Commonwealth of Pennsylvania
Department of Human Services
2015 External Quality Review Report

Statewide Medicaid Managed Care Annual Report

FINAL REPORT

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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), and the Adult Community Autism Program (ACAP) Prepaid Inpatient Health Plan (PIHP). ACAP is currently a small program, with 146 members enrolled as of December 2015, and EQR findings for this program are presented in a separate section within this report

Pennsylvania MMC services are administered separately for PH services, for BH services, for autism 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 2.1 million recipients in 2015.

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 2015, 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 2015 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)
- Geisinger Health Plan (GHP, implemented March 1, 2013)
- AmeriHealth NorthEast (ACN, implemented March 1, 2013)

GHP and ACN were two new PH MCOs to begin managed care operations on March 1, 2013 as part of the PA HealthChoices program expansion. The review period covered in the 2015 EQR and this report represents the first full year of operation for both MCOs in HealthChoices.

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 2015.

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 2015 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 Application 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) 2014, RY 2013 and RY 2012 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 2014, results from reviews conducted within the two prior review years, i.e., RY 2013 and RY 2012, 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

OMHSAS determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program; the mandatory managed care program that

provides Medical Assistance 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. In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the HC BH Contractors while providing an oversight function of the BH-MCOs.

In some cases the HealthChoices Oversight Entity is the HealthChoices Behavioral Health (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. The Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, who in turn, contract with a private sector BH-MCO. The HC BH Contractor is responsible for their regulatory compliance to federal and state regulations, and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the HC BH Contractor's responsibility for the oversight of BH-MCO's compliance.

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of CCBH by OMHSAS monitoring staff within the past three review years (RYs 2014, 2013, 2012). These evaluations are performed at the BH-MCO and HealthChoices Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for RY 2014. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HealthChoices Behavioral Health Program contract are documented in the RAI. If the Readiness Review occurred within the three-year timeframe under consideration, the RAI was provided to IPRO. For those HealthChoices Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current three-year timeframe, the Readiness Review Substandards were deemed as complete. As necessary, the HealthChoices Behavioral Health Program's Program Standards and Requirements (PS&R) are also used.

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2015 and entered into the PEPS Application as of October 2015 for RY 2014. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HealthChoices Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or Items 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 reviewer comments. Based on the PEPS Application, a HealthChoices Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations, as well as related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

Because OMHSAS's review of the HealthChoices Oversight Entities and their subcontracted BH-MCOs occurs 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 that time frame. The PEPS Substandards from RY 2014, RY 2013, and RY 2012 provided the information necessary for the 2015 assessment. Those standards not reviewed through the PEPS system in RY 2014 were evaluated on their performance based on RY 2013 and/or RY 2012 decisions, or other supporting documentation, if necessary. For those HealthChoices Oversight Entities that completed their Readiness Reviews within the three-year timeframe under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

To evaluate HealthChoices Oversight Entity/BH-MCO compliance on individual provisions, IPRO grouped the required and relevant monitoring substandards by provision, and evaluated the HC BH Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of met, partially met or not met in the PEPS Application submitted by the Commonwealth. 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 across the three-year period 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 ('N/A') 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	ACN	GHP	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
Enrollee Rights	C	C	C	C	C	C	C	C	C	C
Provider-Enrollee Communications	C	C	C	C	C	C	C	C	C	C
Marketing Activities	C	C	C	C	C	C	C	C	C	C
Liability for Payment	C	C	C	C	C	C	C	C	C	C
Cost Sharing	C	C	C	C	C	C	C	C	C	C
Emergency Services: Coverage and Payment	C	C	C	C	C	C	C	C	C	C
Emergency and Post-Stabilization Services	C	C	C	C	C	C	C	C	C	C
Solvency Standards	C	C	C	C	C	C	C	C	C	C

- All eight categories in Subpart C were compliant overall for PH MMC.
- All nine 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	P	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).

- All of the five BH-MCOs were partially compliant with the category of Enrollee Rights.
- 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	ACN	GHP	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
Access Standards										
Availability of Services (Access to Care)	C	C	C	C	C	C	C	C	C	C
Coordination and Continuity of Care	C	C	C	C	C	C	C	C	C	C
Coverage and Authorization of Services	C	C	C	C	C	C	C	C	C	C
Structure and Operation Standards										
Provider Selection	C	C	C	C	C	C	C	C	C	C
Provider Discrimination Prohibited	C	C	C	C	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C	C	C	C	C
Enrollment and Disenrollment	C	C	C	C	C	C	C	C	C	C
Grievance Systems	C	C	C	C	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	C	C	C	C	C	C	C	C	C
Measurement and Improvement Standards										
Practice Guidelines	C	C	C	C	C	C	C	C	C	C
Health Information Systems	C	C	P	C	C	C	C	C	C	P

- Eight 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 Health Information Systems. 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	P	C	C	P
Measurement and Improvement Standards						
Practice Guidelines	P	P	P	P	P	P
Quality Assessment and Performance Improvement Program	C	C	P	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 each partially compliant with the following 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 five categories: Availability of Services (Access to Care), Coordination and Continuity of Care, Coverage and Authorization of Services, Practice Guidelines and Subcontractual Relationships and Delegation. CCBH was partially compliant with the categories of Availability of Services (Access to Care), Coverage and Authorization of Services, Subcontractual Relationships and Delegation, Practice Guidelines and Quality Assessment and Performance Improvement Program. 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	ACN	GHP	GH	HPP	KF	UHC	UPMC	TOTAL PH MMC
General Requirements	C	C	C	C	C	C	C	C	C	C
Notice of Action	C	C	C	C	C	C	C	C	C	C
Handling of Grievances and Appeals	C	C	C	C	C	C	C	C	C	C
Resolution and Notification: Grievances and Appeals	C	C	C	C	C	C	C	C	C	C
Expedited Appeals Process/Resolution	C	C	C	C	C	C	C	C	C	C
Information to Providers & Subcontractors	C	C	C	C	C	C	C	C	C	C
Recordkeeping and Recording Requirements	C	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	C
Effectuation of Reversed Resolutions	C	C	C	C	C	C	C	C	C	C

- The nine PH-MCOs were compliant on all nine categories in Subpart F: Federal and State Grievance Standards.
- All nine 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	C	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	C	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	C	P	P
Effectuation of Reversed Resolutions	P	P	P	C	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 ten 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. 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.

All 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

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 nine 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 sustainability of documented 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 one review element.

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. 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 4 - PIP 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%**

PH-MCO PIP Review

In accordance with current BBA regulations, IPRO worked with DHS to research and define Performance Improvement Projects (PIPs) to be validated for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for 2015 activities. For all PH-MCOs, two new PIPs were initiated in 2015 as part of this requirement.

As part of the new EQR PIP cycle that was initiated for all PH MCOs in 2015, PH MCOs are required to implement two internal PIPs in priority topic areas chosen by DHS. For this PIP cycle, two topics were selected: "Improving Access to Pediatric Preventive Dental Care" and "Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits".

