



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

**2015 External Quality Review Report  
Keystone First**

Final Report  
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## Introduction

### Purpose and Background

The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Medicaid Managed Care recipients.

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

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

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

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

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

Information for Section II of this report is derived from activities conducted with and on behalf of DHS to research, select, and define Performance Improvement Projects (PIPs) for a new validation cycle. Information for Section III of this report is derived from IPRO’s validation of each PH MCO’s performance measure submissions. Performance measure validation as conducted by IPRO includes both Pennsylvania specific performance measures as well as Healthcare Effectiveness Data and Information Set (HEDIS<sup>®1</sup>) 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.

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<sup>1</sup> HEDIS<sup>®</sup> 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 Keystone First’s (KF) 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 KF, 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
<b>Subpart C: Enrollee Rights and Protections</b>	
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
<b>Subpart D: Quality Assessment and Performance Improvement</b>	
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
<b>Subpart F: Federal and State Grievance Systems Standards</b>	
General Requirements	8
<b>Subpart F: Federal and State Grievance Systems Standards</b>	

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, 84 items were evaluated and 42 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: KF 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 3 items and was compliant on 3 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.

KF was evaluated against 17 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 17. KF was found to be compliant in all eight of the categories of Enrollee Rights and Protections Regulations. KF 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 KF 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: KF Compliance with Quality Assessment and Performance Improvement Regulations

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REGULATIONS		
Subpart D: Categories	Compliance	Comments
<b>Access Standards</b>		
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on 12 items based on RY 2014.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 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 7 items and was compliant on 7 items based on RY 2014.
<b>Structure and Operation Standards</b>		
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.
<b>Measurement and Improvement Standards</b>		
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.

KF 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, KF was found to be compliant in all 11 categories.

### Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4: KF 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

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

### Accreditation Status

KF underwent an NCQA Accreditation Survey effective August 29, 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 2015 External Quality Review Report: Keystone First

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
<b>Access/Availability to Care</b>	
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
<b>Well Care Visits and Immunizations</b>	
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)
<b>EPSDT: Screenings and Follow up</b>	
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
<b>Dental Care for Children and Adults</b>	
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)
<b>Women s Health</b>	
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
<b>Obstetric and Neonatal Care</b>	
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
<b>Respiratory Conditions</b>	

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)
<b>Comprehensive Diabetes Care</b>	
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)
<b>Cardiovascular Care</b>	
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)
<b>Utilization</b>	
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  $\geq 1$  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  $\geq 37$  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 13<sup>th</sup> 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 13<sup>th</sup> 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 KF. Upon review of rates for the Reducing Potentially Preventable Readmissions (RPR) measure, the 2015 and 2014 rates for 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). 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 KF 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 90<sup>th</sup> percentile is the benchmark for the HEDIS measures.

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

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

## Access to/Availability of Care

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

Table 3.2: Access to Care

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison					
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 12-24 Months)	8,072	7,850	97.2%	96.9%	97.6%	97.3%	n.s.	97.0%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 25 Months-6 Years)	45,601	40,320	88.4%	88.1%	88.7%	88.7%	n.s.	88.6%	n.s.	≥ 25th and < 50th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 7-11 Years)	39,531	36,651	92.7%	92.5%	93.0%	92.3%	+	91.9%	+	≥ 50th and < 75th percentile	
HEDIS	Children and Adolescents' Access to PCPs (Age 12-19 Years)	46,229	41,953	90.8%	90.5%	91.0%	90.6%	n.s.	90.1%	+	≥ 50th and < 75th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20-44 Years)	46,278	37,819	81.7%	81.4%	82.1%	82.4%	-	83.2%	-	≥ 50th and < 75th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45-64 Years)	28,793	26,113	90.7%	90.4%	91.0%	91.0%	n.s.	91.2%	-	≥ 75th and < 90th percentile	
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ Years)	1,639	1,415	86.3%	84.6%	88.0%	88.2%	n.s.	87.2%	n.s.	≥ 25th and < 50th percentile	
HEDIS	Adult BMI Assessment (Ages 18-74 Years)	432	351	81.3%	77.5%	85.0%	78.4%	n.s.	83.0%	n.s.	≥ 25th and < 50th percentile	

Well-Care Visits and Immunizations

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

- The 2015 rate for the Childhood Immunizations Status (Combination 2) measure was statistically significantly higher than the 2015 MMC weighted average by 4.1 percentage points

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

Table 3.3: Well-Care Visits and Immunizations

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison					
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile	
HEDIS	Well Child Visits in the First 15 Months of Life (≥ 6 Visits)	432	264	61.1%	56.4%	65.8%	68.1%	-	65.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)	352	279	79.3%	74.9%	83.6%	80.8%	n.s.	76.4%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Childhood Immunization Status (Combination 2)	432	345	79.9%	76.0%	83.8%	81.9%	n.s.	75.8%	+	≥ 75th and < 90th percentile	
HEDIS	Childhood Immunization Status (Combination 3)	432	328	75.9%	71.8%	80.1%	78.8%	n.s.	72.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	430	272	63.3%	58.6%	67.9%	62.4%	n.s.	58.7%	n.s.	≥ 75th and < 90th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 3-11 Years)	287	201	70.0%	64.6%	75.5%	68.7%	n.s.	68.5%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Body Mass Index: Percentile (Age 12-17 Years)	145	100	69.0%	61.1%	76.8%	72.6%	n.s.	69.1%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Body Mass Index: Percentile (Total)	432	301	69.7%	65.2%	74.1%	69.8%	n.s.	68.7%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Nutrition (Age 3-11 Years)	287	212	73.9%	68.6%	79.1%	70.9%	n.s.	70.2%	n.s.	≥ 75th and < 90th percentile	
HEDIS	WCC Counseling for Nutrition (Age 12-17 Years)	145	91	62.8%	54.5%	71.0%	66.1%	n.s.	64.6%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Nutrition (Total)	432	303	70.1%	65.7%	74.6%	69.6%	n.s.	68.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Physical Activity (Age 3-11 Years)	287	193	67.2%	61.6%	72.9%	62.3%	n.s.	61.9%	n.s.	≥ 75th and < 90th percentile	
HEDIS	WCC Counseling for Physical Activity (Age 12-17 Years)	145	86	59.3%	51.0%	67.7%	66.9%	n.s.	62.1%	n.s.	≥ 50th and < 75th percentile	
HEDIS	WCC Counseling for Physical Activity (Total)	432	279	64.6%	60.0%	69.2%	63.6%	n.s.	62.0%	n.s.	≥ 75th and < 90th percentile	
HEDIS	Immunizations for Adolescents (Combination 1)	293	247	84.3%	80.0%	88.6%	86.7%	n.s.	82.0%	n.s.	≥ 75th and < 90th 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:

- KF's rates for the following ten EPSDT Screenings and Follow-up measures were statistically significantly below the 2015 MMC weighted averages:
  - Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase – 8.7 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication: Continuation Phase – 14.4 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced): Initiation Phase – 9.2 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced): Continuation Phase – 13.7 percentage points
  - EPSDT - Hearing Test (Age 4-20 years) – 5.4 percentage points
  - EPSDT - Vision Test (Age 4-20 years) – 4.6 percentage points
  - Developmental Screening in the First Three Years of Life: Total – 7.0 percentage points
  - Developmental Screening in the First Three Years of Life: 1 year – 10.4 percentage points
  - Developmental Screening in the First Three Years of Life: 2 years – 4.4 percentage points
  - Developmental Screening in the First Three Years of Life: 3 years – 8.1 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	318	73.6%	69.3%	77.9%	74.6%	n.s.	77.2%	n.s.	≥ 50th and < 75th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	2,464	401	16.3%	14.8%	17.8%	15.7%	n.s.	25.0%	-	< 10th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	656	83	12.7%	10.0%	15.3%	14.6%	n.s.	27.1%	-	< 10th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	2,464	419	17.0%	15.5%	18.5%	15.8%	n.s.	26.2%	-	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	619	115	18.6%	15.4%	21.7%	18.6%	n.s.	32.3%	-	NA
PA EQR	EPSDT Hearing Test (Age 4 20 Years)	131,829	46,240	35.1%	34.8%	35.3%	30.0%	+	40.4%	-	NA
PA EQR	EPSDT Vision Test (Age 4 20 Years)	131,829	47,513	36.0%	35.8%	36.3%	32.3%	+	40.7%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life Total <sup>1</sup>	23,977	9,588	40.0%	39.4%	40.6%	30.3%	+	47.0%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year <sup>1</sup>	6,655	2,142	32.2%	31.1%	33.3%	22.0%	+	42.6%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years <sup>1</sup>	8,634	4,010	46.4%	45.4%	47.5%	37.6%	+	50.9%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years <sup>1</sup>	8,688	3,436	39.5%	38.5%	40.6%	31.3%	+	47.7%	-	NA

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

## Dental Care for Children and Adults

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

- Two Dental Care for Children and Adults measures for KF's 2015 rates were statistically significantly higher than the MMC weighted averages.
  - Annual Dental Visit (Age 2–21 years) – 6.3 percentage points
  - Total Eligibles Receiving Preventive Dental Services – 8.1 percentage points

There were no opportunities for improvement identified for KF'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	148,078	95,530	<b>64.5%</b>	64.3%	64.8%	62.7%	+	58.2%	+	≥ 75th and < 90th percentile
PA EQR	Total Eligibles Receiving Preventive Dental Treatment Services	201,464	110,589	<b>54.9%</b>	54.7%	55.1%	54.9%	n.s.	46.8%	+	NA
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 Years)	10,662	5,651	<b>53.0%</b>	52.0%	54.0%	52.1%	n.s.	50.6%	+	NA

## Women's Health

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

- In 2015, KF's rates were statistically significantly above the 2015 MMC weighted averages for the following three measures:
  - Chlamydia Screening in Women (Total) – 11.2 percentage points
  - Chlamydia Screening in Women (Age 16-20 years) – 12.3 percentage points
  - Chlamydia Screening in Women (Age 21-24 years) – 9.4 percentage points

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

Table 3.6: Women's Health

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Breast Cancer Screening (Age 52-74 Years)	9,708	6,405	<b>66.0%</b>	65.0%	66.9%	66.2%	n.s.	63.3%	+	≥ 50th and < 75th percentile
HEDIS	Cervical Cancer Screening	383	270	<b>70.5%</b>	65.8%	75.2%	71.0%	n.s.	66.1%	n.s.	≥ 75th and < 90th percentile
HEDIS	Chlamydia Screening in Women (Total)	11,657	8,221	<b>70.5%</b>	69.7%	71.4%	63.3%	+	59.3%	+	≥ 90th percentile
HEDIS	Chlamydia Screening in Women (Age 16-20 Years)	7,194	4,937	<b>68.6%</b>	67.5%	69.7%	61.1%	+	56.3%	+	≥ 90th percentile
HEDIS	Chlamydia Screening in Women (Age 21-24 Years)	4,463	3,284	<b>73.6%</b>	72.3%	74.9%	66.3%	+	64.2%	+	≥ 90th percentile
HEDIS	Human Papillomavirus Vaccine for Female Adolescents	431	107	<b>24.8%</b>	20.6%	29.0%	24.3%	n.s.	27.9%	n.s.	≥ 50th and < 75th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	13,248	178	<b>1.3%</b>	1.1%	1.5%	1.8%	-	2.6%	-	≥ 90th percentile

## Obstetric and Neonatal Care

One strength was noted for the 2015 (MY 2014) Obstetric and Neonatal Care performance measures.

