



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

**2015 External Quality Review Report
UPMC for You**

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 UPMC for You's (UPMC'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 UPMC, 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 described 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, 85 items were evaluated and 41 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: UPMC 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.

UPMC was evaluated against 18 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 18. UPMC was found to be compliant in all eight of the categories of Enrollee Rights and Protections Regulations. UPMC 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 UPMC 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: UPMC 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 9 items and was compliant on 8 items and partially compliant on 1 item 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 12 items with 1 item under review 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 compliant on 1 item based on RY 2014.

UPMC was evaluated against 54 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on 51 items and partially compliant on 2 items, with 1 item under review. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, UPMC was found to be compliant in 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: UPMC 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

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

Accreditation Status

UPMC underwent an NCQA Accreditation Survey and was granted an Accreditation Status of Commendable effective through December 4, 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: UPMC for You

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.

One measure required additional validation during the review year for UPMC. Upon review of rates for the Reducing Potentially Preventable Readmissions (RPR) measure, the 2015 and 2014 rates for UPMC had been identified as outliers, with a notable decrease beginning in 2014 and continuing in 2015. Although lower rates are preferable and indicate better performance on this measure, the decreases warranted additional review. DHS requested that IPRO work with UPMC to identify issues and re-examine the data. As this measure uses components of the HEDIS Inpatient Utilization (IPU) measure, IPU is a useful comparative measure to evaluate internal consistency of reporting at the MCO, allowing for some differences in criteria. IPRO conducted comparative analyses of RPR and IPU for all MCOs, which confirmed some anomalies for UPMC. UPMC identified a number of issues with its identification of admissions to be included in the source data file. The MCO corrected the issues, and IPRO validated the data. The 2015 and 2014 RPR data presented for UPMC are the rates finalized at the end of the process. The validation process will be enhanced in 2016 to include comparative analyses of RPR and IPU for all MCOs.

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

One strength was noted for UPMC’s 2015 (MY 2014) Access/Availability of Care performance measures.

- UPMC’s 2015 rate for the Adult BMI Assessment (Age 18-74 years) measure was statistically significantly above the 2015 MMC weighted average by 9.3 percentage points.

There were no opportunities for improvement identified for UPMC’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)	8,533	8,360	98.0%	97.7%	98.3%	96.4%	+	97.0%	+	≥ 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 Months-6 Years)	33,422	30,186	90.3%	90.0%	90.6%	88.8%	+	88.6%	+	≥ 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7-11 Years)	23,958	22,207	92.7%	92.4%	93.0%	92.2%	n.s.	91.9%	+	≥ 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12-19 Years)	30,179	27,459	91.0%	90.7%	91.3%	90.4%	+	90.1%	+	≥ 50th and < 75th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20-44 Years)	44,460	38,285	86.1%	85.8%	86.4%	85.8%	n.s.	83.2%	+	≥ 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45-64 Years)	27,988	26,012	92.9%	92.6%	93.2%	92.1%	+	91.2%	+	≥ 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ Years)	658	582	88.4%	85.9%	91.0%	87.8%	n.s.	87.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Adult BMI Assessment (Ages 18-74 Years)	184	170	92.4%	88.3%	96.5%	88.5%	n.s.	83.0%	+	≥ 75th and < 90th percentile

Well-Care Visits and Immunizations

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

- Three Well-Care Visit and Immunizations measures for UPMC’s 2015 rates were statistically significantly higher than the MMC weighted averages.
 - Well-Child Visits in the First 15 Months of Life (≥ 6 Visits) – 11.1 percentage points
 - Body Mass Index: Percentile (Age 3 - 11 years) – 6.9 percentage points
 - Body Mass Index: Percentile (Total) – 5.0 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)	313	239	76.4%	71.5%	81.2%	75.1%	n.s.	65.2%	+	≥ 90th percentile
HEDIS	Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)	305	237	77.7%	72.9%	82.5%	76.5%	n.s.	76.4%	n.s.	≥ 50th and < 75th percentile
HEDIS	Childhood Immunization Status (Combination 2)	411	308	74.9%	70.6%	79.3%	78.6%	n.s.	75.8%	n.s.	≥ 25th and < 50th percentile
HEDIS	Childhood Immunization Status (Combination 3)	411	298	72.5%	68.1%	76.9%	75.4%	n.s.	72.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	405	228	56.3%	51.3%	61.3%	56.0%	n.s.	58.7%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Body Mass Index: Percentile (Age 3-11 Years)	248	187	75.4%	69.8%	81.0%	68.5%	n.s.	68.5%	+	≥ 50th and < 75th percentile
HEDIS	WCC Body Mass Index: Percentile (Age 12-17 Years)	132	93	70.5%	62.3%	78.6%	68.1%	n.s.	69.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Body Mass Index: Percentile (Total)	380	280	73.7%	69.1%	78.2%	68.4%	n.s.	68.7%	+	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Nutrition (Age 3-11 Years)	248	180	72.6%	66.8%	78.3%	73.9%	n.s.	70.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Nutrition (Age 12-17 Years)	132	83	62.9%	54.3%	71.5%	69.6%	n.s.	64.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Nutrition (Total)	380	263	69.2%	64.4%	74.0%	72.4%	n.s.	68.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Physical Activity (Age 3-11 Years)	248	151	60.9%	54.6%	67.2%	64.2%	n.s.	61.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Physical Activity (Age 12-17 Years)	132	77	58.3%	49.5%	67.1%	67.4%	n.s.	62.1%	n.s.	≥ 50th and < 75th percentile

HEDIS	WCC Counseling for Physical Activity (Total)	380	228	60.0%	54.9%	65.1%	65.3%	n.s.	62.0%	n.s.	≥ 50th and < 75th percentile
HEDIS	Immunizations for Adolescents (Combination 1)	229	194	84.7%	79.8%	89.6%	84.2%	n.s.	82.0%	n.s.	≥ 75th and < 90th percentile

EPSDT: Screenings and Follow-up

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

All of the EPSDT: Screenings and Follow-up performance measures for 2015 (MY 2014) were noted as strengths for UPMC.

- UPMC's rates for the following eleven EPSDT Screenings and Follow-up measures were statistically significantly above the 2015 MMC weighted averages:
 - Lead Screening in Children – 8.7 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase – 26.8 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 31.0 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase – 26.7 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 30.2 percentage points
 - EPSDT - Hearing Test (Age 4-20 years) – 7.8 percentage points
 - EPSDT - Vision Test (Age 4-20 years) – 7.5 percentage points
 - Developmental Screening in the First Three Years of Life: Total – 18.2 percentage points
 - Developmental Screening in the First Three Years of Life: 1 year – 18.8 percentage points
 - Developmental Screening in the First Three Years of Life: 2 years – 16.8 percentage points
 - Developmental Screening in the First Three Years of Life: 3 years – 19.7 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	270	232	85.9%	81.6%	90.3%	80.8%	n.s.	77.2%	+	≥ 75th and < 90th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	1,903	985	51.8%	49.5%	54.0%	45.8%	+	25.0%	+	≥ 75th and < 90th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	799	464	58.1%	54.6%	61.6%	53.0%	n.s.	27.1%	+	≥ 50th and < 75th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	1,903	1,006	52.9%	50.6%	55.1%	46.9%	+	26.2%	+	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	765	478	62.5%	59.0%	66.0%	55.2%	+	32.3%	+	NA
PA EQR	EPSDT Hearing Test (Age 4 20 Years)	91,706	44,195	48.2%	47.9%	48.5%	45.9%	+	40.4%	+	NA
PA EQR	EPSDT Vision Test (Age 4 20 Years)	91,706	44,169	48.2%	47.8%	48.5%	45.7%	+	40.7%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life Total ¹	21,830	14,233	65.2%	64.6%	65.8%	64.5%	n.s.	47.0%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year ¹	8,281	5,083	61.4%	60.3%	62.4%	60.8%	n.s.	42.6%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years ¹	6,929	4,688	67.7%	66.5%	68.8%	68.3%	n.s.	50.9%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years ¹	6,620	4,462	67.4%	66.3%	68.5%	64.5%	+	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

There were no strengths noted for UPMC's 2015 (MY 2014) Dental Care for Children and Adults performance measures.

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

- Two Dental Care for Children and Adults measures for UPMC’s 2015 rates were statistically significantly lower than the MMC weighted averages.
 - Annual Dental Visit (Age 2–21 years) – 3.5 percentage points
 - Total Eligibles Receiving Preventive Dental Services – 4.1 percentage points

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	108,748	59,529	54.7%	54.4%	55.0%	53.2%	+	58.2%	-	≥ 50th and < 75th percentile
PA EQR	Total Eligibles Receiving Preventive Dental Treatment Services	146,153	62,373	42.7%	42.4%	42.9%	42.0%	+	46.8%	-	NA
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 Years)	7,367	3,657	49.6%	48.5%	50.8%	47.6%	+	50.6%	n.s.	NA

Women’s Health

There were no strengths noted for UPMC’s 2015 (MY 2014) Women’s Health performance measures.

The following opportunities for improvement were identified for the Women’s Health performance measures for 2015 (MY 2014):

- In 2015, UPMC’s rates were statistically significantly below the 2015 MMC weighted averages for the following three measures:
 - Chlamydia Screening in Women (Total) – 9.4 percentage points
 - Chlamydia Screening in Women (Age 16-20 years) – 8.9 percentage points
 - Chlamydia Screening in Women (Age 21-24 years) – 10.4 percentage points

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)	7,559	4,907	64.9%	63.8%	66.0%	65.9%	n.s.	63.3%	+	≥ 50th and < 75th percentile
HEDIS	Cervical Cancer Screening	360	240	66.7%	61.7%	71.7%	68.9%	n.s.	66.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Total)	10,556	5,272	49.9%	49.0%	50.9%	52.6%	-	59.3%	-	≥ 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 16-20 Years)	6,449	3,060	47.4%	46.2%	48.7%	48.9%	n.s.	56.3%	-	≥ 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Age 21-24 Years)	4,107	2,212	53.9%	52.3%	55.4%	57.9%	-	64.2%	-	≥ 10th and < 25th percentile
HEDIS	Human Papillomavirus Vaccine for Female Adolescents	411	106	25.8%	21.4%	30.1%	22.6%	n.s.	27.9%	n.s.	≥ 75th and < 90th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	10,395	433	4.2%	3.8%	4.6%	6.6%	-	2.6%	+	≥ 25th and < 50th percentile

Obstetric and Neonatal Care

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

- In 2015, UPMC’s rates were statistically significantly higher than the respective 2015 MMC weighted averages for the following thirteen measures:
 - ≥ 61% of Expected Prenatal Care Visits Received – 9.2 percentage points
 - ≥ 81% of Expected Prenatal Care Visits Received – 12.7 percentage points
 - Prenatal and Postpartum Care – Timeliness of Prenatal Care – 8.9 percentage points

- Prenatal Screening for Smoking – 10.6 percentage points
- Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 9.7 percentage points
- Prenatal Screening for Environmental Tobacco Smoke Exposure – 10.2 percentage points
- Prenatal Counseling for Smoking – 11.3 percentage points
- Prenatal Screening for Depression – 10.9 percentage points
- Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 11.6 percentage points
- Postpartum Screening for Depression – 10.3 percentage points
- Prenatal Screening for Alcohol use – 9.5 percentage points
- Prenatal Screening for Illicit drug use – 10.0 percentage points
- Prenatal Screening for Prescribed or over-the-counter drug use – 12.5 percentage points

There were no opportunities for improvement identified for UPMC'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	411	365	88.8%	85.6%	92.0%	95.4%	-	79.6%	+	NA
HEDIS	≥81% of Expected Prenatal Care Visits Received	411	317	77.1%	72.9%	81.3%	87.1%	-	64.4%	+	≥ 90th percentile
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	411	381	92.7%	90.1%	95.3%	93.2%	n.s.	83.8%	+	≥ 90th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	411	275	66.9%	62.2%	71.6%	71.3%	n.s.	62.2%	n.s.	≥ 50th and < 75th percentile
PA EQR	Prenatal Screening for Smoking	399	381	95.5%	93.3%	97.7%	91.4%	+	84.9%	+	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	399	374	93.7%	91.2%	96.2%	NA	NA	84.1%	+	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	399	184	46.1%	41.1%	51.1%	15.2%	+	35.9%	+	NA
PA EQR	Prenatal Counseling for Smoking	142	122	85.9%	79.8%	92.0%	60.9%	+	74.7%	+	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	184	88	47.8%	40.3%	55.3%	32.3%	+	51.3%	n.s.	NA
PA EQR	Prenatal Smoking Cessation	142	6	4.2%	0.6%	7.9%	8.2%	n.s.	8.8%	n.s.	NA
PA EQR	Prenatal Screening for Depression	399	320	80.2%	76.2%	84.2%	60.9%	+	69.3%	+	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	399	301	75.4%	71.1%	79.8%	NA	NA	63.8%	+	NA
PA EQR	Prenatal Screening Positive for Depression	320	55	17.2%	12.9%	21.5%	23.0%	n.s.	18.6%	n.s.	NA
PA EQR	Prenatal Counseling for Depression	55	44	80.0%	68.5%	91.5%	63.2%	+	72.1%	n.s.	NA
PA EQR	Postpartum Screening for Depression	255	216	84.7%	80.1%	89.3%	79.1%	n.s.	74.4%	+	NA
PA EQR	Postpartum Screening Positive for Depression	216	34	15.7%	10.7%	20.8%	17.0%	n.s.	14.7%	n.s.	NA
PA EQR	Postpartum Counseling for Depression	34	31	91.2%	80.2%	100.0%	83.3%	n.s.	85.8%	n.s.	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	2,106	507	24.1%	22.2%	25.9%	24.5%	n.s.	23.0%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	7,947	723	9.1%	8.5%	9.7%	8.4%	n.s.	9.5%	n.s.	NA
PA EQR	Prenatal Screening for Alcohol use	399	357	89.5%	86.3%	92.6%	NA	NA	80.0%	+	NA
PA EQR	Prenatal Screening for Illicit drug use	399	359	90.0%	86.9%	93.0%	NA	NA	80.0%	+	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	399	370	92.7%	90.1%	95.4%	NA	NA	80.2%	+	NA
PA EQR	Prenatal Screening for Intimate partner violence	399	213	53.4%	48.4%	58.4%	NA	NA	54.6%	n.s.	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	399	181	45.4%	40.4%	50.4%	NA	NA	41.7%	n.s.	NA

PA EQR	Elective Delivery ^{1,2}	1,866	258	13.8%	12.2%	15.4%	NA	NA	11.5%	+	NA
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¹ For the Elective Delivery measure, lower rate indicates better performance.

