



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

**2015 External Quality Review Report
AmeriHealth Caritas Pennsylvania**

Final Report
April 2016

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

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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 AmeriHealth Caritas Pennsylvania's (ACP'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 ACP, effective December 2014.

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

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

Table 1.1: SMART Items Count Per Regulation

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

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

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

Determination of Compliance

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO’s compliance status with regard to the SMART Items. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights 438.100. Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS. If an item was not evaluated for a particular MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all items were Compliant, the MCO was evaluated as Compliant. If some were Compliant and some were non-Compliant, the MCO was evaluated as partially-Compliant. If all items were non-Compliant, the MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

Format

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO’s findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol, i.e., Enrollee Rights and Protections; Quality Assessment and Performance Improvement (including access, structure and operation, and measurement and improvement standards); and Federal and State Grievance System Standards.

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

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

Findings

Of the 126 SMART Items, 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: ACP 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.

ACP was evaluated against 18 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 18. ACP was found to be compliant on all eight of the categories of Enrollee Rights and Protections Regulations. ACP 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 ACP 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: ACP 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 11 items and was compliant on 11 items based on RY 2014.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 12 items based on RY 2014.
Coverage and Authorization of Services	Compliant	9 items were crosswalked to this category. The MCO was evaluated against 8 items and was compliant on 8 items based on RY 2014.
Structure and Operation Standards		
Provider Selection	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Provider Discrimination Prohibited	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Confidentiality	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Enrollment and Disenrollment	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Grievance Systems	Compliant	1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2014.
Subcontractual Relationships and Delegations	Compliant	3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2014.
Measurement and Improvement Standards		
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2014.
Health Information Systems	Compliant	18 items were crosswalked to this category. The MCO was evaluated against 14 items and was compliant on 13 items and partially compliant on 1 item based on RY 2014.

ACP was evaluated against 55 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on 54 items and partially compliant on 1 item. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, ACP was found to be compliant on all 11 categories.

Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4: ACP 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 1 item and was compliant on this item 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

ACP was evaluated against 12 of the 40 SMART Items crosswalked to Federal and State Grievance System Standards and was compliant on 12 items. ACP was found to be compliant for all nine categories of Federal and State Grievance System Standards.

Accreditation Status

ACP underwent an NCQA Accreditation Survey effective August 9, 2013 through August 9, 2016 and was granted an Accreditation Status of Commendable.

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 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 ACP. Upon review of rates for the Reducing Potentially Preventable Readmissions (RPR) measure, the 2015 and 2014 rates for an affiliated MCO, Keystone First (KF), had been identified as outliers, with a notable increase beginning in 2014 and continuing in 2015. Higher rates indicate poorer performance on this measure. DHS and IPRO reviewed the validation process; no apparent issues were observed. DHS requested that IPRO work with the MCO 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 KF. The MCO proposed reasons for the rate changes: 1) inclusion of fee-for-service claims from the state that should not have been considered inpatient stays, 2) issues with how the MCO's vendor created the denominator for the measure (re-admissions that should not be counted as admissions in the denominator and newborns counted as an admission when the mother was counted as an admission). As ACP utilizes the same processes as KF, it was discovered that the issue regarding the creation of the denominator impacted ACP as well. The MCO applied a step-by-step approach to correct the issues, and IPRO validated the data at each step. The 2015 and 2014 RPR data presented for ACP 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 identified for the 2015 (MY 2014) Access/Availability of Care performance measures.

- The 2015 Adult BMI Assessment rate was statistically significantly higher than the 2015 MMC weighted average by 5.8 percentage points

There were no opportunities for improvement identified for the 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)	4,050	3,932	97.1%	96.6%	97.6%	96.4%	n.s.	97.0%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 25 Months-6 Years)	17,151	15,074	87.9%	87.4%	88.4%	87.6%	n.s.	88.6%	-	≥ 25th and < 50th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 7-11 Years)	13,241	12,105	91.4%	90.9%	91.9%	91.9%	n.s.	91.9%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 12-19 Years)	16,319	14,797	90.7%	90.2%	91.1%	91.5%	-	90.1%	+	≥ 50th and < 75th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20-44 Years)	19,649	16,711	85.0%	84.5%	85.5%	84.1%	+	83.2%	+	≥ 75th and < 90th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45-64 Years)	10,396	9,632	92.7%	92.1%	93.2%	91.5%	+	91.2%	+	≥ 90th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ Years)	591	527	89.2%	86.6%	91.8%	90.7%	n.s.	87.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Adult BMI Assessment (Ages 18-74 Years)	432	384	88.9%	85.8%	92.0%	87.1%	n.s.	83.0%	+	≥ 50th and < 75th percentile	

Well-Care Visits and Immunizations

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

- Six Well-Care Visit and Immunizations measures for ACP's 2015 rates were statistically significantly higher than the MMC weighted averages.
 - Body Mass Index: Percentile (Age 3 - 11 years) – 9.0 percentage points
 - Body Mass Index: Percentile (Age 12-17 years) – 14.8 percentage points
 - Body Mass Index: Percentile (Total) – 10.9 percentage points
 - Counseling for Nutrition (Total) – 4.9 percentage points
 - Counseling for Physical Activity (Age 12-17 years) – 10.6 percentage points
 - Counseling for Physical Activity (Total) – 7.2 percentage points

The following 2015 Well-Care Visits and Immunizations performance measure opportunities for improvement were identified:

- Two Well-Care Visit and Immunizations measures for ACP's 2015 rates were statistically significantly lower than the MMC weighted averages.
 - Adolescent Well-Care Visits (Age 12 to 21 Years) – 5.2 percentage points
 - Immunization for Adolescents (Combo 1) – 4.5 percentage points

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)	424	294	69.3%	64.8%	73.8%	71.5%	n.s.	65.2%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)	360	267	74.2%	69.5%	78.8%	76.5%	n.s.	76.4%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Childhood Immunization Status (Combination 2)	432	339	78.5%	74.5%	82.5%	79.9%	n.s.	75.8%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Childhood Immunization Status (Combination 3)	432	326	75.5%	71.3%	79.6%	76.4%	n.s.	72.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	432	231	53.5%	48.7%	58.3%	62.7%	-	58.7%	-	≥ 50th and < 75th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 3-11 Years)	289	224	77.5%	72.5%	82.5%	75.9%	n.s.	68.5%	+	≥ 75th and < 90th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 12-17 Years)	143	120	83.9%	77.5%	90.3%	71.5%	+	69.1%	+	≥ 75th and < 90th percentile	
HEDIS	WCC Body Mass Index: Percentile (Total)	432	344	79.6%	75.7%	83.5%	74.5%	n.s.	68.7%	+	≥ 75th and < 90th percentile	

HEDIS	WCC Counseling for Nutrition (Age 3 11 Years)	289	213	73.7%	68.5%	79.0%	74.2%	n.s.	70.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	WCC Counseling for Nutrition (Age 12 17 Years)	143	103	72.0%	64.3%	79.7%	60.6%	+	64.6%	n.s.	≥ 75th and < 90th percentile
HEDIS	WCC Counseling for Nutrition (Total)	432	316	73.1%	68.9%	77.4%	69.9%	n.s.	68.2%	+	≥ 75th and < 90th percentile
HEDIS	WCC Counseling for Physical Activity (Age 3 11 Years)	289	195	67.5%	61.9%	73.0%	65.8%	n.s.	61.9%	+	≥ 75th and < 90th percentile
HEDIS	WCC Counseling for Physical Activity (Age 12 17 Years)	143	104	72.7%	65.1%	80.4%	58.4%	+	62.1%	+	≥ 75th and < 90th percentile
HEDIS	WCC Counseling for Physical Activity (Total)	432	299	69.2%	64.7%	73.7%	63.4%	n.s.	62.0%	+	≥ 75th and < 90th percentile
HEDIS	Immunizations for Adolescents (Combination 1)	360	279	77.5%	73.0%	82.0%	82.0%	n.s.	82.0%	-	≥ 50th and < 75th percentile

