Commonwealth Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

2018 External Quality Review Report
Gateway Health

Final Report
April 2019

IPRO
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realized.

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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 2018 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. 2017 Opportunities for Improvement – MCO Response
V. 2018 Strengths and Opportunities for Improvement
VI. Summary of Activities

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

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

Section IV, 2017 Opportunities for Improvement – MCO Response, includes the MCO's responses to the 2017 EQR Technical Report's opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

Section V has a summary of the MCO's strengths and opportunities for improvement for this review period as determined by IPRO and a "report card" of the MCO's performance as related to selected HEDIS measures. Section VI provides a summary of EQR activities for the PH MCO for this review period.

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

I: Structure and Operations Standards

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

Methodology and Format

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2017, and the most recent NCQA Accreditation Survey for GH, effective December 2017.

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. The SMART database has been maintained internally at DHS since RY 2013. Upon receipt of the findings for RY 2017, IPRO and DHS discussed changes to the information included. First, the only available review conclusions were Compliant and non-Compliant. All other options previously available were re-designated in RY 2017 from review conclusion elements to review status elements and were therefore not included in the RY 2017 findings. Additionally, as of RY 2017, reviewers had the option to review zones covered by an MCO separately, and to provide multiple findings within a year (e.g., quarterly). As a result, there was an increase in the number of partially compliant items for RY 2017. Upon discussion with the DHS regarding the data elements from each version of database, IPRO merged the RY 2017, 2016, and 2015 findings for use in the current review. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 126 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS.

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

Table 1.1: SMART Items Count Per Regulation

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

BBA Regulation	SMART Items
Health Information Systems	18
Subpart F: Federal and State Grievance Systems Standards	
General Requirements	8
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, 80 items were evaluated and 46 were not evaluated for the MCO in Review Year (RY) 2017, RY 2016, or RY 2015. For categories where items were not evaluated for compliance for RY 2017, results from reviews conducted within the two prior years (RY 2016 and RY 2015) 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: GH 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 6 items and was compliant on 6 items based on RY 2017.
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 2017.
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 2017.
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 2017.
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 2017.
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 2017.
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 2017.

GH was evaluated against 16 of the 18 SMART Items crosswalked to Enrollee Rights and Protections Regulations and was compliant on all 16 items. GH was found to be compliant on all eight of the categories of Enrollee Rights and Protections Regulations. GH was found to be compliant on the Cost Sharing provision, based on the HealthChoices agreement.

Subpart D: Quality Assessment and Performance Improvement Regualtions

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 GH 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: GH Compliance with Quality Assessment and Performance Improvement Regulations

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REGULATIONS		
Subpart D: Categories	**Compliance**	**Comments**
Access Standards		
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 10 items and was compliant on 10 items based on RY 2017.
Coordination and Continuity of Care	Compliant	13 items were crosswalked to this category. The MCO was evaluated against 13 items and was compliant on 13 items based on RY 2017.
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 2017.
Structure and Operation Standards		
Provider Selection	Compliant	4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2017.
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 2017.
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 2017.
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 2017.
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 2017.
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 2017.
Measurement and Improvement Standards		
Practice Guidelines	Compliant	2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on 1 item based on RY 2017.
Health Information Systems	Compliant	18 items were crosswalked to this category. The MCO was evaluated against 12 items and was compliant on all 12 items item based on RY 2017.

GH was evaluated against 51 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant all 51 items. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, GH was found to be compliant on all 11 categories.

Subpart F: Federal and State Grievance System Standards

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

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

Table 1.4: GH 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 2017.
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 2017.
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 2017.
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 2017.
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 2017.
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 2017.
Recordkeeping and Recording	Compliant	6 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2017.
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 2017.
Effectuation of Reversed Resolutions	Compliant	Per NCQA Accreditation, 2017

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

Accreditation Status

GH underwent an NCQA Accreditation Survey effective through March 06, 2021 and was granted an Accreditation Status of Commendable.

II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2018 for 2017 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 were 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 months.
- Reducing Potentially Preventable Readmissions (RPR). The target for the indicator is 8.5. This measure replaced the originally designated measure – Plan All-Cause Readmissions (PCR): 30-day Inpatient Readmission.
- Each of the five (5) BH-PH Integrated Care Plan (ICP) 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 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 is January 2015 to December 2015. Following the formal PIP proposal, the timeline defined for the PIPs includes required interim reports in July 2016, June 2017 and June 2018, as well as a final report in June 2019. Based on validation findings in 2016, the timeline has undergone adjustments.

The 2018 EQR is the fifteenth 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

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 can be 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. For the current PIPs, compliance levels were assessed, but no formal scoring was provided.

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 occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of "Met", "Partially Met", or "Not

Met". Elements receiving a "Met" will receive 100% of the points assigned to the element, "Partially Met" elements will receive 50% of the assigned points, and "Not Met" elements will receive 0%.

Table 2.2: Review Element Scoring Weights

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

Findings

To encourage focus on improving the quality of the projects, PIPs were assessed for compliance on all applicable elements, but were not formally scored. The multiple levels of activity and collaboration between DHS, the PH MCOs, and IPRO have continued and progressed throughout the PIP cycle.

Throughout 2016, the initial year of the cycle, there were several levels of feedback provided to MCOs, including:

- An overall summary document outlining common issues that were observed across most of the PIP proposal submissions.
- MCO-specific review findings for each PIP.
- Conference calls with each MCO to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic. MCOs were asked to complete a PIP Proposal Update form following the calls.
- An Interactive Workshop held with all MCOs at the end of August. MCOs were requested to come to the workshop with PIP project summaries that they were to present, which were later submitted to IPRO and distributed to all PH MCOs.
- Information to assist MCOs in preparing their next full PIP submission for the Project Year 1 Update, such as additional instructions regarding collection of the core required measures, three years of CMS-416 Reports with PA state aggregate data and the excerpt on oral health from the 2015 CMS Secretary's report with CMS OHI all-state data from FFY 2014 for MCOs to calculate appropriate benchmarks, and data for all five ICP measures.

In 2017, reviews of the Project Year 1 Update documents submitted in late 2016 were completed. Upon initial review of the submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary. MCOs requiring additional discussion and potential modification were contacted for individual MCO conference calls. Upon completion of applicable resubmissions, MCOs were provided with their final Project Year 1 Update review findings. Following completion of Project Year 1 Update reviews, MCOs were asked to submit a Year 2 Interim Update providing information through June 30 for: 1) interventions implemented, 2) monitoring, or process measure, results, and 3) any performance measure outcome results. Review findings were incorporated into the form, and completed reviews were posted to IPRO's FTP.

For the current review year, 2018, MCOs were requested to submit a full Project Year 3 Update, to include all updated Year 2 information and Year 3 activities to date. MCOs were asked to update their submission with the following information: 1) Final rates for all performance measures for Measurement Year (MY) 2016 (1/1/16-12/31/16), including the rates provided to them for the ICP measures, 2) any available rates MY 2017 (1/1/17-12/31/17); 3) an updated interventions grid to show interventions completed in 2017 and interventions completed to date in 2018; 4)

rates/results as appropriate for the process measures utilized to evaluate each of the ongoing interventions; 5) any additional supporting analysis conducted for the PIP.

Improving Access to Pediatric Preventive Dental Care

For the Dental PIP, GH received full credit for all elements that were reviewed, 1 through 7. GH provided a detailed rationale for topic selection including member specific HEDIS data for annual dental visits, preventive dental service rates for the total eligible population, dental sealant application and topical fluoride varnish application. Through this, the MCO was able to identify gaps in care for different age groups and in relation to national benchmarks. An extensive literature review was done to identify current rates, concerns and common practices in dental care on a national and state level. The MCO is addressing a broad spectrum related to dental care such as annual dental visits (HEDIS), preventive dental services, dental sealants, topical fluoride varnish and incorporating primary care physicians.

Upon review of the Aim Statement, GH added study questions. GH noted the purpose of the PIP is to increase the number of GH members who receive preventive dental services in order to reduce the rates of dental disease and improve the quality of life, specifically to "… [increase] the access to and utilization of preventive services, such as prophylactic dental visits, fluoride varnish, and dental sealants across the population as determined by both HEDIS specifications and the total eligible membership under age 21 years. This will be done over the course of a three year period." GH also included target goals for improvement for the five study indicators.

GH included clearly defined performance measures, including the MCO and Core measures defined for the PIP. The MCO is using reliable measures that will measure the process of care with strong associations of improved outcomes. GH provided each indicator with the defined eligible population, numerators, denominators, benchmarks and long-term goal for GH. It was noted that GH did not include process measures for monitoring/tracking the effectiveness of interventions with the outcome measures. These measures were defined and included in the Interventions section.

GH clearly defined all Medicaid enrollees each indicator will target in the specifications for the measures and noted that the entire eligible population was included in the denominator for each individual measurement. The MCO specified that claims data, member enrollment information and specific CPT codes will be used as sources of data. The MCO stated they use NCQA-certified software to calculate administrative rates for the HEDIS measurement. The Dental claims are submitted by dental professionals through the Scion Provider Web Portal and process claims are stored in an internal data warehouse. Dental services performed by non-dental providers are submitted through medical claims, processed by DST System and stored in the same warehouse. These data are pulled through queries performed using SQL Developer. The code is quality checked for syntax corrections. The data are then validated by comparing current year data to previous year's data. Also, sample records are selected and researched to validate accuracy.

GH specified that data collection will be automated and the MCO provided a detailed explanation of the data analysis plan. Data are received by Decision Support Analyst or Senior DSA. For the age stratified results, the GH DSAs use member enrollment information to identify the age for each appropriate measurement year, as well as continuous enrollment information to identify the age for each appropriate measurement year, in addition to continuous enrollment requirements and exclusions. DSAs look at the rate of the population receiving the intervention compared to those who did not. Individual interventions may target subsets of the total population by looking at different factors, including geographic location, distance providers and age. These subgroups are pulled by a DSA using claims and enrollment information stored in the data warehouse. All measurements are based off of administrative data and will be measured the same way throughout the PIP. Additionally, GH presented a clearly defined timeline.

The MCO conducted a barrier analysis utilizing claims data, 2015 CAHPS results, MCO call campaign data and the National Health and Nutrition Examination Survey (NHANES) data. Qualitative sources included GH's dental benefit provider, participating PCPs, GH PHDHP and Care Management staff, community partners such as the Achieva Dental Task Force and the Allegheny County Health Department Task Force. Barriers were identified for members, dental and non-dental Providers, procedures and staff. Multiple interventions were developed to address each of the barriers identified for members, providers and staff. Examples of active interventions included Enhanced Public Health Dental Hygiene Practitioner (PHDHP) Program, Head Start/ Early Head Start Programming, Embedded Care Coordinators, Incentives, dental events and dashboard reports. The MCO listed a few passive interventions such as booklets,

postcards, resource guides and recorded messages. With these interventions it can be hard to track success, as it is difficult to ensure each member received each postcard/phone call, and each provider read the booklets. Following review, the MCO specified efforts to ensure all contact information for each member is accurate.

In the 2017 Interim Update, there were several clearly identified interventions targeted to address the identified barriers and to impact a wide range of members continued from year 1, including the Enhanced Public Health Dental Hygiene Practitioner (PHDHP) Program, Head Start/ Early Head Start Programming, Embedded Care Coordinators, and both Member and Provider Incentives. The interventions included start/end dates as applicable and the population reached. Monitoring (tracking) measures were described, with numerator and denominator defined for each, although it was noted that there should be a monitoring/process measure for each intervention listed.

GH received partial credit for review elements 8 and 9. Although data were presented for all outcome measures for all applicable time periods in the 2017 Interim Update, the Project Year 3 Update did not include outcome measure/performance data for all measures.

Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits

For the Readmission PIP, GH received full credit for review element 1. Following discussion regarding general research, the MCO included additional literature review to support the project topic selection and rationale, as well as intervention development. The MCO included results of data analysis in the Project Topic Section of the proposal for a number of measures, including HEDIS and those defined by the MCO. GH analyzed 1) distribution of members by volume of the 2015 Emergency Department visits 2) percentage of members with Low acuity diagnosis ED visits (LANE) 3) ED visits by region 4) ED visits by hospital 4) ED visits with a primary behavioral health diagnosis 5) distribution of the intensity of ED visit by CPT code. GH also utilized the data to identify clinical conditions and/or regions to focus on.

GH received partial credit for review element 2 through 5. The Aim Statement, noting that the "primary goal is to decrease avoidable emergency room visits and preventable readmissions across our member network. Using baseline data from 2015, Gateway Health set a goal to decrease readmissions to 8.5% by 2016," addressed a number of factors and as suggested, GH subsequently added study questions to focus the statement. However, it was observed that the goals of the PIP are not limited to decreasing the MCO readmission rate to 8.5%, and that all of the PIP Core Measure goals and any MCO-developed or specific goals should also be listed in the Aim Statement.

Regarding performance measures, GH included all DHS-defined performance measures and MCO-specific measures in the methodology. Additionally, the MCO identified the at-risk population as targeted for the PIP, and noted that the entire eligible population was included for all measures, with no sampling. However, it was noted that the measures were not defined with sufficient detail. For all PIP measures, the specifications need to be defined, including the eligible populations and definitions of the numerators and denominators. It was noted that GH did not include process measures for monitoring/tracking the effectiveness of interventions with the outcome measures. Some process measures were defined and included in the Interventions section.

GH received full credit for review element 6. The MCO discussed a data analysis plan that specified the sources of data and the type of data to be collected for all performance and process measures. GH included a discussion of the processes in place to determine if the data are valid and reliable for the eligible population for all performance and process measures. Additionally, the MCO included information regarding the construct of MCO-developed performance and process measures and how they will be analyzed and as requested, tailored their timeline to better match their MCO-specific project plan.

In its data analysis plan, GH explained that performance measure data are obtained from GH's main medical claims data warehouse and based on specifications provided by the State. "Those that are aligned with HEDIS specifications utilize NCQA-certified software to calculate administrative rates. This information is validated weekly through the Finance Department to ensure completeness through a data matching process. An internal change control process is also in place to test and validate any changes to the process or logic which tests and validates data before being moved to production. Performance indicator rates are calculated monthly through a Key Performance Indicator report to track and trend variances in process. Additional Clinical Indicator data is obtained through the use of GH Health's gDNA platform.

This platform supports population health management, care-gap reporting, and a person-centered, holistic assessment tool that considers the member's Behavioral, Economic, Environmental, Medical, Social and Spiritual (BEEMSS℠) strengths and needs. […] Data retrieval is completed by Decision Support Analysts/Senior Decision Support Analysts."

GH received partial credit for review element 7. GH was requested to clarify if the diagram presented was a Fishbone barrier diagram or a Driver Diagram. It was suggested that GH consider creating categories with less overlap, for example: Members, Providers, Health Plans and ED, and that the Fishbone Diagram include barriers and appropriate descriptions, for example: "lack of routine PCP visits", "fragmented care", and" limited after-hours access." The MCO addressed these issues and presented a complete table of Interventions and Barriers Addressed with appropriate descriptions. The MCO also presented reasonable interventions addressing multiple barriers including BH and PH coordination. However, each initiative needs at least one new or enhanced intervention. Additionally, process measures needed to be defined. Each intervention needs at least one process measure to monitor its impact. In the 2017 Interim Update, the interventions were clearly described and targeted to address both the identified barriers and a wide range of members. Examples included Admission Risk Case Management, Transition Management, Internal and External Interdisciplinary Care Coordination Meetings, and Interactive Voice Calls following discharge and following an Emergency Department Visit for a Non-Emergent Condition. Monitoring (tracking) measures were described, with numerator and denominator defined for each.

GH received partial credit for review elements 8 and 9. In the 2017 Interim Update, data were presented for all outcome measures for all applicable time periods, although it was observed that the denominators for the Ambulatory Care – ED and Inpatient Utilization measures were nearly as large for the six-month period as for each of the previous two calendar years. Additionally, because GH had already met the defined goal for Inpatient Utilization, it was advised that the MCO consider modifying the goal for this measure. The Project Year 3 Update did not include discussion of the Ambulatory Care observation, or an updated goal for Inpatient Utilization.

GH's Project Year 3 compliance assessment by review element is presented in Table 2.3.

Table 2.3: GH PIP Compliance Assessments

Review Element	Improving Access to Pediatric Preventive Dental Care	Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits
1. Project Topic and Topic Relevance	Full	Full
2. Study Question (Aim Statement)	Full	Partial
3. Study Variables (Performance Indicators)	Full	Partial
4. & 5. Identified Study Population and Sampling Methods	Full	Partial
6. Data Collection Procedures	Full	Full
7. Improvement Strategies (Interventions)	Full	Partial
8. & 9. Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement	Partial	Partial
10. Sustainability of Documented Improvement	NA	NA

The next full submission will occur in review year 2019 and will be the final submission. Collaboration between DHS and PH MCOs is expected to continue, and PH MCOs will continue to be asked to participate in multi-plan PIP update calls through the duration of the PIP as applicable to report on their progress or barriers to progress.

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 from December 2017 to June 2018. Source code, raw data and rate sheets were submitted by the MCOs to IPRO for review in 2018. 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. Pseudo 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 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 measures not reported as percentages (e.g. adult admission measures) 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 2018 (MY 2017) Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. 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 2018 measures were validated through a standard HEDIS compliance audit of each PH MCO. This audit includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). A Final Audit Report was submitted to NCQA for each MCO. Because the PA-specific performance measures rely on the same systems and staff, no separate onsite review was necessary for validation of the PA-specific measures. IPRO conducts a thorough review and validation of source code, data and submitted rates for the PA-specific measures.

Evaluation of MCO performance is based on both PA-specific performance measures and selected HEDIS measures for the EQR. The following is a list of the performance measures included in this year's EQR report.