² Rates 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

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

- UPMC's 2015 rate for the Appropriate Testing for Children with Pharyngitis measure was statistically significantly above the 2015 MMC weighted average by 9.9 percentage points.
- UPMC's 2015 rates were statistically significantly below (better than) the MMC weighted averages for the following two measures:
 - Asthma in Younger Adults Admission Rate (Age 18-39 years) – 0.41 admissions per 100,000 member years
 - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years) – 2.22 admissions per 100,000 member years

The following opportunities for improvement for UPMC were identified among the 2015 (MY 2014) Respiratory Conditions performance measures:

- UPMC's 2015 rates were statistically significantly lower than the MMC weighted averages for the following three measures:
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 4.4 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 19-50 years) – 4.5 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 51-64 years) – 7.1 percentage points

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	5,139	4,022	78.3%	77.1%	79.4%	78.3%	n.s.	68.4%	+	≥ 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection ¹	10,100	1,342	86.7%	86.0%	87.4%	86.3%	n.s.	88.6%	-	≥ 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ²	2,452	1,885	23.1%	21.4%	24.8%	23.1%	n.s.	27.5%	-	≥ 25th and < 50th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	737	237	32.2%	28.7%	35.6%	29.4%	n.s.	29.8%	n.s.	≥ 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	475	361	76.0%	72.1%	79.9%	75.3%	n.s.	76.3%	n.s.	≥ 75th and < 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Bronchodilator	475	416	87.6%	84.5%	90.7%	82.3%	+	87.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 11 Years)	1,044	938	89.8%	88.0%	91.7%	90.9%	n.s.	91.7%	-	≥ 25th and < 50th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 12 18 Years)	794	693	87.3%	84.9%	89.7%	85.7%	n.s.	87.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 19 50 Years)	984	753	76.5%	73.8%	79.2%	71.6%	+	77.8%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 51 64 Years)	305	238	78.0%	73.2%	82.8%	70.3%	n.s.	75.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 64 Years)	3,127	2,622	83.9%	82.5%	85.2%	81.1%	+	85.3%	-	≥ 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5 11 Years)	938	329	35.1%	32.0%	38.2%	33.1%	n.s.	34.0%	n.s.	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12 18 Years)	693	252	36.4%	32.7%	40.0%	31.5%	n.s.	33.7%	n.s.	≥ 90th percentile

HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19-50 Years)	753	296	39.3%	35.8%	42.9%	36.9%	n.s.	43.8%	-	≥ 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51-64 Years)	238	123	51.7%	45.1%	58.2%	51.9%	n.s.	58.8%	-	≥ 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-64 Years)	2,622	1,000	38.1%	36.3%	40.0%	35.4%	n.s.	38.6%	n.s.	≥ 75th and < 90th percentile
PA EQR	Annual Percentage of Asthma Patients (Age 2-20 Years) with One or More Asthma Related ER Visit ³	9,878	1,112	11.3%	10.6%	11.9%	9.7%	+	13.1%	-	NA
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years)	863,366	84	0.81	0.64	0.98	0.71	n.s.	1.22	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) ⁴	575,446	501	7.26	6.62	7.89	8.87	-	9.47	-	NA

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

² Per NCQA, 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

Seven strengths were noted for Comprehensive Diabetes Care performance measures for 2015 (MY 2014).

- UPMC's 2015 rates were statistically significantly above the MMC weighted averages for the following four measures:
 - HbA1c Good Control (<7.0%) – 5.9 percentage points
 - Retinal Eye Exam – 9.7 percentage points
 - Medical Attention for Nephropathy – 8.2 percentage points
 - Blood Pressure Controlled <140/90 mm Hg – 6.7 percentage points
- UPMC's 2015 rates were statistically significantly below (better than) the MMC weighted averages for the following three measures:
 - HbA1c Poor Control (>9.0%) – 5.7 percentage points
 - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) – 0.47 admissions per 100,000 member years
 - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) – 0.47 admissions per 100,000 member years

There were no opportunities for improvement identified for UPMC's 2015 (MY 2014) Comprehensive Diabetes Care performance measures.

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	548	484	88.3%	85.5%	91.1%	86.9%	n.s.	85.5%	n.s.	≥ 50th and < 75th percentile	
HEDIS	HbA1c Poor Control (>9.0%) ¹	548	178	32.5%	28.5%	36.5%	30.1%	n.s.	38.1%	-	≥ 75th and < 90th percentile	
HEDIS	HbA1c Control (<8.0%)	548	294	53.6%	49.4%	57.9%	56.0%	n.s.	51.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	HbA1c Good Control (<7.0%)	411	176	42.8%	37.9%	47.7%	40.0%	n.s.	36.9%	+	≥ 90th percentile	
HEDIS	Retinal Eye Exam	548	361	65.9%	61.8%	69.9%	59.5%	+	56.2%	+	≥ 75th and < 90th percentile	
HEDIS	Medical Attention for Nephropathy	548	499	91.1%	88.6%	93.5%	88.3%	n.s.	82.9%	+	≥ 90th percentile	
HEDIS	Blood Pressure Controlled <140/90 mm Hg	548	393	71.7%	67.9%	75.6%	70.3%	n.s.	65.0%	+	≥ 75th and < 90th percentile	

PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 18-64 Years) per 100,000 member years	1,428,003	255	1.49	1.31	1.67	1.48	n.s.	1.96	-	NA
PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 65+ Years) per 100,000 member years	10,809	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	1,438,812	255	1.48	1.30	1.66	1.46	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

Three strengths were noted for UPMC's 2015 (MY 2014) Cardiovascular Care performance measures.

- UPMC's 2015 rate for the Controlling High Blood Pressure (Total Rate) measure was statistically significantly above the 2015 MMC weighted average by 6.4 percentage points.
- UPMC's 2015 rates were statistically significantly below (better than) the MMC weighted averages for the following two measures:
 - Heart Failure Admission Rate (Age 18-64 years) – 0.47 admissions per 100,000 member years
 - Heart Failure Admission Rate (Total Age 18+ years) – 0.49 admissions per 100,000 member years

There were no opportunities for improvement identified for Cardiovascular Care performance measures for 2015 (MY 2014).

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	136	114	83.8%	77.3%	90.4%	90.2%	n.s.	89.5%	n.s.	≥ 25th and < 50th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	366	249	68.0%	63.1%	72.9%	67.6%	n.s.	61.6%	+	≥ 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate ¹ (Age 18-64 Years) per 100,000 member years	1,428,003	218	1.27	1.10	1.44	1.24	n.s.	1.74	-	NA
PA EQR	Heart Failure Admission Rate ¹ (Age 65+ Years) per 100,000 member years	10,809	5	3.85	0.48	7.23	8.88	n.s.	4.61	n.s.	NA
PA EQR	Heart Failure Admission Rate ¹ (Total Age 18+ Years) per 100,000 member years	1,438,812	223	1.29	1.12	1.46	1.30	n.s.	1.78	-	NA

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

Utilization

One strength was noted for UPMC's 2015 (MY 2014) Utilization performance measures:

- UPMC's 2015 rate for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) measure was statistically significantly above the 2015 MMC weighted average by 3.1 percentage points.

There were no opportunities for improvement identified for UPMC's 2015 (MY 2014) Utilization performance measures.

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	23,116	2,378	10.3%	9.9%	10.7%	11.3%	-	11.6%	-	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	790	587	74.3%	71.2%	77.4%	71.2%	n.s.	71.4%	n.s.	≥ 75th and < 90th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	1,299	971	74.7%	72.3%	77.2%	75.5%	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 UPMC 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)	83.25%	▲	78.64%	▲	77.81%	77.96%
Getting Needed Information (Usually or Always)	81.46%	▲	79.17%	▼	79.34%	83.20%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	77.51%	▲	75.15%	▲	71.22%	73.31%
Appointment for Routine Care When Needed (Usually or Always)	82.77%	▼	84.24%	▼	86.91%	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)	86.58%	▼	86.75%	▲	85.90%	84.38%
Getting Needed Information (Usually or Always)	84.78%	▲	83.94%	▲	82.79%	82.42%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	87.50%	▲	84.75%	▲	83.33%	86.13%
Appointment for Routine Care When Needed (Usually or Always)	94.79%	▲	91.97%	▼	93.31%	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 UPMC.

Table 5.1 presents UPMC'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: UPMC 2014.01: The Reducing Potentially Preventable Readmissions PIP received partial credit for the element of study evaluated in 2014 that reflects activities in 2013: Sustained Improvement.
<p>Follow Up Actions Taken Through 09/30/15:</p> <p>MEMBER/MCO INTERVENTIONS:</p> <p>01/01/2014 TO 09/30/2015 – Advanced Illness Care Program. UPMC <i>for You</i> continued to sponsor an Advanced Illness Care Program for members who are coping with serious or advanced illnesses. This program was provided in collaboration with UPMC Community Provider Services and UPMC Palliative and Supportive Institute. Advanced Illness Care was a home-based supportive and care management program. This program provided members with advanced care planning, articulation, and communication of individual goals of care. Additionally the program focused on symptom management, comfort, and stressed collaboration of the decision making processes between the members and their PCP. Advanced Illness Care optimized member quality of life by helping members cope with complications and treatment of their illness. Home-based care teams [registered nurses (RN) and social workers (SW)], provided in collaboration with certified registered nurse practitioners (CRNP), where appropriate, conducted home visits with members. The visits addressed the goals of care conversation, advanced care planning, including physician orders for life sustaining treatment (POLST), and symptom management.</p> <p>01/01/2014 to 09/30/2015 – Care Through Transitions (CTT). The Plan's Care Through Transitions program continued. This program was based on an interdisciplinary model of care designed to optimize transitions in care, up to 30 days post-skilled nursing facility discharge. The program included collaboration between 13 of the Plan's network skilled nursing facilities and featured on-site CRNP clinical evaluation and management of acute and chronic illnesses, including geriatric syndromes. UPMC <i>for You</i> provided on-site Clinical Care Managers as a part of the interdisciplinary team. The Care management and Interdisciplinary Team interventions worked together to maximize member health outcomes and promote member independence. The Clinical Care Managers assist with the development of realistic care plans, helped the members reach shared goals and set expectations of care to achieve a safe, coordinated and effective SNF discharge plan. CTT also collaborated with UPMC Visiting Nurses Association and the member's PCP with the goal of preventing potentially avoidable re-hospitalizations and emergency department visits during SNF stay and 30-days post SNF discharge.</p> <p>01/01/2014 to 09/30/2015 – Community Teams. The Community Team staff continued to address the needs of members who had a high number of hospital and emergency room visits by assessing physical and behavioral health needs. The Program continued to expand in 2015. The Community Team continued to be comprised of nurses, social workers, certified peer specialists, and pharmacists. The program utilized the framework of the Substance Abuse and Mental Health Services Administration (SAMHSA's) Eight Dimensions of Wellness to enhance the members' overall health and recovery. The eight dimensions utilized were: 1. Emotional – Coping effectively with life and creating satisfying relationships; 2. Environmental – Good health by occupying pleasant,</p>

stimulating environments that support well-being; 3. Financial – Satisfaction with current and future financial situation; 4/ Intellectual – Recognizing creative abilities and findings ways to expand knowledge and skills; 5. Occupational – Personal satisfaction and enrichment from one’s work; 6. Physical – Recognizing the need for physical activity, healthy foods, and sleep; 7. Social – Developing a sense of connection, belonging, and a well-developed support system; and 8. Spiritual – Expanding a sense of purpose and meaning in life. A team of Community Workers and provider based programs continued to focus on preventing avoidable readmissions.

01/01/2014 to 09/30/2015 – Congestive Heart Failure (CHF) Telehealth (Telemonitoring) Program continued. The program assisted members on self management techniques of the CHF with the goal of preventing hospital admissions and readmissions.

01/01/2014 to 09/30/2015 – Health Management. *UPMC for You* continued to have Case Management/Health Management programs for:

- Diabetes.
- Cardiac (A-fib, CAD, CHF, Hypertension, Hyperlipidemia).
- Low Back Pain.
- Rare and Chronic (MS, Epilepsy, IBD, RA, Sickle Cell, Hemophilia, Hep-C, Parkinson’s).
- Respiratory (Asthma and COPD).
- Lifestyle Management Programs (Weight Management, Tobacco Cessation, Nutrition, Physical Activity, and Stress Management).

These continued to be offered to members identified through DHS enrollment data, provider referrals, claims and member self-referral. The program continued to offer letters, program materials and case management services to members enrolled in the program. These programs are to promote wellness and appropriate use of services including inpatient care and working to reduce potentially preventable readmissions. (See Prescription for Wellness under Provider Interventions below).

01/01/2014 to 09/30/2015 – HEDDS UP PROGRAM continued. The *UPMC for You* High-Emergency (ED) Drug Seeking Utilization Protocol (HEDDS UP Program) was developed in response to a recognized subgroup of members with a pattern of very high and increasing ED use associated with narcotic use. Many of these members received narcotic prescriptions from multiple providers, filled them at multiple pharmacies, have multiple ED visits, and many have had a high number of duplicative diagnostic tests including CT scans. Both office-based and ED physicians indicated they had been unaware of narcotic prescriptions from other providers. The program’s goals included increasing member safety by promoting safe and appropriate opioid prescribing, increasing member engagement and evaluation, and referring members to more appropriate medical and/or behavioral health services in order to meet their needs. Additional goals included reducing unwarranted utilization of Emergency Department services and diagnostic/lab testing, including potentially harmful radiation exposure from duplicative CT scans. Members with a utilization pattern that met the outlined criteria for the program were identified monthly in an automated stratification process. Identified members were flagged in the Plan’s electronic health record. A portion of the identified population with the highest ED and opioid use, were sent via stratification worklist items for further assessment and intervention through intensive care management. Care management outreach to relevant opioid-prescribing primary care and specialist physicians using a Provider Notification Form (PNF) was the key to the success of this program. The purpose of the PNF was to detail the member’s medical visit and prescription utilization activity that identified them as eligible for the program. Care coordination members included care manager outreach telephonically and through correspondence when appropriate to:

- ED medical directors.
- Urgent Care providers.
- Physician care providers (PCPs) and specialists involved the care of the member.
- Transitional Coordinators (TCs), Practice Base Care Managers (PBCMs).
- Health Plan Pharmacist.
- Special Investigation Unit (SIUI) (if appropriate) for restriction of providers and pharmacies for MA members.

Members were contacted via phone or letter if unable to reach telephonically. Assessments were completed and members were linked to appropriate services. Follow-up calls to both the members and Providers (including Specialists as appropriate) occurred on a monthly basis or as deemed necessary by the care manager.