EPSDT: Screenings and Follow-up

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

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

- ACP's rates for the following seven EPSDT Screenings and Follow-up measures were statistically significantly below the 2015 MMC weighted averages:
 - Lead Screening in Children – 5.5 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase – 3.2 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication: Continuation Phase – 5.7 percentage points
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced): Continuation Phase – 5.2 percentage points
 - Developmental Screening in the First Three Years of Life (Total) – 5.1 percentage points
 - Developmental Screening in the First Three Years of Life (1 year) – 6.9 percentage points
 - Developmental Screening in the First Three Years of Life (2 years) – 5.0 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	432	310	71.8%	67.4%	76.1%	70.4%	n.s.	77.2%	-	≥ 25th and < 50th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	1,187	259	21.8%	19.4%	24.2%	19.5%	n.s.	25.0%	-	< 10th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	388	83	21.4%	17.2%	25.6%	20.2%	n.s.	27.1%	-	< 10th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	1,187	279	23.5%	21.1%	26.0%	19.8%	+	26.2%	-	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	369	100	27.1%	22.4%	31.8%	24.9%	n.s.	32.3%	-	NA
PA EQR	EPSDT Hearing Test (Age 4 20 Years)	49,420	19,866	40.2%	39.8%	40.6%	38.2%	+	40.4%	n.s.	NA
PA EQR	EPSDT Vision Test (Age 4 20 Years)	49,420	19,948	40.4%	39.9%	40.8%	38.1%	+	40.7%	n.s.	NA
PA EQR	Developmental Screening in the First Three Years of Life Total ¹	9,004	3,776	41.9%	40.9%	43.0%	44.0%	-	47.0%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year ¹	3,214	1,146	35.7%	34.0%	37.3%	42.9%	-	42.6%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years ¹	2,951	1,353	45.8%	44.0%	47.7%	43.8%	n.s.	50.9%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years ¹	2,839	1,277	45.0%	43.1%	46.8%	45.2%	n.s.	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 or opportunities for improvement identified for ACP's 2015 (MY 2014) Dental Care for Children and Adults performance measures.

Table 3.5: EPSDT: Dental Care for Children and Adults

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison					
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile	
HEDIS	Annual Dental Visit	57,901	32,748	56.6%	56.2%	57.0%	54.8%	+	58.2%	-	≥ 50th and < 75th percentile	
PA EQR	Total Eligibles Receiving Preventive Dental Treatment Services	87,830	39,406	44.9%	44.5%	45.2%	43.5%	+	46.8%	-	NA	
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 Years)	3,892	1,902	48.9%	47.3%	50.5%	46.9%	n.s.	50.6%	-	NA	

Women's Health

One strength was identified for the 2015 (MY 2014) Women's Health performance measures.

- The 2015 rate for the Human Papillomavirus Vaccine for Female Adolescents measure was statistically significantly higher than the 2015 MMC weighted average by 5.9 percentage points

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

- In 2015, ACP's rates were statistically significantly below the 2015 MMC weighted averages for the following three measures:
 - Chlamydia Screening in Women (Total) – 6.9 percentage points
 - Chlamydia Screening in Women (Age 16-20 years) – 7.4 percentage points
 - Chlamydia Screening in Women (Age 21-24 years) – 5.9 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)	2,849	1,883	66.1%	64.3%	67.8%	68.7%	-	63.3%	+	≥ 75th and < 90th percentile	
HEDIS	Cervical Cancer Screening	398	271	68.1%	63.4%	72.8%	69.0%	n.s.	66.1%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Chlamydia Screening in Women (Total)	5,033	2,638	52.4%	51.0%	53.8%	53.5%	n.s.	59.3%	-	≥ 25th and < 50th percentile	
HEDIS	Chlamydia Screening in Women (Age 16-20 Years)	3,158	1,545	48.9%	47.2%	50.7%	49.7%	n.s.	56.3%	-	≥ 25th and < 50th percentile	
HEDIS	Chlamydia Screening in Women (Age 21-24 Years)	1,875	1,093	58.3%	56.0%	60.6%	58.7%	n.s.	64.2%	-	≥ 25th and < 50th percentile	
HEDIS	Human Papillomavirus Vaccine for Female Adolescents	432	146	33.8%	29.2%	38.4%	33.0%	n.s.	27.9%	+	≥ 90th percentile	
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	5,414	98	1.8%	1.4%	2.2%	3.2%	-	2.6%	-	≥ 75th and < 90th percentile	

Obstetric and Neonatal Care

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

- In 2015, ACP's rates were statistically significantly higher than the respective 2015 MMC weighted averages for the following twelve measures:
 - ≥ 61% of Expected Prenatal Care Visits Received – 9.9 percentage points
 - ≥ 81% of Expected Prenatal Care Visits Received – 13.5 percentage points
 - Prenatal and Postpartum Care – Timeliness of Prenatal Care – 4.1 percentage points

- Prenatal Screening for Smoking – 6.0 percentage points
- Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 6.6 percentage points
- Prenatal Counseling for Depression – 16.4 percentage points
- Postpartum Screening for Depression – 9.0 percentage points
- Prenatal Screening for Alcohol use – 9.7 percentage points
- Prenatal Screening for Illicit drug use – 10.0 percentage points
- Prenatal Screening for Prescribed or over-the-counter drug use – 10.5 percentage points
- Prenatal Screening for Intimate partner violence – 10.4 percentage points
- Prenatal Screening for Behavioral Health Risk Assessment – 8.8 percentage points

One opportunity for improvement was identified for ACP's 2015 (MY 2014) Obstetric and Neonatal Care performance measures.

- The 2015 Prenatal Counseling for Smoking rate was statistically significantly lower than the 2015 MMC weighted average by 8.5 percentage points

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	430	385	89.5%	86.5%	92.5%	93.6%	-	79.6%	+	NA
HEDIS	≥81% of Expected Prenatal Care Visits Received	430	335	77.9%	73.9%	81.9%	82.7%	n.s.	64.4%	+	≥ 90th percentile
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	430	378	87.9%	84.7%	91.1%	92.2%	-	83.8%	+	≥ 50th and < 75th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	430	272	63.3%	58.6%	67.9%	68.0%	n.s.	62.2%	n.s.	≥ 50th and < 75th percentile
PA EQR	Prenatal Screening for Smoking	398	362	91.0%	88.0%	93.9%	92.3%	n.s.	84.9%	+	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	398	361	90.7%	87.7%	93.7%	NA	NA	84.1%	+	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	398	135	33.9%	29.1%	38.7%	45.8%	-	35.9%	n.s.	NA
PA EQR	Prenatal Counseling for Smoking	133	88	66.2%	57.7%	74.6%	77.9%	-	74.7%	-	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	55	23	41.8%	27.9%	55.8%	34.8%	n.s.	51.3%	n.s.	NA
PA EQR	Prenatal Smoking Cessation	133	6	4.5%	0.6%	8.4%	11.9%	-	8.8%	n.s.	NA
PA EQR	Prenatal Screening for Depression	398	284	71.4%	66.8%	75.9%	76.2%	n.s.	69.3%	n.s.	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	398	273	68.6%	63.9%	73.3%	NA	NA	63.8%	n.s.	NA
PA EQR	Prenatal Screening Positive for Depression	284	52	18.3%	13.6%	23.0%	14.9%	n.s.	18.6%	n.s.	NA
PA EQR	Prenatal Counseling for Depression	52	46	88.5%	78.8%	98.1%	95.7%	n.s.	72.1%	+	NA
PA EQR	Postpartum Screening for Depression	265	221	83.4%	78.7%	88.1%	83.8%	n.s.	74.4%	+	NA
PA EQR	Postpartum Screening Positive for Depression	221	30	13.6%	8.8%	18.3%	12.7%	n.s.	14.7%	n.s.	NA
PA EQR	Postpartum Counseling for Depression	30	28	93.3%	82.7%	100.0%	NA	NA	85.8%	n.s.	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	1,090	231	21.2%	18.7%	23.7%	22.1%	n.s.	23.0%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	4,641	420	9.0%	8.2%	9.9%	8.8%	n.s.	9.5%	n.s.	NA
PA EQR	Prenatal Screening for Alcohol use	398	357	89.7%	86.6%	92.8%	NA	NA	80.0%	+	NA
PA EQR	Prenatal Screening for Illicit drug use	398	358	89.9%	86.9%	93.0%	NA	NA	80.0%	+	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	398	361	90.7%	87.7%	93.7%	NA	NA	80.2%	+	NA
PA EQR	Prenatal Screening for Intimate partner violence	398	259	65.1%	60.3%	69.9%	NA	NA	54.6%	+	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	398	201	50.5%	45.5%	55.5%	NA	NA	41.7%	+	NA

PA EQR	Elective Delivery ^{1,2}	1,054	105	10.0%	8.1%	11.8%	NA	NA	11.5%	n.s.	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

