Commonwealth of Pennsylvania
Department of Human Services
2014 External Quality Review Report

Statewide Medicaid Managed Care Annual Report

FINAL REPORT

Issue Date: September 11, 2015

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OVERVIEW

This report is a summary of Medicaid managed care (MMC) external quality review (EQR) findings for the Commonwealth of Pennsylvania's behavioral health (BH) and physical health (PH) Medicaid managed care organizations (MCOs).

Pennsylvania MMC services are administered separately for PH services, for BH services and for long term living (LTL) services as applicable. The HealthChoices Program is the Commonwealth of Pennsylvania's mandatory managed care program for Medical Assistance recipients.

The Pennsylvania (PA) Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) oversees the PH component of the HealthChoices Program. DHS OMAP contracts with PH-MCOs to provide physical healthcare services to recipients.

DHS's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health (BH) component of the HealthChoices program. OMHSAS determined that the Pennsylvania county governments would be offered "right of first opportunity" to enter into capitated contracts with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program, the mandatory managed care program which provides medical assistance (i.e. Medicaid) recipients with services to treat mental health and/or substance abuse diagnoses/disorders. Forty-three of the 67 counties have signed agreements using the right of first opportunity and have sub-contracted with a private sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Twenty-four counties have elected not to enter into a capitated agreement and as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties. Through these BH-MCOs, recipients receive mental health and/or drug and alcohol services.

Starting in 1997, the HealthChoices program was implemented for PH and BH services using a zone phase-in schedule. The zones originally implemented were:

- **Southeast Zone** - Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties
- **Southwest Zone** - Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington, and Westmoreland Counties
- **Lehigh/Capital Zone** - Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York Counties

Expansion of the HealthChoices PH program began in July 2012 with Bedford, Blair, Cambria, and Somerset Counties in the Southwest Zone and Franklin, Fulton and Huntingdon Counties in the Lehigh/Capital Zone. In October 2012, HealthChoices PH expanded into the New West Zone, which includes Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, Mercer, McKean, Potter, Warren, and Venango. In March 2013, HealthChoices PH expanded further, into the remaining Counties: Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming. With the expansion completed, HealthChoices PH served approximately 1.6 million recipients in 2014.

Starting in July 2006, the HealthChoices BH program began statewide expansion in a zone phase-in schedule, incorporating additional zones to the original three listed above. The Northeast region's BH implementation went into effect in July 2006, followed by two North/Central implementations. The first North/Central implementation is a directly held state contract that covers 23 Counties implemented in January 2007, followed by the second implementation of 15 Counties that exercised the right of first opportunity and were implemented in July 2007. The Counties included in each of these zones are indicated below:

- **Northeast Zone** - Lackawanna, Luzerne, Susquehanna, and Wyoming Counties

- **North/Central Zone – State Option** - Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties
- **North/Central Zone – County Option** - Bedford, Blair, Cambria, Carbon, Clinton, Crawford, Erie, Fulton, Franklin, Lycoming, Mercer, Monroe, Pike, Somerset, and Venango Counties

In 2014, all Pennsylvania Counties were covered by the HealthChoices PH program, as it is now mandatory statewide. For PH services in 2014, Medical Assistance enrollees had a choice of three to five PH-MCOs within their county (depending on the Zone of residence).

The HealthChoices BH program differs from the PH component in that for mental health and drug and alcohol services, each county/HC BH Contractor contracts with one BH-MCO to provide services to all enrollees residing in that county. The HealthChoices BH program is also mandatory statewide.

The MCOs that were participating in the HealthChoices program as of December 2014 were:

Physical Health MCOs
- AmeriHealth Caritas Pennsylvania (ACP)
- Gateway Health(GH)
- Health Partners Plan (HPP)
- Keystone First (KF)
- United Healthcare Community Plan (UHCP)
- UPMC for You (UPMC)
- Aetna Better Health (ABH, implemented April 1, 2010)
- CoventryCares (COV, implemented April 1, 2010 and ceased operations October 1, 2014)
- Geisinger Health Plan (GHP, implemented March 1, 2013 and not included in this report)
- AmeriHealth NorthEast (AHNE, implemented March 1, 2013 and not included in this report)

United Healthcare Community Plan (UHCP) was formed as a result of the January 1, 2011 merger of AmeriChoice of Pennsylvania (ACPA) and Unison Health Plan (Unison). For the ACPA and Unison PIPs in progress at the time of the merger, the PA DHS determined that the merged organization would provide separate submissions to assure effective continuation of these PIPs. These PIPs ended in 2013, and UHCP addressed any identified opportunites for improvement associated with these PIPs in its 2013 response.

As of October 1, 2014, CoventryCares ceased operations in the HealthChoices program, and merged with Aetna Better Health. The EQR findings presented in this report reflect activities for CoventryCares through October 1, 2014.

Behavioral Health MCOs
- Community Behavioral Health (CBH)
- PerformCare
- Community Care Behavioral Health (CCBH)
- Magellan Behavioral Health (MBH)
- Value Behavioral Health (VBH)

DHS's Office of Long Term Living (LTL), Bureau of Provider Support – Division of Field Operations (DFO) oversees the managed LTL program in Pennsylvania for Medicaid Managed Care recipients. All LTL Medicaid Managed Care services are arranged through Living Independence for the Elderly (LIFE) providers, which cover a comprehensive all-inclusive package of services. The program is known nationally as the Program of All-inclusive Care for the Elderly (PACE). As previously directed by DFO, external quality review (EQR) was conducted for the LTL MCOs in "pre-PACE" status. The first programs were implemented in Pennsylvania in 1998. As of October 2013, remaining LTL MCOs were moved to full PACE status. Given that there were no LTL MCOs in "pre-PACE" status, there was no LTL EQR in 2014.

INTRODUCTION AND PURPOSE

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 EQR of the services provided by contracted Medicaid 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 recipients.

The EQR-related activities that must be included in the detailed technical reports are reviewed 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.

DHS contracted with IPRO as its EQRO to conduct the 2014 EQRs for the Medicaid MCOs.

Information Sources

The following information sources were used by IPRO to evaluate the MCOs' performance:

- MCO-conducted Performance Improvement Projects (PIPs)
- Healthcare Effectiveness Data Information Set (HEDIS®[1]) performance measure data, as available for each MCO
- Pennsylvania-Specific Performance Measures
- Structure and Operations Standards Reviews conducted by DHS
  - For PH-MCOs, the information is derived from the DHS's monitoring of the MCOs against the Systematic Monitoring, Access and Retrieval Technology (SMART) standards, from the HealthChoices Agreement, and from the National Committee for Quality Assurance (NCQA™) accreditation results for each MCO.
  - For BH-MCOs, the information is derived from monitoring conducted by OMHSAS against the Commonwealth's Program Evaluation Performance Summary (PEPS) review tools for both BH-MCOs and contracted HealthChoices Oversight Entities. As necessary, the HealthChoices BH Program Standards and Requirements (PS&R) and Readiness Assessment Instrument (RAI) are also used.

PH and BH-MCO compliance results are indicated using the following designations in the current report:

Acronym	Description
C	Compliant
P	Partially Compliant
NC	Not Compliant
ND	Not Determined
NA	Not Applicable

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

To evaluate the MMC compliance with the BBA categories, IPRO grouped the appropriate MCOs and assigned the compliance status for the category as a whole. Each MCO individually can be given a compliance status of Compliant (C), Not Compliant (NC), Partially Compliant (P) or Not Determined (ND). Categories regarded as Not Applicable (NA) to the applicable DHS entity are indicated as such. Each category as a whole was then assigned a compliance status value of C, NC, P or ND based on the aggregate compliance of each of the applicable MCOs for the category. Therefore, if all applicable MCOs were Compliant, the category was deemed Compliant; if some MCOs were Compliant and some were Partially Compliant or Not Compliant, the category was deemed Partially Compliant. If all MCOs were Not Compliant, the category was deemed Not Compliant. If none of the MCOs were evaluated for a category, the aggregate compliance status would be Not Determined.

SECTION I: COMPLIANCE WITH STRUCTURE AND OPERATIONS STANDARDS

This section of the EQR report presents a review by IPRO of the PH and BH MCOs with regard to compliance with structure and operations standards.

The format for this section of the report was developed to be consistent with the subparts prescribed by the 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 are the individual regulatory categories appropriate to those headings. IPRO's findings are presented in a manner consistent with the three BBA regulations subparts as explained in the Protocol, i.e., Subpart C: Enrollee Rights and Protections; Subpart D: Quality Assessment And Performance Improvement (including access, structure and operation and measurement and improvement standards); and Subpart F: Federal and State Grievance System Standards.

Evaluation of PH-MCO Compliance

For the PH Medicaid MCOs, the information for the Compliance with Standards section of the report is derived from the OMAP's monitoring of the MCOs against the SMART standards, from the HealthChoices Agreement, and from NCQA accreditation results.

The SMART Items provide much of the information necessary for each PH-MCO's review. The SMART Items are a comprehensive set of monitoring Items that the DHS staff review on an ongoing basis for each PH-MCO. IPRO reviewed the elements in the SMART Item List and created a crosswalk to pertinent BBA regulations. The SMART Items did not directly address two categories, Cost Sharing and Effectuation of Reversed Resolutions. 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. A total of 126 unique SMART Items were identified that were relevant to evaluation of PH-MCO compliance with the BBA regulations. These Items vary in review periodicity from annually, semi-annually, quarterly, monthly and as needed. The SMART Items from Review Year (RY) 2013, RY 2012 and RY 2011 provided the information necessary for this assessment.

To evaluate PH-MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCOs' compliance status with regard to these 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 the OMAP. 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 Not Compliant. For categories where Items were not evaluated, under review, or received an approved waiver for RY 2013, results from reviews conducted within the two prior review years, i.e., RY 2012 and RY 2011, were evaluated to determine compliance. If no Items were evaluated for a given category and no other source of information was available to determine compliance over the three year period, a value of Not Determined was assigned for that specific category.