"Improving Access to Pediatric Preventive Dental Care" was selected because on a number of dental measures, the aggregate HealthChoices rates have consistently fallen short of established benchmarks, or have not improved across years. For one measure, the HEDIS Annual Dental Visit (ADV) measure, from HEDIS 2006 through HEDIS 2013, the Medicaid Managed Care (MMC) average was below the 50th percentile for three years. Further, CMS reporting of FFY 2011-2013 data from the CMS-416 indicates that while PA met its two-year goal for progress on preventive dental services, the percentage of PA children age 1-20 who received any preventive dental service for FFY 2013 (40.0%), was below the National rate of 46.0%. The Aim Statement for the topic is "Increase access to and utilization of routine dental care for pediatric Pennsylvania HealthChoices members." Four common objectives for all PH MCOs were selected:

1. Increase dental evaluations for children between the ages of 6 months and 5 years.
2. Increase preventive dental visits for all pediatric HealthChoices members.
3. Increase appropriate topical application of fluoride varnish by non-oral health professionals.
4. Increase the appropriate application of dental sealants for children ages 6-9 (CMS Core Measure) and 12-14 years.

"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).

The PIPs will extend from January 2015 through December 2018; with research beginning in 2015, initial PIP proposals developed and submitted in first quarter 2016, and a final report due in June 2019. The non-intervention baseline period will be January 2015 to December 2015. Following the formal PIP proposal, PH MCOs will additionally be required to submit interim reports in July 2016, June 2017 and June 2018, as well as a final report in June 2019.

No scoring for the current PIPs could occur for this review year. However, multiple levels of activity and collaboration occurred between DHS, the PH MCOs, and IPRO throughout, and prior to the review year. Beginning in 2014, DHS advised of internal discussions regarding the next PIP cycle to begin in 2015, particularly regarding topics in line with its value-based program. At a 2014 MCO Quality Summit, DHS introduced its value-based program and two key performance goals: 1. Reduce Unnecessary Hospitalizations, and 2. Improve Use of Pediatric Preventive Dental Services. DHS asked IPRO to develop PIP topics related to these goals.

Following multiple discussions between DHS and IPRO, the two PIP topics were developed and further refined throughout 2015. Regarding the Dental topic, information related to the CMS Oral Health Initiative was incorporated into the PIP, including examination of data from the CMS preventive dental measure, and inclusion of the measure as a core performance measure for the PIP. Through quarterly calls with MCOs, DHS discussed and solicited information regarding initiatives that were being developed for improving access to and delivery of quality oral healthcare services. Following additional review of the research and the PIP topic, initiatives that appeared to have potential value were included in the PIP proposal as areas in which PH MCOs can seek to focus their efforts and develop specific interventions for their PIP. The PIP topic was introduced at a PH MCO Medical Directors' meeting in Fall 2015.

Regarding the Readmission topic, initial discussions resulted in a proposal that focused primarily on the research indicating ambulatory care sensitive conditions which, if left unmanaged, could result in admissions and are related to readmissions, focusing on particular conditions. Throughout 2015, DHS continued to refine its focus for this topic. In Fall 2015, DHS introduced two new pay-for-performance programs for the MCOs: the PH MCO and BH MCO Integrated Care Plan (ICP) Program Pay for Performance Program to address the needs of individuals with SPMI, and the Community Based Care

Management (CBCM) Program. As a result, DHS requested that the topic be enhanced to incorporate elements of the new programs, including initiatives outlined for both programs that were provided as examples of activities that may be applicable for use in the PIP. MCOs are to consider and collect measures related to these programs; however, they have been instructed that the focus of the PIP remains on each MCO's entire population, and each MCO is required to analyze and identify indicators relevant to its specific population.

PH MCOs will be asked to participate in multi-plan PIP update calls through the duration of the PIP to report on their progress or barriers to progress. Frequent collaboration between DHS and PH MCOs is also expected to continue.

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 2015 for 2014 activities.

A new EQR PIP cycle began for BH-MCOs and HC BH Contractors in 2015. 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 2015 through December 2018, with initial PIP proposals submitted in 2015 and a final report due in June 2019. The non-intervention baseline period will be January 2015 to December 2015 BH-MCOs were required to submit an initial PIP proposal during November 2015, with a final proposal due in early 2016. BH-MCOs will be required to submit interim reports in June 2017 and June 2018, as well as a final report in June 2019. 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.

As per the timeline distributed by OMHSAS for this review period, BH-MCOs were required to submit their initial proposals in 2015. The initial proposals were reviewed by OMHSAS and IPRO and recommendations were provided to the BH-MCOs. As 2015 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.

All BH-MCOs submitted their PIP Final Proposal document in April 2015, and submitted their PIP Year 1 Update document for review in October 2015. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. The initial proposal was reviewed by OMHSAS and IPRO and recommendations were provided to the BH-MCOs. BH-MCOs were given the opportunity to schedule a technical assistance meeting to review their changes based on the initial review. These assistance calls occurred in August 2015.

SECTION III: PERFORMANCE MEASURES

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 2015, 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 2015. 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 2015: Volume 2: Technical Specifications.* All the PH-MCO HEDIS rates are compiled and provided to DHS on an annual basis. Table 5 represents the HEDIS performance for all eight PH-MCOs in 2015 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 2015 measures.

Table 5 - PH-MCO HEDIS 2015 Measure Results

	ABH	ACP	ACN	GHP	GH	HPP	KF	UHCP	UPMC	PA DHS MEAN	Weighted Average	
Effectiveness of Care												
Prevention and Screening												
Adult BMI Assessment (ABA)												
ABA: Rate	67.36%	88.89%	NR	94.34%	83.21%	83.44%	81.25%	70.49%	92.39%	82.67%	83.04%	▲
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)												
WCC: BMI Percentile Ages 3 - 11 years	50.70%	77.51%	56.49%	79.01%	62.65%	69.47%	70.03%	65.40%	75.40%	67.41%	68.49%	▲
WCC: BMI Percentile Ages 12 - 17 years	52.03%	83.92%	57.82%	79.87%	64.94%	71.23%	68.97%	67.81%	70.45%	68.56%	69.11%	▲
WCC: BMI Percentile Total	51.16%	79.63%	56.94%	79.32%	63.50%	70.07%	69.68%	66.26%	73.68%	67.80%	68.69%	▲
WCC: Counseling for Nutrition Ages 3 - 11 years	54.93%	73.70%	72.98%	66.41%	71.21%	74.04%	73.87 %	64.26%	72.58%	69.33%	70.22%	▲
WCC: Counseling for Nutrition Ages 12 - 17 years	50.68%	72.03%	68.71%	66.44%	65.58%	78.08%	62.76%	57.53%	62.88%	64.97%	64.58%	▼
WCC: Counseling for Nutrition Total	53.47%	73.15%	71.53%	66.42%	69.10%	75.41%	70.14%	61.86%	69.21%	67.81%	68.24%	▲
WCC: Counseling for Physical Activity Ages 3 - 11 years	47.54%	67.47%	66.67%	59.54%	64.59%	58.25%	67.25%	57.79%	60.89%	61.11%	61.94%	▲
WCC: Counseling for Physical Activity Ages 12 - 17 years	49.32%	72.73%	65.99%	68.46%	66.23%	67.12%	59.31%	54.79%	58.33%	62.48%	62.15%	▼
WCC: Counseling for Physical Activity Ages Total	48.15%	69.21%	66.44%	62.77%	65.21%	61.25%	64.58%	56.72%	60.00%	61.59%	62.00%	▲
Childhood Immunization Status (CIS)												
CIS: DtaP/DT	79.17%	80.56%	80.09%	81.27%	76.89%	84.01%	83.33%	77.37%	79.56%	80.25%	80.33%	▼
CIS: IPV	87.27%	92.13%	89.35%	91.73%	92.46%	94.94%	95.60%	86.86%	91.73%	91.34%	92.08%	▼
CIS: MMR	92.59%	92.36%	90.05%	91.73%	90.27%	95.95%	94.91%	92.21%	90.27%	92.26%	92.48%	▲
CIS: HiB	85.42%	92.36%	89.12%	91.48%	91.00%	95.55%	95.60%	89.29%	91.24%	91.23%	91.85%	▼
CIS: Hepatitis B	90.05%	96.06%	91.20%	95.13%	92.94%	95.95%	95.14%	81.51%	92.70%	92.30%	92.68%	▲
CIS: VZV	93.06%	92.82%	90.28%	92.70%	91.24%	95.14%	96.06%	91.73%	89.78%	92.53%	92.84%	▲
CIS: Pneumococcal Conjugate	79.17%	81.94%	78.70%	83.45%	78.10%	85.63%	83.56%	79.08%	83.45%	81.45%	81.71%	▼

