Commonwealth Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

2018 External Quality Review Report
Health Partners Plans

Final Report
April 2019

IPRO
Better healthcare,
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 Health Partners Plans' (HPP's) compliance with structure and operations standards. The review is based on information derived from reviews of the MCO that were conducted within the past three years.

Methodology and Format

The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2017, and the most recent NCQA Accreditation Survey for HPP, 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, 79 items were evaluated and 47 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: HPP Compliance with Enrollee Rights and Protections Regulations

ENROLLEE RIGHTS AND PROTECTIONS REGULATIONS		
Subpart C: Categories	**Compliance**	**Comments**
Enrollee Rights	Compliant	7 items were crosswalked to this category. The MCO was evaluated against 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.

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

Subpart D: Quality Assessment and Performance Improvement 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 HPP enrollees. [42 C.F.R. §438.206 (a)]

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

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

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REGULATIONS		
Subpart D: Categories	**Compliance**	**Comments**
Access Standards		
Availability of Services	Compliant	14 items were crosswalked to this category. The MCO was evaluated against 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 12 items and was compliant on 12 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 based on RY 2017.

HPP was evaluated against 50 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on all 50 items. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, HPP 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: HPP Compliance with Federal and State Grievance System Standards

FEDERAL AND STATE GRIEVANCE SYSTEM STANDARDS		
Subpart F: Categories	**Compliance**	**Comments**
General Requirements	Compliant	8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 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

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

Accreditation Status

HPP underwent an NCQA Accreditation Survey effective through September 12, 2021 and was granted an Accreditation Status of Excellent.

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, HPP received full credit for review element 1 - Project Topic and Topic Relevance. HPP submitted an appropriate title of the PIP along with the outlined timeline for the project. HPP provided a detailed rational for topic selection including member specific HEDIS data for annual dental visits, and a literature review identifying barriers in dental care on a national and state level. HPP addressed a wide variety of contributors to the health for their members by promoting improved coordination of care, initiation of early dental care and fluoride varnish and education on oral hygiene. Poor pediatric oral care is a chronic condition and this PIP has the potential to have a great impact on a large number of members and services provided.

HPP received partial credit for review element 2 – Study Question. In HPP's Aim statement they stated that the baseline rate for HEDIS Annual Dental Visits is reported as 65.89% and the goal is the 90th percentile. It was not clear what the goal percentile for HEDIS 2017 is based on. It is preferable to identify a goal that is already known as opposed to setting one based on the next year's HEDIS results, since it is unknown and the goal may be too high or too low.

HPP received full credit for review elements 3 – 6 which include elements assessing study variable, methods and procedures. HPP stated they will be utilizing core performance measures adopted from CMS, and after feedback, HPP included the denominator and numerator specifications for all outcome and process measures related to the CMS measures. HPP clearly defined all Medicaid enrollees it will target in their first performance indicator, and after consultation, defined the enrollees targeted for the other performance indicators. HPP also clarified that data will be collected for the entire population, with no sampling used. Upon review, HPP clearly identified all data sources, the method to ensure data validity, whether data collection is automated or manual, and details on their data analysis plan. The MCO stated that the measures will be derived from claims data, encounter data, and eligibility data. For the HEDIS Annual Dental Visit measure, HPP noted they will be using a HEDIS certified software vendor to produce rates. For non-HEDIS measures, HPP stated that the Healthcare Economics team uses queries developed to evaluate the measures. The MCO noted that all data obtained from their dental vendor will undergo extensive quality assurance to make sure that all data are obtained and collected for analysis.

HPP received partial credit for review element 7 - Improvement Strategies (Interventions). A Barrier analysis was done by the MCO through discussions with case management teams, and a literature review was reported. The MCO included a diverse group of interventions and plans in order to help improve care for their members. Many of the interventions were initiated late 2016 and one intervention did not have a start date listed in the intervention table. It was recommended that interventions be initiated as soon as possible to have an impact on rates, and that interventions have associated process measures to track effectiveness of interventions on PIP goals.

HPP received partial credit for review elements 8 and 9. In the 2017 Interim Update, performance measure numerators and denominators were reported incorrectly (e.g. the numerator was larger than the denominator). Additionally the outcome table did not include all performance measures. The Project Year 3 Update included all applicable performance measure data across measurement periods, but it was unclear what interventions the process measures were addressing.

Reducing Potentially Preventable Hospital Admissions, Readmissions and ED visits

For the Readmission PIP, HPP received full credit for all review elements. HPP presented a coherent rationale describing the relevance of the PIP Topic to their plan membership, using data to support their claims. The MCO included findings in the literature to support the topic selection rationale. HPP incorporated past experience with this topic area, as well as current efforts to address Potentially Preventable Initial Admissions, Readmissions and Potentially Avoidable ED Utilization. The MCO's Aim statement included aims and sub-aims, and identified plan-specific goals relating to ED visits, potentially avoidable hospitalizations, and readmission; after resubmission all goals were addressed.

After consultation HPP adequately specified each performance and process measure and included the eligible population along with definitions of the numerators and denominators. The MCO identified "at risk" member

populations to be examined. HPP then noted that data will be collected on the universe of members with the given intervention (no sampling).

Data for performance measures was derived from claims data as well as HPP's pharmacy data. HPP identified sources of data for all DHS-defined performance measures and MCO-developed performance and process measures. HPP advised that data will be based on a combination of claims (automated) and manually collected data, such as missed appointments, adherence to COPD meds, etc. After HPP was requested to clarify, the MCO described the internal monitoring systems, method for data collection for all performance and process measures, data analysis plan, and timeline for data collection, analysis and reporting.

HPP conducted a barrier analysis to identify barriers to improvement. Ongoing initiatives and detailed interventions were included in the proposal's background information. Upon review, HPP included at least one new or enhanced intervention for each initiative and noted any new interventions or changes to existing interventions, as well as the date implemented. As suggested, HPP retained those interventions specifically developed, tailored and implemented to address barriers to reducing potentially preventable admission, readmission and ED visits and increase coordination between PH-MCOs and BH-MCOs.

HPP received partial credit for review elements 8 and 9. In the 2017 Interim Update, for some measures, numerators and denominators appeared to be reversed. Review also identified that percentages were sometimes reported incorrectly, and that for several measures the goal was missing. It was also noted that baseline rates for five ICP measures did not match baseline rates provided to MCO, and that some reported ICP rates had not been released. In the Project Year 3 Update, the references to measurement periods in the results table were unclear. Additionally, Reducing Potentially Preventable Readmissions (RPR) was not included. This is a core PIP measure that replaced the original PCR core PIP measure per DHS in 2016. RPR was included by the MCO in subsequent PIP submissions, but not in the Project Year 3 Update, in which the MCO reverted back to PCR.

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

Table 2.3: HPP 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)	Partial	Full
3. Study Variables (Performance Indicators)	Full	Full
4. & 5. Identified Study Population and Sampling Methods	Full	Full
6. Data Collection Procedures	Full	Full
7. Improvement Strategies (Interventions)	Partial	Full
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:
    - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17) – 6.7 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)	6,433	6,152	**95.6%**	95.1%	96.1%	95.4%	n.s.	96.0%	n.s.	>= 25th and < 50th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 25 months 6 years)	26,975	23,772	**88.1%**	87.7%	88.5%	87.3%	+	88.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 7 11 years)	21,930	20,307	**92.6%**	92.3%	92.9%	92.4%	n.s.	92.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Children and Adolescents' Access to PCPs (Age 12 19 years)	27,726	25,028	**90.3%**	89.9%	90.6%	89.9%	n.s.	91.5%	-	>= 50th and < 75th percentile

HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 20 44 years)	69,340	52,186	**75.3%**	74.9%	75.6%	77.2%	-	77.8%	-	>= 25th and < 50th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 45 64 years)	39,402	34,270	**87.0%**	86.6%	87.3%	88.9%	-	86.1%	+	>= 50th and < 75th percentile
HEDIS	Adults' Access to Preventive/ Ambulatory Health Services (Age 65+ years)	1,319	1,115	**84.5%**	82.5%	86.5%	86.3%	n.s.	83.0%	n.s.	>= 25th and < 50th percentile
HEDIS	Adult BMI Assessment (Age 18 74 years)	106	99	**93.4%**	88.2%	98.6%	94.1%	n.s.	91.9%	n.s.	>= 75th and < 90th percentile
PA EQR	Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)	5	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)	71	56	**78.9%**	68.7%	89.1%	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)	109	83	**76.1%**	67.7%	84.6%	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)	185	143	**77.3%**	71.0%	83.6%	NA	NA	70.6%	+	NA

Well-Care Visits and Immunizations

Strengths are identified for the following Well-Care Visits and Immunizations performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Age 3 to 6 years) – 5.0 percentage points
  - Childhood Immunizations Status (Combination 2) – 6.2 percentage points
  - Childhood Immunizations Status (Combination 3) – 6.7 percentage points
  - Counseling for Nutrition (Age 3-11 years) – 8.2 percentage points
  - Counseling for Nutrition (Total) – 8.0 percentage points

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

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)	354	242	**68.4%**	63.4%	73.3%	69.9%	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)	270	223	**82.6%**	77.9%	87.3%	80.2%	n.s.	77.6%	+	>= 75th and < 90th percentile
HEDIS	Childhood Immunizations Status (Combination 2)	411	338	**82.2%**	78.4%	86.1%	81.6%	n.s.	76.1%	+	>= 90th percentile
HEDIS	Childhood Immunizations Status (Combination 3)	411	330	**80.3%**	76.3%	84.3%	79.0%	n.s.	73.6%	+	>= 90th percentile
HEDIS	Adolescent Well Care Visits (Age 12 to 21 Years)	388	253	**65.2%**	60.3%	70.1%	62.0%	n.s.	62.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Body Mass Index: Percentile (Age 3 11 years)	242	194	**80.2%**	74.9%	85.4%	81.9%	n.s.	78.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Age 12 17 years)	129	100	**77.5%**	69.9%	85.1%	80.2%	n.s.	76.3%	n.s.	>= 50th and < 75th percentile
HEDIS	Body Mass Index: Percentile (Total)	371	294	**79.2%**	75.0%	83.5%	81.4%	n.s.	77.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Nutrition (Age 3 11 years)	242	200	**82.6%**	77.7%	87.6%	78.7%	n.s.	74.4%	+	>= 75th and < 90th percentile
HEDIS	Counseling for Nutrition (Age 12 17 years)	129	102	**79.1%**	71.7%	86.5%	83.2%	n.s.	71.7%	n.s.	>= 75th and < 90th percentile
HEDIS	Counseling for Nutrition (Total)	371	302	**81.4%**	77.3%	85.5%	80.1%	n.s.	73.4%	+	>= 75th and < 90th percentile