Evaluation of BH-MCO Compliance

There are 34 HealthChoices Behavioral Health (HC BH) Contractors supported by the counties and OMHSAS, which have selected five private sector behavioral health-managed care organizations (BH-MCOs) to operate the HealthChoices-Behavioral Health (HC BH) program throughout

Pennsylvania. For economies of scale, numerous counties have come together to create HealthChoices Oversight Entities that coordinate HC BH Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the HC BH Contractor, and in other cases multiple HC BH Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. Operational reviews are completed for each HealthChoices Oversight Entity. Information for the Compliance with Standards section of the report is derived from monitoring conducted by OMHSAS. These evaluations are performed at the HealthChoices Oversight Entity and BH-MCO level and the findings are reported in OMHSAS' PEPS review tools. The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of each BH-MCO conducted by OMHSAS monitoring staff within the past three years. As appropriate, IPRO subsequently aggregates the HealthChoices Oversight Entity level findings based on their respective subcontracted BH-MCOs.

The PEPS tools specify the standards for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area to collect additional comments. The PEPS standards are a comprehensive set of monitoring items that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Because OMHSAS reviews the HealthChoices Oversight Entities and their subcontracted BH-MCOs over a three-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within a three-year time frame. The PEPS items from RY 2013, RY 2012, and RY 2011 provided the information necessary for this assessment. Those standards not reviewed through the PEPS system in RY 2013 were evaluated on their performance based on RY 2012 and RY 2011 decisions, or other supporting documentation if necessary. IPRO evaluated the elements in the PEPS Item List against a crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Items that are part of OMHSAS' more rigorous monitoring criteria. Review findings for selected OMHSAS-specific Items are not included in this report.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring standards by provision and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Items. Each substandard was assigned a value of met, partially met or not met in the PEPS tools submitted by OMHSAS. If a substandard was not evaluated for a particular HealthChoices Oversight Entity /BH-MCO, it was assigned a value of Not Determined. Compliance with the BBA provisions was then determined based on the aggregate results of the PEPS Items linked to each provision. If all Items were met, the HealthChoices Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HealthChoices Oversight Entity/BH-MCO was evaluated as non-compliant. If no crosswalked Items were evaluated for a given provision and no other source of information was available to determine compliance, a value of Not Applicable (NA) was assigned for that provision. A value of Null was assigned to a provision when none of the existing PEPS Substandards directly covered the Items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results for all provisions within a given category were aggregated to arrive at a summary compliance status for the category. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights - 438.100.

Subpart C: Enrollee Rights and Protections

The general purpose of the Subpart C regulations is to ensure that each MCO has written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights and that the MCO ensures that the MCO's staff and affiliated providers take into account those rights when furnishing services to enrollees. [42 C.F.R. § 438.100 (a), (b)]

Table 1a - PH-MCO Compliance with Subpart C: Enrollee Rights and Protections Regulations

Subpart C: Enrollee Rights and Protection	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	TOTAL PH MMC
Enrollee Rights	C	C	C	C	C	C	C	C	C
Provider-Enrollee Communications	C	C	C	C	C	C	C	C	C
Marketing Activities	C	C	C	C	C	C	C	C	C
Liability for Payment	C	C	C	C	C	C	C	C	C
Cost Sharing	C	C	C	C	C	C	C	C	C
Emergency Services: Coverage and Payment	C	C	C	C	C	C	C	C	C
Emergency and Post-Stabilization Services	C	C	C	C	C	C	C	C	C
Solvency Standards	C	C	C	C	C	C	C	C	C

- All eight categories in Subpart C were compliant overall for PH MMC.
- All eight PH-MCOs were compliant for all categories in Subpart C.

Table 1b - BH-MCO Compliance with Subpart C: Enrollee Rights and Protections Regulations

Subpart C: Enrollee Rights and Protection	CBH	PerformCare	CCBH	MBH	VBH	TOTAL BH MMC
Enrollee Rights	P	P	C	P	P	P
Provider-Enrollee Communications	C	C	C	C	C	C
Marketing Activities	NA	NA	NA	NA	NA	NA
Liability for Payment	C	C	C	C	C	C
Cost Sharing	C	C	C	C	C	C
Emergency and Post-Stabilization Services	C	C	C	C	C	C
Solvency Standards	C	C	C	C	C	C

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/HC BH Contractors (i.e., if seven HC BH Contractors contract with a BH-MCO and a standard has 10 elements, partial compliance on any one of the 70 elements would generate an overall partial compliance status for the BH-MCO).

- Four of the five BH-MCOs were partially compliant with the category of Enrollee Rights; one BH-MCO was compliant with the category.
- Information pertaining to Marketing Activities was considered Not Applicable (NA) as OMHSAS received a CMS waiver on the Marketing Activities category for PA BH-MCOs. As a result of the Center for Medicare and Medicaid Services (CMS) HealthChoices waiver, DHS has been granted an allowance to offer only one BH-MCO per County.
- All five BH-MCOs were compliant for the remaining categories in Subpart C.

Subpart D: Quality Assessment and Performance Improvement Regulations

The general purpose of the regulations included under this heading is to ensure that all services covered under the DHS's Medicaid managed care program are available and accessible to MCO enrollees. [42 C.F.R. § 438.206 (a)]

Table 2a - PH-MCO Compliance with Subpart D: Quality Assessment and Performance Improvement Regulations

Subpart D: Quality Assessment and Performance Improvement	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	TOTAL PH MMC
Access Standards									
Availability of Services (Access to Care)	C	C	C	C	C	C	C	C	C
Coordination and Continuity of Care	C	C	P	C	C	C	C	C	P
Coverage and Authorization of Services	C	C	C	C	C	C	C	C	C
Structure and Operation Standards									
Provider Selection	C	C	C	C	C	C	C	C	C
Provider Discrimination Prohibited	C	C	C	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C	C	C	C
Enrollment and Disenrollment	C	C	C	C	C	C	C	C	C
Grievance Systems	C	C	C	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	C	C	C	C	C	C	C	C
Measurement and Improvement Standards									
Practice Guidelines	C	C	C	C	C	C	C	C	C
Health Information Systems	C	C	C	C	C	C	C	C	C

- Seven of the PH-MCOs were compliant with all eleven categories of Quality Assessment and Performance Improvement Regulations. One of the PH-MCOs was partially compliant with the category of Coordination and Continuity of Care. Across the eleven categories, the total PH MMC was partially compliant in one category.

Table 2b - BH-MCO Compliance with Subpart D: Quality Assessment and Performance Improvement Regulations

Subpart D: Quality Assessment and Performance Improvement	CBH	PerformCare	CCBH	MBH	VBH	TOTAL BH MMC
Access Standards						
Elements of State Quality Strategies	C	C	C	C	C	C
Availability of Services (Access to Care)	P	P	P	P	P	P
Coordination and Continuity of Care	P	P	NC	P	P	P
Coverage and Authorization of Services	P	P	P	P	P	P
Structure and Operation Standards						
Provider Selection	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	P	C	C	C	P
Measurement and Improvement Standards						
Practice Guidelines	P	P	P	P	P	P
Quality Assessment and Performance Improvement Program	C	P	C	C	P	P
Health Information Systems	C	C	C	C	C	C

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/HC BH Contractors (i.e., if seven HC BH Contractors contract with a BH-MCO and a standard has 10 elements, partial compliance on any one of the 70 elements would generate an overall partial compliance status for the BH-MCO).

- All five BH-MCOs were compliant for four of the ten categories: Elements of State Quality Strategies, Provider Selection, Confidentiality and Health Information Systems. Across the other six categories, some or all of the BH-MCOs were partially compliant, therefore making BH MMC overall partially compliant on those categories. For five categories that were partially compliant for BH MMC, each category had multiple BH-MCOs that were partially compliant.
- Each of the five BH-MCOs was partially compliant with at least one category within Subpart D: Quality Assessment and Performance Improvement Regulations. CBH and MBH were partially compliant with four categories: Availability of Services (Access to Care), Coordination and Continuity of Care, Coverage and Authorization of Services and Practice Guidelines. VBH was partially compliant with each of these categories, as well as Quality Assessment and Performance Improvement Program. PerformCare was partially compliant with six categories: those listed above and Subcontractual Relationships and Delegation. CCBH was partially compliant with the categories of Availability of Services (Access to Care), Coverage and Authorization of Services, and Practice Guidelines. CCBH was Non Compliant (NC) with the category of Coordination and Continuity of Care.

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.

Table 3a - PH-MCO Compliance with Subpart F: Federal and State Grievance System Standards

Subpart F: Federal and State Grievance System Standards	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	TOTAL PH MMC
General Requirements	C	C	C	C	C	C	C	C	C
Notice of Action	C	C	C	C	C	C	C	C	C
Handling of Grievances and Appeals	C	C	C	C	C	C	C	C	C
Resolution and Notification: Grievances and Appeals	C	C	C	C	C	C	C	C	C
Expedited Appeals Process/Resolution	C	C	C	C	C	C	C	C	C
Information to Providers & Subcontractors	C	C	C	C	C	C	C	C	C
Recordkeeping and Recording Requirements	C	C	C	C	C	C	C	C	C
Continuation of Benefits Pending Appeal and State Fair Hearings	C	C	C	C	C	C	C	C	C
Effectuation of Reversed Resolutions	C	C	C	C	C	C	C	C	C

- The eight PH-MCOs were compliant on all nine categories in Subpart F: Federal and State Grievance Standards.
- All eight PH-MCOS were reviewed for Effectuation of Reversed Resolutions based on the most current NCQA Accreditation Survey.

Table 3b - BH-MCO Compliance with Subpart F: Federal and State Grievance System Standards

Subpart F: Federal and State Grievance System Standards	CBH	PerformCare	CCBH	MBH	VBH	TOTAL BH MMC
Statutory Basis and Definitions	P	P	P	P	P	P
General Requirements	P	P	P	P	P	P
Notice of Action	P	P	P	P	P	P
Handling of Grievances and Appeals	P	P	P	P	P	P
Resolution and Notification: Grievances and Appeals	P	P	P	P	P	P
Expedited Appeals Process/Resolution	P	P	P	P	P	P
Information to Providers & Subcontractors	P	C	P	P	P	P
Recordkeeping and Recording Requirements	C	C	C	C	C	C
Continuation of Benefits Pending Appeal and State Fair Hearings	P	P	P	P	P	P
Effectuation of Reversed Resolutions	P	P	P	P	P	P

Note: The BH-MCO compliance determination represents the aggregate status of multiple HealthChoices Oversight Entities/HC BH Contractors (i.e., if seven HC BH Contractors contract with a BH-MCO and a standard has 10 elements, partial compliance on any one of the 70 elements would generate an overall partial compliance status for the BH-MCO).

