



**Commonwealth Pennsylvania
Department of Human Services
Office of Medical Assistance Programs**

**2015 External Quality Review Report
Health Partners Plans**

Final Report
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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 Medicaid Managed Care recipients.

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

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

HealthChoices Physical Health (PH) is the mandatory managed care program that provides Medical Assistance recipients with physical health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO as its EQRO to conduct the 2015 EQRs for the HealthChoices PH MCOs and to prepare the technical reports. This technical report includes six core sections:

- I. Structure and Operations Standards
- II. Performance Improvement Projects
- III. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- IV. 2014 Opportunities for Improvement – MCO Response
- V. 2015 Strengths and Opportunities for Improvement
- VI. Summary of Activities

For the PH Medicaid MCOs, the information for the compliance with Structure and Operations Standards section of the report is derived from the Commonwealth's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from National Committee for Quality Assurance (NCQA™) accreditation results for each MCO.

Information for Section II of this report is derived from activities conducted with and on behalf of DHS to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. Information for Section III of this report is derived from IPRO's validation of each PH MCO's performance measure submissions. Performance measure validation as conducted by IPRO includes both Pennsylvania specific performance measures as well as Healthcare Effectiveness Data and Information Set (HEDIS^{®1}) measures for each Medicaid PH MCO. Within Section III, CAHPS Survey results follow the performance measures.

Section IV, 2014 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2014 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 and a "report card" of the MCO's performance as related to selected HEDIS measures. Section VI provides a summary of EQR activities for the PH MCO for this review period.

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

I: Structure and Operations Standards

This section of the EQR report presents a review by IPRO of Health Partners Plans' (HPP's) compliance with structure and operations standards. The review is based on information derived from reviews of the MCO that were conducted within the past three years.

Methodology and Format

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2014, and the most recent NCQA Accreditation Survey for HPP, effective December 2014.

The SMART items provided much of the information necessary for this review. The SMART items are a comprehensive set of monitoring items that PA DHS staff reviews on an ongoing basis for each Medicaid MCO. The SMART items and their associated review findings for each year are maintained in a database. Prior to RY 2013, the SMART database was maintained by an external organization. Beginning with RY 2013, the SMART database has been maintained internally at DHS. Upon discussion with the DHS regarding the data elements from each version of database, IPRO merged the RY 2014, 2013, and 2012 findings for use in the current review. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 126 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.

The crosswalk linked SMART Items to specific provisions of the regulations, where possible. Some items were relevant to more than one provision. It should be noted that one or more provisions apply to each of the categories in **Table 1.1**. Table 1.1 provides a count of items linked to each category.

Table 1.1: SMART Items Count Per Regulation

BBA Regulation	SMART Items
Subpart C: Enrollee Rights and Protections	
Enrollee Rights	7
Provider-Enrollee Communication	1
Marketing Activities	2
Liability for Payment	1
Cost Sharing	0
Emergency and Post-Stabilization Services – Definition	4
Emergency Services: Coverage and Payment	1
Solvency Standards	2
Subpart D: Quality Assessment and Performance Improvement	
Availability of Services	14
Coordination and Continuity of Care	13
Coverage and Authorization of Services	9
Provider Selection	4
Provider Discrimination Prohibited	1
Confidentiality	1
Enrollment and Disenrollment	2
Grievance Systems	1
Subcontractual Relationships and Delegations	3
Practice Guidelines	2
Health Information Systems	18
Subpart F: Federal and State Grievance Systems Standards	
General Requirements	8
Subpart F: Federal and State Grievance Systems Standards	

BBA Regulation	SMART Items
Notice of Action	3
Handling of Grievances and Appeals	9
Resolution and Notification	7
Expedited Resolution	4
Information to Providers and Subcontractors	1
Recordkeeping and Recording	6
Continuation of Benefits Pending Appeal and State Fair Hearings	2
Effectuation of Reversed Resolutions	0

Two categories, Cost Sharing and Effectuation of Reversed Resolutions, were not directly addressed by any of the SMART Items reviewed by DHS. Cost Sharing is addressed in the HealthChoices Agreements. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals.

Determination of Compliance

To evaluate MCO compliance on individual provisions, IPRO 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 enrollee rights are summarized under Enrollee Rights 438.100. Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS. 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.

Format

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 three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO’s findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol, i.e., Enrollee Rights and Protections; Quality Assessment and Performance Improvement (including access, structure and operation, and measurement and improvement standards); and Federal and State Grievance System Standards.

In addition to this analysis of DHS’s MCO compliance monitoring, IPRO reviewed and evaluated the most recent NCQA accreditation report for each MCO.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO’s required assessment of the MCO’s compliance with BBA regulations as an element of the analysis of the MCO’s strengths and weaknesses.

Findings

Of the 126 SMART Items, 88 items were evaluated and 38 were not evaluated for the MCO in Review Year (RY) 2014, RY 2013, or RY 2012. For categories where items were not evaluated, under review, or received an approved waiver for RY 2014, results from reviews conducted within the two prior years (RY 2013 and RY 2012) were evaluated to determine compliance, if available.

Subpart C: Enrollee Rights and Protections

The general purpose of the regulations included in this category is to ensure that each MCO had written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights, and that

the MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. [42 C.F.R. §438.100 (a), (b)]

Table 1.2: HPP Compliance with Enrollee Rights and Protections Regulations

ENROLLEE RIGHTS AND PROTECTIONS REGULATIONS		
Subpart C: Categories	Compliance	Comments
Enrollee Rights	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 7 items and was compliant on 7 items based on RY 2014.
Provider-Enrollee Communication	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Marketing Activities	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Liability for Payment	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Cost Sharing	Compliant	Per HealthChoices Agreement
Emergency Services: Coverage and Payment	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Emergency and Post Stabilization Services	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 4 items and was compliant on 4 items based on RY 2014.
Solvency Standards	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.

HPP was evaluated against 18 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 18. HPP was found to be compliant in all eight of the categories of Enrollee Rights and Protections Regulations. HPP was found to be compliant on the Cost Sharing provision, based on the HealthChoices agreement.

Subpart D: Quality Assessment and Performance Improvement Regulations

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

The SMART database includes an assessment of the MCO’s compliance with regulations found in Subpart D. **Table 1.3** presents the findings by categories consistent with the regulations.

Table 1.3: HPP Compliance with Quality Assessment and Performance Improvement Regulations

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REGULATIONS		
Subpart D: Categories	Compliance	Comments
Access Standards		
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 12 items based on RY 2014.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 13 items and was compliant on 13 items based on RY 2014.
Coverage and Authorization of Services	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 8 items and was compliant on 8 items based on RY 2014.
Structure and Operation Standards		
Provider Selection	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Provider Discrimination Prohibited	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
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 2014.
Enrollment and Disenrollment	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Grievance 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 2014.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2014.
Measurement and Improvement Standards		
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 2014.
Health Information Systems	Compliant	18 items were crosswalked to this category. The MCO was evaluated against 14 items and was compliant on 13 items and partially complaint on 1 item based on RY 2014.

HPP was evaluated against 57 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on 56 items and partially compliant on 1 item. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, HPP was found to be compliant in all 11 categories.

Subpart F: Federal and State Grievance System Standards

The general purpose of the regulations included under this heading is to ensure that enrollees have the ability to pursue grievances.

The Commonwealth’s audit document information includes an assessment of the MCO’s compliance with regulations found in Subpart F. **Table 1.4** presents the findings by categories consistent with the regulations.

Table 1.4: HPP Compliance with Federal and State Grievance System Standards

FEDERAL AND STATE GRIEVANCE SYSTEM STANDARDS		
Subpart F: Categories	Compliance	Comments
General Requirements	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Notice of Action	Compliant	3 items was crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Handling of Grievances & Appeals	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Resolution and Notification	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Expedited Resolution	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Information to Providers and Subcontractors	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Recordkeeping and Recording	Compliant	6 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Continuation of Benefits Pending Appeal and State Fair Hearings	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2014

HPP was evaluated against 13 of the 40 SMART Items crosswalked to Federal and State Grievance System Standards and was compliant on 13 items. HPP was found to be compliant in all nine categories of Federal and State Grievance System Standards.

Accreditation Status

HPP underwent an NCQA Accreditation Survey effective through September 11, 2015 and was granted an Accreditation Status of Commendable. The next NCQA review was scheduled for June 16, 2015.

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO worked with DHS to research and define Performance Improvement Projects (PIPs) to be validated for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for 2015 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH MCOs are required to conduct focused studies each year. For all PH MCOs, two new PIPs were initiated as part of this requirement. For all PIPs, PH 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 PH MCOs in 2015, PH MCOs are required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: “Improving Access to Pediatric Preventive Dental Care” and “Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits”.

“Improving Access to Pediatric Preventive Dental Care” was selected because on a number of dental measures, the aggregate HealthChoices rates have consistently fallen short of established benchmarks, or have not improved across years. For one measure, the HEDIS Annual Dental Visit (ADV) measure, from HEDIS 2006 through HEDIS 2013, the Medicaid Managed Care (MMC) average was below the 50th percentile for three years. Further, CMS reporting of FFY 2011-2013 data from the CMS-416 indicates that while PA met its two-year goal for progress on preventive dental services, the percentage of PA children age 1-20 who received any preventive dental service for FFY 2013 (40.0%), was below the National rate of 46.0%. The Aim Statement for the topic is “Increase access to and utilization of routine dental care for pediatric Pennsylvania HealthChoices members.” Four common objectives for all PH MCOs were selected:

1. Increase dental evaluations for children between the ages of 6 months and 5 years.
2. Increase preventive dental visits for all pediatric HealthChoices members.
3. Increase appropriate topical application of fluoride varnish by non-oral health professionals.
4. Increase the appropriate application of dental sealants for children ages 6-9 (CMS Core Measure) and 12-14 years.

For this PIP, OMAP is requiring all PH MCOs to submit the following core measures on an annual basis:

- Adapted from CMS form 416, the percentage of children ages 0-1 who received, in the last year:
 - any dental service,
 - a preventive dental service,
 - a dental diagnostic service,
 - any oral health service,
 - any dental or oral health service
- Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider
- Total Eligibles Receiving Preventive Dental Services
- The percentages of children, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who received at least one topical application of fluoride.

Additionally, MCOs are encouraged to consider other performance measures such as:

- Percentage of children with ECC who are disease free at one year.
- Percentage of children with dental caries (ages 1-8 years of age).
- Percentage of oral health patients that are caries free.
- Percentage of all dental patients for whom the Phase I treatment plan is completed within a 12 month period.

“Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits” was selected as the result of a number of observations. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall Statewide readmission rates and results from several applicable Healthcare Effectiveness Data and Information Set (HEDIS) and PA Performance Measures across multiple years, have highlighted this topic as an area of concern to be addressed for improvement. The Aim Statement for the topic is “To reduce potentially avoidable ED visits

and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable.” Five common objectives for all PH MCOs were selected:

1. Identify key drivers of avoidable hospitalizations, as specific to the MCO’s population (e.g., by specific diagnoses, procedures, comorbid conditions, and demographics that characterize high risk subpopulations for the MCO).
2. Decrease avoidable initial admissions (e.g., admissions related to chronic or worsening conditions, or identified health disparities).
3. Decrease potentially preventable readmissions (e.g., readmissions related to diagnosis, procedure, transition of care, or case management)
4. Decrease avoidable ED visits (e.g., resulting from poor ambulatory management of chronic conditions including BH/SA conditions or use of the ED for non-urgent care).
5. Demonstrate improvement for a number of indicators related to avoidable hospitalizations and preventable readmissions, specifically for Individuals with Serious Persistent Mental Illness (SPMI).

For this PIP, OMAP is requiring all PH MCOs to submit the following core measures on an annual basis:

MCO-developed Performance Measures

MCOS are required to develop their own indicators tailored to their specific PIP (i.e., customized to the key drivers of avoidable hospitalizations identified by each MCO for its specific population).

DHS-defined Performance Measures

- Ambulatory Care (AMB): ED Utilization. The target goal is 72 per 1,000 member months.
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges. The target goal is 8.2 per 1,000 member months.
- Plan All-Cause Readmissions (PCR): 30-day Inpatient Readmission. The target for the 30-day indicator is 8.5.
- Each of the five (5) BH-PH Integrated Care Plan Program measures:
 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
 - Emergency Room Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
 - Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
 - Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI).

The PIPs will extend from January 2015 through December 2018; with research beginning in 2015, initial PIP proposals developed and submitted in first quarter 2016, and a final report due in June 2019. The non-intervention baseline period will be January 2015 to December 2015. Following the formal PIP proposal, PH MCOs will additionally be required to submit interim reports in July 2016, June 2017 and June 2018, as well as a final report in June 2019.

The 2015 EQR is the twelfth year to include validation of PIPs. For each PIP, all PH MCOs share the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS 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.

All PH 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 protocol for evaluation of PIPs is consistent with the protocol issued by the Centers for Medicare & Medicaid Services (CMS) (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on EQR of Medicaid MCOs issued on January 24, 2003. IPRO's review evaluates each project against ten review elements:

1. Project Topic And Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation Of Study Results (Demonstrable Improvement)
9. Validity Of Reported Improvement
10. Sustainability Of Documented Improvement

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

Review Element Designation/Weighting

As 2015 is the baseline year, no scoring for the current PIPs can occur for this review year. This section describes the scoring elements and methodology that will occur during the intervention and sustainability periods.

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

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

Table 2.1: Element Designation

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

Overall Project Performance Score

The total points earned for each review element are weighted to determine the MCO's overall performance score for a PIP. For the EQR PIPs, the review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance; **Table 2.2**).

PIPs also are reviewed for the achievement of sustained improvement. For the EQR PIPs, this has a weight of 20%, for a possible maximum total of 20 points (**Table 2.2**). The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP 2015 External Quality Review Report: Health Partners Plans

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%.

Table 2.2: Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Topic and Topic Relevance	5%
2	Study Question (Aim Statement)	5%
3	Study Variables (Performance Indicators)	15%
4/5	Identified Study Population and Sampling Methods	10%
6	Data Collection Procedures	10%
7	Improvement Strategies (Interventions)	15%
8/9	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	20%
Total Demonstrable Improvement Score		80%
10	Sustainability of Documented Improvement	20%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

Findings

As noted previously, no scoring for the current PIPs can occur for this review year. However, multiple levels of activity and collaboration occurred between DHS, the PH MCOs, and IPRO throughout, and prior to the review year.

Beginning in 2014, DHS advised of internal discussions regarding the next PIP cycle to begin in 2015, particularly regarding topics in line with its value-based program. At a 2014 MCO Quality Summit, DHS introduced its value-based program and two key performance goals: 1. Reduce Unnecessary Hospitalizations, and 2. Improve Use of Pediatric Preventive Dental Services. DHS asked IPRO to develop PIP topics related to these goals.

Following multiple discussions between DHS and IPRO, the two PIP topics were developed and further refined throughout 2015. Regarding the Dental topic, information related to the CMS Oral Health Initiative was incorporated into the PIP, including examination of data from the CMS preventive dental measure, and inclusion of the measure as a core performance measure for the PIP. Through quarterly calls with MCOs, DHS discussed and solicited information regarding initiatives that were being developed for improving access to and delivery of quality oral healthcare services. Following additional review of the research and the PIP topic, initiatives that appeared to have potential value were included in the PIP proposal as areas in which PH MCOs can seek to focus their efforts and develop specific interventions for their PIP. The PIP topic was introduced at a PH MCO Medical Directors’ meeting in Fall 2015.