Table 3.1: Performance Measure Groupings

Source	Measures
Access/Availability to Care	
HEDIS	Children and Adolescents' Access to PCPs (Age 12 - 24 months)
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months - 6 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 7-11 years)
HEDIS	Children and Adolescents' Access to PCPs (Age 12-19 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years)
HEDIS	Adults' Access to Preventive/Ambulatory Health Services (Age 65+)
HEDIS	Adult Body Mass Index Assessment
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)
PA EQR	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)
Well Care Visits and Immunizations	
HEDIS	Well-Child Visits in the First 15 Months of Life (6+ Visits)
HEDIS	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)

Source	Measures
HEDIS	Childhood Immunizations Status by Age 2 (Combination 2)
HEDIS	Childhood Immunizations Status by Age 2 (Combination 3)
HEDIS	Adolescent Well-Care Visits (Age 12 to 21 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Total)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition: (Total)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 3-11 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical activity: (Age 12-17 years)
HEDIS	Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Physical Activity: (Total)
HEDIS	Immunizations for Adolescents (Combination 1)
EPSDT: Screenings and Follow up	
HEDIS	Lead Screening in Children (Age 2 years)
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) – Initiation Phase
HEDIS	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – Continuation and Maintenance Phase
PA EQR	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (BH Enhanced) – Initiation Phase
PA EQR	Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (BH Enhanced) – Continuation and Maintenance Phase
PA EQR	Developmental Screening in the First Three Years of Life – 1 year
PA EQR	Developmental Screening in the First Three Years of Life – 2 years
PA EQR	Developmental Screening in the First Three Years of Life – 3 years
PA EQR	Developmental Screening in the First Three Years of Life – Total
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for AOD abuse or dependence, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for mental illness, follow-up within 30 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for AOD abuse or dependence, follow-up within 7 days)
PA EQR	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: Ages: 65 and older - ED visits for mental illness, follow-up within 7 days)
Dental Care for Children and Adults	
HEDIS	Annual Dental Visit (Age 2-20 years)
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Ages 2-20 years)
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA)

Source	Measures
PA EQR	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CHIPRA: Dental-Enhanced)
Women's Health	
HEDIS	Breast Cancer Screening (Age 50–74 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	Non-Recommended Cervical Cancer Screening in Adolescent Females
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 21 to 44)
PA EQR	Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
Obstetric and Neonatal Care	
PA EQR	Frequency of Ongoing Prenatal Care – Greater than or Equal to 61% of Expected Prenatal Care Visits Received
PA EQR	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	Cesarean Rate for Nulliparous Singleton Vertex
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams
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	Elective Delivery
Respiratory Conditions	
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
HEDIS	Pharmacotherapy Management of COPD Exacerbation - Bronchodilator

Source	Measures
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 19-50 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Age 51-64 years)
HEDIS	Medication Management for People with Asthma - 75% Compliance (Total)
HEDIS	Asthma Medication Ratio (5-11 years)
HEDIS	Asthma Medication Ratio (12-18 years)
HEDIS	Asthma Medication Ratio (19-50 years)
HEDIS	Asthma Medication Ratio (51-64 years)
HEDIS	Asthma Medication Ratio (Total)
PA EQR	Asthma in Younger Adults Admission Rate (Age 18-39 years) – Admission per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months
PA EQR	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (40+ years) - Admission per 100,000 Member Months
Comprehensive Diabetes Care	
HEDIS	Hemoglobin A1c (HbA1c) Testing
HEDIS	HbA1c Poor Control (>9.0%)
HEDIS	HbA1c Control (<8.0%)
HEDIS	HbA1c Good Control (<7.0%)
HEDIS	Retinal Eye Exam
HEDIS	Medical Attention for Nephropathy
HEDIS	Blood Pressure Controlled <140/90 mm Hg
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 18-64 years)
PA EQR	Diabetes Short-Term Complications Admission Rate (Age 65+ years)
PA EQR	Diabetes Short-Term Complications Admission Rate (Total Rate)
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age)
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 65 - 75 Years of Age)
Cardiovascular Care	
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack
HEDIS	Controlling High Blood Pressure
PA EQR	Heart Failure Admission Rate1 (Age 18-64 Years) per 100,000 member months
PA EQR	Heart Failure Admission Rate1 (Age 65+ Years) per 100,000 member months
PA EQR	Heart Failure Admission Rate1 (Total Age 18+ Years) per 100,000 member months
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21-75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 21-75 years (Male)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female)
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia
Utilization	
PA EQR	Reducing Potentially Preventable Readmissions
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 1 - 5 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 6 - 11 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Age 12 - 17 years)
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)

Source	Measures
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 1 - 5 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 6 - 11 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 12 - 17 years)
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)
HEDIS	Use of Opioids at High Dosage[2]
HEDIS	Use of Opioids from Multiple Provider (4 or more prescribers)
HEDIS	Use of Opioids From Multiple Providers- (4 or more pharmacies)
HEDIS	Use of Opioids From Multiple Providers - (4 or more prescribers & pharmacies)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CLABSI)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Central line-associated blood stream infections (CLABSI) - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CAUTI)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Catheter-associated urinary tract infections (CAUTI) - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (MRSA)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Methicillin-resistant Staphylococcus aureus (MRSA) blood lab-identified events - unavailable SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Plan-weighted SIR (CDIFF)
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - high SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - moderate SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - low SIR
HEDIS	Standardized Healthcare-Associated Infection Ratio: Clostridium difficile laboratory-identified events (CDIFF) - unavailable SIR
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 4+ Stays (Ages Total)

[2] A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

Source	Measures
HEDIS	Plan All-Cause Readmissions (PCR): Observed Readmission Rate - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Expected Readmission Rate - Total Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 1-3 Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 4+ Stays (Ages Total)
HEDIS	Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - Total Stays (Ages Total)

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 2018 as mandated in accordance with the ACA. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, as well as other specifications, as needed. Indicator rates are 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

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (New - 2018)

This performance measure assesses the percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

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 2018 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.

Developmental Screening in the First Three Years of Life– CHIPRA Core Set

This performance measure assesses the percentage of children screened for risk of developmental, behav
ioral, 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.

Follow-Up After Emergency Department Visit for Mental illness or Alcohol and Other Drug Abuse or Dependence (New - 2018)

This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness or alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for mental illness or AOD. Four rates are reported:

Mental Illness

- The percentage of ED visits for mental illness for which the member received follow-up within 7 days of the ED visit (8 total days)
- The percentage of ED visits for mental illness for which the member received follow-up within 30 days of the ED visit (31 total days).

Alcohol and Other Drug Abuse or Dependence

- The percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7 days of the ED visit (8 total days)
- The percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30 days of the ED visit (31 total days).

Per the CMS specifications, rates are reported for age cohorts 18 to 64 and 65 and older.

Annual Dental Visits For Enrollees with Developmental Disabilities

This performance measure assesses the percentage of enrollees with a developmental disability age two through 20 years of age, who were continuously enrolled and had at least one dental visit during the measurement year. This indicator utilizes the HEDIS 2018 measure Annual Dental Visit (ADV).

Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk – CHIPRA Core Set

This performance measure assesses the percentage of enrolled children ages 6-9 years at elevated risk of dental caries who received a sealant on a permanent first molar tooth within the measurement year.

Additionally, to be more closely aligned to the CHIPRA Core Set Measure specifications, a second enhanced measure is reported which includes additional available dental data (Dental-enhanced).

Contraceptive Care for All Women Ages 15-44 - CMS Core measure – New 2018

This performance measure assesses the percentage of women ages 15 through 44 at risk of unintended pregnancy who were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC). Four rates are reported – two rates are reported for each of the age groups (15-20 and 21-44): (1) provision of most or moderately effective contraception, and (2) provision of LARC.

Contraceptive Care for Postpartum Women Ages 15-44 - CMS Core measure– New 2018

This performance measure assesses the percentage of women ages 15 through 44 who had a live birth and were provided a most effective/moderately effective contraception method or a long-acting reversible method of contraception (LARC), within 3 days and within 60 days of delivery. Eight rates are reported – four rates for each of the age groups (15-20 and 21-44): (1) Most or moderately effective contraception – 3 days, (2) Most or moderately effective contraception – 60 days, (3) LARC – 3 days, and (4) LARC – 60 days.

Frequency of Ongoing Prenatal Care

This performance measure assesses the percentage of pregnant enrollees who delivered on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal care visits:

- ≥ than 61 percent of expected visits
- ≥ than 81 percent of expected visits

Cesarean Rate for Nulliparous Singleton Vertex – CHIPRA Core Set

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

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.

Elective Delivery – Adult Core Set

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

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 months.

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 per 100,000 member months for Medicaid members 40 years and older. Three age groups will be reported: ages 40-64 years and age 65 years and older, and 40+ years.

Diabetes Short-Term Complications Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for diabetes short-term complications (ketoacidosis, hyperosmolarity or coma) in adults 18 years and older per 100,000 Medicaid member months. Two age groups will be reported: ages 18-64 years and age 65 years and older.

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (New - 2018)

This performance measure assess the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) in poor control (>9.0%)

Heart Failure Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for heart failure in adults 18 years and older per 100,000 Medicaid member months. Three age groups are reported: ages 18-64 years, ages 65 years and older and total age.

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 2018 HEDIS Inpatient Utilization – General Hospital/Acute Care measure methodology to identify inpatient acute care discharges. For this measure, a lower rate indicates better performance.

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

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. Members in hospice are excluded from eligible population.

DHS enhanced this measure using Behavioral Health (BH) encounter data contained in IPRO's encounter data warehouse.

PA Specific Hybrid Measures

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 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.
4. Screened for smoking in one of their first two prenatal visits, who smoke (i.e., a smoker during the pregnancy), and 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 (i.e., smoked at the time of one of their first two prenatal visits) that stopped smoking during their pregnancy.

This performance measure uses components of the HEDIS 2018 Prenatal and Postpartum Care Measure.

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 2018 Prenatal and Postpartum Care Measure.

Maternity Risk Factor Assessment

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 2018 Prenatal and Postpartum Care Measure.

Behavioral Health Risk Assessment– 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 2018. 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 2018, Volume 2 Narrative. The measurement year for HEDIS 2018 measures is 2017, 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 assesses the percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years 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 assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line. The following age groups are reported: 20-44, 45-64, and 65+

Adult Body Mass Index (BMI) Assessment

This measure assessed the percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was 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 3, 4, 5, or 6 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.

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) Haemophilius Influenza Type B (HiB)
(3) Hepatitis B (HepB)
(1) Chicken Pox (VZV)
(4) Pneumococcal Conjugate Vaccine – Combination 3 only

Adolescent Well-Care Visits

This measure assessed the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

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

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation.
- Counseling for nutrition.
- Counseling for physical activity

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Immunization for Adolescents (Combo 1)

This measure assessed the percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine and one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday.

Lead Screening in Children

This measure assessed the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Follow-up Care for Children Prescribed ADHD Medication

This measure assessed the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, 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.

Annual Dental Visit

This measure assessed the percentage of children and adolescents between the ages of 2 and 20 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 50–74 years of age who had a mammogram to screen for breast cancer.

The eligible population for this measure is women 52–74 years of age as of December 31 of the measurement year. Members are included in the numerator if they had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year. Eligible members who received mammograms beginning at age 50 are included in the numerator.

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 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Three age cohorts are reported: 16 – 20 years, 21 – 24 years, and total.

Non-Recommended Cervical Cancer Screening in Adolescent Females

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

Prenatal and Postpartum Care

This measure assessed the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Appropriate Testing for Children with Pharyngitis

This measure assessed the percentage of children 3–18 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 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measure assessed the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

This measure assessed the percentage of members 40 years of age and older with a new diagnosis of COPD 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 visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Medication Management for People with Asthma - 75% Compliance

This measure assessed the percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period and remained on an asthma controller medication for at least 75% of their treatment period. The following age groups are reported: 5-11 years, 12-18 years, 19-50 years, 51-64 years, and total years.

Asthma Medication Ratio – New 2018

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. The following age groups are reported: 5-11 years, 12-18 years, 19-50 years, 51-64 years, and total years.

Comprehensive Diabetes Care

This measure assessed the percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- HbA1c control (<7.0%) for a selected population.
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

Statin Therapy for Patients With Diabetes

This measure assessed the percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Persistence of Beta-Blocker Treatment After a Heart Attack

This measure assessed the percentage of members 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 AMI and who received persistent beta-blocker treatment for six months after discharge.

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.

Statin Therapy for Patients With Cardiovascular Disease

This measure assessed the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. *Received Statin Therapy.* Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.
2. *Statin Adherence 80%.* Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Total rates for 1 and 2 are also reported.

Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia

This measure assessed the percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

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.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

This measure assessed the percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications. Age groups 1 -5, 6-11, 12-17 and total are reported.

For this measure a lower rate indicates better performance.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assessed the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Age groups 1-5, 6-11, 12-17, and total years are reported.

Use of Opioids at High Dosage – New 2018

This measure assessed for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days at a high dosage (average morphine equivalent dose [MED] >120 mg).

Note: A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

Use of Opioids from Multiple Providers – NEW 2018

This measure assessed for members 18 years and older, the rate per 1,000 receiving prescription opioids for ≥15 days who received opioids from multiple providers. Three rates are reported:

1. **Multiple Prescribers:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
2. **Multiple Pharmacies:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
3. **Multiple Prescribers and Multiple Pharmacies:** The rate per 1,000 of members receiving prescriptions for opioids from four or more different prescribers ***and*** four or more different pharmacies during the measurement year

Standardized Healthcare-Associated Infection Ratio – NEW 2018

This measure assessed hospital-reported standard infection ratios (SIR) for four different healthcare-associated infections (HAI), adjusted for the proportion of members discharged from each acute care hospital. The measure reports the percentage of total discharges from hospitals with a high, moderate, low or unavailable SIR, next to a total plan-weighted SIR for each of the following infections:

- *HAI-1:* Central line-associated blood stream infections (CLABSI)
- *HAI-2:* Catheter-associated urinary tract infections (CAUTI)
- *HAI-5:* Methicillin-resistant Staphylococcus aureus (MRSA) blood laboratory-identified events (bloodstream infections)
- *HAI-6:* Clostridium difficile laboratory-identified events (intestinal infections) (CDIFF)

Note: *A lower SIR indicates better performance. SIRs >1.0 indicate that more infections occurred than expected; SIRs <1.0 indicate fewer infections occurred than expected.*

Plan All-Cause Readmissions (PCR) – NEW 2018

The measure assessed for members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported for members with 1-3, 4+, and total index hospital stays in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator)
2. Count of 30-Day Readmissions (numerator)
3. Observed Readmission Rate
4. Expected Readmissions Rate
5. Observed to Expected Readmission Ratio

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 2018 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 2018 Department of Health Birth File to identify the denominator, numerator and rate for the Birth-related measures.

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.

In 2018 it was identified that 6 of 9 PH MCOs incorrectly excluded denied claims from the 2017 (MY 2016) Reducing Potentially Preventable Readmissions (RPR) rate. This affected the RPR rate reported in the 2017 EQR reports. Corrected 2017 (MY 2016) data files were resubmitted by affected MCOs. Revised RPR 2017 (MY 2016) rates are included in this report.

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., 2018 (MY 2017) and 2017 (MY 2016)]. In addition, statistical comparisons are made between the 2018 and 2017 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 2018 rates to 2017 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 2018 (MY 2017) 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 2018 rates to MMC rates, the "+" symbol denotes that the plan rate exceeds the MMC rate; the "–" symbol denotes that the MMC rate exceeds the plan rate and "n.s." denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a **3**-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, "NA" (Not Applicable) appears in the corresponding cells. However, "NA" (Not Available) also appears in the cells under the HEDIS 2018 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

Strengths are identified for the following Access/Availability of Care performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
    - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years) – 4.4 percentage points
    - Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years) – 3.1 percentage points
    - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years) – 5.1 percentage points

No opportunities for improvement are identified for Access/Availability of Care performance measures.

Table 3.2: Access to Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 24 months)	7,594	7,363	**97.0%**	96.6%	97.4%	97.1%	n.s.	96.0%	+	>= 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months 6 years)	31,338	27,971	**89.3%**	88.9%	89.6%	88.6%	+	88.4%	+	>= 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7 11 years)	27,795	25,943	**93.3%**	93.0%	93.6%	90.7%	+	92.6%	+	>= 75th and < 90th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 19 years)	37,362	34,386	**92.0%**	91.8%	92.3%	88.8%	+	91.5%	+	>= 50th and < 75th percentile

HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20 44 years)	68,188	56,104	**82.3%**	82.0%	82.6%	81.6%	+	77.8%	+	>= 50th and < 75th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45 64 years)	34,485	30,773	**89.2%**	88.9%	89.6%	88.8%	n.s.	86.1%	+	>= 75th and < 90th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ years)	761	670	**88.0%**	85.7%	90.4%	86.0%	n.s.	83.0%	+	>= 50th and < 75th percentile
HEDIS	Adult BMI Assessment (Age 18 74 years)	411	368	**89.5%**	86.5%	92.6%	92.1%	n.s.	91.9%	n.s.	>= 50th and < 75th percentile
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)	6	4	**NA**	NA	NA	NA	NA	60.7%	NA	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)	177	137	**77.4%**	71.0%	83.8%	NA	NA	72.7%	n.s.	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)	310	225	**72.6%**	67.5%	77.7%	NA	NA	69.6%	n.s.	NA
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)	493	366	**74.2%**	70.3%	78.2%	NA	NA	70.6%	n.s.	NA

Well-Care Visits and Immunizations

No Strengths are identified for Well-Care Visits and Immunizations performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Body Mass Index: Percentile (Age 3 - 11 years) – 5.7 percentage points
  - Body Mass Index: Percentile (Age 12-17 years) – 12.2 percentage points
  - Body Mass Index: Percentile (Total) – 8.5 percentage points
  - Counseling for Nutrition (Age 3-11 years) – 9.7 percentage points
  - Counseling for Nutrition (Age 12-17 years) – 12.4 percentage points
  - Counseling for Nutrition (Total) – 10.9 percentage points
  - Counseling for Physical Activity (Age 3-11 years) – 8.0 percentage points
  - Counseling for Physical Activity (Age 12-17 years) – 11.1 percentage points
  - Counseling for Physical Activity (Total) – 9.1 percentage points