HEDIS	Counseling for Physical Activity (Age 3 11 years)	242	150	**62.0%**	55.7%	68.3%	61.7%	n.s.	65.4%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Age 12 17 years)	129	93	**72.1%**	64.0%	80.2%	75.6%	n.s.	68.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Counseling for Physical Activity (Total)	371	243	**65.5%**	60.5%	70.5%	66.2%	n.s.	66.5%	n.s.	>= 50th and < 75th percentile
HEDIS	Immunization for Adolescents (Combo 1)	411	362	**88.1%**	84.8%	91.3%	87.4%	n.s.	85.9%	n.s.	>= 75th and < 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 – 13.5 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 16.7 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase – 13.1 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 19.4 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:
  - Developmental Screening in the First Three Years of Life - Total – 9.8 percentage points
  - Developmental Screening in the First Three Years of Life - 1 year – 12.8 percentage points
  - Developmental Screening in the First Three Years of Life - 2 years – 6.8 percentage points
  - Developmental Screening in the First Three Years of Life - 3 years – 10.2 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) – 15.3 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) – 17.9 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 AOD abuse or dependence, follow-up within 7 days) – 3.3 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 AOD abuse or dependence, follow-up within 30 days) – 3.6 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	340	**82.7%**	78.9%	86.5%	77.4%	n.s.	80.3%	n.s.	>= 75th and < 90th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Initiation Phase	1,382	746	**54.0%**	51.3%	56.6%	49.0%	+	40.5%	+	>= 75th and < 90th percentile
HEDIS	Follow up Care for Children Prescribed ADHD Medication Continuation Phase	239	148	**61.9%**	55.6%	68.3%	55.3%	n.s.	45.2%	+	>= 50th and < 75th percentile
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase	1,382	750	**54.3%**	51.6%	56.9%	49.3%	+	41.2%	+	NA
PA EQR	Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase	218	148	**67.9%**	61.5%	74.3%	59.1%	n.s.	48.5%	+	NA
PA EQR	Developmental Screening in the First Three Years of Life Total	16,787	7,699	**45.9%**	45.1%	46.6%	40.1%	+	55.7%	-	NA

PA EQR	Developmental Screening in the First Three Years of Life 1 year	5,592	2,092	**37.4%**	36.1%	38.7%	34.8%	+	50.3%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 2 years	5,795	3,032	**52.3%**	51.0%	53.6%	47.1%	+	59.1%	-	NA
PA EQR	Developmental Screening in the First Three Years of Life 3 years	5,400	2,575	**47.7%**	46.3%	49.0%	38.4%	+	57.9%	-	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)	85	17	**20.0%**	10.9%	29.1%	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)	85	27	**31.8%**	21.3%	42.3%	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)	2,373	285	**12.0%**	10.7%	13.3%	NA	NA	15.3%	-	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 AOD abuse or dependence, follow up within 30 days)	2,373	465	**19.6%**	18.0%	21.2%	NA	NA	23.2%	-	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)	5	0	**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)	5	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

Strengths are identified for the following Dental Care for Children and Adults performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
    - Annual Dental Visit (Age 2–20 years) – 3.5 percentage points
    -

No opportunities for improvement are identified.

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)	89,973	59,838	**66.5%**	66.2%	66.8%	64.5%	+	63.0%	+	>= 75th and < 90th percentile
PA EQR	Annual Dental Visits for Members with Developmental Disabilities (Age 2 20years)	4,350	2,816	**64.7%**	63.3%	66.2%	61.3%	+	62.5%	+	NA
PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk	13,822	3,292	**23.8%**	23.1%	24.5%	27.4%	-	24.4%	n.s.	NA
PA EQR	Dental Sealants for 6 9 Year Of Children At Elevated Caries Risk (Dental Enhanced)	14,695	3,695	**25.1%**	24.4%	25.8%	23.5%	+	25.3%	n.s.	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:
  - Breast Cancer Screening (Age 50-74 years) – 4.9 percentage points
  - Cervical Cancer Screening (Age 21-64 years) – 8.3 percentage points
  - Chlamydia Screening in Women (Total) – 14.7 percentage points
  - Chlamydia Screening in Women (Age 16-20 years) – 18.1 percentage points
  - Chlamydia Screening in Women (Age 21-24 years) – 10.8 percentage points
  - Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44) – 4.9 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20) – 8.7 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15 to 20) – 10.4 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20) – 4.9 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20) – 5.2 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20) – 3.6 percentage points
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44) – 12.6 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44) – 3.6 percentage points

No opportunities for improvement are identified.

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)	10,735	6,794	**63.3%**	62.4%	64.2%	66.1%	-	58.4%	+	>= 50th and < 75th percentile
HEDIS	Cervical Cancer Screening (Age 21 64 years)	366	253	**69.1%**	64.3%	74.0%	67.6%	n.s.	60.8%	+	>= 75th and < 90th percentile
HEDIS	Chlamydia Screening in Women (Total)	10,909	8,209	**75.2%**	74.4%	76.1%	75.9%	n.s.	60.6%	+	>= 90th percentile
HEDIS	Chlamydia Screening in Women (Age 16 20 years)	5,457	4,091	**75.0%**	73.8%	76.1%	75.3%	n.s.	56.9%	+	>= 90th percentile
HEDIS	Chlamydia Screening in Women (Age 21 24 years)	5,452	4,118	**75.5%**	74.4%	76.7%	76.4%	n.s.	64.8%	+	>= 90th percentile
HEDIS	Non Recommended Cervical Cancer Screening in Adolescent Females	9,432	51	**0.5%**	0.4%	0.7%	0.7%	n.s.	0.9%	-	>= 75th and < 90th percentile
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)	11,264	3,137	**27.8%**	27.0%	28.7%	NA	NA	28.5%	n.s.	NA

PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)	11,264	641	**5.7%**	5.3%	6.1%	NA	NA	5.0%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)	39,923	11,900	**29.8%**	29.4%	30.3%	NA	NA	25.0%	+	NA
PA EQR	Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)	39,923	2,985	**7.5%**	7.2%	7.7%	NA	NA	6.4%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 15 to 20)	515	84	**16.3%**	13.0%	19.6%	NA	NA	7.6%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 15 to 20)	515	248	**48.2%**	43.7%	52.6%	NA	NA	37.7%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 15 to 20)	515	42	**8.2%**	5.7%	10.6%	NA	NA	3.3%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 15 to 20)	515	97	**18.8%**	15.4%	22.3%	NA	NA	13.7%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 21 to 44)	4,445	771	**17.3%**	16.2%	18.5%	NA	NA	13.8%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 21 to 44)	4,445	2,307	**51.9%**	50.4%	53.4%	NA	NA	39.3%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 3 days (Ages 21 to 44)	4,445	202	**4.5%**	3.9%	5.2%	NA	NA	2.1%	+	NA
PA EQR	Contraceptive Care for Postpartum Women: LARC 60 days (Ages 21 to 44)	4,445	632	**14.2%**	13.2%	15.3%	NA	NA	10.6%	+	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:
  - ≥ 81% of Expected Prenatal Care Visits Received – 6.3 percentage points
  - Prenatal and Postpartum Care – Postpartum Care – 6.7 percentage points
  - Prenatal Screening for Smoking – 12.0 percentage points
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 11.2 percentage points
  - Prenatal Screening for Environmental Tobacco Smoke Exposure – 26.2 percentage points
  - Prenatal Smoking Cessation – 11.8 percentage points
  - Prenatal Screening for Depression – 20.6 percentage points
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 19.6 percentage points
  - Postpartum Screening for Depression – 6.0 percentage points
  - Prenatal Screening for Alcohol use – 15.5 percentage points
  - Prenatal Screening for Illicit drug use – 14.8 percentage points
  - Prenatal Screening for Prescribed or over-the-counter drug use – 11.5 percentage points
  - Prenatal Screening for Intimate partner violence – 21.3 percentage points
  - Prenatal Screening for Behavioral Health Risk Assessment – 25.4 percentage points
  - Elective Delivery – 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:
  - Prenatal Counseling for Smoking – 13.2 percentage points
  - Prenatal Screening Positive for Depression – 4.6 percentage points
  - Postpartum Screening Positive for Depression – 5.6 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	358	**87.1%**	83.7%	90.5%	84.8%	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	316	**76.9%**	72.7%	81.1%	78.1%	n.s.	70.6%	+	NA
HEDIS	Prenatal and Postpartum Care Timeliness of Prenatal Care	411	367	**89.3%**	86.2%	92.4%	89.9%	n.s.	86.6%	n.s.	>= 75th and < 90th percentile
HEDIS	Prenatal and Postpartum Care Postpartum Care	411	306	**74.5%**	70.1%	78.8%	75.3%	n.s.	67.7%	+	>= 90th percentile
PA EQR	Prenatal Screening for Smoking	407	386	**94.8%**	92.6%	97.1%	88.7%	+	82.8%	+	NA
PA EQR	Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)	407	380	**93.4%**	90.8%	95.9%	86.0%	+	82.2%	+	NA
PA EQR	Prenatal Screening for Environmental Tobacco Smoke Exposure	407	296	**72.7%**	68.3%	77.2%	59.1%	+	46.5%	+	NA
PA EQR	Prenatal Counseling for Smoking	70	51	**72.9%**	61.7%	84.0%	76.3%	n.s.	86.1%	-	NA
PA EQR	Prenatal Counseling for Environmental Tobacco Smoke Exposure	52	42	**80.8%**	69.1%	92.4%	NA	NA	78.5%	n.s.	NA
PA EQR	Prenatal Smoking Cessation	69	15	**21.7%**	11.3%	32.2%	10.5%	n.s.	10.0%	+	NA
PA EQR	Prenatal Screening for Depression	407	379	**93.1%**	90.5%	95.7%	84.2%	+	72.5%	+	NA
PA EQR	Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)	407	345	**84.8%**	81.2%	88.4%	77.1%	+	65.2%	+	NA
PA EQR	Prenatal Screening Positive for Depression	379	59	**15.6%**	11.8%	19.3%	11.7%	n.s.	20.2%	-	NA
PA EQR	Prental Counseling for Depression	59	50	**84.7%**	74.7%	94.8%	85.0%	n.s.	73.7%	n.s.	NA
PA EQR	Postpartum Screening for Depression	340	270	**79.4%**	75.0%	83.9%	67.3%	+	73.4%	+	NA
PA EQR	Postpartum Screening Positive for Depression	270	26	**9.6%**	5.9%	13.3%	6.2%	n.s.	15.2%	-	NA
PA EQR	Postpartum Counseling for Depression	26	25	**NA**	NA	NA	NA	NA	87.3%	NA	NA
PA EQR	Cesarean Rate for Nulliparous Singleton Vertex	1,227	284	**23.1%**	20.7%	25.5%	21.7%	n.s.	23.6%	n.s.	NA
PA EQR	Percent of Live Births Weighing Less than 2,500 Grams (Positive)	6,026	605	**10.0%**	9.3%	10.8%	9.8%	n.s.	9.9%	n.s.	NA
PA EQR	Prenatal Screening for Alcohol use	407	385	**94.6%**	92.3%	96.9%	88.4%	+	79.1%	+	NA
PA EQR	Prenatal Screening for Illicit drug use	407	382	**93.9%**	91.4%	96.3%	89.2%	+	79.0%	+	NA
PA EQR	Prenatal Screening for Prescribed or over the counter drug use	407	387	**95.1%**	92.9%	97.3%	91.6%	+	83.6%	+	NA
PA EQR	Prenatal Screening for Intimate partner violence	407	314	**77.1%**	72.9%	81.4%	70.9%	+	55.9%	+	NA
PA EQR	Prenatal Screening for Behavioral Health Risk Assessment	407	284	**69.8%**	65.2%	74.4%	58.6%	+	44.3%	+	NA
PA EQR	Elective Delivery	1,460	22	**1.5%**	0.8%	2.2%	8.9%	-	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