09/15/2014 to 09/30/2015 – Home Transitions Program continued. *UPMC for You* continued to collaborate with UPMC Community Provider Services, UPMC Visiting Nurses Association, and the Palliative and Supportive Institute to provide the Home Transitions Program. Home Transitions was a home health care management program designed to reduce potentially avoidable 30-day readmissions for those identified as moderate to high risk for readmission. Home Transitions was designed for members who were receiving skilled home health services and who had been identified as Moderate-High risk for 30-day readmission at the time of hospital or SNF discharge. Home Transitions provided care management predicated on evidenced-based, high risk clinical predictive triggers and principles of care to prevent complications. The program worked to identify changes in condition/deterioration, and interceded with the skilled home health plan of care. All care was done in collaboration with the member’s PCP. Home Transitions

offered skilled home health visits with increased timeliness post-hospital or post-SNF discharge and reviewed frequency of visits. Home Transitions focused care coordination efforts and included additional member assessments (functional status, social needs, and home safety), communication tools, and medication reconciliation done through collaboration with pharmacy staff. CRNPs were also available, where appropriate, to provide in-home interventions to address high-risk triggers for readmission. Nurse and Social Worker training focused on ways to continue to improve care coordination and avoid additional readmissions. The program also included collaboration with the member, their PCP, the program's Medical Director, the Plan's Patient Centered Medical Home, and if needed, the Plan's Pharmacy team to set goals for the member's care. (See Patient Centered Medical Home in the provider section below.)

07/01/2015 to 09/30/2015 – UPMC Total Care Inflammatory Bowel Disease (IBD) Specialty Medical Home. This program provided high quality, comprehensive, cost effective, patient centered health care for patients diagnosed with IBD. The essential functions included:

- Providing members with the ability to have an established relationship with a physician who is trained to provide first contact continuous and comprehensive care.
- Providing members with care for acute and chronic conditions, preventive services, end of life care and/or arrange for other professionals to provide these services.
- Utilizing patient registries/information technologies to coordinate care across the health system.
- Providing enhanced access to care through systems such as open scheduling, expanded hours, and the use of telemedicine.

01/01/2014 to 09/30/2015 – Increased Case/Health Management in all zones continued. The program continued to focus on members' connection with their PCP or their medical home. The program focused on understanding members' physical health needs, educating members about their gaps in preventive care, and addressed barriers to getting care. Case managers also worked with members to address visual/hearing/special communication needs that may have been barriers to getting care. Additionally, the team worked with members' caregivers, family support of social support services, as appropriate. Case Managers continued to assist members with medication reconciliation, financial concerns, and transportation issues. Care plans continued to be developed and reviewed with the member at each contact.

01/01/2014 to 09/30/2015 – Maternity Program continued. The UPMC *for You* New Beginnings Maternity program case managers continued to routinely assess the issue of unplanned care as part of the prenatal health review. Members were educated on the appropriate use of and alternatives to urgent care and emergency utilization such as 24/7 Advice Line and Anywhere Care. Members were assisted with selection of a PCP and/or OB/GYN. The program included educating members on signs and symptoms of illness and when to contact their PCP or OB/GYN or other applicable healthcare providers. Education also focused on optimizing health and wellness and self-management of chronic conditions to prevent avoidable hospital admissions and pregnancy complications.

01/01/2014 to 09/30/2015 – Member newsletter articles – articles entitled:

- **Spring 2015**—*7 ways to take your medication right* – focused on medication adherence and the importance of taking medications as prescribed. Article – *Teamwork: work with your doctor* (focused on the importance of coordination of care with physical health and behavioral health providers).

01/01/2014 to 09/30/2015 – Staying at Home Program continued. UPMC *for You* continued to collaborate with UPMC Community Provider Services to promote the Staying-At-Home Program (SAH). The program's aim was to assess the health status of the most complex or frail clients who may benefit from the support of a community based interdisciplinary care management team. UPMC SAH was a client-centered, care coordination program offered to older adults living in their own homes.

SAH provided:

- RN and SW home visits and telephonic care management interventions.
- RN Medication Management.
- Linkage with community resources and transportation.
- Interdisciplinary Team (RN, SW, Geriatrician, and Pharmacist) review and PCP recommendations.

SAH Goals:

- Maintain the members'/clients' safely in their home environment.
- Facilitate PCP visits and care coordination amongst providers.
- Prevent potentially avoidable Emergency Department visits and acute hospitalizations.
- Provide individual goal setting and assist with advanced care planning and with utilizing a shared care plan.

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015 – Optimal Discharge Program continued. UPMC *for You* found that engaging members and providing education when they are still inpatient at a facility improved their understanding of their condition and effectively reduced 30 day readmission rates by 2.8%. Transition Coordinators through the Optimal Discharge Planning Program provided extensive education

to these members regarding any existing and new diagnoses or changes in their treatment plans. Transition Coordinators also reviewed the members' discharge instructions and assessed their understanding of their discharge plans.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes. The program continued to address members' physical, behavioral and social needs. PBCM contacted members following emergency department visits to assess for ongoing care needs and assisted members to schedule an appointment within five days following discharge. The staff also assisted members who were hospitalized in finding specialists, connect with community services, coordinate care with other providers and agencies. The staff assisted members in arranging for medical transportation and county transportation services; scheduling preventive appointments, and enrolling in appropriate health or lifestyle management programs. One of the primary goals the PBCM was to work with the members to reduce potentially preventable readmissions. (See Shared Savings Section below.)

01/01/2014 to 09/30/2015 – Optimal Discharge Planning and PBCM Five Day Post Discharge Follow Up Programs continued. The TC and PBCM continued to have tools in place to know real-time when an inpatient utilization occurred. The TC offered to schedule the PCP appointment prior to the members being discharged from the hospital and the PBCM continued to utilize the data to conduct member outreach to schedule them with their PCP within five days of discharge. The PBCM and Transition Coordinators affiliated with the Optimal Discharge Planning program continued to work together to assist members and work to reducing potentially preventable readmissions.

01/01/2015 to 09/30/2015 – Prescription (RX) For Wellness Program. This program continued to be offered to providers utilizing the EpicCare software. Providers were encouraged to prescribe a wellness program or health management program for UPMC *for You* members. The program was developed based on literature which found that patients were more likely to follow through with participation in a health/care management program if it was prescribed by their doctor. UPMC *for You* providers were educated about the program through newsletter articles (see below) and through interactions with their UPMC *for You* Physician Account Executive. Providers not on EpicCare were able to utilize the Prescription for Wellness beginning in March 2015 from the Plan's Provider Portal (website). Beginning in 2nd Quarter 2015, the Plan staff was able to initiate two way conversations with providers utilizing both EpicCare and the portal version.

01/01/2014 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **02/2014:** *Quality Corner Readmissions Revisited* (focused on use of a discharge checklist).
- **05/2014:** *Celebrating National Nurses Week, May 6-12 – We highlight two programs build around the passion and expertise of nurses* (included details of the Community Team and Staying at Home Programs).
- **11/2014:** *A new kind of RX – Prescription for Wellness brings health management support to your patients—Fast* (focus on program where providers who have EpicCare can give members a prescription for a wellness program – including all plan health and case management programs. Direction for providers who do not have EpicCare was also included).
- **12/2014:** *New tool to help COPD patients avoid hospital readmission (which focuses on the UPMC COPD pathway team's SMART Tool[®].)*
- **03/2015:** *Quality Corner, Preventing COPD readmissions* (focused on provider driven interventions with members with COPD that are designed to promote member health and prevent hospital admissions and readmissions) and *Now available on Provider Online: Prescription for Wellness – Use your influence to guide patients to good health* (focused on providers offering members a prescription to join one of the Plan's health or case management programs).
- **06/2015:** *Stay up to date on policy changes* [focused on providers reviewing the Provider Manual and other UPMC Health Plan (including UPMC *for You*) provider materials which are relevant to their care of members].
- **07/2015:** *We make a great team – Health Plan programs that support your efforts every day* (focused on offering members health management programs and the ability to work with a health coach to understand their condition and identify and manage symptoms).
- **08/2015:** *Update on Prescription for Wellness* (focused on providers offering members a prescription to join one of the Plan's health or case management programs).

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to contain information on the availability of case management programs. The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of the availability of the Provider Manual continued to be published in the provider newsletter.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access.

Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on how to avoid unplanned care.

01/01/2015 to 09/30/2015 – Shared Savings Providers Reviews of Inpatient and Readmission Data continued. Providers in the Plan's Shared Savings Program continued to receive data about their performance regarding hospital admissions and readmissions. Additionally, the Shared Savings practices received monthly clinical reports that included a Care Need Index predictive model score for each member in the patient panel. A high Care Need Index score was indicative of members at risk of high costs, including readmissions in the relatively near future. Combined with claims data from the Health Plan and clinical/lab data from the UPMC Health System electronic medical records (EMR), the reports provided the Shared Savings practices with a powerful tool to predict readmission risk. This information is provided to practices to focus their efforts on those at greatest risk and to coordinate care and optimal timing of follow-up with their patients. As of July 2015, the UPMC *for Your* Shared Savings program increased from 21 to 32 practices, office sites increased from 411 to 582. Seventy-four Practice Base Care Managers supported the program (See Patient Centered Medical Home Section above).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/15 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical and Quality teams.

- Community Team – UPMC *for You* will continue to look to expand the Community Teams.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/15 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical and Quality teams.

- **Optimal Discharge Program** – UPMC *for You* will continue to look for hospital locations across the HealthChoices zone in which to expand the Optimal Discharge Program.
- **Patient Centered Medical Home Expansion** – UPMC *for You* will continue to expand the PCMH program into PCP, pediatric and OB/GYN practices. New programs are being explored for the Lehigh/Capital zone.
- **Shared Savings Program for Providers** – UPMC *for You* will explore expansion of the Provider Shared Savings program to additional pediatric practices and to additional practices in the Lehigh/Capital zone.
- **Super User Strategy** – UPMC *for You* will explore ways to direct care for members who are not attached to a Shared Savings Practice or a Patient Centered Medical Home group and who have high rates of unplanned care, hospital admissions and readmissions. The Plan will work with the members and their providers to promote health management/care management participation and will assist in linking members to community resource programs that may help them overcome barriers to preventive care. The program is designed to promote better outcomes for members, reduce potentially preventable readmissions, as well as avoidable costs of care.

GOALS/OUTCOMES

The expected program goals/outcomes are to improve member outcomes by reducing potentially preventable hospital admissions for members. Secondary goals include improving rates in the related HEDIS and Pennsylvania (PA) Performance measures.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included the metrics:
 - Plan All Cause Readmissions (PRC).
 - Inpatient Hospital Utilization (IHU).
 - Other HEDIS measures as appropriate.

These measures continued to be collected and analyzed to determine performance trends and the need for interventions. Additionally data from the Pennsylvania Performance Measures (PAPM) continued to be analyzed. These measures included:

- Reducing Potentially Preventable Readmissions (RPR).
- Other PAPM as appropriate.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.

- Both member and provider satisfaction results are reviewed and analyzed annually by UPMC *for You* Senior Leadership.

Reference Number: UPMC 2014.02: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Annual Dental Visit (Age 2–21 years) measure.

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015 – Clark Resources (Vendor). UPMC *for You* continued to utilize the vendor Clark Resources outreach calls to members' parents/guardians of children ages 3-20. The Clark team assisted parents/guardians with scheduling appointments for one or more children in their household. The lists were stratified to include households where one or more of the children had high dental utilization costs previously. The outreach representatives also conducted reminder calls prior to the appointments.

01/01/2014 to 09/30/2015 – CYS/JPO Outreach. CYS/JPO outreach continued under the Plan's Special Needs/EPSTDT programs. UPMC *for You* staff continued to meet with representatives from CYS/JPO to promote EPSTDT care for children in these programs. Among the topics discussed were dental care goals for members to verify that care will begin at age one or by eruption of first tooth and continue as the child ages. The program promoted establishing a dental home for the child/children.

2nd Quarter 2015 – Dental awareness postcard. An educational postcard was mailed in April 2015 to parents/guardians of members ages 1-3 years about the importance of dental care, starting at eruption of the first tooth. The card also included information on the importance of establishing a dental office home. The Plan mailed 31,000 postcards, once to every household with a UPMC *for You* member age three and under.

01/01/2014 to 09/30/15 – Distribution of Brochures and Educational Materials Focused on Dental Health. UPMC *for You* continued to distribute *Show off Their Smiles* brochure to members during case management outreach. The brochure was also distributed at community events. Beginning in June 2015, UPMC *for You* added a section on the importance of dental care for expectant women and children in the Welcome Kit for the Plan's New Beginnings Maternity Program. As part of the New Beginnings Programs, the health coach worked with the expectant women to assess their dental needs for and stressed the importance of dental care for their children – including care for the baby when he/she had eruption of his/her first tooth.

01/01/2014 to 09/30/2015 – EPSTDT Outreach Calls to Members. These calls continued to be made reminding parents/guardians that their children were due for an EPSTDT screen (included dental evaluation). If the parent/guardian selected the option to speak to a UPMC *for You* staff member, the staff assisted the caller with locating a provider and scheduling an appointment. If staff assisted in scheduling an appointment, they would make a reminder call to the family within one to two business days of their scheduled dental appointment date.

01/01/2014 to 09/30/2015 – Head Start Program. UPMC *for You* continued to share data on member gaps in dental care with designated Head Start organizations. The goal was to leverage resources from both the Health Plan and the Head Start program to close the children's gap in dental care.

01/01/2014 to 09/30/2015 – Member Handbook. UPMC *for You* continued to include several sections in the Member Handbook regarding dental care. Sections included a section entitled *Dental Benefits, Dentists, Vision/Dental, and Services for Children through Age 20 – What is an Early and Periodic Screening, Diagnosis, and Treatment (EPSTDT) Exam*. The sections focused on need for care, establishing a dental home, and benefits offered under the UPMC *for You* dental program.

01/01/2014 to 09/30/2015 – Member newsletter articles – articles entitled:

- **Spring 2014:** *Benefit information is online (included information about the Member Handbook availability (dental health information) and the Pediatric Preventive Care Guidelines (dental).*
- **Fall 2014:** *Benefit information is online (included information about the Member Handbook availability (dental health information) and the Pediatric Preventive Care Guidelines (dental).*
- **Spring 2015:** **Benefit Information is Online** *(included information about the Member Handbook availability (dental health information) and the Pediatric Preventive Care Guidelines (dental).*

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015 – Access for Medical Assistance members to dental providers. UPMC *for You* continued to partner with dental administrator, Avesis, to promote access to routine and specialty dental care. Avesis continued to recruit pediatric dentists to serve members in all zones. Avesis partnered with UPMC *for You* to notify dental providers of important programs and initiatives including information about provider incentives and the importance of seeing children at the eruption of their first tooth. Methodology for education included written communication and face-to-face meetings with Avesis staff.