- The 2015 rate for the Prenatal Screening for Behavioral Health Risk Assessment measure was statistically significantly higher than the 2015 MMC weighted average by 6.0 percentage points

The following opportunities for improvement identified for KF's 2015 (MY 2014) Obstetric and Neonatal Care performance measures.

- In 2015, KF's rates were statistically significantly below the 2015 MMC weighted averages for the following twelve measures:
  - ≥ 61% of Expected Prenatal Care Visits Received – 11.4 percentage points
  - ≥ 81% of Expected Prenatal Care Visits Received – 14.4 percentage points
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care – 6.4 percentage points

- Prenatal Screening for Smoking – 11.2 percentage points
- Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 10.4 percentage points
- Prenatal Counseling for Smoking – 15.0 percentage points
- Prenatal Screening for Depression – 5.6 percentage points
- Postpartum Screening for Depression – 12.8 percentage points
- Postpartum Screening Positive for Depression – 7.3 percentage points
- Prenatal Screening for Alcohol use – 7.6 percentage points
- Prenatal Screening for Illicit drug use – 6.8 percentage points
- Prenatal Screening for Prescribed or over-the-counter drug use – 7.3 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	293	<b>68.1%</b>	63.6%	72.7%	78.9%	-	79.6%	-	NA
HEDIS	≥81% of Expected Prenatal Care Visits Received	430	215	<b>50.0%</b>	45.2%	54.8%	63.1%	-	64.4%	-	≥ 25th and < 50th percentile
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	430	333	<b>77.4%</b>	73.4%	81.5%	84.0%	-	83.8%	-	≥ 25th and < 50th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	430	257	<b>59.8%</b>	55.0%	64.5%	58.7%	n.s.	62.2%	n.s.	≥ 25th and < 50th percentile
PA EQR	Prenatal Screening for Smoking	388	286	<b>73.7%</b>	69.2%	78.2%	95.8%	-	84.9%	-	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	388	286	<b>73.7%</b>	69.2%	78.2%	NA	NA	84.1%	-	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	388	123	<b>31.7%</b>	26.9%	36.5%	37.5%	n.s.	35.9%	n.s.	NA
PA EQR	Prenatal Counseling for Smoking	62	37	<b>59.7%</b>	46.7%	72.7%	74.4%	-	74.7%	-	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	30	14	<b>46.7%</b>	27.1%	66.2%	38.5%	n.s.	51.3%	n.s.	NA
PA EQR	Prenatal Smoking Cessation	61	5	<b>8.2%</b>	0.5%	15.9%	18.8%	n.s.	8.8%	n.s.	NA
PA EQR	Prenatal Screening for Depression	388	247	<b>63.7%</b>	58.7%	68.6%	78.8%	-	69.3%	-	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	388	247	<b>63.7%</b>	58.7%	68.6%	NA	NA	63.8%	n.s.	NA
PA EQR	Prenatal Screening Positive for Depression	247	41	<b>16.6%</b>	11.8%	21.4%	15.2%	n.s.	18.6%	n.s.	NA
PA EQR	Prenatal Counseling for Depression	41	33	<b>80.5%</b>	67.1%	93.8%	89.6%	n.s.	72.1%	n.s.	NA
PA EQR	Postpartum Screening for Depression	242	149	<b>61.6%</b>	55.2%	67.9%	85.5%	-	74.4%	-	NA
PA EQR	Postpartum Screening Positive for Depression	149	11	<b>7.4%</b>	2.8%	11.9%	13.3%	n.s.	14.7%	-	NA
PA EQR	Postpartum Counseling for Depression	11	10	<b>NA</b>	NA	NA	NA	NA	85.8%	NA	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	1,397	307	<b>22.0%</b>	19.8%	24.2%	22.8%	n.s.	23.0%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	7,615	817	<b>10.7%</b>	10.0%	11.4%	10.5%	n.s.	9.5%	+	NA
PA EQR	Prenatal Screening for Alcohol use	388	281	<b>72.4%</b>	67.8%	77.0%	NA	NA	80.0%	-	NA
PA EQR	Prenatal Screening for Illicit drug use	388	284	<b>73.2%</b>	68.7%	77.7%	NA	NA	80.0%	-	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	388	283	<b>72.9%</b>	68.4%	77.5%	NA	NA	80.2%	-	NA
PA EQR	Prenatal Screening for Intimate partner violence	388	216	<b>55.7%</b>	50.6%	60.7%	NA	NA	54.6%	n.s.	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	388	185	<b>47.7%</b>	42.6%	52.8%	NA	NA	41.7%	+	NA
PA EQR	Elective Delivery <sup>12</sup>	1,746	156	<b>8.9%</b>	7.6%	10.3%	NA	NA	11.5%	-	NA

<sup>1</sup>For the Elective Delivery measure, lower rate indicates better performance.

<sup>2</sup>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:

- KF's 2015 rates were statistically significantly higher than the MMC weighted averages for the following four measures:
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 4.0 percentage points
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator – 4.1 percentage points
  - Medication Management for People with Asthma: 75% Compliance (Age 19-50 years) – 3.6 percentage points
  - Medication Management for People with Asthma: 75% Compliance (Age 51-64 years) – 6.5 percentage points

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

- The 2015 rate for the Appropriate Testing for Children with Pharyngitis measure was statistically significantly below the 2015 MMC weighted average by 13.4 percentage points
- KF's 2015 rates were statistically significantly above (worse than) the MMC weighted averages for the following two measures:
  - Asthma in Younger Adults Admission Rate (Age 18-39 years) – 0.87 admissions per 100,000 member years
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years) – 2.51 admissions per 100,000 member years

Table 3.8: Respiratory Conditions

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis	4,749	2,609	54.9%	53.5%	56.4%	64.6%	-	68.4%	-	≥ 10th and < 25th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection <sup>1</sup>	10,494	994	90.5%	90.0%	91.1%	89.2%	+	88.6%	+	≥ 50th and < 75th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis <sup>2</sup>	1,579	1,081	31.5%	29.2%	33.9%	27.0%	+	27.5%	+	≥ 50th and < 75th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1,230	342	27.8%	25.3%	30.3%	25.8%	n.s.	29.8%	n.s.	≥ 25th and < 50th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	965	764	79.2%	76.6%	81.8%	78.3%	n.s.	76.3%	n.s.	≥ 90th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation Bronchodilator	965	885	91.7%	89.9%	93.5%	91.4%	n.s.	87.6%	+	≥ 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 11 Years)	4,020	3,712	92.3%	91.5%	93.2%	92.6%	n.s.	91.7%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 12 18 Years)	2,466	2,199	89.2%	87.9%	90.4%	89.4%	n.s.	87.6%	+	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 19 50 Years)	2,216	1,753	79.1%	77.4%	80.8%	79.0%	n.s.	77.8%	n.s.	≥ 75th and < 90th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 51 64 Years)	854	634	74.2%	71.2%	77.2%	75.7%	n.s.	75.6%	n.s.	≥ 50th and < 75th percentile
HEDIS	Use of Appropriate Medications for People with Asthma (Age 5 64 Years)	9,556	8,298	86.8%	86.2%	87.5%	86.9%	n.s.	85.3%	+	≥ 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5 11 Years)	3,708	1,365	36.8%	35.2%	38.4%	32.3%	+	34.0%	+	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12 18 Years)	2,198	787	35.8%	33.8%	37.8%	35.5%	n.s.	33.7%	n.s.	≥ 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19 50 Years)	1,749	830	47.5%	45.1%	49.8%	42.7%	+	43.8%	+	≥ 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51 64 Years)	634	414	65.3%	61.5%	69.1%	59.7%	+	58.8%	+	≥ 90th percentile

HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5-64 Years)	8,289	3,396	41.0%	39.9%	42.0%	37.6%	+	38.6%	+	≥ 75th and < 90th percentile
PA EQR	Annual Percentage of Asthma Patients (Age 2-20 Years) with One or More Asthma Related ER Visits <sup>3</sup>	30,840	4,248	13.8%	13.4%	14.2%	13.9%	n.s.	13.1%	+	NA
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years)	874,015	219	2.09	1.81	2.36	1.88	n.s.	1.22	+	NA
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) <sup>4</sup>	594,139	854	11.98	11.17	12.78	16.15	-	9.47	+	NA

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

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

<sup>3</sup> For Emergency Department Encounter Rate for Asthma, lower rates indicate better performance.

<sup>4</sup> For the Adult Admission Rate measures, lower rates indicate better performance.

## Comprehensive Diabetes Care

There were no strengths noted for Comprehensive Diabetes Care performance measures for 2015 (MY 2014).

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

- KF's 2015 rates were statistically significantly below the MMC weighted averages for the following three measures:
  - Hemoglobin A1c (HbA1c) Testing – 4.6 percentage points
  - Retinal Eye Exam – 15.4 percentage points
  - Medical Attention for Nephropathy – 5.1 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	466	80.9%	77.6%	84.2%	82.5%	n.s.	85.5%	-	≥ 10th and < 25th percentile	
HEDIS	HbA1c Poor Control (>9.0%) <sup>1</sup>	576	228	39.6%	35.5%	43.7%	36.7%	n.s.	38.1%	n.s.	≥ 50th and < 75th percentile	
HEDIS	HbA1c Control (<8.0%)	576	309	53.6%	49.5%	57.8%	55.2%	n.s.	51.2%	n.s.	≥ 50th and < 75th percentile	
HEDIS	HbA1c Good Control (<7.0%)	376	141	37.5%	32.5%	42.5%	39.2%	n.s.	36.9%	n.s.	≥ 50th and < 75th percentile	
HEDIS	Retinal Eye Exam	576	235	40.8%	36.7%	44.9%	51.7%	-	56.2%	-	≥ 10th and < 25th percentile	
HEDIS	Medical Attention for Nephropathy	576	448	77.8%	74.3%	81.3%	80.9%	n.s.	82.9%	-	≥ 10th and < 25th percentile	
HEDIS	Blood Pressure Controlled <140/90 mm Hg	576	372	64.6%	60.6%	68.6%	66.9%	n.s.	65.0%	n.s.	≥ 50th and < 75th percentile	
PA EQR	Diabetes Short Term Complications Admission Rate <sup>2</sup> (Age 18-64 Years) per 100,000 member years	1,440,010	364	2.11	1.89	2.32	2.56	-	1.96	n.s.	NA	
PA EQR	Diabetes Short Term Complications Admission Rate <sup>2</sup> (Age 65+ Years) per 100,000 member years	28,144	0	0.00	0.00	0.00	0.91	n.s.	0.40	n.s.	NA	
PA EQR	Diabetes Short Term Complications Admission Rate <sup>2</sup> (Total Age 18+ Years) per 100,000 member years	1,468,154	364	2.07	1.85	2.28	2.53	-	1.94	n.s.	NA	

<sup>1</sup> For HbA1c Poor Control, lower rates indicate better performance.

<sup>2</sup> For the Adult Admission Rate measures, lower rates indicate better performance

## Cardiovascular Care

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

- KF's 2015 rate for the Persistence of Beta Blocker Treatment After Heart Attack measure was statistically significantly above the 2015 MMC weighted average by 5.5 percentage points.