- BH MMC was partially compliant with nine categories in Subpart F. All five BH-MCOs were compliant with the category of Recordkeeping and Recording Requirements.

SECTION II: PERFORMANCE IMPROVEMENT PROJECTS

In accordance with current BBA regulations, IPRO undertook validation of PIPs for each Medicaid MCO.

IPRO's protocol for evaluation of PIPs is consistent with the protocol issued by CMS (*Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002*) and meets the requirements of the final rule on External Quality Review (EQR) of Medicaid Managed Care Organizations issued on January 24, 2003. IPRO's review evaluates each project against nine elements:

1. Project Topic, Type, Focus Area
2. Topic Relevance
3. Quality Indicators
4. Baseline Study Design and Analysis
5. Baseline Study Population
6. Interventions Aimed at Achieving Demonstrable Improvement
7. Demonstrable Improvement

1S. Subsequent or Modified Interventions
2S. Sustained Improvement

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last two relate to sustaining improvement from the baseline measurement. Each element carries a separate weight. IPRO's scoring for each element is based on full, partial and non-compliance. Points are awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance.

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. The seven review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all seven demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance).

PIPs also are reviewed for the achievement of sustained improvement. This has a weight of 20%, for a possible maximum total of 20 points. 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

For PH and BH, when the PIPs are reviewed, all projects are evaluated for the same elements according to the timeline established for that PIP. For all PIPs, the scoring matrix is completed for those review elements where activities have occurred in the review year. At the time of the review, a project is reviewed for only the elements that are due, according to the PIP submission schedule. It will then be evaluated for the remaining elements at later dates, according to the PIP submission schedule.

Table 4 - PIP Review Element Scoring Weights

Review Element	Standard	Scoring Weight
1	Project Title, Type, Focus Area	5%
2	Topic Relevance	5%
3	Quality Indicators	15%
4	Baseline Study and Analysis	10%
5	Baseline Study Population and Baseline Measurement Performance	10%
6	Interventions Aimed at Achieving Demonstrable Improvement	15%
7	Demonstrable Improvement	20%
Total Demonstrable Improvement Score		80%
1S	Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement	5%
2S	Sustained Improvement	15%
Total Sustained Improvement Score		20%
Overall Project Performance Score		100%

PH-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of two Performance Improvement Projects (PIPs) for each Medicaid PH-MCO in 2014 for 2013 activities. For all PH-MCOs, two new PIPs were initiated in 2011 as part of this requirement. All PH-MCOs were required to implement two internal PIPs in priority topic areas chosen by DHS. Prior to the new PIP cycle, DHS required all PH-MCOs with Medicaid managed care operations at the time to implement an Emergency Department (ED) Utilization PIP in the 2009 review year. DHS introduced the ED PIP to address concerns regarding the continued increase in ED utilization for MMC recipients, and selected the topic, indicators, and methodology to be used by all PH-MCOs as applicable. This PIP ended in 2012, and final results were previously included in the 2013 EQR reports for each MCO and previous Statewide reports. 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.

All PH-MCOs were directed to submit their projects using the NCQA Quality Improvement Activity (QIA) form for Conducting Performance Improvement Projects.

Table 5 reflects an overall summary of PIP topics conducted by each PH-MCO.

Table 5 - PH-MCO PIP Topic

PH-MCO	PIP Topic
ABH	1. Reducing BH-PH Admission for Members with SMI through Managed Care Coordination for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventable Readmissions
ACP	1. Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
COV	1. Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
GH	1. Reducing Pediatric Obesity for the Pennsylvania Medical Managed Care Population 2. Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
HPP	1. Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
KF	1. Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potential Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
UHCP	1. Reducing Pediatric Obesity for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventable Readmissions for the Pennsylvania Medicaid Managed Care Population
UPMC	1. Reducing BH-PH Admission for Members with SMI through Managed Care Coordination for the Pennsylvania Medicaid Managed Care Population 2. Reducing Potentially Preventative Readmissions

As per the timeline distributed by DHS for this review period, PH-MCOs were required to submit information for the element of Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement and information for Sustained Improvement.

The following table represents the scores each PH-MCO achieved on the two EQR PIPs that were submitted to IPRO for review in 2014 for activities that occurred through 2013.

Table 6a - PH-MCO PIP Review Score – New EQR Project One

Project 1	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	TOTAL PH MMC
1. Project Title, Type, Focus Area	C	C	C	C	C	C	C	C	C
2.Topic Relevance	C	C	C	C	C	C	C	C	C
3. Quality Indicators	C	C	C	C	C	C	C	C	C
4. Baseline Study and Analysis	C	C	C	C	C	C	C	C	C
5. Baseline Study Population and Baseline Measurement Performance	C	C	C	C	C	C	C	C	C
6. Interventions Aimed at Achieving Demonstrable Improvement	P	P	C	P	C	C	P	P	P
7. Demonstrable Improvement	C	C	P	NA	C	C	C	C	P
Total Demonstrable Improvement Score	72.5	72.5	70	52.5	80	80	72.5	72.5	71.6
1S. Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement	C	P	P	NA	C	C	C	C	P
2S. Sustained Improvement	C	C	P	NA	C	C	C	C	P
Total Sustained Improvement Score	20	17.5	10	0	20	20	20	20	P
Overall Project Performance Score	92.5	90	80	52.5	100	100	92.5	92.5	P

Table 6b - PH-MCO PIP Review Score – New EQR Project Two

Project 2	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	TOTAL PH MMC
1. Project Title, Type, Focus Area	C	C	C	C	C	C	C	C	C
2.Topic Relevance	C	C	C	C	C	C	C	C	C
3. Quality Indicators	C	C	C	C	C	C	C	C	C
4. Baseline Study and Analysis	C	C	C	C	C	C	C	C	C
5. Baseline Study Population and Baseline Measurement Performance	C	C	C	C	C	C	C	C	C
6. Interventions Aimed at Achieving Demonstrable Improvement	P	P	C	C	C	C	C	C	P
7. Demonstrable Improvement	C	C	C	C	C	C	C	C	C
Total Demonstrable Improvement Score	72.5	72.5	80	80	80	80	80	80	78.1
1S. Subsequent or Modified Interventions Aimed at Achieving Sustained Improvement	P	C	C	C	P	C	C	C	P
2S. Sustained Improvement	C	C	C	NC	C	NC	C	P	P
Total Sustained Improvement Score	17.5	20	20	5	17.5	5	20	12.5	P
Overall Project Performance Score	90	92.5	100	85	97.5	85	100	92.5	P

BH-MCO PIP Review

In accordance with current BBA regulations, IPRO undertook validation of one Performance Improvement Project (PIP) for each HealthChoices BH-MCO. Under the existing HealthChoices Behavioral Health agreement with OMHSAS, HC BH Contractors along with the responsible subcontracted entities (i.e., BH-MCOs), are required to conduct a minimum of two focused studies per year. The HC BH Contractors and BH-MCOs are required to implement improvement actions and to conduct follow-up including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action. For the purposes of the EQR, BH-MCOs were required to participate in a study selected by OMHSAS for validation by IPRO in 2014 for 2013 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2014. For this PIP cycle, OMHSAS selected the topic, "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis" as the topic for this PIP. The topic was selected because the Aggregate HealthChoices 30-day Readmission Rate has consistently not met the OMHSAS goal of a rate of 10% or less. In addition, all HealthChoices BH-MCOs continue to remain below the 75th percentile in the Healthcare Effectiveness Data and Information Set (HEDIS) Follow-Up After Hospitalization (FUH) metrics.

The Aim Statement for this PIP is "Successful transition from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices members hospitalized with a mental health or a substance abuse diagnosis." OMHSAS selected three common objectives for all BH-MCOs:

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.
2. Increase kept ambulatory follow-up appointments post-inpatient discharge.
3. Improve medication adherence post-inpatient discharge.

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report due in June 2018. The non-intervention baseline period will be January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal due in early 2015. BH-MCOs will be required to submit interim reports in June 2016 and June 2017, as well as a final report in June 2018. BH-MCOs are required to develop performance indicators and implement interventions based on evaluations of HC BH Contractor-level and BH-MCO-level data, including clinical history and pharmacy data. This PIP is designed to be a collaboration between the HC BH Contractors and BH-MCOs. The BH-MCOs and each of their HC BH Contractors are required to collaboratively develop a root-cause/barrier analysis that identifies potential barriers at the BH-MCO level of analysis. Each of the barriers identified should include the contributing HC BH Contract level data and illustrate how HC BH Contractor knowledge of their high risk populations contributes to the barriers within their specific service areas. Each BH-MCO will submit the single root-cause/barrier analysis according to the PIP schedule.

This PIP was formally introduced to the BH-MCOs and HC BH Contractors during a Quality Management Directors meeting on June 4th 2014. During the latter half of 2014, OMHSAS and IPRO conducted follow-up calls with the BH-MCOs and HC BH Contractors as needed.

As per the timeline distributed by OMHSAS for this review period, BH-MCOs were required to submit their initial proposals in 2014. The initial proposals were reviewed by OMHSAS and IPRO and recommendations were provided to the BH-MCOs. As 2014 is the baseline year, no scoring for the current PIP could occur for the review year. No baseline data were included in the proposal, nor were final goals set for improvement in subsequent years. These elements will be required for future PIP submissions.

The BBA requires that performance measures be validated in a manner consistent with the EQR protocol *Validating Performance Measures*. Audits of MCOs are to be conducted as prescribed by *NCQA's HEDIS 2014, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures* and is consistent with the validation method as described in the EQRO protocols.