Table 3.3: Well-Care Visits and Immunizations

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Well Child Visits in the First 15 Months of Life (≥ 6 Visits)	411	281	**68.4%**	63.8%	73.0%	66.6%	n.s.	69.9%	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)	411	314	**76.4%**	72.2%	80.6%	78.1%	n.s.	77.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Childhood Immunizations Status (Combination 2)	411	297	**72.3%**	67.8%	76.7%	75.7%	n.s.	76.1%	n.s.	>= 25th and < 50th percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	286	**69.6%**	65.0%	74.2%	72.1%	n.s.	73.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	411	253	**61.6%**	56.7%	66.4%	58.4%	n.s.	62.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Age 3 11 years)	244	178	**73.0%**	67.2%	78.7%	73.7%	n.s.	78.6%	-	>= 25th and < 50th percentile
HEDIS	Body Mass Index: Percentile (Age 12 17 years)	167	107	**64.1%**	56.5%	71.6%	69.9%	n.s.	76.3%	-	>= 10th and < 25th percentile
HEDIS	Body Mass Index: Percentile (Total)	411	285	**69.3%**	64.8%	73.9%	72.4%	n.s.	77.8%	-	>= 25th and < 50th percentile
HEDIS	Counseling for Nutrition (Age 3 11 years)	244	158	**64.8%**	58.6%	71.0%	77.8%	-	74.4%	-	>= 25th and < 50th percentile

HEDIS	Counseling for Nutrition (Age 12 17 years)	167	99	**59.3%**	51.5%	67.0%	70.5%	-	71.7%	-	>= 25th and < 50th percentile
HEDIS	Counseling for Nutrition (Total)	411	257	**62.5%**	57.7%	67.3%	75.2%	-	73.4%	-	>= 25th and < 50th percentile
HEDIS	Counseling for Physical Activity (Age 3 11 years)	244	140	**57.4%**	51.0%	63.8%	65.6%	n.s.	65.4%	-	>= 25th and < 50th percentile
HEDIS	Counseling for Physical Activity (Age 12 17 years)	167	96	**57.5%**	49.7%	65.3%	68.5%	-	68.6%	-	>= 25th and < 50th percentile
HEDIS	Counseling for Physical Activity (Total)	411	236	**57.4%**	52.5%	62.3%	66.6%	-	66.5%	-	>= 25th and < 50th percentile
HEDIS	Immunization for Adolescents (Combo 1)	411	363	**88.3%**	85.1%	91.5%	81.7%	+	85.9%	n.s.	>= 90th percentile

EPSDT: Screenings and Follow-up

Strengths are identified for the following EPSDT: Screenings and Follow-up performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase – 9.8 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 12.7 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase – 9.4 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 11.6 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days) – 9.8 percentage points
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days) – 9.6 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Lead Screening in Children (Age 2 years) – 4.9 percentage points
  - Developmental Screening in the First Three Years of Life - 1 year – 3.4 percentage points
  - Developmental Screening in the First Three Years of Life - 2 years – 3.8 percentage points

Table 3.4: EPSDT: Screenings and Follow-up

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Lead Screening in Children (Age 2 years)	411	310	**75.4%**	71.1%	79.7%	77.9%	n.s.	80.3%	-	>= 50th and < 75th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	2,124	1,067	**50.2%**	48.1%	52.4%	46.7%	+	40.5%	+	>= 50th and < 75th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	648	375	**57.9%**	54.0%	61.7%	52.6%	+	45.2%	+	>= 50th and < 75th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	2,124	1,074	**50.6%**	48.4%	52.7%	47.1%	+	41.2%	+	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	626	376	**60.1%**	56.1%	64.0%	55.2%	n.s.	48.5%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life Total	19,840	10,461	**52.7%**	52.0%	53.4%	49.7%	+	55.7%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 1 year	7,218	3,385	**46.9%**	45.7%	48.1%	44.9%	+	50.3%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years	6,268	3,468	**55.3%**	54.1%	56.6%	53.0%	+	59.1%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years	6,354	3,608	**56.8%**	55.6%	58.0%	51.5%	+	57.9%	n.s.	NA

PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for mental illness, follow up within 7 days)	113	51	**45.1%**	35.5%	54.8%	NA	NA	35.3%	+	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for mental illness, follow up within 30 days)	113	67	**59.3%**	49.8%	68.8%	NA	NA	49.7%	+	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for AOD abuse or dependence, follow up within 7 days)	2,070	311	**15.0%**	13.5%	16.6%	NA	NA	15.3%	n.s.	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 ED visits for AOD abuse or dependence, follow up within 30 days)	2,070	459	**22.2%**	20.4%	24.0%	NA	NA	23.2%	n.s.	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for AOD abuse or dependence, follow up within 30 days)	4	1	**NA**	NA	NA	NA	NA	31.8%	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for mental illness, follow up within 30 days)	0	0	**NA**	NA	NA	NA	NA	NA	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for AOD abuse or dependence, follow up within 7 days)	4	2	**NA**	NA	NA	NA	NA	13.6%	NA	NA
PA EQR	Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 65 and older ED visits for mental illness, follow up within 7 days)	0	0	**NA**	NA	NA	NA	NA	NA	NA	NA

Dental Care for Children and Adults

No strengths or opportunities for improvement are identified for Dental Care for Children and Adults performance measures.

Table 3.5: EPSDT: Dental Care for Children and Adults

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	**Indicator**	**Denom**	**Num**	**Rate**	**Lower 95% Confidence Interval**	**Upper 95% Confidence Interval**	**2017 (MY2016) Rate**	**2018 Rate Compared to 2017**	**MMC**	**2018 Rate Compared to MMC**	**HEDIS 2018 Percentile**
HEDIS	Annual Dental Visit (Age 2 20 years)	109,958	70,041	**63.7%**	63.4%	64.0%	56.4%	+	63.0%	+	>= 50th and < 75th percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2 20years)	8,475	5,409	**63.8%**	62.8%	64.9%	48.0%	+	62.5%	+	NA
PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk	14,354	3,414	**23.8%**	23.1%	24.5%	24.6%	n.s.	24.4%	n.s.	NA

PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk (Dental Enhanced)	14,532	3,462	**23.8%**	23.1%	24.5%	24.3%	n.s.	25.3%	-	NA

Women's Health

Strengths are identified for the following Women's Health performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20) – 6.7 percentage points
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44) – 3.7 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44) – 3.2 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Breast Cancer Screening (Age 50-74 years) – 3.9 percentage points
  - Chlamydia Screening in Women (Age 16-20 years) – 3.2 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20) – 3.2 percentage points

Table 3.6: Women's Health

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Breast Cancer Screening (Age 50 74 years)	9,750	5,317	**54.5%**	53.5%	55.5%	53.1%	n.s.	58.4%	-	>= 25th and < 50th percentile
HEDIS	Cervical Cancer Screening (Age 21 64 years)	411	232	**56.4%**	51.5%	61.4%	57.9%	n.s.	60.8%	n.s.	>= 25th and < 50th percentile
HEDIS	Chlamydia Screening in Women (Total)	12,243	7,107	**58.0%**	57.2%	58.9%	54.7%	+	60.6%	-	>= 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Age 16 20 years)	6,827	3,667	**53.7%**	52.5%	54.9%	50.3%	+	56.9%	-	>= 50th and < 75th percentile
HEDIS	Chlamydia Screening in Women (Age 21 24 years)	5,416	3,440	**63.5%**	62.2%	64.8%	59.9%	+	64.8%	n.s.	>= 25th and < 50th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	11,649	106	**0.9%**	0.7%	1.1%	1.1%	n.s.	0.9%	n.s.	>= 50th and < 75th percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)	13,872	4,879	**35.2%**	34.4%	36.0%	NA	NA	28.5%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)	13,872	756	**5.4%**	5.1%	5.8%	NA	NA	5.0%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)	40,588	11,639	**28.7%**	28.2%	29.1%	NA	NA	25.0%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)	40,588	2,566	**6.3%**	6.1%	6.6%	NA	NA	6.4%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 15 to 20)	649	29	**4.5%**	2.8%	6.1%	NA	NA	7.6%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 15 to 20)	649	260	**40.1%**	36.2%	43.9%	NA	NA	37.7%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 15 to 20)	649	6	**0.9%**	0.1%	1.7%	NA	NA	3.3%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 15 to 20)	649	73	**11.2%**	8.7%	13.8%	NA	NA	13.7%	n.s.	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 21 to 44)	4,374	572	**13.1%**	12.1%	14.1%	NA	NA	13.8%	n.s.	NA

PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 21 to 44)	4,374	1,862	**42.6%**	41.1%	44.0%	NA	NA	39.3%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 21 to 44)	4,374	40	**0.9%**	0.6%	1.2%	NA	NA	2.1%	-	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 21 to 44)	4,374	424	**9.7%**	8.8%	10.6%	NA	NA	10.6%	n.s.	NA

[1] For the Non-Recommended Cervical Cancer Screening in Adolescent Females measure, lower rate indicates better performance

Obstetric and Neonatal Care

Strengths are identified for the following Obstetric and Neonatal Care performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Prenatal Screening Positive for Depression – 10.4 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care – 5.0 percentage points
  - Prenatal Screening for Smoking – 16.6 percentage points
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 16.7 percentage points
  - Prenatal Screening for Environmental Tobacco Smoke Exposure – 28.3 percentage points
  - Prenatal Screening for Depression – 27.4 percentage points
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 27.2 percentage points
  - Prenatal Screening for Alcohol use – 32.3 percentage points
  - Prenatal Screening for Illicit drug use – 31.0 percentage points
  - Prenatal Screening for Prescribed or over-the-counter drug use – 15.8 percentage points
  - Prenatal Screening for Intimate partner violence – 31.5 percentage points
  - Prenatal Screening for Behavioral Health Risk Assessment – 33.5 percentage points

Table 3.7: Obstetric and Neonatal Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
PA EQR	Frequency of Ongoing Prenatal Care Greater than or Equal to 61% of Expected Prenatal Care Visits Received	411	357	**86.9%**	83.5%	90.2%	85.2%	n.s.	84.6%	n.s.	NA
PA EQR	Frequency of Ongoing Prenatal Care Greater than or Equal to 81% of Expected Prenatal Care Visits Received	411	300	**73.0%**	68.6%	77.4%	73.2%	n.s.	70.6%	n.s.	NA
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	411	335	**81.5%**	77.6%	85.4%	86.2%	n.s.	86.6%	-	>= 25th and < 50th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	411	272	**66.2%**	61.5%	70.9%	63.4%	n.s.	67.7%	n.s.	>= 50th and < 75th percentile
PA EQR	Prenatal Screening for Smoking	406	269	**66.3%**	61.5%	71.0%	67.6%	n.s.	82.8%	-	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	406	266	**65.5%**	60.8%	70.3%	66.3%	n.s.	82.2%	-	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	406	74	**18.2%**	14.3%	22.1%	21.1%	n.s.	46.5%	-	NA
PA EQR	Prenatal Counseling for Smoking	90	73	**81.1%**	72.5%	89.8%	62.3%	+	86.1%	n.s.	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	22	13	**NA**	NA	NA	NA	NA	78.5%	NA	NA
PA EQR	Prenatal Smoking Cessation	90	7	**7.8%**	1.7%	13.9%	16.0%	n.s.	10.0%	n.s.	NA
PA EQR	Prenatal Screening for Depression	406	183	**45.1%**	40.1%	50.0%	45.5%	n.s.	72.5%	-	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	406	154	**37.9%**	33.1%	42.8%	36.4%	n.s.	65.2%	-	NA
PA EQR	Prenatal Screening Positive for Depression	183	56	**30.6%**	23.7%	37.6%	21.6%	+	20.2%	+	NA
PA EQR	Prental Counseling for Depression	56	40	**71.4%**	58.7%	84.2%	67.5%	n.s.	73.7%	n.s.	NA

PA EQR	Postpartum Screening for Depression	302	226	**74.8%**	69.8%	79.9%	63.5%	+	73.4%	n.s.	NA
PA EQR	Postpartum Screening Positive for Depression	226	39	**17.3%**	12.1%	22.4%	11.6%	n.s.	15.2%	n.s.	NA
PA EQR	Postpartum Counseling for Depression	39	33	**84.6%**	72.0%	97.2%	NA	NA	87.3%	n.s.	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	1,228	317	**25.8%**	23.3%	28.3%	22.5%	+	23.6%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	6,070	633	**10.4%**	9.7%	11.2%	10.2%	n.s.	9.9%	n.s.	NA
PA EQR	Prenatal Screening for Alcohol use	406	190	**46.8%**	41.8%	51.8%	57.2%	-	79.1%	-	NA
PA EQR	Prenatal Screening for Illicit drug use	406	195	**48.0%**	43.0%	53.0%	56.5%	-	79.0%	-	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	406	275	**67.7%**	63.1%	72.4%	66.6%	n.s.	83.6%	-	NA
PA EQR	Prenatal Screening for Intimate partner violence	406	99	**24.4%**	20.1%	28.7%	24.3%	n.s.	55.9%	-	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	406	44	**10.8%**	7.7%	14.0%	11.1%	n.s.	44.3%	-	NA
PA EQR	Elective Delivery	1,500	37	**2.5%**	1.6%	3.3%	18.9%	-	4.7%	-	NA

[1] Lower rate indicates better performance for three measures that are related to live births: Cesarean Rate for Nulliparous Singleton Vertex, Percent of Live Births Weighing Less than 2,500 Grams (Positive), and Elective Delivery.

Respiratory Conditions

No strengths are identified for Respiratory Conditions performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator – 3.1 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years) – 7.0 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 12-18 years) – 5.8 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 19-50 years) – 8.0 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 51-64 years) – 5.8 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years) – 6.4 percentage points

Table 3.8: Respiratory Conditions

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Appropriate Testing for Children with Pharyngitis	5,548	4,507	**81.2%**	80.2%	82.3%	74.4%	+	82.9%	-	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection	7,622	763	**90.0%**	89.3%	90.7%	89.4%	n.s.	91.1%	-	>= 25th and < 50th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	2,770	1,730	**37.5%**	35.7%	39.4%	31.5%	+	36.4%	n.s.	>= 75th and < 90th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	1,161	342	**29.5%**	26.8%	32.1%	27.7%	n.s.	29.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	1,620	1,175	**72.5%**	70.3%	74.7%	72.8%	n.s.	74.9%	-	>= 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	1,620	1,329	**82.0%**	80.1%	83.9%	83.4%	n.s.	85.2%	-	>= 25th and < 50th percentile

HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5 11 years)	1,164	362	**31.1%**	28.4%	33.8%	33.0%	n.s.	38.1%	-	>= 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12 18 years)	966	331	**34.3%**	31.2%	37.3%	36.2%	n.s.	40.0%	-	>= 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19 50 years)	1,654	646	**39.1%**	36.7%	41.4%	38.9%	n.s.	47.0%	-	>= 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51 64 years)	553	310	**56.1%**	51.8%	60.3%	55.6%	n.s.	61.8%	-	>= 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Total Age 5 64 years)	4,337	1,649	**38.0%**	36.6%	39.5%	37.7%	n.s.	44.5%	-	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (5 11 years)	1,274	944	**74.1%**	71.7%	76.5%	77.2%	n.s.	72.1%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (12 18 years)	1,111	761	**68.5%**	65.7%	71.3%	67.6%	n.s.	67.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (19 50 years)	2,071	1,187	**57.3%**	55.2%	59.5%	54.9%	n.s.	57.8%	n.s.	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (51 64 years)	702	437	**62.3%**	58.6%	65.9%	64.9%	n.s.	61.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (Total)	5,158	3,329	**64.5%**	63.2%	65.9%	65.7%	n.s.	64.5%	n.s.	>= 50th and < 75th percentile
PA EQR	Asthma in Younger Adults Admission Rate (Age 18 39 years) per 100,000 member months	1,038,536	73	**7.0**	5.4	8.6	6.3	n.s.	7.3	n.s.	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months	644,776	657	**101.9**	94.1	109.7	NA	NA	94.5	n.s.	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	10,936	8	**73.2**	22.5	123.8	NA	NA	55.5	n.s.	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months	655,712	665	**101.4**	93.7	109.1	81.3	+	93.7	n.s.	NA

[1] Per NCQA, a higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).
[2] Per NCQA, a higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).
[3] For the Adult Admission Rate measures, lower rates indicate better performance.