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

- KF's 2015 rates were statistically significantly above (worse than) the MMC weighted averages for the following two measures:
  - Heart Failure Admission Rate (Age 18-64 years) – 0.72 admissions per 100,000 member years
  - Heart Failure Admission Rate (Total Age 18+ years) – 0.73 admissions per 100,000 member years

**Table 3.10: Cardiovascular Care**

Indicator Source	Indicator	2015 (MY 2014)					2015 (MY 2014) Rate Comparison				
		Denom	Num	Rate	Lower 95% Confidence Limit	Upper 95% Confidence Limit	2014 (MY2013) Rate	2015 Rate Compared to 2014	MMC	2015 Rate Compared to MMC	HEDIS 2015 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	140	133	<b>95.0%</b>	91.0%	99.0%	94.7%	n.s.	89.5%	+	≥ 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	447	279	<b>62.4%</b>	57.8%	67.0%	60.4%	n.s.	61.6%	n.s.	≥ 50th and < 75th percentile
PA EQR	Heart Failure Admission Rate <sup>1</sup> (Age 18-64 Years) per 100,000 member years	1,440,010	425	<b>2.46</b>	2.23	2.69	3.37	-	1.74	+	NA
PA EQR	Heart Failure Admission Rate <sup>1</sup> (Age 65+ Years) per 100,000 member years	28,144	16	<b>4.74</b>	2.42	7.06	8.17	n.s.	4.61	n.s.	NA
PA EQR	Heart Failure Admission Rate <sup>1</sup> (Total Age 18+ Years) per 100,000 member years	1,468,154	441	<b>2.50</b>	2.27	2.74	3.46	-	1.78	+	NA

<sup>1</sup> For the Adult Admission Rate measures, lower rates indicate better performance

## Utilization

Two strengths were noted for KF's 2015 (MY 2014) Utilization performance measures.

- The following rates were statistically significantly above the respective 2015 MMC weighed averages:
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia – 7.5 percentage points
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) – 5.4 percentage points

There were no opportunities for improvement identified for KF'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 <sup>1</sup>	31,444	4,429	<b>14.1%</b>	13.7%	14.5%	14.1%	n.s.	11.6%	+	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1,243	981	<b>78.9%</b>	76.6%	81.2%	75.4%	+	71.4%	+	≥ 90th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	2,178	1,680	<b>77.1%</b>	75.3%	78.9%	76.6%	n.s.	71.7%	+	NA

<sup>1</sup> 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 KF 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
<b>Your Health Plan</b>						
Satisfaction with Adult's Health Plan (Rating of 8 to 10)	78.10%	▼	81.40%	▲	74.32%	77.96%
Getting Needed Information (Usually or Always)	81.98%	▼	86.47%	▲	81.55%	83.20%
<b>Your Healthcare in the Last Six Months</b>						
Satisfaction with Health Care (Rating of 8-10)	69.89%	▼	74.33%	▲	70.98%	73.31%
Appointment for Routine Care When Needed (Usually or Always)	80.74%	▼	84.69%	▲	82.04%	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
<b>Your Child's Health Plan</b>						
Satisfaction with Child's Health Plan (Rating of 8 to 10)	87.12%	▼	87.61%	▲	84.72%	84.38%
Getting Needed Information (Usually or Always)	81.51%	▼	83.56%	▼	84.38%	82.42%
<b>Your Healthcare in the Last Six Months</b>						
Satisfaction with Health Care (Rating of 8-10)	88.69%	▼	90.99%	▲	84.67%	86.13%
Appointment for Routine Care When Needed (Usually or Always)	84.00%	▲	88.69%	▼	88.71%	89.66%

▲ ▼ = Performance compared to prior years' rate

Shaded boxes reflect rates above the 2015 MMC Weighted Average.

## IV: 2014 Opportunities for Improvement MCO Response

### Current and Proposed Interventions

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

DHS requested the MCOs to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

- Follow-up actions that the MCO has taken through September 30, 2015 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of November 2015, as well as any additional relevant documentation provided by KF.

Table 5.1 presents KF'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

<b>Reference Number: KF 2014.01: The Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care population PIP received no credit for the element of study evaluated in 2014 that reflected activities in 2013: Sustained Improvement.</b>
<p>Follow Up Actions Taken Through 09/30/15:</p> <ul style="list-style-type: none"><li>• The Outpatient Management Checklist provides all levels an opportunity to inquire and document in assessment the needs of member at time of discharge.</li><li>• Meds to Home project which ensures medications are available to members at time of discharge. Meds</li><li>• Meds to Home project which ensures medications are available to members at time of discharge. Meds are sent to the residence member identifies. Plan to expand outreach.</li><li>• Implemented Medication Adherence Program (PDC Program) in support of AOP goals</li><li>• Case management outreach and follow up with discharge members for coordination of care/services.</li><li>• Enrolling members in case management for continued coordination of care</li><li>• Home Health authorization waived for first 6 visits</li><li>• Provider/Member newsletter articles</li><li>• Spring Mailing</li><li>• Expanded DTM program Drug Therapy Management program- Drug Therapy Management (DTM) 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.</li><li>• Receipt of real-time information re: members seen in ER but not admitted; members are contacted for follow up and support</li><li>• Coordination between ACT nurses and RROT coordinator to facilitate interventions begun at hospital and follow thru with case management needs</li><li>• ACT nurse continue to facilitate post ER/IP PCP and specialist follow up appointments</li><li>• ACT nurses continue to work with members to ensure post DME and homecare visits are in place as required</li><li>• Community group (Walnut Hill) available to visit members post discharge for non-clinical assessment and referrals to RROT as indicated</li><li>• Smart Care Doc-TeleMedicine initiative-offers physical exams, health screenings, patient education, minor medical conditions and injuries, evaluation and treatment procedures and diagnostic laboratory tests Screenings done through, blue tooth operated diagnostic device. Kiosk or portable device available.</li><li>• COS (Community Outreach Solutions) Team Outreach (door to door, face to face outreach to members who have not been seen by</li></ul>

PCP to re-engage them in care and minimize ER use)

- Integrated Sickle Cell Program
- UNITS structure (described below)

UNITS are Unified Interdisciplinary Teams comprising multiple functions including Medical Directors, Utilization Management, Care Management, Rapid Response, Community Care Outreach, Provider Network Management, Pharmacy, Claims and Behavioral Health that are assigned specifically to groups of facilities. The goal of the UNITS model is to engage our members in a fully integrated, holistic approach to care through active collaboration with our providers and practitioners to improve the health of the populations we serve.

The UNITS structure improves accountability and ownership by holding each UNIT responsible for the data driven performance of their assigned facilities. This collaborative model align UM, CM, RROT, PNM, MD, Claims, and BH functions to develop internal and external relationships that achieve better outcomes, improve provider engagement and satisfaction, and integrate UM, CM, PNM, and MD efforts to close all gaps in the Transition of Care (TOC) for members discharged from IP care. This process was discontinued in June 2015.

**Future Actions Planned:**

- Investigating feasibility of Smart Care Doc-TeleMedicine initiative-offers physical exams, health screenings, patient education, minor medical conditions and injuries, evaluation and treatment procedures and diagnostic laboratory tests Screenings done through, blue tooth operated diagnostic device. Kiosk or portable device available.
- Increasing availability of real-time information re: members seen in ER but not admitted; members are contacted for follow up and support
- Plans are to extend the outreach of the Meds to Home project which ensures medications are available to members at time of discharge. Meds are sent to member's residence
- Integrated Sickle Cell Program with CHOP

When and how will these actions be accomplished?

- The actions will be accomplished by the end of 2015 and some will continue into CY 2016

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

- To reduce the rate of preventable readmissions for Keystone First members

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.02: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Follow-up Care for Children Prescribed ADHD Medication – All Phases (Initiation Phase, Continuation Phase, BH Enhanced Initiation Phase, and BH Enhanced Continuation Phase) measures.**

Follow Up Actions Taken Through 09/30/15:

- The Plan is currently generating data to send to the Rapid Response Team to help members schedule their initial visit in 30 days and or the 2 subsequent visits. The program is reaching approximately 180 every two weeks using HEDIS specifications (this is all three PA Plans, not exclusively KF)
- Clinical Practice Guideline on provider website

**Future Actions Planned:**

- Continuation of RROT outreach calls based on data from pharmacy

When and how will these actions be accomplished?

- These efforts are continuing

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

- Increased follow-up care for members diagnosed with ADHD

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.03: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the EPSDT - Hearing Test (Age 4-20 years) measure.**

Follow Up Actions Taken Through 09/30/15:

Keystone First covers Pediatric Preventive Care for members younger than 21 years old. This special health care program is called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT was created to make sure that children get the medical checkups, tests, and immunizations (shots) they need. This will help prevent early childhood diseases and illnesses and allow you to learn more about them.

- Just In Time campaign (JIT) In order to ensure that members 21 and younger are receiving needed well visits (EPSDT visits), Member Services outreaches to these members and their parents, in order to remind them of the importance of well care, and to help with scheduling appointments as needed. This outreach is known as "Just in Time". The purpose of the "Just in Time"

campaign is to follow up with members' parents/guardians to ensure members are getting to their appointments. These outreaches will also give Keystone First the ability to assist with scheduling appointments and define/overcome barriers that may be preventing members from attending these appointments.

- Member incentive for AWC and WC15
- Member newsletter article: "Prep for your Child's Check-up"
- Continuation of EPSDT outreach unit. The EPSDT Unit's outreach representative's primary responsibilities are to contact members via phone who have not fulfilled the requirements for an EPSDT screening in accordance to Pennsylvania's recommended periodicity immunization schedule. The outreach representatives are responsible for educating members of the available EPSDT services. Calls are made daily to member households to explain EPSDT, the importance of preventive health services and to offer Plan support in obtaining medical care. The outreach representative contacts the PCP to schedule appointments and will remind members about their appointment. The services include members who need immunizations, a blood lead test, dental, vision, hearing and assistance with scheduling appointments for a full comprehensive EPSDT screening. The Rapid Response unit provides support to the EPSDT unit by referring members with EPSDT care gap to the EPSDT unit.
- Continuation of the birthday cards mailing that includes age-specific annual screening recommendations.
- Continuation of automated telephonic message campaign for Adolescent Well visit
- The Preventive Health Clinical Practice guidelines are available to our providers on our web site.

**Future Actions Planned:**

- The EPSDT unit will continue to conduct outreach calls and services to parents

When and how will these actions be accomplished?

- These actions will be completed through the EPSDT unit telephonically through the end of CY 2015 and into CY 2016

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

- Parents/guardians will have an increased awareness of the importance of preventive screenings and prioritize this for their child (rate increased)

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly for members 1-3 years old without claims in the system

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

Follow Up Actions Taken Through 09/30/15:

Keystone First covers Pediatric Preventive Care for members younger than 21 years old. This special health care program is called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT was created to make sure that children get the medical checkups, tests, and immunizations (shots) they need. This will help prevent early childhood diseases and illnesses and allow you to learn more about them.