PH-MCO Performance Measures

Each PH-MCO underwent a full HEDIS Compliance Audit™ in 2014. The PH-MCOs are required by DHS to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the *HEDIS 2014: Volume 2: Technical Specifications.* All the PH-MCO HEDIS rates are compiled and provided to DHS on an annual basis. Table 7 represents the HEDIS performance for all eight PH-MCOs in 2014 as well as the PH MMC mean and the PH MMC weighted average. All reported HEDIS measure results are displayed in Table 7; a subset of these measures is provided in the PH-MCO annual technical reports.

Comparisons to fee for service Medicaid data are not included in this report as the fee for service data and processes were not subject to a HEDIS compliance audit for HEDIS 2014 measures.

Table 7 - PH-MCO HEDIS 2014 Measure Results

	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	PADHS MEAN	Weighted Average	
Effectiveness of Care											
Prevention and Screening											
Adult BMI Assessment (ABA)											
ABA: Rate	74.77%	87.08%	81.58%	80.78%	79.87%	78.44%	78.16%	88.51%	81.15%	81.18%	▲
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)											
WCC: BMI Percentile Ages 3 - 11 years	66.14%	75.93%	56.21%	53.28%	61.00%	68.71%	52.35%	68.48%	62.76%	62.90%	▲
WCC: BMI Percentile Ages 12 - 17 years	53.45%	71.53%	53.97%	61.84%	69.28%	72.58%	58.21%	68.12%	63.62%	66.15%	▲
WCC: BMI Percentile Total	62.73%	74.54%	55.56%	56.45%	63.80%	69.78%	54.26%	68.35%	63.18%	63.99%	▲
WCC: Counseling for Nutrition Ages 3 - 11 years	71.52%	74.24%	68.63%	66.02%	66.00%	70.86%	65.70%	73.93%	69.61%	69.46%	▲
WCC: Counseling for Nutrition Ages 12 - 17 years	56.03%	60.58%	74.60%	61.18%	66.67%	66.13%	69.40%	69.57%	65.52%	65.47%	▲
WCC: Counseling for Nutrition Total	67.36%	69.91%	70.37%	64.23%	66.23%	69.56%	66.91%	72.41%	68.37%	68.17%	▲
WCC: Counseling for Physical Activity Ages 3 - 11 years	49.37%	65.76%	59.48%	53.28%	46.00%	62.27%	53.43%	64.20%	56.72%	57.73%	▲
WCC: Counseling for Physical Activity Ages 12 - 17 years	56.03%	58.39%	69.84%	60.53%	62.09%	66.94%	72.39%	67.39%	64.20%	64.77%	▲
WCC: Counseling for Physical Activity Ages Total	51.16%	63.43%	62.50%	55.96%	51.43%	63.56%	59.61%	65.32%	59.12%	60.03%	▲
Childhood Immunization Status (CIS)											
CIS: DtaP/DT	79.40%	83.22%	78.70%	77.13%	83.00%	84.99%	82.97%	82.00%	81.43%	81.93%	▲
CIS: IPV	89.58%	95.36%	90.74%	90.02%	93.16%	95.58%	92.46%	93.92%	92.60%	93.13%	▼
CIS: MMR	88.43%	93.82%	89.58%	89.29%	94.92%	93.82%	92.46%	92.94%	91.91%	92.40%	▲
CIS: HiB	88.89%	95.36%	90.28%	89.54%	94.04%	96.91%	91.73%	93.92%	92.58%	93.37%	▼
CIS: Hepatitis B	87.96%	94.70%	90.51%	86.86%	96.03%	94.92%	92.70%	94.16%	92.23%	92.61%	▲
CIS: VZV	89.12%	93.60%	90.51%	89.54%	94.70%	93.60%	92.94%	93.67%	92.21%	92.56%	▲

CIS: Pneumococcal Conjugate	79.17%	83.89%	79.86%	81.02%	83.66%	84.11%	83.21%	85.64%	82.57%	83.19%	▲
CIS: Hepatitis A	82.18%	85.65%	81.71%	82.73%	89.18%	86.98%	87.59%	84.18%	85.03%	85.60%	▲
CIS: Rotavirus	73.84%	74.83%	62.27%	73.97%	72.63%	75.72%	71.05%	75.91%	72.53%	74.04%	▲
CIS: Influenza	62.04%	65.56%	54.17%	61.07%	63.58%	67.33%	60.83%	53.77%	61.04%	62.21%	▲
CIS: Combination 2	71.53%	79.91%	75.46%	69.10%	81.68%	81.90%	77.86%	78.59%	77.00%	77.53%	▲
CIS: Combination 3	67.36%	76.38%	72.69%	66.18%	78.37%	78.81%	75.18%	75.43%	73.80%	74.39%	▲
CIS: Combination 4	62.96%	72.63%	67.36%	62.04%	75.28%	75.50%	71.78%	69.59%	69.64%	70.43%	▲
CIS: Combination 5	58.80%	63.80%	53.70%	57.66%	64.68%	66.89%	58.39%	63.99%	60.99%	62.45%	▲
CIS: Combination 6	50.69%	57.62%	46.30%	50.12%	58.50%	59.60%	54.01%	47.45%	53.04%	54.26%	▲
CIS: Combination 7	55.79%	61.59%	50.23%	54.74%	62.25%	64.24%	56.69%	61.07%	58.33%	59.84%	▲
CIS: Combination 8	49.31%	56.51%	44.44%	48.18%	56.73%	57.17%	52.80%	45.74%	51.36%	52.43%	▲
CIS: Combination 9	46.53%	50.33%	35.19%	44.77%	49.23%	51.43%	44.28%	42.09%	45.48%	46.98%	▲
CIS: Combination 10	45.60%	50.11%	34.03%	43.07%	47.68%	49.45%	43.55%	41.36%	44.36%	45.64%	▲
Immunizations for Adolescents (IMA)											
IMA: Meningococcal	78.94%	83.82%	76.32%	83.70%	90.91%	88.50%	78.83%	85.77%	83.35%	85.06%	▲
IMA: Tdap/Td	80.32%	88.59%	76.83%	86.13%	89.82%	91.15%	80.20%	86.92%	85.00%	86.98%	▲
IMA: Combination #1	77.08%	81.96%	74.56%	82.00%	88.73%	86.73%	76.27%	84.23%	81.44%	83.16%	▲
Lead Screening in Children (LSC)											
LSC: Rate	67.59%	70.42%	71.30%	73.97%	77.48%	74.61%	73.47%	80.83%	73.71%	74.86%	▲
Breast Cancer Screening (BCS)											
BCS: Rate	47.92%	68.72%	56.35%	57.42%	68.71%	66.19%	54.89%	65.86%	60.76%	63.72%	▲
Cervical Cancer Screening (CCS)											
CCS: Rate	53.95%	69.04%	58.51%	62.53%	71.05%	70.95%	63.08%	68.86%	64.75%	67.17%	
Chlamydia Screening in Women (CHL)											
CHL: Ages 16 - 20 years	54.60%	49.73%	57.17%	53.83%	81.51%	61.08%	59.52%	48.91%	58.29%	58.77%	▲
CHL: Ages 21 - 24 years	59.43%	58.66%	65.84%	61.89%	78.16%	66.32%	66.46%	57.91%	64.33%	64.90%	▼
CHL: Total Rate	56.57%	53.45%	61.09%	57.02%	80.05%	63.27%	62.02%	52.57%	60.76%	61.27%	▲
Human Papillomavirus Vaccine for Female Adolescents (HPV)											
HPV: Rate	19.23%	32.96%	17.74%	32.85%	27.81%	24.28%	21.28%	22.63%	24.85%	26.55%	▲
Non-Recommended Cervical Cancer Screening in Adolescent Females											
NCS: Rate	2.71%	3.25%	5.17%	4.56%	3.58%	1.84%	3.08%	6.64%	3.85%	3.79%	
Respiratory Conditions											
Appropriate Testing for Children with Pharyngitis (CWP)											
CWP: Rate	67.71%	58.28%	70.94%	69.23%	71.67%	64.60%	68.35%	78.35%	68.64%	68.99%	▲
Appropriate Treatment for Children with Upper Respiratory Infection (URI)											
URI: Rate	88.43%	85.90%	83.25%	87.50%	89.34%	89.20%	84.88%	86.28%	86.85%	87.23%	▲
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)											
AAB: Rate	31.96%	21.48%	35.59%	26.32%	35.67%	27.03%	26.30%	23.12%	28.43%	26.94%	▲
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)											
SPR: Rate	NA	28.52%	NA	26.87%	32.30%	25.82%	29.25%	29.36%	28.69%	28.57%	▲
Pharmacotherapy Management of COPD Exacerbation (PCE)											
PCE: Systemic Corticosteroid	70.00%	78.76%	68.61%	74.43%	81.81%	78.30%	72.05%	75.26%	74.90%	76.10%	▲

