^\text{28}\) That figure doesn’t include the substantial number of young people that are undiagnosed or considered to be pre-diabetic. Hemoglobin A1c (HbA1c) testing measures how close to normal blood glucose levels are maintained over time; therefore, it is an important indicator of management of the diabetic patient.

Measure Definition

This measure assesses the extent to which patients, ages 5-17 with a diagnosis of diabetes had a Hemoglobin A1c (HbA1c) test during the measurement year. To be included, children must be continuously enrolled in MaineCare (i.e. enrolled for at least 11 out of the 12 months of the measurement year). Children with diabetes can be identified based either on MaineCare pharmacy data or claims; children who were dispensed insulin or oral hypoglycemics/anti-hyperglycemics or those with a diagnosis of diabetes on one or more claims are used to identify children with diabetes.

Results

Figure 14 shows the results for the diabetes testing measure, rates have remained above 80% over the past five years. Rates for annual HbA1c testing in 2016 for children between the ages of 5 and 17 with diabetes increased 6% over 2015.

---

The average number of tests per child was 2.9 in CY2016, no increase from CY2015. Also notable is the fact that there are relatively few children enrolled in MaineCare identified as having diabetes—ranging from a low of 298 in CY2016 to a high of 396 in CY2013 (Figure 15).

Figure 15
Average Number of Diabetes Tests

Source: MaineCare Claims Data

Follow-up Care for Children Prescribed ADHD Medication

CHIPRA Measure ADD-CH
Maine Pediatric Measure 36

Background

The percentage of children estimated to have attention deficit hyperactivity disorder (ADHD) continues to grow, up from 3% in 2003 to 9.4% in 2016. This translates into almost 1 in 10 children ages 2 – 17 having been diagnosed with ADHD in 2016. Estimates show that approximately 5.2% of children nationally take medication for ADHD. In 2011, 12.9% of children in Maine had a current diagnosis of ADHD, and 6.6% of those children were currently taking a medication for ADHD.

29 Information gathered from the Centers for Disease Control report: [https://www.cdc.gov/ncbddd/adhd/data.html#cost](https://www.cdc.gov/ncbddd/adhd/data.html#cost)
30 Information gathered from the Centers for Disease Control report: [https://www.cdc.gov/ncbddd/adhd/data.html#cost](https://www.cdc.gov/ncbddd/adhd/data.html#cost)
the disorder. Since medications affect children differently, follow-up care for medicated children is critical for their health and well-being, as well as the treatment of their ADHD.

Measure Definition

This measure assesses the percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed. The first 30 days are referred to as the Initiation Phase and the next nine months are referred to as the Continuation and Maintenance (C&M) phase. The measure is limited to children ages 6 – 12 years. To be included in the denominator for the Initiation Phase, children must be enrolled in MaineCare continuously for four months prior to the medication dispensing date through 30 days after that date. To be included in the denominator for the C&M phase, children must be enrolled in MaineCare continuously for four months prior to the medication dispensing date through 10 months after that date.

Results

As shown in Figure 16, follow-up care for children prescribed ADHD medication far exceeds the 2016 HEDIS averages. However, follow-up during the initiation phase has increased in CY2016 to CY2012 levels. Rates for the C&M phase measures have improved over the past five years (increasing 8%). In CY2016, there were a total of 1,677 children ages 6 – 12 enrolled in MaineCare who were identified as having received a prescription for ADHD and two-thirds of those children (67%) received appropriate follow-up care during the Initiation Phase. This group’s rate for the C&M phase is a bit higher, with 72% of children in MaineCare receiving appropriate follow-up care for ADHD medications in CY2016.

![Figure 16: Follow-Up Care for Children Prescribed ADHD medication (Ages 6-12)](source: MaineCare Claims Data)

Results data is as follows:

- **Follow-Up During the Initiation Phase**:
  - CY2012: 67%
  - CY2013: 66%
  - CY2014: 65%
  - CY2015: 64%
  - CY2016: 67%

- **Follow-Up During the Continuation & Maintenance Phase**:
  - CY2012: 64%
  - CY2013: 70%
  - CY2014: 71%
  - CY2015: 70%
  - CY2016: 72%

The 2016 HEDIS Average for the Continuation and Maintenance phase is 55%.