Comprehensive Diabetes Care

Strengths are identified for the following Comprehensive Diabetes Care performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
    - Statin Therapy for Patients With Diabetes: Received Statin Therapy – 4.4 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
    - HbA1c Control (<8.0%) – 7.3 percentage points
    - HbA1c Good Control (<7.0%) – 5.5 percentage points
    - Blood Pressure Controlled <140/90 mm Hg – 7.2 percentage points
    - Statin Therapy for Patients With Diabetes: Statin Adherence 80% – 4.8 percentage points
    - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age) – 18.7 percentage points
    - HbA1c Poor Control (>9.0%) – 5.2 percentage points

- Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months – 11.18 admissions per 100,000 member months
- Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months – 11.17 admissions per 100,000 member months

Table 3.9: Comprehensive Diabetes Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Hemoglobin A1c (HbA1c) Testing	627	548	**87.4%**	84.7%	90.1%	88.7%	n.s.	87.2%	n.s.	>= 25th and < 50th percentile
HEDIS	HbA1c Poor Control (>9.0%)	627	250	**39.9%**	36.0%	43.8%	43.1%	n.s.	34.7%	+	>= 25th and < 50th percentile
HEDIS	HbA1c Control (<8.0%)	627	286	**45.6%**	41.6%	49.6%	45.4%	n.s.	52.9%	-	>= 25th and < 50th percentile
HEDIS	HbA1c Good Control (<7.0%)	411	133	**32.4%**	27.7%	37.0%	33.3%	n.s.	37.8%	-	>= 25th and < 50th percentile
HEDIS	Retinal Eye Exam	627	350	**55.8%**	51.9%	59.8%	57.3%	n.s.	59.0%	n.s.	>= 25th and < 50th percentile
HEDIS	Medical Attention for Nephropathy	627	568	**90.6%**	88.2%	93.0%	89.8%	n.s.	89.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Blood Pressure Controlled <140/90 mm Hg	627	389	**62.0%**	58.2%	65.9%	62.5%	n.s.	69.2%	-	>= 25th and < 50th percentile
PA EQR	Diabetes Short Term Complications Admission Rate (Age 18 64 years) per 100,000 member months	1,683,312	435	**25.8**	23.4	28.3	22.2	+	14.7	+	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Age 65+ years) per 100,000 member months	10,936	1	**9.1**	0.0	27.1	9.7	n.s.	1.8	n.s.	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months	1,694,248	436	**25.7**	23.3	28.1	22.1	+	14.6	+	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	5,588	3,614	**64.7%**	63.4%	65.9%	61.7%	+	60.3%	+	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	3,614	2,225	**61.6%**	60.0%	63.2%	64.3%	-	66.4%	-	>= 50th and < 75th percentile
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 64 Years of Age)	1,237	848	**68.6%**	65.9%	71.2%	NA	NA	87.2%	-	NA
PA EQR	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 65 75 Years of Age)	14	10	**NA**	NA	NA	NA	NA	86.4%	NA	NA

[1] For HbA1c Poor Control, lower rates indicate better performance.
[2] For the Adult Admission Rate measures, lower rates indicate better performance

Cardiovascular Care

Strengths are identified for the following Cardiovascular Care performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female) – 3.9 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate – 3.0 percentage points

Opportunities for improvement are identified for Cardiovascular Care performance measures

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Controlling High Blood Pressure (Total Rate) – 12.0 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female) – 4.1 percentage points

- Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate – 3.1 percentage points
- Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months – 4.17 admissions per 100,000 member months
- Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months – 4.41 admissions per 100,000 member months

Table 3.10: Cardiovascular Care

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
HEDIS	Persistence of Beta Blocker Treatment After Heart Attack	193	163	**84.5%**	79.1%	89.8%	82.2%	n.s.	85.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	411	215	**52.3%**	47.4%	57.3%	56.3%	n.s.	64.3%	-	>= 25th and < 50th percentile
PA EQR	Heart Failure Admission Rate (Age 18 64 years) per 100,000 member months	1,683,312	396	**23.5**	21.2	25.8	18.7	+	19.4	+	NA
PA EQR	Heart Failure Admission Rate (Age 65+ years) per 100,000 member months	10,936	13	**118.9**	54.3	183.5	106.5	n.s.	70.2	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months	1,694,248	409	**24.1**	21.8	26.5	19.1	+	19.7	+	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21 75 years (Male)	904	737	**81.5%**	78.9%	84.1%	78.5%	n.s.	79.2%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40 75 years (Female)	725	578	**79.7%**	76.7%	82.7%	78.4%	n.s.	75.8%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,629	1,315	**80.7%**	78.8%	82.7%	78.4%	n.s.	77.7%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 21 75 years (Male)	737	498	**67.6%**	64.1%	71.0%	65.4%	n.s.	69.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 40 75 years (Female)	578	382	**66.1%**	62.1%	70.0%	64.7%	n.s.	70.2%	-	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Total Rate	1,315	880	**66.9%**	64.3%	69.5%	65.1%	n.s.	70.0%	-	>= 50th and < 75th percentile
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia	38	28	**73.7%**	58.4%	89.0%	82.1%	n.s.	78.1%	n.s.	>= 10th and < 25th percentile

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

Utilization

Strengths are identified for the following Utilization performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Use of Opioids at High Dosage – 10.5 per 1000
  - Use of Opioids From Multiple Providers (4 or more pharmacies) – 36.8 per 1000

Opportunities for improvement are identified for Utilization performance measures

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Use of Opioids from Multiple Providers (4 or more prescribers) – 77.9 per 1000
  - Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies) – 3.9 per 1000

Table 3.11: Utilization

		2018 (MY 2017)					2018 (MY 2017) Rate Comparison				
Indicator Source	Indicator	Denom	Num	Rate	Lower 95% Confidence Interval	Upper 95% Confidence Interval	2017 (MY2016) Rate	2018 Rate Compared to 2017	MMC	2018 Rate Compared to MMC	HEDIS 2018 Percentile
PA EQR	Reducing Potentially Preventable Readmissions	18,126	1,722	**9.5%**	9.1%	9.9%	12.15%	-	10.3%	-	NA

HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	945	625	**66.1%**	63.1%	69.2%	65.57%	n.s.	66.6%	n.s.	>= 75th and < 90th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	2,233	1,535	**68.7%**	66.8%	70.7%	69.76%	n.s.	69.0%	n.s.	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 5 years	13	0	**NA**	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 6 11 years	601	4	**0.7%**	0.0%	1.4%	1.01%	n.s.	0.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 12 17 years	1,206	25	**2.1%**	1.2%	2.9%	2.20%	NA	1.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Total Rate	1,820	29	**1.6%**	1.0%	2.2%	1.79%	n.s.	1.5%	n.s.	>= 50th and < 75th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 5 years	18	11	**NA**	NA	NA	61.76%	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 6 11 years	720	460	**63.9%**	60.3%	67.5%	49.67%	+	64.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 12 17 years	1,454	934	**64.2%**	61.7%	66.7%	49.88%	+	62.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Total Rate	2,192	1,405	**64.1%**	62.1%	66.1%	49.94%	+	63.1%	n.s.	>= 90th percentile
HEDIS	Use of Opioids at High Dosage[3]	9,134	673	**73.7**	NA	NA	NA	NA	84.2	-	NA
HEDIS	Use of Opioids from Multiple Providers (4 or more proscribers)	10,714	2,587	**241.5**	NA	NA	NA	NA	163.5	+	NA
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)	10,714	635	**59.3**	NA	NA	NA	NA	96.1	-	NA
HEDIS	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)	10,714	367	**34.3**	NA	NA	NA	NA	30.4	+	NA
HEDIS	Plan weighted SIR (CLABSI)			**0.69**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) high SIR			**0.21**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) moderate SIR			**0.10**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) low SIR			**0.59**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) unavailable SIR			**0.10**			NA	NA			NA
HEDIS	Plan weighted SIR (CAUTI)			**0.77**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) high SIR			**0.24**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) moderate SIR			**0.13**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) low SIR			**0.55**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) unavailable SIR			**0.08**			NA	NA			NA
HEDIS	Plan weighted SIR (MRSA)			**0.66**			NA	NA			NA

[3] A similar measure called Use of Opioids at High Doses was a PA Specific Administrative measure in 2017. This measure was retired in 2018 and replaced by the new HEDIS measure, Use of Opioids at High Dosage. No comparison is made between the new 2018 HEDIS Opioid measure and the retired 2017 PA Specific Administrative measure in this report.

HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events high SIR			**0.25**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events moderate SIR			**0.27**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events low SIR			**0.35**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events unavailable SIR			**0.13**			NA	NA			NA
HEDIS	Plan weighted SIR (CDIFF)			**0.83**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) high SIR			**0.36**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) moderate SIR			**0.03**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) low SIR			**0.55**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) unavailable SIR			**0.06**			NA	NA			NA
		2018 (MY 2017)					**2018 (MY 2017) Rate Comparison**				
Indicator Source	**Indicator**		**Count**	**Rate**			**2017 (MY2016) Rate**	**2018 Rate Compared to 2017**			**HEDIS 2018 Percentile**
HEDIS	PCR: Count of Index Hospital Stays (IHS) 1 3 Stays (Ages Total)		8,367								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) 4+ Stays (Ages Total)		1,736								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) Total Stays (Ages Total)		10,103								NA
HEDIS	PCR: Count of 30 Day Readmissions 1 3 Stays (Ages Total)		747								NA
HEDIS	PCR: Count of 30 Day Readmissions 4+ Stays (Ages Total)		879								NA
HEDIS	PCR: Count of 30 Day Readmissions Total Stays (Ages Total)		1,626								NA
HEDIS	PCR: Observed Readmission Rate 1 3 Stays (Ages Total)			**8.9%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate 4+ Stays (Ages Total)			**50.6%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate Total Stays (Ages Total)			**16.1%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate 1 3 Stays (Ages Total)			**16.6%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate 4+ Stays (Ages Total)			**37.0%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate Total Stays (Ages Total)			**20.1%**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 1 3 Stays (Ages Total)			**0.54**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 4+ Stays (Ages Total)			**1.37**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio Total Stays (Ages Total)			**0.80**			NA	NA			NA

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

[2] For the Use of Multiple Concurrent Antipsychotics in Children and Adolescents 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 GH 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.

2018 Adult CAHPS 5.0H Survey Results

Table 3.12: CAHPS 2018 Adult Survey Results

Survey Section/Measure Your Health Plan	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2017 Rate Compared to 2016	2016 (MY 2015)	2018 MMC Weighted Average
Satisfaction with Adult's Health Plan (Rating of 8 to 10)	81.72%	▼	83.39%	▲	79.78%	79.32%
Getting Needed Information (Usually or Always)	82.95%	▼	86.21%	▼	86.99%	84.96%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	74.79%	▼	76.89%	▲	73.79%	74.94%
Appointment for Routine Care When Needed (Usually or Always)	81.74%	▲	79.67%	▼	82.29%	83.30%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2018 MMC Weighted Average.

2018 Child CAHPS 5.0H Survey Results

Table 3.13: CAHPS 2018 Child Survey Results

CAHPS Items Your Child's Health Plan	2018 (MY 2017)	2018 Rate Compared to 2017	2017 (MY 2016)	2017 Rate Compared to 2016	2016 (MY 2015)	2018 MMC Weighted Average
Satisfaction with Child's Health Plan (Rating of 8 to 10)	87.75%	▼	87.91%	▲	84.76%	86.50%
Getting Needed Information (Usually or Always)	87.23%	▲	87.16%	▲	73.53%	84.26%
Your Healthcare in the Last Six Months						
Satisfaction with Health Care (Rating of 8-10)	83.68%	▼	84.23%	▲	82.06%	84.69%
Appointment for Routine Care When Needed (Usually or Always)	92.06%	▲	88.50%	▼	91.13%	88.89%

▲▼ = Performance compared to prior years' rate
Shaded boxes reflect rates above the 2018 MMC Weighted Average.

IV: 2017 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 2017 EQR Technical Reports, which were distributed June 2018. The 2018 EQR is the tenth to include descriptions of current and proposed interventions from each PH MCO that address the 2017 recommendations.

DHS requested that MCOs 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 June 30, 2018 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the response submitted to IPRO as of August 2018, as well as any additional relevant documentation provided by GH.

Table 4.1 presents GH's responses to opportunities for improvement cited by IPRO in the 2017 EQR Technical Report, detailing current and proposed interventions.

Table 4.1: Current and Proposed Interventions

Reference Number: GH 2017.01: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Developmental Screening in the First Three Years of Life – (1year, 2 years, 3 years, & Total)
Follow Up Actions Taken Through 06/30/18: **Provider Education (November 2015 – ongoing).** Gateway Health published a section on the provider website that provided links to EPSDT information, including both the Bright Futures/AAP and Pennsylvania Periodicity Schedules. The Pennsylvania Periodicity Schedule includes coding specifics on the matrix. The Gateway Health website has been reorganized to highlight the Structured Developmental Screenings clearly in the EPSDT section of the website. An updated listed of validated screening tools that providers can use to complete formal developmental screenings was added in Q2 of 2018. Additionally, a coding and billing guide began being distributed to all pediatric practices beginning in January 2018 with an additional handout specific to billing Developmental Screenings. **Omni-channel Well-Baby Education Program (May 2016 – ongoing).** Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to encourage new parents to follow the periodicity schedule by educating on well-baby visits, immunizations, and lead screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care. **EPSDT Coordinator Position (January 2017 – ongoing).** The EPSDT Coordinator is responsible to ensure enterprise wide compliance with Early Periodic Screening, Diagnosis and Treatment of members under 21 in accordance with the Federal Medicaid Program (Title XIX of the Social Security Act) and multi-state level requirements to screen, diagnose, track and follow up for individuals under 21, including those in substitute care, those in residential facility placement, and those with special needs. **EPSDT Dashboard (Q2 2017 – ongoing).** The EPSDT Dashboard allows the EPSDT Coordinator to monitor both the member and the provider level for completion of the Developmental Screenings at each indicated age on the periodicity schedule. **Member Newsletter Article (August 2017, Spring 2018).** An article in the August and Spring member newsletters provided education on current recommendations for EPSDT Screenings, including Developmental Screenings. **Provider Webinar (2018).** A provider webinar focusing on when to complete and how to properly bill for Structured Developmental screenings was held in February 2018. It was recorded and posted to the Gateway Health website for additional viewing at providers' convenience. This webinar also addressed correct billing and coding of Developmental

Screenings.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Developmental Screening in the First Three Years of Life (1 year, 2 years, and Total) measure in 2019.

Future Actions Planned:

Provider Reporting (July 2018 – Ongoing) – Direct reporting of EPSDT screening status for all members on the provider's panel. This is distributed quarterly to all pediatric providers.

Member Newsletter (Summer 2018). An article addressing the importance of developmental screenings will be included in the Summer 2018 member newsletter.

Provider Newsletter (August 2018). An article in the provider newsletter for August 2018 will address the Developmental Screening schedule as well as proper coding and billing of the screening.

Reference Number: GH 2017.02: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Annual Dental Visit (Age 2–20 years)

Follow Up Actions Taken Through 06/30/18:

"Care Gap" Button (October 2014 – ongoing). All Gateway Health member-facing representatives utilize the "Care Gap" function made available in current software configuration. The function displays actionable open gaps, including annual dental visits. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.

Public Health Dental Hygiene Practitioner Program (January 2015 – ongoing). Gateway Health employs dental hygienists with a public health certification that allows them to practice in certain community settings. These PHDHPs contact members and heads of households of eligible members by telephone to discuss proper oral hygiene and nutrition, as well as assist with barrier analysis and finding the member a dental home. The PHDHPs also educate large numbers of members about good oral hygiene at community events, such as health fairs. The PHDHPs utilize their knowledge of the dental landscape in the 3 HealthChoices zones that Gateway Health serves. They focus their efforts on members ages 0-5 years to help establish a dental home at a young age.

Collaboration with Head Start Programs (September 2015 – ongoing). The PHDHPs in the Northwest, Southwest and Lehigh Cap zones attend Head Start and Early Head Start programs to educate students on the importance of proper oral hygiene and nutrition. They also provide education to parents/guardians at events associated with the Head Start programs.

No Contact Postcards (November 2015 – ongoing). Members who live in households where the PHDHPs are unable to reach telephonically receive a postcard. The postcards provide a reminder that the member is due for a dental visit as well as a call back number for the PHDHP who attempted the outreach. These postcards are primarily mailed to households with members ages 0-5 years as part of the effort to establish a dental home at an early age.

Practice Reference Guide (January 2016 – ongoing). The Annual Dental Visit tip sheet was revised to contain information for medical providers about oral health services that they can perform and resources for training. The reference guides are made available to all providers and promoted at onsite practice visits by the Provider Engagement Team as well as the Provider Relations representatives.

Omnichannel Dental Education Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is parents/guardians of children ages 6-18 and members ages 18-20. Members who are historically non-compliant are targeted and members ages 18-20 years receive a postcard if they are unable to be reached. The purpose of the program is to encourage good oral hygiene and at least annual dental visits. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

Community Dental Days (June 2016 – ongoing). Dental events are scheduled at medical practices and community centers using area dentists who have mobile equipment. The locations tend to be in areas with less access to dentists in all 3 HealthChoices zones served by Gateway. Gateway Health PHDHPs are present to counsel members on good oral hygiene and nutrition as well as assist with finding a permanent dental home. The majority of these events take place over the summer when children are out of school. Through June 30th, 22 events have occurred throughout the 3 zones. An additional 28 dental events are scheduled through the remainder of the year.

Medical Provider Oral Health Education (July 2016 – ongoing). In collaboration with the PA Chapter of the American Academy of Pediatrics (PAAAP), Gateway Health began to educate medical providers on the oral health services that they can provide to members, such as topical fluoride varnish application. The PAAAP trained Gateway Health Clinical Transformation Consultants (CTCs) on the services that can be offered, reimbursement for the services, and how to get certified to provide them. A process was established for the CTCs to connect interested providers to the Healthy Teeth,

Healthy Children training to be certified for topical fluoride varnish application. In June 2018 a training webinar was conducted in partnership with PAAAP where medical providers received the Healthy Teeth, Healthy Children training that made them eligible for fluoride varnish application certification.

Dental Provider Early Intervention Education (November 2016 – ongoing). Using a survey, dental providers not currently seeing children under age 5 were identified and queried about their interest in learning best practices for the age population. These dentists were contacted to set up in-office educational sessions to teach staff about techniques for examining infants and young children, such as the knee to knee method, and how to begin incorporating these members into their practices. The training sessions began in June 2017 and were performed by Gateway Health PHDHPs and United Concordia Professional Relations Representatives.

Member Incentive (November 2016 – ongoing). Pediatric and young adult members are eligible to receive an incentive once per year through Gateway Health's Goodness Rewards™ program. Members receive the incentive if they complete at least one dental visit during the calendar year. The member can attest to completing the health activity through multiple channels, including mail, phone, or an online portal. Members receive communications about incentive eligibility throughout the year via IVR [Interactive Voice Response] and direct mail.

Gateway to Practitioner Excellence (GPE®) Dental Provider Incentive (January 2017 - ongoing). The dental provider GPE® program was altered in 2017 to promote more preventive dental services and an increase in providers who are willing to see children under age 6. Dentists can receive an incentive for providing episodes of care that include an examination, prophylaxis, and fluoride application on the same day. Dentists receive a larger incentive for bringing on new patients, especially those under the age of 6.

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Dental Education Program. Households with members ages 6-20 who have a history of a dental visit in the past year are contacted ahead of the expected date of their next appointment to remind them to schedule one if they have not already.

First Birthday Mailer (May 2017 – ongoing). Postcards are sent to households with children after they reach 6 months of age to provide education about scheduling the first dental visit no later than the first birthday. Parents/ guardians are urged to contact Gateway Health if they do not have a dentist to take their child for assistance with scheduling. This is in line with Gateway Health's plan to increase the number of children with a permanent dental home at an early age.

Pre Queue Member Messaging (May 2018 – July 2018). When members/ heads of household call into the Medicaid Customer Service line they hear a message about important checkups for pediatric members, which includes regular dental visits. The message reminds member households that it's important to see a dentist at least once a year as part of maintain good overall health.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Educational Webinar for Dental Providers (July 2017- ongoing). United Concordia educated its dental provider network on the current GPE® incentive program as well as the importance of providing services to children under age 5. The webinar featured discussion by United Concordia's Chief Dental Officer and was recorded for future viewing. A second webinar for providers around seeing children under age 5 was presented in June 2018 to 9 providers and posted to the United Concordia website for additional viewing.

Dental Provider Scorecard (August 2017). As an enhancement to the GPE® provider incentive, dentists receive a quarterly scorecard that presents data on how many members they saw in the previous quarter as well as how many members are due for a visit at their practice. This information provides a better understanding of the dentist's GPE® performance and potential opportunities.