PCE: Bronchodilator	76.67%	89.87%	80.91%	82.12%	91.10%	91.39%	81.82%	82.27%	84.52%	86.00%	▲
Use of Appropriate Medications for People with Asthma (ASM)											
ASM: Ages 5 - 11 years	91.95%	91.34%	85.71%	90.52%	89.96%	92.60%	90.92%	90.87%	90.48%	91.39%	▲
ASM: Ages 12 - 18 years	93.40%	86.73%	NA	87.55%	88.22%	89.35%	85.32%	85.68%	88.04%	87.90%	▼
ASM: Ages 19 - 50 years	78.81%	77.95%	71.79%	79.37%	81.82%	78.97%	68.75%	71.58%	76.13%	78.24%	▲
ASM: Ages 51 - 64 years	85.37%	75.31%	NA	80.90%	77.56%	75.66%	73.08%	70.27%	76.88%	76.52%	▼
ASM: Total Rate	87.50%	84.05%	78.22%	85.93%	84.89%	86.91%	83.28%	81.10%	83.99%	85.33%	▲
Cardiovascular Conditions											
Cholesterol Management for Patients with Cardiovascular Conditions (CMC)											
CMC: LDL-C Screening	77.78%	86.77%	67.39%	81.51%	90.70%	79.20%	80.78%	82.48%	80.83%	82.99%	▼
CMC: LDL-C Level <100 mg/dL	42.86%	52.67%	43.48%	40.39%	47.78%	43.14%	40.63%	43.55%	44.31%	43.99%	▲
Controlling High Blood Pressure (CBP)											
CBP: Total Rate	55.43%	65.59%	62.24%	51.58%	58.35%	60.44%	58.19%	67.59%	59.93%	60.05%	▲
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)											
PBH: Rate	NA	95.12%	NA	88.14%	93.20%	94.74%	76.47%	90.16%	89.64%	90.23%	▲
Diabetes											
Comprehensive Diabetes Care (CDC)											
CDC: HbA1c Testing	79.36%	84.83%	84.36%	84.67%	87.52%	82.51%	81.04%	86.86%	83.90%	84.58%	▲
CDC: HbA1c Poor Control (>9.0%)	46.64%	33.33%	37.91%	45.26%	32.95%	36.72%	45.82%	30.11%	38.59%	37.18%	▼
CDC: HbA1c Control (<8.0%)	45.47%	56.17%	51.82%	47.45%	55.41%	55.17%	45.82%	56.02%	51.66%	52.86%	▲
CDC: HbA1c Control (<7.0%)	31.52%	39.68%	39.73%	34.32%	39.39%	39.23%	29.59%	40.00%	36.68%	36.93%	▲
CDC: Eye Exam	48.15%	65.50%	56.56%	57.66%	64.23%	51.67%	57.01%	59.49%	57.53%	58.07%	▼
CDC: LDL-C Screening	73.83%	77.83%	79.46%	76.16%	83.03%	79.81%	73.13%	81.75%	78.13%	79.11%	▲
CDC: LDL-C Level (<100 mg/dL)	30.54%	39.00%	38.70%	31.39%	43.59%	37.68%	31.34%	46.35%	37.32%	38.59%	▲
CDC: Medical Attention for Nephropathy	81.04%	80.50%	81.36%	81.75%	87.69%	80.92%	80.45%	88.32%	82.75%	83.56%	▲
CDC: Blood Pressure Control (<140/80 mm Hg)	37.25%	45.50%	45.97%	34.79%	32.61%	40.22%	40.90%	47.45%	40.59%	39.97%	▲
CDC: Blood Pressure Control (<140/90 mm Hg)	58.89%	69.50%	71.25%	53.04%	57.07%	66.93%	65.52%	70.26%	64.06%	63.50%	▲
Musculoskeletal											
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)											
ART: Rate	74.36%	77.69%	62.71%	76.05%	78.46%	73.94%	73.17%	71.43%	73.48%	74.28%	▲
Use of Imaging Studies for Low Back Pain (LBP)											
LBP: Rate	75.34%	73.43%	74.40%	72.96%	81.08%	78.53%	72.33%	76.36%	75.55%	75.91%	▼
Behavioral Health											
Follow-up Care for Children Prescribed ADHD Medication (ADD)											
ADD: Initiation Phase	15.30%	19.54%	20.78%	24.30%	13.88%	15.68%	7.39%	45.82%	20.34%	20.01%	▼
ADD: Continuation and Maintenance Phase	10.59%	20.25%	NA	23.12%	8.20%	14.58%	8.16%	53.05%	19.71%	22.35%	▲
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)											
SSD: Rate	81.97%	85.12%	86.18%	85.14%	77.61%	67.12%	79.30%	86.86%	81.16%	78.78%	▼
Diabetes Monitoring for People With Diabetes And Schizophrenia (SMD)											
SMD: Rate	NA	74.77%	65.71%	72.16%	75.69%	67.04%	62.07%	74.64%	70.30%	70.62%	▼
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia (SMC)											
SMC: Rate	NA	NA	NA	75.00%	77.14%	74.49%	NA	59.97%	71.65%	63.30%	▼

Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA: Rate	60.24%	72.04%	54.00%	64.74%	63.86%	75.35%	64.92%	71.16%	65.79%	69.05%	▲
Medication Management											
Annual Monitoring for Patients on Persistent Medications (MPM)											
MPM: ACE inhibitors or ARBs	89.11%	89.60%	85.49%	87.11%	90.17%	83.18%	85.72%	87.67%	87.26%	86.85%	▼
MPM: Digoxin	NA	94.34%	90.91%	92.82%	94.64%	88.64%	88.99%	91.98%	91.76%	91.44%	▲
MPM: Diuretics	86.48%	89.52%	87.21%	86.49%	88.90%	82.01%	85.24%	87.78%	86.70%	86.09%	▼
MPM: Anticonvulsants	66.20%	61.60%	66.38%	69.45%	51.56%	57.38%	58.74%	68.95%	62.53%	62.24%	▼
MPM: Total Rate	85.49%	86.11%	83.74%	84.17%	86.51%	79.75%	81.72%	85.47%	84.12%	83.61%	▼
Medication Management for People With Asthma (MMA)											
MMA: 50% Ages 5 - 11 years	49.38%	63.42%	43.33%	83.81%	50.04%	55.43%	55.78%	61.09%	57.78%	60.27%	▲
MMA: 50% Ages 12 - 18 years	55.56%	64.24%	NA	81.85%	51.81%	57.10%	55.76%	63.09%	61.34%	62.35%	▲
MMA: 50% Ages 19 - 50 years	60.50%	70.09%	NA	84.13%	57.99%	62.57%	59.09%	59.54%	64.85%	65.63%	▲
MMA: 50% Ages 51 - 64 years	77.14%	75.82%	NA	91.45%	77.27%	78.89%	74.44%	67.31%	77.47%	78.77%	▲
MMA: 50% Total	56.42%	66.96%	60.26%	83.80%	56.97%	59.29%	57.49%	61.61%	62.85%	63.88%	▲
MMA: 75% Ages 5 - 11 years	33.75%	39.87%	33.33%	63.55%	24.19%	32.32%	33.51%	33.05%	36.70%	37.17%	▲
MMA: 75% Ages 12 - 18 years	33.33%	43.42%	NA	64.19%	27.26%	35.50%	34.14%	31.55%	38.48%	40.64%	▲
MMA: 75% Ages 19 - 50 years	40.34%	48.44%	NA	68.35%	35.84%	42.73%	38.24%	36.90%	44.40%	45.47%	▲
MMA: 75% Ages 51 - 64 years	57.14%	55.74%	NA	81.04%	53.74%	59.68%	54.14%	51.92%	59.06%	59.39%	▲
MMA: 75% Total	37.53%	44.99%	39.74%	66.13%	32.93%	37.59%	35.79%	35.37%	41.26%	42.21%	▲
Asthma Medication Ratio (AMR)											
AMR: 5-11 years	76.74%	76.25%	65.71%	81.95%	76.82%	71.26%	77.01%	82.43%	76.02%	75.70%	▲
AMR: 12-18 years	73.58%	67.07%	NA	75.45%	69.41%	65.91%	68.26%	70.68%	70.05%	69.29%	▲
AMR: 19-50 years	62.16%	55.38%	47.37%	60.65%	56.67%	50.34%	48.39%	52.41%	54.17%	54.41%	▲
AMR: 51-64 years	70.73%	54.80%	NA	65.77%	58.71%	52.51%	60.56%	56.76%	59.98%	57.38%	▲
AMR: Total Rate	70.88%	64.88%	58.00%	72.99%	65.66%	63.12%	67.19%	66.96%	66.21%	66.28%	▲
Access/Availability of Care											
Adults' Access to Preventive/Ambulatory Health Services (AAP)											
AAP: Ages 20 - 44 years	71.71%	84.10%	75.81%	84.07%	82.77%	82.38%	77.68%	85.76%	80.54%	82.42%	▲
AAP: Ages 45 - 64 years	81.66%	91.49%	85.90%	90.90%	91.64%	91.03%	85.96%	92.15%	88.84%	90.38%	▲
AAP: Ages 65 years and older	83.51%	90.70%	82.17%	88.05%	88.40%	88.17%	83.70%	87.80%	86.56%	87.52%	▲
AAP: Total Rate	74.87%	86.55%	79.30%	86.23%	86.40%	85.57%	80.69%	88.11%	83.47%	85.28%	▲
Children and Adolescents' Access to Primary Care Practitioners (CAP)											
CAP: Ages 12 - 24 months	95.01%	96.43%	94.55%	96.84%	97.32%	97.35%	95.99%	96.39%	96.24%	96.65%	▼
CAP: Ages 25 months - 6 years	82.16%	87.61%	85.96%	88.95%	87.91%	88.67%	87.92%	88.84%	87.25%	88.16%	▲
CAP: Ages 7 - 11 years	81.67%	91.94%	79.52%	92.31%	91.32%	92.29%	90.34%	92.21%	88.95%	91.59%	▲
CAP: Ages 12 - 19 years	78.08%	91.51%	75.72%	90.80%	89.40%	90.60%	88.51%	90.36%	86.87%	89.88%	▼
Annual Dental Visits (ADV)											
ADV: Ages 2 - 3 years	40.15%	34.20%	29.34%	28.56%	54.29%	53.30%	38.76%	30.49%	38.64%	40.18%	▲
ADV: Ages 4 - 6 years	59.14%	61.20%	51.24%	60.11%	74.75%	73.25%	62.34%	61.55%	62.95%	65.55%	▲
ADV: Ages 7 - 10 years	57.61%	62.86%	50.91%	60.77%	73.75%	70.50%	63.26%	60.45%	62.51%	64.78%	▲
ADV: Ages 11 - 14 years	52.28%	58.62%	47.69%	57.78%	67.64%	64.51%	58.78%	58.60%	58.24%	60.36%	▲