Regarding the Readmission topic, initial discussions resulted in a proposal that focused primarily on the research indicating ambulatory care sensitive conditions which, if left unmanaged, could result in admissions and are related to readmissions, focusing on particular conditions. Throughout 2015, DHS continued to refine its focus for this topic. In Fall 2015, DHS introduced two new pay-for-performance programs for the MCOs: the PH MCO and BH MCO Integrated Care Plan (ICP) Program Pay for Performance Program to address the needs of individuals with SPMI, and the Community Based Care Management (CBCM) Program. As a result, DHS requested that the topic be enhanced to incorporate elements of the new programs, including initiatives outlined for both programs that were provided as examples of activities that may be applicable for use in the PIP. MCOs are to consider and collect measures related to these programs; however, they have been instructed that the focus of the PIP remains on each MCO’s entire population, and each MCO is required to analyze and identify indicators relevant to its specific population.

PH MCOs will be asked to participate in multi-plan PIP update calls through the duration of the PIP to report on their progress or barriers to progress. Frequent collaboration between DHS and PH MCOs is also expected to continue.

III: Performance Measures and CAHPS Survey

Methodology

IPRO validated PA specific performance measures and HEDIS data for each of the Medicaid PH MCOs.

The MCOs were provided with final specifications for the PA Performance Measures in February and March 2015. Source code, raw data and rate sheets were submitted by the MCOs to IPRO for review in 2015. A staggered submission was implemented for the performance measures. IPRO conducted an initial validation of each measure, including source code review and provided each MCO with formal written feedback. The MCOs were then given the opportunity for resubmission, if necessary. Source code was reviewed by IPRO. Raw data were also reviewed for reasonability and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally, beginning in 2015, MCOs were provided with comparisons to the previous year’s rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For the adult admission measures, which are not reported as percentages, differences were highlighted based only on statistical significance, with no minimum threshold.

For three PA performance Birth-related measures: Cesarean Rate for Nulliparous Singleton Vertex (CRS), Live Births Weighing Less Than 2,500 Grams (PLB), and Elective Delivery, rates for each of the measures were produced utilizing MCO Birth files in addition to the 2014 Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. Similar to the methodology used in 2014, IPRO then utilized the MCO file in addition to the most recent applicable PA Department of Health Birth File to identify the denominator, numerator and rate for the three measures.

HEDIS 2015 measures were validated through a standard HEDIS compliance audit of each PH MCO. This audit includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). A Final Audit Report was submitted to NCQA for each MCO. Because the PA-specific performance measures rely on the same systems and staff, no separate onsite review was necessary for validation of the 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. The following is a list of the performance measures included in this year’s EQR report.

Table 3.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS	Children and Adolescents’ Access to PCPs (Age 12 - 24 months)
HEDIS	Children and Adolescents’ Access to PCPs (Age 25 months - 6 years)
HEDIS	Children and Adolescents’ Access to PCPs (Age 7-11 years)
HEDIS	Children and Adolescents’ Access to PCPs (Age 12-19 years)
HEDIS	Adults’ Access to Preventive/Ambulatory Health Services (Age 20-44 years)
HEDIS	Adults’ Access to Preventive/Ambulatory Health Services (Age 45-64 years)
HEDIS	Adults’ Access to Preventive/Ambulatory Health Services (Age 65+)
HEDIS	Adult Body Mass Index Assessment
Well Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 15 Months of Life (6+ Visits)
HEDIS	Well-Child Visits (Age 3 to 6 years)
HEDIS	Childhood Immunizations by Age 2 (Combination 2)
HEDIS	Childhood Immunizations by Age 2 (Combination 3)
HEDIS	Adolescent Well-Care Visits (Age 12 to 21 years)
HEDIS	Immunizations for Adolescents
HEDIS	WCC Body Mass Index: Percentile (Age 3-11 years)

Source	Measures
HEDIS	WCC Body Mass Index: Percentile (Age 12-17 years)
HEDIS	WCC Body Mass Index: Percentile (Total)
HEDIS	WCC Counseling for Nutrition (Age 3-11 years)
HEDIS	WCC Counseling for Nutrition (Age 12-17 years)
HEDIS	WCC Counseling for Nutrition (Total)
HEDIS	WCC Counseling for Physical Activity (Age 3-11 years)
HEDIS	WCC Counseling for Physical Activity (Age 12-17 years)
HEDIS	WCC Counseling for Physical Activity (Total)
EPSDT: Screenings and Follow up	
HEDIS	Lead Screening in Children (Age 2 years)
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
PA EQR	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (BH Enhanced)
PA EQR	EPSDT Screenings: Annual Vision Screen and Hearing Test (Age 4-20 years)
PA EQR	Developmental Screening in the First Three Years of Life
Dental Care for Children and Adults	
HEDIS	Annual Dental Visits (Age 2-21 years)
PA EQR	Total Eligibles Receiving Preventive Dental Services
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 years)
Women s Health	
HEDIS	Breast Cancer Screening (Age 52–74 years)
HEDIS	Cervical Cancer Screening (Age 21-64 years)
HEDIS	Chlamydia Screening in Women (Total Rate)
HEDIS	Chlamydia Screening in Women (Age 16-20 years)
HEDIS	Chlamydia Screening in Women (Age 21-24 years)
HEDIS	Human Papillomavirus Vaccine for Female Adolescents
HEDIS	Non-Recommended Cervical Cancer Screening in Adolescent Females
Obstetric and Neonatal Care	
HEDIS	Frequency of Ongoing Prenatal Care – Greater than or Equal to 61% of Expected Prenatal Care Visits Received
HEDIS	Frequency of Ongoing Prenatal Care – Greater than or Equal to 81% of Expected Prenatal Care Visits Received
HEDIS	Prenatal and Postpartum Care - Timeliness of Prenatal Care
HEDIS	Prenatal and Postpartum Care - Postpartum Care
PA EQR	Prenatal Screening for Smoking
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure (ETS)
PA EQR	Prenatal Counseling for Smoking
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure (ETS)
PA EQR	Prenatal Smoking Cessation
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression
PA EQR	Perinatal Depression Screening: Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
PA EQR	Perinatal Depression Screening: Prenatal Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Prenatal Counseling for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening for Depression
PA EQR	Perinatal Depression Screening: Postpartum Screening Positive for Depression
PA EQR	Perinatal Depression Screening: Postpartum Counseling for Depression
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Alcohol use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Illicit drug use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Prescribed or over-the-counter drug use
PA EQR	Maternity Risk Factor Assessment: Prenatal Screening for Intimate partner violence
PA EQR	Behavioral Health Risk Assessment
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams
PA EQR	Elective Delivery
Respiratory Conditions	

Source	Measures
HEDIS	Appropriate Testing for Children with Pharyngitis
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
HEDIS	Pharmacotherapy Management of COPD Exacerbation (Systemic Corticosteroid and Bronchodilator)
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5-11 years)
HEDIS	Use of Appropriate Medications for People with Asthma (Age 12-18 years)
HEDIS	Use of Appropriate Medications for People with Asthma (Age 19-50 years)
HEDIS	Use of Appropriate Medications for People with Asthma (Age 51-64 years)
HEDIS	Use of Appropriate Medications for People with Asthma (Total Rate)
HEDIS	Medication Management for People with Asthma: 75% Compliance
PA EQR	Annual Percentage of Asthma Patients (Age 2-20 years old) with One or more Asthma Related ER Visits
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years)
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years)
Comprehensive Diabetes Care	
HEDIS	Hemoglobin A1c (HbA1c) Testing
HEDIS	HbA1c Poor Control (>9.0%)
HEDIS	HbA1c Control (<8.0%)
HEDIS	HbA1c Good Control (<7.0%)
HEDIS	Retinal Eye Exam
HEDIS	Medical Attention for Nephropathy
HEDIS	Blood Pressure Controlled <140/90 mm Hg
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 18-64 years, Age 65+ years, and Total Rate)
Cardiovascular Care	
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack
HEDIS	Controlling High Blood Pressure
PA EQR	Heart Failure Admission Rate (Age 18-64 years, Age 65+ years, and Total Rate)
Utilization	
PA EQR	Reducing Potentially Preventable Readmissions
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)

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) and for adults in accordance with the Affordable Care Act (ACA) were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2015 as mandated in accordance with the ACA. For each indicator, the criteria that were specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications, as needed. Indicator rates were calculated through one of two methods: (1) administrative, which uses only the MCO’s data systems to identify numerator positives and (2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator “hits” for rate calculation.

PA Specific Administrative Measures

1) Annual Dental Visits For Enrollees with Developmental Disabilities

This performance measure assesses the percentage of enrollees with a developmental disability age two through 21 years of age, who were continuously enrolled during calendar year 2014 that had at least one dental visit during the measurement year. This indicator utilized the HEDIS 2015 measure Annual Dental Visit (ADV) measure specifications.

2) Total Eligibles Receiving Preventive Dental Services – CHIPRA Core Set

This performance measure assesses the total number of eligible and enrolled children age one to twenty years who received preventive dental services.

3) Annual Percentage of Asthma Patients (Age 2-20 years old) with One or more Asthma Related ER Visits – CHIPRA Core Set

This performance measure assesses the percentage of children and adolescents, two years of ages through 20 years of age, with an asthma diagnosis who have ≥ 1 asthma related emergency department (ED) visit during 2014. This indicator utilizes the 2013 CHIPRA measure “Annual Percentage of Asthma Patients with One of More Asthma-Related Emergency Room Visits.”

4) Cesarean Rate for Nulliparous Singleton Vertex – CHIPRA Core Set

This performance measure assesses Cesarean Rate for low-risk first birth women [aka NTSV CS rate: nulliparous, term, singleton, vertex].

5) Percent of Live Births Weighing Less than 2,500 Grams – CHIPRA Core Set

This performance measure is event-driven and identifies all live births during the measurement year in order to assess the number of live births that weighed less than 2,500 grams as a percent of the number of live births.

6) Elective Delivery – Adult Core Set

This performance measure assesses the percentage of enrolled women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed.

7) Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – CHIPRA Core Set

DHS enhanced this measure using Behavioral Health (BH) encounter data contained in IPRO’s encounter data warehouse. IPRO evaluated this measure using HEDIS 2015 Medicaid member level data submitted by the PH MCO.

This performance measure assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (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. Two rates are reported:

Initiation Phase: The percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: The percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and, 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.

8) EPSDT Annual Vision Screen and Hearing Test

This performance measure assesses the percentage of enrollees four through 20 years of age with an annual vision screen and hearing test.

9) Reducing Potentially Preventable Readmissions

This performance measure assesses the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of the initial inpatient acute discharge. This measure utilized the 2015 HEDIS Inpatient Utilization – General Hospital/Acute Care measure methodology to identify inpatient acute care discharges.

For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.

10) Asthma in Younger Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for asthma in adults ages 18 to 39 years per 100,000 Medicaid member years.

11) Diabetes Short-Term Complications Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for diabetes short-term complications per 100,000 Medicaid member years. Two age groups will be reported: ages 18-64 years and age 65 years and older.

12) Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for chronic obstructive pulmonary disease (COPD) or asthma in adults aged 40 years and older per 100,000 Medicaid member years.

13) Heart Failure Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for Heart Failure in adults aged 18 and older per 100,000 Medicaid member years. Two age groups will be reported: ages 18-64 years and age 65 years and older.

14) Adherence to Antipsychotic Medications for Individuals with Schizophrenia – Adult Core Set

DHS enhanced this measure using Behavioral Health (BH) encounter data contained in IPRO's encounter data warehouse. IPRO evaluated this measure using HEDIS 2015 Medicaid member level data submitted by the PH MCO.

This performance measure assesses the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

15) Developmental Screening in the First Three Years of Life (New for 2015) – 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.

PA Specific Hybrid Measures

16) Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit

This performance measure assesses the percentage of pregnant enrollees who were:

1. Screened for smoking during the time frame of one of their first two prenatal visits or during the time frame of their first two visits following initiation of eligibility with the MCO.
2. Screened for smoking during the time frame of one of their first two prenatal visits (CHIPRA indicator).

3. Screened for environmental tobacco smoke exposure during the time from of one of their first two prenatal visits or during the time frame of their first two visits following initiation of eligibility with the MCO.
4. Screened for smoking in one of their first two prenatal visits who smoke (i.e., a smoker during the pregnancy), that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
5. Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
6. Screened for smoking in one of their first two prenatal visits and found to be current smokers that stopped smoking during their pregnancy.

This performance measure uses components of the HEDIS 2015 Prenatal and Postpartum Care Measure.

17) Perinatal Depression Screening

This performance measure assesses the percentage of enrollees who were:

1. Screened for depression during a prenatal care visit.
2. Screened for depression during a prenatal care visits using a validated depression screening tool.
3. Screened for depression during the time frame of the first two prenatal care visits (CHIPRA indicator).
4. Screened positive for depression during a prenatal care visit.
5. Screened positive for depression during a prenatal care visits and had evidence of further evaluation or treatment or referral for further treatment.
6. Screened for depression during a postpartum care visit.
7. Screened for depression during a postpartum care visit using a validated depression screening tool.
8. Screened positive for depression during a postpartum care visit.
9. Screened positive for depression during a postpartum care visit and had evidence of further evaluation or treatment or referral for further treatment.

This performance measure uses components of the HEDIS 2015 Prenatal and Postpartum Care Measure.

18) Maternity Risk Factor Assessment (New for 2015)

This performance measure assesses, for each of the following risk categories, the percentage of pregnant enrollees who were:

1. Screened for alcohol use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
2. Screened for illicit drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
3. Screened for prescribed or over-the-counter drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
4. Screened for intimate partner violence during the time frame of one of their first two prenatal visits (CHIPRA indicator).

This performance measure uses components of the HEDIS 2015 Prenatal and Postpartum Care Measure.

19) Behavioral Health Risk Assessment (New for 2015) – CHIPRA Core Set

This performance measure is a combination of the screening assessments for all risk factors identified by each of the CHIPRA indicators in the Perinatal Depression Screening (PDS), Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS), and Maternity Risk Factor Assessment (MRFA) measures.

This performance measure assesses the percentage of enrollees who were screened during the time frame of one of their first two prenatal visits for all of the following risk factors:

1. depression screening,
2. tobacco use screening,
3. alcohol use screening,

4. drug use screening (illicit and prescription, over the counter), and
5. intimate partner violence screening.

HEDIS Performance Measure Selection and Descriptions

Each MCO underwent a full HEDIS compliance audit in 2015. 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 2015, Volume 2 Narrative. The measurement year for HEDIS 2015 measures is 2014, 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 Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the HEDIS Technical Specifications, Volume 2. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.0 – Child Survey.

Children and Adolescents' Access to Primary Care Practitioners

This measure assessed the percentage of members 12 to 24 months and 25 months to six years of age who had a visit with a PCP who were continuously enrolled during the measurement year. For children ages seven to 11 years of age and adolescents 12 to 19 years of age, the measure assessed the percentage of children and adolescents who were continuously enrolled during the measurement year and the year prior to the measurement year who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Adults' Access to Preventive/Ambulatory Health Services

This measure assessed the percentage of enrollees aged 20 to 44 years of age, 45 to 64 years of age, and 65 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Adult Body Mass Index (BMI) Assessment

This measure assessed the percentage of enrollees 18-74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to the measurement year.