CIS: Hepatitis A	82.18%	84.95%	79.17%	80.78%	83.94%	93.32%	91.90%	87.35%	86.13%	85.52%	86.77%	▲
CIS: Rotavirus	69.21%	71.99%	65.05%	78.59%	71.05%	71.46%	73.61%	70.32%	72.02%	71.48%	71.93%	▼
CIS: Influenza	53.24%	61.57%	41.67%	54.50%	55.47%	61.54%	64.35%	60.83%	56.69%	56.65%	58.37%	▼
CIS: Combination 2	70.60%	78.47%	75.93%	76.16%	73.48%	81.17%	79.86%	69.10%	74.94%	75.52%	75.79%	▼
CIS: Combination 3	67.59%	75.46%	70.14%	73.24%	70.80%	78.14%	75.93%	65.69%	72.51%	72.17%	72.61%	▼
CIS: Combination 4	62.50%	70.83%	63.19%	65.21%	67.64%	77.33%	74.07%	63.75%	69.34%	68.21%	69.34%	▼
CIS: Combination 5	55.09%	62.27%	56.02%	65.94%	59.37%	63.97%	62.73%	56.69%	60.34%	60.27%	60.60%	▼
CIS: Combination 6	41.90%	55.32%	35.88%	46.96%	47.93%	55.26%	55.56%	45.01%	49.15%	48.11%	49.73%	▼
CIS: Combination 7	52.31%	59.49%	52.08%	59.61%	57.66%	63.36%	62.04%	55.96%	58.88%	57.93%	58.78%	▼
CIS: Combination 8	40.51%	53.70%	33.56%	43.80%	46.72%	55.06%	55.09%	44.77%	47.93%	46.79%	48.65%	▼
CIS: Combination 9	35.19%	47.92%	30.09%	43.55%	41.61%	46.36%	46.53%	39.90%	42.34%	41.50%	42.70%	▼
CIS: Combination 10	34.03%	46.76%	28.47%	41.12%	40.88%	46.36%	46.30%	39.90%	41.36%	40.57%	41.96%	▼
Immunizations for Adolescents (IMA)												
IMA: Meningococcal	75.69%	79.17%	77.97%	83.70%	84.91%	89.66%	86.69%	80.33%	85.59%	82.63%	83.82%	▼
IMA: Tdap/Td	75.93%	86.67%	81.93%	86.13%	86.13%	92.12%	89.08%	82.62%	88.21%	85.42%	86.33%	▼
IMA: Combination #1	73.15%	77.50%	75.74%	81.51%	82.97%	88.67%	84.30%	79.02%	84.72%	80.84%	82.05%	▼
Lead Screening in Children (LSC)												
LSC: Rate	74.77%	71.76%	77.55%	78.83%	77.86%	77.94%	73.61%	74.70%	85.93%	76.99%	77.24%	▲
Breast Cancer Screening (BCS)												
BCS: Rate	54.46%	66.09%	NA	NA	55.19%	70.53%	65.98%	54.39%	64.92%	61.65%	63.28%	▼
Cervical Cancer Screening (CCS)												
CCS: Rate	53.99%	68.09%	65.02%	59.12%	63.50%	77.56%	70.50%	58.07%	66.67%	64.73%	66.11%	▼
Chlamydia Screening in Women (CHL)												
CHL: Ages 16 - 20 years	51.19%	48.92%	42.19%	44.64%	50.81%	79.41%	68.63%	57.29%	47.45%	54.50%	56.32%	▼
CHL: Ages 21 - 24 years	59.32%	58.29%	52.70%	57.95%	61.47%	78.54%	73.58%	66.46%	53.86%	62.46%	64.22%	▼
CHL: Total Rate	54.40%	52.41%	46.25%	49.33%	54.71%	79.03%	70.52%	60.44%	49.94%	57.45%	59.33%	▼
Human Papillomavirus Vaccine for Female Adolescents (HPV)												
HPV: Rate	21.76%	33.80%	28.94%	28.47%	31.63%	32.32%	24.83%	25.55%	25.79%	28.12%	27.92%	▲
Non-Recommended Cervical Cancer Screening in Adolescent Females												
NCS: Rate	2.72%	1.81%	4.76%	4.96%	2.68%	1.82%	1.34%	1.67%	4.17%	2.88%	2.64%	▼
Respiratory Conditions												
Appropriate Testing for Children with Pharyngitis (CWP)												
CWP: Rate	62.98%	63.05%	65.94%	67.56%	70.10%	77.16%	54.94%	73.26%	78.26%	68.14%	68.37%	▼
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
URI: Rate	88.91%	87.53%	85.24%	88.52%	89.08%	91.83%	90.53%	86.97%	86.71%	88.37%	88.57%	▲
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)												
AAB: Rate	30.64%	20.26%	18.10%	22.95%	26.40%	44.27%	31.54%	27.71%	23.12%	27.22%	27.52%	▲
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)												
SPR: Rate	39.19%	31.41%	NA	NA	28.08%	31.58%	27.80%	28.47%	32.16%	31.24%	29.80%	▲
Pharmacoptherapy Management of COPD Exacerbation (PCE)												
PCE: Systemic Corticosteroid	70.45%	78.21%	74.71%	79.35%	74.24%	81.45%	79.17%	69.62%	76.00%	75.91%	76.33%	▲
PCE: Bronchodilator	79.75%	91.34%	84.71%	88.26%	84.50%	93.27%	91.71%	82.45%	87.58%	87.06%	87.62%	▲