31 Information gathered from the Centers for Disease Control report at: [https://www.cdc.gov/ncbddd/adhd/prevalence.html](https://www.cdc.gov/ncbddd/adhd/prevalence.html) & [https://www.cdc.gov/ncbddd/adhd/medicated.html](https://www.cdc.gov/ncbddd/adhd/medicated.html)
Antipsychotic prescribing in children and adolescents has increased rapidly in recent decades.32,33 Children and adolescents prescribed antipsychotics are at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects.34

About 1 in 10 children and adolescents who are prescribed these medications are prescribed more than one antipsychotic at the same time.35 Because risks of multiple concurrent antipsychotic use in children and adolescents has not been systematically investigated, guidelines caution against their use, due to the lack of evidence supporting use and the risks these medications pose.36 This measure can highlight potentially unsafe use of antipsychotic medications.

Measure Definition

This measure assesses the percentage of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications. It shows the rate of eligible members with 90 days of continuous antipsychotic medication treatment with no more than one month gap during the measurement year. Since this was a new HEDIS measure in 2015, we coded the measurement year and the previous year 2014 to use as baseline.

Results

As shown in Table 2, there are very few children ages 1-5 prescribed multiple antipsychotic medications; most of the multiple use is in the 12-17 age cohort, which has approximately double the number of children of the 6-11 age cohort. In 2016 the overall rate decreased slightly from the year before from 1.54% to 1.52%, but is below the 2015 HEDIS average of 2.5%. 2016 HEDIS data not available on this measure at the time of this report.

References

Table 2

Children and Adolescents Using Multiple Concurrent Antipsychotic Medications, by Age Cohort

<table>
<thead>
<tr>
<th>Age Cohort</th>
<th>CY2014</th>
<th>Rate</th>
<th>CY2015</th>
<th>Rate</th>
<th>CY2016</th>
<th>Rate</th>
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<tr>
<td>1-5 Years</td>
<td>18</td>
<td>0.00%</td>
<td>20</td>
<td>0.00%</td>
<td>16</td>
<td>0.00%</td>
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<tr>
<td>6-11 Years</td>
<td>600</td>
<td>0.83%</td>
<td>528</td>
<td>0.95%</td>
<td>503</td>
<td>0.99%</td>
</tr>
<tr>
<td>12-17 years</td>
<td>1,162</td>
<td>1.64%</td>
<td>1,078</td>
<td>1.86%</td>
<td>1,058</td>
<td>1.80%</td>
</tr>
<tr>
<td>All, 1-17 years</td>
<td>1,780</td>
<td>1.35%</td>
<td>1,626</td>
<td>1.54%</td>
<td>1,577</td>
<td>1.52%</td>
</tr>
</tbody>
</table>

2015 HEDIS average (ages 1-17): 2.5%
(Note: 2016 data not yet available as of October 2018.)

Follow-up after Hospitalization for Mental Illness

CHIPRA Measure FUH-CH

Maine Pediatric Measure 44

Background

Mental health disorders are an important public health issue because of their prevalence, early onset, and impact on a child, their families and the community, with an estimated total annual cost of $247 billion. In any given year, between 13% to 20% of children living in the United States experience a mental disorder and research shows that the prevalence of these conditions among children has continued to increase over the past two decades. Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), and autism spectrum disorders (1.1%). In 2006, the most common conditions for which children with Medicaid were hospitalized in community hospitals were mood disorders and ADHD/disruptive behaviors. Follow-up care after hospitalization is necessary to maintain children’s mental health and continuity of care in the community. In addition, follow-up care aids in reducing health care cost by decreasing the rate of re-hospitalizations.

Measure Definition

This measure assesses whether individuals aged 6-20 years who have had a mental illness hospitalization and were discharged from the hospital had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a

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37 Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children-United States, 2005 – 2011. Available at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm)

38 Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children-United States, 2005 – 2011. Available at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm)

39 Information gathered from the Center for Disease Control report, Mental Health Surveillance Among Children-United States, 2005 – 2011. Available at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm)

mental health provider within 7 or 30 days after discharge (two rates are reported). To be eligible for this measure, the child must be continuously enrolled in MaineCare from the day of discharge through 30 days after.

Results

Figure 17 shows the total number of hospitalizations for mental illness for calendar years 2012 through 2016; this is the denominator for the measure. Hospitalizations increased between 2012 and 2015, but rates have dropped 8% in 2016.

The actual measure results are displayed in Figure 18, and show that the 7-day and 30-day follow-up rates have remained steady in 2015 & 2016. These rates are 9 and 15 percentage points lower than CY2012, respectively.
Background

Early prenatal care (in the first trimester of pregnancy) helps prevent premature birth and other infant health problems, as well as, helps improve the health of women during pregnancy.