01/01/2014 to 09/30/2014 – Early Periodic Screening and Diagnostic Testing (EPSTDT) quarterly rosters. UPMC *for You* continued to

send quarterly EPSDT rosters included dental gaps for members who are ages 0 to 21 to members' PCPs and, if the child was in substitute care, the gap rosters were also sent to the appropriate Children and Youth Services (CYS) representative. The data included a reminder of when the child was due for an EPSDT visit or if the child was overdue. As part of the PESDT screening, it is recommended that PCPs refer children for their first dental examination at the time of the eruption of the first tooth and no later than 12 months of age. UPMC *for You* received a referral via fax or telephone call from the PCP when they make a dental referral [see Provider Pay for Performance (P4P) Dental Incentive below].

1st Quarter 2015 – Federally Qualified Health Center (FQHC) Collaboration. Starting in March 2015, UPMC, *for You* began a partnership with the Sto-Rox Neighborhood Family Health Center, which is a Federally Qualified Health Center (FQHC) located in Allegheny County. The partnership utilized Community Based Care Management funding to employ a full time outreach coordinate within the FQHC's two offices. The outreach coordinator contacts members/families of UPMC *for You* members ages one through 21 to assist in facilitating a dental appointment and connected members to participating dentists within the service area.

01/01/2015 to 09/30/2015 – High Volume Pediatric Practice Care Coordination. Starting in 2015, UPMC *for You* funded 2.5 Full Time Employee (FTE) Care Coordinators within high volume PCP practices, including the General Academic Pediatric (GAP) practice and two Children's Community Care Pediatric (CCP) practice locations. These coordinators worked to increase pediatric well visits and close gaps in dental care by face to face interactions. The coordinators reviewed practice member rosters for dental gaps and placed outreach calls to the families. The calls included information on oral health education and assistance in scheduling appointments.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes, including review of children's gaps in dental care. (See Shared Savings below).

01/01/2014 to 09/30/2015 – Provider Continuing Education Programs. Starting in 2014, UPMC *for You* developed and piloted provider continuing education programs in an effort to increase the number of network dentists willing to see members under the age of 3. UPMC *for You*, through a partnership with University of Pittsburgh Dental School and the Head Start Association of Pennsylvania offered a continuing education program entitled *Connect the Dots*. The program focused on the importance of dental care for members at age one or eruption of first tooth. The *Connect the Dots* program provided an overview of the importance of infant/toddler oral health in the prevention of early childhood dental carries. The program included hands on practice and demonstration of the knee to knee dental exams and included examples of how to bill for the infant/toddler exams. Two *Connect the Dots* programs were held in November 2014 – one at the University of Pittsburgh – Pittsburgh Campus and one at UPMC Hamot Erie. Forty-five participants attended the Pittsburgh session and 83 attended in Erie.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on the components of EPSDT care, which include dental metrics.

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to contain the following information:

- Requirements for Early Periodic Screening, Diagnosis and Treatment and Services (EPSDT) including dental care.
- A recommendation to see children starting at the eruption of the first tooth.
- The Periodicity Recommendations from the Commonwealth of Pennsylvania, Department of Public Welfare/ Department of Human Services, and Office of Medical Assistance Programs.
 - These recommendations continued to discuss the need for clinical oral examinations for children, prophylaxis/topical fluoride treatment, radiographic assessment, assessment for pit and fissure sealants, treatment of dental disease/caries risk assessment.
 - The information also contained recommendations for anticipatory guidance for appropriate oral hygiene
- Availability of Pediatric Clinical Practice Guidelines (which include dental care).
- Availability of pay for performance measures (incentives) (including those related to children's dental care).

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.
- A separate EPSDT periodicity schedule continued to be available to providers online.

01/01/2014 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **06/2014:** *Simple procedure can help your pediatric patients* (focus on application of fluoride varnish) and *Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more* (included EPSDT with dental reminders).
- **08/2014:** *Quality Corner Preventing dental carries in children.*
- **10/2014:** *A reminder of resources and guidelines* (included Pediatric preventive guidelines which include dental).
- **02/2015:** *February is National Children’s Dental Health Month.*
- **05/2015:** *Quality Corner Dental care during pregnancy* (included information on the need for care for *Young* children) and *Help prevent early childhood caries diseases.*
- **06/2015:** *Stay Up to Date on policy a change* (included information about EPSDT visits and the availability of Pediatric Preventive Health Guidelines).

01/01/2014 to 09/30/2015–Provider Pay for Performance (P4P) Dental Incentive. Provider incentives UPMC *for You* continued to recognize the important role that primary care physicians played in influencing member dental utilization and oral health education. The 2014 provider pay for performance program (which is based on the member being in the denominator for the HEDIS measure and closing the gap in care) featured:

2014 Provider P4P – Dental, PCP (HEDIS age range)

- $\geq 55\%$ of gaps closed = \$4 per denominator member
- 51%-54.99% of gaps closed = \$2 per denominator member
- $< 51\%$ = no payment

2014 Provider P4P – Dental, Dentist (HEDIS age range)

- \$5 per closed gap, all regions

The program was expanded in 2015 and featured:

2015 Provider P4P – Dental, PCP (HEDIS ages 2-21, preventive age one)

- \$5 per member – HEDIS age range
- \$5 per member – age one (preventive)

2015 Provider P4P – Dental, Dentist (HEDIS ages 2-21, preventive age one)

- \$30 per closed HEDIS gap, ages 1-3
- \$20 per closed HEDIS gap, ages 4-21

In this process if a member was eligible (was in the denominator of the HEDIS measure) and received the appropriate dental service, UPMC *for You* paid the assigned practice the incentive payment regardless of whether that member was on a quarterly roster. Dentists received incentives based on claims data showing closed gaps in care for members active as of the end of the calendar quarter. Both PCP and dental providers received information about the availability of incentives and will continue to receive updates as appropriate.

01/01/2015 to 09/30/2015 – Shared Saving Providers program continued. Providers in the Plan’s Shared Savings Program continued to receive data about their performance regarding closing children’s dental gaps. As of July 2015, the UPMC *for You* Shared Savings program increased from 21 to 32 practices, office sites increased from 411 to 582. Seventy-four Practice Base Care Managers supported the program.

3rd Quarter 2015 – Sharon Dental Days. UPMC *for You* partnered with a high volume pediatric practice in Sharon, PA to [host] a Dental Day. The event featured a mobile dental van to help close dental gaps in care for children from that practice. Clark Resources and the provider scheduled the appointments. Over 20 members attended the event.

3rd Quarter 2015 – Text Reminders. UPMC *for You* started a dental reminder text messaging program for parents/guardians of Medical Assistance children when the parent/guardian has a TracFone. The messages are sent to the parent/guardian if the child is due for dental care within 45 days or is overdue for care. The texts were approved for use by DHS.

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams. Additional plans include:

- **Allegheny County Under Three Outreach Initiative.** Starting in Fall 2015, UPMC *for You* will implement a quarterly outreach

initiative entitled Allegheny County Under 3 Outreach. This program was created based on analysis for preventive dental gaps for pediatric members under the age of 3 who reside in Allegheny County. The program will feature UPMC *for You* staff contacting the parents/guardians of these members. Staff will assist them in setting up appointments with a pediatric dentist. The staff will utilize the Avesis Provider Directory to locate the parent/guardian on providers in their area who will see their child beginning at age one or eruption of their first tooth. The staff will also provide the parents/guardians with an overview of the importance of care starting at age one, by giving information from the American Academy of Pediatrics and American Dental association recommendations.

- **Head Start Program.** The Plan will explore developing new relationships with additional Head Start programs located throughout the zones.
- **Mobile Dental Outreach.** UPMC *for You* will review opportunities to develop new partnerships with the UPMC Health System Mobile Dental Van to close gaps in dental care for children. Additionally, the Plan is exploring opportunities with the St. Joseph's Health Ministry to utilize their mobile dental van for members in the Lancaster area.

FUTURE MCO INTERVENTIONS

10/01/2015 to 12/31/2015 – Staff training. UPMC *for You* will work with the physician account representatives and pediatric care managers to train them on changes to the dental recommendations, which included the need for dental care from age one or eruption of the first tooth. The information was designed to foster appropriate discussions between staff and members when discussing the importance of dental care for children.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams. Additional plans include:

- **AVESIS Collaboration.** UPMC *for You* will continue to collaborate with Avesis to discuss needs for dental care for children starting at age one. Plan staff will work with Avesis to speak to dental providers at their annual provider regional training sessions.
- **Community Based Care Management.** UPMC *for You* is working with DHS to gain approval to utilize grant monies to support Public Health Dental Hygiene Practitioners (PHDHPs) to increase member accessibility to dental education and increase dental utilization. If approved, the PHDHPs will be located in high volume pediatric practices Allegheny County without embedded dental support. The PHDHPs will perform care management duties within the practices. Care management duties will include providing in-person counseling and oral hygiene instruction, referrals to community dentists for comprehensive dental care, and referrals to community programs such as Head Start and other community organizations. The PHDHP program will begin pending review and approval from the Department of Human Services. The revised program proposal is expected to be submitted to DHS in 4th Quarter 2015. The Plan is working toward a 2016 go live date.
- **Patient Centered Medical Home Expansion –** UPMC *for You* will continue to expand the PCMH program into PCP and pediatric practices. New programs are being explored for the Lehigh/Capital zone.
- **Medical/Dental Provider Collaboration.** UPMC *for You* leadership and Avesis working to develop a program to bring pediatricians and dentists together to set up clinical “meet and greets”. The goal of these meetings will be to have the providers develop relationships and set up referral systems to increase access for children to both dental and medical services. Plans for this collaboration include identifying educational needs for medical practices and offering continuing education on opportunities such as applying topical fluoride varnish (Health Teeth, Health Children) and an age one dental visit demonstration/education (Connect the Dots). A tentative go live has been set for 4th Quarter 2015.
- **Shared Savings Program for Providers –** UPMC *for You* will explore expansion of the Provider Shared Savings program to additional pediatric practices and to additional practices in the Lehigh/Capital and Northwest zones.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member outcomes by increasing HEDIS and PA Performance Measure rates for dental visits.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:

- Annual Dental Visit (ADV).

These measures continued to be collected and analyzed to determine performance trends and the need for interventions. Additionally data from the Pennsylvania Performance Measures continued to be analyzed. These measures included:

- Annual Dental Visits For Members With Developmental Disabilities.
- Total Eligibles Who Received Preventive Dental Services.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
 - Additional dental specific questions will be continued to be monitored through the CAHPS survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.03: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Total Eligibles Receiving Preventative Dental Services measure.

Follow Up Actions Taken Through 09/30/15:

See above section "UPMC 2014.2"

Future Actions Planned:

See above section "UPMC 2014.2"

Reference Number: UPMC 2014.04: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Chlamydia Screening in Women – All Ages (Total, Age 16-20 years, and Age 21-24 years) measures.

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015 – Adult Preventive Guidelines and Pediatric Preventive Guidelines. Adult and pediatric preventive guidelines continue to be available to members on the Plan's website and in paper format, if requested. Both documents focused on the appropriate times to screen (annually for under age 25 if sexually active or pregnant) and screen women over 25 if they are at risk for infection or have inconsistent use of barrier contraception. Members are made aware of the guidelines at least annually through the member newsletter.

01/01/2014 to 09/30/2015 – Health Management. Health coaches continued to discuss gaps in care (including for chlamydia screen) with members who were engaged in health management programs at the Plan (i.e. Diabetes; Cardiac (A-fib, CAD, CHF, Hypertension, Hyperlipidemia); Low Back Pain; Rare and Chronic (MS, Epilepsy, IBD, RA, Sickle Cell, Hemophilia, Hep-C, Parkinson's); Respiratory (Asthma and COPD); and Lifestyle Management Programs (Weight Management, Tobacco Cessation, Nutrition, Physical Activity and Stress Management). Plan staff continued to educate on the importance of the screen and offered assistance to scheduling, if needed.

01/01/2014 to 09/30/2015 – Member Education (web based). Members continued to have web based educational materials available to them on Plan's public website and the private (secure log in) member portal. Information from member portal included information from WebMD which continued to be hosted on the site. The materials include information on chlamydia symptoms, risk factors, tests and diagnosis, treatment, and decision support. A symptom checker and medical encyclopedia are also available. Additionally, members who visit UPMC practitioners/providers may be given information from the UPMC Health System patient education library. Information about chlamydia, including information on the condition, testing and treatment are available. A video entitled *Why to get A Chlamydia Test* is also available for members through their providers/practitioners or by visiting UPMC.edu.

01/01/2014 to 09/30/2015 – Member Handbook. The Member Handbook continued to offer members information about the importance of chlamydia screening for women.

01/01/2014 to 09/30/2015 – Member newsletter articles – articles entitled:

- **Spring 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).
- **Fall 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).
- **Spring 2015:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).

Spring 2014 and Spring 2015 – Pediatric Health Living mailing. UPMC *for You* sent parents/guardians of member 0-17 years of age a preventive health quick reference guide for children. The documents included information on the importance of chlamydia screening.

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015 – Adult Preventive Guidelines and Pediatric Preventive Guidelines. Adult and pediatric preventive guidelines and the Perinatal Clinical Practice Guideline continued to be available to members on the Plan's website and in paper format, if requested. All three documents focus on the clinically appropriate time for chlamydia screening.

11/01/2014 to 09/30/2015 – Patient Centered Medical Home for OB/GYN. In addition to the Patient Centered Medical Home (PCP practices) where staff address gaps in care, including chlamydia screening, the plan, in November 2014, the UPMC *for You* maternity team initiated several innovative approaches to directly engage pregnant members to assess their needs and encourage participation in the New Beginnings Program. This was accomplished through a Practice Based Care Manager (PBCM) being embedded at a high volume OB clinic located in Allegheny County. A transition coordinator (TC) was also located at the same high volume hospital. The PBCM and TC conducted comprehensive assessments to determine actual/potential needs for ongoing case management services, coordination of care issues or referrals to applicable lifestyle or health management programs. This team also addressed gaps in care, including chlamydia screening.

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF) Automation Project. As part of the Adult Quality Measures Grant, UPMC *for You* continued to meet with EpicCare staff and Senior Leadership at Gateway Health Plan to create an EPIC/ONAF data transfer. ONAFs contained a section on Chlamydia screening during pregnancy. Two milestones were met in the project. The first one was June 1, 2015 with the kick off of EpicCare data being transmitted to an electronic, preprinted ONAF (for providers). The second was on July 29, 2015, when implementation began with the ONAF data from the EpicCare system being transmitted directly to the UPMC *for You* HealthplaNET system. (HealthplaNET is the Plan's integrated health management system which provides care advisers with access to members' health profiles, including current and historical information.) The ONAF data will be utilized to populate and generate work lists for the staff outreaching to women who may benefit from the Plan's Maternity Program. Post grant work will continue with other high volume practices who utilize EpicCare to have their data rolled into HealthplaNET.