Use of Appropriate Medications for People with Asthma (ASM)												
ASM: Ages 5 - 11 years	90.14%	92.77%	NA	94.74%	91.23%	91.72%	92.34%	91.39%	89.85%	91.77%	91.72%	▲
ASM: Ages 12 - 18 years	88.21%	87.99%	NA	93.33%	86.56%	86.92%	89.17%	85.25%	87.28%	88.09%	87.64%	▼
ASM: Ages 19 - 50 years	75.79%	78.38%	NA	NA	77.47%	79.43%	79.11%	71.20%	76.52%	76.84%	77.75%	▼
ASM: Ages 51 - 64 years	69.70%	76.67%	NA	NA	78.81%	74.58%	74.24%	73.91%	78.03%	75.13%	75.62%	▼
ASM: Total Rate	83.79%	85.35%	NA	92.41%	84.77%	84.43%	86.84%	83.91%	83.85%	85.67%	85.27%	▼
Cardiovascular Conditions												
Controlling High Blood Pressure (CBP)												
CBP: Total Rate	58.48%	66.15%	71.02%	66.91%	50.12%	65.49%	62.42%	47.88%	68.03%	61.83%	61.64%	▲
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)												
PBH: Rate	84.62%	94.12%	NA	92.31%	89.92%	95.88%	95.00%	81.33%	83.82%	89.62%	89.53%	▼
Diabetes												
Comprehensive Diabetes Care (CDC)												
CDC: HbA1c Testing	84.91%	85.42%	84.90%	88.50%	85.58%	87.56%	80.90%	83.83%	88.32%	85.55%	85.53%	▲
CDC: HbA1c Poor Control (>9.0%)	43.28%	38.54%	40.28%	31.57%	42.52%	36.00%	39.58%	44.67%	32.48%	38.77%	38.13%	▲
CDC: HbA1c Control (<8.0%)	46.93%	50.87%	47.57%	55.29%	45.62%	54.07%	53.65%	46.17%	53.65%	50.42%	51.24%	▼
CDC: HbA1c Control (<7.0%)	33.33%	36.03%	34.72%	40.23%	32.36%	40.39%	37.50%	28.88%	42.82%	36.25%	36.89%	▼
CDC: Eye Exam	47.76%	62.50%	46.18%	62.41%	54.74%	63.70%	40.80%	55.83%	65.88%	55.53%	56.17%	▼
CDC: Medical Attention for Nephropathy	81.26%	79.69%	76.74%	81.75%	82.12%	85.04%	77.78%	81.00%	91.06%	81.83%	82.86%	▼
CDC: Blood Pressure Controlled (<140/90 mm Hg)	61.03%	66.15%	73.61%	73.18%	66.42%	56.44%	64.58%	56.83%	71.72%	65.55%	65.02%	▲
Musculoskeletal												
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)												
ART: Rate	74.34%	84.89%	68.66%	77.34%	80.25%	75.08%	71.70%	76.74%	72.25%	75.70%	75.50%	▲
Use of Imaging Studies for Low Back Pain (LBP)												
LBP: Rate	74.94%	73.67%	73.04%	76.13%	73.40%	80.56%	78.08%	71.54%	73.03%	74.93%	75.28%	▼
Behavioral Health												
Follow-up Care for Children Prescribed ADHD Medication (ADD)												
ADD: Initiation Phase	24.35%	21.82%	26.74%	36.81%	23.79%	15.96%	16.27%	14.54%	51.76%	25.78%	24.99%	▲
ADD: Continuation and Maintenance Phase	26.29%	21.39%	22.41%	34.29%	20.82%	13.48%	12.65%	14.32%	58.07%	24.86%	27.06%	▲
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)												
SSD: Rate	84.83%	90.39%	88.04%	89.05%	87.34%	79.08%	72.21%	80.87%	87.84%	84.41%	82.49%	▲
Diabetes Monitoring for People With Diabetes And Schizophrenia (SMD)												
SMD: Rate	72.53%	69.23%	60.00%	79.25%	68.16%	75.83%	67.44%	65.92%	79.63%	70.89%	71.40%	▲
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia (SMC)												
SMC: Rate	NA	NA	NA	NA	75.00%	76.47%	70.00%	NA	61.92%	70.85%	63.86%	▲
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)												
SAA: Rate	64.51%	77.07%	78.95%	71.03%	67.98%	62.54%	78.92%	64.53%	73.80%	71.04%	71.33%	▲
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)												
APC: Ages 1 - 5 years	NA	NA	NA	0.00%	NA	NA	NA	NA	NA	0.00%	0.00%	
APC: Ages 6 - 11 years	3.85%	1.83%	5.56%	0.54%	6.78%	0.00%	3.07%	0.53%	1.70%	2.65%	1.37%	
APC: Ages 12 - 17 years	11.76%	10.67%	14.04%	1.70%	19.83%	0.60%	6.25%	1.32%	2.51%	7.63%	3.52%	
APC: Total Rate	8.97%	6.98%	10.31%	1.22%	15.54%	0.37%	4.98%	1.02%	2.26%	5.74%	2.73%	