Measure Definition

These measures assess the timeliness and frequency of prenatal care that MaineCare-enrolled women received for all deliveries during the measurement year (calendar year). Timeliness measures the number of MaineCare-enrolled women in the denominator sample who had a prenatal visit in the first trimester or within 42 days of enrollment. The Frequency of Ongoing Prenatal Care measure is computed based on the number of reported prenatal care visits on the birth certificate and the expected number of visits for the period between when care began and the date of delivery. The expected number of visits is based on guidelines for perinatal care defined by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG). The measure categorizes births where the mother received less than 21% of the expected visits; 21-80%; or more than 81% of the expected visits. Those in the last category are usually defined as having received “adequate” prenatal care.

Results

Vital statistics data presented below shows the timeliness and frequency of prenatal care for CYs 2012 -2016. Figure 19 shows that while MaineCare deliveries to mothers who received prenatal care in the first trimester of their pregnancy dropped 9 percentage points between CY2012-2016, in 2016 that is 7 percentage points higher than the HEDIS average. (*Note, 2013 FPC and TPC measures were calculated using a subset of the vital stats data from 1/1/2013 to 7/31/2013 birth due to the PNC # not reported on the record -- changed over to New Birth Certificate.)

41 Because of limitations with the self-reported prenatal care information available in the Vital Statistics data, we had to make some modifications to the CHIPRA measure specifications to compute these two measures. The Vital Statistics data only included a total count of prenatal visits received during the pregnancy, and the month in which the first visit was received (e.g. 1 through 9). For the timeliness measure, we counted all mothers who reported their first prenatal visit in month 1, 2 or 3 OR who reported their first visit as taking place within 2 months of MaineCare enrollment as meeting numerator criteria. For the frequency of ongoing prenatal care measure, we only adjusted the number of expected visits based on gestational age at delivery (with no adjustment for date of enrollment in MaineCare). Essentially, we made a simplifying assumption that all prenatal care visits were covered by MaineCare for deliveries identified in the denominator.
The frequency of prenatal care among MaineCare recipients has remained consistent since 2014. Figure 20 shows that over the five years, between 87-91% of those deliveries who received an “adequate” number of prenatal visits according to the AAP/ACOG.

Source: MaineCare Eligibility and Vital Statistics Data

Source: MaineCare Eligibility and Vital Statistics Data
**Live Births Weighing Less than 2,500 Grams**

*CHIPRA Measure LBW-CH*

*Maine Pediatric Measure 48*

**Background**

Low birth weight (often used as a proxy for premature birth) is an important condition that is highly prevalent. Low birth weight is an important predictor of health outcomes for infants, and it is costly to the health care system and society.

**Measure Definition**

This measure assesses the percentage of live births per year to women enrolled in MaineCare that weighed less than 2,500 grams (5.5 pounds) during the calendar year.

**Results**

Figure 21 shows that approximately 9% of babies born to MaineCare-enrolled mothers in calendar year 2016 were low birth weight, which is a slight increase from 2015 where rates were 8.4%.

**Figure 21**

Percentage of Live Births Weighing Less than 2500 Grams

Source: MaineCare Eligibility and Vital Statistics Data
Developmental Screening in the First Three Years of Life

CHIPRA Measure DEV-CH

Maine Pediatric Measure 7, 8 and 10

Background

In the United States, about 13% of children 3 to 17 years of age have a developmental or behavioral disability such as autism, intellectual disability or ADHD. An estimated 9.5 million Medicaid- and CHIP-enrolled preschool children are eligible for developmental screening. In the United States, 17% of children (12 million children) were found to have a behavioral disability such as autism, mental retardation, or attention-deficit/hyperactivity disorder. Medicaid serves more than 25% of all children in the United States (and more than half of all poor and low-income children). Children from poor families are at greater risk than those from non-poor families for poorer outcomes, including those related to mental development. The 2011-2012 National Survey of Children’s Health (NSCH) found that publicly insured children ages 2 to 17 were 2.1 times more likely than privately insured children to currently have developmental delay.

Measure Definition

This measure assesses the extent to which children at various young ages from 0-36 months were screened for social and emotional development with a standardized, documented tool or set of tools. Eligible children include those who turn age 1, age 2, or age 3 and who were enrolled continuously in MaineCare during the measurement year. For claims-based reporting, screening is identified using CPT code 96110.

Results

The results for the developmental screening of children who turn 1, 2 and 3 years old during the measurement year are shown in Figures 22 and 23. The rates have significantly increased over the past five years.