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

- ACP's 2015 rates were statistically significantly higher than the MMC weighted averages for the following six measures:
 - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator – 3.7 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 5-11 years) – 12.0 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 12-18 years) – 8.6 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 19-50 years) – 9.5 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Age 51-64 years) – 7.6 percentage points
 - Medication Management for People with Asthma: 75% Compliance (Total - Age 5-64 years) – 10.8 percentage points

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

- ACP's 2015 rates were statistically significantly below the MMC weighted averages for the following measures:
 - Appropriate Testing for Children with Pharyngitis – 5.3 percentage points
 - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 7.3 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	2,379	1,500	63.1%	61.1%	65.0%	58.3%	+	68.4%	-	≥ 25th and < 50th percentile	
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection ¹	4,883	609	87.5%	86.6%	88.5%	85.9%	+	88.6%	-	≥ 25th and < 50th percentile	
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ²	913	728	20.3%	17.6%	22.9%	21.5%	n.s.	27.5%	-	≥ 10th and < 25th percentile	
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	277	87	31.4%	25.8%	37.1%	28.5%	n.s.	29.8%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	358	280	78.2%	73.8%	82.6%	78.8%	n.s.	76.3%	n.s.	≥ 90th percentile	
HEDIS	Pharmacotherapy Management of COPD Exacerbation Bronchodilator	358	327	91.3%	88.3%	94.4%	89.9%	n.s.	87.6%	+	≥ 90th percentile	
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 11 Years)	1,010	937	92.8%	91.1%	94.4%	91.3%	n.s.	91.7%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Use of Appropriate Medications for People with Asthma (Age 12 18 Years)	658	579	88.0%	85.4%	90.6%	86.7%	n.s.	87.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Use of Appropriate Medications for People with Asthma (Age 19 50 Years)	916	718	78.4%	75.7%	81.1%	78.0%	n.s.	77.8%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Use of Appropriate Medications for People with Asthma (Age 51 64 Years)	330	253	76.7%	72.0%	81.4%	75.3%	n.s.	75.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 64 Years)	2,914	2,487	85.3%	84.0%	86.6%	84.0%	n.s.	85.3%	n.s.	≥ 50th and < 75th percentile	

HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-11 Years)	936	430	45.9%	42.7%	49.2%	39.9%	+	34.0%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12-18 Years)	579	245	42.3%	38.2%	46.4%	43.4%	n.s.	33.7%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19-50 Years)	716	382	53.4%	49.6%	57.1%	48.4%	n.s.	43.8%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51-64 Years)	253	168	66.4%	60.4%	72.4%	55.7%	+	58.8%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-64 Years)	2,484	1,225	49.3%	47.3%	51.3%	45.0%	+	38.6%	+	≥ 90th percentile
PA EQR	Annual Percentage of Asthma Patients (Age 2-20 Years) with One or More Asthma Related ER Visit ³	9,544	1,077	11.3%	10.6%	11.9%	12.3%	-	13.1%	-	NA
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years)	412,186	48	0.97	0.70	1.24	1.17	n.s.	1.22	n.s.	NA
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) ⁴	238,498	253	8.84	7.75	9.93	8.59	n.s.	9.47	n.s.	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

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

- ACP's 2015 rate for the Retinal Eye Exam measure was statistically significantly above the 2015 MMC weighted average by 6.3 percentage points.

One opportunity for improvement was identified for Comprehensive Diabetes Care performance measures for 2015 (MY 2014).

- ACP's 2015 rate for the Medical Attention for Nephropathy measure was statistically significantly below the 2015 MMC weighted average by 3.2 percentage points.

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	576	492	85.4%	82.4%	88.4%	84.8%	n.s.	85.5%	n.s.	≥ 25th and < 50th percentile
HEDIS	HbA1c Poor Control (>9.0%) ¹	576	222	38.5%	34.5%	42.6%	33.3%	n.s.	38.1%	n.s.	≥ 50th and < 75th percentile
HEDIS	HbA1c Control (<8.0%)	576	293	50.9%	46.7%	55.0%	56.2%	n.s.	51.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	HbA1c Good Control (<7.0%)	433	156	36.0%	31.4%	40.7%	39.7%	n.s.	36.9%	n.s.	≥ 25th and < 50th percentile
HEDIS	Retinal Eye Exam	576	360	62.5%	58.5%	66.5%	65.5%	n.s.	56.2%	+	≥ 50th and < 75th percentile
HEDIS	Medical Attention for Nephropathy	576	459	79.7%	76.3%	83.1%	80.5%	n.s.	82.9%	-	≥ 25th and < 50th percentile
HEDIS	Blood Pressure Controlled <140/90 mm Hg	576	381	66.1%	62.2%	70.1%	69.5%	n.s.	65.0%	n.s.	≥ 50th and < 75th percentile
PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 18-64 Years) per 100,000 member years	640,772	160	2.08	1.76	2.40	2.30	n.s.	1.96	n.s.	NA
PA EQR	Diabetes Short Term Complications Admission Rate ² (Age 65+ Years) per 100,000 member years	9,912	1	0.84	0.00	2.49	0.97	n.s.	0.40	n.s.	NA

PA EQR	Diabetes Short Term Complications Admission Rate ² (Total Age 18+ Years) per 100,000 member years	650,684	161	2.06	1.74	2.38	2.28	n.s.	1.94	n.s.	NA
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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 ACP's 2015 (MY 2014) Cardiovascular Care performance measures.

- In 2015, ACP's rates were statistically significantly below (better than) the MMC weighted averages for the following measures:
 - Heart Failure Admission Rate (Age 18-64 years) – 0.49 admissions per 100,000 member years
 - Heart Failure Admission Rate (Total Age 18+ years) – 0.45 admissions per 100,000 member years
- ACP's 2015 rate for the Controlling High Blood Pressure (Total Rate) measure was statistically significantly above the 2015 MMC weighted average by 4.5 percentage points.

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	51	48	94.1%	86.7%	100.0%	95.12%	n.s.	89.5%	n.s.	≥ 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	452	299	66.2%	61.7%	70.6%	65.59%	n.s.	61.6%	+	≥ 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate ¹ (Age 18-64 Years) per 100,000 member years	640,772	96	1.25	1.00	1.50	1.51	n.s.	1.74	-	NA
PA EQR	Heart Failure Admission Rate ¹ (Age 65+ Years) per 100,000 member years	9,912	8	6.73	2.07	11.39	22.22	-	4.61	n.s.	NA
PA EQR	Heart Failure Admission Rate ¹ (Total Age 18+ Years) per 100,000 member years	650,684	104	1.33	1.08	1.59	1.79	-	1.78	-	NA

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

Utilization

One strength was noted for ACP's 2015 (MY 2014) Utilization performance measures.

- ACP's 2015 rate for the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure was statistically significantly above the 2015 MMC weighted average by 5.7 percentage points.

There were no opportunities for improvement were identified for ACP'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	11,463	1,199	10.5%	9.9%	11.0%	9.98%	n.s.	11.6%	-	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	314	242	77.1%	72.3%	81.9%	72.04%	n.s.	71.4%	+	≥ 90th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	634	459	72.4%	68.8%	76.0%	70.80%	n.s.	71.7%	n.s.	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 ACP 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)	81.16%	▲	76.19%	▼	82.57%	77.96%
Getting Needed Information (Usually or Always)	83.91%	▲	74.36%	▼	78.35%	83.20%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	75.82%	▲	71.35%	▼	71.83%	73.31%
Appointment for Routine Care When Needed (Usually or Always)	84.34%	▲	83.01%	▲	81.89%	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)	84.84%	▲	84.53%	▲	80.65%	84.38%
Getting Needed Information (Usually or Always)	89.68%	▲	83.33%	▲	80.35%	82.42%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	87.98%	▲	85.19%	▲	84.45%	86.13%
Appointment for Routine Care When Needed (Usually or Always)	91.18%	▲	89.38%	▲	87.47%	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 response submitted to IPRO as of November 2015, as well as any additional relevant documentation provided by ACP.