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)												
APM: Ages 1 - 5 years	NA	22.58%	NA	20.00%	24.19%	NA	22.41%	NA	37.84%	25.41%	24.37%	
APM: Ages 6 - 11 years	26.77%	28.08%	28.14%	30.54%	33.65%	14.17%	17.14%	30.88%	50.55%	28.88%	29.58%	
APM: Ages 12 - 17 years	33.26%	36.21%	31.40%	34.05%	38.47%	17.86%	20.50%	34.51%	43.20%	32.16%	33.00%	
APM: Total Rate	30.72%	32.45%	29.82%	32.34%	36.50%	16.72%	19.33%	33.13%	45.47%	30.72%	31.59%	
Medication Management												
Annual Monitoring for Patients on Persistent Medications (MPM)												
MPM: ACE inhibitors or ARBs	86.56%	89.35%	85.50%	89.99%	86.48%	89.41%	85.67%	86.89%	88.07%	87.55%	87.58%	▲
MPM: Digoxin *	44.87%	52.38%	50.00%	58.82%	58.22%	57.84%	55.03%	52.27%	56.16%	53.96%	55.07%	▼
MPM: Diuretics	86.03%	88.98%	89.29%	90.39%	86.42%	87.34%	85.00%	85.90%	89.11%	87.61%	87.19%	▲
MPM: Total Rate	85.85%	89.00%	86.50%	89.72%	86.12%	88.34%	85.16%	86.04%	88.06%	87.20%	87.10%	▲
Medication Management for People With Asthma (MMA)												
MMA: 50% Ages 5 - 11 years	70.21%	70.51%	NA	72.22%	56.13%	47.43%	60.17%	52.91%	57.68%	60.91%	58.15%	▼
MMA: 50% Ages 12 - 18 years	69.40%	65.11%	NA	NA	57.77%	45.60%	60.10%	50.00%	59.60%	58.22%	57.48%	▼
MMA: 50% Ages 19 - 50 years	74.27%	74.02%	NA	NA	60.28%	63.27%	69.18%	58.06%	61.89%	65.85%	65.58%	▼
MMA: 50% Ages 51 - 64 years	91.30%	82.21%	NA	NA	73.67%	76.33%	83.12%	73.11%	76.05%	79.40%	78.71%	▼
MMA: 50% Total	72.29%	71.46%	NA	69.86%	59.18%	55.37%	63.81%	54.08%	61.06%	63.39%	61.63%	▼
MMA: 75% Ages 5 - 11 years	46.50%	45.94%	NA	47.22%	31.61%	22.11%	36.81%	26.46%	35.07%	36.47%	33.97%	▼
MMA: 75% Ages 12 - 18 years	44.40%	42.31%	NA	NA	33.08%	23.35%	35.81%	26.78%	36.36%	34.58%	33.71%	▼
MMA: 75% Ages 19 - 50 years	47.72%	53.35%	NA	NA	40.16%	41.11%	47.46%	35.48%	39.31%	43.51%	43.85%	▼
MMA: 75% Ages 51 - 64 years	65.22%	66.40%	NA	NA	53.22%	55.10%	65.30%	52.10%	51.68%	58.43%	58.82%	▼
MMA: 75% Total	47.29%	49.32%	NA	47.95%	36.14%	32.15%	40.97%	29.68%	38.14%	40.20%	38.55%	▼
Asthma Medication Ratio (AMR)												
AMR: 5-11 years	74.50%	75.83%	NA	92.11%	76.13%	66.69%	67.27%	73.65%	78.51%	75.59%	71.42%	▼
AMR: 12-18 years	68.06%	66.77%	NA	NA	64.57%	58.49%	62.56%	63.98%	66.33%	64.39%	63.55%	▼
AMR: 19-50 years	51.59%	55.89%	NA	NA	56.00%	50.71%	52.50%	50.18%	57.33%	53.46%	53.62%	▼
AMR: 51-64 years	48.48%	58.72%	NA	NA	60.62%	52.07%	49.88%	55.28%	64.26%	55.62%	54.97%	▼
AMR: Total Rate	63.86%	65.56%	NA	82.05%	65.63%	57.90%	61.07%	64.28%	67.38%	65.97%	62.93%	▼
Access/Availability of Care												
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
AAP: Ages 20 - 44 years	77.94%	85.05%	84.89%	88.71%	83.72%	82.76%	81.72%	78.52%	86.11%	83.27%	83.20%	▲
AAP: Ages 45 - 64 years	86.93%	92.65%	90.90%	94.04%	91.47%	92.29%	90.69%	86.04%	92.94%	90.88%	91.16%	▲
AAP: Ages 65 years and older	79.05%	89.17%	87.86%	86.78%	91.68%	89.32%	86.33%	85.12%	88.45%	87.08%	87.16%	▼
AAP: Total Rate	80.82%	87.71%	86.95%	90.62%	86.38%	86.80%	85.19%	81.30%	88.75%	86.06%	86.15%	▲
Children and Adolescents' Access to Primary Care Practitioners (CAP)												
CAP: Ages 12 - 24 months	95.80%	97.09%	97.44%	98.10%	96.29%	96.68%	97.25%	96.92%	97.97%	97.06%	97.01%	▲
CAP: Ages 25 months - 6 years	85.67%	87.89%	90.28%	92.96%	88.46%	87.25%	88.42%	87.71%	90.32%	88.77%	88.64%	▲
CAP: Ages 7 - 11 years	85.84%	91.42%	NA	96.24%	91.88%	92.24%	92.71%	91.20%	92.69%	91.78%	91.89%	▲
CAP: Ages 12 - 19 years	83.90%	90.67%	NA	96.55%	90.37%	89.80%	90.75%	89.57%	90.99%	90.33%	90.15%	▲
Annual Dental Visits (ADV)												
ADV: Ages 2 - 3 years	38.05%	35.91%	30.25%	37.74%	30.57%	64.14%	57.83%	42.46%	31.94%	40.99%	42.56%	▲
ADV: Ages 4 - 6 years	59.58%	63.38%	58.80%	65.10%	60.89%	78.60%	74.07%	65.65%	62.65%	65.41%	66.50%	▲