Strengths are identified for the following Respiratory Conditions performance measures.

- The following rates are statistically significantly above/better than the 2018 MMC weighted average:
  - Appropriate Treatment for Children with Upper Respiratory Infection – 4.3 percentage points
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 8.2 percentage points
  - Pharmacotherapy Management of COPD Exacerbation: Bronchodilator – 5.6 percentage points
  - Asthma Medication Ratio (51-64 years) – 3.6 percentage points
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months – 23.46 admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months – 23.70 admissions per 100,000 member months

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2018 MMC weighted average:
  - Medication Management for People with Asthma - 75% Compliance (Age 5-11 years) – 8.9 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 12-18 years) – 9.9 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Age 19-50 years) – 4.1 percentage points
  - Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years) – 5.0 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	2,141	1,755	**82.0%**	80.3%	83.6%	78.1%	+	82.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Appropriate Treatment for Children with Upper Respiratory Infection	4,606	212	**95.4%**	94.8%	96.0%	95.0%	n.s.	91.1%	+	>= 75th and < 90th percentile
HEDIS	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	1,427	790	**44.6%**	42.0%	47.3%	40.6%	+	36.4%	+	>= 75th and < 90th percentile
HEDIS	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	851	247	**29.0%**	25.9%	32.1%	32.8%	n.s.	29.6%	n.s.	>= 25th and < 50th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid	1,193	867	**72.7%**	70.1%	75.2%	77.7%	-	74.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Pharmacotherapy Management of COPD Exacerbation: Bronchodilator	1,193	1,083	**90.8%**	89.1%	92.5%	90.7%	n.s.	85.2%	+	>= 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 5 11 years)	1,637	478	**29.2%**	27.0%	31.4%	26.6%	n.s.	38.1%	-	>= 25th and < 50th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 12 18 years)	1,024	309	**30.2%**	27.3%	33.0%	29.8%	n.s.	40.0%	-	>= 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 19 50 years)	1,851	794	**42.9%**	40.6%	45.2%	41.9%	n.s.	47.0%	-	>= 50th and < 75th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Age 51 64 years)	837	528	**63.1%**	59.8%	66.4%	61.3%	n.s.	61.8%	n.s.	>= 75th and < 90th percentile
HEDIS	Medication Management for People with Asthma 75% Compliance (Total Age 5 64 years)	5,349	2,109	**39.4%**	38.1%	40.7%	37.3%	+	44.5%	-	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (5 11 years)	1,773	1,302	**73.4%**	71.4%	75.5%	71.4%	n.s.	72.1%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (12 18 years)	1,148	754	**65.7%**	62.9%	68.5%	67.7%	n.s.	67.9%	n.s.	>= 50th and < 75th percentile
HEDIS	Asthma Medication Ratio (19 50 years)	2,352	1,402	**59.6%**	57.6%	61.6%	59.5%	n.s.	57.8%	n.s.	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (51 64 years)	1,044	676	**64.8%**	61.8%	67.7%	61.1%	n.s.	61.2%	+	>= 75th and < 90th percentile
HEDIS	Asthma Medication Ratio (Total)	6,317	4,134	**65.4%**	64.3%	66.6%	64.9%	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	1,019,664	79	**7.7**	6.0	9.5	10.7	-	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	702,585	499	**71.0**	64.8	77.3	NA	NA	94.5	-	NA
PA EQR	Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months	18,405	6	**32.6**	6.5	58.7	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	720,990	505	**70.0**	63.9	76.2	78.6	n.s.	93.7	-	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 – 7.0 percentage points
  - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months – 4.85 admissions per 100,000 member months
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months – 4.86 admissions per 100,000 member months

No opportunities for improvement are identified.