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF)/Provider ONAF Incentives. ONAFs continued to include a section screening member for chlamydia. UPMC *for You* continued to encourage providers to complete ONAFs at specific intervals in the member's pregnancy. Additionally providers continued to receive an incentive for submission of the ONAF to the Plan. Incentives were as follows:

2014 Provider P4P – Maternity/OB/GYNs

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week
- \$20 for ONAF postpartum

2015 Provider P4P – Maternity/OB/GYNs

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of Adult Preventive Guidelines.
- Availability of Pediatric Preventive Health Guidelines.
- Availability of Perinatal Clinical Practice Guidelines.
- Information on the importance of ONAF completion/submission.
- Availability of pay for performance measures (including those related to ONAF submission).

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **06/2014:** *Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more* (included adult and pediatric preventive health guidelines which include chlamydia screening).
- **09/2014:** *New Clinical Guidelines: Adult Preventive and Pediatric preventive* (included chlamydia screenings).
- **10/2014:** *A reminder of resources and guidelines* (included adult and pediatric preventive health guidelines and the perinatal guideline, all of which include information on chlamydia screening).

- **12/2014:** *New clinical guidelines – Perinatal* (included a reminder on chlamydia screening).
- **01/2015:** *Quality Corner Chlamydia* (focused on Center for Disease Control (CDC) recommendations for screening).
- **06/2015:** *ONAF trigger maternity support from UPMC Health Plan* (ONAF has information about chlamydia screening embedded in the form) and *Clinical Practice Guidelines* (all guidelines) and *Stay up to date on policy changes* (included reminders about access to the Provider Manual and all guidelines).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Member Education.** The Plan will explore additional methods to educate members on the importance of chlamydia screening.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure criteria for chlamydia.

GOALS/OUTCOMES

The expected program goals/outcomes improving member outcomes by increasing HEDIS chlamydia screening rates in women.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Chlamydia Testing in Women (CHL).
 These measures continued to be collected and analyzed to determine performance trends and the need for interventions.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.05: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Prenatal Screening for Environmental Tobacco Smoke Exposure measure.

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015 – Member Handbook. The Member Handbook continued to offer members information about the importance of care when pregnant and details program goals and expectations for women to receive care they need during the course of their pregnancy. Information included a section on the availability of the New Beginnings Maternity Program. Additionally there was information the dangers of breathing secondhand smoke and risks to the unborn child.

01/01/2014 to 09/30/2015 – Member newsletter articles – articles entitled:

- **Spring 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).
- **Fall 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).
- **Spring 2015:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).

01/01/2014 to 09/30/2015 – New Beginnings Maternity Program. The UPMC *for You* New Beginnings Maternity program continued to be offered to members identified as pregnant through DHS enrollment data, provider referrals (including ONAF submissions) claims and member self-referral. The program continued to offer letters, program materials including case management services, and incentives to members. The information focused their ability to join the maternity program and included information on the incentives for completing the appropriate number of prenatal visits and a postpartum visit which promoted healthy outcomes for their babies. The program was designed to help promote full-term pregnancies. Program focus continued to include information to help women change behaviors which contribute to low weight births such a smoking cessation and avoidance of second hand

smoke. The program also promoted scheduling and keeping all prenatal visits and appropriate lab testing. Member incentives continued to be offered for women who met program criteria for prenatal and postpartum visits. UPMC *for You's* website continued to include a section about the availability of the program under the additional benefits section of the Plan's public website.

MCO ONLY INTERVENTIONS

4th Quarter 2014 – Staff Training. UPMC *for You* conducted training programs for care managers to address best practices in assessing members to determine if they are at risk for preterm labor and making appropriate referrals or recommendations to help reduce the risk of preterm labor and delivery. The training included a section on identification of risk factors (included tobacco and exposure to second hand smoke) and focused on the role of the case manager to assist the member in risk reduction and prevention

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF) Automation Project. As part of the Adult Quality Measures Grant, UPMC *for You* continued to meet with EpicCare staff and Senior Leadership at Gateway Health Plan to create an EPIC/ONAF data transfer. ONAFs contained a section on Chlamydia screening during pregnancy. Two milestones were met in the project. The first one was June 1, 2015 with the kick off of EpicCare data being transmitted to an electronic, preprinted ONAF (for providers). The second was on July 29, 2015, when implementation began with the ONAF data from the EpicCare system being transmitted directly to the UPMC *for You* HealthplaNET system. (HealthplaNET is the Plan's integrated health management system which provides care advisers with access to members' health profiles, including current and historical information.) The ONAF data will be utilized to populate and generate work lists for the staff outreaching to women who may benefit from the Plan's Maternity Program. Post grant work will continue with other high volume practices who utilize EpicCare to have their data rolled into HealthplaNET.

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF)/Provider ONAF Incentives. ONAFs continued to include a section screening member for exposure to environmental tobacco (second hand smoke) and if exposed, confirmed that the member received counseling about prevention. UPMC *for You* continued to encourage providers to complete ONAFs at specific intervals in the member's pregnancy. Additionally providers continued to receive an incentive for submission of the ONAF to the Plan.

11/01/2014 to 09/30/2015 – Patient Centered Medical Home for OB/GYN. In November 2014, the UPMC *for You* maternity team initiated several innovative approaches to directly engage pregnant members to assess their needs and encourage participation in the New Beginnings Program. This was accomplished through a Practice Based Care Manager (PBCM) being embedded at a high volume OB clinic located in Allegheny County. A transition coordinator (TC) was also located at the same high volume hospital. These staff worked to increase the face to face interactions with members admitted to this facility for delivery and/or pregnancy complications. The PBCM and TC conducted comprehensive assessments to determine actual/potential needs for ongoing case management services, coordination of care issues or referrals to applicable lifestyle or health management programs. The PBCM and TC provide face to face education focused on healthy pregnancies, included information on smoking cessation and exposure to environmental tobacco/second hand smoke, encouraging participation in the Plan's New Beginnings Program and/or the Plan's smoking cessation health management program.

01/01/2014 to 09/30/2015 – Perinatal Clinical Practice Guideline. UPMC *for You* continued to offer providers information about maternity care best practice, which included screening for exposure to environmental tobacco/second hand smoke and counseling if the member was exposed. This information continued to be available in the Perinatal Clinical Practice Guideline.

01/01/2015 to 09/30/2015 Prescription (RX) For Wellness Program. This program continued to be offered to providers utilizing the EpicCare software. Providers were encouraged to prescribe a wellness program or health management program for UPMC *for You* members. The program was developed based on literature which found that patients were more likely to follow through with participation in a health/care management program if it was prescribed by their doctor. UPMC *for You* providers were educated about the program through newsletter articles (see below) and through interactions with their UPMC *for You* Physician Account Executive. Providers not on EpicCare were able to utilize the Prescription for Wellness beginning in March 2015 from the Plan's Provider Portal (website). Beginning in 2nd Quarter 2015, the Plan staff was able to initiate two way conversations with providers utilizing both EpicCare and the portal version.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on availability of health management programs (like the maternity program).

01/01/2014 to 09/30/2015 – Provider Incentives for Maternity Care. Providers continued to receive incentives when their members received appropriate prenatal and postpartum care. Incentives were as follows:

2014 Provider P4P – Maternity/OB/GYNS

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week
- \$20 for ONAF postpartum
- \$15 each per closed administrative HEDIS gap:
 - Prenatal Care in First Trimester
 - Frequency of Prenatal Care $\geq 81\%$ of Expected Visits
 - Postpartum Visit

2015 Provider P4P – Maternity/OB/GYNS

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week
- \$30 for ONAF postpartum
- \$20 each per closed administrative HEDIS gap (must submit ONAF for relevant time period):
 - Prenatal Care in First Trimester
 - Frequency of Prenatal Care $\geq 81\%$ of Expected Visits
 - Postpartum Visit

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of pay for performance measures (including those related to ONAF submission).
- Availability of Perinatal Clinical Practice Guidelines.
- Details of the members’ incentives for participation in the New Beginnings Maternity Program.
- Importance of completing the Obstetric Needs Assessment Form to identify members for enrollment in the maternity program.

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider’s initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **03/2014:** *Asthma Coding in ICD-10 CM* (included codes for exposure to environmental tobacco smoke and exposure in the perinatal period).
- **05/2014:** *Utilizing the ONAF to help your patients* (focused on new guide provider received with complete details on the maternity program, included information on environmental tobacco exposure).
- **06/2014:** *Quality Corner Reducing neonatal intensive care unit admissions* (focus included risk such as smoking cessation and need to complete ONAF – which reminded provider to screen for exposure to environmental tobacco exposure/second hand smoke) and *Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more* (included all clinical practice guidelines – perinatal).
- **10/2014:** *A reminder of resources and guidelines* (included Perinatal guideline which has information on screening for environmental tobacco exposure).
- **11/2014:** *A new kind of RX – Prescription for Wellness bring health management support to your patients—Fast* (focus on program where providers who have EpicCare can give members a prescription for a wellness program (included the Maternity New Beginnings Program.) Direction for providers who do not have EpicCare were also included).
- **12/2014:** *New clinical guidelines – Perinatal.*
- **03/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (included health management programs including the maternity program).
- **05/2015:** *Quality Corner—Help your patients find and effective way to quit smoking.*
- **06/2015:** *ONAF trigger maternity support from UPMC Health Plan* (ONAF has information about chlamydia screening embedded in the form) and *Clinical Practice Guidelines* (all guidelines) and *Stay up to date on policy changes* (included reminders about access to the Provider Manual, Perinatal Clinical Practice Guidelines and the Adult Preventive Guidelines).
- **08/2015:** *Update on prescription for wellness... Improving your patients’ health, quality of care and decision-making* (focused on prescribing members to join a health management program—including the New Beginnings Program).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **New Beginnings Program Materials.** The Plan will explore options to produce the New Beginnings Maternity Program in additional languages.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Community Team (Mobile Maternity Unit).** The Plan will explore creating a mobile maternity unit which would include nurses and/or social workers. The team will meet with members in a variety of community locations, including their homes, provider offices and other sites within the community to facilitate the program. The team will promote participation in the Plan's New Beginnings maternity program. The team will provide education, and referrals to appropriate resources to members, as well as screen for tobacco use, exposure to second hand tobacco, and depression.
- **Obstetric Needs Assessment Form (ONAF) Automation.** The Plan will continue to explore options for rolling out the automation project to other EpicCare providers as well as to develop a program for non-EpicCare providers.
- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure criteria for the maternity measures, including providing information about the importance of timing of prenatal visits.

GOALS/OUTCOMES

The expected goals/outcomes are to improve member and baby outcomes by increasing the number of women screened for and counseled regarding avoidance of environmental tobacco/second hand smoke explore and improved rates in the Pennsylvania Performance Measure Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS).

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Prenatal and Postpartum care (PPC).
 - Frequency of Ongoing Prenatal Care (FPC).
 - CAHPS question Medical Assistance with Smoking and Tobacco Use Cessation (MSC).

These measures continued to be collected and analyzed to determine performance trends and the need for interventions. Additionally data from the Pennsylvania Performance Measures continued to be analyzed. These measures included:

- Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS) which included a section on exposure to environmental tobacco/second hand smoke.
 - Annual data collection and review of charts will continue to be conducted annually on the Pennsylvania Performance Measure Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit (PSS) measure.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

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

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015 – Member Handbook. The Member Handbook continued to offer members information about the importance of care when pregnant and details program goals and expectations for women to receive care they need during the course of their pregnancy. Information included a section on the availability of the New Beginnings Maternity Program, which a call out to remind members that they can obtain services to help them if they are depressed during or after their pregnancy. NOTE: Because behavioral health is a carve out, information is provided to help the member locate the behavioral health services in their zone.

01/01/2014 to 09/30/2015 – Member newsletter articles – articles entitled:

- **Spring 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).
- **Fall 2014:** *Benefit information is online* (included information about the medical benefits, preventive health and clinical

practice guidelines, health management programs and the Member Handbook).

- **Spring 2015: Benefit information is online** (included information about the medical benefits, preventive health and clinical practice guidelines, health management programs and the Member Handbook).

01/01/2014 to 09/30/2015 – New Beginnings Maternity Program. The UPMC *for You* New Beginnings Maternity program continued to be offered to members identified as pregnant through DHS enrollment data, provider referrals (including ONAF submissions) claims and member self-referral. The program continued to offer letters, program materials including case management services, and incentives to members. The information focused their ability to join the maternity program and included information on the incentives for completing the appropriate number of prenatal visits and a postpartum visit which promoted healthy outcomes for their babies. The program was designed to help promote full-term pregnancies. Program focus continued to include information to help have health outcomes and included information on the importance of screening for and treatment of depression. The program also promoted scheduling and keeping all prenatal visits. Member incentives continued to be offered for women who met program criteria for prenatal and postpartum visits. UPMC *for You's* website continued to include a section about the availability of the program under the additional benefits section of the Plan's public website.

MCO ONLY INTERVENTIONS

4th Quarter 2014 – Staff Training. UPMC *for You* conducted training programs for care managers to address best practices in assessing members to determine if they are at risk for preterm labor and making appropriate referrals or recommendations to help reduce the risk of preterm labor and delivery. The training included a section on identification of risk factors (included depression) and focused on the role of the case manager to assist the member in risk reduction and prevention

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF) Automation Project. As part of the Adult Quality Measures Grant, UPMC *for You* continued to meet with EpicCare staff and Senior Leadership at Gateway Health Plan to create an EPIC/ONAF data transfer. ONAFs contained a section on Chlamydia screening during pregnancy. Two milestones were met in the project. The first one was June 1, 2015 with the kick off of EpicCare data being transmitted to an electronic, preprinted ONAF (for providers). The second was on July 29, 2015, when implementation began with the ONAF data from the EpicCare system being transmitted directly to the UPMC *for You* HealthplaNET system. (HealthplaNET is the Plan's integrated health management system which provides care advisers with access to members' health profiles, including current and historical information.) The ONAF data will be utilized to populate and generate work lists for the staff outreaching to women who may benefit from the Plan's Maternity Program. Post grant work will continue with other high volume practices who utilize EpicCare to have their data rolled into HealthplaNET.

01/01/2014 to 09/30/2015 – Obstetric Needs Assessment Form (ONAF)/Provider ONAF Incentives. ONAFs continued to include a section screening members for depression and if depressed if referral were made. UPMC *for You* continued to encourage providers to complete ONAFs at specific intervals in the member's pregnancy. Additionally providers continued to receive an incentive for submission of the ONAF to the Plan. (See Provider Incentives for Maternity Care Below).

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on availability of health management programs (like the maternity program).