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42 Information gathered from the Center for Disease Control report, Developmental Monitoring and Screening. Available at: [http://www.cdc.gov/ncbddd/childdevelopment/screening.html](http://www.cdc.gov/ncbddd/childdevelopment/screening.html)

The percentage of children who were screened for risk of developmental, behavioral and social delays using a standardized tool on or before their 1st birthday increased from 7% in CY2012 to 28% in CY2016. One year old screening rates were four times higher in 2016 than they were in 2012. Likewise, rates of screening for children after their 1st birthday and on or by their second birthday were over 3 times higher in CY2016 than they were in CY2012, increasing from 10% to 34%. For children between their 2nd and 3rd birthday’s rates increased markedly going from 7% in CY2012 to 27% in CY2016. Finally, the total number of screenings for all children has increased substantially from just over 1,500 screens in CY2012 to over 4,800 screens in CY2016, a 9% increase from CY2015 (Figure 23).
The main purpose of the annual Survey of Children Served by MaineCare is to monitor the quality of services delivered by MaineCare, the state of Maine’s Medicaid and Child Health Insurance (CHIP) program. The 2016 survey uses a standardized instrument—the Consumer Assessment of Healthcare Providers and Systems (CAHPS 5.0H)—as its primary means of examining the experiences of families with children enrolled in MaineCare. The CAHPS 5.0H is designed to provide feedback to Medicaid fee-for-service and managed care plans by identifying performance dimensions in which they excel and areas in which they need improvement. The 2016 survey included children aged 17 or younger who were enrolled in MaineCare for at least 5 months, with no more than a 30-day break in enrollment, between April 2015 and September 2015.

In addition to CAHPS, Maine’s annual survey includes supplemental questions that focus on priority areas for the Department including the degree to which providers discuss recommended preventive topics at well-child visits, the prevalence of childhood obesity anti-tobacco use/second-hand smoke exposure among children served by MaineCare, as well as questions about developmental screening, dental care, the affordability of Children’s Health Plan premiums, and availability/access to employer-sponsored health insurance. Of the total 2,315 eligible families who...
were contacted, 1,114 interviews were completed — including 479 children enrolled in Title XXI programs and 529 who were identified as having a chronic condition diagnosis in the claims data — for an overall response rate of 48.1%.

**Measure Definition**

This measure provides information on parents’ experience with their child’s health plan. Results summarize member experiences through ratings, composites and individual question summary rates. Topics covered in the survey include: rating of all health care and personal doctor, customer service, getting care quickly, getting needed care, how well doctors communicate, shared decision making, family centered care, coordination of care for children with chronic conditions, and access to prescription medicines.

**Results**

- **MaineCare higher than the national average on many patient experience measures.** As in the previous year, MaineCare’s patient experience scores compared favorably to those of other state child Medicaid programs on CAHPS measures related to providing care quickly and how well a child’s doctor communicated, with ratings at or above the 75th percentile on the domain scores for these categories.

- **MaineCare below the national average on care coordination for chronic care services.** The percentage of those stating that they received help with care coordination was essentially the same in 2016 (45%) as 2015 (46%), which is below the national average of 61% and places MaineCare in the lowest percentile range nationally (less than 25th percentile). Compared to MaineCare survey results from 2015, significantly more respondents indicated that it was always easy to get treatment or counseling for a child, going from 55% in 2015 to 71% in 2016. MaineCare continued to have high scores for doctors or health providers asking parents/guardians which treatment or care choice would be best for the child (92%), as well as doctors or health providers discussing pros and cons of each treatment or care choice (96%).

- **Many MaineCare children have special health care needs.** Forty two percent of children enrolled in MaineCare had special health care needs according to the 2016 survey. This is consistent with the number of children with special health care needs (CSHCN) identified in the 2015 survey (39%), and still exceeds the prevalence in the general population of Maine children (19%). Of the five qualifying health consequences, use or need of prescription medications was the most prevalent at 28%. (The five qualifying health consequences for CSHCN include: use or need of prescription medication; above average use or need of medical, mental health or educational services; functional limitations compared with others of the same age; use or need of specialized therapies; and treatment or counseling for emotional, behavioral or developmental problems.)

- **As in 2015, for nearly three quarters of MaineCare children, physicians discussed physical activity, nutrition/diet and avoiding sugar-sweetened drinks.** Physicians also discussed television viewing/other screen time, risks of second hand smoke, and weight with approximately two thirds of children enrolled in MaineCare. The percentage of physicians who had conversations about tobacco products increased slightly from 2015 (51%) to 53% in 2016.