Well-Child Visits in the First 15 Months of Life

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

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

This measure assessed the percentage of enrollees who were three, four, five, or six 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.

Adolescent Well-Care Visits

This measure assessed the percentage of enrollees between 12 and 21 years of age, who were continuously enrolled during the measurement year and who received one or more well-care visits with a PCP or Obstetrician/Gynecologist (OG/GYN) during the measurement year.

Immunizations for Adolescents

This measure assessed the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and

one tetanus, diphtheria toxoids and acellular Pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Human Papillomavirus Vaccine for Female Adolescents

This measure assessed the percentage of female adolescents 13 years of age who had three doses of human papillomavirus (HPV) vaccine by their 13th birthday.

Childhood Immunization Status

This measure assessed the percentage of children who turned two years of age in the measurement year who were continuously enrolled for the 12 months preceding their second birthday and who received one or both of two immunization combinations on or before their second birthday. Separate rate were calculated for each Combination. Combination 2 and 3 consists of the following immunizations:

- (4) Diphtheria and Tetanus, and Pertussis Vaccine/Diphtheria and Tetanus (DTaP/DT)
- (3) Injectable Polio Vaccine (IPV)
- (1) Measles, Mumps, and Rubella (MMR)
- (3) Haemophilus Influenza Type B (HiB)
- (3) Hepatitis B (HepB)
- (1) Chicken Pox (VZV)
- (4) Pneumococcal Conjugate Vaccine – Combination 3 only

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

This measure assessed the percentage of children three to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Lead Screening in Children

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

Annual Dental Visit

This measure assessed the percentage of children and adolescents between the ages of two and 21 years of age who were continuously enrolled in the MCO for the measurement year who had a dental visit during the measurement year.

Breast Cancer Screening

This measure assessed the percentage of women ages 52 to 74 years who were continuously enrolled in the measurement year and the year prior to the measurement year that had a mammogram in either of those years.

Cervical Cancer Screening

This measure assessed the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Chlamydia Screening in Women

This measure assessed the percentage of women 16 to 24 years of age, who were continuously enrolled in the measurement year, who had at least one test for Chlamydia during the measurement year. Two age stratifications (16-20 years and 21-24 years) and a total rate are reported.

Prenatal and Postpartum Care

This measure assessed the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were enrolled for at least 43 days prior to delivery and 56 days after delivery who received timely prenatal care and who had a postpartum visit between 21 and 56 days after their delivery. Timely prenatal care is defined as care initiated in the first trimester or within 42 days of enrollment in the MCO.

Frequency of Ongoing Prenatal Care

This measure assessed the percentage of women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were enrolled for at least 43 days prior to delivery and 56 days after delivery who had $\geq 61\%$ or $\geq 81\%$ of the expected prenatal visits during their pregnancy. Expected visits are defined with reference to the month of pregnancy at the time of enrollment and the gestational age at time of delivery. This measure uses the same denominator and deliveries as the Prenatal and Postpartum Care measure.

Appropriate Testing for Children with Pharyngitis

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

Appropriate Treatment for Children with Upper Respiratory Infection

This measure assessed the percentage of children three months to 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measure assessed the percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)

This measure assessed the percentage of members 40 years of age and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation

This measure assessed the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 through November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1) Dispensed a systemic corticosteroid within 14 days of the event, and 2) dispensed a bronchodilator within 30 days of the event.

Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication

This measure assessed the percentage of children newly prescribed attention deficit/hyperactivity disorder (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. Two rates are reported.

Initiation Phase: The percentage of children 6 to 12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

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

Use of Appropriate Medications for People with Asthma

This measure assessed the percentage of members age five to 64 years during the measurement year continuously enrolled in the measurement year and the year prior to the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.

Medication Management for People with Asthma

This measure assessed the percentage of members age five to 64 years during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. One rate is reported: the percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Comprehensive Diabetes Care

This measure assessed the percentage of members 18 to 75 years of age who were diagnosed prior to or during the measurement year with diabetes type 1 and type 2, who were continuously enrolled during the measurement year and who had each of the following:

- Hemoglobin A1c (HbA1c) tested
- HbA1c Poor Control (<9.0%)
- HbA1c Control (<8.0%)
- HbA1c Good Control (<7.0%)
- Retinal eye exam performed
- Medical attention for Nephropathy
- Blood pressure control (<140/90 mm Hg)

For the HbA1c Poor Control (>9.0%) measure, lower rates indicate better performance.

Controlling High Blood Pressure

This measure assessed the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18-59 years of age whose BP was <140/90 mm Hg.
- Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

For this measure, a single rate, the sum of all three groups, is reported.

Persistence of Beta-Blocker Treatment After a Heart Attack

This measure assessed the percentage of enrollees 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment. MCOs report the percentage of enrollees who receive treatment with beta-blockers for six months (180 days) after discharge.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

This measure assessed the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Non-Recommended Cervical Cancer Screening in Adolescent Females (New for 2015)

This measure assessed the percentage of adolescent females 16-20 years to age who were screened unnecessarily for cervical cancer. For this measure, a lower rate indicates better performance.

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 2015 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. As previously indicated, for three PA Birth-related performance measures IPRO utilized the MCO Birth files in addition to the 2014 Department of Health Birth File to identify the denominator, numerator and rate for the Birth-related measures.

During the 2015 performance measure validation process, an issue was identified with HPP's HEDIS identification of inpatient admissions for the HEDIS Inpatient Utilization (IPU) measure that would impact the admission rate measures: Reducing Potentially Preventable Readmissions (RPR), Chronic Obstructive Pulmonary Disease (COPD), Diabetes Short-term Complications Admission Rate (DAR), Heart Failure Admission Rate (HF), and Asthma in Younger Adults Admission Rate (AAR). RPR is a HealthChoices Pay for Performance measure. HPP had a process in place for its largest provider to submit Observations as Inpatient (IP) claims, upon which HPP then added an Observation revenue code to pay the claim as an observation room stay, rather than denying it and requesting a bill for observation. HPP is working on a methodology to change this process, but it impacts the current review year. To ensure that the PA measures rates reported are accurate, IPRO required validation of the claims that appeared to be identified as IP but were more accurately considered Observation. IPRO conducted member level data analysis on HPP's IPU, RPR and four admission measures, and worked with HPP to confirm the data reported in the final rates for the 2015 performance measures. The 2015 RPR, COPD, DAR, HF, and AAR data presented for HPP are the rates finalized at the end of the process.

IPRO validated the medical record abstraction of the three PA-specific hybrid measures consistent with the protocol used for a HEDIS audit. The validation process includes a MRR process evaluation and review of the MCO's MRR tools and instruction materials. This review ensures that the MCO's MRR process was executed as planned and the abstraction results are accurate. A random sample of 16 records from each selected indicator across the three measures was evaluated. The indicators were selected for validation based on preliminary rates observed upon the MCO's completion of abstraction. The MCO passed MRR Validation for the Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit, the Perinatal Depression Screening, and the Maternity Risk Factor Assessment measures.

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 Tables 3.2 through 3.11. 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., 2015 (MY 2014) and 2014 (MY 2013)]. In addition, statistical comparisons are made between the 2015 and 2014 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 2015 rates to 2014 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’s rate, the MMC average for 2014 (MY 2013) 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 2014 rates to MMC rates, the “+” symbol denotes that the plan rate exceeds the MMC rate; the “-” symbol denotes that the MMC rate exceeds the plan rate and “n.s.” denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a 3-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, “NA” (Not Applicable) appears in the corresponding cells. However, “NA” (Not Available) also appears in the cells under the HEDIS 2015 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

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

Access to/Availability of Care

There were no strengths or opportunities for improvement identified for HPP’s 2015 (MY 2014) Access/Availability of Care performance measures.

Table 3.2: Access to Care

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Children and Adolescents’ Access to PCPs (Age 12 24 Months)	5,814	5,621	96.7%	96.2%	97.1%	97.3%	-	97.0%	n.s.	≥ 50th and < 75th percentile

HEDIS	Children and Adolescents' Access to PCPs (Age 25 Months 6 Years)	22,932	20,008	87.2%	86.8%	87.7%	87.9%	-	88.6%	-	≥ 25th and < 50th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7 11 Years)	16,362	15,092	92.2%	91.8%	92.7%	91.3%	+	91.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 19 Years)	20,706	18,595	89.8%	89.4%	90.2%	89.4%	n.s.	90.1%	n.s.	≥ 25th and < 50th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20 44 Years)	31,524	26,089	82.8%	82.3%	83.2%	82.8%	n.s.	83.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45 64 Years)	22,826	21,066	92.3%	91.9%	92.6%	91.6%	+	91.2%	+	≥ 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ Years)	852	761	89.3%	87.2%	91.5%	88.4%	n.s.	87.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Adult BMI Assessment (Ages 18 74 Years)	320	267	83.4%	79.2%	87.7%	79.9%	n.s.	83.0%	n.s.	≥ 25th and < 50th percentile

Well-Care Visits and Immunizations

The following strengths were identified for the 2015 (MY 2014) Well-Care Visits and Immunizations performance measures.

- Six Well-Care Visit and Immunizations measures for HPP's 2015 rates were statistically significantly higher than the MMC weighted averages.
 - Childhood Immunizations Status (Combination 2) – 5.4 percentage points
 - Childhood Immunizations Status (Combination 3) – 5.5 percentage points
 - Adolescent Well-Care Visits (Age 12 to 21 Years) – 4.7 percentage points
 - Counseling for Nutrition (Age 12-17 years) – 13.5 percentage points
 - Counseling for Nutrition (Total) – 7.2 percentage points
 - Immunization for Adolescents (Combo 1) – 6.6 percentage points

There were no opportunities for improvement identified for the 2015 (MY 2014) Well-Care Visits and Immunizations performance measures.

Table 3.3: Well-Care Visits and Immunizations

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison					
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile	
HEDIS	Well Child Visits in the First 15 Months of Life (≥ 6 Visits)	427	271	63.5%	58.8%	68.2%	62.2%	n.s.	65.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)	347	270	77.8%	73.3%	82.3%	77.2%	n.s.	76.4%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Childhood Immunization Status (Combination 2)	494	401	81.2%	77.6%	84.7%	81.7%	n.s.	75.8%	+	≥ 75th and < 90th percentile	
HEDIS	Childhood Immunization Status (Combination 3)	494	386	78.1%	74.4%	81.9%	78.4%	n.s.	72.6%	+	≥ 75th and < 90th percentile	
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	494	313	63.4%	59.0%	67.7%	62.2%	n.s.	58.7%	+	≥ 75th and < 90th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 3 11 Years)	285	198	69.5%	64.0%	75.0%	61.0%	+	68.5%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 12 17 Years)	146	104	71.2%	63.5%	78.9%	69.3%	n.s.	69.1%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Body Mass Index: Percentile (Total)	431	302	70.1%	65.6%	74.5%	63.8%	+	68.7%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Nutrition (Age 3 11 Years)	285	211	74.0%	68.8%	79.3%	66.0%	+	70.2%	n.s.	≥ 75th and < 90th percentile	
HEDIS	WCC Counseling for Nutrition (Age 12 17 Years)	146	114	78.1%	71.0%	85.1%	66.7%	+	64.6%	+	≥ 90th percentile	
HEDIS	WCC Counseling for Nutrition (Total)	431	325	75.4%	71.2%	79.6%	66.2%	+	68.2%	+	≥ 75th and < 90th percentile	
HEDIS	WCC Counseling for Physical Activity (Age 3 11 Years)	285	166	58.2%	52.3%	64.1%	46.0%	+	61.9%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Physical Activity (Age 12 17 Years)	146	98	67.1%	59.2%	75.1%	62.1%	n.s.	62.1%	n.s.	≥ 75th and < 90th percentile	
HEDIS	WCC Counseling for Physical Activity (Total)	431	264	61.3%	56.5%	66.0%	51.4%	+	62.0%	n.s.	≥ 50th and < 75th percentile	

HEDIS	Immunizations for Adolescents (Combination 1)	203	180	88.7%	84.1%	93.3%	88.7%	n.s.	82.0%	+	≥ 90th percentile
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EPSDT: Screenings and Follow-up

There were no strengths identified for EPSDT: Screenings and Follow-up performance measures for 2015 (MY 2014).

The following opportunities for improvement was identified for 2015 (MY 2014) for EPSDT: Screenings and Follow-up performance measures:

- HPP's rates for the following ten EPSDT Screenings and Follow-up measures were statistically significantly below the 2015 MMC weighted averages:
 - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase – 9.0 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 13.6 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase – 9.9 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 9.8 percentage points
 - EPSDT - Hearing Test (Age 4-20 years) – 6.7 percentage points
 - EPSDT - Vision Test (Age 4-20 years) – 5.7 percentage points
 - Developmental Screening in the First Three Years of Life - Total – 20.7 percentage points
 - Developmental Screening in the First Three Years of Life - 1 year – 21.1 percentage points
 - Developmental Screening in the First Three Years of Life - 2 years – 19.3 percentage points
 - Developmental Screening in the First Three Years of Life - 3 years – 21.4 percentage points

Table 3.4: EPSDT: Screenings and Follow-up

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Lead Screening in Children	494	385	77.9%	74.2%	81.7%	77.5%	n.s.	77.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	1,391	222	16.0%	14.0%	17.9%	13.9%	n.s.	25.0%	-	< 10th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	230	31	13.5%	8.8%	18.1%	8.2%	n.s.	27.1%	-	< 10th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	1,391	227	16.3%	14.3%	18.3%	14.1%	n.s.	26.2%	-	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	218	49	22.5%	16.7%	28.2%	13.8%	+	32.3%	-	NA
PA EQR	EPSDT Hearing Test (Age 4 20 Years)	61,262	20,686	33.8%	33.4%	34.1%	30.0%	+	40.4%	-	NA
PA EQR	EPSDT Vision Test (Age 4 20 Years)	61,262	21,452	35.0%	34.6%	35.4%	33.0%	+	40.7%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life Total ¹	13,167	3,465	26.3%	25.6%	27.1%	20.0%	+	47.0%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year ¹	4,612	990	21.5%	20.3%	22.7%	15.5%	+	42.6%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years ¹	4,266	1,345	31.5%	30.1%	32.9%	25.2%	+	50.9%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years ¹	4,289	1,130	26.3%	25.0%	27.7%	19.0%	+	47.7%	-	NA

¹Developmental Screening in the First Three Years of Life was suspended for 2014 (MY 2013). For this measure, the MCO's 2015 (MY 2014) rates were compared against the MCO's 2013 (MY 2012) rates.

Dental Care for Children and Adults

The following strengths were identified for the 2015 (MY 2014) Dental Care for Children and Adults performance measures.

- Three Dental Care for Children and Adults measures for HPP’s 2015 rates were statistically significantly higher than the MMC weighted averages.
 - Annual Dental Visit (Age 2–21 years) – 12.1 percentage points
 - Total Eligibles Receiving Preventive Dental Services – 11.2 percentage points
 - Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 years) – 14.3 percentage points

There were no opportunities for improvement identified for HPP’s 2015 (MY 2014) Dental Care for Children and Adults performance measures.