PHDHPs in FQHCs (Q2 2018). Gateway Health is partnering with an FQHC in the SW zone that has a dental scope of practice to increase the number of members receiving preventive health services by embedding a PHDHP in the office. The PHDHP counsels members as they visit the FQHC for medical appointments and provides preventive services, such as prophylaxis, fluoride application, and dental sealants. The PHDHP also refers members for dental appointments and

assist with appointment scheduling and reminders.

Member Opportunity Report for Dental Providers (October 2017). Gateway Health provides participating dentists with a monthly opportunity report that lists members who are overdue for a visit as a way to promote outreach by the dentist to schedule the members for a visit.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 75th percentile benchmark of 62.49%.

Future Actions Planned:

Member Newsletter Article (September 2018). An article in the September member newsletter will provide information about different ways to maintain a healthy mouth as a way of improving overall health. The article will offer tips on good habits at home, healthy snacks, proper oral hygiene, and current recommendations for dental visits.

Block Scheduling with Practices (Q4 2018). Gateway Health will partner with dental practices to reserve time on their calendars for Gateway Health members to schedule appointments to help increase access to care.

Gateway Health Website Updates (Q2 2019). The Gateway Health website will be updated with a Health and Wellness section that will include an oral health component.

Reference Number: GH 2017.03: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years)

Follow Up Actions Taken Through 06/30/18:

"Care Gap" Button (October 2014 – ongoing). All Gateway Health member-facing representatives utilize the "Care Gap" function made available in current software configuration. The function displays actionable open gaps, including annual dental visits. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.

Public Health Dental Hygiene Practitioner Program (January 2015 – ongoing). Gateway Health employs dental hygienists with a public health certification that allows them to practice in certain community settings. These PHDHPs contact members and heads of households of eligible members by telephone to discuss proper oral hygiene and nutrition, as well as assist with barrier analysis and finding the member a dental home. The PHDHPs also educate large numbers of members about good oral hygiene at community events, such as health fairs. The PHDHPs utilize their knowledge of the dental landscape in the 3 HealthChoices zones that Gateway Health serves. They focus their efforts on members ages 0-5 years to help establish a dental home at a young age.

Collaboration with Head Start Programs (September 2015 – ongoing). The PHDHPs in the Northwest, Southwest and Lehigh Cap zones attend Head Start and Early Head Start programs to educate students on the importance of proper oral hygiene and nutrition. They also provide education to parents/guardians at events associated with the Head Start programs.

No Contact Postcards (November 2015 – ongoing). Members who live in households where the PHDHPs are unable to reach telephonically receive a postcard. The postcards provide a reminder that the member is due for a dental visit as well as a call back number for the PHDHP who attempted the outreach. These postcards are primarily mailed to households with members ages 0-5 years as part of the effort to establish a dental home at an early age.

Practice Reference Guide (January 2016 – ongoing). The Annual Dental Visit tip sheet was revised to contain information for medical providers about oral health services that they can perform and resources for training. The reference guides are made available to all providers and promoted at onsite practice visits by the Provider Engagement Team as well as the Provider Relations representatives.

Special Needs Indicator for Providers on the Gateway Health Website (May 2016 – ongoing). Gateway Health's website was updated with an indicator for dental providers who can accommodate special needs children. This indicator makes it easier for parents/guardians of special needs children to locate a dentist in their area.

Omnichannel Dental Education Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The target population is parents/guardians of children ages 6-18 and members ages 18-20. Members who are historically non-compliant are targeted and members ages 18-20 years receive a postcard if they are unable to be reached. The purpose of the program is to encourage good oral hygiene and at least annual dental visits. Live agents are available to assist with scheduling appointments or resolving barriers to care.

Community Dental Days (June 2016 – ongoing). Dental events are scheduled at medical practices and community centers utilizing area dentists who have mobile equipment. The locations tend to be in areas with less access to dentists in all 3 HealthChoices zones served by Gateway. Gateway Health PHDHPs are present to counsel members on good oral hygiene and nutrition as well as assist with finding a permanent dental home. The majority of these events take place over

the summer when children are out of school. Through June 30th, 22 events have occurred throughout the 3 zones. An additional 28 dental events are scheduled through the remainder of the year.

Medical Provider Oral Health Education (July 2016 – ongoing). In collaboration with the PA Chapter of the American Academy of Pediatrics (PAAAP), Gateway Health began to educate medical providers on the oral health services that they can provide to members, such as topical fluoride varnish application. The PAAAP trained Gateway Health Clinical Transformation Consultants (CTCs) on the services that can be offered, reimbursement for the services, and how to get certified to provide them. A process was established for the CTCs to connect interested providers to the Healthy Teeth, Healthy Children training to be certified for topical fluoride varnish application. In June 2018 a training webinar was conducted in partnership with PAAAP where medical providers received the Healthy Teeth, Healthy Children training that made them eligible for fluoride varnish application certification.

Dental Provider Early Intervention Education (November 2016 – ongoing). Using a survey, dental providers not currently seeing children under age 5 were identified and queried about their interest in learning best practices for the age population. These dentists were contacted to set up in-office educational sessions to teach staff about techniques for examining infants and young children, such as the knee to knee method, and how to begin incorporating these members into their practices. The training sessions began in June 2017 and were performed by Gateway Health PHDHPs and United Concordia Professional Relations Representatives.

Member Incentive (November 2016 – ongoing). Pediatric and young adult members are eligible to receive an incentive once per year through Gateway Health's Goodness Rewards™ program. Members receive the incentive if they complete at least one dental visit during the calendar year. The member can attest to completing the health activity through multiple channels, including mail, phone, or an online portal. Members receive communications about incentive eligibility throughout the year via IVR and direct mail.

Gateway to Practitioner Excellence (GPE®) Dental Provider Incentive (January 2017 - ongoing). The dental provider GPE® program was altered in 2017 to promote more preventive dental services and an increase in providers who are willing to see children under age 6. Dentists can receive an incentive for providing episodes of care that include an examination, prophylaxis, and fluoride application on the same day. Dentists receive a larger incentive for bringing on new patients, especially those under the age of 6.

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Dental Education Program. Households with members ages 6-20 who have a history of a dental visit in the past year are contacted ahead of the expected date of their next appointment to remind them to schedule one if they have not already.

First Birthday Mailer (May 2017 – ongoing). Postcards are sent to households with children after they reach 6 months of age to provide education about scheduling the first dental visit no later than the first birthday. Parents/ guardians are urged to contact Gateway Health if they do not have a dentist to take their child for assistance with scheduling. This is in line with Gateway Health's plan to increase the number of children with a permanent dental home at an early age.

Pre Queue Member Messaging (May 2018 – July 2018). When members/ heads of household call into the Medicaid Customer Service line they hear a message about important checkups for pediatric members, which includes regular dental visits. The message reminds member households that it's important to see a dentist at least once a year as part of maintain good overall health.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Educational Webinar for Dental Providers (July 2017- ongoing). United Concordia educated its dental provider network on the current GPE® incentive program as well as the importance of providing services to children under age 5. The webinar featured discussion by United Concordia's Chief Dental Officer and was recorded for future viewing. A second webinar for providers around seeing children under age 5 was presented in June 2018 to 9 providers and posted to the United Concordia website for additional viewing.

Dental Provider Scorecard (August 2017). As an enhancement to the GPE® provider incentive, dentists receive a

quarterly scorecard that presents data on how many members they saw in the previous quarter as well as how many members are due for a visit at their practice. This information provides a better understanding of the dentist's GPE® performance and potential opportunities.

PHDHPs in FQHCs (Q2 2018). Gateway Health is partnering with an FQHC in the SW zone that has a dental scope of practice to increase the number of members receiving preventive health services by embedding a PHDHP in the office. The PHDHP counsels members as they visit the FQHC for medical appointments and provides preventive services, such as prophylaxis, fluoride application, and dental sealants. The PHDHP also refers members for dental appointments and assist with appointment scheduling and reminders.

Member Opportunity Report for Dental Providers (October 2017). Gateway Health provides participating dentists with a monthly opportunity report that lists members who are overdue for a visit as a way to promote outreach by the dentist to schedule the members for a visit.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 years) measure in 2019.

Future Actions Planned:

Member Newsletter Article (September 2018). An article in the September member newsletter will provide information about different ways to maintain a healthy mouth as a way of improving overall health. The article will offer tips on good habits at home, healthy snacks, proper oral hygiene, and current recommendations for dental visits.

Block Scheduling with Practices (Q4 2018). Gateway Health will partner with dental practices to reserve time on their calendars for Gateway Health members to schedule appointments to help increase access to care.

Gateway Health Website Updates (Q2 2019). The Gateway Health website will be updated with a Health and Wellness section that will include an oral health component.

Reference Number: GH 2017.04: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Breast Cancer Screening (Age 50-74 years)

Follow Up Actions Taken Through 06/30/18:

"Care Gap" Button (October 2014 – ongoing). All Gateway Health member-facing representatives utilize the "Care Gap" function made available in current software configuration. The function displays actionable open gaps, including breast cancer screening. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.

Practice Reference Guide (January 2016 – ongoing). The Breast Cancer Screening Tip Sheet is included in a Practice Reference Guide made available to all providers and promoted at onsite practice visits by the Provider Engagement Team as well as Provider Relations Representatives. The guide includes tips for communicating with members about breast cancer screening and how to include a gap alert in the electronic health records.

Omnichannel Women's Prevention Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is adult females with one or more open gaps included as part of women's preventive health care. The purpose of the program is to encourage women to get mammograms. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Women's Prevention Program. Members who are recently due for a mammogram are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already.

Breast Cancer Health Awareness Series (October 2017). Gateway Health Community Engagement staff, in collaboration with the American Cancer Society, presented information on breast cancer and screening recommendations at the Health Awareness Series event in October. The presentation offered an opportunity for attendees to ask questions.

Breast Cancer Awareness Month (October 2017). Gateway Health promoted breast cancer screening during Breast Cancer Awareness Month through social media messaging and a pre queue message that members hear whenever they call into the Medicaid Customer Service number.

Direct EHR Feeds (Q4 2017- ongoing). Secure EHR exchanges with select practices will allow for the ongoing capture

of medical record data relevant to clinical care and quality measures.

Provider Webinar (September 2017). As part of Gateway Health's provider webinar series, there was a discussion around breast cancer screening ahead of Breast Cancer Awareness Month in October. The webinar included an external speaker from the American Cancer Society who presented on best practices for improving rates of screening in the office setting. Attendees were eligible for a CME credit and the webinar was recorded for future viewing.

Mammography Event (October 2017). In partnership with a Radiology center in the Northwest Zone, members in the surrounding area with an open gap were invited to receive a mammogram as well as education about breast cancer and prevention.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 58.99% for the Breast Cancer Screening measure.

Future Actions Planned:

Breast Cancer Awareness Month (October 2018). Gateway Health will promote breast cancer screening during Breast Cancer Awareness Month through social media messaging and a pre queue message that members will hear whenever they call into the Medicaid Customer Service number.

Mammography Events (Q4 2018). Based off of lessons learned from the mammography event in 2017, Gateway Health will partner with additional radiology facilities to provide members with days dedicated to scheduling appointments and receiving women's health education.

Gateway Listens Member Insight (Q3 2018). The Gateway Listens platform will be used to better understand the barriers that members face in getting a mammogram as well as to develop new materials based off of feedback received.

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.

Reference Number: GH 2017.05: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Chlamydia Screening in Women (Age 16-20 years, 21-24 years, & Total)

Follow Up Actions Taken Through 06/30/18:

"Care Gap" Button (October 2014 – ongoing). All Gateway Health member-facing representatives utilize the "Care Gap" function made available in current software configuration. The function displays actionable open gaps, including chlamydia screening. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.

Online Member Education (November 2015 – ongoing). The member section of Gateway Health's website includes a piece on teen and youth health and wellness. This page supplies members and heads of households with information about the importance of sexually transmitted disease (STD) testing for any members who are sexually active, which includes chlamydia. There is a link to additional resources for education about chlamydia and screening for the disease.

Practice Reference Guide (January 2016 – ongoing). The Chlamydia Screening Tip Sheet is included in a Practice Reference Guide made available to all providers and promoted at onsite practice visits by the Provider Engagement Team as well as Provider Relations Representatives. The guide includes tips for communicating with members about chlamydia screening and how to include a gap alert in the electronic health records. This tool educates providers who may be unaware that this screening can be accomplished with a urine specimen.

Omnichannel Women's Prevention Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is adult females with one or more open gaps included as part of women's preventive health care. The purpose of the program is to encourage women to get a chlamydia screening test. Live agents are available to assist with scheduling appointments or resolving barriers to care.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Appointment Reminder Outreach Campaign (April 2017 – ongoing). VR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Women's Prevention Program. Members who are recently due for a chlamydia screening test are contacted ahead of the expected date of their next appointment to remind them to schedule one if they have not already.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

STI Resources for Providers (Q3 2017). In collaboration with the PA DoH, Gateway Health provided resources for providers regarding ways to improve STI screening rates, including chlamydia. The resources included online training programs that are opportunities for eligible providers to earn CME credits.

Direct EHR Feeds (Q4 2017). Secure EHR exchanges with select practices will allow for the ongoing capture of medical record data relevant to clinical care and quality measures.

Provider Newsletter Article (December 2017). An article posted in the December provider newsletter described the importance of chlamydia screening in sexually active females including the effects of untreated chlamydia. The article included information on best practices for improving chlamydia screening rates and the current recommendation for testing.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark for the following components of the Chlamydia Screening in Women measure:

- 52.81% (ages 16-20)
- 62.76% (ages 21-24)
- 56.69% (total)

Future Actions Planned:

Member Newsletter Article (Q4 2018). An article in the Q4 member newsletter will describe the importance of chlamydia screening in sexually active females including the effects of untreated chlamydia.

Reference Number: GH 2017.06: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal and Postpartum Care – Postpartum Care

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing

education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

Prenatal and Postpartum Education Programs (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about early and frequent prenatal care, and timely postpartum care. The program runs the length of members' pregnancies with contact occurring at least once per month. Provides reminders on frequency for prenatal visits as pregnancy progresses and on the timing of postpartum care. Provides live agent assistance to schedule appointments and resolve barriers/SDoH impediments to care.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform.

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Gateway to Practitioner Excellence (GPE®) 2017 Program (January 2017 – ongoing). Timeliness of Prenatal Care and Postpartum Care measures are a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

Revised Provider Materials (May 2018). Gateway Health completed revisions to all provider-facing maternity documents to ensure alignment with HEDIS specifications. New content was approved for the Obstetrical Billing Guide and Medicaid Provider Manual.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff meets monthly to review rates, problem solve any barriers or opportunities. This method applies both to actions implemented previously and those planned in the future.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 64.3% for Postpartum Care.

Future Actions Planned:

Quality Gap Closure (Q4 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.

Home Health Visit Policy Change (Q4 2018). The home health visit max unit payment policy will be expanded to increase access to postpartum care for members.

Reference Number: GH 2017.07: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Smoking

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and SPostpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Smoking measure in 2019.

Future Actions Planned:

Provider Webinar (September 2018). As part of Gateway Health's webinar series an expert speaker will present best practices on tobacco cessation for adults to network providers.

Provider Reference Tool (Q1 2019). Gateway Health is developing a reference tool for OB/GYNs related to all components of the perinatal measures, including screening for tobacco use.

Reference Number: GH 2017.08: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) measure in 2019.

Future Actions Planned:

Provider Webinar (September 2018). As part of Gateway Health's webinar series an expert speaker will present best practices on tobacco cessation for adults to network providers.

Provider Reference Tool (Q1 2019). Gateway Health is developing a reference tool for OB/GYNs related to all components of the perinatal measures, including screening for tobacco use.

Reference Number: GH 2017.09: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Environmental Tobacco Smoke Exposure

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Environmental Tobacco Smoke Exposure measure in 2019.

Future Actions Planned:
Provider Webinar (September 2018). As part of Gateway Health's webinar series an expert speaker will present best practices on tobacco cessation for adults to network providers.
Provider Reference Tool (Q1 2019). Gateway Health is developing a reference tool for OB/GYNs related to all components of the perinatal measures, including screening for tobacco use.
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Reference Number: GH 2017.10: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Counseling for Smoking

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Counseling for Smoking measure in 2019.

Future Actions Planned:

Provider Webinar (September 2018). As part of Gateway Health's webinar series an expert speaker will present best practices on tobacco cessation for adults to network providers.

Provider Reference Tool (Q1 2019). Gateway Health is developing a reference tool for OB/GYNs related to all components of the perinatal measures, including screening for tobacco use.

Reference Number: GH 2017.11: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Depression

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
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- Pharmacy review of all medications
- Reminder call for postpartum visit
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- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Depression measure in 2019.

Future Actions Planned:

Perinatal Support for Rural Areas (Q4 2018 – ongoing). Gateway Health is exploring improved methods of care delivery, such as telemedicine, that will allow for specialized perinatal behavioral health providers to connect with rural OB and Pediatric practices to support appropriate screening and intervention for behavioral health concerns.
Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.12: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
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- Reminder call for postpartum visit
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- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.
The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) measure in 2019.

Future Actions Planned:
Perinatal Support for Rural Areas (Q4 2018 – ongoing). Gateway Health is exploring improved methods of care delivery, such as telemedicine, that will allow for specialized perinatal behavioral health providers to connect with rural OB and Pediatric practices to support appropriate screening and intervention for behavioral health concerns.
Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.13: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Counseling for Depression

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
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- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Counseling for Depression measure in 2019.

Future Actions Planned:

Perinatal Support for Rural Areas (Q4 2018 – ongoing). Gateway Health is exploring improved methods of care delivery, such as telemedicine, that will allow for specialized perinatal behavioral health providers to connect with rural OB and Pediatric practices to support appropriate screening and intervention for behavioral health concerns.
Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.14: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Postpartum Screening for Depression

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Postpartum Screening for Depression

Future Actions Planned:

Perinatal Support for Rural Areas (Q4 2018 – ongoing). Gateway Health is exploring improved methods of care delivery, such as telemedicine, that will allow for specialized perinatal behavioral health providers to connect with rural OB and Pediatric practices to support appropriate screening and intervention for behavioral health concerns.

Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.15: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Alcohol use

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
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- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

Provider SBIRT Code Initiative (February 2018 – ongoing). Gateway Health opened up reimbursement for Screening, Brief Intervention and Referral to Treatment (SBIRT) codes to promote the use by providers for detecting substance use disorder and to assist with referral for treatment.