- Just In Time campaign (JIT) In order to ensure that members 21 and younger are receiving needed well visits (EPSDT visits), Member Services outreaches to these members and their parents, in order to remind them of the importance of well care, and to help with scheduling appointments as needed. This outreach is known as "Just in Time". The purpose of the "Just in Time" campaign is to follow up with members' parents/guardians to ensure members are getting to their appointments. These outreaches will also give Keystone First the ability to assist with scheduling appointments and define/overcome barriers that may be preventing members from attending these appointments.
- Member incentive for AWC and WC15
- Member newsletter article: "Prep for your Child's Check-up"
- Continuation of EPSDT outreach unit. The EPSDT Unit's outreach representative's primary responsibilities are to contact members via phone who have not fulfilled the requirements for an EPSDT screening in accordance to Pennsylvania's recommended periodicity immunization schedule. The outreach representatives are responsible for educating members of the available EPSDT services. Calls are made daily to member households to explain EPSDT, the importance of preventive health services and to offer Plan support in obtaining medical care. The outreach representative contacts the PCP to schedule appointments and will remind members about their appointment. The services include members who need immunizations, a blood lead test, dental, vision, hearing and assistance with scheduling appointments for a full comprehensive EPSDT screening. The Rapid Response unit provides support to the EPSDT unit by referring members with EPSDT care gap to the EPSDT unit.
- Continuation of the birthday cards mailing that includes age-specific annual screening recommendations.
- Continuation of automated telephonic message campaign for Adolescent Well visit
- The Preventive Health Clinical Practice guidelines are available to our providers on our web site.

**Future Actions Planned:**

- The EPSDT unit will continue to conduct outreach calls and services to parents

When and how will these actions be accomplished?

- These actions will be completed through the EPSDT unit telephonically through the end of CY 2015 and into CY 2016

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

- Parents/guardians will have an increased awareness of the importance of preventive screenings and prioritize this for their child (rate increased)

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly for members 1-3 years old without claims in the system

**Reference Number: KF 2014.05: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the ≥ 61% of Expected Prenatal Care Visits Received and ≥ 81% of Expected Prenatal Care Visits Received measures.**

Follow Up Actions Taken Through 09/30/15:

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 coordinating 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 prenatal appointment tracking calls and information after delivery regarding depression and breastfeeding. They also complete a post-partum 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 Plans 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 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 fax in the Plans Obstetrical Needs 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 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, education and Case Management services.
- Self-referral promotion (Welcome Card, Magnet, Newsletter and toll-free-number) – All member materials contain language encouraging members who are pregnant to contact The Plans Bright Start Program via a toll-free 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.
- Members identified as pregnant or have recently given birth receive sound-bytes encouraging them to contact the Bright Start department for assistance and information.

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. For all maternity members we are in contact with:

- The care managers complete a screening tool (PHO9) that includes depression screening during pregnancy and a screening tool after delivery specifically for depression only (Edinburgh).
- CM's follow up on the member's emotional status each trimester.
- A post-partum brochure is mailed that contains information on depression and directs them to call Bright Start.
- Support, resources and coordination of behavioral health is addressed for any positive result
- The ONAF form has a depression question that the OB must answer. If positive, physicians are to state whether or not resources were provided.

Specific Interventions

- Various links on plan web/member tab. These include links to the Bright Start Program, the CDC and WebMD, as well as tips on having a healthy baby

- Volume 1 2014 and 2015, member newsletter – *Do you want your baby to have a bright start* article
- If Bright Starts is unable to reach member telephonically, member is referred to Community Outreach Solutions team who will go into community looking for member. There are currently 5 such maternity navigators and thus far in 2015, 297 members completed post-partum visit with direct assistance by a maternity community advocate.
- 2014-Current – Members are offered cab rides if transportation is a barrier to receiving prenatal or postpartum care. We have provided 62 cab rides thus far in 2015
- 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.
- Bright Start “Baby Book” to help women keep track of prenatal appointments, month-by-month information about growing baby and pregnancy issues, space for members to write questions for their doctor, space for ultrasound pictures, etc.
- Availability of pregnancy test with Bright Start contact information at all KF community partner locations, and in some schools.
- Early identification pregnancy campaign-includes prenatal PSA and distribution of pregnancy tests at schools, and community partners.

**Future Actions Planned:**

Keystone First is launching a new maternity initiative called Keys to Your Care. This is a holistic engagement and incentive program to encourage members to make and keep doctor’s appointments throughout their pregnancy and into the first 15 months of their baby’s life (ACP and CAN will extend the texting through 15 months, KF is texting through postpartum).

Early and frequent prenatal care is the primary way to identify and manage early indicators of premature birth. This will optimize the health of the mom and the baby. “Health happens everywhere”, so Keys to Your Care engages with multiple touch-points – text messaging and (mobile-optimized) website. While prenatal-postpartum programs are not new to Medicaid plans, Keys to Your Care will push the boundaries of innovation through its emphasis on text messaging and incorporation of picture messaging.

Incentives have long been used to motivate behavior change. For Keys to Your Care, we plan to send members that meet the HEDIS Frequency of Ongoing Pregnancy Care criteria a crib at 38 weeks gestation. This is made possible through a partnership with Cribs for Kids.

The objectives of the Keys to Your Care program are:

- Empower members with more information and evidence-based resources to take better care of themselves, further supporting improved health outcomes and satisfaction
- Improve rates for the following HEDIS measures:
  - PPC1 Prenatal Care in First Trimester (or within 42 days of enrollment)
  - PPC2 Postpartum Care (between 21-56 days after delivery)
  - FPC Frequency of Ongoing Pregnancy Care (81+% of recommended visits)

Over time, reduce low birth weight events and volume of NICU/ED visits. The Keys to Your Care program is currently going to be deployed for Keystone First PA and is available for our members opt-in by text messaging or calling toll-free phones. The Rewards page will be branded Keys to Your Care to align with the Bright Start program brand.

When and how will these actions be accomplished?

- The activities of the Bright Start program will continue.
- Keys to Your Care and the Baby Book will be available for members to join and use in 2016.

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

- The expected outcome is to increase member’s awareness of the importance of early and consistent prenatal care and to change behavior.
- The Plan will be able to improve early identification of pregnant members for outreach and case management.
- Improve the rates/measures by 5% (of current gap to 100%).
- Utilize community doulas to reinforce prenatal education, improve prenatal appointment compliance, enhance preterm labor prevention education efforts with care managers, decrease prematurity rates, increase post-partum exam compliance rates within 21-56 days and improve breastfeeding rates (initiation of breastfeeding within the 1<sup>st</sup> 24 hours of life and continuity throughout the first year of life)

What is the MCO’s process for monitoring the actions to determine the effectiveness of the actions taken?

- Weekly workgroup meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to brainstorm new initiatives to improve prenatal and postpartum care
- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.06: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Prenatal and Postpartum Care: Postpartum Care 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 assessments 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
  - 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 coordinating 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 prenatal appointment tracking calls and information after delivery regarding depression and breastfeeding. They also complete a post-partum 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 Plans 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 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 fax in the Plans Obstetrical Needs 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 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, education and Case Management services.
- Self-referral promotion (Welcome Card, Magnet, Newsletter and toll-free-number) – All member materials contain language encouraging members who are pregnant to contact The Plans Bright Start Program via a toll-free 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.

#### Specific Interventions

- Various links on plan web/member tab. These include links to the Bright Start Program, the CDC and WebMD, as well as tips on having a healthy baby
- Volume 1 2014 and 2015, member newsletter – *Do you want your baby to have a bright start* article
- If Bright Starts is unable to reach member telephonically, member is referred to Community Outreach Solutions team who will go into community looking for member. There are currently 5 such maternity navigators and thus far in 2015, 297 members completed post-partum visit with direct assistance by a maternity community advocate.
- 2014-Current – Members are offered cab rides if transportation is a barrier to receiving prenatal or postpartum care. We have provided 62 cab rides thus far in 2015
- 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.
- Bright Start “Baby Book” to help women keep track of prenatal appointments, month-by-month information about growing baby and pregnancy issues, space for members to write questions for their doctor, space for ultrasound pictures, etc.
- Availability of pregnancy test with Bright Start contact information at all KF community partner locations, and in some schools.
- Early identification pregnancy campaign-includes prenatal PSA and distribution of pregnancy tests at schools, and community partners.
- For members that have logistical difficulties making or keeping their postpartum visit, the Plan offers the option to have the visit completed in their home. In 2015, 65 members have accepted this services

#### Future Actions Planned:

Keystone First is launching a new maternity initiative called Keys to Your Care. This is a holistic engagement and incentive program to encourage members to make and keep doctor's appointments throughout their pregnancy and into the first 15 months of their baby's life (ACP and CAN will extend the texting through 15 months, KF is texting through postpartum).

Early and frequent prenatal care is the primary way to identify and manage early indicators of premature birth. This will optimize the health of the mom and the baby. “Health happens everywhere”, so Keys to Your Care engages with multiple touch-points – text messaging and (mobile-optimized) website. While prenatal-postpartum programs are not new to Medicaid plans, Keys to Your Care will push the boundaries of innovation through its emphasis on text messaging and incorporation of picture messaging.

Incentives have long been used to motivate behavior change. For Keys to Your Care, we plan to send members that meet the HEDIS Frequency of Ongoing Pregnancy Care criteria a crib at 38 weeks gestation. This is made possible through a partnership with Cribs for Kids.

The objectives of the Keys to Your Care program are:

- Empower members with more information and evidence-based resources to take better care of themselves, further supporting improved health outcomes and satisfaction
- Improve rates for the following HEDIS measures:
  - PPC1 Prenatal Care in First Trimester (or within 42 days of enrollment)
  - PPC2 Postpartum Care (between 21-56 days after delivery)
  - FPC Frequency of Ongoing Pregnancy Care (81+% of recommended visits)

Over time, reduce low birth weight events and volume of NICU/ED visits. The Keys to Your Care program is currently going to be deployed for Keystone First PA and is available for our members opt-in by text messaging or calling toll-free phones. The Rewards page will be branded Keys to Your Care to align with the Bright Start program brand.

When and how will these actions be accomplished?

- The activities of the Bright Start program will continue.
- Keys to Your Care and the Baby Book will be available for members to join and use in 2016.

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

- The expected outcome is to increase member's awareness of the importance of early and consistent prenatal care and to

change behavior.

- The Plan will be able to improve early identification of pregnant members for outreach and case management.
- Improve the rates/measures by 5% (of current gap to 100%).
- Utilize community doulas to reinforce prenatal education, improve prenatal appointment compliance, enhance preterm labor prevention education efforts with care managers, decrease prematurity rates, increase post-partum exam compliance rates within 21-56 days and improve breastfeeding rates (initiation of breastfeeding within the 1<sup>st</sup> 24 hours of life and continuity throughout the first year of life)

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- Weekly workgroup meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to brainstorm new initiatives to improve prenatal and postpartum care
- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.07: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC 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 assessments 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
  - 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 coordinating 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 prenatal appointment tracking calls and information after delivery regarding depression and breastfeeding. They also complete a post-partum 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 Plans 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 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 fax in the Plans Obstetrical Needs 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 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, education and Case Management services.
- Self-referral promotion (Welcome Card, Magnet, Newsletter and toll-free-number) – All member materials contain language encouraging members who are pregnant to contact The Plans Bright Start Program via a toll-free 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. For all maternity members we are in contact with:

- The care managers complete a screening tool (PHO9) that includes depression screening during pregnancy and a screening tool after delivery specifically for depression only (Edinburgh).
- CM’s follow up on the member’s emotional status each trimester.
- A post-partum brochure is mailed that contains information on depression and directs them to call Bright Start.
- Support, resources and coordination of behavioral health is addressed for any positive result
- The ONAF form has a depression question that the OB must answer. If positive, physicians are to state whether or not resources were provided.