Table 3.5: EPSDT: Dental Care for Children and Adults

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Annual Dental Visit	72,973	51,299	70.3%	70.0%	70.6%	64.2%	+	58.2%	+	≥ 90th percentile
PA EQR	Total Eligibles Receiving Preventive Dental Treatment Services	100,518	58,228	57.9%	57.6%	58.2%	53.8%	+	46.8%	+	NA
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 Years)	2,523	1,637	64.9%	63.0%	66.8%	60.0%	+	50.6%	+	NA

Women’s Health

The following strengths were noted for the Women’s Health performance measures for 2015 (MY 2014):

- In 2015, HPP’s rates were statistically significantly above the 2015 MMC weighted averages for the following six measures:
 - Breast Cancer Screening (Age 52-74 years) – 7.2 percentage points
 - Cervical Cancer Screening – 11.4 percentage points
 - Chlamydia Screening in Women (Total) – 19.7 percentage points
 - Chlamydia Screening in Women (Age 16-20 years) – 23.1 percentage points
 - Chlamydia Screening in Women (Age 21-24 years) – 14.3 percentage points
 - Human Papillomavirus Vaccine for Female Adolescents – 4.4 percentage points

There were no opportunities for improvement identified for HPP’s 2015 (MY 2014) Women’s Health performance measures.

Table 3.6: Women’s Health

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Breast Cancer Screening (Age 52-74 Years)	7,079	4,993	70.5%	69.5%	71.6%	68.7%	+	63.3%	+	≥ 75th and < 90th percentile
HEDIS	Cervical Cancer Screening	361	280	77.6%	73.1%	82.0%	71.0%	+	66.1%	+	≥ 90th percentile
HEDIS	Chlamydia Screening in Women (Total)	8,020	6,338	79.0%	78.1%	79.9%	80.1%	n.s.	59.3%	+	≥ 90th percentile
HEDIS	Chlamydia Screening in Women (Age 16-20 Years)	4,516	3,586	79.4%	78.2%	80.6%	81.5%	-	56.3%	+	≥ 90th percentile
HEDIS	Chlamydia Screening in Women (Age 21-24 Years)	3,504	2,752	78.5%	77.2%	79.9%	78.2%	n.s.	64.2%	+	≥ 90th percentile
HEDIS	Human Papillomavirus Vaccine for Female Adolescents	461	149	32.3%	27.9%	36.7%	27.8%	n.s.	27.9%	+	≥ 90th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	7,360	134	1.8%	1.5%	2.1%	3.6%	-	2.6%	-	≥ 75th and < 90th percentile

Obstetric and Neonatal Care

The following strengths were noted for the 2015 (MY 2014) Obstetric and Neonatal Care performance measures.

- In 2015, HPP's rates were statistically significantly higher than the respective 2015 MMC weighted averages for the following ten measures:
 - Prenatal and Postpartum Care – Postpartum Care – 10.2 percentage points
 - Prenatal Screening for Environmental Tobacco Smoke Exposure – 23.1 percentage points
 - Prenatal Counseling for Environmental Tobacco Smoke Exposure – 26.2 percentage points
 - Prenatal Smoking Cessation – 9.1 percentage points
 - Prenatal Screening for Depression – 19.6 percentage points
 - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 16.6 percentage points
 - Prenatal Counseling for Depression – 12.7 percentage points
 - Postpartum Screening for Depression – 8.9 percentage points
 - Prenatal Screening for Intimate partner violence – 9.1 percentage points
 - Prenatal Screening for Behavioral Health Risk Assessment – 15.4 percentage points

There were no opportunities for improvement identified for HPP's 2015 (MY 2014) Obstetric and Neonatal Care performance measures.

Table 3.7: Obstetric and Neonatal Care

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	≥61% of Expected Prenatal Care Visits Received	428	349	81.5%	77.7%	85.3%	82.6%	n.s.	79.6%	n.s.	NA
HEDIS	≥81% of Expected Prenatal Care Visits Received	428	293	68.5%	63.9%	73.0%	74.6%	-	64.4%	n.s.	≥ 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	428	366	85.5%	82.1%	89.0%	86.9%	n.s.	83.8%	n.s.	≥ 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	428	310	72.4%	68.1%	76.8%	68.6%	n.s.	62.2%	+	≥ 90th percentile
PA EQR	Prenatal Screening for Smoking	403	356	88.3%	85.1%	91.6%	92.3%	n.s.	84.9%	n.s.	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	403	339	84.1%	80.4%	87.8%	NA	NA	84.1%	n.s.	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	403	238	59.1%	54.1%	64.0%	65.0%	n.s.	35.9%	+	NA
PA EQR	Prenatal Counseling for Smoking	86	63	73.3%	63.3%	83.2%	67.0%	n.s.	74.7%	n.s.	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	40	31	77.5%	63.3%	91.7%	65.0%	n.s.	51.3%	+	NA
PA EQR	Prenatal Smoking Cessation	84	15	17.9%	9.1%	26.6%	19.7%	n.s.	8.8%	+	NA
PA EQR	Prenatal Screening for Depression	403	358	88.8%	85.6%	92.0%	94.3%	-	69.3%	+	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	403	324	80.4%	76.4%	84.4%	NA	NA	63.8%	+	NA
PA EQR	Prenatal Screening Positive for Depression	358	59	16.5%	12.5%	20.5%	16.8%	n.s.	18.6%	n.s.	NA
PA EQR	Prenatal Counseling for Depression	59	50	84.7%	74.7%	94.8%	84.4%	n.s.	72.1%	+	NA
PA EQR	Postpartum Screening for Depression	305	254	83.3%	78.9%	87.6%	90.1%	-	74.4%	+	NA
PA EQR	Postpartum Screening Positive for Depression	254	36	14.2%	9.7%	18.7%	9.4%	n.s.	14.7%	n.s.	NA
PA EQR	Postpartum Counseling for Depression	36	30	83.3%	69.8%	96.9%	NA	NA	85.8%	n.s.	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	1,261	284	22.5%	20.2%	24.9%	24.0%	n.s.	23.0%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	5,722	553	9.7%	8.9%	10.4%	10.8%	n.s.	9.5%	n.s.	NA
PA EQR	Prenatal Screening for Alcohol use	403	334	82.9%	79.1%	86.7%	NA	NA	80.0%	n.s.	NA
PA EQR	Prenatal Screening for Illicit drug use	403	330	81.9%	78.0%	85.8%	NA	NA	80.0%	n.s.	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	403	319	79.2%	75.1%	83.2%	NA	NA	80.2%	n.s.	NA
PA EQR	Prenatal Screening for Intimate partner violence	403	257	63.8%	59.0%	68.6%	NA	NA	54.6%	+	NA

PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	403	230	57.1%	52.1%	62.0%	NA	NA	41.7%	+	NA
PA EQR	Elective Delivery ¹²	1,343	129	9.6%	8.0%	11.2%	NA	NA	11.5%	-	NA

¹For the Elective Delivery measure, lower rate indicates better performance.

²Rates for this measure were not presented in the 2014 EQR report, as it was the first year of implementation, and was calculated utilizing an alternative data source. Data for this measure are presented for informational purposes, and are not included in the identification of strengths/opportunities for 2015.

Respiratory Conditions

The following strengths were noted for the 2015 (MY 2014) Respiratory Conditions performance measures:

- HPP's 2015 rates were statistically significantly higher than the MMC weighted averages for the following five measures:
 - Appropriate Testing for Children with Pharyngitis – 8.8 percentage points
 - Appropriate Treatment for Children with Upper Respiratory Infection – 3.3 percentage points
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 16.7 percentage points
 - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid – 5.1 percentage points
 - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator – 5.6 percentage points

Eight opportunities for improvement for HPP were identified among the 2015 (MY 2014) Respiratory Conditions performance measures:

- HPP's 2015 rates were statistically significantly lower than the MMC weighted averages for the following three measures:
 - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years) – 11.9 percentage points
 - Medication Management for People with Asthma - 75% Compliance (Age 12-18 years) – 10.4 percentage points
 - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years) – 6.4 percentage points
- HPP's 2015 rates were statistically significantly above (worse than) the MMC weighted averages for the following three measures:
 - Annual Number of Asthma Patients (Age 2-20 years) with One or More Asthma Related ER Visit – 3.7 percentage points
 - Asthma in Younger Adults Admission Rate (Age 18-39 years) – 0.48 admissions per 100,000 member years
 - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years) – 1.20 admissions per 100,000 member years

Table 3.8: Respiratory Conditions

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis	2,307	1,780	77.2%	75.4%	78.9%	71.7%	+	68.4%	+	≥ 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection ¹	4,673	382	91.8%	91.0%	92.6%	89.3%	+	88.6%	+	≥ 50th and < 75th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ²	1,116	622	44.3%	41.3%	47.2%	35.7%	+	27.5%	+	≥ 90th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	931	294	31.6%	28.5%	34.6%	32.3%	n.s.	29.8%	n.s.	≥ 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	787	641	81.4%	78.7%	84.2%	81.8%	n.s.	76.3%	+	≥ 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Bronchodilator	787	734	93.3%	91.5%	95.1%	91.1%	n.s.	87.6%	+	≥ 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 11 Years)	1,534	1,407	91.7%	90.3%	93.1%	90.0%	n.s.	91.7%	n.s.	≥ 50th and < 75th percentile

HEDIS	Use of Appropriate Medications for People with Asthma (Age 12-18 Years)	948	824	86.9%	84.7%	89.1%	88.2%	n.s.	87.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 19-50 Years)	1,415	1,124	79.4%	77.3%	81.6%	81.8%	n.s.	77.8%	n.s.	≥ 75th and < 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 51-64 Years)	657	490	74.6%	71.2%	78.0%	77.6%	n.s.	75.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5-64 Years)	4,554	3,845	84.4%	83.4%	85.5%	84.9%	n.s.	85.3%	n.s.	≥ 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-11 Years)	1,402	310	22.1%	19.9%	24.3%	24.2%	n.s.	34.0%	-	≥ 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12-18 Years)	818	191	23.3%	20.4%	26.3%	27.3%	n.s.	33.7%	-	≥ 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19-50 Years)	1,119	460	41.1%	38.2%	44.0%	35.8%	+	43.8%	n.s.	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51-64 Years)	490	270	55.1%	50.6%	59.6%	53.7%	n.s.	58.8%	n.s.	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-64 Years)	3,829	1,231	32.1%	30.7%	33.6%	32.9%	n.s.	38.6%	-	≥ 50th and < 75th percentile
PA EQR	Annual Percentage of Asthma Patients (Age 2-20 Years) with One or More Asthma Related ER Visits ³	14,941	2,514	16.8%	16.2%	17.4%	17.3%	n.s.	13.1%	+	NA
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years)	578,992	118	1.70	1.39	2.00	3.28	-	1.22	+	NA
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) ⁴	451,466	578	10.67	9.80	11.54	18.02	-	9.47	+	NA

¹ Per NCOA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

² Per NCOA, a higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

³ For Emergency Department Encounter Rate for Asthma, lower rates indicate better performance.

⁴ For the Adult Admission Rate measures, lower rates indicate better performance.

Comprehensive Diabetes Care

One strength was noted for Comprehensive Diabetes Care performance measures for 2015 (MY 2014).

- HPP's 2015 rate for the Retinal Eye Exam measure was statistically significantly above the 2015 MMC weighted average by 7.5 percentage points.

Three opportunities for improvement were identified for Comprehensive Diabetes Care performance measures for 2015 (MY 2014).

- HPP's 2015 rate for the Blood Pressure Controlled <140/90 mm Hg measure was statistically significantly below the 2015 MMC weighted average by 8.6 percentage points.
- HPP's 2015 rates were statistically significantly above (worse than) the MMC weighted averages for the following two measures:
 - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) – 0.34 admissions per 100,000 member years
 - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) – 0.32 admissions per 100,000 member years

Table 3.9: Comprehensive Diabetes Care

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Hemoglobin A1c (HbA1c) Testing	675	591	87.6%	85.0%	90.1%	87.5%	n.s.	85.5%	n.s.	≥ 50th and < 75th percentile
HEDIS	HbA1c Poor Control (>9.0%) ¹	675	243	36.0%	32.3%	39.7%	32.9%	n.s.	38.1%	n.s.	≥ 50th and < 75th percentile

HEDIS	HbA1c Control (<8.0%)	675	365	54.1%	50.2%	57.9%	55.4%	n.s.	51.2%	n.s.	≥ 75th and < 90th percentile
HEDIS	HbA1c Good Control (<7.0%)	411	166	40.4%	35.5%	45.3%	39.4%	n.s.	36.9%	n.s.	≥ 75th and < 90th percentile
HEDIS	Retinal Eye Exam	675	430	63.7%	60.0%	67.4%	64.2%	n.s.	56.2%	+	≥ 75th and < 90th percentile
HEDIS	Medical Attention for Nephropathy	675	574	85.0%	82.3%	87.8%	87.7%	n.s.	82.9%	n.s.	≥ 75th and < 90th percentile
HEDIS	Blood Pressure Controlled <140/90 mm Hg	675	381	56.4%	52.6%	60.3%	57.1%	n.s.	65.0%	-	≥ 10th and < 25th percentile
PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 18-64 Years) per 100,000 member years	1,015,554	280	2.30	2.03	2.57	2.43	n.s.	1.96	+	NA
PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 65+ Years) per 100,000 member years	14,904	0	0.00	0.00	0.00	0.00	NA	0.40	n.s.	NA
PA EQR	Diabetes Short Term Complications Admission Rate ² (Total Age 18+ Years) per 100,000 member years	1,030,458	280	2.26	2.00	2.53	2.40	n.s.	1.94	+	NA

¹ For HbA1c Poor Control, lower rates indicate better performance.

² For the Adult Admission Rate measures, lower rates indicate better performance

Cardiovascular Care

One strength was noted for HPP's 2015 (MY 2014) Cardiovascular Care performance measures.

- HPP's 2015 rate for the Persistence of Beta Blocker Treatment After Heart Attack measure was statistically significantly above the 2015 MMC weighted average by 6.3 percentage points.

The following opportunities for improvement were identified for Cardiovascular Care performance measures for 2015 (MY 2014).

- HPP's 2015 rates were statistically significantly above (worse than) the MMC weighted averages for the following two measures:
 - Heart Failure Admission Rate (Age 18-64 years) – 0.85 admissions per 100,000 member years
 - Heart Failure Admission Rate (Total Age 18+ years) – 0.80 admissions per 100,000 member years

Table 3.10: Cardiovascular Care

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	97	93	95.9%	91.4%	100.0%	93.2%	n.s.	89.5%	+	≥ 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	452	296	65.5%	61.0%	70.0%	58.4%	+	61.6%	n.s.	≥ 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate ¹ (Age 18-64 Years) per 100,000 member years	1,015,554	316	2.59	2.31	2.88	4.88	-	1.74	+	NA
PA EQR	Heart Failure Admission Rate ¹ (Age 65+ Years) per 100,000 member years	14,904	3	1.68	0.00	3.58	9.73	-	4.61	n.s.	NA
PA EQR	Heart Failure Admission Rate ¹ (Total Age 18+ Years) per 100,000 member years	1,030,458	319	2.58	2.30	2.86	4.95	-	1.78	+	NA

¹ For the Adult Admission Rate measures, lower rates indicate better performance

Utilization

There were no strengths noted for HPP's 2015 (MY 2014) Utilization performance measures.

Two opportunities for improvement were identified for HPP's 2015 (MY 2014) Utilization performance measures.