ADV: Ages 7 - 10 years	59.66%	64.62%	60.09%	65.35%	62.06%	79.62%	71.52%	65.27%	62.70%	65.65%	66.37%	▲
ADV: Ages 11 - 14 years	53.53%	60.29%	54.63%	59.02%	58.49%	74.57%	66.28%	60.92%	58.96%	60.74%	61.54%	▲
ADV: Ages 15 - 18 years	45.56%	53.41%	48.46%	51.58%	51.93%	61.11%	56.33%	52.49%	53.88%	52.75%	53.46%	▲
ADV: Ages 19 - 21 years	35.46%	41.56%	35.05%	37.66%	38.11%	46.08%	41.92%	38.27%	41.35%	39.50%	40.18%	▲
ADV: Total Rate	51.13%	56.56%	51.05%	56.04%	53.73%	70.30%	64.51%	57.75%	54.74%	57.31%	58.20%	▲
Prenatal and Postpartum Care (PPC)												
PPC: Timeliness of Prenatal Care	76.74%	87.91%	83.76%	90.02%	80.05%	85.51%	77.44%	82.00%	92.70%	84.01%	83.84%	▼
PPC: Postpartum Care	60.00%	63.26%	64.97%	72.26%	52.31%	72.43%	59.77%	54.01%	66.91%	62.88%	62.23%	▼
Call Answer Timeliness (CAT)												
CAT: Rate	87.50%	89.74%	89.94%	92.57%	71.33%	77.48%	89.66%	86.24%	77.32%	84.64%	82.81%	▲
Use of Services												
Frequency of Ongoing Prenatal Care (FPC)												
FPC: <21 percent	12.33%	3.72%	9.74%	2.92%	7.79%	5.61%	8.84%	9.49%	2.68%	7.01%	6.82%	▲
FPC: 21 - 40 percent	4.88%	2.56%	3.71%	4.62%	4.87%	3.50%	10.00%	5.60%	3.41%	4.79%	5.01%	▲
FPC: 41 - 60 percent	9.07%	4.19%	4.18%	4.14%	11.19%	9.35%	13.02%	11.68%	5.11%	7.99%	8.58%	▲
FPC: 61 - 80 percent	11.86%	11.63%	10.90%	13.63%	20.92%	13.08%	18.14%	19.95%	11.68%	14.64%	15.21%	▲
FPC: >= 81 percent	61.86%	77.91%	71.46%	74.70%	55.23%	68.46%	50.00%	53.28%	77.13%	65.56%	64.38%	▼
Well-Child Visits in the First 15 Months of Life (W15)												
W15: 0 Visits	1.85%	1.18%	0.00%	0.97%	1.99%	0.70%	0.46%	1.48%	0.32%	1.00%	1.04%	▲
W15: 1 Visit	1.62%	0.94%	1.16%	1.46%	1.55%	1.17%	0.69%	1.23%	0.32%	1.13%	1.06%	▲
W15: 2 Visits	3.47%	2.59%	2.55%	2.68%	2.91%	2.11%	3.24%	1.73%	0.64%	2.44%	2.41%	▼
W15: 3 Visits	6.48%	4.01%	5.79%	3.65%	5.45%	5.62%	4.86%	3.95%	2.56%	4.71%	4.64%	▲
W15: 4 Visits	9.26%	6.60%	8.80%	6.08%	10.43%	10.07%	12.27%	7.65%	5.75%	8.55%	8.98%	▼
W15: 5 Visits	19.91%	15.33%	20.14%	12.65%	18.37%	16.86%	17.36%	15.06%	14.06%	16.64%	16.63%	▼
W15: >= 6 Visits	57.41%	69.34%	61.57%	72.51%	59.30%	63.47%	61.11%	68.89%	76.36%	65.55%	65.24%	▲
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)												
W34: Rate	71.30%	74.17%	77.32%	79.08%	73.58%	77.81%	79.26%	75.30%	77.70%	76.17%	76.36%	▼
Adolescent Well-Care Visits (AWC)												
AWC: Rate	53.94%	53.47%	59.03%	60.34%	58.15%	63.36%	63.26%	56.48%	56.30%	58.26%	58.68%	▼
Frequency of Selected Procedures (FSP)												
FSP: Bariatric Weight Loss Surgery F Ages 0-19 Procs/1000 MM	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00		
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1000 MM	0.09	0.17	0.13	0.10	0.10	0.08	0.13	0.10	0.17	0.12		
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1000 MM	0.14	0.27	0.27	0.13	0.09	0.06	0.13	0.13	0.18	0.16		
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	0.00		
FSP: Bariatric Weight Loss Surgery M Ages 20-44 Procs/1000 MM	0.03	0.05	0.04	0.05	0.01	0.02	0.04	0.04	0.04	0.03		
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1000 MM	0.04	0.03	0.03	0.07	0.01	0.01	0.03	0.02	0.07	0.03		
FSP: Tonsillectomy MF Ages 0-9 Procs/1000 MM	0.51	0.56	0.68	0.53	0.55	0.74	0.52	0.45	0.78	0.59		
FSP: Tonsillectomy MF Ages 10-19 Procs/1000 MM	0.21	0.25	0.35	0.30	0.25	0.20	0.20	0.20	0.35	0.26		
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1000 MM	0.12	0.15	0.15	0.18	0.13	0.16	0.13	0.09	0.18	0.14		
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1000 MM	0.30	0.31	0.25	0.34	0.26	0.38	0.33	0.30	0.27	0.30		
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1000 MM	0.10	0.17	0.11	0.14	0.13	0.08	0.07	0.11	0.18	0.12		
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1000 MM	0.13	0.37	0.13	0.08	0.18	0.19	0.18	0.16	0.17	0.18		

FSP: Cholecystectomy, Open M Ages 30-64 Procs/1000 MM	0.11	0.03	0.07	0.05	0.04	0.06	0.03	0.03	0.06	0.05		
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1000 MM	0.01	0.01	0.01	0.01	0.02	0.02	0.01	0.01	0.00	0.01		
FSP: Cholecystectomy Open F Ages 45-64 Procs/1000 MM	0.08	0.03	0.00	0.05	0.05	0.03	0.07	0.03	0.05	0.04		
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1000 MM	0.31	0.31	0.40	0.45	0.41	0.16	0.22	0.26	0.43	0.33		
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1000 MM	0.66	0.78	0.82	0.90	0.69	0.50	0.45	0.62	0.95	0.71		
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1000 MM	0.66	0.80	0.90	0.94	0.66	0.56	0.50	0.73	0.81	0.73		
FSP: Back Surgery M Ages 20-44 Procs/1000 MM	0.26	0.42	0.43	0.59	0.32	0.09	0.15	0.27	0.48	0.33		
FSP: Back Surgery F Ages 20-44 Procs/1000 MM	0.19	0.23	0.19	0.28	0.23	0.11	0.10	0.22	0.36	0.21		
FSP: Back Surgery M Ages 45-64 Procs/1000 MM	0.77	0.96	0.99	0.86	0.98	0.34	0.44	0.68	1.07	0.79		
FSP: Back Surgery F Ages 45-64 Procs/1000 MM	0.56	0.69	0.58	0.82	0.84	0.31	0.31	0.61	1.00	0.64		
FSP: Mastectomy F Ages 15-44 Procs/1000 MM	0.01	0.03	0.05	0.02	0.03	0.04	0.03	0.02	0.02	0.03		
FSP: Mastectomy F Ages 45-64 Procs/1000 MM	0.30	0.26	0.51	0.13	0.18	0.18	0.18	0.14	0.23	0.23		
FSP: Lumpectomy F Ages 15-44 Procs/1000 MM	0.16	0.12	0.10	0.19	0.13	0.20	0.15	0.15	0.12	0.15		
FSP: Lumpectomy F Ages 45-64 Procs/1000 MM	0.41	0.48	0.49	0.44	0.42	0.50	0.59	0.39	0.48	0.47		
Ambulatory Care: Total (AMBA)												
AMBA: Outpatient Visits/1000 MM	287.40	369.19	404.63	454.83	355.18	345.72	314.33	321.26	440.53	365.90	360.37	▲
AMBA: Emergency Department Visits/1000 MM	73.74	82.16	73.32	68.21	81.86	81.05	66.42	68.18	72.66	74.18	73.98	▼
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)												
IPUA: Total Discharges/1000 MM	8.07	8.40	8.11	7.25	7.66	12.13	10.21	7.47	7.97	8.58		
IPUA: Medicine Discharges/1000 MM	3.71	3.61	3.58	3.04	4.24	8.33	5.47	3.41	3.74	4.35		
IPUA: Surgery Discharges/1000 MM	1.63	1.76	1.73	1.51	1.85	3.13	2.49	1.76	1.95	1.98		
IPUA: Maternity Discharges/1000 MM	4.28	4.75	4.36	4.12	2.46	1.01	3.60	3.56	3.44	3.51		
Antibiotic Utilization: Total (ABXA)												
ABXA: Total # of Antibiotic Prescriptions M&F	153,283	121,022	69,915	161,556	257,946	138,801	253,312	136,614	296,704	176,573		
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	0.90	0.94	1.24	1.26	0.97	0.81	0.86	0.82	1.14	0.99		
ABXA: Total Days Supplied for all Antibiotic Prescriptions M&F	1,497,680	1,162,364	665,154	1,560,650	2,521,427	1,275,393	2,468,471	1,338,039	2,925,845	1,712,780		
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	9.77	9.60	9.51	9.66	9.78	9.19	9.74	9.79	9.86	9.66		
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	60,578	45,623	29,957	70,578	100,502	49,815	92,538	53,291	124,605	69,721		
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.36	0.36	0.53	0.55	0.38	0.29	0.31	0.32	0.48	0.40		
ABXA: Percent Antibiotics of Concern of all Antibiotic Prescriptions	39.52%	37.70%	42.85%	43.69%	38.96%	35.89%	36.53%	39.01%	42.00%	39.57%		
Health Plan Descriptive Information												
Board Certification (BCR)												
BCR: % of Family Medicine Board Certified	72.56%	86.03%	80.14%	83.15%	78.26%	80.04%	88.60%	80.11%	87.84%	81.86%		
BCR: % of Internal Medicine Board Certified	76.29%	84.70%	79.02%	81.14%	85.04%	78.60%	80.41%	82.13%	87.09%	81.60%		
BCR: % of OB/GYNs Board Certified	75.16%	81.15%	69.74%	82.91%	50.68%	79.09%	79.33%	83.19%	79.97%	75.69%		
BCR: % of Pediatricians Board Certified	81.61%	88.60%	85.42%	82.71%	55.65%	84.05%	87.16%	86.95%	90.09%	82.47%		
BCR: % of Geriatricians Board Certified	57.65%	90.16%	100.00%	73.08%	30.95%	96.30%	87.06%	66.94%	82.79%	76.10%		
BCR: % of Other Physician Specialists Board Certified	72.21%	88.13%	87.44%	82.34%	94.95%	84.33%	85.85%	83.89%	90.28%	85.49%		