#### Specific Interventions:

- 2014-Developed postpartum trifold on importance of going to postpartum visit, explaining provider will screen for depression
- Volume 1 2014 and 2015, member newsletter – *Do you want your baby to have a bright start* article
- 2014-Current – Members are offered cab rides if transportation is a barrier to receiving prenatal or postpartum care. We have provided 62 cab rides thus far in 2015
- 4<sup>th</sup> Qtr 2014-Current – Members are offered Post partum home visit if necessary. In 2015 we have provided 65 home post-partum care visits.
- Various links on plan web/member tab. These include links to the Bright Start Program, the CDC and WebMD, as well as tips on having a healthy baby
- 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.
- Availability of pregnancy test with Bright Start contact information at all KF community partner locations, and in some schools.
- Early identification pregnancy campaign-includes prenatal PSA and distribution of pregnancy tests at schools, and community partners.

#### Future Actions Planned:

When and how will these actions be accomplished?

- The activities of the Bright Start program will continue.
- Keys to Your Care and the Baby Book will be available for members to join and use in 2016.

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

- The expected outcome is to increase member’s awareness of the importance of early and consistent prenatal care and to change behavior.
- The Plan will be able to improve early identification of pregnant members for outreach and case management.
- Improve the rates/measures by 5% (of current gap to 100%).
- Utilize community doulas to reinforce prenatal education, improve prenatal appointment compliance, enhance preterm labor prevention education efforts with care managers, decrease prematurity rates, increase post-partum exam compliance rates within 21-56 days and improve breastfeeding rates (initiation of breastfeeding within the 1<sup>st</sup> 24 hours of life and continuity throughout the first year of life)

What is the MCO’s process for monitoring the actions to determine the effectiveness of the actions taken?

- Weekly workgroup meetings to assess effectiveness of implemented initiatives and discuss member outcomes, continue to brainstorm new initiatives to improve prenatal and postpartum care
- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.08: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Appropriate Testing for Children with Pharyngitis measure.**

Follow Up Actions Taken Through 09/30/15:

- Launched an education 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

**Future Actions Planned:**

- Continue current actions
- Develop Prescriber letter for antibiotic HEDIS measures to target under-performing providers in measures that involve inappropriate antibiotic use
- Creation of Antibiotic Utilization Review Reports
- Considering Medical Director visits to under-performing providers to educate providers on standards

**Reference Number: KF 2014.09: The MCO's rates were statistically significantly below the 2014 (MY 2013) MMC averages for the Medication Management for People with Asthma: 75% Compliance (Age 5-11 years), (Age 12-18 years), and (Age 5-64 years) measures.**

Follow Up Actions Taken Through 09/30/15:

- Physician and member newsletter articles
- Spring Mailing – approved by DPW – will be sent in May 2014.
- Smoking Cessation program
- Perform Rx provides asthma reports to member PCPs for monitoring
- Adult and child asthma program materials sent to newly identified members.
- Asthma education information link on Member website
- Healthy Hoops asthma education program
- “For your Kids Care” ER prevention and education program
- Clinical Practice Guidelines on Provider Website
- Automated reminder calls to non compliant members
- Bi annual DM mailings
- On Hold message
- CM outreach to new members from the Medication Non-Adherence List
- Medication home delivery Program/Rite Aid/Walmart/NorthEast Pharmacy
- Asthma education Case Rounds provided to case managers
- Asthma Adherence Pilot Program w/ Keystone First in collaboration with CHOPs Karabots Center. Pilot program uses health assessment and electronic inhaler to monitor member compliance with asthma meds. Education and member incentives are included in the program.
- Care gaps
- BEST-Asthma Consignment Program- Asthma spacers, inhalers, and masks of various sizes are available to members through the provider offices. King of Prussia pharmacy calls members to remind about refills. If members are not using the inhalers, they get educated on proper use and if they need a refill, KOP pharmacy delivers medication to the member's home.
- Case Managers outreach to members on current Special Needs member list with dx of Asthma
- Keystone First, in collaboration with the Pennsylvania Academy of Family Physicians Foundation (PAFP), presents a free, on-demand, recorded, webinar series on patient and physician barriers to optimal asthma control.
- Improving Patient Outcomes Using Asthma Guidelines
- The importance of Inhaled Steroids & improving Effectiveness
- Pharmacy mediation home delivery program-participating pharmacies include-Sunray Drugs, Neighborcare-Crozier medical center, Bright Medical
- Asthma Navigator program with CHOP and Crozer – Members with 2 ED and 1 IP due to asthma will receive an asthma home assessment within 1 week of release. Trained community health workers will visit the member and administer a knowledge quiz and review of asthma medications and asthma triggers avoidance, then scheduled a follow-up appointment with PCP
- Asthma – Controller Medication Therapy
- Purpose: the purpose of this measure is to identify and track members who are diagnosed with asthma and are not filling asthma controller medications regularly.
- At Risk Status: Pharmacy claims show a ratio of controller medications to all asthma medications of <0.5 which is positively

correlated with an increase in asthma-related exacerbations including hospitalizations.

- Pharmacy Claim Data: Ratio of asthma controller medications: (controller + rescue) medications. Reviews claims from the previous 6 months.
- Controller medications = inhaled corticosteroids, combination inhalers containing corticosteroids, inhaled cromolyn, oral leukotriene modifiers, and omalizumab (Xolair)
- Rescue medications = above medications plus short acting beta agonists (albuterol, levalbuterol)
- Asthma Medication Adherence
- Purpose: The purpose of this measure is to identify and track asthmatic members and to determine if they are having their asthma-related drug prescriptions appropriately filled within the measurement year
- Members Included: Members aged 5-64 with a documented history of asthma. Members identified as having persistent asthma with active coverage with the insurance plan, eligible for the Rx benefits as of the last day of the reporting period, and with at least one asthma controller prescription fill during the reporting period.

**Future Actions Planned:**

- The plan will continue all of the programs identified as Follow-Up Actions through 9/30/15

When and how will these actions be accomplished?

- Member materials will continue to be sent through the member communications department
- Public Affairs and Marketing will continue outreach efforts
- Pharmacy will maintain communication with PCPs

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

- The expected outcome of these actions is increased member adherence to medication therapy for asthma, as well as to provide education on asthma control.

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze data claims monthly and discuss at monthly workgroup

**Reference Number: KF 2014.10: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Adult Asthma Admission Rate (Age 18-39 years) measure.**

Follow Up Actions Taken Through 09/30/15:

- Physician and member newsletter articles
- Spring Mailing – approved by DPW – will be sent in May 2014.
- Smoking Cessation program
- Perform Rx provides asthma reports to member PCPs for monitoring
- Adult and child asthma program materials sent to newly identified members.
- Asthma education information link on Member website
- Healthy Hoops asthma education program
- "For your Kids Care" ER prevention and education program
- Clinical Practice Guidelines on Provider Website
- Automated reminder calls to non compliant members
- Bi annual DM mailings
- On Hold message
- CM outreach to new members from the Medication Non-Adherence List
- Medication home delivery Program/Rite Aid/Walmart/NorthEast Pharmacy
- Asthma education Case Rounds provided to case managers
- Asthma Adherence Pilot Program w/ Keystone First in collaboration with CHOPs Karabots Center. Pilot program uses health assessment and electronic inhaler to monitor member compliance with asthma meds. Education and member incentives are included in the program.
- Care gaps
- BEST-Asthma Consignment Program- Asthma spacers, inhalers, and masks of various sizes are available to members through the provider offices. King of Prussia pharmacy calls members to remind about refills. If members are not using the inhalers, they get educated on proper use and if they need a refill, KOP pharmacy delivers medication to the member's home.
- Case Managers outreach to members on current Special Needs member list with dx of Asthma
- Keystone First, in collaboration with the Pennsylvania Academy of Family Physicians Foundation (PAFP), presents a free, on-demand, recorded, webinar series on patient and physician barriers to optimal asthma control.
- Improving Patient Outcomes Using Asthma Guidelines
- The importance of Inhaled Steroids & improving Effectiveness
- Pharmacy mediation home delivery program-participating pharmacies include-Sunray Drugs, Neighborcare-Crozier medical center, Bright Medical
- Asthma Navigator program with CHOP and Crozer – Members with 2 ED and 1 IP due to asthma will receive an asthma home assessment within 1 week of release. Trained community health workers will visit the member and administer a knowledge quiz

and review of asthma medications and asthma triggers avoidance, then scheduled a follow-up appointment with PCP

- Asthma – Controller Medication Therapy- identify and track members who are diagnosed with asthma and are not filling asthma controller medications regularly. At Risk Status: Pharmacy claims show a ratio of controller medications to all asthma medications of <0.5 which is positively correlated with an increase in asthma-related exacerbations including hospitalizations. Pharmacy Claim Data: Ratio of asthma controller medications: (controller + rescue) medications. Reviews claims from the previous 6 months. [Controller medications = inhaled corticosteroids, combination inhalers containing corticosteroids, inhaled cromolyn, oral leukotriene modifiers, and omalizumab (Xolair) Rescue medications = above medications plus short acting beta agonists (albuterol, levalbuterol)]
- Asthma Medication Adherence- identify and track asthmatic members and to determine if they are having their asthma-related drug prescriptions appropriately filled within the measurement year. Members Included: Members aged 5-64 with a documented history of asthma. Members identified as having persistent asthma with active coverage with the insurance plan, eligible for the Rx benefits as of the last day of the reporting period, and with at least one asthma controller prescription fill during the reporting period.

**Future Actions Planned:**

- Continuation of the above mentioned activities
- When and how will these actions be accomplished?
- These actions will be accomplished by the end of CY 2014 and continue into 2015 by Integrated Care Management
- What is the expected outcome or goals of the actions that were taken or will be taken?
- Reduce the rate for adult asthma admissions
- What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?
- The plan will monitor and analyze data claims monthly and discuss at monthly workgroup

**Reference Number: KF 2014.11: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Chronic Obstructive Pulmonary Disease Admission Rate (Age 40+ years) measure.**

Follow Up Actions Taken Through 09/30/15:

- Clinical Practice Guidelines on Provider Website
- Asthma Medication Adherence- identify and track asthmatic members and to determine if they are having their asthma-related drug prescriptions appropriately filled within the measurement year. Members Included: Members aged 5-64 with a documented history of asthma. Members identified as having persistent asthma with active coverage with the insurance plan, eligible for the Rx benefits as of the last day of the reporting period, and with at least one asthma controller prescription fill during the reporting period.
- Pharmacy mediation home delivery program-participating pharmacies include-Sunray Drugs, Neighborcare-Crozier medical center, Bright Medical, Rite Aid, Walmart, NorthEast Pharmacy
- Physician and member newsletter articles
- Welcome letter/educational material mailed to newly identified members
- Focused educational mailings
- Annual reminders for flu/pneumonia vaccine
- Access to Rapid Response Unit
- Access to 24/7 Nurse Line
- Smoking Cessation Program referral
- Integrated Care Management Assessment per applicable department available upon request
- Care Management doing comprehensive assessments of asthmatic members
- Individualized Care Plans for asthmatic members
- Outreach based according to level of intensity
- Focused education, based on assessment including preventive measures, trigger identification/avoidance, 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
- Identification, communication and intervention to resolve Gaps in Care
- Connection to appropriate community resources and services
- Provide high level supportive services and equipment
- Updated Clinical Practice Guideline on Provider website
- Community Screening Events
- Monthly Asthma Workgroup

**Future Actions Planned:**

- Continuation of the above-mentioned activities
- Utilization of Mobile Spirometry Unit (MSU): The MSU is a screening program that provides essential screenings and lung

function testing, and distributes educational materials on lung health. The screenings are administered by respiratory therapists in health fairs and community events.

When and how will these actions be accomplished?