ADV: Ages 15 - 18 years	43.51%	52.68%	41.71%	51.58%	56.52%	54.52%	50.58%	52.67%	50.47%	52.45%	▲
ADV: Ages 19 - 21 years	33.58%	40.69%	30.22%	38.38%	42.57%	41.26%	35.85%	39.22%	37.72%	39.31%	▲
ADV: Total Rate	49.42%	54.80%	43.21%	52.71%	64.18%	62.73%	55.29%	53.23%	54.45%	56.71%	▲
Prenatal and Postpartum Care (PPC)											
PPC: Timeliness of Prenatal Care	86.21%	92.22%	86.85%	81.75%	86.86%	84.00%	82.00%	93.19%	86.64%	86.38%	▼
PPC: Postpartum Care	63.79%	68.00%	62.68%	61.56%	68.60%	58.67%	56.20%	71.29%	63.85%	63.86%	▲
Call Answer Timeliness (CAT)											
CAT: Rate	74.81%	89.08%	84.50%	67.73%	68.94%	90.18%	89.94%	82.63%	80.98%	80.15%	▼
Use of Services											
Frequency of Ongoing Prenatal Care (FPC)											
FPC: <21 percent	5.61%	1.78%	8.45%	5.60%	4.45%	5.11%	5.60%	0.24%	4.60%	4.18%	▼
FPC: 21 - 40 percent	4.91%	1.33%	3.99%	4.38%	6.24%	5.56%	4.87%	1.22%	4.06%	4.05%	▲
FPC: 41 - 60 percent	5.84%	3.33%	7.28%	6.08%	6.68%	10.44%	11.19%	3.16%	6.75%	6.78%	▼
FPC: 61 - 80 percent	15.19%	10.89%	14.55%	12.65%	8.02%	15.78%	14.60%	8.27%	12.49%	12.16%	▼
FPC: >= 81 percent	68.46%	82.67%	65.73%	71.29%	74.61%	63.11%	63.75%	87.10%	72.09%	72.84%	▲
Well-Child Visits in the First 15 Months of Life (W15)											
W15: 0 Visits	3.01%	1.77%	4.98%	1.45%	0.23%	0.23%	1.43%	0.00%	1.64%	0.93%	▼
W15: 1 Visit	0.69%	0.22%	1.56%	1.34%	1.13%	1.13%	2.23%	0.00%	1.04%	1.04%	▼
W15: 2 Visits	2.78%	1.10%	1.87%	2.84%	3.15%	2.26%	3.58%	1.87%	2.43%	2.51%	▲
W15: 3 Visits	2.55%	3.31%	7.79%	5.36%	4.73%	4.52%	6.15%	3.12%	4.69%	4.56%	▼
W15: 4 Visits	9.95%	6.84%	12.46%	10.24%	11.26%	7.47%	12.56%	7.79%	9.82%	9.29%	▲
W15: 5 Visits	17.82%	15.23%	17.13%	18.50%	17.34%	16.29%	20.12%	12.15%	16.82%	16.71%	▼
W15: >= 6 Visits	63.19%	71.52%	54.21%	60.26%	62.16%	68.10%	53.94%	75.08%	63.56%	64.96%	▲
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)											
W34: Rate	71.76%	76.50%	75.42%	74.06%	77.17%	80.80%	73.15%	76.54%	75.68%	76.58%	▲
Adolescent Well-Care Visits (AWC)											
AWC: Rate	46.06%	62.70%	56.94%	59.37%	62.20%	62.42%	54.05%	56.02%	57.47%	58.91%	▼
Frequency of Selected Procedures (FSP)											
FSP: Bariatric Weight Loss Surgery F Ages 0-19 Procs/1000 MM	0.00	0.01	0.00	0.00	0.00	0.01	0.00	0.01	0.00		
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1000 MM	0.10	0.26	0.05	0.11	0.06	0.22	0.17	0.17	0.14		
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1000 MM	0.21	0.34	0.03	0.13	0.05	0.18	0.13	0.17	0.15		
FSP: Bariatric Weight Loss Surgery M Ages 0-19 Procs/1000 MM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
FSP: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1000 MM	0.01	0.10	0.01	0.04	0.00	0.08	0.03	0.06	0.04		
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1000 MM	0.07	0.08	0.00	0.04	0.02	0.06	0.01	0.05	0.04		
FSP: Tonsillectomy MF Ages 0-9 Procs/1000 MM	0.51	0.67	0.47	0.66	0.70	0.56	0.55	0.89	0.63		
FSP: Tonsillectomy MF Ages 10-19 Procs/1000 MM	0.21	0.32	0.23	0.26	0.26	0.22	0.25	0.38	0.27		
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1000 MM	0.13	0.14	0.14	0.15	0.12	0.12	0.16	0.25	0.15		
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1000 MM	0.42	0.37	0.36	0.34	0.35	0.42	0.32	0.33	0.36		
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1000 MM	0.11	0.13	0.17	0.15	0.07	0.07	0.10	0.19	0.12		
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1000 MM	0.33	0.24	0.15	0.19	0.13	0.18	0.19	0.35	0.22		
FSP: Cholecystectomy, Open M Ages 30-64 Procs/1000 MM	0.04	0.04	0.02	0.07	0.04	0.05	0.03	0.05	0.04		
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1000 MM	0.03	0.03	0.02	0.02	0.01	0.02	0.01	0.01	0.02		

FSP: Cholecystectomy Open F Ages 45-64 Procs/1000 MM	0.05	0.09	0.04	0.04	0.04	0.09	0.03	0.04	0.05		
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1000 MM	0.30	0.38	0.41	0.36	0.18	0.22	0.30	0.51	0.33		
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1000 MM	0.51	0.66	0.79	0.78	0.45	0.46	0.68	0.89	0.65		
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1000 MM	0.40	0.83	0.66	0.80	0.51	0.47	0.59	0.87	0.64		
FSP: Back Surgery M Ages 20-44 Procs/1000 MM	0.43	0.40	0.32	0.38	0.14	0.25	0.28	0.48	0.33		
FSP: Back Surgery F Ages 20-44 Procs/1000 MM	0.22	0.27	0.20	0.28	0.06	0.14	0.16	0.34	0.21		
FSP: Back Surgery M Ages 45-64 Procs/1000 MM	0.68	0.89	0.50	0.97	0.28	0.61	0.71	1.16	0.72		
FSP: Back Surgery F Ages 45-64 Procs/1000 MM	0.40	0.79	0.49	0.92	0.30	0.36	0.67	0.93	0.61		
FSP: Mastectomy F Ages 15-44 Procs/1000 MM	0.04	0.02	0.02	0.01	0.01	0.03	0.02	0.02	0.02		
FSP: Mastectomy F Ages 45-64 Procs/1000 MM	0.26	0.13	0.26	0.23	0.12	0.21	0.23	0.19	0.21		
FSP: Lumpectomy F Ages 15-44 Procs/1000 MM	0.15	0.12	0.13	0.10	0.18	0.17	0.18	0.15	0.15		
FSP: Lumpectomy F Ages 45-64 Procs/1000 MM	0.75	0.60	0.51	0.48	0.69	0.62	0.44	0.40	0.56		
Ambulatory Care: Total (AMBA)											
AMBA: Outpatient Visits/1000 MM	268.46	325.05	337.83	344.68	346.15	311.92	292.21	370.65	324.62	330.54	▲
AMBA: Emergency Department Visits/1000 MM	68.35	85.21	78.46	83.16	79.99	68.60	70.81	73.21	75.97	75.74	▲
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)											
IPUA: Total Discharges/1000 MM	9.29	9.24	8.22	8.38	12.93	11.16	8.56	7.65	9.43		
IPUA: Medicine Discharges/1000 MM	3.86	4.13	3.86	3.68	7.44	6.00	4.13	3.24	4.54		
IPUA: Surgery Discharges/1000 MM	2.07	1.92	1.77	1.95	2.47	2.85	2.09	1.68	2.10		
IPUA: Maternity Discharges/1000 MM	5.46	5.05	3.83	4.32	4.48	3.75	3.62	4.01	4.32		
Antibiotic Utilization: Total (ABXA)											
ABXA: Total # of Antibiotic Prescriptions M&F	54,657	126,755	88,443	279,260	141,473	285,448	148,786	298,440	177,908		
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	0.84	1.02	1.02	1.03	0.86	0.94	0.90	1.21	0.98		
ABXA: Total Days Supplied for all Antibiotic Prescriptions M&F	536,441	1,203,627	859,557	2,703,607	1,291,590	2,765,717	1,438,449	2,881,891	1,710,110		
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	9.81	9.50	9.72	9.68	9.13	9.69	9.67	9.66	9.61		
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	21,177	49,163	36,353	110,454	51,389	106,893	59,080	125,186	69,962		
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.33	0.40	0.42	0.41	0.31	0.35	0.36	0.51	0.38		
ABXA: Percent Antibiotics of Concern of all Antibiotic Prescriptions	38.75%	38.79%	41.10%	39.55%	36.32%	37.45%	39.71%	41.95%	39.20%		
Health Plan Descriptive Information											
Board Certification (BCR)											
BCR: % of Family Medicine Board Certified	81.00%	83.37%	78.90%	89.77%	78.85%	82.56%	78.06%	87.17%	82.46%		
BCR: % of Internal Medicine Board Certified	77.61%	82.96%	81.03%	92.30%	76.57%	81.57%	80.45%	86.13%	82.33%		
BCR: % of OB/GYNs Board Certified	75.29%	76.33%	79.48%	78.04%	78.38%	77.59%	81.08%	81.21%	78.42%		
BCR: % of Pediatricians Board Certified	82.77%	87.14%	88.96%	91.52%	80.51%	86.88%	87.42%	92.51%	87.21%		
BCR: % of Geriatricians Board Certified	61.07%	86.57%	64.29%	86.67%	93.75%	84.81%	60.50%	82.76%	77.55%		
BCR: % of Other Physician Specialists Board Certified	69.92%	86.54%	83.63%	91.47%	86.42%	85.32%	83.30%	90.97%	84.70%		

Note: Due to Gateway's initial sampling issues for the CDC measure and required exclusions for the HbA1c<7 indicator, the rate presented for this indicator is based on a sample of 271, and is not the final rate presented to NCQA

▲ ▼ : Comparisons to HEDIS 2013 weighted averages where available and applicable

In addition to HEDIS, PH-MCOs are required to calculate Pennsylvania specific performance measures, which are validated by IPRO on an annual basis. The individual PH-MCO reports include:

- A description of each PA performance measure.
- The MCO's review year rates with 95% upper and lower confidence intervals (95% CI).
- Two years of data (the measurement year and previous year) and the MMC rate.
- Comparisons to the MCO's previous year rate and to the MMC rate.