Note: There were significant changes to the HEDIS specifications for the Annual Monitoring for Patients on Persistent Medications (MPM): Digoxin indicator, which appear to have impacted rates. 2015 rates for this indicator are notably lower than for 2014.

▲ ▼ : Comparisons to HEDIS 2014 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 6 along with the PH MMC Average and PH MMC Weighted Average.

Table 6 - PH-MCO PA Performance Measure 2015 Results

	ABH	ACP	ACN	GHP	GH	HPP	KF	UHCP	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities											
Rate	45.7%	48.9%	47.6%	54.1%	47.8%	64.9%	53.0%	47.6%	49.6%	51.0%	50.6%
Annual number of Asthma Patients (2-20 years old) with one or more asthma-related emergency room visits											
Rate	13.8%	11.3%	9.5%	8.1%	12.5%	16.8%	13.8%	14.0%	11.3%	12.3%	13.1%
Cesarean rate for Nulliparous Singleton Vertex											
Rate	23.9%	21.2%	26.1%	23 0%	22.4%	22.5%	22.0%	22.9%	24.1%	23.1%	23.0%
Percent of Live Births weighing less than 2,500 grams											
Rate	8.5%	9.1%	9.9%	8.8%	9.5%	9.7%	10.7%	9.7%	9.1%	9.4%	9.5%
Elective Delivery (Adult Core Measure PC01-AD)											
Rate	10.9%	10.0%	14.8%	15.0%	11.7%	9.6%	8.9%	11.2%	13.8%	11.8%	11.5%
Total Eligibles Receiving Preventive Dental Services											
Rate	37.9%	44.9%	38.5%	44.2%	44.4%	57.9%	54.9%	46.2%	42.7%	45.7%	46.8%
Reducing Potentially Preventable Readmissions											
Rate	13.0%	9.9%	10.9%	9.7%	8.3%	13.6%	19.2%	12.1%	4.6%	11.3%	12.8%
Prenatal Screening for Smoking											
Rate 1 - Prenatal Screening for Smoking	73.5%	91.0%	89.1%	92.3%	87.5%	88.3%	73.7%	73.1%	95.5%	84.9%	84.9%
CHIPRA Rate 1 - Prenatal Screening for Smoking	73.3%	90.7%	89.1%	92.3%	87.5%	84.1%	73.7%	72.4%	93.7%	84.1%	84.1%
Rate 2 - Prenatal Screening for Environmental Tobacco Smoke	20.3%	33.9%	37.2%	48.4%	21.1%	59.1%	31.7%	22.8%	46.1%	35.6%	35.9%
Rate 3 - Prenatal Counseling for Smoking*	73.6%	66.2%	78.4%	72.7%	75.7%	73.3%	59.7%	76.5%	85.9%	73.5%	74.7%
Rate 4 - Prenatal Counseling for Environmental Tobacco Smoke*	65.5%	41.8%	55.1%	52.5%	40.7%	77.5%	46.7%	38.7%	90.7%	56.6%	59.2%
Rate 5 - Prenatal Smoking Cessation*	2.3%	4.5%	7.0%	0.0%	6.1%	17.9%	8.2%	34.5%	4.2%	9.4%	8.6%
Perinatal Depression Screening											
Rate 1 - Screening for Depression at a Prenatal Visit	55.6%	71.4%	74.3%	66.1%	52.4%	88.8%	63.7%	66.8%	80.2%	68.8%	69.3%
CHIPRA Rate 1 - Screening for Depression at a Prenatal Visit	52.9%	68.6%	72.0%	54.4%	40.2%	80.4%	63.7%	61.4%	75.4%	63.2%	63.8%