- Care Management will continue outreach and management efforts
- Public Affairs and Marketing will facilitate the use of the MSU as necessary

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

- Increase rate of COPD screening and improve medical management. The goal is to decrease the COPD admission rate

**Reference Number: KF 2014.12: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Retinal Eye Exam measure.**

Follow Up Actions Taken Through 09/30/15:

- Incentive for retinal eye exams: \$10 gift card
- Eye glass benefit for diabetics rolled out in August 2015
- Block scheduling with Dr. Hill-Bennett (optometry) for retinal eye exams. Members will also receive screenings for blood glucose, LDL, blood pressure, and BMI. (begun December 20th 2014)
- Drexline Shopping Center PCP offices offer retinal eye exams twice a week in partnership with Wills Eye Hospital (begun June 2013)
- Using care gaps to address diabetic measures such as HgA1C testing, lipid testing, retinal eye exams and micro-albumin testing. Care gaps are integrated into the case management system and for the provider via Navinet. Care gap access has been extended to other departments such as member services, RROT and the retention unit.

**Future Actions Planned:**

Keystone is working with a vendor to have eye exams performed at the member's home along with A1c blood draw and nephropathy urine sample. This is done through the use of a hand held retinal camera. The images are then read by ophthalmologist at Wills Eye hospital. This initiative started in November 2015

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

Follow Up Actions Taken Through 09/30/15:

Members are identified for CCM through many sources, including referrals from internal and external sources. Care Managers perform comprehensive and disease specific assessments, 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, assistances 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 and fully engaged 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 members 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
- Connection to appropriate community resources and services
- Outreach to members with HbA1c < 8.5%
- Outreach to members with no HbA1c on file

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 (ongoing)
- Community Wellness Empowerment Events (ongoing)
- Acute Care Transition CM (ongoing)
- Embedded/Onsite Care Managers at select provider offices to address care gaps in coordination with the physician practices (ongoing)
- Shared Savings Program (ongoing)
- Dedicated Diabetes Web Page for Providers (ongoing)
- Dedicated Diabetes Web Page for Members (ongoing)
- Diabetes Self-Management Programs (ongoing)
- Home lab A1c draws for members that have been unable to reach a lab (Began September 2015)
- Bi monthly meetings involving multi-disciplinary approach to addressing needs of diabetic members began meeting in January 2015.
- Initiative involving in-home nutritional counseling (Family Food) (2015)

**Future Actions Planned:**

- Continue with current approach.
- Engage members in case management.
- Outreach by community outreach solutions team for those members that are unable to be reached telephonically.
- Continue outreach efforts for home lab draws for members with transportation barriers.
- Evaluate effectiveness of in-home nutritional counseling to determine if expansion of program would be beneficial

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

- To reduce the average number of members being admitted for short-term complications

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly, and discuss at bi-monthly workgroup meeting

**Reference Number: KF 2014.14: The MCO's rate was statistically significantly below the 2014 (MY 2013) MMC average for the Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening measure.**

Follow Up Actions Taken Through 09/30/15:

Members are identified for CCM through many sources, including referrals from internal and external sources. Care Managers perform comprehensive and disease specific assessments, 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, assistances 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 and fully engaged 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 (CVD) Management program include:

- Improve medication adherence for members taking antihypertensive and statin medications
- Improve self-management by promoting 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 best practice and clinical guidelines
- 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. Initiatives related to the Heart Failure Program include:

- Community Wellness Empowerment Events
- CVD Assessment and re-assessment tools in system platform to monitor Member outcomes
- Heart Failure Assessment and re-assessment tools in system platform
- Acute Care Transition CM Embedded/Onsite Care Managers at select 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
- Focused education, based on assessment including preventive measures, worsening of symptoms and supportive measures
- Monitoring of pharmaceutical medications and lab values
- Utilization of Heart Failure HRA's 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
- Outreach by community outreach solutions team for those members that are unable to be reached telephonically.
- Referrals to the Community Care Management Team for intensive face to face interactions/interventions by a team consisting of physician, social worker, RN, and community care connector.
- Assistance in obtaining DME items for monitoring weight and blood pressure if warranted.
- Nutritional counseling through Family Food.
- Notification within 24 hours, of inpatient stays, ER visits and discharges (with participating institutions) via electronic Health Share Exchange report.
- Completion of the Outpatient Management Checklist post hospitalization to facilitate a smooth transition.
- Members who are new to the plan with a diagnosis of CVD are contacted by the welcome center and screened for needs. If needs are identified the members are routed to Rapid Response for more in depth screening and referred to case management if warranted.
- Discharge summaries/discharge instructions are provided by select hospitals to facilitate better communication and medication reconciliation post hospitalization.

**Future Actions Planned:**

- Continue with current approach.
- Engage members in case management.
- Utilize community outreach solutions team for those members that are unable to be reached telephonically.
- Working with Temple University Hospital (TUH) to provide follow up care to members with a diagnosis of heart failure who have been admitted to the hospital; this care is provided through the TUH community health worker program. Temple also plans to provide KF with discharge summaries and discharge instructions for these members and collaborate with the case managers.

**Reference Number: KF 2014.15: The MCO's rates were statistically significantly worse than the 2014 (MY 2013) MMC averages for the Congestive Heart Failure Admission Rate (Age 18-64 years) and (Total Age 18+ years) measures.**

**Follow Up Actions Taken Through 09/30/15:**

Members are identified for CCM through many sources, including referrals from internal and external sources. Care Managers perform comprehensive and disease specific assessments, 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, assistances 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 and fully engaged 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 (CVD) 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 best practice and clinical guidelines
- 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. Initiatives related to the Heart Failure Program include:

- Community Wellness Empowerment Events
- CVD Assessment and re-assessment tools in system platform to monitor Member outcomes
- Heart Failure Assessment and re-assessment tools in system platform
- Acute Care Transition CM Embedded/Onsite Care Managers at select 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
- Focused education, based on assessment including preventive measures, worsening of symptoms and supportive measures
- Monitoring of pharmaceutical medications and lab values
- Utilization of Heart Failure HRA's 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
- Outreach by community outreach solutions team for those members that are unable to be reached telephonically.
- Referrals to the Community Care Management Team for intensive face to face interactions/interventions by a team consisting of physician, social worker, RN, and community care connector.
- Assistance in obtaining DME items for monitoring weight and blood pressure if warranted.
- Nutritional counseling through Family Food.
- Notification within 24 hours, of inpatient stays, ER visits and discharges (with participating institutions) via electronic Health Share Exchange report.
- Completion of the Outpatient Management Checklist post hospitalization to facilitate a smooth transition.
- Members who are new to the plan with a diagnosis of CVD are contacted by the welcome center and screened for needs. If needs are identified the members are routed to Rapid Response for more in depth screening and referred to case management if warranted.

Discharge summaries/discharge instructions are provided by select hospitals to facilitate better communication and medication reconciliation post hospitalization.

**Future Actions Planned:**

- Continue with current approach.
- Engage members in case management.
- Utilize community outreach solutions team for those members that are unable to be reached telephonically.
- Working with Temple University Hospital (TUH) to provide follow up care to members with a diagnosis of heart failure who have been admitted to the hospital; this care is provided through the TUH community health worker program. Temple also plans to provide KF with discharge summaries and discharge instructions for these members and collaborate with the case managers.

When and how will these actions be accomplished?

- Integrated Care Management will continue outreach and management efforts

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

- To reduce the average number of members being admitted for short-term complications

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly, and discuss at weekly workgroup meeting

**Reference Number: KF 2014.16: The MCO's rate was statistically significantly worse than the 2014 (MY 2013) MMC average for the Reducing Potentially Preventable Readmissions measure.**

Follow Up Actions Taken Through 09/30/15:

- The Outpatient Management Checklist provides all levels an opportunity to inquire and document in assessment the needs of member at time of discharge.
- Meds to Home project which ensures medications are available to members at time of discharge. Meds
- Implemented Medication Adherence Program (PDC Program) in support of AOP goals
- Case management outreach and follow up with discharge members for coordination of care/services.
- Enrolling members in case management for continued coordination of care
- Home Health authorization waived for first 6 visits
- Provider/Member newsletter articles
- Spring Mailing
- Expanded DTM program Drug Therapy Management program- Drug Therapy Management (DTM) 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.
- Coordination between ACT nurses and RROT coordinator to facilitate interventions begun at hospital and follow thru with case management needs
- ACT nurse continue to facilitate post ER/IP PCP and specialist follow up appointments
- ACT nurses continue to work with members to ensure post DME and homecare visits are in place as required
- Community group (Walnut Hill) available to visit members post discharge for non-clinical assessment and referrals to RROT as indicated
- COS (Community Outreach Solutions) Team Outreach (door to door, face to face outreach to members who have not been seen by PCP to re-engage them in care and minimize ER use)
- Integrated Sickle Cell Program
- UNITS structure (described below)  
UNITS are Unified Interdisciplinary Teams comprising multiple functions including Medical Directors, Utilization Management, Care Management, Rapid Response, Community Care Outreach, Provider Network Management, Pharmacy, Claims and Behavioral Health that are assigned specifically to groups of facilities. The goal of the UNITS model is to engage our members in a fully integrated, holistic approach to care through active collaboration with our providers and practitioners to improve the health of the populations we serve.  
The UNITS structure improves accountability and ownership by holding each UNIT responsible for the data driven performance of their assigned facilities. This collaborative model align UM, CM, RROT, PNM, MD, Claims, and BH functions to develop internal and external relationships that achieve better outcomes, improve provider engagement and satisfaction, and integrate UM, CM, PNM, and MD efforts to close all gaps in the Transition of Care (TOC) for members discharged from IP care. This process was discontinued in June 2015.

**Future Actions Planned:**

- Investigating feasibility of Smart Care Doc-TeleMedicine initiative-offers physical exams, health screenings, patient education, minor medical conditions and injuries, evaluation and treatment procedures and diagnostic laboratory tests Screenings done through, blue tooth operated diagnostic device. Kiosk or portable device available.
- Increasing availability of real-time information re: members seen in ER but not admitted; members are contacted for follow up and support
- Plans are to extend the outreach of the Meds to Home project which ensures medications are available to members at time of discharge. Meds are sent to member's residence
- Integrated Sickle Cell Program with CHOP

When and how will these actions be accomplished?

- The actions will be accomplished by the end of 2015 and some will continue into CY 2016

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

- To reduce the rate of preventable readmissions for Keystone First members

What is the MCO's process for monitoring the actions to determine the effectiveness of the actions taken?

- The plan will monitor and analyze claims data monthly

**Reference Number: KF 2014.17: Decreases were noted in 2014 (MY 2013) as compared to the MCO's 2013 (MY 2012) in two of the four Child CAHPS composite survey items. One survey item evaluated fell below the 2014 MMC weighted average.**

Follow Up Actions Taken Through 09/30/15:

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
- Option for survey to be conducted over phone with interpreter in any of the tagline languages
- Call Center Script to respond to members’ CAHPS questions
- CAHPS presentation given at “all Associate Staff meetings”
- Member newsletter article: “What to do When You are Sick.”
- Distribution of Ask Me 3 brochure to members – “Prepare for Your Doctor Visit.”
- Review of 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
- On line Health literacy CMEs
- Provider newsletter articles: “Speaking Their Language” and “Get Interpreter Services for Your Practices at Discounted Prices.”
- Distribution of Ask Me 3 poster to providers

Analysis has allowed for the identification of specific areas of opportunities, such as the *Getting Care Quickly* and *Getting Needed Care* composite scores, where member satisfaction was not as strong as the other measures. These findings give Keystone First 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 associated as well as to increase our member satisfaction rates. We will continue to monitor and evaluate our CAHPS survey annually.