Table 5.1 presents ACP'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: ACP 2014.01: The Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care population PIP for ACP received partial credit for the element of study evaluated in 2014 that reflects activities in 2013: Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement.
Follow Up Actions Taken Through 09/30/15: <ul style="list-style-type: none">• 1st Qtr 2013 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 29 programs• 2nd Qtr 2013 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 45 programs• 3rd Qtr 2013 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 31 programs• 4th Qtr 2013 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 39 programs• 1st Qtr 2014 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 19 programs• 2nd Qtr 2014 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 18 programs• 3rd Qtr 2014 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 31 programs• 4th Qtr 2014 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 15 programs• 1st Qtr 2015 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 25 programs• 2nd Qtr 2015 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 28 programs• 3rd Qtr 2015 Childhood Weight Management Health Education Program (Healthy You, Healthy Me) to members/community held in various counties by community outreach staff – 24 programs• 4th Qtr 2012 Member Newsletter Article 5 Steps to Improve Your Health, Information about Healthy You, Healthy Me Program• 2013-2015 EPSDT information updated on provider web• 2013-2015 Clinical Practice Guidelines updated on provider web• 2013-2015 CME-asthma control, pediatric obesity on provider web

- 4th Qtr 2013 Well Visit Provider Bonus Campaign
- 2013-2015 Coding Guidelines updated on web, includes WCC codes
- 2014-2015 Member education information and link obesity information on member web
- 2014-2015 Member portal went live, personal health record
- 2014-2015 Member EPSDT information on member web
- 2013-2015 Links to health education topics – CDC and WebMD – on member web
- 2nd QTR 2013 Healthy food swap article in member newsletter
- 1st Qtr and 3rd Qtr 2014 health recipe in member newsletter
- HEDIS Coding Guidelines made available to providers, fall 2014
- Case management outreach and assessment, goal planning continue
- Implemented 2014-2015 Let us Know program, providers can refer members in need of assistance to case management
- March 2014 – information about clinical resources on web in provider newsletter
- November 2014 – Information on clinical practice guidelines and HEDIS coding guidelines in provider newsletter
- March 2015 – article on improving health outcomes for members in provider newsletter and information about community outreach programs available

Future Actions Planned: ACP continually seeks out community partners to collaborate with to deliver our Child Weight Management Programs within the community, continue to reinforce case management. Agencies/providers often call upon us to come to their locations to deliver this very educational program. Our HEDIS rates for counseling for physical activity and nutrition have steadily increased.

Reference Number: ACP 2014.02: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC weighted average for the Lead Screening in Children measure.

Follow Up Actions Taken Through 09/30/15:

EPSDT Unit continues to telephonically outreach to parents/guardians/members to remind them about missed immunizations and screenings. In addition, Members/Consumers are enrolled in the Pediatric Preventive Health Care Program in order to receive preventive health services. The Program makes provisions for screenings, immunizations, etc. During the outreach call the staff reviews gaps in care, including lead and encourages the parent/guardian to make an appointment with their PCP and obtain a lead level. Children with elevated blood lead levels receive outreach letters encouraging follow up evaluations with their health care providers, as well as case management outreach and follow up. Educational materials and resource information are included in the mailings. Providers are notified of children on their panel with elevated lead levels by telephone, email, or facsimile.

- Issue 1, 2014 – lead article in member newsletter
- Issue 1, 2015 – the doctor will see you now article in member newsletter
- Annual Birthday card reminders
- Care Gaps – alerts for missing lead screening – and contact with parent/guardian
- PCP \$10 bill above
- EPSDT requirements reinforced with providers, available on web
- EPSDT billing reminder fast facts sent to providers 1/2015
- Provider POST newsletter, updated DHS Periodicity schedule and coding matrix 8/2015
- HEDIS Guide available for providers 2015 and for 2016

Future Actions Planned: Continue with above actions. Reinforce/educate parent/guardian – need for lead screening. Continue to educate providers on Medicaid requirements. HEDIS Guide available for providers 2015 and for 2016.

Reference Number: ACP 2014.03: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC weighted averages for the Chlamydia Screening in Women (Age 16-20 Years), (Age 21-24 Years), and (Total) measures.

Follow Up Actions Taken Through 09/30/15:

Efforts continue to educate both the member and the provider on the importance of the screening

- Clinical Practice Guidelines and clinical resources always available on website for provider assistance/guidance
- Reminder of availability of clinical resources and CPG in Provider Newsletter
- Links to Health Education, CDC web and WebMD on member website
- Women's Health educational material and PowerPoint presentation for use at community outreach education sessions
- Important tests for women education one sheets available for distribution at community events
- HEDIS coding guidelines distributed to providers, 3rd quarter 2014, also available on website
- Pap screening events will include chlamydia screening as indicated for members
- July 2014 Promoting health equity in provider newsletter
- November 2014 expanding diversity article provider newsletter
- Member newsletter issue 1 2015, The doctor will see you now article
- Member newsletter issue 2 2015, Teens need check-ups too

Future Actions Planned: Continue education both members and providers as in the above interventions. Expected outcome is to

increase awareness and importance of screenings. Monthly reports may be generated to monitor and analyze rates and implement additional if required. Drill down of providers not doing the screenings, education with PNM and medical director to those providers that are not doing the screenings. Plan also reviews and updates existing member educational materials.

Reference Number: ACP 2014.04: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC weighted average for the Prenatal Screening Positive for Depression measure.

Follow Up Actions Taken Through 09/30/15:

Our Bright Start Program is designed to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. This comprehensive prenatal risk reduction program strives to decrease poor obstetrical outcomes for the pregnant population. Extensive assessment and reassessments throughout pregnancy.

The Bright Start Maternity Program is a focused collaboration designed to improve compliance with prenatal care. Using the Bright Start Maternity Program allows for collaboration between the Bright Start Care Manager, the member, the Obstetrician, and the MCBHO for assessment and interventions to support management of behavioral/social and health issues. The Bright Start team assesses, plans, implements, teaches, coordinates, monitors and evaluates options and services required to meet the individual's health needs.

Program Goals:

- Early identification of pregnant members and accurate contact information
- Improve health outcomes for neonates
- Facilitate access to needed services and resources
 - Community partners or Maternity advocates
 - Dental Screenings
 - Behavioral Health screenings
 - Text for Babies
 - Breastfeeding
 - WIC and other community resources
 - Food banks
 - Housing assistance (shelters/group homes)
- Build collaborative relationships with community-based agencies that specialize in services for maternal-child health
- Encourage early prenatal care and continuum of care from the beginning of pregnancy through the post-partum period, increasing awareness through member newsletters, media engagements, provider education and community alliances
- Assess and address healthcare disparities in pregnant women

Members enrolled in the Bright Start Program receive a variety of interventions depending upon the assessed risk of their pregnancy. Care Managers play a hands-on role, as necessary, in coordination and facilitating care with the members' physicians and home health care agencies. They also outreach to ensure member follow-up with medical appointments, identify potential barriers to getting care, and encourage appropriate prenatal behavior.

Members are triaged using informatics reports and assessment information provided by the obstetrics practitioner into low-risk, moderate-risk, and high-risk populations. Low-risk members receive educational material about pregnancy, preparing for delivery, and how to access a Plan Bright Start Care Manager for any questions/issues. Low-risk members receive information after delivery regarding depression and breastfeeding. They also complete a postpartum survey to ensure that they are scheduling their post-partum checkup and to identify any additional case management needs. Members that are triaged as high-risk receive "high touch" case management interventions by a Care Manager.

The Plan's pregnant members are identified through a variety of sources:

- New enrollee assessment – All new enrollee contacts and information contain the question "Are you pregnant?" Enrollees responding with a "yes" are referred to the Bright Start Program for assessment and connection to an obstetrician.
- Physician incentives – Physicians who see a pregnant member for an initial visit and fix in the Plan's Obstetrical Assessment Form are paid a substantial amount above the office visit fee.
- Claim identification – Enrollees who are pregnant are identified through an analysis of claim data. Those identified are cross-checked against the list of enrollees known to the Bright Start department. Enrollees not already known receive an outreach contact for an assessment.
- Lab identification – Enrollees who are pregnant are identified through an analysis of lab data and pharmacy data. Those identified are cross-checked against the list of enrollees known to the Bright Start department. Enrollees not already known receive an outreach contact for an assessment.
- Inter-departmental referral/coordination – Other departments within The Plans who come in contact with a pregnant member refer the member to the Bright Start Program for assessment and education.
- Self-referral promotion (Welcome Card, Magnet, Newsletter and toll-free number) – All member materials contain language encouraging members who are pregnant to contact The Plan's Bright Start Program via a toll-free phone number. Additionally, members can refer themselves to the participating OB/GYN specialist of choice for maternity care services.
- 24/7 Nurse Line Referral
- Telephone "on hold" message – members who are placed on hold when contacting departments hear messages rather than

music. One of these messages encourages women who are pregnant (or think they may be pregnant) to seek prenatal care and provides the Bright Start number.