- The following rates were statistically significantly below the respective 2015 MMC weighed averages:
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia – 8.9 percentage points
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) – 9.4 percentage points

Table 3.11: Utilization

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
PA EQR	Reducing Potentially Preventable Readmissions ¹	17,888	2,431	13.6%	13.1%	14.1%	15.2%	-	11.6%	+	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	678	424	62.5%	58.8%	66.3%	63.9%	n.s.	71.4%	-	≥ 50th and < 75th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	1,105	688	62.3%	59.4%	65.2%	65.2%	n.s.	71.7%	-	NA

¹ For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

The following tables provide the survey results of four composite questions by two specific categories for HPP across the last three measurement years, as available. The composite questions will target the MCOs performance strengths as well as opportunities for improvement.

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

2015 Adult CAHPS 5.0H Survey Results

Table 4.1: CAHPS 2015 Adult Survey Results

Survey Section/Measure	2015 (MY 2014)	2015 Rate Compared to 2014	2014 (MY 2013)	2014 Rate Compared to 2013	2013 (MY 2012)	2015 MMC Weighted Average
Your Health Plan						
Satisfaction with Adult's Health Plan (Rating of 8 to 10)	84.12%	▲	79.27%	▲	74.43%	77.96%
Getting Needed Information (Usually or Always)	84.56%	▲	76.40%	▼	83.10%	83.20%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	71.49%	▲	71.43%	▲	70.26%	73.31%
Appointment for Routine Care When Needed (Usually or Always)	81.60%	▲	79.03%	▲	78.52%	81.58%

▲ ▼ = Performance compared to prior years' rate

Shaded boxes reflect rates above the 2015 MMC Weighted Average.

2015 Child CAHPS 5.0H Survey Results

Table 4.2: CAHPS 2015 Child Survey Results

CAHPS Items	2015 (MY 2014)	2015 Rate Compared to 2014	2014 (MY 2013)	2014 Rate Compared to 2013	2013 (MY 2012)	2015 MMC Weighted Average
Your Child's Health Plan						
Satisfaction with Child's Health Plan (Rating of 8 to 10)	88.26%	▼	88.40%	▼	88.67%	84.38%
Getting Needed Information (Usually or Always)	83.72%	▲	80.13%	▲	79.10%	82.42%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	87.74%	▲	84.64%	▲	81.79%	86.13%
Appointment for Routine Care When Needed (Usually or Always)	82.52%	▼	85.24%	▲	85.22%	89.66%

▲ ▼ = Performance compared to prior years' rate

Shaded boxes reflect rates above the 2015 MMC Weighted Average.

IV: 2014 Opportunities for Improvement MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each PH MCO has addressed the opportunities for improvement made by IPRO in the 2014 EQR Technical Reports, which were distributed in April 2015. The 2015 EQR is the seventh to include descriptions of current and proposed interventions from each PH MCO that address the 2014 recommendations.

DHS requested the MCOs to 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 September 30, 2015 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 responses submitted to IPRO as of November 2015, as well as any additional relevant documentation provided by HPP.

Table 5.1 presents HPP's responses to opportunities for improvement cited by IPRO in the 2014 EQR Technical Report, detailing current and proposed interventions.

Table 5.1: Current and Proposed Interventions

Reference Number: HPP 2014.01: The Reducing Potentially Preventable Readmissions for the PA Medicaid Managed Care population PIP received partial credit for the element of study evaluated in 2014 that reflected activities in 2013: Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.					
Follow Up Actions Taken Through 09/30/15: HPP had implemented a Transitional Care program in 2 high volume hospitals in 2013 to present. Since then, HPP has continued and added an additional position at the highest volume facility (Temple University Hospital) and funded a position at Einstein Medical Center, both inner city high risk facilities.					
Readmissions	2011	2012	2013	2014	2015 YTD
All Plan	15.10%	13.90%	13.70%	14.00%	14.26%
Temple	18.50%	17.30%	15.90%	16.10%	13.74%
Einstein	10.80%	11.20%	10.50%	10.30%	11.12%
We have seen overall improvement of the readmission rate at Temple, where this facility started out with a higher readmission rate. Einstein had an overall lower rate at baseline and has stayed between 10%-11% which is commendable. We believe the Temple program with HPP staff onsite has been more effective in lowering the rate of readmission. Other interventions initiated to support readmissions reduction is as follows:					
1) 2013 – present Participation in development Healthshare the SE PA Health Information exchange to support exchange of ADT and care management information with medical community.					
2) January 2013 – present HPP convened bi-weekly meetings with hospitals where transitional care programs are embedded to focus on members with high readmission rate.					
3) January 1, 2014 Telephonic High cost/Rare disease case management through Vendor (Accordant).					
4) March 2014 Development of predictive modeling to identify members with low, medium, to high risk for case management interventions.					
5) 2015 1st quarter In Home Assessments and management by physician for members with chronic illnesses (Care Plus program).					
6) May 2015 Telephonic Cancer Case management through Vendor (Optum).					
7) January 2015 Development of CBCM program for nurse navigators with BH integration model to be on –site at select network practices with high cost members/					
8) June 2015 Work with Vendor (Crimson) in development of a HIPAA secure sharing portal for PCP offices to view plan care management information and also be to communicate electronically with HPP staff close care gaps and coordinate member care management interventions for improved health outcomes.					
Future Actions Planned:					
• What future actions are planned to address each opportunity? In 2016 there will be the launch of the CBCM program where care					

4) Evolution of a fragmented care delivery model.

Reference Number: HPP 2014.02: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Physical Activity (Age 3-11 years) and (Total) measures.

Follow Up Actions Taken Through 09/30/15:

- **What follow-up actions has the managed care organization (MCO) taken through 09/30/15 to address each opportunity?** Provider newsletters: Articles related to Fit kids programs and Member Fitness benefit (YMCA membership and Safe Swim) in the following editions: 01/2014, 10/2014, 07/2015; Managing BMI article 05/2015. Hot Topic articles 2nd quarter 2014 regarding BMI, weight and nutrition. The Network Account Managers (NAM) visit the sites and review information regarding counseling with the providers and their staff. The Clinical Audit Nurses visits medical sites that take care of pediatric members and provided education on the need to counsel or educate pediatric members on the need for physical activity since the 06/01/2013 up until 09/30/2015:



Record of educational visits 06.1

- **What is the expected outcome or goals of the actions that were taken?** The expected outcome is to see an increase in all of the components of the WCC measure BMI, Nutrition and Physical Activity counseling.
- **What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?** Monthly monitoring of HEDIS administrative rates. Below are the reported rates for HEDIS 2014 and HEDIS 2015.

	2015 (MY 2014)	2014 (MY 2013)
Counseling for Physical Activity HEDIS reported Rate	61.25	51.43%

Future Actions Planned:

- **What future actions are planned to address each opportunity? Please specify dates.** Future actions are to continue to educate the provider at site visits, maintain and update the provider webpage as needed, offered educational articles in our Provider Newsletters and send out information via HPP Insider.
- **For future actions, when and how will these actions be accomplished?** These actions will be accomplished by continuing site visits for recertification and educational audits, and continue to have the NAM review need for counseling documentation with the providers and staff. Maintaining the Provider website with pertinent information and provide education letter to the provider centered on HEDIS topics.
- **What is the expected outcome or goals of the actions that were taken?** The expected outcome is to see a continued increase in all of the components of the WCC measure BMI, Nutrition and Physical Activity counseling.

Reference Number: HPP 2014.03: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Follow-up Care for Children Prescribed ADHD Medication – All phases (Initiation Phase, Continuation Phase, BH Enhanced Initiation Phase, BH Enhanced Continuation Phase) measures.

Follow Up Actions Taken Through 09/30/15:

- **What follow-up actions has the managed care organization (MCO) taken through 09/30/15 to address each opportunity?** HPP continues to participate in collaborative meetings with Community Behavioral Health (CBH) which serves members in Philadelphia County. The meetings in 2014 were held on the following dates: 01/01/2014; 02/04/2014; 03/04/2014; 04/01/2014; 05/06/2014; 06/03/2014; 07/01/2014; 08/05/2014; 10/07/2014; 11/04/2014; 12/02/2014. In 2015, the meetings were held on the following dates: 01/06/2015; 02/03/2015; 03/03/2015; 04/07/2015; 05/05/2015; 06/02/2015; 07/07/2015; 08/04/2015; 09/01/2015. Magellan continues to be the behavioral health vendor for those members that do not reside in Philadelphia County. The Special Needs Unit (SNU) continues to assist members/providers with referrals to behavior health services. The member website has a

listing of behavior health (BH) providers (<https://www.healthpartnersplans.com/members/health-partners/using-the-plan/drug-alcohol-and-mental-health-services>). HPP also includes information regarding behavioral health in the provider manual which is available on line (https://www.healthpartnersplans.com/media/100087721/hpp-provider-manual-sec10_healthier-you.pdf and https://www.healthpartnersplans.com/media/100087715/hpp-provider-manual-sec08_utilization-mgmt.pdf). Providers can access HPP's formularies on the provider website, as well (<https://www.healthpartnersplans.com/providers/resources/formulary>)

• What is the expected outcome or goals of the actions that were taken?

		2015	2014
Rate (%)	MCO Defined Rate 1 - Initial Phase	15.96%	13.88%
Rate (%)	MCO Defined Rate 2 - Continuation and Maintenance (C&M) Phase	13.48%	8.20%
Rate (%)	BH ED Enhanced Rate 1 - Initial Phase	16.32%	14.08%
Rate (%)	BH ED Defined Rate 2 - Continuation and Maintenance (C&M) Phase	22.48%	13.75%

• What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken? To collect and analyze administrative data.

Future Actions Planned:

- **What future actions are planned to address each opportunity?** This measure is being considered for the Quality Care Plus (QCP) 2016 PCP incentive program. Continue Provider education via the website, newsletters and pharmacy bulletins.
- **For future actions, when and how will these actions be accomplished?** HPP will work with pharmacy and send notices about ADHD care from the medical site to providers.
- **What is the expected outcome or goals of the actions that were taken?** Increase in the 2016 rates for the measure Follow-Up Care for Children Prescribed ADHD Medication.

Reference Number: HPP 2014.04: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the EPSDT - Hearing Test (Age 4-20 years) measure.

Follow Up Actions Taken Through 09/30/15: Hearing test (Age 4 – 20 years) – 2015 reported rate 33.77%; 2014 reported rate 30.02%; 2013 reported rate 27.69%

- Winter 2015-Provider Newsletter
- Fall 2015-Newsletter Article
- 6/13/15-Crazy Praise – Where EPSDT staff is present for education of parents/guardians re: EPSDT screening, lead screening, all well child visits and dental services.
- 3/4/15 MCIC Meeting in Norristown – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- 3/9/15 Early Head Start Meeting – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- 3/11/15 Acelero Early Learning Academy Meeting – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- Continuous-EPSDT staff outreach to all EPSDT members in order to assist with scheduling appointments and educate caregivers regarding the importance of well childcare and EPSDT screening.
- Education of providers regarding HEDIS Specifications surrounding all well child visits, EPSDT visits and dental services.

Future Actions Planned:

- 01/2016 – resume site visits for re-education to providers by the staff of the EPSDT department to reinforce the need for Well Child Visits in the first 15 months of life and EPSDT screening visits, especially 18 and 30 month visits and Dental Services
- 10/19/2015-Meet and greet workshops for Pediatricians and Pediatric dentists to form partnerships for coordinating care of members
- 12/2015-HPP Community Health Holiday Event – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- Continue with Provider newsletter and Hot Topic articles addressing the need for all Well Child Care visits and EPSDT screening according to the periodicity schedule
- Continue working in conjunction with Community Relations to meet the members in the community and educated the caregivers about the need for all Well Child Care visits EPSDT, and dental services
- Continuation of EPSDT outreach re: well child visits EPSDT screening and dental services
- Continuation of automated telephonic outreach to remind member's care givers to schedule PCP appointment for all Well Child Care visits EPSDT, and dental services with directions to call the EPSDT department if they require assistance.
- Continue to educate providers regarding HEDIS specifications and suggest coding using modifier 25 if components of a well visit are completed during sick visit
- Educate providers regarding components of well child visits (health history, developmental history, physical exam and education/anticipatory guidance)

- Continue to educate community partners on PSDT required screening according to the periodicity schedule.

Reference Number: HPP 2014.05: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the EPSDT - Vision Test (Age 4-20 years) measure.

Follow Up Actions Taken Through 09/30/15: 2015 reported rate 35.02%; 2014 reported rate 32.97%; 2013 reported rate 27.36%

- Winter 2015-Provider Newsletter
- Fall 2015-Newsletter Article
- 6/13/15-Crazy Praise – Where EPSDT staff is present for education of parents/guardians re: EPSDT screening, lead screening, all well child visits and dental services.
- 3/4/15 MCIC Meeting in Norristown – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- 3/9/15 Early Head Start Meeting – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- 3/11/15 Acelero Early Learning Academy Meeting – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- Continuous-EPSDT staff outreach to all EPSDT members in order to assist with scheduling appointments and educate caregivers regarding the importance of well childcare and EPSDT screening.
- Education of providers regarding HEDIS Specifications surrounding all well child visits, EPSDT visits and dental services.

Future Actions Planned:

- 01/2016 – resume site visits for re-education to providers by the staff of the EPSDT department to reinforce the need for Well Child Visits in the first 15 months of life and EPSDT screening visits, especially 18 and 30 month visits and Dental Services
- 10/19/2015-Meet and greet workshops for Pediatricians and Pediatric dentists to form partnerships for coordinating care of members
- 12/2015-HPP Community Health Holiday Event – EPSDT Staff is present to educate community partners on EPSDT required screening according to the periodicity schedule.
- Continue with Provider newsletter and Hot Topic articles addressing the need for all Well Child Care visits and EPSDT screening according to the periodicity schedule
- Continue working in conjunction with Community Relations to meet the members in the community and educated the caregivers about the need for all Well Child Care visits EPSDT, and dental services
- Continuation of EPSDT outreach re: well child visits EPSDT screening and dental services
- Continuation of automated telephonic outreach to remind member's care givers to schedule PCP appointment for all Well Child Care visits EPSDT, and dental services with directions to call the EPSDT department if they require assistance.
- Continue to educate providers regarding HEDIS specifications and suggest coding using modifier 25 if components of a well visit are completed during sick visit
- Educate providers regarding components of well child visits (health history, developmental history, physical exam and education/anticipatory guidance)
- Continue to educate community partners on PSDT required screening according to the periodicity schedule.

Reference Number: HPP 2014.06: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Postpartum Screening Positive for Depression measure.

Follow Up Actions Taken Through 09/30/15:

1. Staff training to enhance case management skills:

- 8/13 & 9/2/15 Customer service with respect training
- 5/8/2015 39th Annual Regional Conference on Developmental Disabilities
- 4/28/2015 Motivational interviewing training completed
- 11/6/2014 Who Will Catch Me? Mother Woman Perinatal Support Group
- 10/3/2014 Reasoning with Unreasonable People Seminar
- 7/23/2014 HIV and Mental Health
- 11/9/2014 Reducing Effects of Post-Partum Depressions

Outcome: Improved member engagement & satisfaction with services provided.