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	640	570	**89.1%**	86.6%	91.6%	90.0%	n.s.	87.2%	n.s.	>= 50th and < 75th percentile
HEDIS	HbA1c Poor Control (>9.0%)	640	212	**33.1%**	29.4%	36.8%	31.3%	n.s.	34.7%	n.s.	>= 50th and < 75th percentile
HEDIS	HbA1c Control (<8.0%)	640	354	**55.3%**	51.4%	59.2%	57.6%	n.s.	52.9%	n.s.	>= 50th and < 75th percentile
HEDIS	HbA1c Good Control (<7.0%)	417	164	**39.3%**	34.5%	44.1%	40.4%	n.s.	37.8%	n.s.	>= 50th and < 75th percentile
HEDIS	Retinal Eye Exam	640	401	**62.7%**	58.8%	66.5%	57.1%	+	59.0%	n.s.	>= 50th and < 75th percentile
HEDIS	Medical Attention for Nephropathy	640	586	**91.6%**	89.3%	93.8%	90.3%	n.s.	89.6%	n.s.	>= 50th and < 75th percentile
HEDIS	Blood Pressure Controlled <140/90 mm Hg	640	424	**66.3%**	62.5%	70.0%	66.7%	n.s.	69.2%	n.s.	>= 50th and < 75th percentile
PA EQR	Diabetes Short Term Complications Admission Rate (Age 18 64 years) per 100,000 member months	1,722,249	169	**9.8**	8.3	11.3	11.1	n.s.	14.7	-	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Age 65+ years) per 100,000 member months	18,405	0	**0.0**	0.0	0.0	0.0	NA	1.8	n.s.	NA
PA EQR	Diabetes Short Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months	1,740,654	169	**9.7**	8.2	11.2	11.0	n.s.	14.6	-	NA
HEDIS	Statin Therapy for Patients With Diabetes: Received Statin Therapy	7,631	5,132	**67.3%**	66.2%	68.3%	65.9%	n.s.	60.3%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Diabetes: Statin Adherence 80%	5,132	3,334	**65.0%**	63.6%	66.3%	63.6%	n.s.	66.4%	-	>= 75th and < 90th 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)	1,329	1,148	**86.4%**	84.5%	88.3%	NA	NA	87.2%	n.s.	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)	7	5	**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:
  - Controlling High Blood Pressure (Total Rate) – 5.3 percentage points
  - Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female) – 3.4 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:
  - Persistence of Beta Blocker Treatment After Heart Attack – 5.6 percentage points
  - Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months – 9.80 admissions per 100,000 member months
  - Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months – 9.85 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	199	158	**79.4%**	73.5%	85.3%	86.4%	n.s.	85.0%	-	>= 25th and < 50th percentile
HEDIS	Controlling High Blood Pressure (Total Rate)	376	262	**69.7%**	64.9%	74.5%	65.5%	n.s.	64.3%	+	>= 75th and < 90th percentile
PA EQR	Heart Failure Admission Rate (Age 18 64 years) per 100,000 member months	1,722,249	502	**29.1**	26.6	31.7	21.1	+	19.4	+	NA
PA EQR	Heart Failure Admission Rate (Age 65+ years) per 100,000 member months	18,405	13	**70.6**	32.2	109.0	44.5	n.s.	70.2	n.s.	NA
PA EQR	Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months	1,740,654	515	**29.6**	27.0	32.1	21.4	+	19.7	+	NA
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 21 75 years (Male)	917	743	**81.0%**	78.4%	83.6%	79.7%	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)	803	636	**79.2%**	76.3%	82.1%	77.3%	n.s.	75.8%	+	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy Total Rate	1,720	1,379	**80.2%**	78.3%	82.1%	78.5%	n.s.	77.7%	+	>= 50th and < 75th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% 21 75 years (Male)	743	508	**68.4%**	65.0%	71.8%	71.5%	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)	636	442	**69.5%**	65.8%	73.2%	73.4%	n.s.	70.2%	n.s.	>= 75th and < 90th percentile
HEDIS	Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% Total Rate	1,379	950	**68.9%**	66.4%	71.4%	72.5%	-	70.0%	n.s.	>= 75th and < 90th percentile
HEDIS	Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia	43	36	**83.7%**	71.5%	95.9%	71.4%	n.s.	78.1%	n.s.	>= 50th and < 75th 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 From Multiple Providers (4 or more pharmacies) – 38.7 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:
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia – 6.7 percentage points
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) – 6.1 percentage points
  - Use of Opioids at High Dosage – 6.3 per 1000
  - Use of Opioids from Multiple Providers (4 or more prescribers) – 11.3 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	21,811	2,537	**11.6%**	11.2%	12.1%	11.53%	n.s.	10.3%	+	NA
HEDIS	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1,054	631	**59.9%**	56.9%	62.9%	62.02%	n.s.	66.6%	-	>= 25th and < 50th percentile
PA EQR	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)	2,278	1,432	**62.9%**	60.9%	64.9%	64.76%	n.s.	69.0%	-	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1 5 years	2	0	**NA**	NA	NA	NA	NA	NA	NA	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 6 11 years	122	0	**0.0%**	0.0%	0.4%	0.00%	NA	0.8%	n.s.	NA
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 12 17 years	239	2	**0.8%**	0.0%	2.2%	0.40%	NA	1.9%	n.s.	>= 75th and < 90th percentile
HEDIS	Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Total Rate	363	2	**0.6%**	0.0%	1.5%	0.26%	n.s.	1.5%	n.s.	>= 75th and < 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 1 5 years	6	4	**NA**	NA	NA	NA	NA	NA	NA	NA
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 6 11 years	176	118	**67.0%**	59.8%	74.3%	57.29%	n.s.	64.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Ages 12 17 years	335	202	**60.3%**	54.9%	65.7%	60.16%	n.s.	62.4%	n.s.	>= 90th percentile
HEDIS	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Total Rate	517	324	**62.7%**	58.4%	66.9%	59.17%	n.s.	63.1%	n.s.	>= 90th percentile
HEDIS	Use of Opioids at High Dosage[3]	10,662	965	**90.5**	NA	NA	NA	NA	84.2	+	NA
HEDIS	Use of Opioids from Multiple Providers (4 or more proscribers)	12,335	2,157	**174.9**	NA	NA	NA	NA	163.5	+	NA
HEDIS	Use of Opioids From Multiple Providers (4 or more pharmacies)	12,335	708	**57.4**	NA	NA	NA	NA	96.1	-	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	Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)	12,335	373	**30.2**	NA	NA	NA	NA	30.4	-	NA
HEDIS	Plan weighted SIR (CLABSI)			**0.85**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) high SIR			**0.52**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) moderate SIR			**0.11**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) low SIR			**0.26**			NA	NA			NA
HEDIS	Central line associated blood stream infections (CLABSI) unavailable SIR			**0.12**			NA	NA			NA
HEDIS	Plan weighted SIR (CAUTI)			**0.88**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) high SIR			**0.56**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) moderate SIR			**0.04**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) low SIR			**0.29**			NA	NA			NA
HEDIS	Catheter associated urinary tract infections (CAUTI) unavailable SIR			**0.11**			NA	NA			NA
HEDIS	Plan weighted SIR (MRSA)			**0.60**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events high SIR			**0.12**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events moderate SIR			**0.39**			NA	NA			NA
HEDIS	Methicillin resistant Staphylococcus aureus (MRSA) blood lab identified events low SIR			**0.36**			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)			**0.79**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) high SIR			**0.34**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) moderate SIR			**0.10**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) low SIR			**0.44**			NA	NA			NA
HEDIS	Clostridium difficile laboratory identified events (CDIFF) unavailable SIR			**0.11**			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)		6,946								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) 4+ Stays (Ages Total)		1,061								NA
HEDIS	PCR: Count of Index Hospital Stays (IHS) Total Stays (Ages Total)		8,007								NA
HEDIS	PCR: Count of 30 Day Readmissions 1 3 Stays (Ages Total)		364								NA
HEDIS	PCR: Count of 30 Day Readmissions 4+ Stays (Ages Total)		407								NA
HEDIS	PCR: Count of 30 Day Readmissions Total Stays (Ages Total)		771								NA
HEDIS	PCR: Observed Readmission Rate 1 3 Stays (Ages Total)			**5.2%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate 4+ Stays (Ages Total)			**38.4%**			NA	NA			NA
HEDIS	PCR: Observed Readmission Rate Total Stays (Ages Total)			**9.6%**			NA	NA			NA

HEDIS	PCR: Expected Readmission Rate 1 3 Stays (Ages Total)			**17.4%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate 4+ Stays (Ages Total)			**40.2%**			NA	NA			NA
HEDIS	PCR: Expected Readmission Rate Total Stays (Ages Total)			**20.4%**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 1 3 Stays (Ages Total)			**0.30**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio 4+ Stays (Ages Total)			**0.95**			NA	NA			NA
HEDIS	PCR: Observed to Expected Readmission Ratio Total Stays (Ages Total)			**0.47**			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 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 HPP.

Table 4.1 presents HPP'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: HPP 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 – (1 year, 2 years, 3 years, & Total)
Follow Up Actions Taken Through 06/30/18: Provider Outreach: Developmental Screening Tools: In 2017 HPP identified, from a quality review audit of pediatric provider records, that pediatric providers were not utilizing standardized developmental screening tools or properly billing/coding for developmental screening. HPP sent educational letters in June 2017 to pediatric providers with information and guidance on standardized developmental screening tools and the appropriate coding to report these screenings. The educational letter was again sent out via the following communication vehicles: Fax (6/20/18); NaviNet Provider Portal (6/20/18), VIP email (6/22/18) with additional educational information on lead screenings and Attention Deficit Hyperactivity Disorder (ADHD) medication follow up. During monthly visits, HPP's Network Account Managers (NAMs) reviewed the educational letter and stressed the importance of billing and coding for developmental screenings. As of 6/30/2018, the NAMs educated 236 providers on developmental screenings. In order to track provider compliance with developmental screening, as of 2018, we monitor the utilization of the billing code for developmental screening assessment quarterly for opportunities for further provider education. Head Start Collaboration: HPP has been working with several Head Start programs to reduce the HIPAA barrier identified by several Head Start programs. We have attempted to identify PA Head Start Programs in the Southeast Pennsylvania (SE PA) region and the data systems they use to input members' health information in order to increase the ability to share data and help close member care gaps for developmental screening and other preventive screenings. In March of 2018, HPP co-sponsored with PA Head Start a round table forum to discuss ways Managed Care Organizations (MCOs) and Head Start programs could share health information to increase the well-being of members. There were 33 attendees and 4 MCOs represented at the round table. Member outreach: Members' caregivers are sent annual birthday cards and age appropriate postcard reminders emphasizing the importance of obtaining developmental screenings. Developmental diagnoses from claims and/or a provider referral are used to identify members for telephonic outreach. During the telephonic outreach, the head of household/caregiver is educated on the importance of developmental screening and follow-up. The caregiver is also educated about CONNECT, a hotline used for head of households (HOH) and/or providers to refer members for Early Intervention (EI) services. The CONNECT hotline is overseen by the Office of Child Development and Early Learning (OCDEL). From Birth to 3 years of age, the program is administered by county EI programs but funded by the Department of Public Welfare (DPW); 3 to 5 years of age the services are provided through intermediate units (IUs), school districts, private agencies and funded through the Pennsylvania Department of Education (PDE). HPP does not make referrals to CONNECT; they give HOH the contact number and assist if needed.

Outcome: To increase the developmental screening code 96110 utilization from 2017 baseline of 40.34% by 5% in 2018.
Monitoring: 96110 utilization per thousand has increased from 595 in January 2017 to 649 in January 2018. Quarterly review of the developmental behavior health screenings claims and adjust outreach activities will continue as needed; annual review to determine effectiveness of the department.

Future Actions Planned:
Action:
Head Start: HPP is working to share member health related information with targeted Head Starts, by using an authorized HIPAA form on a member-by-member basis and verbal consent if the HOH is present to help close member's care gaps. HPP has initiated collaboration with one Head Start, Acelero, by providing most recent lead and dental screening information, and plans to extend this partnership with other Head Starts.
Report Cards: HPP is developing pediatric provider performance report cards for high volume practices to identify missed opportunities by providers for developmental screening during well child visits. NAMs will conduct targeted outreach to high volume pediatric practices to review report card results and have discussions with providers to educate on the American Academy of Pediatrics (AAP) standardized developmental tools and on billing opportunities.
Outcome: Increase rate of developmental screening by 5%.
Monitoring: Quarterly review of the developmental screenings to adjust outreach activities for HOH and providers as needed; annual review to determine effectiveness of the interventions.

Reference Number: HPP 2017.02: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Prenatal Screening Positive for Depression

Follow Up Actions Taken Through 06/30/18:
Action:
Care Coordination: On 8/17/17, HPP educated the entire Baby Partners (BP) staff (clinical and non-clinical) on the correct use of the standardized prenatal screening tools (Edinburgh, PHQ2, PHQ9), and shared best practices for establishing rapport with members to encourage open disclosure. We educated staff about available resources for managing depression when identified. All contacts (BP outreach coordinators, BP care coordinators and Maternity Care Coalition (MCC) community health workers) screen for depression at each encounter. We perform monthly chart audits of each staff to ensure that screening is documented, and that appropriate referrals are made when depression is identified. Staff audit scores indicate 100% compliance.

Providers: Initiation of the electronic Obstetrical Needs Assessment Form (ONAF) in September 2017 helped to improve providers' documentation of prenatal events, including prenatal screening positive for depression.

Community Resources: We search out community resources such as Nurse-Family Partnership (a non- profit organization that works by having specially trained nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy, and continuing through the child's second birthday) and other agencies to assist in addressing depression when the screen is positive. In CY 2017, 528 unique members were referred to Nurse-Family Partnership and similar community agencies.

SPMI: The addition of a Serious Persistent Mental Illness (SPMI) flag in HPP's Clinical Care Management System (CCMS) has added valuable information to our understanding of the pregnant member's previous history and enabled care coordinators to focus their conversation about depression. Members with a history of depression, as identified by the SPMI flag, are now included in the Integrated Care Plan (ICP) process (with member consent) so their care is coordinated with the BH-MCO and an ICP is developed.