The pregnant members are provided with educational mailings and information on how to contact the Bright Start Department or 24/7 nurse line for assistance. Care Managers assigned to high-risk members coordinate and facilitate care with the members' physicians, home health care agencies and community resources/partners.

- 2014-current - Links to your health education on plan web/member tab. Also links to CDC and WebMD. Links to Information for You, which includes information about tips on having a healthy baby.
- Current – Link to Healthy programs for members, link to Bright Start program
- Volume 1 2014 and 2015, member newsletter – Do you want your baby to have a bright start article
- 2014 – Developed postpartum trifold on importance of going to postpartum visit, explaining provider will screen for depression
- January 2015, all pregnant members are screened for postpartum depression via telephone, if unable to reach member telephonically, member is referred to Community Outreach Solutions team who will go into community looking for member. To date, we have reached 90% of our members.

Future Actions Planned: Continue current actions, possibly analyzing under-performing providers and having the medical director visit and educate providers on standards.

Reference Number: ACP 2014.05: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC weighted average for the Appropriate Testing for Children With Pharyngitis measure.

Follow Up Actions Taken Through 09/30/15:

- Launched an educational page to provider website
- Updated Clinical Practice Guidelines on Provider website
- Developing an educational program to encourage the appropriate use of antibiotics among providers
- Provider newsletter article
- Antibiotic education page on the provider website
- Creation of Antibiotic Utilization Review Reports
- Prescriber letter for antibiotic HEDIS measures to target under-performing providers in measures that involve inappropriate antibiotic use

Future Actions Planned: Continue current actions, possibly analyzing under-performing providers and having the medical director visit and educate providers on standards.

Reference Number: ACP 2014.06: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC weighted average for the Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measure

Follow Up Actions Taken Through 09/30/15:

- Launched an educational page to provider website
- Updated Clinical Practice Guidelines on Provider website
- Developing an educational program to encourage the appropriate use of antibiotics among providers
- Provider newsletter article
- Antibiotic education page on the provider website
- Developed provider communication tips
- Developed materials for provider:
 - [Get Smart Antibiotic Page](#)
 - [Acute Pharyngitis in Adults Summary](#)
 - [Pediatric Antibiotic Tips](#)
- Develops materials for providers to share with members:
 - [Get Smart Rx Sheet](#)
 - [Get Smart Rx Sheet \(Spanish\)](#)
 - [No Antibiotics Please Poster](#)
 - [Know When Antibiotics Work](#)
- Creation of Antibiotic Utilization Review Reports
- Prescriber letter for antibiotic HEDIS measures to target under-performing providers in measures that involve inappropriate antibiotic use
- Develop antibiotic drug utilization review reports

Future Actions Planned: Continue with current actions. Possibly developing antibiotic drug utilization review reports.

Reference Number: ACP 2014.07: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC weighted average for the Medical Attention for Nephropathy measure.

Follow Up Actions Taken Through 09/30/15:

- Member and provider newsletter articles
- Drug Therapy Management Program is a distinct service or group of services that optimizes therapeutic outcomes for

individual patients. DTM encompasses a broad range of professional activities and responsibilities within the licensed pharmacist's, or other qualified health care provider's, scope of practice. These services are comprised of individual interventions each of which is intended to elicit a change in a patient's drug therapy, reduce the incidence of adverse drug events and improve adherence to medication regimens.

- "Care Coordination Services" pilot program provides comprehensive case management and disease management services to the highest risk health plan members.
- Screening events at targeted provider offices to perform with member incentive of \$10 at point of service
- Oral diabetic medications to insulin provider outreach program to actively outreach diabetic members receiving 2 or more oral medications that are not insulin
- Grand round educational presentations to case managers
- Embedded Case Managers at ER (1) and targeted provider offices (1) to provide education and resource information to members. (ACP in Reading and Lancaster)
- Neighborhood Diabetes Program provides delivery of in home diabetes testing supplies prescription medications, insulin pump supplies, provides in home training and follow up outreach calls.
- Pharmacy medication home delivery program – participating pharmacies included
- Call out reminders to schedule appointments by quality team
- HEDIS Guide available for providers 2015 and 2016
- COS (feet on the street) team deployed to diabetic members unable to be reached telephonically by case management
- Office-based testing placed on our fee schedule, reimbursing providers \$5 for doing the test in their office. Notice going out to providers in the current issue of the provider newsletter, fall 2015
- Just in Time (JIT) call campaigns started 7/2015 all members showing care gap are called by rapid response teams
- Met to consider how the developed check list will be deployed at events and how it might be used to obtain data more timely
- Meetings with a number of practices in to discuss QEP/CPT II
- Provider bonus campaign October 2015
- CPT 2 coding letter sent to providers 4/2015, also available on website

Future Actions Planned: Continue with above, perform analysis of provider under-performing, visit with medical director and account executive. Increase member screening events.

Reference Number: ACP 2014.08: The MCO's rates were statistically significantly worse than the 2014 (MY 2013) MMC weighted averages for the Diabetes Short-Term Complications Admission Rate (Age 18-64 years) and (Total Age 18+ years) measures.

Follow Up Actions Taken Through 09/30/15:

Members are identified for CCM through the many sources, including referrals from internal and external sources. Care Managers perform comprehensive and disease specific assessments, re-assessments, address goals, and develop a plan of care with input from the member and the physician(s). The case management process includes reassessing and adjusting the care plan and its goals as needed. Care Connectors are assigned activities to assist the member with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address various issues including but not limited to: Pharmacy, DME and/or Dental access, assistance with transportation, identification of and access to Specialists and referral and coordination with behavioral health providers or other community resources. Based on assessment, members are stratified into various levels. There are four sub-levels of intensity; Episode class A with Very High Intensity (outreach every 1-2 weeks), Episode class B with High Intensity (outreach every 2-3 weeks), Episode class C with Moderate Intensity (outreach every 4-6 weeks), and Episode class D with Low Intensity (outreach every 3-6 months). Members enrolled in the CCM component of Integrated Healthcare Management remain in the program for the duration of their eligibility and continue to be monitored and re-stratified accordingly.

Low-risk member interventions:

- Welcome letter/educational material mailed to newly identified members
- Focused educational Mailings
- Monitoring for medication adherence
- Annual reminders for flu/pneumonia vaccine
- Access to Rapid Response Unit
- Access to 24/7 Nurse Line
- Smoking Cessation Program referral
- Integrated Healthcare Management Assessment per applicable department available upon request
- Monitoring for lab screening and results

High-risk members interventions:

In addition to low-risk interventions, Integrated Healthcare Management services, including:

- Comprehensive Assessment
- Individualized Care Plan focusing on Priority Interventions (detailed below)

- Outreach based according to level of intensity
- Focused education, based on assessment including preventive measures, worsening of symptoms and supportive measures
- Monitoring of pharmaceutical medication
- Utilization of Health risk assessments tools to monitor member outcomes
- Provider contact and care plan collaboration
- Provide high level supportive services and equipment
- Identification, communication and intervention to resolve Gaps in Care
- Connections to appropriate community resources and services
- Outreach to members with HbA1c >8.5%
- Outreach to members with no HbA1c on file

Program Plusses:

The Plans use a variety of innovative strategies that integrate information, technology and community to address disease-specific needs of the population. Initiatives related to the Diabetes Program include:

- Drug Therapy Management (DTM) by Perform Rx
- Community Wellness Empowerment Events
- Acute Care Transition CM
- Embedded/Onsite Care Managers at select provider offices to address care gaps in coordination with physician practices
- Shared Savings Program
- Dedicated Diabetes Web Page for Providers
- Dedicated Diabetes Web Page for Members
- WURD Wellness 101 Series
- Diabetes Self-Management Programs

Future Actions Planned: Continue with planned and current approach. Engage members in case management. Outreach by community outreach solutions team for those members that are unable to be reached telephonically.

Reference Number: ACP 2014.09: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC weighted average for the Congestive Heart Failure Admission Rate (Age 65+ years) measure.