Monitoring: Annual member CAHPS report provides individual case management detail; Monthly customer service staff audits and documentation review

Case manager effectiveness

Table A

HEDIS Measure	HEDIS 2015 Data Collection Method	HEDIS 2014 Members in CCMS Baby Partners That Are HEDIS Compliant (%)	HEDIS 2014 Final Reported Rate	HEDIS 2015 Members in CCMS Baby Partners That Are HEDIS Compliant (%)	HEDIS 2015 Final Reported Rate
Frequency of Prenatal Care (FPC) 81%+ Expected Visits	Admin	62.02%	59.15%	61.38%	58.47%
Prenatal and Postpartum Care (PPC) Postpartum Care	Admin	65.90%	61.47%	71.80%	67.49%
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	Admin	78.60%	76.48%	81.77%	79.06%
Frequency of Prenatal Care (FPC) 81%+ Expected Visits	Hybrid	62.63%	74.61%	64.20%	68.46%
Prenatal and Postpartum Care (PPC) Postpartum Care	Hybrid	67.11%	68.60%	72.44%	72.43%
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	Hybrid	82.11%	86.86%	82.95%	85.51%

Table A demonstrates the effectiveness of the Baby Partners Program as it relates to the members who are known to care management and the members' attendance at prenatal and postpartum services. The total maternity population known to Baby partners decreased from 85/01% to 84/01%, although the unique number of members increased from 3257 to 3709 administratively. There was an overall increase in Baby Partners staff HEDIS 2015 maternity measures rates compared to the prior year with the exception of frequency of prenatal care administrative rates.

2. Doula services expanded to postpartum members and visit includes depression screening with a validated tool. Ongoing – 1/1/2013; Bimonthly conference calls and case review; 1/2015; education provided on handling members with PP depression 3/2015.

Outcome: Members in need of behavioral health services will be assisted [at] doula visits.

Monitoring: care coordinators review intake and follow up visit summaries on receipt from doula. Issues or concerns are referred to management.

3. Practice Based Care Coordinator (PBCC) – ongoing (started 5/2012) on site at high volume site to provide education, screening and support and coordination of care for high risk members: DME, nursing home care visits, nutritionist referral, pharmacy and doula support. May 2014 – increased to 3 sites, 4 days a week; high risk clinic added

Goal: improved member engagement and adherence to prenatal care so depression issues may be addressed in collaboration with practitioner.

Monitoring – 1. Annual Review with provider office to obtain feedback regarding effectiveness; Completed telephonically October 2014 – positive feedback on program; 2. Annual review of HEDIS rates for PBCC case managed members – Review was conducted in August 2015 to review the effectiveness of this program based on the HEDIS rates of members that received Practice-based case management services prenatally or postpartum. The postpartum care rate was 87.5% for the 275 members that were in the HEDIS denominator that received prenatal or postpartum Practice-based case management services. This is a positive difference of 15.07% when compared to the final postpartum reporting rate. The frequency of ongoing prenatal was 65.7% for the members in the HEDIS 2015 denominator. This is a negative difference of 2.76% when compared to the final HEDIS rate for frequency of prenatal care.

Future Actions Planned:

Continued staff education:

Customer service with respect training for all staff by the end of 2015.

Staff training scheduled 9/21/15 in Adult Protective Services

Continue bimonthly doula calls – scheduled at the end of Sept and November 2015

Meeting scheduled for 10/2/2015 with office managers at 2 practice based care coordination site.

Continuing these actions will assist HPP and doula staff to provide appropriate services and improve member engagement and adherence to prenatal care so depression issues may be addressed in collaboration with practitioner.

Reference Number: HPP 2014.07: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Medication Management for People with Asthma: 75% Compliance – All ages (Age 5-11 years, Age 12-18 years, Age 19-50 years, Age 51-64 years, and Age 5-64 years) measures.

Follow Up Actions Taken Through 09/30/15:

1. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

2. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

3. May 2015-Community Health Worker (CHW) on site at high volume pediatric asthma site to work with pediatric members. CHWs are onsite to coordinate the closing of asthma and preventive care gaps, meet face to face at the hospital during a hospitalization for asthma, conduct in home environmental assessments and refer to community resources.

Outcome: To see improved preventive treatment for asthmatics as reflected by HEDIS quality measures, reduction in hospitalization and emergency department use for asthma, closure of preventive care gaps for asthmatics, improved quality of life and patient satisfaction.

Monitoring: Monitoring of CHW activities with a tracking registry and monthly reporting and analysis of trends and barriers.

Monthly process meetings with HPP and high volume pediatric asthma practice, and quarterly outcomes reports and meeting.

4. April 2015-Onsite procurement of prescription strength asthma medication as prescribed by the treating practitioner along with real time education on medication use and arrangement of home delivery of asthma medications.

Outcome: To see improved medication adherence and thus decrease inpatient and ER usage

Monitoring: Monitoring of CHW activities with a tracking registry that identifies members who have opted into the onsite medication. Monthly reporting and analysis of trends and barriers. Monthly process meetings with HPP and high volume pediatric asthma practice, and quarterly outcomes reports and meeting.

5. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PBCM and HEDIS rates.

6. September 2015- outreach to adult noncompliant asthma members to assess barriers to care, provide member education, provide pharmacy delivery resources, link members back into care, and link members to ongoing case management.

Outcome: to see improved compliance with asthma medication as well as members linked into care.

Monitoring: Tracking via care management system of members outreached as well as excel spreadsheet. Evaluation of effectiveness will be examining HEDIS rates for improvement in all asthma related measures. Reports run annually on individual case managers and HEDIS rates of members case managed.

7. Transitional Care Management Program – In 2015 added additional RN to existing transitional care staffing. Case managers onsite high volume HPP member facilities (TUH). Funded FTE Transitions coach at Einstein Medical Center with utilization of pilot project using local ambulance provider to have follow up visits post hospital discharge. Evaluating a new proposal to expand this resource to HPP members admitted to Einstein.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.

Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand asthma toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

Reference Number: HPP 2014.08: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Annual Number of Asthma Patients (Age 2-20 years) with One or More Asthma Related ER Visit measure.

Follow Up Actions Taken Through 09/30/15:

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.

Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand asthma toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

Reference Number: HPP 2014.09: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Adult Asthma Admission Rate (Age 18-39 years) measure.

Follow Up Actions Taken Through 09/30/15:

Admissions Per 100,000 Member Months by Age Cohort:

2013 18-39 years old 42.20

2013 40+ 125.96

2013 18+ total 78.99

2014 18-39 years old 39.40

2014 40+ rate not reported- Source Code: 7/28 - Age cohort logic incorrectly assigns Ages 40 - 64 to age cohort 1. This measure only reports age 18 to 39 in 2014.

2014 18+total 39.40

1. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

2. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

3. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PCBM and HEDIS rates.

4. September 2015- outreach to adult noncompliant asthma members to assess barriers to care, provide member education, provide pharmacy delivery resources, link members back into care, and link members to ongoing case management.

Outcome: to see improved compliance with asthma medication as well as members linked into care.

Monitoring: Tracking via care management system of members outreached as well as excel spreadsheet. Evaluation of effectiveness will be examining HEDIS rates for improvement in all asthma related measures. Reports run annually on individual case managers and HEDIS rates of members case managed.

5. Transitional Care Management Program – In 2015 added additional RN to existing transitional care staffing. Case managers onsite high volume HPP member facilities (TUH). Funded FTE Transitions coach at Einstein Medical Center with utilization of pilot project using local ambulance provider to have follow up visits post hospital discharge. Evaluating a new proposal to expand this resource to HPP members admitted to Einstein.

6. Weekly meeting with high volume facilities and care management team to work collaboratively. Monthly meetings with Temple team and HPP team to discuss complex cases and identify interventions for those members. Same month for Einstein Medical Center.

7. Health care management meets bi-weekly to review readmission data with internal staff and evaluate readmission programs for continuous improvement.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.
Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand asthma toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

3. Integrated rounds to be expanded to other owner hospitals to be implemented in 4th quarter 2015.

Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.

Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

4. Re-evaluate readmission approach while addressing a proactive plan before admissions or readmissions occur as well as a reactive plan. 4th quarter 2014.

Reference Number: HPP 2014.10: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Chronic Obstructive Pulmonary Disease Admission Rate (Age 40+ years) measure.

Follow Up Actions Taken Through 09/30/15:

Admissions per 100,000 Member Months by Age Cohort:

2013 18+ 91.74

2014 18+ 216.25

1. September 2014-COPD Brochure created and approved for mailing to members to assist in member education. Brochures are available in both English and Spanish. Brochures are mailed to members upon outreaching to a member who identifies as having COPD or has been inpatient with a diagnosis of COPD.

Outcomes: Care Coordinators have educational materials to mail to members to use for teaching. Members have education reading materials to use when needed.

Monitoring: Coordinators discuss the reading material with members on follow up phone calls. Yearly Disease management and case management survey addresses educational materials and their usefulness. These survey results are reviews and recommendations are considered.

2. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

3. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

4. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PCBM and HEDIS rates.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.

Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand COPD toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

3. Integrated rounds to be expanded to other owner hospitals to be implemented in 4th quarter 2015.

Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.

Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

4. Expand Manna program-to begin in 4th quarter 2015

Actions: Offer Manna program to provide medically therapeutic and nutritious meals to high risk COPD members.

Outcomes: Decrease inpatient and ER usage.

Reference Number: HPP 2014.11: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Blood Pressure Controlled <140/90 mm Hg measure.

Follow Up Actions Taken Through 09/30/15:

2013 Rate: 59.67% 2014 Rate: 57.07%

1. July 2014-Expanding hypertension incentive. Members are rewarded for completing a PCP visit, completing an LDL screening, keeping in touch with a peer coach monthly, improving their BP, and adherence to antihypertensive medications. Expanded to include the entire hypertension population for potential enrollment.

Outcome: Increased member enrolled in the program. To date 1,901 members have enrolled.

Monitoring: Monitor the number of members enrolling per week and evaluation of HEDIS rates.

2. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

3. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

4. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PCBM and HEDIS rates.

5. September 2015-Sodium Brochure created and approved for mailing to members to assist in member education. Brochures are available in both English and Spanish. Brochures are mailed to members upon outreaching to a member who identifies as having HTN, requests to be in our case management program, or a member enrolled in our hypertension incentive program.

Outcomes: Care Coordinators have educational materials to mail to members to use for teaching. Members have education reading materials to use when needed.

Monitoring: Coordinators discuss the reading material with members on follow up phone calls. Yearly Disease management and case management survey addresses educational materials and their usefulness. These survey results are reviews and recommendations are considered.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.

Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand cardiovascular toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

3. Integrated rounds to be expanded to other owner hospitals to be implemented in 4th quarter 2015.

Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.

Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

4. Expand Manna program-to begin in 4th quarter 2015

Actions: Offer Manna program to provide medically therapeutic and nutritious meals to high risk COPD members.

Outcomes: Decrease inpatient and ER usage.

Reference Number: HPP 2014.12: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Blood Pressure Controlled <140/80 mm Hg measure.

Follow Up Actions Taken Through 09/30/15:

2013 Rate: 39.60% 2014 Rate: 32.61%

1. July 2014-Expanding hypertension incentive. Members are rewarded for completing a PCP visit, completing an LDL screening, keeping in touch with a peer coach monthly, improving their BP, and adherence to antihypertensive medications. Expanded to include the entire hypertension population for potential enrollment.

Outcome: Increased member enrolled in the program. To date 1,901 members have enrolled.

Monitoring: Monitor the number of members enrolling per week and evaluation of HEDIS rates.

2. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

3. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

4. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PCBM and HEDIS rates.

5. September 2015-Sodium Brochure created and approved for mailing to members to assist in member education. Brochures are available in both English and Spanish. Brochures are mailed to members upon outreaching to a member who identifies as having HTN, requests to be in our case management program, or a member enrolled in our hypertension incentive program.

Outcomes: Care Coordinators have educational materials to mail to members to use for teaching. Members have education reading materials to use when needed.

Monitoring: Coordinators discuss the reading material with members on follow up phone calls. Yearly Disease management and case management survey addresses educational materials and their usefulness. These survey results are reviews and recommendations are considered.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.

Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.

Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.

2. Expand cardiovascular toolkit to reflect the growing needs of the population – 4th quarter 2015

Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.

Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

3. Integrated rounds to be expanded to other owner hospitals to be implemented in 4th quarter 2015.
Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.
Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

4. Expand Manna program-to begin in 4th quarter 2015
Actions: Offer Manna program to provide medically therapeutic and nutritious meals to high risk COPD members.
Outcomes: Decrease inpatient and ER usage.

Reference Number: HPP 2014.13: The MCO's rates were statistically significantly worse than the 2014 (MY 2013) MMC averages for the Diabetes Short-Term Complications Admission Rate (Age 18-64 years) and (Total Age 18+ years) measures.

Follow Up Actions Taken Through 09/30/15:

Admissions per Member months by age cohort:

2013 Age 18-64 years of age 25.80

Age 65 years and older 7.27

Total 25.53

2014 Age 18-64 years of age 29.18

Age 65 years and older 0.00

Total 28.77

1. July 2014-Expanding the diabetic incentive. Members are rewarded for completing a PCP visit, completing an HgbA1c screening test, completing and LDL test, and keeping in touch with a peer coach monthly. Expanded to include the entire diabetic population for potential enrollment.

Actions: Increased members enrolled in the program. To date 1,667 members have enrolled.

Outcomes/Goals: Monitor number of members enrolling per week and evaluation of diabetic HEDIS rates.

2. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.

Outcome: Increased member interventions with practice based care manager leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.

3. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.

Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.

Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.

4. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.

Outcome: Face to face member interventions leading to improved member self-management.

Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PBCM and HEDIS rates.

5. June 2015-vision vendor outreaching to diabetic population to educate about the importance of eye exams and yearly screenings. The vendor also provides information to the member about benefits as well as provides assistance in locating an eye provider in the member's area.

Outcome: Members will be better informed about their benefits, be aware of how to locate an eye provider, and complete diabetic eye exams.

Actions: Yearly evaluation of diabetic HEDIS rates.

6. Integrated rounds to be expanded to other owner hospitals to be implemented in 4th quarter 2015.

Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.

Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

7. Re-evaluate readmission approach while addressing a proactive plan before admissions occur as well as a reactive plan. 4th quarter 2015.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.
Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.
Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.
2. Expand diabetic toolkit to reflect the growing needs of the population – 4th quarter 2015
Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.
Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.
3. Expand integrated rounds with high volume owner hospitals to be implemented in 4th quarter 2015.
Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.
Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.

Reference Number: HPP 2014.14: The MCO's rates were statistically significantly worse than the 2014 (MY 2013) MMC averages for the Congestive Heart Failure Admission Rate (Age 18-64 years) and (Total Age 18+ years) measures.

Follow Up Actions Taken Through 09/30/15:

2013 Rates: Admissions per 100,000 Member months by age Cohort

18-64 years and older: 54.97

65 years and older: 116.30

Total 18-65 years and older: 171.27

2014 Rates: Admissions per 100,000 Member months by age Cohort

18-64 years and older: 58.56

65 years and older: 116.74

Total 18-65 years and older: 175.30

1. September 2014-Bilingual Practice Based Care Manager (PBCM) on site at [high] volume site increased to 4-5 days a week to conduct face to face interviews, assist to alleviate any barriers to care, and coordinate resources as needed.
Outcome: Increased member interventions with practice based care manager leading to improved member self-management.
Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of members seen by PBCM and HEDIS rates.
2. May 2015-Optum Care Plus Program is outreaching and evaluating high risk members with multiple comorbidities in their homes to assist with education, care coordination and medication reconciliation.
Outcome: Improved adherence with treatment plan and medication adherence, decrease ER usage, decrease inpatient usage, increase PCP usage, and decrease in member care gaps.
Monitoring: Weekly meeting with OPTUM to review and streamline processes, discuss high risk members, and review member interventions and outcomes. Weekly scorecard of interactive members.
3. July 2015-2nd practice based case manager places at high volume site. Working face to face with the members, assisting with barriers to care, linking to community resources and educating about their medical conditions.
Outcome: Face to face member interventions leading to improved member self-management.
Monitoring: Monthly reports of PBCM activity to trend patterns. Yearly outcomes evaluation of the PBCM program and impact on reducing inpatient admissions, ER usage and PCP visits. Yearly evaluation of member seen by PBCM and HEDIS rates.