11/01/2014 to 09/30/2015 – Patient Centered Medical Home for OB/GYN. In November 2014, the UPMC *for You* maternity team initiated several innovative approaches to directly engage pregnant members to assess their needs and encourage participation in the New Beginnings Program. This was accomplished through a Practice Based Care Manager (PBCM) being embedded at a high volume OB clinic located in Allegheny County. A transition coordinator (TC) was also located at the same high volume hospital. These staff worked to increase the face to face interactions with members admitted to this facility for delivery and/or pregnancy complications. The PBCM and TC conducted comprehensive assessments to determine actual/potential needs for ongoing case management services, coordination of care issues or referrals to applicable lifestyle or health management programs. The PBCM and TC provide face to face education focused on healthy pregnancies, included information on depression, depression screening, encouraging participation in the Plan's New Beginnings Program and the Beating the Blues US™ program.

01/01/2015 to 09/30/2015 Prescription (RX) For Wellness Program. This program continued to be offered to providers utilizing the EpicCare software. Providers were encouraged to prescribe a wellness program or health management program for UPMC *for You* members. The program was developed based on literature which found that patients were more likely to follow through with participation in a health/care management program if it was prescribed by their doctor. UPMC *for You* providers were educated about the program through newsletter articles (see below) and through interactions with their UPMC *for You* Physician Account Executive. Providers not on EpicCare were able to utilize the Prescription for Wellness beginning in March 2015 from the Plan's

Provider Portal (website). Beginning in 2nd Quarter 2015, the Plan staff was able to initiate two way conversations with providers utilizing both EpicCare and the portal version.

01/01/2014 to 09/30/2015 – Provider Incentives for Maternity Care. Providers continued to receive incentives when their members received appropriate prenatal and postpartum care. Incentives were as follows:

2014 Provider P4P – Maternity/OB/GYNS

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week
- \$20 for ONAF postpartum
- \$15 each per closed administrative HEDIS gap:
 - Prenatal Care in First Trimester
 - Frequency of Prenatal Care $\geq 81\%$ of Expected Visits
 - Postpartum Visit

2015 Provider P4P – Maternity/OB/GYNS

- \$20 for ONAF for initial visit $\geq 14^{\text{th}}$ week of pregnancy
- \$30 for ONAF for initial visit $< 14^{\text{th}}$ week of pregnancy
- \$20 for ONAF 28-32 week
- \$30 for ONAF postpartum
- \$20 each per closed administrative HEDIS gap (must submit ONAF for relevant time period):
 - Prenatal Care in First Trimester
 - Frequency of Prenatal Care $\geq 81\%$ of Expected Visits
 - Postpartum Visit

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of pay for performance measures (including those related to ONAF submission).
- Availability of Perinatal Clinical Practice Guidelines.
- Details of the members' incentives for participation in the New Beginnings Maternity Program.
- Importance of completing the Obstetric Needs Assessment Form to identify members for enrollment in the maternity program.

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **01/2014:** *Parental depression can delay development in children-New report highlights the prevalence of the program in our region.*
- **03/2014:** *Do you have patients dealing with stress, anxiety, or depression (focused on availability of Beating the Blues US™ program).*
- **05/2014:** *Utilizing the ONAF to help your patients (focused on new guide provider received with complete details on the maternity program, included information on environmental tobacco exposure).*
- **06/2014:** *Quality Corner Reducing neonatal intensive care unit admissions (focused on risk factor screening and need to complete ONAF—which reminds providers to screen for depression) and Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more (included all clinical practice guidelines – perinatal).*
- **08/2014:** *Helping patients with depression—UPMC Health Plan supports you at every step (focused on options available, included the Beating the Blues US™ program) and We make a great team—Two excellent Health Plan Programs that support your efforts every day (focused on health management programs, including the New Beginnings Program).*
- **09/2014:** *Robin Williams and the challenge of depression (focused on Beating the Blues US™ program)*
- **10/2014:** *A reminder of resources and guidelines (included Perinatal).*
- **11/2014:** *A new kind of RX – Prescription for Wellness bring health management support to your patients—Fast (focus on program where providers who have EpicCare can give members a prescription for a wellness program (included the Maternity New Beginnings Program.) Direction for providers who do not have EpicCare were also included).*
- **12/2014:** *New clinical guidelines – Perinatal.*
- **03/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health (included health management programs including the maternity program).*

- **08/2015:** *Update on prescription for wellness... Improving your patients' health, quality of care and decision-making* (focused on prescribing members to join a health management program—including the New Beginnings Program).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **New Beginnings Program Materials.** The Plan will explore options to produce the New Beginnings Maternity Program in additional languages.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Community Team (Mobile Maternity Unit).** The Plan will explore creating a mobile maternity unit which would include nurses and/or social workers. The team will meet with members in a variety of community locations, including their homes, provider offices and other sites within the community to facilitate the program. The team will promote participation in the Plan's New Beginnings maternity program. The team will provide education, and referrals to appropriate resources to members, as well as screen for tobacco use, exposure to second hand tobacco, and depression.
- **Obstetric Needs Assessment Form (ONAF) Automation.** The Plan will continue to explore options for rolling out the automation project to other EpicCare providers as well as to develop a program for non-EpicCare providers.
- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure criteria for the maternity measures, including providing information about the importance of timing of prenatal visits.

GOALS/OUTCOMES

The expected goals/outcomes are to improve member and baby outcomes by increasing the number of women screened for and counseled regarding the importance of screening and treatment for depression in both the prenatal and postpartum periods and improved rates in the Pennsylvania Performance Measure Perinatal Depression Screening (PDS).

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Prenatal and Postpartum care (PPC).
 - Frequency of Ongoing Prenatal Care (FPC).

These measures continued to be collected and analyzed to determine performance trends and the need for interventions.

Additionally data from the Pennsylvania Performance Measures continued to be analyzed. These measures included:

- Perinatal Depression Screening (PDS).
- Annual data collection and review of charts will continue to be conducted annually on the Pennsylvania Performance Measure Perinatal Depression Screening (PDS) measure.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.07: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure.

Follow Up Actions Taken Through 09/30/15:

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015—Asthma Clinical Practice Guideline. UPMC *for You* continued to offer providers information about the avoidance of antibiotic treatment in adults with acute bronchitis in the Asthma Clinical Practice Guideline.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes. The program included discussions with members and providers about avoidance of antibiotic treatment in adults with acute bronchitis.

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of Asthma Clinical Practice Guideline.

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – UPMC *for You* will explore additional methods of member education regarding the avoidance of antibiotics in adults with acute bronchitis.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure for avoidance of antibiotics in adults with acute bronchitis.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member outcomes by promoting the avoidance of antibiotics in adults with acute bronchitis and improvement of the HEDIS rate Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB).

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB).This measure continued to be collected and analyzed to determine performance trends and the need for interventions.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.08: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Pharmacotherapy Management of COPD Exacerbation: Bronchodilator measure.

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015. UPMC *for You* COPD Case Management Program continued to be offered to members identified as having COPD through DHS enrollment data, provider referrals, claims and member self referral. The program continued to offer letters, program materials and case management services to members enrolled in the program.

01/01/2014 to 09/30/2015—Mobile Events. UPMC *for You* members continued to be invited to mobile events where spirometry testing could be conducted if the member had a gap in that care.

01/01/2014 to 09/30/2015—Member newsletters articles—articles entitled:

- **Fall 2014:** *Our health [coaches] can help you with all of your health care needs* (focused on health management—COPD).

MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Medication Therapy Management (MTM) program for Medical Assistance members who meet MTM program eligibility. The MTM program continued with four interventions. Intervention 1—The Plan's Pharmacy Team sent letters to providers and copied the Plan's Case Management Team who called members regarding their lack of adherence to long acting inhalers for asthma and COPD. Intervention 2—The Care Manager called members regarding potential overuse of short acting albuterol inhalers used for asthma and COPD. Nurses reached out to physician offices to discuss the need for long acting therapy if

overuse of albuterol was an issue. Intervention 3—Members received a physician letter if they had a recent COPD exacerbation or diagnosis of asthma and no controller medication. Intervention 4—Members received a physician letter if they were using a long acting beta agonist but no inhaled corticosteroid.

MCO/PROVIDER INTERVENTIONS

21/01/2014 through 09/30/2015—COPD SMART TOOL®. UPMC Health Plan (including UPMC *for You*) partnered with the UPMC COPD pathway team to pilot a preventive readmission tool, the Pittsburgh COPD SMART Tool®. This seven-item tool was developed in collaboration with a nationally recognized expert in patient-reported outcome assessment. This tool assesses symptoms predictive of poor trajectory including shortness of breath, cough, phlegm, and chest tightness. Starting in December 2014, Plan respiratory health coaches started contacting members discharged from a UPMC hospital with a primary diagnosis of COPD via phone for four weeks (daily for two weeks and twice a week for two weeks). During each interaction, the cumulative score of the readmission tool was assessed. If warranted, the health coach followed the prescribed intervention. The prescribed intervention advised the Health Plan coach to contact the patient's treating physician (PCP or pulmonologist). The physician office was encouraged to contact the patient for phone triage.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes. The program included discussions with members and providers about appropriate treatment for members who have COPD.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on availability of health management programs (like the COPD health management program).

01/01/2014 to 09/30/2015—COPD Clinical Practice Guideline. UPMC *for You* continued to offer providers information about COPD best practice, which included spirometry testing for diagnosis and ongoing monitoring through the COPD Clinical Practice Guideline.

01/01/2015 to 09/30/2015 Prescription (RX) For Wellness Program. This program continued to be offered to providers utilizing the EpicCare software. Providers were encouraged to prescribe a wellness program or health management program for UPMC *for You* members. The program was developed based on literature which found that patients were more likely to follow through with participation in a health/care management program if it was prescribed by their doctor. UPMC *for You* providers were educated about the program through newsletter articles (see below) and through interactions with their UPMC *for You* Physician Account Executive. Providers not on EpicCare were able to utilize the Prescription for Wellness beginning in March 2015 from the Plan's Provider Portal (website). Beginning in 2nd Quarter 2015, the Plan staff was able to initiate two way conversations with providers utilizing both EpicCare and the portal version.

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **01/2014:** *Support is just a phone call away* (focused on health management programs including those for COPD).
- **06/2014:** *Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more* (included all clinical practice guidelines – COPD).
- **08/2014:** *We make a great team—Two excellent Health Plan Programs that support your efforts every day* (focused on health management programs, including COPD and complex case management).
- **10/2014:** *A reminder of resources and guidelines.*
- **11/2014:** *A new kind of RX – Prescription for Wellness bring health management support to your patients—Fast* (focus on program where providers who have EpicCare can give members a prescription for a wellness program (included the Maternity New Beginnings Program.) Direction for providers who do not have EpicCare was also included).
- **12/2014:** *New clinical guidelines—COPD and New tool to help COPD patients avoid hospital readmissions which focuses on the UPMC COPD pathway teams' SMART Tool®.*
- **03/2015:** *Quality Corner, Preventing COPD readmissions—*(focused on provider driven interventions with members with COPD that are designed to promote member health and prevent hospital admissions and readmission) and *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on providers offering members a prescription to join one of the Plan's case management programs such as the COPD program).
- **08/2015:** *Update on prescription for Wellness* (focused on providers offering members a prescription to join one of the Plan's case management programs such as the COPD program).

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of Case Management Programs, including Respiratory (COPD).
- Availability of COPD Clinical Practice Guideline.

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

FUTURE MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Medication Therapy Management (MTM) program for Medical Assistance members who meet MTM program eligibility. The Plan is exploring updating the program to include—for Intervention 1, the addition of the Case Manager calling the provider. For Intervention 2, having the pharmacist contact the member instead of the Case Manager. For Intervention 3 and 4, having the pharmacist call the provider.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure for spirometry use and COPD and the PA Performance Measure on COPD.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member outcomes by promoting the use of spirometry testing and appropriate condition management of members with COPD and improvement of the HEDIS and PA Performance measures related to spirometry and COPD.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR).
 - Pharmacotherapy Management of COPD Exacerbation (PCE).
 - Relative Resource Use for People with COPD (RCO).

This measure continued to be collected and analyzed to determine performance trends and the need for interventions. Additionally data from the Pennsylvania Performance Measures continued to be analyzed. This included the measure:

- Chronic Obstructive Pulmonary Disease (COPD) or Asthma In Older Adults Admission Rate.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.09: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Use of Appropriate Medications for People with Asthma (Age 19-50 years) and (Age 5-64 years) measures.

Follow Up Actions Taken Through 09/30/15:

MCO/MEMBER INTERVENTIONS

01/01/2014 to 09/30/2015—Case/Health Management. UPMC *for You* Asthma Case Management Program continued to be offered to members identified as having Asthma through DHS enrollment data, provider referrals, claims and member self-referral. The program continued to offer letters, program materials and case management services to members enrolled in the program. Additionally, in 2014, the Plan dedicated a Pediatric Case Manager for Asthma outreach. The Pediatric staff worked with members who had two encounters in 12 months and an emergency department visit, or inpatient admission with a primary diagnosis of Asthma. The Pediatric team also received daily information on members who met an emergency department threshold and had a primary diagnosis of asthma to coordinate needs and care as appropriate.

01/01/2014 to 09/30/2015—Mall Kiosks. UPMC for You members continued to visit the mall kiosks that are supported by UPMC Health Plan (all products). The staff at the kiosks encourages Plan members to join health management programs (like the Asthma program) as appropriate.

01/01/2014 to 09/30/2015—Member newsletter articles—article entitled:

- **Fall 2014:** *Our health coaches can help you with all of our health care needs* (focused on health management—asthma).

MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Medication Therapy Management (MTM) program for Medical Assistance members who meet MTM program eligibility. The MTM program continued with four interventions. Intervention 1—The Plan's Pharmacy Team sent letters to providers and copied the Plan's Case Management Team who called members regarding their lack of adherence to long acting inhalers for asthma and COPD. Intervention 2—The Care Manager called members regarding potential overuse of short acting albuterol inhalers used for asthma and COPD. Nurses reached out to physician offices to discuss the need for long acting therapy if overuse of albuterol was an issue. Intervention 3—Members received a physician letter if they had a recent COPD exacerbation or diagnosis of asthma and no controller medication. Intervention 4—Members received a physician letter if they were using a long acting beta agonist but no inhaled corticosteroid.

MCO/PROVIDER INTERVENTIONS

01/01/2014 to 09/30/2015—Asthma Clinical Practice Guideline. UPMC for You continued to offer providers information about the avoidance of antibiotic treatment in adults with acute bronchitis in the Asthma Clinical Practice Guideline.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes. The program included discussions with members and providers about appropriate treatment for members who have asthma.