Community Action Network: HPP participates in a Community Action Network (CAN) on the topic of perinatal mood and anxiety disorders (PMAD). This is a collaboration among MCOs, providers, community agencies, and other interested parties. The CAN has developed an informative video to educate the public about PMAD, which was shown to the BP staff at the meeting on August 16, 2017.

Outcome: To increase prenatal screening positive for depression on the electronic ONAF by 5%from 2017 rate of 11.70%.
Monitoring: We continue to monitor the rate of depression screening and positive screens by provider as a part of ONAF submissions.

Future Actions Planned:

Electronic ONAF: Promotion of the universal electronic ONAF submission to increase submission via this platform. To monitor and track provider prenatal depression screenings to identify providers who could benefit from brief re-education on this important topic.

SPMI: We will continue the ICP process for all members with an SPMI diagnosis and encourage our partners at the MCC to continue

to screen, refer and document.
The CAN has developed a series of facilitator-led support groups for women with, or at risk for, PMAD. These groups began in late spring 2018. Women are referred to these groups by their providers, by community health workers, and by their health plan. Metric data is not yet available.

Outcome: Improve Prenatal Screening Positive for Depression by 5% from 2017 rate of 11.70%.

Reference Number: HPP 2017.03: 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:

Care Coordination: We reviewed the correct use of the validated screening tools (Edinburgh, PHQ2, and PHQ9) and shared best practices for establishing rapport with members to encourage open disclosure, and we educated staff about available resources for managing depression when identified. All contacts (BP outreach coordinators, BP care coordinators and MCC community health workers) screen for depression at each encounter. The importance of screening for depression at each contact was reviewed in a staff meeting. Staff audits for 2017 and Q1 2018 confirm that 100% of staff members and vendors are screening appropriately at each encounter.

Provider: We implemented the universal electronic ONAF submission to increased submission via this platform in September 2017 to help to improve providers' documentation of postpartum events, including postpartum screening for depression.

Future Actions Planned:

Electronic ONAF: We will track each provider's report of screening via the electronic ONAF submission, and will be able to re-educate on its importance. We will continue to monitor each care coordinator's rate of screening and re-educate as needed.

Maternity Quality Care Plus Program (MQCP): Postpartum depression screening will be a monitoring metric in our maternity care incentive program for 2019 and will be communicated to providers in 2018.

Outcome: Improve Postpartum Screening for Depression by 5% from 2017 rate of 67.32%.

Reference Number: HPP 2017.04: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Postpartum Screening Positive for Depression

Follow Up Actions Taken Through 06/30/18:

Care Coordination: Staff education on 8/17/17 for both clinical and non-clinical staff, stressed the importance of timing of screening to ensure accurate identification of women with postpartum depression. Baby Partners has implemented screening at each call with the member to ensure that timeframes are met as well as ongoing evaluation of the member's behavioral healthcare needs.

Future Actions Planned:

Education of Baby Partners staff for screening of patients identified as positive from depression during the postpartum period to ensure that these patients receive referrals for treatment and supportive services. We will offer doula care to women who are at risk for postpartum depression based on known risk factors (absence of social support, difficult or unanticipated events during the birth, difficulty breastfeeding, past history, etc.). The doulas are trained to screen for depression. We will look to expand this program with a focus on language appropriate staffing to address the sensitive needs and disclosure around depression and other postpartum concerns of our maternity population.

Outcome: Improve Postpartum Screening Positive for Depression by 5% from 2017 rate of 6.22%.

Reference Number: HPP 2017.05: 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 age 5-64)

Follow Up Actions Taken Through 06/30/18:

Action: An educational letter is sent out monthly to new HPP members with asthma and newly diagnosed asthma members with information on HPP's disease management program, inviting them to join. From 7/1/17 -6/30/18, 6,804 letters were sent to eligible members.
Outcome: Increased members in the asthma disease management program – The asthma disease management program focuses on educating members about their condition, as well as medication adherence and support for monitoring their condition. In 2016 there were 648 Asthma Disease Management cases opened, which was 1.8% of the population of all asthma members in HPP. In 2017, there were 730 Asthma Disease Management cases opened which was 1.9% of the population of all asthma members in HPP.

All members in the program receive one-on-one support from a nurse and or social worker, a full assessment of needs, and medication reconciliation. Evaluation of HEDIS rates for members who are in the disease management program indicate that they have a higher compliance rate compared to the reported rate. Members in the asthma disease management program in 2016 had a 39.07% rate for Medication Management for asthma (75% compliance) as compared to the overall HEDIS 2016 reported rate of 34.33%. In 2017, members in the program had a 48.15% rate for Medication Management for people with asthma (75% compliance) as compared to the overall HEDIS 2017 reported rate of 37.34%.
Monitoring: Reports of program referrals and effectiveness of the asthma program using HEDIS rates.

Action: Adult members are able to log into the member portal and join Lifetracks specific to their condition. Lifetracks is a self-management tool to assist members with managing and understanding their chronic condition(s) and medication(s), and improve medication adherence. Learning modules are available for members to have an interactive learning experience.
Outcome: In 2017 there were 337 members who logged into the member portal into the asthma Lifetracks. From 1/1/18 through 6/30/18 there have been 19 members who have logged into the asthma Lifetracks tool. There were competing priorities with the introduction of the new members reward system that resulted in decreased promotion of the Lifetracks tool.
Monitoring: Monitor usage of member portal/ asthma Lifetracks.

Action: St. Chris Pediatric Asthma Pilot - From April 2015 through December 2017, HPP collaborated with St. Christopher Pediatric Associates (primary care practice) for targeted outreach and care coordination for HPP asthmatic pediatric members. A Community Health Worker (CHW) conducted outreach to improve preventive asthma care and reduce low acuity ER use, hospitalizations, and readmissions, and improve medication adherence.
Outcome: Medication adherence improved by more than 5% on a rolling 12 months basis for the 134 asthmatic members touched by the CHW, from 24% in 2015 to 31% in 2017.

Action: Onsite dispensing of asthma inhalers - This program has been in effect since September 2015. Collaborating with a practice site to permit onsite dispensing of asthma inhalers. There are different types of asthma and asthma related products through the dispensing program (ex. rescue and maintenance inhalers). Participants in the program include – Castor Pediatrics, Children's Health Center VNA, Crozer Pediatrics, Falls Ped and Teen Care, Germantown Pediatrics, Memphis Street Pediatrics, Pediatric & Adolescent, Pediatric Care Group P.C., Quien Pediatrics, Spectrum Health Haverford, St. Chris Hospital, St. Chris Special Needs.
Outcomes: From January – April 2018, there were 681 unique pediatric members with 1,284 asthma prescription claims (rescue and maintenance); there were 147 unique members with 280 claims in May 2018 (June data is not yet available).

Action: Conduct ongoing member outreach calls to members who are overdue or due soon (defined as due within the next 10 days) for their asthma medication(s). Members are identified for outreach if and when they have 2 or more fills of asthma medications in the calendar year. This was done to attempt to catch members as early as possible (HEDIS measure requires 4 fills in order to count in the denominator) while reducing the number of members who do not have asthma but are taking the medication(s) for other reasons (e.g., allergies).
Outcome: Through our pilot, we have seen a 40-50% success rate (for both reaching the members and for members picking up medications within 2 weeks of the telephonic contact).
Monitoring: HPP will continue to make outbound calls throughout 2018 and re-evaluate our solution.

Future Actions Planned:

Action: Continue to promote utilization of Lifetracks for asthmatic members.

Action: Continue outbound calls throughout 2018 to members who are overdue or due soon for their asthma medications.

Action: Explore continued promotion of the onsite dispensing of asthma rescue and controller medications to increase utilization of unique pediatric member by 5% from 681 in 2017 to 715.

Outcome: Improve Medication Management for People with Asthma - 75% Compliance by 5% from 2017 rate of 37.34%.

Reference Number: HPP 2017.06: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months

Follow Up Actions Taken Through 06/30/18:

Action: In 2017, there were 411 opened Complex Case Management Program cases with outreach to high risk members in an attempt to increase compliance, increase PCP follow up and decrease ER and Inpatient usage. Care Coordinators conduct a full assessment with members, focusing on barriers to care, creating goals and emphasizing self-management. Targeted focus on compliance with provider follow up and medication reconciliation.

Outcome: The Complex Case Management Program worked with 40 high risk asthma members (with inpatient admissions) in 2017 that were provided asthma specific education. Six months after enrollment in case management, members' inpatient utilization showed significant improvement with a 22.9% reduction in Inpatient utilization, compared to 6 months prior to case management enrollment.
Monitoring: Monthly and yearly reports of referral into the programs as well as effectiveness of the Complex Case Management Program.

Action: St. Chris Pediatric Asthma Pilot - From April 2015 through December 2017, HPP collaborated with St. Christopher Pediatric Associates for targeted outreach and care coordination for HPP asthmatic pediatric members. A Community Health Worker (CHW) conducted outreach to improve preventive asthma care and reduce low acuity ER use, hospitalizations, and readmissions, and improve medication adherence.
Outcome: Inpatient admissions per thousand improved by 5% from 136 in 2015 to 119 in 2017 on a rolling 12 month basis for the asthmatic members touched by the CHW.

Action: An educational letter is sent out monthly to new HPP members with asthma and newly diagnosed asthma members with information on HPP's disease management program, inviting them to join. From 7/1/17 -6/30/18, 6,804 letters were sent to eligible members.

Future Actions Planned:

Action: Will continue to monitor outcomes for members in Complex Case Management Program.

Action: Work to increase participation into the Complex Case Management Program by 5% by continuing monthly letters to members who join HPP with asthma or have a new asthma diagnosis, and utilizing other communication vehicles: member newsletter and social media when applicable.

Outcome: Improve Asthma in Younger Adults Admission Rate by 5% from 2017 rate of 10.70.