PA Performance Measure results are presented for each PH-MCO in Table 8 along with the PH MMC Average and PH MMC Weighted Average.

Table 8 - PH-MCO PA Performance Measure 2014 Results

	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities										
Rate	39.4%	46.9%	36.8%	47.1%	60.0%	52.1%	48.8%	47.6%	47.3%	49.19%
Annual number of Asthma Patients (2-20 years old) with one or more asthma-related emergency room visits										
Rate	12.9%	12.3%	12.6%	12.3%	17.3%	13.9%	13.6%	9.7%	13.08%	13.50%
Cesarean rate for Nulliparous Singleton Vertex										
Rate	22.9%	22.1%	21.7%	23.2%	24.0%	22.8%	22.1%	24.5%	22.9%	23.18%
Percent of Live Births weighing less than 2,500 grams										
Rate	8.8%	8.8%	9.9%	8.8%	10.8%	10.5%	9.9%	8.4%	9.5%	9.48%
Dental Sealants for Children (By Age 8)										
Rate	38.3%	52.1%	NA	40.8%	53.6%	50.5%	44.2%	48.5%	48.6%	48.64%
Total Eligibles Receiving Preventive Dental Services										
Rate	36.0%	43.5%	33.6%	42.9%	53.8%	54.9%	43.8%	42.0	43.8%	45.77%
Total Eligibles Receiving Dental Treatment Services										
Rate	16.7%	22.3%	17.0%	23.0%	26.4%	27.3%	23.2%	21.7%	22.19%	23.37%
Reducing Potentially Preventable Readmissions										
Rate	12.3%	10.4%	13.6%	8.8%	15.2%	19.1%	13.1%	4.8%	12.17%	13.26%
Prenatal Screening for Smoking										
Rate 1 - Prenatal Screening for Smoking	80.4%	92.3%	76.6%	NR	92.3%	95.8%	74.2%	91.4%	86.1%	86.24%
Rate 2 - Prenatal Screening for Environmental Tobacco Smoke	23.4%	45.8%	13.3%	NR	65.0%	37.5%	22.5%	15.2%	31.8%	31.96%
Rate 3 - Prenatal Counseling for Smoking*	61.0%	77.9%	56.7%	NR	67.0%	74.4%	65.3%	60.9%	66.2%	65.76%
Rate 4 - Prenatal Counseling for Environmental Tobacco Smoke*	NA	34.8%	NA	NR	65.0%	38.5%	15.0%	32.3%	36.9%	37.94%
Rate 5 - Prenatal Smoking Cessation*	4.2%	11.9%	1.6%	NR	19.7%	18.8%	19.8%	8.2%	12.0%	11.33%
Perinatal Depression Screening										
Rate 1 - Screening for Depression at a Prenatal Visit	63.3%	76.2%	53.1%	NR	94.3%	78.8%	72.7%	60.9%	71.3%	71.44%
Rate 2 - Screening Positive for Depression at a Prenatal Visit	22.6%	14.9%	30.4%	NR	16.8%	15.2%	29.0%	23.0%	21.7%	20.85%

	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC	PH MMC Average	PH MMC Weighted Average
Rate 3 - Counseling for Depression at a Prenatal Visit*	68.4%	95.7%	38.7%	NR	84.4%	89.6%	48.7%	63.2%	69.8%	67.48%
Rate 4 - Screening for Depression at a Postpartum Visit	68.0%	83.8%	52.4%	NR	90.1%	85.5%	100.0%	79.1%	79.8%	78.60%
Rate 5 - Screening Positive for Depression at a Postpartum Visit	18.8%	12.7%	18.8%	NR	9.4%	13.3%	19.6%	17.0%	15.7%	15.03%
Rate 6 - Counseling for Depression at a Postpartum Visit*	91.2%	NA	NA	NR	NA	NA	NA	83.3%	81.3%	81.68%
Follow-Up for Care Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (include the BH data) (CHIPRA 21) – 2013										
Rate 1 MCO Defined	15.3%	19.5%	20.8%	24.3%	13.9%	15.7%	7.4%	45.8%	20.34%	20.02%
Rate 2 MCO Defined	10.6%	20.2%	NA	23.1%	8.2%	14.6%	8.2%	53.0%	19.46%	22.34%
Rate 1 BH ED Enhanced	15.3%	19.8%	20.8%	25.6%	14.1%	15.8%	8.1%	46.9%	20.81%	20.64%
Rate 2 BH ED Enhanced	15.7%	24.9%	NA	28.7%	13.8%	18.6%	21.0%	55.2%	24.43%	27.94%
Adult Asthma Admission Rate (PQI 15)										
Adult Asthma Admission Rate (Age 18-39 years) per 100,000 member years	1.59	1.17	1.11	1.12	3.28	1.88	1.62	0.71	1.56	1.54
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 05)										
Chronic Obstructive Pulmonary Disease Admission Rate (Age 40+ years) per 100,000 member years	8.09	8.59	8.95	11.50	18.02	16.15	11.87	8.87	11.51	12.47
Diabetes Short- Term Complications Admission Rate (PQI 01)										
Age cohort 1-18 to 64 Years of Age	2.05	2.30	1.91	2.31	2.43	2.56	1.85	1.48	2.11	2.13
Age Cohort 2- 65 years and older	2.70	0.97	3.17	0.80	0.00	0.91	0.78	0.00	1.16	0.90
Total 3-18 to 65 Years and Older	2.07	2.28	1.92	2.30	2.40	2.53	1.84	1.46	2.10	2.12
Congestive Heart Failure Admissions Rate (PQI 08)										
Age Cohort 1-18 to 64 years of age	1.76	1.51	1.78	1.57	4.88	3.37	2.68	1.24	2.35	2.45
Age Cohort 2-65 years and older	4.04	22.22	7.92	7.98	9.73	8.17	7.04	8.88	9.50	9.34
Total 3-18 to 65 years and older	1.80	1.79	1.84	1.63	4.95	3.46	2.73	1.30	2.44	2.53
Early Period Screening, Diagnosis and Treatment (EPSDT) Screenings										
Annual Hearing Rate (Ages 4-20 years)	25.7%	38.2%	32.0%	42.9%	30.0%	30.0%	38.4%	45.9%	35.39%	36.62%
Annual Vision Rate (Ages 4-20 years)	26.9%	38.1%	31.7%	43.0%	33.0%	32.3%	38.7%	45.7%	36.16%	37.62%

* Some denominators contained fewer than 100 members. Caution should be exercised when interpreting results for small denominators, as they produce rates that are less stable.

BH-MCO Performance Measures

In accordance with OMHSAS, BH-MCOs are not required to complete a HEDIS Compliance Audit. BH-MCOs and HC BH Contractors are required to calculate Pennsylvania Performance Measures, which are validated annually by IPRO. For 2014 (MY 2013), these measures were: Follow-up After Hospitalization for Mental Illness (both HEDIS and Pennsylvania-specific) and Readmission within 30 Days of Inpatient Psychiatric Discharge. Beginning in 2012, OMHSAS adopted HEDIS percentiles as performance goals for the HEDIS follow-up indicators. The 3-year OMHSAS goal is to achieve the 75th percentile for ages 6-64 based on the annual HEDIS published percentiles for 7-day and 30-day FUH indicators by Measurement Year 2016. Additionally, for Measurement Years 2013 through 2015, BH-MCOS will be given annual interim goals the 7- and 30-day follow-up rates based on the previous year's results. MY 2013 performance measure results are presented in Table 9 for each BH-MCO.

In 2014 OMHSAS elected to implement a statewide measure that focuses on substance abuse services, the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS measure. Results for the initial review year were not reported in the 2014 EQR reports. The results of this measure will be reported beginning with the 2015 External Quality Review Reports.

Table 9 - BH-MCO Performance Measure Results

	CBH	PerformCare	CCBH	MBH	VBH	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	47.4%	36.1%	48.1%	51.3%	46.5%	45.9%	46.9%
Within 30 Days – All Ages	63.0%	60.9%	69.8%	68.4%	70.3%	66.5%	67.5%
Within 7 Days – Ages 6-20	55.3%	52.2%	58.6%	51.9%	57.5%	55.1%	56.0%
Within 30 Days – Ages 6-20	73.1%	74.4%	79.1%	71.1%	81.7%	75.9%	76.8%
Within 7 Days – Ages 6-64	47.7%	36.4%	48.4%	51.5%	46.8%	46.2%	47.1%
Within 30 Days – Ages 6-64	63.5%	61.3%	70.1%	68.6%	70.6%	66.8%	67.8%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	50.3%	48.8%	60.3%	62.5%	57.7%	55.7%	57.0%
Within 30 Days – All Ages	63.9%	69.1%	77.0%	75.3%	75.9%	72.3%	73.4%
Readmission within 30 Days of Inpatient Psychiatric Discharge							
Rate	11.3%	15.5%	14.4%	14.9%	11.4%	13.5%	13.6%

Note: the 2012 report was the first to include rates for the 6-20 age group, which were calculated for MY 2012. The MY 2013 rates for this age group are included again to align with the MY reported in this report.

- The BH MMC average takes the sum of the individual BH-MCO rates and divides that sum by the total number of MCOs participating in the measurement. Note that the BH MMC average therefore is *not* weighted. The MY 2013 BH MMC average for the HEDIS 7-Day Follow-up After Hospitalization measure was 45.9%. Rates for four of the five BH-MCOs (CBH, CCBH, MBH, and VBH) were higher than the BH MMC average. PerformCare was below the BH MMC Average with a rate of 36.1%.
- The BH MMC average for the HEDIS 30-Day Follow-up After Hospitalization for Mental Illness measure was 66.5%. For this indicator, VBH had the highest rate at 70.3%, while PerformCare had the lowest rate at 60.9%. VBH, CCBH and MBH performed above the BH MMC average by 3.8, 3.3 and 1.9 percentage points, respectively.
- Three of the five plans, CBH, MBH and VBH, met their interim goals for the HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness measure for the 6-64 year age group. Two plans, CBH and MBH, met their interim goals for the HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness measure for the 6-64 year age group.
- The OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by any of the five BH-MCOs in MY 2013 for the 7-Day or 30-Day measures.
- The BH MMC average for the 7-Day Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness measure was 55.7%. MBH, CCBH, and VBH performed above the BH MMC average, while performance rates for CBH and PerformCare were below the average by 5.4 and 6.9 percentage points, respectively.