Follow Up Actions Taken Through 09/30/15:

Members are identified for CCM through the many sources, including referrals from internal and external sources. Care Managers perform comprehensive and disease-specific assessment, and re-assessments, address goals, and develop a plan of care with input from the member and the physician(s). The case management process includes reassessing and adjusting the care plan and its goals as needed. Care Connectors are assigned activities to assist the member with various interventions under the direct supervision of the Care Manager. Care Managers coordinate care and address various issues including but not limited to: Pharmacy, DME and/or Dental access, assistance with transportation, identification of and access to Specialists and referral and coordination with behavioral health providers or other community resources. Based on assessment, members are stratified into various levels. There are four sub-levels of intensity; Episode class A with Very High Intensity (outreach every 1-2 weeks), Episode class B with High Intensity (outreach every 2-3 weeks), Episode class C with Moderate Intensity (outreach every 4-6 weeks), and Episode class D with Low Intensity (outreach every 3-6 months). Members enrolled in the CCM component of Integrated Healthcare Management remain in the program for the duration of their eligibility and continue to be monitored and re-stratified accordingly.

The goals of the Cardiovascular Disease Management program include:

- Improve medication adherence for members taking antihypertensive and statin medications
- Improve self-management by promoting healthy lifestyle – diet and nutrition, weight management, physical activity, smoking cessation, routine physician office visits, screenings, and treatment
- Close care gaps based on nest practice and clinical guidelines
- TO design and implement strategies to promote/support Primary Cardiovascular disease prevention
- Increase the number of adult members with a documented BMI Assessment

The Plan uses a variety of innovative strategies that integrate information, technology, and community to address disease specific needs of the population. Initiative related to the Heart Failure Program include:

- Missed refill Program – report done monthly, based on disease state, on any member that has not had their prescription refilled or is 6 days late. An outreach letter to members educating on importance of getting medications filled timely and outreach calls are made to member currently being case managed.
- A quarterly missed refill report is done to identify repeat members that were on the monthly lists. These members will be referred for enrollment into case management.
- Community Wellness Empowerment Events
- Heart Failure Assessment and re-assessment tools in system platform
- Acute Care Transition CM Embedded/Onsite Care Managers at selected provider offices to address care gaps in coordination with the physician practices

- Drug Therapy Management Program
- Comprehensive assessment
- Individualized Care Plan focusing on Priority interventions
- Frequent outreach based according to level of intensity
- Monitoring of pharmaceutical medications and lab values
- Utilization of Heart Failure HRAs to monitor Member outcomes
- Provider contact and care plan collaboration
- Outreach to Members for monitoring of fluid balance & functional status
- Identification, communication & interventions to resolve care gaps
- Smoking cessation program as appropriate
- Connection to community resources and services

Future Actions Planned: Continue with planned and current approach. Engage members in case management. Outreach by community outreach solutions team for those members that are unable to be reached telephonically.

Reference Number: ACP 2014.10: Decreases were noted in 2014 (MY 2013) as compared to 2013 (MY 2012) in three comparable items from ACP's Adult CAHPS survey. The rates for two composite survey items evaluated fell below the 2014 MMC weighted average

Follow Up Actions Taken Through 09/30/15:

AmeriHealth Caritas Pennsylvania systematically monitors its member satisfaction on an annual basis to acquire a complete understanding of the drivers behind member dissatisfaction thereby enabling the Plan to identify opportunities for improvement as well as barriers. Furthermore, this analysis enables the Plan to develop and implement interventions to increase member's satisfaction and evaluate the effectiveness of those interventions.

A CAHPS Committee meets regularly to determine key drivers behind poor performance, based on vendor survey findings and suggestions. To address access issues, several letters of agreements are in place with providers to allow for better access for our members. In addition, if members have difficulty finding a participating provider, referrals are made to the Special Needs Unit for assistance. This committee is digging into disparities analysis, trending of outcomes and developing recommendations for future actions. The Committee looks at all aspects such as Access to Care, Provider Communication, and Rating of the Health Plan to determine action plans. The Customer Service Area continually monitors and updates the "on-line" help center for the customer service reps to better handle member issues. Also, monthly audits of dissatisfactions are reviewed to determine if there is a common issue.

Member Communication and Outreach:

- Multiple Member newsletter articles
- Soundbite Campaign to Members – reminder to fill out survey
- Reviewed complaints and dissatisfaction results and reports – no trends were identified
- Spanish CAHPS survey sent
- Call Center Script to respond to members' CAHPS questions
- CAHPS presentation given at "all Associate Staff meetings"
- Member educational material for mailing and distribution at community events
- Member newsletter article: "What to do When You are Sick"
- Distribution of Ask Me 3 brochure to members – "Prepare for Your Doctor Visit"
- Review disparity analysis, plan interventions based on findings

Provider Communication and Outreach:

- Culturally Linguistic Appropriate Services (CLAS) presentation at Provider Symposiums
- Multiple provider newsletter articles
- On-line Provider Directory Initiatives
 - Improved explanations on terms
 - Looking to combine specialties for ease in searching
 - Adding transportation
 - Adding urgent care centers
- Online Health literacy CMEs
- Provider newsletter articles: "Speaking Their Language" and "Get Interpreter Services for Your Practices at Discount Prices"
- Distribution of Ask Me 3 poster to providers

Analysis has allowed for the identification of specific areas of opportunities, such as Rating of Health Care, where member satisfaction was not as strong as the other measures. These findings give AmeriHealth Caritas Pennsylvania the information necessary to develop targeted interventions to improve the satisfaction in areas with lower ratings.

Future Actions Planned: Continue monthly workgroups to address member needs, articles to address access member health, CLAS, services available, etc. in provider and member newsletters. Continue with health promotion and education to assist our members to get care, stay well and build health communities. The expected outcome is to increase awareness of the importance of the

CAHPS survey for plan members and associates as well as to increase our member satisfaction rates. We will continue to monitor and evaluate our CAHPS survey annually.

- Continuation of Member/Provider newsletter articles that address CAHPS measures, such as health literacy, shared decision making, language services, UCCs
- CAHPS presentation given at “all Associate staff meetings”
- Availability of “How to prepare for your Dr. visit” brochure in English and Spanish
- ACP will continue to outreach to members on the importance of responding to the CAHPS survey in 2016

Reference Number: ACP 2014.11: For ACP’s Child CAHPS survey, the rate for one comparable item evaluated in 2014 (MY 2013) fell below the 2014 MMC weighted average.

Follow Up Actions Taken Through 09/30/15:

AmeriHealth Caritas Pennsylvania systematically monitors its member satisfaction on an annual basis to acquire a complete understanding of the drivers behind member dissatisfaction thereby enabling the Plan to identify opportunities for improvement as well as barriers. Furthermore, this analysis enables the Plan to develop and implement interventions to increase member’s satisfaction and evaluate the effectiveness of those interventions.

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 - Improved explanations on terms
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- CAHPS presentation given at “all Associate staff meetings”
- Availability of “How to prepare for your Dr. visit” brochure in English and Spanish

ACP will continue to outreach to members on the importance of responding to the CAHPS survey in 2016

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, ACP was required to prepare a Root Cause Analysis and Action Plan for the following performance measures:

1. Emergency Department Utilization (Table 5.2)
2. Annual Dental Visits (Table 5.3)

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

Table 5.2: RCA and Action Plan – Emergency Department Utilization

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

<i>Managed Care Organization (MCO):</i>	AmeriHealth Caritas Pennsylvania
<i>Measure:</i>	Emergency Department Utilization ²
<i>Response Date:</i>	November 20, 2015
<i>Goal Statement:</i> Please specify goal(s) for measure.	Decrease ER Utilization rate by 2% by 2014 through Member and Provider education
<i>Analysis:</i> What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	Findings: ACP had an increase in ER utilization in CY 2013 compared to CY 2012 (85.21 versus 83.45 respectively). Notably, the CY 2014 rate was 82.16, a decrease of 3.05.
<i>Policies</i> (e.g., data systems, delivery systems, provider facilities)	ER utilization across all facilities (claims data thru 12/31) show that the majority of ER visits continue to occur during normal PCP business hours and not during evenings and weekends as previously suspected. Utilization patterns remain consistent to previous analysis: ER volume increases around 7 a.m. and peaks close to 4 p.m., decreasing around 11 p.m. Mondays and Tuesdays continue to be the highest utilized days, slowly tapering off by Fridays and ticking up again on Sundays. There are no changes in trending or utilization patterns compared to previous analyses. Providers continue to tell ACP that even though they always have appointments available the time is not convenient for the member. Discussions with member’s ER usage continues to show that the trends in utilization and barriers has not changed and continue to be the lead cause of ER usage among our members. Barriers driving member ER usage: 1. Member knowledge: a) Appropriate use of the ER versus the PCP office b) Transportation resources