Reference Number: HPP 2017.07: 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:

Action: Working with COPD vendor to provide telehealth monitoring of members' COPD symptoms to alert them to any changes in their conditions. HPP began referring members in March of 2016 to COPD vendor for symptom management of COPD.
Outcome: Currently 105 COPD members are participating in the COPD program. Of the percentage of COPD program members with at least 1 COPD related claim (76 members) there is a reduction in ER usage by 7.1% and inpatient usage 26.1%. Effectiveness is based on members that could have utilization evaluated 6 months prior to enrollment into the program and 6 months after enrollment into the program). Although we recognize regression to the mean to play a role in this calculation, the direction in improvement is encouraging.
Monitoring: Continue to monitor inpatient admissions for COPD members.

Action: In 2017 there were 353 opened Complex Case Management Program cases with outreach to high risk members in an attempt to increase compliance, increase PCP follow up and decrease ER and Inpatient usage. Care Coordinators conduct a full assessment with members, focusing on barriers to care, creating goals and emphasizing self-management. There is a targeted focus on compliance with provider follow up and medication reconciliation.
Outcome: The Complex Case Management Program worked with 56 high risk COPD members (members with inpatient admissions) in 2017 that were provided COPD specific education. Six months after enrollment in case management, members' inpatient utilization showed improvement with a 31.5% reduction in Inpatient utilization, compared to 6 months prior to case management enrollment. Although we recognize regression to the mean to play a role in this calculation, the direction in improvement is encouraging.

Future Actions Planned:

COPD: Increase participation in the COPD telehealth program by 10% from 105 COPD members to 115 members.

Complex Case Management: Work to increase participation into the Complex Case Management Program by 5% by continuing monthly letters to members who join HPP with COPD or have a new COPD diagnosis, and utilizing other communication vehicles: member newsletter and social media when applicable.

Outcome: To improve Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate by 5% from 2017 rate of 78.63.

Reference Number: HPP 2017.08: 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:

HPP did not have any initiatives for statin therapy for patients with diabetes in this time period.

Future Actions Planned:

Action: Member education on the importance of statin therapy adherence for patients with diabetes.

Action: Explore HPP Pharmacy working with an outreach vendor (Magellan RX) to reach out to providers and members to encourage adherence of statin therapy for patients with diabetes.

Action: Provider education - will post clinical guidelines for statin therapy for patients with diabetes on the provider website.

Outcome: Improve Statin Therapy for Patients With Diabetes by 5% from 2017 rate of 63.62%.

Reference Number: HPP 2017.09: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Heart Failure Admission Rate (Age 18-64 years & Total Age 18+) per 100,000 member months

Follow Up Actions Taken Through 06/30/18:

Action: In 2017 there were 858 opened Complex Case Management Program cases with outreach to high risk members in an attempt to increase compliance, increase PCP follow up and decrease ER and Inpatient usage. Care Coordinators conduct a full assessment with members, focusing on barriers to care, creating goals and emphasizing self-management. Targeted focus on compliance with provider follow up and medication reconciliation. An educational letter is sent out monthly to new HPP members with heart failure and newly diagnosed heart failure members with information on HPP's disease management program, inviting them to join. From 7/1/17 -6/30/18, 1,318 letters were sent to eligible members.
Outcome: The Complex Case Management Program worked with 56 high risk heart failure members (with inpatient admissions) in 2017 that were provided heart failure specific education. Six months after enrollment in case management, members' Inpatient utilization showed significant improvement with a 15.8% reduction in Inpatient utilization, compared to 6 months prior to case management enrollment.
Monitoring: Monthly and yearly reports of referral into the programs as well as effectiveness of the Complex Case Management Program.

Action: Members are able to log into the member portal and join Lifetracks specific to their condition. Lifetracks is a self-management tool to assist members with managing and understanding their chronic condition(s) and medication(s), and improve medication adherence. Learning modules are available for members to have an interactive learning experience.
Outcome: In 2017 there were 613 members who logged into the member portal into the heart failure Lifetracks. From 1/1/18 through 6/30/18 there have been 49 members who have logged into the heart failure Lifetracks tool. There were competing priorities with the introduction of the new members reward system that resulted in decreased promotion of the Lifetracks tool.
Monitoring: Monitor usage of member portal/ asthma Lifetracks.

Future Actions Planned:
Action: Increase promotion and participation of the Complex Case Management Program by 5%, and continue to monitor outcomes for members in the program.

Action: Continue to promote utilization of Lifetracks for heart failure members.

Outcome: Improve Heart Failure Admission Rate (Age 18-64 years & Total Age 18+) by 5% from 2017 rate of 21.37.

Reference Number: HPP 2017.10: 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:

Community Behavior Health (CBH) Identification of Non-Adherence: CBH is the behavioral health MCO that provides behavioral healthcare to HPP Medicaid members. They use claims information to identify members that were noted to be non-adherent with filling antipsychotic medications in the previous year and shares this information with HPP (initial list contained approximately 50 members). During ICP coordination of care calls with CBH, the members are discussed and collaboration of efforts are completed on the individual level. HPP leverages this information to identify members for HPP case management outreach to attempt to determine the reason for nonadherence and resolve any issues.

Provider Education: HPP Pharmacy and CBH have a workgroup that meets monthly to strategize ways to address medication non-adherence for individuals diagnosed with schizophrenia. In the fall of 2017, HPP and CBH identified members with a past history of non-adherence to antipsychotic medications and sent an educational letter to 190 providers (mostly behavioral health providers) with medication adherence improvement strategies and a list of specific members that are non-adherent to antipsychotics. The improvement strategies included adherence scales: Drug Attitude Inventory (DAI-10 and DAI-30), the Personal Evaluations of Transitions in Treatment (PETiT), Medication Adherence Rating Scale (MARS) and Clinician Rating Scale (CRS). A survey was also included with the letter that asked if the providers found the educational letter informative. There has not been sufficient provider response from the CBH survey to produce conclusive results. Additionally, HPP partners with community pharmacies through our ongoing Medication Therapy Management (MTM) program where there is a Targeted Intervention Protocol (TIP) specific to antipsychotic non-adherence.

Targeted Outreach: Through Pharmacy claims analysis we have identified SPMI members who are non-compliant with antipsychotics. From this cohort, 21 members who are Community Based Care Management (CBCM) eligible were identified. CBCM staff, in collaboration with CBH, will outreach to these non-compliant members for targeted outreach and case management to address any barriers that this group may be experiencing. The majority of these members were eligible for ICPs, which CBH is managing.

Future Actions Planned:

Collaborating with Members to Resolve Barriers: HPP requested an updated list from Community Behavior Health (CBH) of members identified as medication non-adherent. These members are discussed during the ICP coordination of care calls with CBH and collaboration of efforts are completed on the individual member level. HPP assures that these members are assigned to case management. We are developing a group of questions for case managers to assist in assessing why members are non-adherent to better focus our efforts. We will coordinate with Pharmacy as needed. Additionally, a flag is being developed in the case management system so non-adherent members are easily identifiable.

Member Education: CBH and HPP are working on identifying and developing member education materials (to be approved by Department of Human Services (DHS)) to be sent to members that are currently non-adherent to antipsychotic medications (based on HPP Pharmacy claims).

Provider Education: HPP and CBH will evaluate, based on provider feedback, if a future annual provider educational letter will be conducted in the fall of 2018 identifying members that are non-adherent to antipsychotic medications (similar to the letter sent at the end of 2017). Additionally, HPP will continue to partner with community pharmacies through our ongoing MTM program where there is a Targeted Intervention Protocol (TIP) specific to antipsychotic non-adherence.

PCMH: HPP is working to coordinate a pilot program with Patient-Centered Medical Home (PCMH) providers to notify them of their patients that are medication non-adherent.

Outcome: Improve Adherence to Antipsychotic Medications for Individuals with Schizophrenia by 5% from 2017 rate of 60.46%.

Reference Number: HPP 2017.11: The MCO's rate was statistically significantly below the 2017 (MY 2016) MMC weighted average for Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)

Follow Up Actions Taken Through 06/30/18:

Community Behavior Health (CBH) Identification of Non-Adherence: CBH uses claims information to identify members that were noted to be non-adherent with filling antipsychotic medications in the previous year and shares this information with HPP (initial list contained approximately 50 members). HPP leverages this information to identify members for case management outreach to attempt to determine the reason for nonadherence and resolve any issues.

Provider Education: HPP Pharmacy and CBH have a workgroup that meets monthly to strategize ways to address medication non-adherence for individuals diagnosed with schizophrenia. In the fall of 2017, HPP and CBH identified members with a past history of

non-adherence to antipsychotic medications and sent an educational letter (to 190 providers – mostly behavioral health providers) with medication adherence improvement strategies and specific members that are non-adherent to antipsychotics. The improvement strategies included adherence scales: *Drug Attitude Inventory (DAI-10 and DAI-30), the Personal Evaluations of Transitions in Treatment (PETiT), Medication Adherence Rating Scale (MARS) and Clinician Rating Scale (CRS).* A survey was also included with the letter that asked if the providers found the educational letter informative. There has not been sufficient provider response from the CBH survey to produce conclusive results. Additionally, HPP partners with community pharmacies through our ongoing Medication Therapy Management (MTM) program where there is a Targeted Intervention Protocol (TIP) specific to antipsychotic non-adherence.

Targeted Outreach: Through Pharmacy claims analysis we have identified SPMI members who are non-compliant with antipsychotics. From this cohort, 21 members who are Community Based Care Management (CBCM) eligible were identified. CBCM staff, in collaboration with CBH, outreached to these non-compliant members for targeted outreach and case management to address any barriers that this group may be experiencing. The majority of these members were eligible for ICPs, which CBH is managing.

Future Actions Planned:

Collaborating with Members to Resolve Barriers: HPP requested an updated list from Community Behavior Health (CBH) of members identified as medication non-adherent. These members are discussed during the unit ICP coordination of care calls with CBH and collaboration of efforts are completed on the individual member level. HPP assures that these members are assigned to case management. We are developing a group of questions for case managers to assist in assessing why members are non-adherent to better focus our efforts. We will coordinate with Pharmacy as needed. Additionally, a flag is being developed in the case management system so non-adherent members are easily identifiable.

Member Education: CBH and HPP are working on identifying and developing member education materials (to be approved by Department of Human Services (DHS)) to be sent to members that are currently non-adherent to antipsychotic medications (based on HPP Pharmacy claims).