When and how will these actions be accomplished?

- KF will continue outreach to members on the importance of responding to the CAHPS survey
- These actions will be accomplished through a collaborative effort by the internal CAHPS committee

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

- The expected outcome is to increase positive member response in the appropriate measures

What is the MCO’s process for monitoring the actions to determine the effectiveness of the actions taken?

- The MCO will monitor actions through the CAHPS work plan and the monthly CAHPS meeting

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

1. Frequency of Ongoing Prenatal Care:  $\leq 81\%$  of Expected Prenatal Care Visits Received (Table 5.2)
2. Reducing Potentially Preventable Readmissions (Table 5.3)

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

**Table 5.2: RCA and Action Plan – Frequency of Ongoing Prenatal Care:  $\leq 81\%$  of Expected Prenatal Care Visits Received**

**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.

<b>Managed Care Organization (MCO):</b>	Keystone First																													
<b>Measure:</b>	Frequency of Ongoing Prenatal Care: $\leq 81\%$ of Expected Prenatal Care Visits Received																													
<b>Response Date:</b>	November 20, 2015																													
<b>Goal Statement:</b> Please specify goal(s) for measure.	Increase by 5% of the gap from HEDIS 2014 rates to 100 = 64.96% $100 - 63.11 = 36.89$ $36.89 * .05 = 1.845$ $63.11 + 1.845 = 64.96$ Goal: 64.96%																													
<b>Analysis:</b> What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	<b>Findings:</b> To assist in the determination of contributing factors, the Plan examined the racial, ethnic, language, age and geographic breakdowns of the data. Additionally, the Quality Department spoke with the maternity management department (BrightStarts), as well as providers at an OB/GYN Provider Seminar to better assess barriers and receive feedback.  <b>2014 HEDIS RESULTS</b> Differences between REL groups are provided below. The difference between African Americans and Caucasians and race category “Other” was found to be statistically significant ( $p < .05$ ) <table border="1" data-bbox="505 1528 1421 1738"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">RACE</th> <th colspan="2">ETHNICITY</th> <th colspan="2">LANGUAGE</th> </tr> <tr> <th>Caucasian</th> <th>African American</th> <th>Other</th> <th>Hispanic</th> <th>Non-Hispanic</th> <th>English</th> <th>Other Language</th> </tr> </thead> <tbody> <tr> <td>&gt;81% of Expected Visits</td> <td>58.06%</td> <td>43.32%</td> <td>61.02%</td> <td>55.17%</td> <td>49.63%</td> <td>50.12%</td> <td>44.44%</td> </tr> </tbody> </table> A drill down on compliance rate by location and age group is provided below to determine which categories have lowest rates of compliance.								RACE			ETHNICITY		LANGUAGE		Caucasian	African American	Other	Hispanic	Non-Hispanic	English	Other Language	>81% of Expected Visits	58.06%	43.32%	61.02%	55.17%	49.63%	50.12%	44.44%
	RACE			ETHNICITY		LANGUAGE																								
	Caucasian	African American	Other	Hispanic	Non-Hispanic	English	Other Language																							
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<b>County</b>	<b># of Pregnant Members</b>	<b># of Compliant members</b>	<b>Compliance Rate</b>
Philadelphia County	4122	1368	33.19%
Bucks County	521	245	47.02%
Delaware County	1084	519	47.88%
Montgomery County	676	329	48.67%
Chester County	158	83	52.53%

<b>Philadelphia Neighborhood</b>	<b># of Pregnant Members</b>	<b># of Compliant Members</b>	<b>Compliance Rate</b>
West Philadelphia	931	264	28.36%
Northwest Philadelphia*	373	106	28.42%
North Philadelphia	952	297	31.20%
Southwest Philadelphia	213	70	32.86%
South Philadelphia	485	183	37.73%
Greater Northeast Philadelphia	1035	396	38.26%
Center City	133	52	39.10%

<b>Age</b>	<b># of pregnant Members</b>	<b># of Compliant Members</b>	<b>Compliance Rate</b>
25 Years and Under	2861	1022	35.72%
26 Years and Older	3743	1539	41.12%

**GEOACCESS DATA**

**Table 1** displays the percentage of female members with the appropriate availability to Obstetricians/Gynecologists (Ob/Gyns) within the urban/suburban and rural areas. In year 2015, the percentage of members who had access to at least two Ob/Gyns in urban/suburban and rural areas was 100%. Additionally, the average time it would require for a member to reach two different Ob/Gyns was 2.2 minutes in urban/suburban areas and 4.9 minutes in rural areas.

**Table 1A** displays year 2015 availability for the purpose of analyzing any change in availability in the current network.

**Table 1: GeoAccess for Keystone First – 1<sup>st</sup> Quarter 2014 Obstetricians/Gynecologists**

<b>2014</b>	<b>Availability Standards</b>	<b>Members with Availability</b>		<b>Members Without Availability</b>		<b>Numbers of Practitioners</b>	<b>Number of Sites</b>
		<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>		
Urban/Suburban	2 Ob/Gyns/ 30 min.	149,512	100%	0	0%	618	1,854
Rural	2 Ob/Gyns/ 60 min.	10,509	100%	0	0%	618	1,854

**Table 1A: GeoAccess® for Keystone First– 2015 Obstetricians/Gynecologists**

<b>2015</b>	<b>Availability Standard</b>	<b>Members with Availability</b>		<b>Members Without Availability</b>		<b>Numbers of Practitioners</b>	<b>Number of Sites</b>
		<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>		
Urban/Suburban	2 Ob/Gyns/30 min.	162,791	100%	0	0%	642	342
Rural	2 Ob/Gyns/60 min.	12,519	100%	0	0%	642	342

*Policies*  
(e.g., data systems, delivery systems, provider facilities)

N/A

*Procedures*

A review of the claims data indicated that complete documentation was not being

(e.g., payment/reimbursement, credentialing/collaboration)	submitted by providers.
<i>People</i> (e.g., personnel, provider network, patients)	Data indicate that African Americans' compliance rate was lower than that of Caucasians and members in race category of "other" (p<.05). Also, younger members were less likely to be compliant than older members.  When examining member location, it was determined that compliance was lowest in the West and Northwest Philadelphia communities. However, review of Keystone First Network geo-access analysis for OB/GYNs indicates that the distribution of the network is sufficient.  This suggests the Plan should better target African American Communities for interventions and younger members. Particularly those residing in West Philadelphia and Northwest Philadelphia neighborhoods.
<i>Provisions</i> (e.g., screening tools, medical record forms, provider and enrollee educational materials)	Manual ONAF form completion is leading to data entry errors and low participation rate.
<i>Other (specify)</i>	N/A

<b>MCO:</b>	<b>Keystone First</b>
<b>Measure:</b>	<b>Frequency of Ongoing Prenatal Care: &lt;=81% of Expected Prenatal Care Visits Received</b>

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

<b><u>Action</u></b> Include those planned as well as already implemented. Add rows if needed.	<b><u>Implementation Date</u></b> Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	<b><u>Monitoring Plan</u></b> How will you know if this action is working? What will you measure and how often? Include what measurements will be used, as applicable.
Hosted Community Baby Showers in West Philadelphia and Chester City to increase member awareness of the importance of prenatal care and identify pregnant members for follow up by BrightStarts program. West Philadelphia is an area that had the lowest levels of compliance and has a significant African-American population, as does the city of Chester, which also had lower compliance rates than the other race categories.	5/16/14 9/25/14 6/12/15 9/11/15	<b>How will you know if this action is working?</b> Increase in calls to KF BrightStarts program as a result of the baby shower connections.  <b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> 1. # calls from members not part of BrightStarts. Measured for month after baby showers 2. The percentage of members in 2015 that received frequent prenatal care as compared to the previous year. Measured monthly.
Maternity Care Connectors in the field to provide face to face assistance to pregnant members.	August 4, 2014 – ongoing	<b>How will you know if this action is working?</b> Increase in timely prenatal care visits.  <b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> The percentage of members in 2015 that received frequent prenatal care as compared to the previous year. Measured monthly.
Cab Transportation – this is to assist those members that are unable to attend prenatal care visits due to transportation	Ongoing	<b>How will you know if this action is working?</b> Increase in timely prenatal care visits.

barriers.		<p><b>What will you measure and how often? Include what measurements will be used, as applicable.</b></p> <p>The percentage of members in 2015 that received frequent prenatal care as compared to the previous year. Measured monthly.</p>
Keys to Your Care program – program for pregnant members which will assist in guiding them through the prenatal process and provide pertinent information. This is thought to be a strong approach for our younger pregnant members.	Planned for 2016	<p><b>How will you know if this action is working?</b></p> <p>Number of members participating in the program. Also, a comparison of compliance rates between participants and those not participating.</p> <p><b>What will you measure and how often? Include what measurements will be used, as applicable.</b></p> <p>The percentage of members in 2015 that received frequent prenatal care as compared to the previous year. Measured monthly.</p>
Restructure reimbursement process so that providers are paid at initial visits as well as at the last visit. This helped to ensure claims were submitted throughout the pregnancy.	January 2015	<p><b>How will you know if this action is working?</b></p> <p>Increase in the number of claims submitted for pregnant members.</p> <p><b>What will you measure and how often? Include what measurements will be used, as applicable.</b></p> <p>Claims submitted for pregnancy members for the codes specified in the new payment structure.</p> <p>The percentage of members in 2015 that received frequent prenatal care as compared to the previous year. Measured monthly.</p>

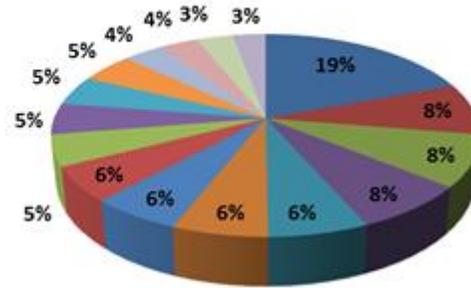
Table 5.3: RCA and Action Plan – Reducing Potentially Preventable Readmissions

<b>Managed Care Organization (MCO):</b>	<b>Keystone First</b>
<b>Measure:</b>	<b>Reducing Potentially Preventable Readmissions<sup>2</sup></b>
<b>Response Date:</b>	<b>November 20, 2015</b>
<b>Goal Statement:</b> Please specify goal(s) for measure.	Decrease by 5% of the gap from 2014 rates to 0 – 18.16% $19.12 * .05 = .956$ $19.12 - .956 = 18.164$ Goal: 18.16%
<b>Analysis:</b> What factors contributed to poor performance? Please enter "N/A" if a category of factors does not apply.	<p><b>Findings:</b></p> <p>To further investigate the Plan's readmission rates, reports on top readmission categories were reviewed. Historically, the top rationales for 30-day readmission in the Keystone network have been:</p> <ul style="list-style-type: none"> <li>• Sickle Cell Crisis</li> <li>• CHF</li> <li>• Exacerbation of bronchitis</li> </ul> <p>These diagnoses are in line with the Plans' top Inpatient admissions categories (excluding pregnancy).</p>

<sup>2</sup> Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.  
2015 External Quality Review Report: Keystone First

## Keystone First 30 Day Readmission Diagnoses 2012

- Hb-SS disease w crisis
- Obs chr bronc w(ac) exac
- Other postop infection
- Ch obst asth w (ac) exac
- Pneumonia, organism NOS
- Urin tract infection NOS
- Chest pain NEC
- Asthma NOS w (ac) exac



1<sup>st</sup> Qtr 2015

LOB	CCS_GROUP_DESC	Highest Frequency Diagnosis_Desc	# Of CLAIM	Freq
0100	Liveborn	SINGLE LIVEBORN HOSPITAL W/O C-SECTION	2323	
0100	Asthma	ASTHMA UNSPECIFIED WITH EXACERBATION	491	
0100	Ot preg comp	OTH CURRENT MATERNAL CCE W/DELIVERY	476	
0100	Ot compl bir	ABN FETL HRT RATE/RHYTHM DELIV W/WO ANTPRTM COND	425	
0100	Bronchitis	ACUTE BRONCHIOLITIS DUE TO RSV	327	
0100	Septicemia	UNSPECIFIED SEPTICEMIA	325	
0100	HTN in preg	TRANSIENT HYPERTENSION OF PREGNANCY W/DELIVERY	269	
0100	Sickle cell	HB-SS DISEASE WITH CRISIS	264	
0100	DiabMel w/cm	DIABETES W/KETOACIDOSIS TYPE I [JUV] UNCNTL	262	
0100	Prev c-sectn	PREV C/S DELIV DELIV W/WO MENTION ANTPRTM COND	256	

*Policies*  
(e.g., data systems, delivery systems, provider facilities)

N/A

*Procedures*  
(e.g., payment/reimbursement, credentialing/collaboration)

Better coordination with Hospitals is needed in order to ensure coordination of services at the time of discharge and complete discharge planning.