01/01/2015 to 09/30/2015 Prescription (RX) For Wellness Program. This program continued to be offered to providers utilizing the EpicCare software. Providers were encouraged to prescribe a wellness program or health management program for UPMC for You members. The program was developed based on literature which found that patients were more likely to follow through with participation in a health/care management program if it was prescribed by their doctor. UPMC for You providers were educated about the program through newsletter articles (see below) and through interactions with their UPMC for You Physician Account Executive. Providers not on EpicCare were able to utilize the Prescription for Wellness beginning in March 2015 from the Plan's Provider Portal (website). Beginning in 2nd Quarter 2015, the Plan staff was able to initiate two way conversations with providers utilizing both EpicCare and the portal version.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services. Past topics have been education on availability of health management programs (like the asthma health management program).

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **01/2014:** *Support is just a phone call away* (focused on health management programs including those for asthma).
- **03/2014:** *Asthma Coding in ICD-10-CM.*
- **06/2014:** *Find it fast online – Our website offers quick and easy access to forms, guidelines, policies and more* (included all clinical practice guidelines – asthma).
- **08/2014:** *We make a great team—Two excellent Health Plan Programs that support your efforts every day* (focused on health management programs, including asthma).
- **10/2014:** *A reminder of resources and guidelines* (included the Asthma Clinical Practice Guideline).
- **11/2014:** *A new kind of RX – Prescription for Wellness bring health management support to your patients—Fast* (focus on program where providers who have EpicCare can give members a prescription for a wellness program—including the asthma program. Direction for providers who do not have EpicCare was also included).
- **03/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on providers offering members a prescription to join one of the Plan's case management programs such as the asthma program).
- **08/2015:** *Update on prescription for Wellness* (focused on providers offering members a prescription to join one of the Plan's case management programs such as the COPD program).

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of Case Management Programs, including Respiratory (Asthma).
- Availability of Asthma Clinical Practice Guideline.

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider's initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

Future Actions Planned:

NOTE: FUTURE INTERVENTIONS CONTINUED THROUGH 12.31.2015 ONLY. NCQA HAS RETIRED THIS MEASURE AS OF 01/01/2016; THEREFORE, DATA FROM CALENDAR YEAR 2015 WILL NOT BE REPORTABLE.

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

FUTURE MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Medication Therapy Management (MTM) program for Medical Assistance members who meet MTM program eligibility. The Plan is exploring updating the program to include—for Intervention 1, the addition of the Case Manager calling the provider. For Intervention 2, having the pharmacist contact the member instead of the Case Manager. For Intervention 3 and 4, having the pharmacist call the provider.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Provider Education.** The Plan will explore additional methods to educate providers on the HEDIS measure for asthma medication management and the PA Performance Measure Annual Percentage of Asthma Patients with One or More Asthma Related Emergency Department Visits; Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate; and Asthma in Younger Adults Admission Rate.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member outcomes by promoting the correct use of medication for asthma and promoting appropriate management of Asthma and improvement of the HEDIS and PA Performance measures related to asthma.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Ongoing administrative (claims data) review of HEDIS data included in the metric:
 - Medication Management for People with Asthma (MMA).
 - Asthma Medication Ratio (AMR).
 - Relative Resource Use for People with Asthma (RAS).

This measure continued to be collected and analyzed to determine performance trends and the need for interventions.

Additionally data from the Pennsylvania Performance Measures continued to be analyzed. These measures included:

- Annual Percentage of Asthma Patients with One or More Asthma Related Emergency Department Visits.
- Asthma in Younger Adults Admission Rate.
- Chronic Obstructive Pulmonary Disease (COPD) or Asthma In Older Adults Admission Rate.
- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.10: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Medication Management for People with Asthma: 75% Compliance (Age 12-18 years), (Age 19-50 years), and (Age 5-64 years)

measures.

Follow Up Actions Taken Through 09/30/15:

See above section “UPMC 2014.09”

Future Actions Planned:

See above section “UPMC 2014.09” with the exception of that note that unlike the Use of Appropriate Medications for People with Asthma (Age 19-50 years) and (Age 5-64 years) measures, this measure will continue in HEDIS 2016 (CY 2015 data).

Reference Number: UPMC 2014.11: Decreases were noted in 2014 (MY 2013) as compared to the MCO's 2013 (MY 2012) in two of the four Adult CAHPS composite survey items.

Follow Up Actions Taken Through 09/30/15:

Two CAHPS measures were published in the Commonwealth of Pennsylvania Department of Human Services Office of Medical Assistance Programs 2014 External Quality Review Report—UPMC for You Final Report were:

- Getting Needed Information (Usually or Always)
- Appointment for Routine Care When Needed (Usually or Always)

01/01/2014 to 09/30/2015—UPMC for You continued to focus on improving CAHPS rates through the following programs and protocols listed below. Member satisfaction was reviewed by the Plan through a 360 degree approach, which includes programs for members, providers and Plan initiatives. This holistic approach was designed to help the Plan improve CAHPS rates for all composites, including Getting Information Needed and satisfaction with Appointment for Routine Care When Needed. The programs and protocols include those listed below.

MCO/MEMBER INTERVENTIONS—GETTING NEEDED INFORMATION/APPOINTMENTS

01/01/2014 to 09/30/2015—Community Events continued. Events featured DHS approved health and wellness materials and offered members an opportunity to speak to staff to answer questions about the Plan and the services available—including information about benefits, services, and scheduling appointments.

01/01/2014 to 09/30/2015—Health and Case Management Assistance With Needed Information/Appointment Scheduling.

Members who are enrolled in health or case management services continued to be assisted, as appropriate, in locating important information about the Plan, member benefits, and their personal health conditions. Additionally, members enrolled in the programs continued to be offered assistance to scheduling routine appointments. Assistance included warm transfer telephone connections where staff/members/office are on the same line.

01/01/2014 to 09/30/2015—Member Educational Materials. These materials which included member handbook, provider directory, dental, vision, and pharmacy information continued to be made available to members via mail, fax, and email or through internet access. Information continued to be available to members in a language other than English or alternate format (i.e. Braille) if requested by the member. Member services continued to offer verbal information as requested. The Member Handbook included information to help members overcome barriers to care, including transportation assistance for their appointments.

01/01/2014 to 09/30/2015—Member newsletters articles—articles entitled:

- **Spring 2014:** *Member Service is here to help you* (focused on calling for assistance for benefits or services and included information on secure messaging online) and *How to choose a PCP* (focused on the importance of locating a PCP and scheduling for preventive care—including the Plan's ability to help locate a provider and schedule an appointment) and *View your plan benefit materials through our secure member website—MyHealth Online* (focused on members ability to locate important Plan and health information).
- **Fall 2014:** *Member Service is here to help you* (focused on calling for assistance for benefits or services (scheduling appointments) and included information on secure messaging online) and *Materials available in other languages* (focused on getting needed Plan information in a language other than English) and *I need a doctor! What should I do?* (encouraged members to seek out their PCP for care).
- **Spring 2015:** *Benefit Information Is Online* (focused on members' ability to obtain member handbook and other Plan materials on the Plan's website) and *Our MyHealth Advice Line provides you with health care expertise 24/7* (focused on members' ability to get general health advice or information on a specific medical issue).

01/01/2014 to 09/30/2015—Member Service Assistance with Scheduling/Materials continued. Members who contacted member services and needed assistance or information about the Plan were assisted in finding what they needed. Additionally, members who contacted member services and needed assistance locating a provider or scheduling appointments continued to be offered assistance to schedule routine appointments. Scheduling assistance included warm transfer telephone connections where staff/members/office are on the same line. Member Services continued to focus on First Call Resolution, where members received the help they needed in their first call to the Plan. Member services team continued to focus on first call resolution to promote member satisfaction in answering questions and providing needed information. First call resolution was a high-touch form of

customer service the Plan used to provide members with not only the answers to the questions that prompted their calls, but also connect them with additional resources, both internal and external, that resolve issues, and improve their health and enrich their lives.

01/01/2014 to 09/30/2015—New Member Outreach Calls continued. UPMC *for You* continued to utilize enrollment files sent by DHS to identify new managed care members. The member/caregiver received automated reminder phone calls and messages welcoming them to UPMC *for You*. The message advised the member that UPMC *for You* has care management programs to assist the member, and it included a prompt if they would like to speak to a health coach/care manager. When a member/caregiver selected the option to speak with a care manager, a comprehensive health assessment survey was completed with the member/caregiver to identify any physical or psychosocial issues. The health coach worked ongoing with the member/caregiver as appropriate to resolve any issues and provide education and support for whole person wellness.

01/01/2014 to 09/30/2015—Personal Health Guide Mailing for Adults. Members received three mailings two in 2014 and one in 2015. The materials offered members personalized (2014) and general (2015) information of their health and Plan benefits. Additionally, the mailing had call to action sections which stressed the importance of preventive care and scheduling an appointment for routine (preventive) care. The mailings included Member Service information and called to members' attention that they could receive assistance in locating a provider and scheduling an appointment.

01/01/2014 to 09/30/2015—TracFones with 250 minutes and unlimited texting were offered to eligible UPMC *for You* members.

MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Credentialing and Recredentialing of doctors and facilities who served UPMC *for You* members continued to promote member access to health care providers. Access and availability studies were conducted to verify that members have access to providers and were able to schedule appointments. The provider directory advises members of which practices accept new patients.

01/01/2014 to 09/30/2015—Member Services

- **After Call Survey** continued to be conducted to gauge the quality of the experience created by the customer services representatives. The Plan listens to and tracks comments on each team members. Positive comments were communicated to the team and the Plan reaches out to members who dissatisfied. The customer services representatives also continued to receive ongoing training and development.
- **First Call Resolution** continued. Member Services had a program in place to promote first call resolution to any issue (including questions about scheduling appointments or getting needed information about the Plan. The program was monitored by After Call Surveys (see above) and internal team statistics.
- **Live Chat** continued. Member Services implemented a live chat process where members can speak with Member Services through a chat function on the Plan's website. Members were able to use the feature to address any question they had (including assistance scheduling an appointment and getting needed information).
- **Member Satisfaction Team** continued. This team continued to focus on member feedback and recommendations for improvement for overall member satisfaction.

July 2015—Plan Website Updated. To address member feedback that they were unable to obtain needed Plan information, UPMC Health Plan (all products) updated its public website, www.upmchealthplan.com. The site featured important UPMC *for You* member information (for example the Member Handbook and the Notice of Privacy Practices) as well as links to important information including, National Domestic Violence Hotline, Head Start program, Healthy Smiles for Autism, Pennsylvania Head Start, Medical Assistance Transportation Program assistance and behavioral health care information. The Plan is phasing in materials available in other languages, with the Notice of Privacy Practices currently available in English and three other languages. All materials continued to advise members of how to get information in other languages (included Braille and TTY/TDD as needed).

MCO/PROVIDER INTERVENTIONS

09/2014—Mystery Shopper Calls To PCP's. The Plan (all products) conducted a PCP Mystery Shopper Project where staff utilizing a standard script called PCP offices to attempt to obtain an appointment. Data from the program was reviewed by Senior Leadership and the Plan's Network Staff. Immediate outreach was conducted to providers where providers did not meet program standards for results/findings (i.e. the provider stated they were not accepting new patients or did not follow contractual requirements for member access). The Plan utilized program data to develop future provider education materials.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination

and care planning to enhance member/caregiving understanding and improve outcomes. The staff assisted members in arranging for medical transportation and county transportation services; scheduling preventive appointments, and enrolling in appropriate health or lifestyle management programs. (See Shared Saving below.)

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **01/2014:** *Support is just a phone call away* (focused on health management programs for members).
- **05/2014:** *Can you be reached after hours? Patient access survey coming in July* (focused providers need to be available to members) and *Quality Corner Is your practice a medical house or home?* (focused on importance of the medical home concept, including true open access).
- **08/2014:** *We make a great team—Two excellent Health Plan Programs that support your efforts every day* (focused on health management programs, for members).
- **11/2014:** *Quality improvement goals and results—The results are in* (focused on CAHPS results and what metrics are measured).
- **03/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on providers offering members a prescription to join one of the Plan’s health management or case management programs).
- **08/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on prescribing health or case management services).

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of health and case management programs for members.
- Plan access standards

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider’s initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

01/01/2014 to 09/30/2015 – Provider Education Programs are periodically offered to providers, including information on access. Physician Account Executives from the Plan discuss the importance of open member panels with providers, as well as educate them on the importance of extended office hours and how to bill for those services.

01/01/2015 to 09/30/2015 – Shared Saving Providers program continued. Providers in the Plan’s Shared Savings Program continued to receive data about their performance regarding closing children’s dental gaps. As of July 2015, the UPMC *for You* Shared Savings program increased from 21 to 32 practices, office sites increased from 411 to 582. Seventy-four Practice Base Care Managers supported the program (See Patient Centered Medical Home Section above).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams. The Plan will continue to assess the information available on the public website and make updates as needed.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Shared Savings Program for Providers** – UPMC *for You* will explore expansion of the Provider Shared Savings program to additional pediatric practices and to additional practices in the Lehigh/Capital zone. Additionally, UPMC *for You* will have an enhanced access metric that must be met for 2016 for providers to receive monies in this program. The focus of the metric will be expanded office hours and availability of same day or walk in appointments.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member experience with their health insurance/health care and improvement in CAHPS rates.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Member perception of their ability to receive needed care will continue to be measured annually through the annual

(Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.
- Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

Reference Number: UPMC 2014.12: A decrease was noted in 2014 (MY 2013) as compared to the MCO's 2013 (MY 2012) in one of four comparable items from UPMC's Child CAHPS survey. One of the rates for the composite survey items evaluated fell below the 2014 MMC weighted average.

Follow Up Actions Taken Through 09/30/15:

One CAHPS measures were published in the Commonwealth of Pennsylvania Department of Human Services Office of Medical Assistance Programs 2014 External Quality Review Report—UPMC *for You* Final Report were:

- Appointment for Routine Care When Needed (Usually or Always)

01/01/2014 to 09/30/2015—UPMC *for You* continued to focus on improving CAHPS rates through the following programs and protocols listed below. Member satisfaction was reviewed by the Plan through a 360 degree approach, which includes programs for members, providers and Plan initiatives. This holistic approach was designed to help the Plan improve CAHPS rates for all composites, including satisfaction with Appointment for Routine Care When Needed. The programs and protocols include those listed below.

MCO/MEMBER INTERVENTIONS—GETTING NEEDED INFORMATION/APPOINTMENTS

01/01/2014 to 09/30/2015—Community Events continued. Events featured DHS approved health and wellness materials and offered members an opportunity to speak to staff to answer questions about the Plan and the services available to their children—including assistance in scheduling appointments.

01/01/2014 to 09/30/2015—Health and Case Management Assistance With Needed Information/Appointment Scheduling.