Provider Education: HPP and CBH will evaluate, based on provider feedback, if a future annual provider educational letter will be conducted in the fall of 2018 identifying members that are non-adherent to antipsychotic medications (similar to the letter sent at the end of 2017). Additionally, HPP will continue to partner with community pharmacies through our ongoing MTM program where there is a Targeted Intervention Protocol (TIP) specific to antipsychotic non-adherence.

PCMH: HPP is working to coordinate a pilot program with Patient-Centered Medical Home (PCMH) providers to notify them of their patients that are medication non-adherent.

Outcome: Improve Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH) by 5% from 2017 rate of 64.76%.

Reference Number: HPP 2017.12: 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 6/30/18:

Satisfaction with Health Care (Rating of 8 to 10) (Adult): Although this composite remains above the 2017 MMC Weighted Average, the plan summary rate decreased from 2016 and remains an area to monitor. The three point score for the Rating of Health Care composite was 2.4643.

Actions taken by HPP through 6/30/18 to address Satisfaction with Health Care include:
Member Education: Communication of health related events, tips and educational information utilizing - the member portal, member website, member newsletter, and information posted on HPP social media.

HPP Customer Experience Training: In 2017, HPP instituted a companywide education which all employees will attend in order to improve customer experience.

Events: HPP hosted several events throughout 2017-2018 focusing on Wellness topics such as walking, yoga and healthy cooking, as well as participated in events and provided informational tables at various WIC offices and community centers.
Examples of DHS approved activities that occurred in the community to raise the member's awareness regarding their healthcare:

- July 2017: Wellness Partners Farmstand Days, 2017 Hispanic Fiesta, Rep. Vazquez's First Annual Health Fair.
- August 2017: Back to school event sponsored by St. Christopher's and Drexel, RV Allegheny Biking Days, State Rep. Morgan

Cephas Inaugural Constituent District Day

- September 2017: Neighborhood to Neighborhood Festival, HPP Health & Music Festival, 2017 Matryoshka Festival, 36th Annual Neighborhood Festival
- October 2017: Philly Pride Outfest, Health Partners Plans 5K
- November 2017: 11th Annual Wellness Fair, Fall 2017 Health Expo
- December 2017: Wellness Partners Yoga Days
- January 2018: Informational tables at multiple WIC offices
- February 2018: 2018 National Children's Dental Health Month @ GPHA, 4th Annual Red Heart Awareness Event,
- March 2018: 2018 PA School for the Deaf Transition and Resource Fair
- April 2018: Feria De Salud, 2018 Open House: Boy Scout Troop with HPP, 2018 Ridley Health Awareness Day, Informational tables at the Mexican Consulate
- May 2018: Good Food for All Conference, Salvation Army - West Philadelphia Branch Health Fair, State Representative Margo Davidson's 8th Annual Community Health Fair; Father's Fun Day
- June 2018: Pride Festival, Kids Fest 2018, PCDC's 10th Annual Expo

Getting Needed Information (Usually or Always) (Adult): Although this composite remains above the 2017 MMC Weighted Average, the plan summary rate decreased from 2016 and remains an area to monitor. The three point score for the Customer Service Care composite was 2.6471.

Actions taken by HPP through 06/30/2018 to address Getting Needed Information include:
Member Relations: conduct monthly audits of their representatives. Agents must maintain 97% or better audit score based on accuracy, technical ability, and customer service. If an agent is below the departmental standards threshold the agent will have performance expectations reviewed, reeducated on processes, and provided with resource documents. Trainings conducted between 7/1/17 – 6/30/18:

- Recipient Restriction Training/August 2017

HPP Customer Experience Training: In 2017 HPP instituted a companywide educational initiative for employees that consists of educational sessions to improve customer experience; this training identifies customers as all internal and external customers.

Member Education: Members were offered information via the member website regarding benefits overview, the member handbook and frequently asked questions so they may research the information on the website if they prefer.

Appointment for Routine Care When Needed (Usually or Always) (Adult): Although this measure fell below the 2017 MMC Weighted Average it was highlighted as a statistically significant improvement from the 2016 Plan Summary Rate. The three point score for the Getting Needed Care composite was 2.3833.

Actions taken by HPP through 6/30/18 to address Appointment for Routine Care When Needed include:
Announced Shopper Calls: Quarterly announced shopper calls were conducted with providers to confirm that they meet HPP's Access and Availability Standards as outlined in the provider manual:

- Q1: after hours PCP – (657/700 calls completed (3 wrong numbers and 40 remaining records); 632/657 passed (96.19%) and 25 failed (3.81%).
- Q2: OB and oncology– (OB/GYN: 46/125 calls completed (1 wrong number, 4 invalid numbers, 17 declined participation and 57 remaining records); 11/46 passed (23.91%) and 35/46 failed (76.09%). ONC: 32/80 calls completed (2 wrong numbers, 6 declined participation and 40 remaining records); 14/32 passed (43.75%) and 18/32 failed (56.25%))

The information for appointment standards is posted on the provider website and the information for access and appointment standards was included in the provider newsletter dated September 2017. Also the access and availability standards are now included on the annual provider web-based training. The member's website contains information on appointment standards and information was included in the Winter 2018 member newsletter.

Member Satisfaction: HPP has also expanded their pilot program for randomly selected member post-visit satisfaction surveys, which are conducted after a member visits their PCP. The survey covers 201 practice sites and so far 10,109 members have responded to the survey. The survey asks approximately 45 questions specific to the members' experience with their PCP. Only 24.33% of sites thus far performed better than the industry benchmark of 92.80%.

Provider Education: The Provider Outreach and Education team has developed a TIP sheet for the Team to share with providers in order to improve customer experience, which will be distributed to providers quarterly.

Composite	2017 (MY 2016)	2017 Opportunity	2016 (MY 2015)	2016 Opportunity	2015 (MY 2014)	2015 Opportunity

	Percentile Ranking	Analysis	Percentile Ranking	Analysis	Percentile Ranking	Analysis
Satisfaction with Health Care (Rating of 8 to 10) (Adult)	78th	Monitor	94th	Strength	32nd	Opportunity
Getting Needed Information (Usually or Always) (Adult)	70th	Monitor	78th	Monitor	85th	Strength
Appointment for Routine Care When Needed (Usually or Always) (Adult)	63rd	Opportunity	56th	Opportunity	76th	Monitor

Composite	2017 (MY 2016) Plan Summary Rate	2016 (MY 2015) Plan Summary Rate	2015 (MY 2014) Plan Summary Rate	2017 MMC Weighted Average
Satisfaction with Health Care (Rating of 8 to 10) (Adult)	76.79%	78.99%	71.49%	76.08%
Getting Needed Information (Usually or Always) (Adult)	84.31%	84.33%	84.56%	82.24%
Appointment for Routine Care When Needed (Usually or Always) (Adult)	79.85%	71.98%	81.60%	81.68%

Future Actions Planned:

Satisfaction with Health Care (Rating of 8 to 10) (Adult):
Member Engagement: HPP will look to engage members utilizing social media to help learn more about their benefits, health services and events to increase their participation in their health and potential increase satisfaction with their health care.

HPP Customer Experience Training: HPP will continue the companywide education to improve customer experience until all employees attend.

Events: HPP will continue participation and hosting of events that empower and educate members in their health care. All activities have been approved by DHS or are awaiting approval. HPP will continue to host community walking, yoga and cooking events.
The below list demonstrates examples of events that occurred in July 2018:

- 2018 Hispanic Fiesta
- Let's Love Logan Day Community Festival 2018
- 2018 Community Day @ Jehovah Jireh Worship Center

Examples of planned events waiting for approval:

- August 2018: South Phila Library Community Health & Literacy Center Health Fair, Dental Screening with St. Chris, 24th Annual Across Colors Cultural Festival
- September 2018: Neighborhood to Neighborhood Festival, BPAC Community Health Fair
- October 2018: Spring City Food Pantry Informational Table, 2018 Girard Avenue Street Festival
- November 2018: Montgomery County SAP Conference 2018

Getting Needed Information (Usually or Always) (Adult):

Member Relations: Planned activities for the Member Relations Department will focus on skills sets to improve communications with members to boost member satisfaction:

Member Engagement: HPP will continue to engage members in their health care using a variety of measures such as the member portal, member website, member newsletters and social media platforms. Information posted on HPP social media platforms will inform members of programs offered by HPP, health, diet and exercise tips, and HPP events in the community.

Appointment for Routine Care When Needed (Rating of 8 to 10) (Adult):
Announced Shopper Calls: HPP will continue announced shopper calls to providers to confirm that they meet HPP's Access and Availability Standards as outlined in the provider manual. The schedule is planned as follows:

- Q3: all specialists
- Q4: PCP

The information regarding access and availability standards will continue to be available via the member's website and in hardcopy when requested.

Provider Education: HPP will also broaden the number of providers included in the random member post-visit satisfaction surveys which are conducted after a member visits their PCP. Network Management plans to continue to distribute the TIP sheet to providers quarterly.

Outcomes: In 2018 the goals for the identified CAHPS measures are as follows:

- Satisfaction with Health Care – increase to the 90th percentile ranking
- Getting Needed Care composite - increase to the 50th percentile ranking
- Customer Service composite – increase to the 90th percentile ranking

Reference Number: HPP 2017.13: Of the four Child CAHPS composite survey items reviewed, two fell below the 2017 MMC weighted average. Two items decreased in 2017 (MY 2016).

Follow Up Actions Taken Through 06/30/2018:

The composites of Satisfaction with Child's Health Plan and Getting Needed Information decreased in the plan summary rates and identify dissatisfaction with HPP as a health plan.

Satisfaction with Child's Health Plan (Rating of 8 to 10): This measure decreased in the plan summary rate in comparison to the 2016 plan summary rate and fell below the 2017 MMC Weighted Average.

See Follow-Up Actions through 6/30/18 for HPP **2017.11** for **Satisfaction with Health care (Adult)** for Member Education and HPP Customer Experience training.