Integrated Care Plan Flag (Q1 2018 - ongoing). A maternity flag has been added to the ICP to alert Care Managers if a member is pregnant to better support her during the pregnancy.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Alcohol use measure in 2019.

Future Actions Planned:

First Year Care Management Support (Q3 2018 – ongoing). Gateway Health Care Management will offer continued support for the first year after childbirth to mothers with a history of addiction to provide resources that may help prevent a relapse.
Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.16: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Illicit drug use

Follow Up Actions Taken Through 06/30/18:
MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

Provider SBIRT Code Initiative (February 2018 – ongoing). Gateway Health released reimbursement for Screening, Brief Intervention and Referral to Treatment (SBIRT) codes to promote the use by providers for detecting substance use disorder and to assist with referral for treatment.

Integrated Care Plan Flag (Q1 2018 - ongoing). A maternity flag has been added to the ICP to alert Care Managers if a

member is pregnant to better support her during the pregnancy.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Illicit drug use measure in 2019.

Future Actions Planned:

First Year Care Management Support (Q3 2018 – ongoing). Gateway Health Care Management will offer continued support for the first year after childbirth to mothers with a history of addiction to provide resources that may help prevent a relapse.

Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.17: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Prescribed or over-the-counter drug use

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

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Provider SBIRT Code Initiative (February 2018 – ongoing). Gateway Health released reimbursement for Screening, Brief Intervention and Referral to Treatment (SBIRT) codes to promote the use by providers for detecting substance use disorder and to assist with referral for treatment.

Integrated Care Plan Flag (Q1 2018 - ongoing). A maternity flag has been added to the ICP to alert Care Managers if a member is pregnant to better support her during the pregnancy.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Prescribed or over-the-counter drug use measure in 2019.

Future Actions Planned:

First Year Care Management Support (Q3 2018 – ongoing). Gateway Health Care Management will offer continued support for the first year after childbirth to mothers with a history of addiction to provide resources that may help prevent a relapse.

Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.18: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Intimate partner violence

Follow Up Actions Taken Through 06/30/18:

MOM Matters® Program (prior to 2104 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach.

The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.
The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Intimate partner violence measure in 2019.

Future Actions Planned:
Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.19: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening for Behavioral Health Risk Assessment

Follow Up Actions Taken Through 06/30/18:
MOM Matters® Program (prior to 2104 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.
Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status
- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

Data Optimization (January 2016 – ongoing). Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

Community Health Workers (October 2016 – ongoing). Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care.

Expanded e-ONAF Capabilities (November 2016 – ongoing). Gateway Health now supports submission of ONAFs through the provider portal (November 2016 - ongoing) as well as via Optum web platform (September 2017- ongoing).

Internal Medical Record Capture (December 2016 – ongoing). Gateway Health nurses began to collect maternity medical records to better leverage the organization's member-level data and coordinate record retrieval with our providers.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (January 2018). A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU

Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Prenatal Screening for Smoking measure in 2019.

Future Actions Planned:

Provider Reference Tool (Q1 2019). Development of a reference tool for OB/GYNs related to all components of the perinatal MRR measures.

Reference Number: GH 2017.20: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Medication Management for People with Asthma - 75% Compliance (Age 5-11 years, 12-18, 19-50, & Total 5-64 years))

Follow Up Actions Taken Through 06/30/18:

Self-Management Education (Prior to 2014-Ongoing). Asthma "sticker letters" were mailed on a rolling basis to members newly identified as having asthma. This mailing contains education and stickers to help members differentiate between their rescue and controller inhalers.

Embedded Care Managers (November 2015 - Ongoing). Gateway Health has embedded care managers located at a variety of high-volume PCP practices. Embedded CMs work with members living with asthma to resolve barriers to medication compliance and assist with care coordination.

Clinical Practice Guidelines (January 2016 – Ongoing). Clinical Practice Guidelines are published on Gateway Health's website for providers to access and review. "Guidelines for the Diagnosis and Management of Asthma" is a National Guideline developed by the National Heart, Lung and Blood Institute as part of the National Asthma Education and Prevention Program.

Omnichannel Asthma Medication Adherence and Education Program (May 2016 - Ongoing). Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to increase asthma medication adherence among members and to educate on the difference between controller and rescue medications. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Gateway to Practitioner Excellence (GPE®) (January 2017-Ongoing). Asthma management is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Interdisciplinary Asthma Workgroup (January 2017 - Ongoing). The purpose of the workgroup is to identify asthma initiatives and barriers across departments, as well as examine asthma clinical quality trends.

Member Incentive (July 2017 – Ongoing). Members have the opportunity to receive an incentive for filling controller medications.

Provider Webinar (August 2017). As part of Gateway Health's provider webinar series, a discussion around caring for patients with asthma was conducted. The webinar included an external speaker who spoke about best practices for promoting medication adherence. Attendees were eligible for a CME credit and the webinar was recorded for future viewing.

Care Management Outreach (October 2017- Ongoing). Care Managers outreach to members with low asthma medication compliance, or historically low compliance, on a quarterly basis.

Retail Pharmacy Collaboration (November 2017- Ongoing). Asthma specific telephonic outreach to higher-risk members that includes medication compliance and pharmacist referrals for additional support.

Embedded Pharmacist Collaboration (March 2018 - Ongoing). Pharmacists embedded at practices receive lists of members who are patients at the practice and are currently in the MMA denominator or have a high likelihood of falling into the denominator. The pharmacist uses the information in face-to-face discussions with members or heads of households for education and to assist with getting prescriptions filled.

Data Optimization (February 2018 - Ongoing). Automated report created to identify members for asthma intervention. This report now identifies members with exclusions like COPD.

Care Management Staff Education (February 2018). Education provided on asthma best practices for member facing Care Management staff.

Asthma Medication Adherence Dashboard (May 2018). The monthly dashboard that goes out to providers was updated to include information on medication adherence for members diagnosed with asthma including the percentage of days covered.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 90th percentile benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:

- 43.58% (ages 5-11)
- 40.96% (ages 12-18)
- 51.74% (ages 19-50)
- 50.00% (Total 5-64 years)

Future Actions Planned:

Report on Days Covered (Q1 2019). Exploring the creation of an automated report for long-term controller fills identified with potentially erroneous days coverage. This report will be used during outreach to members.

Reimbursement for Asthma Environmental Triggers (Q3 2018): Exploring reimbursement programs to provide in-home asthma management services.

Website and Social Media Promotion (Q4 2018): Exploring enhanced focus on asthma and COPD self-management tools and materials on social media platforms.

Self-Management Educational Materials (Q3 2018): Exploring the development of in-home asthma and COPD self-management educational materials for members.

Reference Number: GH 2017.21: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years) per 100,000 member months

Follow Up Actions Taken Through 06/30/18:

Transition Management Program (2014 – ongoing). Gateway Health's Transition Management (TM) Program focuses on a subset of diagnoses, which includes but is not exclusive to diabetes, COPD, and asthma. Cases are created for members for the Transition Management team when they are authorized for inpatient admissions related to specific diagnoses. The Transition Management team receives cases for members who are admitted regardless of diagnosis if they have been identified as being at risk for an inpatient admission. Both of these referral sources could include members with diabetes, COPD, and asthma, in addition to other diagnosis. The Transition Management Case Manager initiates outreach during the inpatient stay at the earliest point when the member is able to engage. They follow the Eric Coleman Transition Management Guidelines triangle and maintain contact with the member through a series of interventions. The interventions focus on medications, appointments, home health, transportation, durable medical equipment, and care gaps.

Embedded Care Managers (November 2015 – ongoing). Gateway Health has embedded care managers located at a variety of high-volume PCP practices. Embedded CMs work with members living with COPD and/ or asthma to resolve barriers to medication compliance and represent an additional point of contact for members post-discharge should the TM team not be able to engage the members following a hospitalization for asthma or COPD.

Clinical Practice Guidelines (January 2016 – ongoing). Clinical Practice Guidelines are published on Gateway Health's website for providers to access and review. The Clinical Practice Guideline for the "Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease" was formed through the collaborative efforts of the National Heart, Lung, and Blood Institute, National Institutes of Health, USA and the World's Health Organization. "Guidelines for the Diagnosis and Management of Asthma" is a National Guideline developed by the National Heart, Lung and Blood Institute as part of the National Asthma Education and Prevention Program.

Gateway to Practitioner Excellence (GPE®) (January 2017 – ongoing). Asthma management using a validated asthma assessment tool is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Self-Management Educational Materials (Q1 2017 – ongoing). Asthma "sticker letters" were mailed on a rolling basis in 2017 and 2018 to members newly identified as having asthma. This mailing contains education and stickers to help members differentiate between their rescue and controller inhalers.

Omnichannel Asthma Medication Adherence and Education Program (May 2016 – ongoing). Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to increase asthma medication adherence among members and to educate on the difference between controller and rescue medications. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Interdisciplinary Asthma and COPD Workgroup (January 2017 – ongoing). The purpose of the workgroup is to identify asthma initiatives and barriers across departments, as well as examine asthma and COPD clinical quality trends.

Asthma Member Incentive (July 2017 – Ongoing). Members have the opportunity to receive an incentive for filling controller medications.

Care Management Staff Education (February 2018). Education is provided to member facing staff on asthma care.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40+ years) measure in 2019.

Future Actions Planned:

Reimbursement for Asthma Environmental Triggers (Q3 2018): Exploring reimbursement programs to provide in-home asthma management services.

Website and Social Media Promotion (Q4 2018): Exploring enhanced focus on asthma and COPD self-management tools and materials on social media platforms.

Self-Management Educational Materials (Q3 2018): Exploring the development of in-home asthma and COPD self-management educational materials for members.

Tobacco Cessation (Q3 2018). Tobacco cessation strategic plan created to reduce and prevent tobacco use focusing on provider outreach, member outreach, care management, behavioral health and physical health care coordination, coordination with DOH QuitLine, staff training and community partnerships.

Reference Number: GH 2017.22: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for HbA1c Poor Control (>9.0%)

Follow Up Actions Taken Through 06/30/18:

Gateway to Lifestyle Management® (GTLM) Diabetes program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence- based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care

Care Management Staff Training (ongoing). Staff received in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Diabetes Clinical Specialist, Pharmacist, Medical Director, or external partners as warranted.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Provider Newsletter Article (May 2015 – ongoing). Provider newsletter articles focusing on diabetes are mailed at least twice a year. Articles contain information for providers around available resources.

Member Newsletter (May 2015 – ongoing). Member newsletter articles focusing on diabetes are mailed at least twice a year. Newsletters contain information on evidenced based diabetes self-management methodologies.

Focused Provider Education and Practice Reference Guide (January 2016 – ongoing). The Gateway Health Provider Engagement Team visits participating providers in an ongoing outreach effort. During the visits, the team educates providers about the importance of diabetes care/testing and documentation at each visit. An overview of CDC

measure components is included in the 2017 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information of HEDIS coding, and tips to improve HEDIS scores.

Omnichannel Condition Management Education Program (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about diabetes screenings, including HbA1c and favorable values, as well as on the importance of regular screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program, members who obtain diabetes care are eligible to obtain incentives for HbA1c testing up to two times per year.

Gateway to Practitioner Excellence (GPE®) 2017 Program (January 2017 – ongoing). The HbA1c poor control measure is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (July 2017). As part of Gateway Health's provider webinar series, a discussion about best practices in diabetes care will occur in July 2017. The webinar includes an external speaker, as well as education on the provider incentive. Attendees are eligible for a CME credit and the webinar is recorded for future viewing at the health plan website.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

Direct EHR Feeds (Q4 2017). Secure EHR exchanges with select practices allow for the ongoing capture of medical record data relevant to clinical care and quality measures.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 41.12% for HbA1c Poor Control (>9.0%).

Future Actions Planned:

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.

Targeted Provider Outreach (Q3 2018). Send targeted lists of members with a history of poor HbA1c control or a history of not being tested to high volume, low-performing practices as a way to identify members for outreach.

Reference Number: GH 2017.23: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for HbA1c Control (<8.0%)

Follow Up Actions Taken Through 06/30/18:

Gateway to Lifestyle Management® (GTLM) Diabetes program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence- based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care

Care Management Staff Training (ongoing). Staff received in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Diabetes Clinical Specialist,

Pharmacist, Medical Director, or external partners as warranted.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Provider Newsletter Article (May 2015 – ongoing). Provider newsletter articles focusing on diabetes are mailed at least twice a year. Articles contain information for providers around available resources.

Member Newsletter (May 2015 – ongoing). Member newsletter articles focusing on diabetes are mailed at least twice a year. Newsletters contain information on evidenced based diabetes self-management methodologies.

Focused Provider Education and Practice Reference Guide (January 2016 – ongoing). The Gateway Health Provider Engagement Team visits participating providers in an ongoing outreach effort. During the visits, the team educates providers about the importance of diabetes care/testing and documentation at each visit. An overview of CDC measure components is included in the 2017 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information of HEDIS coding, and tips to improve HEDIS scores.

Omnichannel Condition Management Education Program (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about diabetes screenings, including HbA1c and favorable values, as well as on the importance of regular screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Provides live agent assistance to schedule appointment and resolve barriers/SDoH impediments to care.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program, members who obtain diabetes care are eligible to obtain incentives for HbA1c testing up to two times per year.

Gateway to Practitioner Excellence (GPE®) (January 2017 – ongoing). The HbA1c poor control measure is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (July 2017). As part of Gateway Health's provider webinar series, a discussion about best practices in diabetes care will occur in July 2017. The webinar includes an external speaker, as well as education on the provider incentive. Attendees are eligible for a CME credit and the webinar is record for future viewing.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

Direct EHR Feeds (Q4 2017). Secure EHR exchanges with select practices allow for the ongoing capture of medical record data relevant to clinical care and quality measures.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 48.87% for HbA1c Control (<8.0%).

Future Actions Planned:

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.
Targeted Provider Outreach (Q3 2018). Send targeted lists of members with a history of poor HbA1c control or a history of not being tested to high volume, low-performing practices as a way to identify members for outreach.

Reference Number: GH 2017.24: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Blood Pressure Controlled <140/90 mm Hg

Follow Up Actions Taken Through 06/30/18:
Gateway to Lifestyle Management® (GTLM) Diabetes program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence- based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care

Care Management Staff Training (ongoing). Staff received in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Diabetes Clinical Specialist, Pharmacist, Medical Director, or external partners as warranted.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Provider Newsletter Article (May 2015 – ongoing). Provider newsletter articles focusing on diabetes are mailed at least twice a year. Articles contain information for providers around available resources.

Member Newsletter (May 2015 – ongoing). Member newsletter articles focusing on diabetes are mailed at least twice a year. Newsletters contain information on evidenced based diabetes self-management methodologies.

Focused Provider Education and Practice Reference Guide (January 2016 – ongoing). The Gateway Health Provider Engagement Team visits participating providers in an ongoing outreach effort. During the visits, the team educates providers about the importance of diabetes care/testing and documentation at each visit. An overview of CDC measure components is included in the 2017 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information of HEDIS coding, and tips to improve HEDIS scores.

Omnichannel Condition Management Education Program (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about diabetes screenings, including HbA1c and favorable values, as well as on the importance of regular screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Provider Webinar (July 2017). As part of Gateway Health's provider webinar series, a discussion about best practices in diabetes care will occur in July 2017. The webinar includes an external speaker, as well as education on the provider

incentive. Attendees are eligible for a CME credit and the webinar is record for future viewing.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

Direct EHR Feeds (Q4 2017). Secure EHR exchanges with select practices allow for the ongoing capture of medical record data relevant to clinical care and quality measures.

American Heart Association & Gateway Health Partnership (June 2018 – ongoing). Partnership that is aimed at blood pressure management at the member and provider level. Through Check. Change. Control program members track their blood pressure readings. Target BP program allows providers to also track blood pressures and deliver evidenced based care to members. Enhanced outreach strategy in June 2018 for providers including the use of CTCs and program materials to better assist with registration and monitoring.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 60.61% for Blood Pressure Controlled <140/90 mm Hg.

Future Actions Planned:

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.

Targeted Provider Outreach (Q3 2018). Send targeted lists of members with a history of poor HbA1c control or a history of not being tested to high volume, low-performing practices as a way to identify members for outreach.

Reference Number: GH 2017.25: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Diabetes Short-Term Complications Admission Rate (Age 18-64 years & Total Age 18+ years) per 100,000 member months

Follow Up Actions Taken Through 06/30/18:

Gateway to Lifestyle Management® (GTLM) Diabetes program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence- based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care

Care Management Staff Training (ongoing). Staff receive in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Diabetes Clinical Specialist, Pharmacist, Medical Director, or external partners as warranted.

Transition Management Program (2014 – ongoing). Gateway Health's Transition Management (TM) Program focuses on a subset of diagnoses, which includes but is not exclusive to diabetes, COPD, and asthma. Cases are created for members for the Transition Management team when they are authorized for inpatient admissions related to specific diagnoses. The Transition Management team receives cases for members who are admitted regardless of diagnosis if they have been identified as being at risk for an inpatient admission. Both of these referral sources could include members with diabetes, COPD, and asthma, in addition to other diagnosis. The Transition Management Case Manager initiates outreach during the inpatient stay at the earliest point when the member is able to engage. They follow the Eric Coleman Transition Management Guidelines triangle and maintain contact with the member through a series of interventions. The interventions focus on medications, appointments, home health, transportation, durable medical equipment, and care gaps.

Embedded Care Managers (November 2015 – ongoing). Gateway Health has embedded care managers located at a variety of high-volume PCP practices. Embedded CMs work with members living with diabetes to resolve barriers to medication and self-care compliance and represent an additional point of contact for members post-discharge should the TM team not be able to engage the members following a hospitalization for diabetes.

Wellness Coaches (November 2016-ongoing). Wellness Coach CDE assists members to develop and improve self-management skills for diabetes. Education focuses on the prevention or delay of diabetes related complications while aiming to implement lifestyle changes for a healthier wellbeing.

Member Incentive (November 2016 – ongoing). Through Gateway Health's Goodness Rewards Program, members

who obtain diabetes care are eligible to obtain incentives for HbA1c testing up to two times per year.

Clinical Practice Guidelines (January 2016 – ongoing). The Clinical Practice Guideline "Standards of Medical Care in Diabetes-2018", produced by the American Diabetes Association, is published on Gateway Health's website for providers to access and review

Gateway to Practitioner Excellence (GPE®) (January 2017 – ongoing). Diabetes management is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for the Diabetes Short-Term Complications Admission Rate (Age 18-64 years & Total Age 18+ years) per 100,000 member months measure in 2019.