- **Just under half (44%) of respondents reported being asked to complete a questionnaire about their child’s development, communication and social behavior.** For those who were asked about their child’s development, in 26% of the cases the doctor expressed some concern and in the majority (85%), the provider recommended a follow-up plan. Two thirds of follow-up plans included a referral to a specialist in 2016, a decrease from 2015 (75%). Providers were significantly more likely to express a specific concern about a child’s development, communications or social behavior to parents if their child was between the ages of 6 and 12.
Majority of MaineCare children received dental care and gave high ratings on quality of care received. Nearly two-thirds (64%) of all children enrolled in MaineCare received dental services in the past six months. By comparison, in a study using FFY2012-FFY2014 Medicaid administrative data from fifty-one states, 48% of children had a preventive dental service and 22% had used a dental treatment service provided by Medicaid in the past year. Younger children were significantly less likely to report receiving any dental services in the last six months; only 66% of children 5 and younger had recent dental care versus 89% of children 6-12 and 88% of children 13 and older.

Appendix A
<table>
<thead>
<tr>
<th>Measure Source</th>
<th>Rate Description</th>
<th>12/31/2012</th>
<th>12/31/2013</th>
<th>12/31/2014</th>
<th>12/31/2015</th>
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<tbody>
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<td>DOHS_8_PCT</td>
<td>Sealant for 6-9 Children at Elevated Risk, Dental or Oral Health Services - Age 6</td>
<td>97.8%</td>
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<td>DPS_PCT</td>
<td>Total Eligibles Who Received Preventive Dental Services</td>
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<td>DS3_1_PCT</td>
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<td>DTS_PCT</td>
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<td>97.8%</td>
<td>97.8%</td>
<td>97.8%</td>
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<tr>
<td>APC_TOT_PCT</td>
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<td>97.8%</td>
<td>97.8%</td>
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<td>APC_TOT_PCT</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents - Age 5-9</td>
<td>97.8%</td>
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<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents - Age 10-14</td>
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<td>APC_TOT_PCT</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents - Age 15-17</td>
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<td>Annual Number of Asthma Patients with &gt; 1 asthma-related Emergency Room Visit</td>
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<tr>
<td>ATM_PCT</td>
<td>Use of Appropriate Medications for People With Asthma - Age 5-11</td>
<td>97.8%</td>
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<td>ASM10TO18_PCT</td>
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<td>ASM19TO20_PCT</td>
<td>Use of Appropriate Medications for People With Asthma - Age 19-20</td>
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<td>ASM_TOT_PCT</td>
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<td>97.8%</td>
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<td>AWIC_PCT</td>
<td>Adolescent Well-Care Visits</td>
<td>97.8%</td>
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<td>CAP_12M_PCT</td>
<td>Children and Adolescents Access to Primary Care Practitioners - Age 12M-24M</td>
<td>97.8%</td>
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<td>CAP_7_PCT</td>
<td>Children and Adolescents Access to Primary Care Practitioners - Age 7-11</td>
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<td>Children and Adolescents Access to Primary Care Practitioners - Age 12-17</td>
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<td>CDC5H_ATPM</td>
<td>Comprehensive Diabetes Care - HbA1c Average # of Test Per Member</td>
<td>97.8%</td>
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<td>CDC5H_PMT1</td>
<td>Comprehensive Diabetes Care - HbA1c Percent with 1 or More Tests</td>
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<td>CHL16_PCT</td>
<td>Chlamydia Screening Age 16-20</td>
<td>97.8%</td>
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<td>CWP_PCT</td>
<td>Appropriate Testing for Children With Pharyngitis</td>
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<tr>
<td>FUT10_PCT</td>
<td>Follow-Up After Hospitalization for Mental Illness - &lt; 10 Days</td>
<td>97.8%</td>
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<td>FUT30_PCT</td>
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<td>MMA2PDC50_PCT</td>
<td>Medication Management for People with Asthma 50% Compliance Age 5-11</td>
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<td>Medication Management for People with Asthma 75% Compliance Age 5-11</td>
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<td>W34_PCT</td>
<td>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
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<td>WC711_PCT</td>
<td>Well Child Visits between 7 years of age and 11 years of age</td>
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<td>HEDIS - AMB</td>
<td>Age Grp 1 (&lt;1)</td>
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<td>Age Grp 2 (1-9)</td>
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<td>Age Grp 4 (20-21)</td>
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<td>Total (&lt;21)</td>
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