² A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

	<ol style="list-style-type: none"> 2. Member/PCP relationship, lack of trust in the PCP recommendations (e.g. give Tylenol for a fever) 3. Member's ability to access the PCP <ol style="list-style-type: none"> a) PCP availability <ol style="list-style-type: none"> i. Appointment hours, time not convenient or PCP tells member to go to the ER ii. After hours coverage/phone message, unable to reach live person b) Member's ability to get to the PCP's office <ol style="list-style-type: none"> i. Transportation ii. Social/family situations (e.g. child care) 4. Incomplete discharge planning post-hospitalization 5. ER viewed as "one stop shopping" where members can have an x-ray or have blood work drawn <p>Facilities with the highest ER utilization are consistent with counties where ACP has high volume membership.</p>
<p><i>Procedures</i> (e.g., payment/reimbursement, credentialing/collaboration)</p>	<p>N/A</p>
<p><i>People</i> (e.g., personnel, provider network, patients)</p>	<ul style="list-style-type: none"> • Lack of member understanding regarding the appropriate use of the ER versus their PCP for non-urgent issues • Lack of provider knowledge of contract requirements • Lack of knowledge of alternative options to ER usage other than the PCP • Lack of appointment availability/convenience <p>Despite continued efforts, discussions with members indicate no change in ER utilization trends.</p> <p>Members continue to use the ER instead of their PCP stating that when they call their PCP, they are instructed to go to the ER. However, providers indicate that the issue is appointment convenience, not appointment availability.</p> <p>Provider access surveys indicate that providers have availability for same day urgent appointments and after hour surveys do not indicate issues with access to providers.</p> <p>To further drill down, when case management outreach is done, members are asked if they contacted their PCP prior to going to the ER. Most members indicated that they do not call their PCP for an appointment or if they did call, the appointment time that was available was not convenient for them.</p> <p>Review of 2014 claims data continues to show that URI, abdominal pain, sprains, otitis media, headaches, and viral infections continue to drive non-emergent use of the ER and further illustrates the members' lack of understanding of the proper use of the ER versus their PCP.</p> <p>Claims data continues to show that the trend in utilization and barriers has not changed despite continued efforts. These barriers have been a recurring theme and continue to appear in our re-analysis of ER utilization from year to year.</p>
<p><i>Provisions</i> (e.g., screening tools, medical record forms, provider and enrollee educational materials)</p>	<p>Lack of member understanding regarding the appropriate use of the ER versus their PCP for non-urgent issues results in the Barriers identified under Policies.</p> <p>To address barriers identified upon member surveys, educational materials were developed and updated to educate members on the proper use of the ER versus their PCP:</p> <ul style="list-style-type: none"> • Emergency Hand Out • How and Where to Get Care • Nurse Call Line

	<ul style="list-style-type: none"> What is Urgent Care? <p>Urgent Care one sheets were also developed to help the member find an urgent care center in their areas, along with bus routes and times the urgent centers are open. In addition, articles are incorporated in Member Newsletters.</p>
Other (specify)	N/A

MCO:	AmeriHealth Caritas Pennsylvania
Measure:	Emergency Department Utilization³

For the analysis findings/barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014.

<u>Action</u> Include those planned as well as already implemented. Add rows if needed.	<u>Implementation Date</u> Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	<u>Monitoring Plan</u> How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Your Child's Health, Be Prepared Member ER education programs at various sites throughout counties	Ongoing educational outreach continued in 2014 and into 2015	ACP has intensified efforts to make "every member contact count" to educate members on the appropriate use of the ER. Most recently, our Community Health Navigators meet face-to-face with each member at our events and discusses their gaps in care and review educational materials about the use of the ER. Your Child's Health, Be Prepared is an interactive educational session for parents of young children.
Flu shot campaign to head of households	Annually in 3 rd Quarter 2014	Flu shot sound bite campaign to all members to encourage them to get a flu shot, availability to get their shot at no-charge pharmacies or to contact their PCP. Analysis is completed on percentages of members who receive a flu shot.
ER education calls based on ER dashboard (referred to case management if appropriate): <ul style="list-style-type: none"> Pregnant members Pediatric asthma Dental Adult asthma Adult diabetes CHF/CAD COPD 	Ongoing outreach continued in 2014 and into 2015	Monitored by management and outreach is reported quarterly.
Provider Access to Care Surveys (to all existing provider locations) Providers who are non-compliant are educated on contract requirements and standards	Annually	ACP educates providers on after hour reimbursement to alleviate access to care issues and discuss the access to care contract requirements. Basic re-education and reinforcement of contractual requirements leads to better understanding of provider responsibilities. After hour reimbursement can enhance the office's revenue. After Hours Access Survey is completed annually and providers that do not meet the standards are re-educated on the access standards.
Rapid Response and Outreach (RROT) calls made to members with a recent ER visits, identified by our internal reports, to	Ongoing	Monitored by management and outreach is reported quarterly.

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

identify barriers and refer the member to applicable programs.		
Community Outreach Solutions (COS) deployed in community	Ongoing since June 2013	Door to door, face-to-face outreach to members that have not been able to be reached telephonically and to re-engage them in care. Since January 2015, we have had 2004 referrals with approximately an 80% connect rate back to CM.
Remove Barriers to Appropriate ER Utilization and Increase Alternative Options by: <ul style="list-style-type: none"> • Member Education • Urgent Care Flyers – include hours of operation, location including a map, services available at each site • Your Child’s Health, Be Prepared – Interactive educational sessions for parents of young children • 24/7 Nurse Line available • Provider Information and Education • PCPs educated on locations and services available at Urgent Care Centers • Urgent Care Centers provide visit summaries to PCPs • PCPs informed of members’ on their panel that are frequenting the ER 	Ongoing	Education and outreach information is reviewed and updated annually.
Telephonic Messaging <ul style="list-style-type: none"> • Summer Emergencies – alerts regarding heat and how to prevent dehydration • Fractures – focused membership ages 5-12; alerts/messaging regarding safety and use of protective gear to help prevent fractures 	Telephonic outreach conducted during various times throughout the year to head of household. Ongoing	Education and outreach information is reviewed and updated annually.
Acute Care Transition (ACT) Manager located in Berks County is responsible for facilitating transition to the next level of care by working with the hospital staff and ACP staff for successful post discharge care. ACP collaborates with Berks County providers to send letters to ER patients stating they are available for non-emergent care in their offices.	Summer 2015	Monitored via monthly HEDIS dashboard reports.
Embedded Care Manager (RN) on site a Southeast Lancaster Health Center who assists with identifying their patients/our members that are ER High Utilizers and works with the PCP to schedule office visits where barriers are addressed and works with the member after the office visit as needed.	Summer 2015	Monitored via monthly HEDIS dashboard reports.
Breathe Easy Start Today (B.E.S.T.) Asthma program to increase medication adherence, hands on education, and patient therapy starting in the provider office.	Ongoing	Monitored via monthly HEDIS dashboard reports.
Identify and engage with members in inpatient setting to schedule post discharge follow-up with PCP and/or specialist, provide discharge summary that identifies	Ongoing	Monitored via monthly HEDIS dashboard reports.

follow-up provider, arranges for home care follow-up, address barriers associated with DMS, SNF, or pharmacy, facilitate medication reconciliation, and coordinates Meds to Home Program to ensure medications are at member's home when they are discharged.		
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Table 5.3: RCA and Action Plan – Annual Dental Visits

Managed Care Organization (MCO):	AmeriHealth Caritas Pennsylvania	
Measure:	Annual Dental Visits	
Response Date:	November 20, 2015	
Goal Statement: Please specify goal(s) for measure.	Increase the Annual Dental Visits rate by 3% by 2016 through member outreach, education, and closing care gaps.	
Analysis: What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	Findings: ACP showed a decrease in Annual Dental Visits in CY 2013 (H 2014) compared to CY 2012 (H 2013) (54.80% and 55.99% respectively). This is the only decrease reported going back to CY 2009 (H 2010). It is worth noting that the CY 2014 (H 2015) rate was 56.56% which is higher than both the H 2013 and H 2014 rates.	
Policies (e.g., data systems, delivery systems, provider facilities)	<ul style="list-style-type: none"> • Previous subcontractor's management of dental network • Data system interaction issues between plan and dental subcontractor 	
Procedures (e.g., payment/reimbursement, credentialing/collaboration)	<ul style="list-style-type: none"> • Reimbursement rates • Authorization requirements 	
People (e.g., personnel, provider network, patients)	<ul style="list-style-type: none"> • Member lack of knowledge of importance of regular dental care • High rate of missed appointments/no-shows 	
Provisions (e.g., screening tools, medical record forms, provider and enrollee educational materials)	N/A	
Other (specify)	The oversight of the dental subcontractor indicated a decline in the dental network and provider participation. The dental subcontractor became more restrictive than what regulations permitted and poor interaction between data systems negatively impacted claims adjudication.	