Future Actions Planned:

1. Community Based Case Management program (CBCM) in the process of being implemented. Implement in November 2015.
Actions: Nurse Navigators and CHW on site at [high] volume sites dedicated to face to face encounters with high risk members.
Outcomes/Goals: Decrease in ER and Inpatient rates, improved HEDIS rates and improved member compliance.
2. Expand heart failure toolkit to reflect the growing needs of the population – 4th quarter 2015
Actions: Research community resources available and benefit allowance. Implement training for case managers around topics of medication and asthma management.
Outcomes/Goal: Improved member compliance through education and available resources creating a better informed member.

3. Integrated rounds with high volume owner hospitals to be implemented in 4th quarter 2015.
 Actions: Collaboration with HPP and owner hospital's transition program to implement rounds to discuss high risk members with multiple comorbidities.
 Outcomes/Goals: Improved compliance with discharge plan with improved rate of follow up to PCP in 7-10 days after inpatient event.
4. Expand Manna program-to begin in 4th quarter 2015
 Actions: Offer Manna program to provide medically therapeutic and nutritious meals to high risk COPD members.
 Outcomes: Decrease inpatient and ER usage.

Reference Number: HPP 2014.15: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia (PH rate and BH enhanced rate) measures.

Follow Up Actions Taken Through 09/30/15:

- **What follow-up actions has the managed care organization (MCO) taken through 09/30/15 to address each opportunity?** HPP continues to participate in collaborative meetings with Community Behavioral Health (CBH) which serves members in Philadelphia County. The meetings in 2014 were held on the following dates: 01/01/2014; 02/04/2014; 03/04/2014; 04/01/2014; 05/06/2014; 06/03/2014; 07/01/2014; 08/05/2014; 10/07/2014; 11/04/2014; 12/02/2014. In 2015, the meetings were held on the following dates: 01/06/2015; 02/03/2015; 03/03/2015; 04/07/2015; 05/05/2015; 06/02/2015; 07/07/2015; 08/04/2015; 09/01/2015. Magellan continues to be the behavioral health vendor for those members that do not reside in Philadelphia County. The Special Needs Unit (SNU) continues to assist members/providers with referrals to behavior health services. The member website has a listing of behavior health (BH) providers (<https://www.healthpartnersplans.com/members/health-partners/using-the-plan/drug-alcohol-and-mental-health-services>). HPP also includes information regarding behavioral health in the provider manual which is available on line (https://www.healthpartnersplans.com/media/100087721/hpp-provider-manual-sec10_healthier-you.pdf and https://www.healthpartnersplans.com/media/100087715/hpp-provider-manual-sec08_utilization-mgmt.pdf). Providers can access HPP's formularies on the provider website, as well (<https://www.healthpartnersplans.com/providers/resources/formulary>)

- **What is the expected outcome or goals of the actions that were taken?**
 2015 Rate Sheet

ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA (SAA)

		2015	2014
Denominator	MCO Defined Denominator	678	653
Numerator	MCO Defined Numerator	424	417
Rate (%)	MCO Defined Rate	62.54%	63.86%
	Is the 2015 rate statistically significantly different than the 2014 rate?	No	
	Rate difference	-1.32%	

		2015	2014
Denominator	BH ED Enhanced Denominator	1,105	1,034
Numerator	BH ED Enhanced Numerator	688	674
Rate (%)	BH ED Enhanced Rate	62.26%	65.18%
	Is the 2015 rate statistically significantly different than the 2014 rate?	No	
	Rate difference	-2.92%	

Future Actions Planned:

- **What future actions are planned to address each opportunity?** This measure is being considered for the Quality Care Plus (QCP) 2016 or 2017 PCP incentive program. Continue Provider education via the website, newsletters and pharmacy bulletins.
- **For future actions, when and how will these actions be accomplished?** HPP will work with pharmacy and send notices about Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure.
- **What is the expected outcome or goals of the actions that were taken?** Increase in the 2016 rates for the measure Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure.
- Pharmacy confirmed that the medications are written by psychiatrist primarily, so this can be discussed in the CBH collaboration meetings.

Reference Number: HPP 2014.16: A decrease was noted in 2014 (MY 2013) as compared to the MCO's 2013 (MY 2012) in one of

the four Adult CAHPS composite survey items. The rates for three composite survey items evaluated fell below the 2014 MMC weighted averages.

Follow Up Actions Taken Through 09/30/15:

- **What follow-up actions has the managed care organization (MCO) taken through 09/30/15 to address each opportunity?** Meetings were held with key stakeholders on the following dates: 09/15/2014, 10/08/2014, 10/13/2014, and 10/20/2014, 10/30/2014, 11/11/2014, 11/14/2014, 11/17/2014, 11/18/2014, 02/02/2015, 02/03/2015, and 4/24/2015.
- **What is the expected outcome or goals of the actions that were taken?** The expected outcome is to see an increase in CAHPS composite survey items scores in the 2015 CAHPS survey. This would be interrupted as the members are experiencing increased satisfaction.
- **What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?** To continue with the annual CAHPS survey to track and trend customer satisfaction.

Key Drivers of Health Plan Rating	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
Customer Service	69th	Monitor	25th	Opportunity	81st	Strength
Getting Needed Care	57th	Monitor	53rd	Monitor	24th	Opportunity
Key Drivers of Health Care Rating*	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
How Well Doctors Communicate	75th	Strength	21st	Opportunity	57th	Monitor
Getting Needed Care	57th	Monitor	53rd	Monitor	24th	Opportunity
Customer Service					81st	Strength
Getting Care Quickly	76th	Strength	48th	Opportunity		
* The composites for this measure were changed in 2014						
Key Drivers of Personal Doctor Rating**	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
How Well Doctors Communicate	75th	Strength	21st	Opportunity	57th	Monitor
Coordination of Care	75th	Strength	82nd	Strength		
Getting Needed Care					24th	Opportunity

** The composites for this measure were changed in 2014

Future Actions Planned:

- **What future actions are planned to address each opportunity? Please specify dates.** Health Partners Plans (HPP) will continue to meet with key stakeholders throughout the year in order to improve CAHPS scores. Plans that may be implemented are social media and texting, expanded member portal, education at the provider and member level, continued education of internal staff regarding improving the customer experience.
- **For future actions, when and how will these actions be accomplished?** The future actions will be implemented throughout the year. The departments that will play a role in education for the providers and members are Health Care Management (HCM), Provider Network, and Business Development. Staff training will be organized by Learning and Development department.
- **What is the expected outcome or goals of the actions that were taken?** A documented increase in customer satisfaction which will be evident in the 2016 (MY 2015) CAHPS survey.

Reference Number: HPP 2014.17: A decrease was noted in 2014 (MY 2013) as compared to the MCO's 2013 (MY 2012) in one of the four Child CAHPS composite survey items. The rates for three composite survey items evaluated fell below the 2014 MMC weighted averages.

Follow Up Actions Taken Through 09/30/15:

- **What follow-up actions has the managed care organization (MCO) taken through 09/30/15 to address each opportunity?** Meetings were held with key stakeholders on the following dates: 09/15/2014, 10/08/2014, 10/13/2014, and 10/20/2014, 10/30/2014, 11/11/2014, 11/14/2014, 11/17/2014, 11/18/2014, 02/02/2015, 02/03/2015, and 4/24/2015.
- **What is the expected outcome or goals of the actions that were taken?** The expected outcome is to see an increase in CAHPS composite survey items scores in the 2015 CAHPS survey. This would be interrupted as the members are experiencing increased satisfaction.
- **What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?** To continue with the annual CAHPS survey to track and trend customer satisfaction.

Key Drivers of Health Plan Rating	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
Customer Service	52nd	Monitor	42nd	Opportunity	21st	Opportunity
Getting Needed Care	13th	Opportunity	35th	Opportunity	23rd	Opportunity
Key Drivers of Health Care Rating*	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
How Well Doctors Communicate	19th	Opportunity	12th	Opportunity	10th	Opportunity
Getting Needed Care	13th	Opportunity	35th	Opportunity	23rd	Opportunity
Customer Service	52th	Monitor				
Coordination of Care			32nd	Opportunity		

* The composites for this measure were changed in 2014 and 2015

Key Drivers of Personal Doctor Rating**	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis	2014 (MY 2013) Percentile Ranking	2014 Opportunity Analysis	2013 (2012 MY) Percentile Ranking	2013 Opportunity Analysis
How Well Doctors Communicate	19th	Opportunity	21st	Opportunity	10th	Opportunity
Coordination of Care	83th	Strength	82nd	Strength	34th	Opportunity

Future Actions Planned:

- **What future actions are planned to address each opportunity? Please specify dates.** Health Partners Plans (HPP) will continue to meet with key stakeholders throughout the year in order to improve CAHPS scores. Plans that may be implemented are social media and texting, expanded member portal, education at the provider and member level, continued education of internal staff regarding improving the customer experience.
 - **For future actions, when and how will these actions be accomplished?** The future actions will be implemented throughout the year. The departments that will play a role in education for the providers and members are Health Care Management (HCM), Provider Network, and Business Development. Staff training will be organized by Learning and Development department.
- What is the expected outcome or goals of the actions that were taken?** A documented increase in customer satisfaction which will be evident in the 2016 (MY 2015) CAHPS survey.

Root Cause Analysis and Action Plan

The 2015 EQR is the sixth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS 2014 P4P Measure Matrix receiving either “D” or “F” ratings. Each P4P measure in categories “D” and “F” required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

For the 2015 EQR, HPP was required to prepare a Root Cause Analysis and Action Plan for the following performance measure:

1. Reducing Potentially Preventable Readmissions (Table 5.2)

HPP submitted an initial Root Cause Analysis and Action Plan in October 2015.

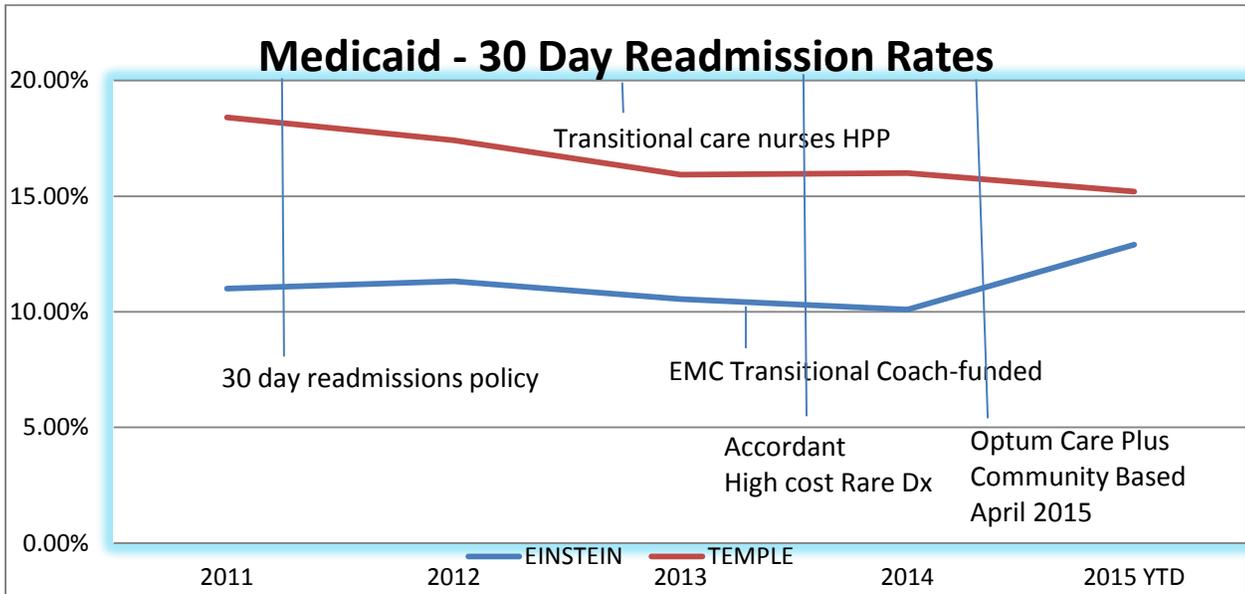
Table 5.2: RCA and Action Plan – Reducing Potentially Preventable Readmissions

Instructions: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance and your internal goal for improvement. Some or all of the areas below may apply to each measure.

<i>Managed Care Organization (MCO):</i>	Health Partners Plans
<i>Measure:</i>	Reducing Potentially Preventable Readmissions ²
<i>Response Date:</i>	November 20, 2015
<i>Goal Statement:</i> Please specify goal(s) for measure.	Annual goal for remeasurement is to reduce readmission rate by 5%
<i>Analysis:</i> What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	<p>Findings:</p> <p>In the Pennsylvania five-county Southeastern region, rates are higher than state and national norms. As a result, Health Partners Plans determined that a focused program was necessary to address hospital readmissions to improve quality of care. From 2011-2013, we participated in the Department of Human Services’ (DHS) Performance Improvement Project (PIP) for “All Cause Readmissions.” This project was conducted and monitored by an Independent Peer Review Organization, who designed a comprehensive data methodology with inclusions and exclusions. It was aimed at capturing percentage of readmissions within 30 days of discharge for the initial admission. The results of the study are below.</p> <p>Also identified in our region was the poor follow up with PCPs or specialists post hospital discharge.</p> <p>We improved from 26% in 2011 for PCP/Specialist follow up within 7 days of discharge and increased to 31.5% in 2015 up from 26%.</p> <p>Another issue that may have impacted our readmission rate was the fact that members who did not meet acute care criteria were given a lower reimbursement (Downgrade) but billed as a POS 21 and were part of the universe. Since then, we have had signoff to exclude those “IP downgrades” which artificially inflate our rate.</p> <p>Our rate for 2015 is 13.59 for 2015 YTD compared to previous IPRO calculation of 15.25%.</p>
<i>Policies</i>	

² Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.