Future Actions Planned:

Care Management Staff Training (July 2018). Care Management will receive a focused training on "Diabetic Keto-Acidosis" (DKA). The goal of this program is to provide staff with an overview of diabetes, description of DKA, causes of DKA, signs and symptoms of DKA, what to do for DKA. Staff will also be supplied with a DKA Conversation Desk Aide.

Reference Number: GH 2017.26: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Statin Therapy for Patients With Diabetes: Statin Adherence 80%

Follow Up Actions Taken Through 06/30/18:

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan includes information on statin use, including the medication and date of the last fill, if applicable. The care plan is sent at least annually.

Embedded Pharmacists (Q2 2018 - ongoing). Gateway Health placed 2 pharmacists into physician practices that meet with patients face-to-face to discuss medications and adherence.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 59.59% for Statin Therapy for Patients with Diabetes: Statin Adherence 80%.

Future Actions Planned:

Point of Sale Pharmacy Intervention (Q3 2018 - ongoing). Point of Sale intervention within partnering pharmacies in the Pennsylvania Pharmacy Network for members to receive medication review and counseling.

Multi-Dose Packaging (August 2018 - ongoing). Members who are taking medications for multiple, chronic conditions have been offered a multi-dose packaging service that delivers the medication to the members' homes.

Pharmacist Outreach Program (Q4 2018 - ongoing). Gateway Health pharmacists will dedicate time to contact members using certain medications. The pharmacist will perform a barrier analysis and promote programs to assist the member with adherence.

Reference Number: GH 2017.27: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Controlling High Blood Pressure (Total Rate)

Follow Up Actions Taken Through 06/30/18:

Gateway to Lifestyle Management® (GTLM) Cardiac program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including cardiovascular disease. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence- based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care

Care Management Staff Training (ongoing). Staff received in-services on hypertension protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Clinical Specialists, Pharmacist, Medical Director, or external partners as warranted.

Provider Newsletter Article (May 2015 – ongoing). Provider newsletter articles focusing on hypertension are mailed at least twice a year. Articles contain information for providers around available resources.

Member Newsletter (May 2015 – ongoing). Member newsletter articles focusing on hypertension and/or cardiac disease are mailed at least twice a year. Newsletters contain information on evidenced based self-management methodologies.

Focused Provider Education and Practice Reference Guide (January 2016 – ongoing). The Gateway Health Provider Engagement Team visits participating providers in an ongoing outreach effort. During the visits, the team educates providers about the importance of hypertension care/screening and documentation at each visit. An overview of CBP measure is included in the 2017 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information of HEDIS coding, and tips to improve HEDIS scores.

Omnichannel Condition Management Education Program (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about hypertension, the importance of regular screenings, and favorable values. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Gateway to Practitioner Excellence (GPE®) 2017 Program (January 2017 – ongoing). The Controlling High Blood Pressure measure is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Member Incentive (January 2017 – ongoing). Through Gateway Health's Goodness Rewards Program, members who are diagnosed with hypertension and received blood pressure screenings are eligible to obtain incentives up to two times per year.

Direct EHR Feeds (Q4 2017). Secure EHR exchanges with select practices will allow for the ongoing capture of medical record data relevant to clinical care and quality measures.

American Heart Association & Gateway Health Partnership (June 2018 – ongoing). Partnership that is aimed at blood pressure management at the member and provider level. Through Check. Change. Control program members track their blood pressure readings. Target BP program allows providers to also track blood pressures and deliver evidenced based care to members. Enhanced outreach strategy in June 2018 for providers including the use of CTCs and program materials to better assist with registration and monitoring.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th

percentile benchmark of 56.93% for Controlling High Blood Pressure.

Future Actions Planned:

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.

Targeted Provider Outreach (Q3 2018). Send targeted lists of members with a history of uncontrolled hypertension or a no recent history of being tested to high volume, low-performing practices as a way to identify members for outreach.

Reference Number: GH 2017.28: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - [21-75 years (Male); 40 – 75years (Female); Total Rate]

Follow Up Actions Taken Through 06/30/18:

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

Diabetes Care Plan (August 2017 - ongoing). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan includes information on statin use, including the medication and date of the last fill, if applicable. The care plan is sent at least annually.

Embedded Pharmacists (Q2 2018 - ongoing). Gateway Health placed 2 pharmacists into physician practices that meet with patients face-to-face to discuss medications and adherence.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 61.47% for Statin Therapy for Patients with Cardiovascular Disease: Statin Adherence 80%.

Future Actions Planned:

Point of Sale Pharmacy Intervention (Q3 2018 - ongoing). Point of Sale intervention within partnering pharmacies in the Pennsylvania Pharmacy Network for members to receive medication review and counseling.

Multi-Dose Packaging (August 2018 - ongoing). Members who are taking medications for multiple, chronic conditions have been offered a multi-dose packaging service that delivers the medication to the members' homes.

Pharmacist Outreach Program (Q4 2018 - ongoing). Gateway Health pharmacists will dedicate time to contact members using certain medications. The pharmacist will perform a barrier analysis and promote programs to assist the member with adherence.

Reference Number: GH 2017.29: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Follow Up Actions Taken Through 06/30/18:

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Care Management Medication Reconciliation (January 2016 – ongoing). Care Management reinforces medication adherence to anti-psychotics during member interactions. Care Managers complete medication reconciliation with each member enrolled in Care Management. Care managers regularly discuss with the member the importance of medication adherence and work with members to resolve barriers to medication adherence.

Care Management Staff Education (April 2016 – ongoing). Care Manager education regarding LAIs in order to support conversations with members and providers regarding consideration of the use of LAIs when a member is non adherent to oral anti-psychotics.

Member Medication Adherence Mailer (November 2016 – ongoing). Quarterly mailings to members who are identified as having a PDC less than 85%. Letter provides education regarding the importance of medication compliance.

Provider Medication Adherence Mailer (November 2016 – ongoing). Quarterly mailing to prescribers of members who are non-adherent. Letter educates the provider that the member is at risk for non-adherence and encourages the provider to have a conversation with their patient regarding non-adherence. Enhanced in 2018 to include letters to prescribers.

Provider Webinar (October 2017). As part of Gateway Health's provider webinar series, there is a planned discussion around "Caring for the SMI patient in the Primary Care Setting" scheduled for October. The webinar will include an external speaker who will talk about best practices. Attendees are eligible for a CME credit and the webinar is record for future viewing.

Collaboration with the BH-MCOs (January 2018 - ongoing). Gateway Health works with members' BH-MCOs to provide information regarding non-adherence to medications, such as antipsychotics, as part of the integrated care plan. This allows BH-MCO Care Management staff to work with members individually to increase their medication adherence.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 75th percentile benchmark of 66.03% for Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Future Actions Planned:

Integrated Care Plan Member Letter (Q3 2018). Gateway Health will send a letter to members to notify them that an integrated care plan has been opened and how to interact with the health plan, prescribers and other providers.

Point of Sale Pharmacy Intervention (Q3 2018 - ongoing). Point of Sale intervention within partnering pharmacies in the Pennsylvania Pharmacy Network for members to receive medication review and counseling.

Provider Education (Q4 2018). A provider reference guide is being developed for both physical and behavioral health providers that will support integrated care to improve member outcomes.

Care Manager medication reference guide (Q4 2018). Gateway Health developed a tool that care managers will use to guide conversations with members and providers regarding the importance of medication adherence and talking points that support adherence.

Reference Number: GH 2017.30: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Metabolic Monitoring for Children and Adolescents on Antipsychotics: (Ages 6 - 11 years , 12-17, & Total rate)

Follow Up Actions Taken Through 06/30/18:

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Anti-psychotic Dashboard for Children in Substitute Care (2015 – ongoing). Dashboard which indicates open care gaps, including metabolic monitoring factors, for clinical testing indicated for appropriate use of antipsychotics for children in substitute care. Clinical review of the dashboard occurs with the member's BH MCO and OCYF office on a quarterly basis to ensure follow up and closure of the care gaps.

Prior Authorization Requirement (2016- on-going): All requests for Antipsychotics for children younger than 18 years of age require a prior authorization and will be screened for medical necessity and appropriateness which includes documentation of weight or BMI, blood pressure fasting glucose and fasting lipid panel to have occurred within the past year. Initial duration of approval is 3 months. For re-authorization to occur chart information supporting metabolic monitoring must be included. Re-authorizations are for a duration of 12 months.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark for the following Metabolic Monitoring for Children and Adolescents on Antipsychotics measures:

- 28.73% (6-11 years)

- 33.33% (12-17 years)
- 31.79% (Total)

Future Actions Planned:

Provider Education (Q4 2018). A provider reference guide is being developed for both physical and behavioral health providers that will support integrated care to improve member outcomes.

Care Manager medication reference guide (Q4 2018). Gateway Health developed a tool that care managers will use to guide conversations with members and providers regarding the importance of medication adherence and talking points that support adherence.

Reference Number: GH 2017.31: Of the four Adult CAHPS composite survey items reviewed, two decreased between 2017 (MY 2016) and 2016 (MY 2015). One item fell below the 2017 MMC weighted average.

Follow Up Actions Taken Through 06/30/18:

Member Services Quality Audits & Training (ongoing). Gateway Health conducts monthly audits to assess Member Services staff performance when speaking with both members and providers, allowing supervisors to share regular feedback on call performance and support the goal of performance excellence.

Provider Education (Prior to 2014 - ongoing). The Provider Newsletter continues to be a source to educate providers on a variety of topics, including appointment standards, effective communication strategies, and providing an excellent patient experience.

Dedicated Provider Engagement (April 2015 – ongoing). Gateway Health created the Provider Engagement Team to interact with providers on a regular basis with regard to quality performance issues. The building of this relationship helps to circumvent any misconceptions and misunderstandings that may occur as it relates to our membership and our business operations. The Provider Engagement team also works to encourage extended hours and participation in our Gateway to Practitioner Excellence programs.

IVR Flu Shot Survey (Q3 2017). Gateway Health conducted a flu shot survey to ask members if they have received (or intend to receive) a flu shot this year. The IVR call offered an opportunity to educate members who do not usually receive their flu shot.

Enhanced Website (Q3 2017). Gateway Health launched its new website designed to make it easier for members to access information about their health care benefits and find providers.

CAHPS Workgroup (Q3 2017 – ongoing). The CAHPS workgroup consists of collaboration between interdepartmental staff to identify opportunities to reduce member abrasion and improve the member experience. Workgroup tasks include conducting a barrier analysis and creating new interventions.

Customer Service Soft-Skills Training (Q3 2017 - ongoing). Customer Service Representatives receive soft-skills training during orientation and refresher trainings on an as needed basis. This intervention was enhanced in 2017.

IVR Off-Cycle Member Satisfaction Survey (Q4 2017). Gateway Health conducted an off-cycle member satisfaction survey, via IVR, to glean specific perception information from the Medicaid membership. We aimed to ascertain patterns and trends in member satisfaction and identify opportunities to intervene in areas where members expressed dissatisfaction.

IVR Off-Cycle Transfers to Customer Service (Q4 2017). Gateway Health conducted immediate intervention by Customer Service Representatives during the Off-Cycle calls to members who indicated dissatisfaction with certain areas of their health plan or health care. The purpose was to increase member satisfaction and ensure our members' needs were being met.

Custom Hold and Pre-queue Messages (Q3 2017 and Q2 2018) In an effort to share information with members, Gateway Health developed a new set of short messages to play on the phone line as members wait to speak with a Member Services Representative. These messages range in subject from reminders about vaccinations to making appointments with a doctor. Members are welcome to speak more about these topics once they reach a Member Services Representative.

Take Charge of Your Health (Q1 2018 – Q2 2018). Gateway Health's Community Engagement team presented Take Charge of Your Health to community members to empower them to come prepared to their health care appointments. By preparing themselves with the right tools, they will more likely be able to have all of their health care concerns addressed during their appointment

Enhanced Social Media Platform (Q3 2017 – ongoing). Gateway Health has expanded its social media presence to promote good health practices and educate the social media community on various health topics, including the flu vaccine and tobacco cessation.

Provider Tobacco Cessation Outreach (Q2 2018 – ongoing): During provider office visits, Provider Relations Representatives review tobacco cessation resources available to Gateway members to encourage tobacco cessation.

Provider Appointment and After-hours Access and Availability Audit (Ongoing). Annual survey used to evaluate Gateway Health's Provider Network appointment and after-hours access. Providers not meeting standards were asked to complete an action plan to improve appointment and after-hours access.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for all Adult CAHPS composite measures in 2019.

Future Actions Planned:

Provider Webinar (September 2018). As part of Gateway Health's webinar series an expert speaker will present best practices on tobacco cessation for adults to network providers.

Enhanced Automated Off-cycle survey (Q4 2018). The off-cycle survey will have additional outreach channels added. In addition to IVR, channels will include email and an online portal for members to complete the survey. Supplemental questions will also be added to the survey, allowing for an additional barrier analysis.

Enhanced Automated Flu Shot Survey (Q3 2018). Gateway Health will utilize member communication preferences to remind members that it is time for the annual flu vaccine. Channels will include IVR, Email, and SMS options.

IVR Off-Cycle Transfers to Customer Service (Q4 2018). Gateway Health will conduct immediate intervention by Customer Service Representatives during the Off-Cycle calls to members who are not highly satisfied with their health plan.

Outbound Getting Care, Care Management Calls (Q4 2018). Gateway Health Case Managers will outreach to members from the off-cycle survey who indicate they have had difficulty receiving needed care. CMs will assist members in making appointments, answering questions about their health and providing any additional help to our members.

Customer Service Focus Groups (Q3 2018). The focus groups will help identify concerns and opportunities so Gateway can support its Customer Service staff in providing excellent service to our members. Following the focus groups, an action plan will be developed and implemented throughout 2019.

Reference Number: GH 2017.32: Of the four Child CAHPS composite survey items reviewed, all fell below the 2017 MMC weighted average. Two items decreased in 2017 (MY 2016).

Follow Up Actions Taken Through 06/30/18:

Member Services Quality Audits & Training (ongoing). Gateway Health conducts monthly audits to assess Member Services staff performance when speaking with both members and providers, allowing supervisors to share regular feedback on call performance and support the goal of performance excellence.

Provider Education (Prior to 2014 - ongoing). The Provider Newsletter continues to be a source to educate providers on a variety of topics, including appointment standards, effective communication strategies, and providing an excellent patient experience.

Dedicated Provider Engagement (April 2015 – ongoing). Gateway Health created the Provider Engagement Team to interact with providers on a regular basis with regard to quality performance issues. The building of this relationship helps to circumvent any misconceptions and misunderstandings that may occur as it relates to our membership and our business operations. The Provider Engagement team also works to encourage extended hours and participation in our Gateway to Practitioner Excellence programs.

Enhanced Website (Q3 2017). Gateway Health launched its new website designed to make it easier for members to access information about their health care benefits and find providers.

CAHPS Workgroup (Q3 2017 – ongoing). The CAHPS workgroup consists of collaboration between interdepartmental staff to identify opportunities to reduce member abrasion and improve the member experience. Workgroup tasks include conducting a barrier analysis and creating new interventions.

Customer Service Soft-Skills Training (Q3 2017 - ongoing). Customer Service Representatives receive soft-skills training during orientation and refresher trainings on an as needed basis. This intervention was enhanced in 2017.

IVR Off-Cycle Member Satisfaction Survey (Q4 2017). Gateway Health conducted an off-cycle member satisfaction survey, via IVR, to glean specific perception information from the Medicaid membership. We aimed to ascertain patterns and trends in member satisfaction and identify opportunities to intervene in areas where members expressed

dissatisfaction. In order to effectively achieve this goal, data were returned at the member level, thus allowing for geographic analysis and/or other demographic influences.

IVR Off-Cycle Transfers to Customer Service (Q4 2017). Gateway Health conducted immediate intervention by Customer Service Representatives during the Off-Cycle calls to members who indicated dissatisfaction with certain areas of their health plan or health care. The purpose was to increase member satisfaction and ensure our members' needs were being met.

Custom Hold and Pre-queue Messages (Q3 2017 and Q2 2018) In an effort to share information with members, Gateway Health developed a new set of short messages to play on the phone line as members wait to speak with a Member Services Representative. These messages range in subject from reminders about vaccinations to making appointments with a doctor. Members are welcome to speak more about these topics once they reach a Member Services Representative.

Take Charge of Your Health (Q1 2018 – Q2 2018). Gateway Health's Community Engagement team presented Take Charge of Your Health to community members to empower them to come prepared to their health care appointments. By preparing themselves with the right tools, they will more likely be able to have all of their health care concerns addressed during their appointment

Enhanced Social Media Platform (Q3 2017 – ongoing). Gateway Health has expanded its social media presence to promote good health practices and educate the social media community on various health topics, including the flu vaccine and tobacco cessation.

Provider Appointment and After-hours Access and Availability Audit (Ongoing). Annual survey used to evaluate Gateway Health's Provider Network appointment and after-hours access. Providers not meeting standards were asked to complete an action plan to improve appointment and after-hours access.

The expected outcome/goals of these collective actions is to meet or exceed the 2018 MMC weighted average for all Child CAHPS composite measures in 2019.

Future Actions Planned:

Enhanced Automated Off-cycle survey (Q4 2018). The off-cycle survey will have additional outreach channels added. In addition to IVR, channels will include email and an online portal for members to complete the survey. Supplemental questions will also be added to the survey, allowing for an additional barrier analysis.

IVR Off-Cycle Transfers to Customer Service (Q4 2018). Gateway Health will conduct immediate intervention by Customer Service Representatives during the Off-Cycle calls to members who are not highly satisfied with their health plan.

Outbound Getting Care, Care Management Calls (Q4 2018). Gateway Health Case Managers will outreach to members from the off-cycle survey who indicate they have had difficulty receiving needed care. CMs will assist members in making appointments, answering questions about their health and providing any additional help to our members.

Customer Service Focus Groups (Q3 2018). The focus groups will help identify concerns and opportunities so Gateway can support its Customer Service staff in providing excellent service to our members. Following the focus groups, an action plan will be developed and implemented throughout 2019.

Root Cause Analysis and Action Plan

The 2018 EQR is the nineth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS 2017 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 2018 EQR, GH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures:

1. Medication Management for People With Asthma: 75% Total (Table 4.2)

GH submitted an initial Root Cause Analysis and Action Plan in July 2018.