*People*  
(e.g., personnel, provider network, patients)

Review of the data indicate that members with asthma and Sickle Cell disease were more likely to be readmitted than other conditions.

Poor care of the initial problem could result in a readmission.

Patients can have inadequate access to care.

Patients may not understand or follow their discharge instructions, which includes timely follow up with their primary care physician.

*Provisions*  
(e.g., screening tools, medical record forms, provider and enrollee educational materials)

Members lacked a reference document for what they would need to do once they were released from the hospital. Steps they could take to ensure their health.

*Other (specify)*

N/A

<b>MCO:</b>	Keystone First	
<b>Measure:</b>	Reducing Potentially Preventable Readmissions <sup>3</sup>	
For the analysis findings/barriers identified on the previous page, indicate the actions planned and/or actions taken since July 2014.		
<b>Action</b> Include those planned as well as already implemented. Add rows if needed.	<b>Implementation Date</b> Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)	<b>Monitoring Plan</b> How will you know if this action is working? What will you measure and how often? Include what measures will be used, as applicable.
Integrated Behavioral Services at CHOP's Sickle Cell Clinic – will enhance behavioral and physical health coordination of services for children and young adults with Sickle Cell Disease.	November 2015	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions for Sickle Cell patients.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmission for Sickle Cell patients within 30 days.</p> <p>Percentage of inpatient acute care discharges with subsequent readmission to inpatient care.</p> <p>Both of these can measured monthly.</p>
New Care Gaps created in Navinet for Sickle cell members: <ul style="list-style-type: none"> <li>Hydroxyurea Therapy</li> <li>Penicillin Prophylaxis</li> <li>Past-due refill: Hydroxyurea</li> </ul>	August 2015	<p><b>How will you know if this action is working?</b> Increase prescriptions for Sickle Cell Patients</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmission for Sickle Cell patients within 30 days.</p> <p>Percentage of inpatient acute care discharges with subsequent readmission to inpatient care.</p> <p>Both of these can measured monthly.</p>
Case management outreach and follow up with discharged members for coordination of care/services.	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days.</p> <p>Percentage of inpatient acute care discharges with subsequent readmission to inpatient care.</p> <p>Both of these can measured monthly.</p>

<sup>3</sup> Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.  
2015 External Quality Review Report: Keystone First

Enrolling members in case management for continued coordination of care	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
Provider/Member newsletter articles – these are aimed at improving member and provider understanding of resources available.	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
Drug Therapy Management program offered to members with asthma, coronary artery, or diabetes diagnosis. Medication reconciliation and simplification of the medication regimen and ensuring that the medications are delivered to member on day of discharge.	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
Receipt of real-time information re: members seen in ER but not admitted; members are contacted for follow-up and support	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
Coordination between ACT nurses and RROT coordinator to facilitate interventions begun at hospital and follow thru with case management needs	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
ACT nurses continue to facilitate post ER/IP PCP and specialist follow up appointments and they continue to work with members to ensure post DME and homecare visits are in place as required.	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
BEST program for asthmatics – dispensing of asthma medications and products directly from provider office. Allows for discussions on proper usage and an opportunity for members to ask questions.	Ongoing	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>

<p>Creation of UNITS – Unified Interdisciplinary Teams comprising multiple functions including Medical Directors, Utilization Management, Care Management, Rapid Response, Community Care Outreach, Provider Network Management, Pharmacy, Claims and Behavioral Health that are assigned specifically to groups of facilities. The goal of the UNITS model is to engage our members in a fully integrated, holistic approach to care through active collaboration with our providers and practitioners to improve the health of the populations we serve.</p>	<p>Through June 2015</p>	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
<p>Asthma Navigator program – Select Members with 2 ED and 1 IP due to asthma will receive an asthma home assessment within 1 week of release.</p>	<p>Ongoing</p>	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
<p>Shared savings model contract expanded to additional hospitals. The following hospital systems are participating:</p> <ul style="list-style-type: none"> <li>• Jefferson</li> <li>• Temple</li> <li>• Main Line Health</li> <li>• Crozer</li> <li>• Einstein</li> </ul> <p>The goal is for this to lead to better collaboration and communication between the Plan and the health systems.</p>	<p>Ongoing</p>	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</p>
<p>Creation of <i><b>Your Guide for Care outside of the Hospital</b></i> booklet for members to use upon discharge – This is available on our website. Also distributed by Rapid Response, Case Managers, ACT nurses and Community Outreach Solutions Team.</p>	<p>Started in 2014 and expanded in 2015</p>	<p><b>How will you know if this action is working?</b> Decrease in preventable readmissions.</p> <p><b>What will you measure and how often?</b> <b>Include what measurements will be used, as applicable.</b> Acute inpatient stays followed acute readmissions for any diagnosis within 30 days. Measured monthly.</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

- KF was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.
- The MCO's performance was statistically significantly above/better than the MMC weighted average in 2015 (MY 2014) on the following measures:
  - Childhood Immunizations Status (Combination 2)
  - Annual Dental Visit (Age 2–21 years)
  - Total Eligibles Receiving Preventive Dental Services
  - Chlamydia Screening in Women — All Ages (Age 16-20 years, Age 21-24 years, and Total)
  - Prenatal Screening for Behavioral Health Risk Assessment
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
  - Medication Management for People with Asthma - 75% Compliance (Age 19-50 years) and (Age 51-64 years)
  - Persistence of Beta Blocker Treatment After Heart Attack
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- The following strengths were noted in 2015 for Adult and Child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, one item was higher than the 2015 (MY 2014) MMC weighted averages.
  - For KF's Child CAHPS, one composite survey item increased in 2015 (MY 2014) as compared to 2014 (MY 2013). Two survey items evaluated in 2015 (MY 2014) were above the 2015 MMC weighted averages.

### Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC rate in 2015 (MY 2014) on the following measures:
  - Follow-up Care for Children Prescribed ADHD Medication — All Phases (Initiation Phase and Continuation Phase)
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) — All Phases (Initiation Phase and Continuation Phase)
  - EPSDT - Hearing Test (Age 4-20 years)
  - EPSDT - Vision Test (Age 4-20 years)
  - Developmental Screening in the First Three Years of Life — All Ages (1 year, 2 years, 3 years, and Total)
  - ≥ 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 Smoking
  - Prenatal Screening for Depression
  - Postpartum Screening for Depression
  - Postpartum Screening Positive for Depression
  - Prenatal Screening for Alcohol use
  - Prenatal Screening for Illicit drug use
  - Prenatal Screening for Prescribed or over-the-counter drug use
  - Appropriate Testing for Children with Pharyngitis
  - Asthma in Younger Adults Admission Rate (Age 18-39 years)

- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years)
- Hemoglobin A1c (HbA1c) Testing
- Retinal Eye Exam
- Medical Attention for Nephropathy
- Heart Failure Admission Rate (Age 18-64 years) and (Total Age 18+ years)
  
- The following decreases were noted in 2015 (MY 2014) for Adult and Child CAHPS survey items:
  - KF showed a decrease in all four Adult CAHPS composite survey items between 2015 (MY 2014) and 2014 (MY 2013). The rates for three composite survey items evaluated fell below the 2015 MMC weighted averages.
  - For KF Child CAHPS survey, three composite survey items decreased in 2015 (MY 2014). The rate for two composite survey items fell below the 2015 MMC weighted averages.

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

## P4P Measure Matrix Report Card

2015

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

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

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

The vertical comparison represents the MCO’s performance for each measure in relation to its prior year’s rates for the same measure. The MCO’s rate can trend up (↑), have no change, or trend down (↓). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

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

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

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

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

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

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

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



## KF Key Points

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

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

- Annual Dental Visits

KF's Emergency Department Utilization<sup>4</sup> decreased from 2014 to 2015 and is lower (better) than the 2015 MMC average.

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

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

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

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

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

- Controlling High Blood Pressure
- Comprehensive Diabetes Care – HbA1c Poor Control<sup>5</sup>

### ■ D - Root cause analysis and plan of action required

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

- Reducing Potentially Preventable Readmissions<sup>6</sup>

### ■ F Root cause analysis and plan of action required

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

- Prenatal and Postpartum Care – Timeliness of Prenatal Care
- Frequency of Ongoing Prenatal Care:  $\geq 81\%$  of Prenatal Care Visits Received

<sup>4</sup> A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

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

<sup>6</sup> 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).

Figure 1 - P4P Measure Matrix – KF

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

Figure 2 - Emergency Department Utilization Comparison

		Medicaid Managed Care Average Comparison		
Trend		Below/Poorer than Average	Average	Above/Better than Average
Year to Year	↓	<b>C</b>	<b>B</b>	<b>A</b> Emergency Department Utilization <sup>9</sup>

**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.

<sup>7</sup> 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)

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

<sup>9</sup> 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 – KF

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)	61.3% =	61.3% =	62.3% =	62.4% =	63.3% =	58.7%
Comprehensive Diabetes Care - HbA1c Poor Control <sup>10</sup>	36.1% =	40.9% =	34.0% =	36.7% =	39.6% =	38.1%
Controlling High Blood Pressure	63.1% =	64.0% =	64.4% =	60.4% =	62.4% =	61.6%
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received	54.5% ▼	64.7% ▲	68.4% =	63.1% =	50.0% ▼	64.4%
Prenatal and Postpartum Care - Timeliness of Prenatal Care	78.7% =	81.7% =	83.0% =	84.0% =	77.4% ▼	83.8%
Annual Dental Visits	54.9% ▲	58.3% ▲	61.2% ▲	62.7% ▲	64.5% ▲	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) <sup>11</sup>	64.5	67.9	67.1	68.6	66.4	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 <sup>12</sup>		14.9% NA	15.7% =	14.1% ▼	14.1% =	11.6%

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

<sup>11</sup> A lower rate, indicating better performance, is preferable for Emergency Department Utilization.

<sup>12</sup> 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**

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

### **Performance Measures**

- KF 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**

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