Events: HPP hosted several pediatric events throughout 2017 -2018 focusing on community involvement and wellness topics such as walking and yoga, as well as participated in events and provided informational tables at various WIC offices, and community centers in order to increase satisfaction with the health plan:

Examples of DHS approved activities that occurred in the community to raise the member's awareness regarding their healthcare:

- July 2017: Wellness Partners Farmstand Days, 2017 Hispanic Fiesta, Rep. Vazquez's First Annual Health Fair, 15th Annual Children's and Youth Health Festival
- August 2017: Back to school event sponsored by St. Christopher's and Drexel, Community Appreciation Health and Wellness Summer Jam, Kids Triathlon -YMCA Doylestown- (Central Bucks)
- September 2017: Representative White – Kids Fest, Neighborhood to Neighborhood Festival, Health Partners Plans Health & Music Festival, 2017 Matryoshka Festival, 36th Annual Neighborhood Festival, 2017 Puerto Rican Day Parade
- October 2017: Valley Day 2017, Health Partners Plans 5K, 2017 Give Kids Sight Day - PCCY
- November 2017: 11th Annual Wellness Fair, Fall 2017 Health Expo
- December 2017: Wellness Partners Yoga Days
- January 2018: Informational tables at multiple WIC offices
- February 2018: 2018 National Children's Dental Health Month @ GPHA,
- March 2018: 2018 PA School for the Deaf Transition and Resource Fair
- April 2018: Feria De Salud, 2018 Open House: Boy Scout Troop with HPP, 2018 Ridley Health Awareness Day, 2018 Open House: Boy Scout Troop with HPP, Healthy Kids Day YMCA - Columbia North
- May 2018: Good Food for All Conference, Salvation Army - West Philadelphia Branch health fair, State Representative Margo Davidson's 8th Annual Community Health Fair; Father's Fun Day, Siddiq's Water Ice Family Fun Day & Community Health fair
- June 2018: Porter's 22nd Annual Family Fun Day, Kids Fest 2018, PCDC's 10th Annual Expo; RV Grand as Parents Health Fair

Getting Needed Information (Usually or Always) (Child): This issue was newly identified on the 2017 EQR Technical Report. Although this composite remains above the 2017 MMC Weighted Average, the plan summary rate has decreased from 2016 and remains an area to monitor. The three point score for the Customer Service Care composite was 2.5949.

See Follow-Up Actions through 6/30/18 for HPP **2017.11** for **Getting Needed Information (Usually or Always) (Adult)** for Member Relations, HPP Customer Experience Training, and Member Education.

Appointment for Routine Care When Needed (Usually or Always) (Child): Although this measure fell below the 2017 MMC

Weighted Average, it increased over last year's plan summary rate. This composite remains an area of opportunity. The three point score for the Getting Needed Care composite was 2.3459.

See Follow-Up Actions through 6/30/18 for HPP **2017.11** for **Appointment for Routine Care When Needed (Usually or Always) (Adult)** for Announced Shopper Calls, Member Satisfaction, and Provider Education.

Composite	2017 (MY 2016) Plan Summary Rate	2016 (MY 2015) Plan Summary Rate	2015 (MY 2014) Plan Summary Rate	2017 MMC Weighted Average
Satisfaction with Child's Health Plan (Rating of 8 to 10)	85.87%	89.36%	22.26%	86.82%
Getting Needed Information (Usually or Always) (Child)	83.63%	84.62%	83.72%	82.72%
Appointment for Routine Care When Needed (Usually or Always) (Child)	84.74%	80.90%	82.52%	89.20%

Composite	2017 (MY 2016) Percentile Ranking	2017 Opportunity Analysis	2016 (MY 2015) Percentile Ranking	2016 Opportunity Analysis	2015 (MY 2014) Percentile Ranking	2015 Opportunity Analysis
Satisfaction with Child's Health Plan (Rating of 8 to 10)	50th	Monitor	57th	Monitor	54th	Monitor
Getting Needed Information (Usually or Always) (Child)	61st	Monitor	87th	Strength	83rd	Strength
Appointment for Routine Care When Needed (Usually or Always) (Child)	36th	Opportunity	13th	Opportunity	10th	Opportunity

Future Actions Planned:
The composites of Satisfaction with Child's Health Plan and Getting Needed Information decrease in their plan summary rates identify dissatisfaction with HPP as a health plan.

Satisfaction with Child's Health Plan (Rating of 8 to 10):

See Future Actions Planned for **2017.11** for **Satisfaction with Health Care (Rating of 8 to 10) (Adult)** for Member Engagement, HPP Customer Experience Training, and Events.

Getting Needed Information (Usually or Always) (Child):

See Future Actions Planned for **2017.11** for **Getting Needed Information (Usually or Always) (Adult)** for Member Relations and Member Engagement

Appointment for Routine Care When Needed (Usually or Always) (Child): See Future Actions Planned for **2017.11** for **Appointment for Routine Care When Needed (Rating of 8 to 10) (Adult)** for Announced Shopper Calls and Provider Education.

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, HPP was not required to prepare a Root Cause Analysis and Action Plan.

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

- HPP was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.

- For approximately one third of reported measures, the MCO's performance was statistically significantly above/better than the MMC weighted average in 2018 (MY 2017) on the following measures:
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)
  - Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Age 3 to 6 years)
  - Childhood Immunizations Status (Combination 2)
  - Childhood Immunizations Status (Combination 3)
  - Counseling for Nutrition (Age 3-11 years)
  - Counseling for Nutrition (Total)
  - 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
  - Annual Dental Visit (Age 2–20 years)
  - Breast Cancer Screening (Age 50-74 years)
  - Cervical Cancer Screening (Age 21-64 years)
  - Chlamydia Screening in Women (Total)
  - Chlamydia Screening in Women (Age 16-20 years)
  - Chlamydia Screening in Women (Age 21-24 years)
  - 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 - 3 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: LARC - 3 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20)
  - Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 60 days (Ages 21 to 44)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 21 to 44)
  - ≥ 81% of Expected Prenatal Care Visits Received
  - Prenatal and Postpartum Care – Postpartum 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 Smoking Cessation
  - Prenatal Screening for Depression
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
  - Postpartum Screening for Depression
  - Prenatal Screening for Alcohol use
  - Prenatal Screening for Illicit drug use
  - Prenatal Screening for Prescribed or over-the-counter drug use
  - Prenatal Screening for Intimate partner violence
  - Prenatal Screening for Behavioral Health Risk Assessment

- Elective Delivery
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Pharmacotherapy Management of COPD Exacerbation: Bronchodilator
- Asthma Medication Ratio (51-64 years)
- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months
- Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months
- 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: Received Statin Therapy
- Controlling High Blood Pressure (Total Rate)
- Statin Therapy for Patients With Cardiovascular Disease: Received Statin Therapy 40-75 years (Female)
- 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. One items increased in 2018 (MY 2017) as compared to 2017 (MY 2016).
  - Of the four Child CAHPS composite survey items reviewed, one item was above the 2018 MMC Weighted average. One items increased in 2018 (MY 2017) as compared to 2017 (MY 2016).

Opportunities for Improvement

- The MCO's performance was statistically significantly below/worse than the MMC weighted average in 2018 (MY 2017) on the following measures:
  - Developmental Screening in the First Three Years of Life - Total
  - Developmental Screening in the First Three Years of Life - 1 year
  - Developmental Screening in the First Three Years of Life - 2 years
  - Developmental Screening in the First Three Years of Life - 3 years
  - 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)
  - 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)
  - 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)
  - Prenatal Counseling for Smoking
  - Prenatal Screening Positive for Depression
  - Postpartum Screening Positive for Depression
  - 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 (Total - Age 5-64 years)
  - Persistence of Beta Blocker Treatment After Heart Attack
  - 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
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
  - Use of Opioids at High Dosage
  - Use of Opioids from Multiple Providers (4 or more prescribers)

- 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. Three items decreased between 2018 (MY 2017) and 2017 (MY 2016).
  - Of the four Child CAHPS composite survey items reviewed, three fell below the 2018 MMC weighted average. The same three items decreased in 2018 (MY 2017).

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.***

HPP 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)

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

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

- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits
- Postpartum Care
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

▪ 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
- Comprehensive Diabetes Care: HbA1c Poor Control[4]
- Prenatal Care in the First Trimester
- Well-Child Visits in the First 15 Months of Life, 6 or more

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

- Medication Management for People With Asthma: 75% Total

▪ 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:

- Reducing Potentially Preventable Readmissions[5]

▪ F Root cause analysis and plan of action required

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

- No P4P measures fell into this comparison category

[4] Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
[5] Lower rates for Reducing Potentially Preventable Readmissions 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** Medication Management for People With Asthma: 75% Total	**B**	**A** Annual Dental Visit (Ages 2 20 years)
	No Change	**D** Reducing Potentially Preventable Readmissions[6]	**C** Adolescent Well-Care Visits Comprehensive Diabetes Care: HbA1c Poor Control[7] Prenatal Care in the First Trimester Well-Child Visits in the First 15 Months of Life, 6 or more	**B** Controlling High Blood Pressure Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Postpartum Care Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
	⬇	**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)	63.4% =	63.8% =	62.0% =	65.2% =	62.0%
Comprehensive Diabetes Care HbA1c Poor Control[8]	36.0% =	30.1% ▼	31.3% =	33.1% =	34.7%
Controlling High Blood Pressure	65.5% ▲	67.9% =	65.5% =	69.7% =	64.3%
Prenatal Care in the First Trimester	85.5% =	89.1% =	89.9% =	89.3% =	86.6%
Postpartum Care		73.6% =	75.3% =	74.5% =	67.7%
Annual Dental Visits (Ages 2 20 years)[9]	70.3% ▲	65.9% ▼	64.5% ▼	66.5% ▲	63.0%
Well Child Visits in the First 15 Months of Life, 6 or more		66.7% =	69.9% =	68.4% =	69.9%
Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		82.7% =	80.2% =	82.6% =	77.6%
Medication Management for People with Asthma: 75% Total		34.3% =	37.3% ▲	39.4% ▲	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]	68.5% ▼	75.1% =	78.1% =	76.9% =	70.6%
Reducing Potentially Preventable Readmissions[11]	13.6% ▼	9.6% ▼	11.5% ▲	11.6% =	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

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

Performance Improvement Projects

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

Performance Measures

- HPP 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

- HPP 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 HPP in 2018. A response will be required by the MCO for the noted opportunities for improvement in 2019.