Table 4.2: RCA and Action Plan: Medication Management for People With Asthma: 75% Total

Instructions: For each measure in grade categories D and F, complete this form identifying factors contributing to poor performance.

Managed Care Organization:	***Gateway Health***
Response Date:	**9/4/18**
Measure:	**Medication Management for People With Asthma: 75% Total**
Reason for Root Cause Analysis:	**Medication Management for People With Asthma: 75% Total did not statistically significantly change from 2016, but is statistically significantly lower/worse than the 2017 MMC weighted average**
Goal Statement: Please specify goal(s) for measure	**Gateway Health will meet or exceed the 2017 NCQA Quality Compass 90th percentile benchmark of 50%**
Part A: Identify Factors via Analysis	
Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year. • If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average. and/or • If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.	
Factor categories	**Factors** **Enter "N/A" if a factor category does not apply**
Policies? (e.g., data systems, delivery systems, provider facilities)	- Retail pharmacies may not capture the appropriate number of days covered on long-term controller (LTC) fills
Procedures? (e.g., payment/reimbursement, credentialing/collaboration)	- Members may receive samples or extra LTC medication from inpatient (IP), emergency department (ED), or primary care provider (PCP) visits - Identification of non-adherent members may occur too late to intervene during the year. - Medication fill may have a co-pay
People? (e.g., personnel, provider network, patients)	- Pharmacist may not be aware of poor compliance when member presents for a different medication fill - Member may not follow-up for care with PCP after ED or IP event for asthma - Provider unaware of medication compliance, except by member self-report. Self-report may be falsely elevated due to misunderstanding of LTC vs rescue medications. - Member may not understand the difference between LTC and rescue medications or the need to take LTC daily
Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials)	- Providers may not have streamlined asthma protocol for adherence screening

Other? (specify)	- Providers may not prescribe a spacer device which leads to medication delivery errors for children - Members may fall into the denominator with only seasonal LTC and rescue medication use

Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2018

Actions Include those planned as well as already implemented. Actions should address factors contributing to poor performance compared to MMC average and/or previous year. Add rows if needed.	**Which factor(s) are addressed by this action?**	**Implementation Date** Indicate start date (month, year). Duration and frequency (e.g., Ongoing, Quarterly)	**Monitoring Plan** How will you know if this action is working? What will you measure and how often?
Transition Management Program. Gateway Health's Transition Management (TM) Program focuses on a subset of diagnoses, including asthma. Through daily admission reports, members without an open Care Management case are referred to the TM Team; members with an open case are referred to their existing Case Manager who completes the TM process to ensure continuity of care. The TM Care Coordinator initiates outreach during the inpatient stay at the earliest point when the member is able to engage and maintains contact with the member through a series of interactions.	Member may not follow-up for care with PCP after IP event for asthma	2014-Ongoing	Effectiveness is monitored via participation rates in the program. Members who interact with the TM team are monitored to determine if additional emergency care has been required or if a PCP visit occurred post-discharge. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Embedded Care Managers. Gateway Health has embedded care managers located at a variety of high-volume PCP practices. Embedded CMs work with members living with asthma to resolve barriers to medication compliance and assist with care coordination.	Coordination of care	November 2015-Ongoing	Members identified as having asthma who interact with interact with the embedded Care Managers are monitored quarterly to determine if the percentage of days covered (PDC) is above 75%. The MMA HEDIS rate is monitored through monthly surveillance

			reporting to determine effectiveness.
Clinical Practice Guidelines. Clinical Practice Guidelines are published on Gateway Health's website for providers to access and review. "Guidelines for the Diagnosis and Management of Asthma" is a National Guideline developed by the National Heart, Lung and Blood Institute as part of the National Asthma Education and Prevention Program.	Providers may not have a streamlined asthma protocol	January 2016-Ongoing	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Gateway to Practitioner Excellence (GPE®). Asthma management is a component of Gateway Health's provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.	Providers may not be aware of member medication adherence	January 2017-Ongoing	Effectiveness is monitored via monthly provider dashboard reports. Individual practices are reviewed quarterly to assess performance improvements. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Self-Management Educational. Asthma "sticker letters" were mailed on a rolling basis to members newly identified as having asthma. This mailing contains education and stickers to help members differentiate between their rescue and controller inhalers.	Members may not understand the differences between rescue and controller medications or the need to take LTC daily	Prior to 2014-Ongoing	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Care Management Staff Education. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.	Members may not understand the differences between rescue and controller medications or the need to take LTC daily	February 2018	Post survey of knowledge transfer was completed among participants to determine effectiveness of the education.
Omnichannel Asthma Medication Adherence and Education Program. Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to increase asthma medication adherence among members and to educate on the difference between controller and rescue medications. Live agent assistance available to schedule appointments and resolve barriers/SDoH impediments to care.	Members may not understand the differences between rescue and controller medications or the need to take LTC daily	May 2016- Ongoing	Effectiveness is monitored on a monthly basis through key performance metrics including reach rates, expression of intent to see provider, rate of transfer to live agents for assistance, proportion of members who achieve

			compliance. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Interdisciplinary Asthma Workgroup. The purpose of the workgroup is to identify asthma initiatives and barriers across departments, as well as examine asthma clinical quality trends.	Addresses process improvements for data and systems barriers	January 2017-Ongoing	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Provider Webinar. The webinar included an external speaker who spoke about best practices for promoting medication adherence in a practice setting.	Providers may not have a streamlined asthma protocol	March 2017	Participant attendance was a measure of success for the webinar. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
ED Utilization Dashboard. Member level report on ED utilization sent to provider via Secure Messaging on a monthly basis.	Member may not follow-up for care with PCP after ED or IP event for asthma	May 2017- Ongoing	Dashboard utilization is monitored on an ongoing basis to determine the impact of the intervention. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Asthma Medication Adherence Dashboard. The provider dashboard now includes member level adherence information.	Providers may not be aware of member medication adherence	May 2018 - Ongoing	Dashboard utilization is monitored on a monthly basis to determine impact. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Retail Pharmacy Collaboration. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.	Member may not understand the difference between LTC and rescue medications or the need to take LTC daily	November 2017-Ongoing	Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.

Care Management Outreach. Care Managers outreach to members with low asthma medication compliance, or historically low compliance, on a quarterly basis.	Member may not understand the difference between LTC and rescue medications or the need to take LTC daily	October 2017-Ongoing	Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Embedded Pharmacist Collaboration. Pharmacists embedded at practices receive lists of members who are patients at the practice and are currently in the MMA denominator or have a high likelihood of falling into the denominator. The pharmacist uses the information in face-to-face discussions with members or heads of households for education and to assist with getting prescriptions filled.	Pharmacist may not be aware of poor compliance when member presents for a different medication fill	March 2018-Ongoing	Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Data Optimization. Automated report created to identify members for asthma intervention. This report now identifies members with exclusions like COPD.	Identification of non-adherent members may occur too late to intervene during the year.	February 2018-Ongoing	Utilized for intervention purposes only
Self-Management Educational Materials. Exploring the development of in-home asthma and COPD self-management educational materials for members.	Member may not understand the difference between LTC and rescue medications or the need to take LTC daily	Q3 2018	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Reimbursement for Asthma Environmental Triggers. Exploring reimbursement programs to provide in-home asthma management services.	Member may not understand the difference between LTC and rescue medications or the need to take LTC daily	Q3 2018	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Website and Social Media Promotion. Exploring enhanced focus on asthma and COPD self-management tools and materials on social media platforms.	Member may not understand the difference between LTC and rescue medications or the need to take LTC daily	Q4 2018	The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
Report on Days Covered. Identification of non-adherent members may occur too late to intervene during the year.	Retail pharmacies may not capture that appropriate number of days covered on long-term controller (LTC) fills	Q2 2019.	Evaluation of volume of claims correctly identified and reversed on a quarterly basis. The MMA HEDIS rate is monitored through monthly surveillance

			reporting to determine effectiveness.
Factors not addressed by Actions Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.	- Members may receive samples or extra LTC medication from IP, ED, or PCP visits - Co-pay may be member barrier - Providers may not prescribe spacer device which leads to medication delivery errors for children - Members may fall into the denominator with only seasonal LTC and rescue medication use		

V: 2018 Strengths and Opportunities for Improvement

The review of MCO's 2018 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

- GH 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 2018 (MY 2017) on the following measures:
    - Adults' Access to Preventive/Ambulatory Health Services (Age 20-44 years)
    - Adults' Access to Preventive/Ambulatory Health Services (Age 45-64 years)
    - Adults' Access to Preventive/Ambulatory Health Services (Age 65+ years)
    - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase
    - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
    - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase
    - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 7 days)
    - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
    - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)
    - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)
    - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
    - Prenatal Screening Positive for Depression
    - Statin Therapy for Patients With Diabetes: Received Statin Therapy
    - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
    - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate
    - Use of Opioids at High Dosage
    - Use of Opioids From Multiple Providers (4 or more pharmacies)

- The following strengths were noted in 2018 (MY 2017) for Adult and Child CAHPS survey items:
    - Of the four Adult CAHPS composite survey items reviewed, two items were above the 2018 MMC Weighted average. These same two items increased in 2018 (MY 2017) as compared to 2017 (MY 2016).
    - Of the four Child CAHPS composite survey items reviewed, two items were above the 2018 MMC Weighted average. These same two items increased in 2018 (MY 2017) as compared to 2017 (MY 2016).

Opportunities for Improvement

- For approximately 30 percent of reported measures the MCO's performance was statistically significantly below/worse than the MMC weighted average in 2018 (MY 2017) on the following measures:
    - Body Mass Index: Percentile (Age 3 - 11 years)
    - Body Mass Index: Percentile (Age 12-17 years)
    - Body Mass Index: Percentile (Total)
    - Counseling for Nutrition (Age 3-11 years)
    - Counseling for Nutrition (Age 12-17 years)
    - Counseling for Nutrition (Total)
    - Counseling for Physical Activity (Age 3-11 years)
    - Counseling for Physical Activity (Age 12-17 years)
    - Counseling for Physical Activity (Total)

- Lead Screening in Children (Age 2 years)
- Developmental Screening in the First Three Years of Life - 1 year
- Developmental Screening in the First Three Years of Life - 2 years
- Breast Cancer Screening (Age 50-74 years)
- Chlamydia Screening in Women (Age 16-20 years)
- Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
- Prenatal and Postpartum Care – Timeliness of Prenatal Care
- Prenatal Screening for Smoking
- Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
- Prenatal Screening for Environmental Tobacco Smoke Exposure
- Prenatal Screening for Depression
- Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
- Prenatal Screening for Alcohol use
- Prenatal Screening for Illicit drug use
- Prenatal Screening for Prescribed or over-the-counter drug use
- Prenatal Screening for Intimate partner violence
- Prenatal Screening for Behavioral Health Risk Assessment
- Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
- Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)
- Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)
- Medication Management for People with Asthma - 75% Compliance (Age 19-50 years)
- Medication Management for People with Asthma - 75% Compliance (Age 51-64 years)
- Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years)
- HbA1c Poor Control (>9.0%)
- HbA1c Control (<8.0%)
- HbA1c Good Control (<7.0%)
- Blood Pressure Controlled <140/90 mm Hg
- Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months
- Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months
- Statin Therapy for Patients With Diabetes: Statin Adherence 80%
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age)
- Controlling High Blood Pressure (Total Rate)
- Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months
- Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months
- Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female)
- Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate
- Use of Opioids from Multiple Providers (4 or more prescribers)
- Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)

- The following opportunities were noted in 2018 (MY 2017) for Adult and Child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, two items were below the 2018 MMC weighted average. These same two items decreased between 2018 (MY 2017) and 2017 (MY 2016).
  - Of the four Child CAHPS composite survey items reviewed, two items were below the 2018 MMC weighted average. These same two items decreased between 2018 (MY 2017) and 2017 (MY 2016).

Additional targeted opportunities for improvement are found in the MCO-specific HEDIS 2018 P4P Measure Matrix that follows.

P4P Measure Matrix Report Card 2018

The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." Nine measures are Healthcare Effectiveness Data Information Set (HEDIS®) measures, and the remaining two are PA specific measures. The matrix:

1. Compares the Managed Care Organization's (MCO's) own P4P measure performance over the two most recent reporting years (2018 and 2017); and
2. Compares the MCO's 2018 P4P measure rates to the 2018 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 2018 rate is statistically significantly above/better than the 2018 MMC weighted average and above/better than the MCO's 2017 rate.

The light green boxes (B) indicate either that the MCO's 2018 rate does not differ from the 2018 MMC weighted average and is above/better than 2017 or that the MCO's 2018 rate is statistically significantly above/better than the 2018 MMC weighted average but there is no change from the MCO's 2017 rate.

The yellow boxes (C) indicate that the MCO's 2018 rate is statistically significantly below/worse than the 2018 MMC weighted average and is above/better than the 2017 rate, or the MCO's 2018 rate does not differ from the 2018 MMC weighted average and there is no change from 2017, or the MCO's 2018 rate is statistically significantly above/better than the 2018 MMC weighted average but is lower/worse than the MCO's 2017 rate. No action is required although MCOs should identify continued opportunities for improvement.

The orange boxes (D) indicate either that the MCO's 2018 rate is statistically significantly lower/worse than the 2018 MMC weighted average and there is no change from 2017, or that the MCO's 2018 rate is not different than the 2018 MMC weighted average and is lower/worse than the MCO's 2017 rate. ***A root cause analysis and plan of action is therefore required.***

The red box (F) indicates that the MCO's 2018 rate is statistically significantly below/worse than the 2018 MMC weighted average and is below/worse than the MCO's 2017 rate. ***A root cause analysis and plan of action is therefore required.***

GH Key Points

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

Measures that in 2018 are statistically significantly above/better than 2017, and are statistically significantly above/better than the 2018 MMC weighted average are:

- Annual Dental Visit (Ages 2 – 20 years)
- Reducing Potentially Preventable Readmissions[4]

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

- No P4P measures fell into this comparison category.

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

Measures that in 2018 did not statistically significantly change from 2017, and are not statistically significantly different from the 2018 MMC weighted average are:

- Adolescent Well-Care Visits
- Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits
- Postpartum Care
- Well-Child Visits in the First 15 Months of Life, 6 or more
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

D - Root cause analysis and plan of action required

Measures that in 2018 did not statistically significantly change from 2017, but are statistically significantly lower/worse than the 2018 MMC weighted average are:

- Comprehensive Diabetes Care: HbA1c Poor Control[5]
- Controlling High Blood Pressure
- Prenatal Care in the First Trimester
- Medication Management for People With Asthma: 75% Total

F Root cause analysis and plan of action required

- No P4P measures fell into this comparison category.

[4] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
[5] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance

Figure 5.1: P4P Measure Matrix

		Medicaid Managed Care Weighted Average Statistical Significance Comparison		
Year to Year Statistical Significance Comparison	Trend	Below/Worse than Average	Average	Above/Better than Average
	⬆	**C**	**B**	**A** Annual Dental Visit (Ages 2 20 years) Reducing Potentially Preventable Readmissions[6]
	No Change	**D** Comprehensive Diabetes Care: HbA1c Poor Control[7] Controlling High Blood Pressure Prenatal Care in the First Trimester Medication Management for People With Asthma: 75% Total	**C** Adolescent Well-Care Visits Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Postpartum Care Well-Child Visits in the First 15 Months of Life, 6 or more Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**B**
	⬇	**F**	**D**	**C**

[6] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
[7] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance

P4P performance measure rates for, 2015, 2016, 2017 and 2018 as applicable are displayed in Figure 5.2. 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.

Table 5.1: P4P Measure Rates

Quality Performance Measure HEDIS®	HEDIS® 2015 Rate	HEDIS® 2016 Rate	HEDIS® 2017 Rate	HEDIS® 2018 Rate	HEDIS® 2018 MMC WA
Adolescent Well Care Visits (Age 12 21 Years)	58.2% =	56.5% =	58.4% =	61.6% =	62.0%
Comprehensive Diabetes Care HbA1c Poor Control[8]	42.5% =	48.9% ▲	43.1% ▼	39.9% =	34.7%
Controlling High Blood Pressure	50.1% =	34.1% ▼	56.3% ▲	52.3% =	64.3%
Prenatal Care in the First Trimester	80.0% =	78.5% =	86.2% ▲	81.5% =	86.6%
Postpartum Care		48.1% =	63.4% ▲	66.2% =	67.7%
Annual Dental Visits (Ages 2 20 years)[9]	53.7% ▲	55.8% ▲	56.4% ▲	63.7% ▲	63.0%
Well Child Visits in the First 15 Months of Life, 6 or more		71.3% ▲	66.6% =	68.4% =	69.9%
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		74.1% NA	78.1% =	76.4% =	77.6%
Medication Management for People with Asthma: 75% Total		38.7% NA	37.7% =	38.0% =	44.5%
Quality Performance Measure PA	**2015 Rate**	**2016 Rate**	**2017 Rate**	**2018 Rate**	**2018 MMC WA**
Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received[10]	55.2% ▼	65.0% ▲	73.2% ▲	73.0% =	70.6%
Reducing Potentially Preventable Readmissions[11]	8.3% =	9.1% ▲	12.1% ▲	9.5% ▼	10.3%

[8] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[9] In 2015, the Annual Dental Visit age range was 2-21 years
[10] Frequency of Ongoing Prenatal Care was collected as a first-year PA PM for 2018. Prior to 2018, this measure was collected and validated via HEDIS®.
[11] Lower rates for Reducing Potentially Preventable Readmissions indicate better performance

VI: Summary of Activities

Structure and Operations Standards

- GH was found to be fully compliant on Subparts C, D, and F. Compliance review findings for GH from RY 2017, RY 2016 and RY 2015 were used to make the determinations.

Performance Improvement Projects

- As previously noted, GH's Dental and Readmission PIP proposal submissions were validated. The MCO received feedback and subsequent information related to these activities from IPRO.

Performance Measures

- GH reported all HEDIS, PA-Specific and CAHPS Survey performance measures in 2018 for which the MCO had a sufficient denominator.

2017 Opportunities for Improvement MCO Response

- GH provided a response to the opportunities for improvement issued in the 2017 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2017 P4P Measure Matrix receiving either "D" or "F" ratings

2018 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement have been noted for GH in 2018. A response will be required by the MCO for the noted opportunities for improvement in 2019.