MCO:	AmeriHealth Caritas Pennsylvania	
Measure:	Annual Dental Visits	
For the analysis findings/barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014.		
Action Include those planned as well as already implemented. Add rows if needed.	Implementation Date Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	Monitoring Plan How will you know if this action is working? What will you measure and how often? Include what measures will be used, as applicable.

<p>Insourced dental network, including all dental network functions from Director to account executives within ACP.</p> <p>Structure: Dental Director Dental Program Manager Dental Account Executives (2) Community Based Dental Navigator</p>	<p>September 2014 and ongoing</p>	<p>Monthly HEDIS dashboard reports current ADV rate compared to previous year's rate.</p> <p>Changed dental subcontractor.</p> <p>Dental Director monitors claims and the number of provider and service locations in the network on a monthly basis.</p> <p>The Dental Management program is evaluated annually and includes the program scope, access to care, outcomes, and provider/member appeal outcomes.</p>
<p>Dental/Medical Connections</p> <p>Dental Navigator is ACP's community based dental navigator and Medical Management initiative specialist assist members in scheduling appointments for EPSDT and aid in scheduling appointments through our FQHC HEDIS initiative.</p>	<p>September 2014</p>	<p>Monthly HEDIS dashboard reports current ADV rate compared to previous year's rate.</p>
<p>Cavity Free Kids</p> <p>A Head Start-supported oral health education curriculum throughout the community with the goal of implementing effective and creative ways to teach oral health to preschoolers and their families.</p>	<p>Ongoing</p>	<p>Monthly HEDIS dashboard reports current ADV rate compared to previous year's rate.</p>
<p>Dental Check Quality Incentive Program</p> <p>Provides enhanced compensation to dentists who provide members with instructions on oral hygiene and assess and document their caries risk. High risk members are eligible for an enhanced dental benefit that provides four annual cleanings.</p>	<p>June 2015</p>	<p>Monthly HEDIS dashboard reports current ADV rate compared to previous year's rate.</p>
<p>Telephone Dental Outreach Calls</p> <p>Call lists, developed from gap in care reports that target members by age, geographic location. Plan credentialed dentists execute telephone calls that include, at a minimum, oral hygiene instructions and nutritional counseling. At conclusion of the call, the member is transferred to ACP to provide assistance in arranging a dental appointment, transportation, and address barriers that may prevent the member from accessing dental care.</p>	<p>September 2015</p>	<p>ACP will monitor activity performance via subcontractor reports, documentation, claim submissions, and monthly HEDIS dashboard reports of current ADV rate.</p>
<p>Quality Enhancement Program (QEP)</p> <p>Annual Dental Visit, age 2-21 years is included in ACP's Provider P4P program that targets improvements in the quality of or access to dental care.</p>	<p>June 2015</p>	<p>Annual HEDIS rates are used to determine provider ranking and eligibility for incentive.</p>

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

- ACP was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.
- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2015 (MY 2014) on the following measures:
 - Adult BMI Assessment (Age 18-74 years)
 - Body Mass Index: Percentile — All Ages (Age 3 - 11 years, Age 12-17 years, and Total)
 - Counseling for Nutrition (Total)
 - Counseling for Physical Activity — (Age 12-17 years) and (Total)
 - Human Papillomavirus Vaccine for Female Adolescents
 - ≥ 61% of Expected Prenatal Care Visits Received
 - ≥ 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 Counseling for Depression
 - 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
 - Prenatal Screening for Intimate partner violence
 - Prenatal Screening for Behavioral Health Risk Assessment
 - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
 - Medication Management for People with Asthma - 75% Compliance — All Ages (Age 5-11 years, Age 12-18 years, Age 19-50 years, Age 51-64 years, and Total - Age 5-64 years)
 - Retinal Eye Exam
 - 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
- The following strengths were noted in 2015 for Adult and Child CAHPS survey items:
 - Of the four Adult CAHPS composite survey items reviewed, ACP showed an increase for all four items in 2015 (MY 2014) as compared to 2014 (MY 2013). In addition, all four items were higher than the 2015 (MY 2014) MMC weighted averages.
 - For ACP's Child CAHPS survey, all four comparable items evaluated in 2015 (MY 2014) increased from 2014 (MY 2013). In addition, all four items were higher than the 2015 (MY 2014) MMC weighted average.

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2015 (MY 2014) on the following measures:
 - Adolescent Well-Care Visits (Age 12 to 21 Years)
 - Immunization for Adolescents (Combo 1)
 - Lead Screening in Children
 - Follow-up Care for Children Prescribed ADHD Medication – All Phase (Initiation Phase and Continuation Phase)
 - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
 - Developmental Screening in the First Three Years of Life – (1 year), (2 years), and (Total)

- Chlamydia Screening in Women – All Age (Age 16-20 years, Age 21-24 years, and Total)
- Prenatal Counseling for Smoking
- Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Medical Attention for Nephropathy

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

AmeriHealth Caritas Pennsylvania (ACP)
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.



ACP Key Points

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

- No ACP P4P measures fell into this comparison category.

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 are:

- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care: $\geq 81\%$ of Expected Prenatal Care Visits Received
- Reducing Potentially Preventable Readmissions⁴

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:

- Prenatal and Postpartum Care – Timeliness of Prenatal Care

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

- Comprehensive Diabetes Care – HbA1c Poor Control⁵

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

- Annual Dental Visits

ACP's Emergency Department Utilization⁶ decreased (improved) from 2014 to 2015 but is above (worse than) the 2015 MMC average.

D - Root cause analysis and plan of action required

- No ACP P4P measures fell into this comparison category.

F Root cause analysis and plan of action required

Measure that statistically significantly decreased/worsened from 2014 to 2015 and was statistically significantly below/worse than the 2015 MMC weighted average is:

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

⁴ Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.

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

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

Figure 1 - P4P Measure Matrix – ACP

		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
	No Change	D	C Comprehensive Diabetes Care – HbA1c Poor Control ⁷	B Controlling High Blood Pressure Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received Reducing Potentially Preventable Readmissions ⁸
	↓	F Adolescent Well Care Visits (Age 12-21 Years)	D	C Prenatal and Postpartum Care – Timeliness of Prenatal Care

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 Emergency Department Utilization ⁹	B	A

Key to the P4P Measure Matrix and Emergency Department Utilization Comparison

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

⁷ Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.

⁸ Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.

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

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

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

Figure 3 - P4P Measure Rates – ACP

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)	56% =	57% =	64.8% =	62.7% =	53.5% ▼	58.7%
Comprehensive Diabetes Care - HbA1c Poor Control ¹⁰	33% =	32% ▼	38.3% =	33.3% =	38.5% =	38.1%
Controlling High Blood Pressure	67% =	68% ▲	66.4% =	65.6% =	66.2% =	61.6%
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received	83% =	87% ▲	84.9% =	82.7% =	77.9% =	64.4%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	90% =	93% ▲	90.5% =	92.2% =	87.9% ▼	83.8%
Annual Dental Visits	50% ▲	53% ▼	56.0% ▲	54.8% ▼	56.6% ▲	58.2%
Quality Performance Measure	HEDIS 2011 Rate	HEDIS 2012 Rate	HEDIS 2013 Rate	HEDIS 2014 Rate	HEDIS 2015 Rate	HEDIS 2015 MMC AVG
Emergency Department Utilization (Visits/1,000 MM) ¹¹	80.9	83.3	83.5	85.2	82.2	74.0
Quality Performance Measure	PA 2011 Rate	PA 2012 Rate	PA 2013 Rate	PA 2014 Rate	PA 2015 Rate	PA 2015 MMC WA
Reducing Potentially Preventable Readmissions ¹²		12% NA	10.9% =	10.0% ▼	10.5% =	11.6%

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

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

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

VI: Summary of Activities

Structure and Operations Standards

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

Performance Measures

- ACP 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

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