- Three of five BH-MCOs (CCBH, MBH and VBH) had rates above the BH MMC average of 72.3% for the 30-Day Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness, whereas CBH and PerformCare were below the average by 3.2 and 8.4 percentage points, respectively.
- Rates ranged from 11.3% to 15.5% for the Readmission within 30 Days of Inpatient Psychiatric Discharge measure for the BH-MCOs. The lowest rate was observed for CBH at 11.3%, the highest for PerformCare at 15.5%. The BH MMC average for the rate was 13.5%. The rates for three BH-MCOs, CCBH and MBH and PerformCare, were higher than the BH MMC average. Please note that this is an inverted measure, in that lower rates indicate better performance.

SECTION IV: 2013 OPPORTUNITIES FOR IMPROVEMENT – MCO RESPONSE

To achieve full compliance with federal regulations, the PH and BH-MCOs were requested to respond to the opportunities for improvement from the prior year's reports.

The general purpose of this section of the report was to document the degree to which each MCO had addressed the opportunities for improvement made by IPRO in the 2013 EQR Technical Reports, which were distributed in 2014. The 2014 EQR Technical Report is the seventh report to include descriptions of current and proposed interventions considered by each MCO that address the prior year recommendations.

Both the PH-MCOs and BH-MCOs were required to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses were reported consistently across the Pennsylvania Medicaid MCOs. The activities followed a longitudinal format, and were designed to capture information related to:

- Follow-up actions that the MCOs had taken through September 30, 2014 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.

Beginning with the 2009 EQR, PH and BH-MCOs were also required to prepare a Root Cause Analysis and Action Plan for select performance measures noted as opportunities for improvement in the prior year's EQR Technical Report. For 2013, PH-MCOs were required to address those measures on the HEDIS 2013 P4P Measure Matrix receiving either "D" or "F" ratings, while BH-MCOs were required to address those measures that performed statistically significantly poorer than the HealthChoices BH-MCO Average (i.e., BH MMC Average) and/or as compared to the prior measurement year. MCOs were required to submit the following for each applicable performance measure:

- 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.

Individual current and proposed interventions and applicable Root Cause Analysis and Action Plan for each PH and BH-MCO are detailed in their respective annual technical reports. Corrective action plans that were in place at the OMHSAS level were also forwarded to IPRO for inclusion in the BH-MCO 2014 annual technical reports.

SECTION V: 2014 STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT

Overall Strengths

- All PH-MCOs were compliant on all Structure and Operations Standards of Subparts C: Enrollee Rights and Protections Regulations and F: Federal and State Grievance System Standards.
- The PH and BH-MCOs implemented PIPs and provided documentation of their projects for IPRO's review.
    - Two of the eight PH-MCOs are compliant, as of this report, for all reviewed elements in EQR Project One, and two additional PH-MCOs are compliant for EQR Project Two.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2014. Seven PH-MCOs also successfully calculated and completed validation of PA Performance Measures.
- All five BH-MCOs successfully calculated and completed validation of Performance Measures related to Follow-up After Hospitalization for Mental Illness as well as Readmission within 30 Days of Inpatient Psychiatric Discharge.
- Three of the five BH-MCOs, CBH, MBH and VBH, met their interim goals for the HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness measure for the 6-64 year age group. Two plans, CBH and MBH, met their interim goals for the HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness measure for the 6-64 year age group.
- All PH and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2013 annual technical reports.

Overall Opportunities

- One of the PH-MCOs was partially or non-compliant with categories within Subpart D: Quality Assessment and Performance Improvement Regulations.
- Four of the five BH-MCOs were partially compliant with the Enrollee Rights category within Subpart C: Enrollee Rights and Protections Regulations.
- The five BH-MCOs were partially compliant with categories within Subpart D: Quality Assessment and Performance Improvement Regulations.
- The five BH-MCOs were partially compliant with categories within Subpart F: Federal and State Grievance System Standards.
- One PH-MCO did not report the PA-Specific Prenatal Screening for Smoking and Treatment Discussion During A Prenatal Visit and Perinatal Depression Screening measures due to MRR validation issues.
- The OMHSAS goal of meeting or exceeding the 75th percentile was not achieved by any of the five BH-MCOS in MY 2013 for the HEDIS 7-Day or 30-Day Follow-Up After Hospitalization for Mental Illness measure for the 6-64 year age group

Individual MCO strengths and opportunities are detailed in their respective annual technical reports.

Targeted opportunities for improvement were made for PH and BH-MCOs regarding select measures via MCO-Specific Matrices. For PH-MCOs, each P4P Matrix provides a comparative look at selected measures and indicators included in the Quality Performance Measures component of the "HealthChoices MCO Pay for Performance Program." The P4P matrix indicates when a MCO's performance rates for the P4P measures are notable or whether there is cause for action. Those measures that fall into the "D" and "F" graded categories require a root cause analysis and action plan to assist the MCOs with identifying factors contributing to poor performance.

Table 10 displays the HEDIS measures for each PH-MCO requiring a root cause analysis and action plan:

Table 10: PH-MCO Root Cause Analysis Measures

	ABH	ACP	COV	GH	HPP	KF	UHCP	UPMC
D	Adolescent Well-Care Visits (Age 12-21 Years) Comprehensive Diabetes Care – HbA1c Poor Control[2] Comprehensive Diabetes Care: LDL-C Control (<100 mg/dL)		Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received	Comprehensive Diabetes Care: HbA1c Poor Control Comprehensive Diabetes Care: LDL-C Level Controlled (<100 mg/dL) Controlling High Blood Pressure		Frequency of Ongoing Prenatal Care:>=81% of Expected Prenatal Care Visits Received	Comprehensive Diabetes Care: HbA1c Poor Control Comprehensive Diabetes Care: LDL-C Level Controlled (<100 mg/dL)	
F		Annual Dental Visits Emergency Department Utilization[3]	Emergency Department Utilization	Annual Dental Visits	Reducing Potentially Preventable Readmissions[4]	Reducing Potentially Preventable Readmissions	Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received Prenatal and Postpartum Care: Timeliness of Prenatal Care	

For BH, measures requiring a root cause analysis and action plan were identified for each BH-MCO. However, the methodology was modified for 2013. For the PA-specific performance measures (PA-specific Follow-up After Hospitalization for Mental Illness and Readmission within 30 Days of Inpatient Psychiatric Discharge), root cause is identified for performance that was statistically significantly poorer than the BH-MCO average and/or as compared to the prior measurement year. Measures that fall into the "D" and "F" categories correspond to those measures that demonstrate statistically significant reduction in performance in the current measurement year as compared to the prior measurement year and/or statistically significant poorer performance as compared to the HealthChoices BH-MCO Average (i.e., BH MMC Average). For the HEDIS Follow-up After Hospitalization for Mental Illness measures, root cause analysis was required for any indicator that fell below the 75th percentile, for the 6-64 age group.

Tables 11a and 11b display the performance measures for each BH-MCO identified as requiring a root cause analysis and action plan:

[2] Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.
[3] A lower rate, indicating better performance, is preferable for Emergency Department Utilization
[4] Reducing Potentially Preventable Readmissions is an inverted measure. Lower rates are preferable, indicating better performance.

Table 11a: BH-MCO Root Cause Analysis Measures– PA specific Indicators

	CBH	PerformCare	CCBH	MBH	VBH
D				Readmission within 30 Days of Inpatient Psychiatric Discharge	
F	Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day Follow-up After Hospitalization for Mental Illness QI B (PA Specific 30 Day	Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day Follow-up After Hospitalization for Mental Illness QI B (PA Specific 30 Day Readmission within 30 Days of Inpatient Psychiatric Discharge[5]	Readmission within 30 Days of Inpatient Psychiatric Discharge		

Table 11b: BH-MCO Root Cause Analysis Measures – HEDIS Indicators

	CBH	PerformCare	CCBH	MBH	VBH
Indicators that are greater than or equal to the 50th percentile, but less than the 75th percentile	Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Days – Age 6 to 64))		Follow up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Days – 6-64) Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days)	Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Days - Ages 6 to 64) Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days - Ages 6 to 64)	Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Days – 6 to 64) Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days 6 to 64)
Indicators that are less than the 50th percentile	Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days – Ages 6 to 64))	Follow-up After Hospitalization for Mental Illness QI 1 (HEDIS 7 Days)Age 6 to 64 Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days) Age 6 to 64			

[5] Readmission within 30 Days of Inpatient Psychiatric Discharge is an inverted measure. Lower rates are preferable, indicating better performance.

Upon request, the following reports can be made available:

1. Individual PH-MCO BBA Reports for 2014
2. Individual BH-MCO BBA Reports for 2014
3. Follow-up After Hospitalization for Mental Illness External Quality Review Aggregate Data Tables – Measurement Year 2013 (BH-MCOs), and Report – Measurement Years 2011 and 2013
4. Readmission within 30 Days of Inpatient Psychiatric Discharge External Quality Review Aggregate Data Tables – Measurement Year 2012 (BH-MCOs)
5. HEDIS 2014 Member Level Data Reports, Data Analysis Trends (PH-MCOs)
6. HEDIS 2014 Member Level Data Reports, Data Findings by Measure (PH-MCOs)
7. HEDIS 2014 Member Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
8. HEDIS 2014 Member Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
9. HEDIS 2014 Member Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
10. HEDIS 2014 Member Level Data Reports, Year-to-Year Data Findings – New West Zone/Region (PH-MCOs)
11. Medicaid Managed Care (MMC) Performance Measures, Examination of Year-to-Year Statistical Comparisons for MMC Weighted Averages (PH-MCOs)
12. Medicaid Managed Care Performance Measure Matrices (PH-MCOs and BH-MCOs)

Note: Reports #4 and #5 display data by MMC, BH-MCO, County, Region, Gender, Age, Race and Ethnicity.
Reports #6 through #10 display data by MMC, PH-MCO, Region, Race and Ethnicity.