(e.g., data systems, delivery systems, provider facilities)	
<i>Procedures</i> (e.g., payment/reimbursement, credentialing/collaboration)	<p>Health Partners Plans founded its Transitional Care Management Program in January of 2013. The program has placed two Health Partners Plans Targeted Case Managers (TCM) at our two largest owner hospitals, Temple University Hospital and the Einstein Medical Center, and a Transitional Care Coordinator (TCC) at HPP who facilitates the TCMs' requests. Ranked first and third respectively, for total number of Health Partners Plans member admissions each year, Temple and Einstein challenged us to collaborate and assist them to reduce readmissions.</p> <p>The TCMs and TCC provide guidance and care coordination with members who have been discharged from the hospital and have been identified as high-risk for readmission due to socio-economic factors, chronic conditions and health literacy deficits.</p>
<i>People</i> (e.g., personnel, provider network, patients)	Three (3) hospital-based transitional care nurses, one plan based coordinator who worked on transition of care at 2 hospitals.
<i>Provisions</i> (e.g., screening tools, medical record forms, provider and enrollee educational materials)	<p>Working in tandem with our Special Needs Unit and Complex Case Management program case managers, the TCMs and TCC develop a care plan to avoid readmissions for both members who are being discharged from the hospital, as well as those who returned home. With increased engagement with the identified members, we saw improvement in the decrease of readmissions. As illustrated in the above table, we are below the DHS benchmark of a 16 percent readmission rate at both Temple and Einstein and both continue to trend downward.</p> <p>Strategies for Member Engagement</p> <p>The focus of the Transitional Care Management program is to identify and assist in the four key components that drive successful transitions of care back to the PCP or other key providers involved in the targeted members care:</p> <ul style="list-style-type: none"> • Medication reconciliation • PCP follow-up appointments • Health literacy • Discharge instruction education <p>Prior to discharge from the hospital, a TCM assesses the member's needs via available claims information. This information provides insight into previous illnesses that may still affect the member, chronic conditions and other mitigating factors that can be barriers to care. A coordinated member discussion with the facility's staff then occurs using a transitional care assessment that documents the care the member received in the hospital and any observations that would be beneficial in developing a care plan. The result of the conversation and assessment allows the TCM to form goals with the member or family/caregiver and health care team and apply appropriate interventions.</p> <p>TCM focused on members who were readmitted while our care coordination team focused on proactive outreach to member who were stratified as high risk through data analytics.</p>
<i>Other (specify)</i>	<p>Added additional vendors to support readmission reduction by providing specialty case management in home or telephonically.</p> <ol style="list-style-type: none"> 1) Accordant high cost [rare] disease case management telephonic specialty case management. 2) Care Plus, in home nurse practitioner management for chronic care members. 3) Optum Cancer Care Program – telephonic specialty case management. 4) CBCM program in last quarter 2015 for practice based navigation and BH integration.



MCO:	Health Partners Plans		
Measure:	Reducing Potentially Preventable Readmissions ³		
For the analysis findings/barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014.			
Action	Implementation Date	Monitoring Plan	
Include those planned as well as already implemented. Add rows if needed.	Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.	
TCM program onsite at Temple	1/2013	Immediate intervention for readmitted members. Weekly and monthly monitoring by facility and diagnoses. Monitor all patients readmitted to the hospital and provide face to face assessment and transition of care coordination. Bi-weekly meetings with Temple team and HPP team for combined discussion of high risk members. Continued decrease in readmission rates.	
Transitional coach at Einstein Medical Center	10/2014	Risk assesses all admissions using the Lacey tool, manages transitions of care and follows for 30 days post discharge. Bi-weekly meeting with HPP Case management and Einstein team. Continued decrease readmission rates.	
Physician follow up post discharge	2013	Goal to improve the percentage of discharge members having a PCP appointment or Specialist appointment in 7 days.	
Readmissions monitoring task force	2014	Developed various reports to improve monitoring, facility, provider, diagnoses, predictive scoring, etc.	
Evaluate expansion of transitional care at other sites	2015	In process	

³ Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.
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V: 2015 Strengths and Opportunities for Improvement

The review of MCO's 2015 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 Medicaid members served by this MCO.

Strengths

- HPP was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.
- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2015 (MY 2014) on the following measures:
 - Childhood Immunizations Status(Combination 2) and (Combination 3)
 - Adolescent Well-Care Visits (Age 12 to 21 Years)
 - Counseling for Nutrition (Age 12-17 years) and (Total)
 - Immunization for Adolescents (Combo 1)
 - Annual Dental Visit (Age 2–21 years)
 - Total Eligibles Receiving Preventive Dental Services
 - Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 years)
 - Breast Cancer Screening (Age 52-74 years)
 - Cervical Cancer Screening
 - Chlamydia Screening in Women — All Ages (Age 16-20 years, Age 21-24 years, and Total)
 - Human Papillomavirus Vaccine for Female Adolescents
 - Prenatal and Postpartum Care – Postpartum Care
 - Prenatal Screening for Environmental Tobacco Smoke Exposure
 - Prenatal Counseling for Environmental Tobacco Smoke Exposure
 - Prenatal Smoking Cessation
 - Prenatal Screening for Depression
 - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
 - Prenatal Counseling for Depression
 - Postpartum Screening for Depression
 - Prenatal Screening for Intimate partner violence
 - Prenatal Screening for Behavioral Health Risk Assessment
 - Appropriate Testing for Children with Pharyngitis
 - Appropriate Treatment for Children with Upper Respiratory Infection
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
 - Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid
 - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
 - Retinal Eye Exam
 - Persistence of Beta Blocker Treatment After Heart Attack
- The following strengths were noted in 2015 for Adult and Child CAHPS survey items:
 - Of the four Adult CAHPS composite survey items reviewed, HPP showed an increase for all four items in 2015 (MY 2014) as compared to 2014 (MY 2013). In addition, three items were higher than the 2015 MMC weighted averages.
 - For HPP's Child CAHPS, two composite survey items increased in 2015 (MY 2014) as compared to 2014 (MY 2013). Three survey items evaluated in 2015 (MY 2014) were above the 2015 MMC weighted averages.

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2015 (MY 2014) on the following measures:
 - Follow-up Care for Children Prescribed ADHD Medication — All Phases (Initiation Phase and Continuation Phase)

- Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) — All Phases (Initiation Phase and Continuation Phase)
 - EPSDT - Hearing Test (Age 4-20 years)
 - EPSDT - Vision Test (Age 4-20 years)
 - Developmental Screening in the First Three Years of Life — All Ages (1 year, 2 years, 3 years, and Total)
 - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years), (Age 12-18 years), and (Total - Age 5-64 years)
 - Annual Number of Asthma Patients (Age 2-20 years) with One or More Asthma Related ER Visit
 - Blood Pressure Controlled <140/90 mm Hg
 - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) and (Total Age 18+ years)
 - Heart Failure Admission Rate (Age 18-64 years) and (Total Age 18+ years)
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
 - Asthma in Younger Adults Admission Rate (Age 18-39 years)
 - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years)
- The following decreases were noted in 2015 (MY 2014) for Adult and Child CAHPS survey items:
 - HPP showed no decreases in any of the four Adult CAHPS composite survey items between 2015 (MY 2014) and 2014 (MY 2013). The rate for one composite survey item evaluated fell below the 2015 MMC weighted averages.
 - For HPP's Child CAHPS survey, two composite survey items decreased in 2015 (MY 2014). The rate for one composite survey item fell below the 2015 MMC weighted averages.

Additional targeted opportunities for improvement are found in the MCO-specific HEDIS 2015 P4P Measure Matrix that follows.

P4P Measure Matrix Report Card

2015

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at 7 of the 8 Healthcare Effectiveness Data Information Set (HEDIS®) measures included in the Quality Performance Measures component of the “HealthChoices MCO Pay for Performance Program.” The matrix:

1. Compares the Managed Care Organization’s (MCO’s) own P4P measure performance over the two most recent reporting years (2015 and 2014); and
2. Compares the MCO’s 2015 P4P measure rates to the 2015 Medicaid Managed Care (MMC) Weighted Average.

The table is a three by three matrix. The horizontal comparison represents the MCO’s current performance as compared to the most recent MMC weighted average. When comparing a MCO’s rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average or below average. Whether or not a MCO performed above or below average is determined by whether or not that MCO’s 95% confidence interval for the rate included the MMC Weighted Average for the specific indicator. When noted, the MCO comparative differences represent statistically significant differences from the MMC weighted average.

The vertical comparison represents the MCO’s performance for each measure in relation to its prior year’s rates for the same measure. The MCO’s rate can trend up (↑), have no change, or trend down (↓). 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 study populations.

The matrix is color-coded to indicate when a MCO’s performance rates for these P4P measures are notable or whether there is cause for action:

 The green box (A) indicates that performance is notable. The MCO’s 2015 rate is statistically significantly above the 2015 MMC weighted average and trends up from 2014.

 The light green boxes (B) indicate either that the MCO’s 2015 rate is not different than the 2015 MC weighted average and trends up from 2014 or that the MCO’s 2015 rate is statistically significantly above the 2015 MMC weighted average but there is no change from 2014.

 The yellow boxes (C) indicate that the MCO’s 2015 rate is statistically significantly below the 2015 MMC weighted average and trends up from 2014 or that the MCO’s 2015 rate not different than the 2015 MMC weighted average and there is no change from 2014 or that the MCO’s 2015 rate is statistically significantly above the 2015 MMC weighted average but trends down from 2014. No action is required although MCOs should identify continued opportunities for improvement.

 The orange boxes (D) indicate either that the MCO’s 2015 rate is statistically significantly below the 2015 MMC weighted average and there is no change from 2014 or that the MCO’s 2015 rate is not different than the 2015 MMC weighted average and trends down from 2014. **A root cause analysis and plan of action is therefore required.**

 The red box (F) indicates that the MCO’s 2015 rate is statistically significantly below the 2015 MMC weighted average and trends down from 2014. **A root cause analysis and plan of action is therefore required.**

Emergency Department utilization comparisons are presented in a separate table. Statistical comparisons are not made for the Emergency Department Utilization measure. Arithmetic comparisons as noted for this measure represent arithmetic differences only.



HPP Key Points

■ A Performance is notable. No action required. MCOs may have internal goals to improve

Measure that statistically significantly improved from 2014 to 2015 and was statistically significantly above/better than the 2015 MMC weighted average is:

- Annual Dental Visits

■ B - No action required. MCOs may identify continued opportunities for improvement

Measure that did not statistically significantly change from 2014 to 2015 but was statistically significantly above/better than the 2015 MMC weighted average is:

- Adolescent Well-Care Visits (Age 12-21 Years)

Measure that statistically significantly improved from 2014 to 2015 but was not statistically significantly different from the HEDIS 2015 MMC weighted average is:

- Controlling High Blood Pressure

■ C - No action required although MCOs should identify continued opportunities for improvement

Measure that statistically significantly improved from 2014 to 2015 but was statistically significantly below/worse than the 2015 MMC weighted average is:

- Reducing Potentially Preventable Readmissions⁴

Measures that did not statistically significantly change from 2014 to 2015 and were not statistically significantly different than the 2015 MMC weighted average are:

- Comprehensive Diabetes Care – HbA1c Poor Control⁵
- Prenatal and Postpartum Care – Timeliness of Prenatal Care

■ D - Root cause analysis and plan of action required

Measure that was statistically significantly worsened from 2014 to 2015 but was not statistically significantly different than the 2015 MMC weighted average is:

- Frequency of Ongoing Prenatal Care: $\geq 81\%$ of Prenatal Care Visits Received

■ F Root cause analysis and plan of action required

HPP's Emergency Department Utilization⁶ increased (worsened) from 2014 to 2015 and is higher (worse) than the 2015 MMC average.

⁴ Reducing Potentially Preventable Readmissions was a first year PA specific performance measure in 2012 (MY 2011). Lower rates are preferable, indicating better performance. This measure was added as a P4P measure in 2013 (MY 2012).

⁵ Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

⁶ A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

Figure 1 - P4P Measure Matrix – HPP

		Medicaid Managed Care Weighted Average Statistical Significance Comparison			
		Trend	Below Average	Average	Above Average
Year to Year Statistical Significance Comparison	↑	C Reducing Potentially Preventable Readmissions ⁷	B Controlling High Blood Pressure	A Annual Dental Visits	
	No Change	D	C Comprehensive Diabetes Care – HbA1c Poor Control ⁸ Prenatal and Postpartum Care – Timeliness of Prenatal Care	B Adolescent Well-Care Visits (Age 12-21 Years)	
	↓	F	D Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received	C	

Figure 2 - Emergency Department Utilization Comparison

		Medicaid Managed Care Average Comparison			
		Trend	Below/Poorer than Average	Average	Above/Better than Average
Year to Year	↑	F Emergency Department Utilization ⁹	D	C	

Key to the P4P Measure Matrix and Emergency Department Utilization Comparison

- A: Performance is notable. No action required. MCOs may have internal goals to improve.
- B: No action required. MCOs may identify continued opportunities for improvement.
- C: No action required although MCOs should identify continued opportunities for improvement.
- D: Root cause analysis and plan of action required.
- F: Root cause analysis and plan of action required.

⁷ Reducing Potentially Preventable Readmissions was a first year PA specific performance measure in 2012 (MY 2011). Lower rates are preferable, indicating better performance. This measure was added as a P4P measure in 2013 (MY 2012).

⁸ Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

⁹ A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

P4P performance measure rates for 2011, 2012, 2013, 2014 and 2015, as applicable are displayed in Figure 3. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

- ▲ Statistically significantly higher than the prior year,
- ▼ Statistically significantly lower than the prior year or
- = No change from the prior year.

Figure 3 - P4P Measure Rates – HPP

Quality Performance Measure	HEDIS 2011 Rate	HEDIS 2012 Rate	HEDIS 2013 Rate	HEDIS 2014 Rate	HEDIS 2015 Rate	HEDIS 2015 MMC WA
Adolescent Well Care Visits (Age 12-21 Years)	57.7% =	58.4% =	60.6% =	62.2% =	63.4% =	58.7%
Comprehensive Diabetes Care - HbA1c Poor Control ¹⁰	38.3% =	34.9% =	42.3% =	33.0% ▼	36.0% =	38.1%
Controlling High Blood Pressure	48.7% ▼	50.1% =	55.7% =	58.4% =	65.5% ▲	61.6%
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received	65.0% =	62.8% =	71.1% ▲	74.6% =	68.5% ▼	64.4%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	79.8% =	83.9% =	86.9% =	86.9% =	85.5% =	83.8%
Annual Dental Visits	57.2% ▲	56.8% ▲	61.9% ▲	64.2% ▲	70.3% ▲	58.2%
Quality Performance Measure	HEDIS 2011 Rate	HEDIS 2012 Rate	HEDIS 2013 Rate	HEDIS 2014 Rate	HEDIS 2015 Rate	HEDIS 2015 MMC AVG
Emergency Department Utilization (Visits/1,000 MM) ¹¹	76.5	79.7	80.2	80.0	81.0	74.0
Quality Performance Measure	PA 2011 Rate	PA 2012 Rate	PA 2013 Rate	PA 2014 Rate	PA 2015 Rate	PA 2015 MMC WA
Reducing Potentially Preventable Readmissions ¹²		16.0% NA	16.1% =	15.3% ▼	13.6% ▼	11.6%

¹⁰ Comprehensive Diabetes Care - HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

¹¹ A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

¹² Reducing Potentially Preventable Readmissions was a first year PA specific performance measure in 2012 (MY 2011). Lower rates are preferable, indicating better performance. This measure was added as a P4P measure in 2013 (MY 2012).

VI: Summary of Activities

Structure and Operations Standards

- HPP was found to be fully compliant on Subparts C, D, and F. Compliance review findings for HPP from RY 2014, RY 2013 and RY 2012 were used to make the determinations.

Performance Improvement Projects

- As previously noted, activities were conducted with and on behalf of DHS to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. HPP received information related to these activities from DHS in 2015.

Performance Measures

- HPP reported all HEDIS, PA-Specific and CAHPS Survey performance measures in 2015 for which the MCO had a sufficient denominator.

2014 Opportunities for Improvement MCO Response

- HPP provided a response to the opportunities for improvement issued in the 2014 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2014 P4P Measure Matrix receiving either “D” or “F” ratings

2015 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for HPP in 2015. A response will be required by the MCO for the noted opportunities for improvement in 2016.