Members who are enrolled in health or case management services continued to be assisted in scheduling routine appointments. Assistance included warm transfer telephone connections where staff/members/office are on the same line.

Pediatric Health Living Tips. Members received two mailings one in 2014 and one in 2015. The mailing had call to action sections which stressed the importance of preventive care and scheduling an appointment for routine (preventive) care. The mailings included Member Service information and called to members' attention that they could receive assistance in locating a provider and scheduling appointments for their child/children.

01/01/2014 to 09/30/2015—Member Educational Materials. These materials which included member handbook, provider directory, dental, vision, and pharmacy information continued to be made available to members via mail, fax, and email or through internet access. Information continued to be available to members in a language other than English or alternate format (i.e. Braille) if requested by the member. Member services continued to offer verbal information as requested. The Member Handbook included information to help members overcome barriers to care, including transportation assistance for their appointments.

01/01/2014 to 09/30/2015—Member newsletters articles—articles entitled:

- **Spring 2014:** *Member Service is here to help you* (focused on calling for assistance for benefits or services and included information on secure messaging online) and *How to choose a PCP* (focused on the importance of locating a PCP and scheduling for preventive care—including the Plan's ability to help locate a provider and schedule an appointment)
- **Fall 2014:** *Member Service is here to help you* (focused on calling for assistance for benefits or services (scheduling appointments) and included information on secure messaging online) and *Materials available in other languages* (focused on getting needed Plan information in a language other than English) and *I need a doctor! What should I do?* (encouraged members to seek out their PCP for care).
- **Spring 2015:** *Benefit Information Is Online* (focused on members' ability to obtain member handbook and other Plan materials on the Plan's website).

01/01/2014 to 09/30/2015—Member Service Assistance with Scheduling/Materials continued. Members who contacted member services and needed assistance or information about the Plan were assisted in finding what they needed. Additionally, members who contacted member services and needed assistance locating a provider or scheduling appointments continued to be offered assistance to schedule routine appointments. Scheduling assistance included warm transfer telephone connections where staff/members/office are on the same line. Member Services continued to focus on First Call Resolution, where members received the help they needed in their first call to the Plan. Member services team continued to focus on first call resolution to promote member satisfaction in answering questions and providing needed information. First call resolution was a high-touch form of

customer service the Plan used to provide members with not only the answers to the questions that prompted their calls, but also connect them with additional resources, both internal and external, that resolve issues, and improve their health and enrich their lives.

01/01/2014 to 09/30/2015—New Member Outreach Calls continued. UPMC *for You* continued to utilize enrollment files sent by DHS to identify new managed care members. The member/caregiver received automated reminder phone calls and messages welcoming them to UPMC *for You*. The message advised the member that UPMC *for You* has care management programs to assist the member, and it included a prompt if they would like to speak to a health coach/care manager. When a member/caregiver selected the option to speak with a care manager, a comprehensive health assessment survey was completed with the member/caregiver to identify any physical or psychosocial issues. The health coach worked ongoing with the member/caregiver as appropriate to resolve any issues and provide education and support for whole person wellness.

MCO INTERVENTIONS

01/01/2014 to 09/30/2015—Credentialing and Recredentialing of doctors and facilities who served UPMC *for You* members continued to promote member access to health care providers. Access and availability studies were conducted to verify that members have access to providers and were able to schedule appointments. The provider directory advises members of which practices accept new patients.

01/01/2014 to 09/30/2015—Member Services

- **After Call Survey** continued to be conducted to gauge the quality of the experience created by the customer services representatives. The Plan listens to and tracks comments on each team members. Positive comments were communicated to the team and the Plan reaches out to members who dissatisfied. The customer services representatives also continued to receive ongoing training and development.
- **First Call Resolution** continued. Member Services had a program in place to promote first call resolution to any issue (including questions about scheduling appointments or getting needed information about the Plan. The program was monitored by After Call Surveys (see above) and internal team statistics.
- **Live Chat** continued. Member Services implemented a live chat process where members can speak with Member Services through a chat function on the Plan's website. Members were able to use the feature to address any question they had (including assistance scheduling an appointment and getting needed information).
- **Member Satisfaction Team** continued. This team continued to focus on member feedback and recommendations for improvement for overall member satisfaction.

July 2015—Plan Website Updated. To address member feedback that they were unable to obtain needed Plan information, UPMC Health Plan (all products) updated its public website, www.upmchealthplan.com. The site featured important UPMC *for You* member information (for example the Member Handbook and the Notice of Privacy Practices) as well as links to important information including, National Domestic Violence Hotline, Head Start program, Healthy Smiles for Autism, Pennsylvania Head Start, Medical Assistance Transportation Program assistance and behavioral health care information. The Plan is phasing in materials available in other languages, with the Notice of Privacy Practices currently available in English and three other languages. All materials continued to advise members of how to get information in other languages (included Braille and TTY/TDD as needed).

MCO/PROVIDER INTERVENTIONS

09/2014—Mystery Shopper Calls To PCP's. The Plan (all products) conducted a PCP Mystery Shopper Project where staff utilizing a standard script called PCP offices to attempt to obtain an appointment. Data from the program was reviewed by Senior Leadership and the Plan's Network Staff. Immediate outreach was conducted to providers where providers did not meet program standards for results/findings (i.e. the provider stated they were not accepting new patients or did not follow contractual requirements for member access). The Plan utilized program data to develop future provider education materials.

01/01/2014 to 09/30/2015 – Patient Centered Medical Home (PCMH) continued. As of September 2015, the PCMH program continued to grow and serviced over 92,500 Medical Assistance Members (26% of the total population managed). The program also increased the number of provider sites to 413. The Practice Based Care Managers (PBCM) continued to provide care coordination and care planning to enhance member/caregiving understanding and improve outcomes. The staff assisted members in arranging for medical transportation and county transportation services; scheduling preventive appointments, and enrolling in appropriate health or lifestyle management programs. (See Shared Saving below.)

01/01/2015 to 09/30/2015 – Provider newsletter articles – articles entitled:

- **01/2014:** *Support is just a phone call away* (focused on health management programs for members).
- **05/2014:** *Can you be reached after hours? Patient access survey coming in July* (focused providers need to be available to members) and *Quality Corner Is your practice a medical house or home?* (focused on importance of the medical home)

concept, including true open access).

- **08/2014:** *We make a great team—Two excellent Health Plan Programs that support your efforts every day* (focused on health management programs, for members).
- **11/2014:** *Quality improvement goals and results—The results are in* (focused on CAHPS results and what metrics are measured).
- **03/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on providers offering members a prescription to join one of the Plan’s health management or case management programs).
- **08/2015:** *Now available on Provider Online: Prescription for Wellness—Use your influence to guide patients to good health* (focused on prescribing health or case management services).

01/01/2014 to 09/30/2015 – Provider Manual. The Provider Manual continued to include the following information:

- Availability of health and case management programs for members.
- Plan access standards

The Provider Manual continued to be available via paper, by telephone and online. Providers were advised of the availability of these materials by:

- A notice in the provider’s initial credentialing letter.
- An annual reminder of availability of the Provider Manual and clinical practice guidelines continued to be published in the provider newsletter.

01/01/2015 to 09/30/2015 – Shared Saving Providers program continued. Providers in the Plan’s Shared Savings Program continued to receive data about their performance regarding closing children’s dental gaps. As of July 2015, the UPMC *for You* Shared Savings program increased from 21 to 32 practices, office sites increased from 411 to 582. Seventy-four Practice Base Care Managers supported the program (See Patient Centered Medical Home Section above).

Future Actions Planned:

FUTURE MCO/MEMBER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams. The Plan will continue to assess the information available on the public website and make updates as needed.

FUTURE MCO/PROVIDER INTERVENTIONS

10/01/2015 to 12/31/2015 – The programs listed above will continue. Newsletter articles will continue to be developed and published based on data analysis from the Clinical Quality teams.

- **Patient Centered Medical Home.** The Plan will explore partnering with additional PCP and OB/GYN practices to embed Practice Based Care Managers (PBCM) in the practices.
- **Shared Savings Program for Providers** – UPMC *for You* will explore expansion of the Provider Shared Savings program to additional pediatric practices and to additional practices in the Lehigh/Capital zone. Additionally, UPMC *for You* will have an enhanced access metric that must be met for 2016 for providers to receive monies in this program. The focus of the metric will be expanded office hours and availability of same day or walk in appointments.

GOALS/OUTCOMES

The expected program goals/outcomes are improving member experience with their health insurance/health care and improvement in CAHPS rates.

MONITORING EFFECTIVENESS

Effectiveness is monitored as noted:

- Member perception of their ability to receive needed care will continue to be measured annually through the annual (Member) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
- Member satisfaction with written and internet materials (including the Member Handbook) will also continue to be measured annually through CAHPS.
- Provider satisfaction regarding written materials, program initiatives and clinical practice guidelines are measured annually through the Provider Satisfaction Survey.

Both member and provider satisfaction results are reviewed and analyzed by UPMC *for You* Leadership.

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, UPMC was not required to prepare a Root Cause Analysis and Action Plan for any performance measures.

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

- UPMC was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.
- For approximately one-half of the measures under study, including all of the EPSDT: Screenings and Follow-up performance measures, the MCO's performance was statistically significantly above/better than the MMC weighted average in 2015 (MY 2014) as indicated by the following measures:
 - Adult BMI Assessment (Age 18-74 years)
 - Well-Child Visits in the First 15 Months of Life (≥ 6 Visits)
 - Body Mass Index: Percentile (Age 3 - 11 years)
 - Body Mass Index: Percentile (Total)
 - Lead Screening in Children
 - 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)
 - $\geq 61\%$ of Expected Prenatal Care Visits Received
 - $\geq 81\%$ of Expected Prenatal Care Visits Received
 - Prenatal and Postpartum Care – Timeliness of Prenatal Care
 - Prenatal Screening for Smoking
 - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
 - Prenatal Screening for Environmental Tobacco Smoke Exposure
 - Prenatal Counseling for Smoking
 - Prenatal Screening for Depression
 - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
 - Postpartum Screening for Depression
 - Prenatal Screening for Alcohol use
 - Prenatal Screening for Illicit drug use
 - Prenatal Screening for Prescribed or over-the-counter drug use
 - Appropriate Testing for Children with Pharyngitis
 - Asthma in Younger Adults Admission Rate (Age 18-39 years)
 - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years)
 - HbA1c Poor Control ($>9.0\%$)
 - HbA1c Good Control ($<7.0\%$)
 - Retinal Eye Exam
 - Medical Attention for Nephropathy
 - Blood Pressure Controlled $<140/90$ mm Hg
 - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) and (Total Age 18+ years)
 - Controlling High Blood Pressure (Total Rate)
 - Heart Failure Admission Rate (Age 18-64 years) and (Total Age 18+ years)
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
- The following strengths were noted in 2015 for Adult and Child CAHPS survey items:
 - Of the four Adult CAHPS composite survey items reviewed, UPMC showed an increase for three items in 2015 (MY 2014) as compared to 2014 (MY 2013). In addition, three items were higher than the 2015 (MY 2014) MMC weighted averages.

- For UPMC's Child CAHPS, three composite survey items increased in 2015 (MY 2014) as compared to 2014 (MY 2013). All four 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:
 - Annual Dental Visit (Age 2–21 years)
 - Total Eligibles Receiving Preventive Dental Services
 - Chlamydia Screening in Women — All Ages (Age 16-20 years, Age 21-24 years, and Total)
 - Medication Management for People with Asthma: 75% Compliance (Age 19-50 years) and (Age 51-64 years)
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- The following decreases were noted in 2015 (MY 2014) for Adult and Child CAHPS survey items:
 - UPMC showed a decrease in one 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 UPMC's Child CAHPS survey, one composite survey items decreased in 2015 (MY 2014).

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.



UPMC 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:

- Reducing Potentially Preventable Readmissions²

UPMC's Emergency Department Utilization³ decreased (improved) from 2014 to 2015 and is lower (better) than the 2015 MMC average.

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

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

- Controlling High Blood Pressure
- Comprehensive Diabetes Care – HbA1c Poor Control⁴
- Prenatal and Postpartum Care – Timeliness of Prenatal Care

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

Measure that statistically significantly decreased/worsened from 2014 to 2015 but was statistically significantly above/better than the 2015 MMC weighted average is:

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

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

- Annual Dental Visits

Measure that did not statistically significantly change from 2014 to 2015 and was not statistically significantly different than the 2015 MMC weighted average is:

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

D - Root cause analysis and plan of action required

- No UPMC P4P measures fell into this comparison category.

F Root cause analysis and plan of action required

- No UPMC P4P measures fell into this comparison category.

² 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).

³ A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

⁴ Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

Figure 1 - P4P Measure Matrix – UPMC

		Medicaid Managed Care Weighted Average Statistical Significance Comparison			
		Trend	Below Average	Average	Above Average
Year to Year Statistical Significance Comparison	↑		C Annual Dental Visits	B	A Reducing Potentially Preventable Readmissions ⁵
	No Change		D	C Adolescent Well-Care Visits (Age 12-21 Years)	B Controlling High Blood Pressure Comprehensive Diabetes Care – HbA1c Poor Control ⁶ Prenatal and Postpartum Care – Timeliness of Prenatal Care
	↓		F	D	C Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received

Figure 2 - Emergency Department Utilization Comparison

		Medicaid Managed Care Average Comparison			
		Trend	Below/Poorer than Average	Average	Above/Better than Average
Year to Year	↓		C	B	A Emergency Department Utilization ⁷

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.

⁵ 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).

⁶ Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

⁷ 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 – UPMC

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)	58.6% =	59.4% =	55.96% =	56.0% =	56.3% =	58.7%
Comprehensive Diabetes Care - HbA1c Poor Control ⁸	35.0% =	33.6% =	35.22% =	30.1% =	32.5% =	38.1%
Controlling High Blood Pressure	66.7% =	61.1% =	59.37% =	67.6% ▲	68.0% =	61.6%
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received	88.3% =	87.6% =	74.21% ▼	87.1% ▲	77.1% ▼	64.4%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	95.6% =	94.2% =	92.70% =	93.2% =	92.7% =	83.8%
Annual Dental Visits	46.9% =	45.2% ▼	46.79% ▲	53.2% ▲	54.7% ▲	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) ⁹	75.9	77.4	73.0	73.2	72.7	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 ¹⁰		10.2% NA	10.0% =	11.3% ▲	10.3% ▼	11.6%

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.

¹⁰ 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

- UPMC was found to be fully compliant on Subparts C, D, and F. Compliance review findings for UPMC 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. UPMC received information related to these activities from DHS in 2015.

Performance Measures

- UPMC 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

- UPMC 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 UPMC in 2015. A response will be required by the MCO for the noted opportunities for improvement in 2016.