	ABH	ACP	ACN	GHP	GH	HPP	KF	UHCP	UPMC	PH MMC Average	PH MMC Weighted Average
Rate 2 - Screening Positive for Depression at a Prenatal Visit	23.1%	18.3%	14.7%	20.3%	17.0%	16.5%	16.6%	25.7%	17.2%	18.8%	18.6%
Rate 3 - Counseling for Depression at a Prenatal Visit*	68.8%	88.5%	76.7%	42.9%	66.7%	84.7%	80.5%	59.7%	80.0%	72.0%	72.1%
Rate 4 - Screening for Depression at a Postpartum Visit	55.7%	83.4%	72.2%	65.0%	78.1%	83.3%	61.6%	89.8%	84.7%	74.9%	74.4%
Rate 5 - Screening Positive for Depression at a Postpartum Visit	17.4%	13.6%	13.5%	19.4%	15.2%	14.2%	7.4%	15.3%	15.7%	14.6%	14.7%
Rate 6 - Counseling for Depression at a Postpartum Visit*	82.6%	93.3	96.2	70.3%	84.2%	83.3%	90.9%	87.0%	91.2%	86.6%	85.8%
Maternity Risk Factor Assessment											
CHIPRA Rate 1 - Prenatal Screening for Alcohol use	70.6%	89.7%	84.5%	88.5%	77.4%	82.9%	72.4%	63.7%	89.5%	79.9%	80.0%
CHIPRA Rate 2 - Prenatal Screening for Illicit drug use	70.6%	89.9%	86.3%	88.5%	74.7%	81.9%	73.2%	63.7%	90.0%	79.9%	80.0%
CHIPRA Rate 3 - Prenatal Screening for Prescribed or over-the-counter drug use	74.87%	90.70%	87.53%	87.98%	72.62%	79.16%	72.94%	62.40%	92.73%	80.10%	80.25%
CHIPRA Rate 4 - Prenatal Screening for Intimate partner violence	28.34%	65.08%	57.51%	65.57%	52.98%	63.77%	55.67%	48.34%	53.38%	54.52%	54.64%
Behavioral Health Risk Assessment (BHRA-CH)											
CHIPRA Rate Prenatal Screening for Behavioral Health Risk Assessment	21.1%	50.5%	47.1%	42.3%	25.9%	57.1%	47.7%	34.5%	45.4%	41.3%	41.7%
Follow-Up for Care Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (include the BH data) (CHIPRA 21) – 2013											
Rate 1 MCO Defined	24.3%	21.8%	26.7%	36.8%	23.8%	16.0%	16.3%	14.5%	51.8%	25.8%	25.0%
Rate 2 MCO Defined	26.3%	21.4%	22.4%	34.3%	20.8%	13.5%	12.7%	14.3%	58.1%	24.9%	27.1%
Rate 1 BH ED Enhanced	25.6%	23.5%	29.4%	38.8%	25.4%	16.3%	17.0%	15.9%	52.9%	27.2%	26.2%
Rate 2 BH ED Enhanced	32.5%	27.1%	25.5%	39.6%	26.1%	22.5%	18.6%	16.8%	62.5%	30.1%	32.3%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA Rate: MCO Defined	64.5%	77.1%	78.9%	71.0%	68.0%	62.5%	78.9%	64.5%	74.3%	71.1%	71.4%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA Rate: BH ED Enhanced	62.2%	72.4%	78.9%	69.9%	72.3%	62.3%	77.1%	67.0%	74.7%	70.8%	71.7%
Adult Asthma Admission Rate (PQI 15)											
Adult Asthma Admission Rate (Age 18-39 years) per 100,000 member years	1.28	0.97	0.58	0.62	0.85	1.70	2.09	1.27	0.81	1.13	1.22
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 05)											
Chronic Obstructive Pulmonary Disease Admission Rate (Age 40+ years) per 100,000 member years	7.70	8.84	7.36	6.84	10.95	10.67	11.98	10.09	7.26	9.08	9.47
Diabetes Short- Term Complications Admission Rate (PQI 01)											
Age cohort 1-18 to 64 Years of Age	2.21	2.08	1.63	1.58	2.40	2.30	2.11	1.50	1.49	1.92	1.96
Age Cohort 2- 65 years and older	1.30	0.84	0.00	0.00	0.00	0.00	0.00	1.55	0.00	0.41	0.40
Total 3-18 to 65 Years and Older	2.20	2.06	1.61	1.57	2.38	2.26	2.07	1.50	1.48	1.90	1.94

	ABH	ACP	ACN	GHP	GH	HPP	KF	UHCP	UPMC	PH MMC Average	PH MMC Weighted Average
Congestive Heart Failure Admissions Rate (PQI 08)											
Age Cohort 1-18 to 64 years of age	1.44	1.25	1.05	1.06	1.68	2.59	2.46	1.83	1.27	1.63	1.74
Age Cohort 2-65 years and older	3.24	6.73	5.90	5.67	11.40	1.68	4.74	1.55	3.85	4.97	4.61
Total 3-18 to 65 years and older	1.46	1.33	1.09	1.10	1.76	2.58	2.50	1.83	1.29	1.66	1.78
Developmental Screening in the First Three Years of Life (CHIPRA Measure DEV-CH)5											
Rate 1: Total	47.6%	41.9%	50.4%	54.2%	47.2%	26.3%	40.0%	47.2%	65.2%	46.7%	47.0%
Rate 2: 1 year	43.6%	35.7%	45.1%	48.7%	42.8%	21.5%	32.2%	44.0%	61.4%	41.7%	42.6%
Rate 3: 2 years	52.2%	45.8%	54.4%	56.8%	50.3%	31.5%	46.4%	50.1%	67.7%	50.6%	50.9%
Rate 4: 3 years	47.4%	45.0%	52.8%	57.3%	50.1%	26.3%	39.5%	47.4%	67.4%	47.4%	47.7%
Early Period Screening, Diagnosis and Treatment (EPSDT) Screenings											
Annual Hearing Rate (Ages 4-20 years)	36.1%	40.2%	43.1%	45.6%	42.8%	33.8%	35.1%	41.6%	48.2%	40.7%	40.4%
Annual Vision Rate (Ages 4-20 years)	36.0%	40.4%	42.8%	44.9%	42.9%	35.0%	36.0%	41.3%	48.2%	40.8%	40.7%

* 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 2015 (MY 2014), 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 MY 2013, 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 2016, BH-MCOS will be given annual interim goals the 7- and 30-day follow-up rates based on the previous year's results. MY 2014 performance measure results are presented in Table 7 for each BH-MCO.

In 2015 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 reported for the first time in the 2015 External Quality Review Reports.

Table 7 - 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	45.7%	44.9%	47.4%	50.2%	47.3%	47.1%	47.2%
Within 30 Days – All Ages	62.0%	69.0%	68.2%	67.5%	71.2%	67.6%	67.4%
Within 7 Days – Ages 6-20	57.3%	56.3%	56.7%	51.8%	60.1%	56.4%	56.5%
Within 30 Days – Ages 6-20	73.9%	78.0%	78.0%	70.6%	82.8%	76.6%	77.0%
Within 7 Days – Ages 6-64	46.1%	45.3%	47.7%	50.3%	47.6%	47.4%	47.6%
Within 30 Days – Ages 6-64	62.6%	69.6%	68.5%	67.7%	71.7%	68.0%	67.9%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	56.9%	56.9%	59.6%	59.8%	57.6%	58.2%	58.5%
Within 30 Days – All Ages	71.7%	76.4%	75.8%	73.5%	76.6%	74.8%	74.8%
Readmission within 30 Days of Inpatient Psychiatric Discharge							
Rate	13.1%	15.9%	14.8%	15.4%	12.1%	14.3%	14.3%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment							
Initiation of AOD Treatment – Ages 13-17	48.9%	30.8%	38.8%	28.9%	26.2%	34.7%	37.0%
Engagement of AOD Treatment – Ages 13-17	38.3%	14.7%	27.4%	19.1%	17.8%	23.5%	25.8%
Initiation of AOD Treatment – Ages 18+	33.9%	26.7%	29.7%	26.3%	27.0%	28.7%	29.8%
Engagement of AOD Treatment – Ages 18+	25.3%	13.8%	19.3%	18.3%	17.3%	18.8%	20.1%
Initiation of AOD Treatment – Ages 13+	34.6%	27.1%	30.5%	26.5%	26.9%	29.1%	30.3%
Engagement of AOD Treatment – Ages 13+	26.0%	13.9%	20.0%	18.4%	17.3%	19.1%	20.5%

- 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 2014 BH MMC average for the HEDIS 7-Day Follow-up After Hospitalization measure was 47.1%. Rates for three of the five BH-MCOs (CCBH, MBH, and VBH) were higher than the BH MMC average. CBH and PerformCare were below the BH MMC.
- The BH MMC average for the HEDIS 30-Day Follow-up After Hospitalization for Mental Illness measure was 67.6%. For this indicator, VBH had the highest rate at 71.2%, while CBH had the lowest rate at 62.0%. PerformCare, CCBH and VBH performed above the BH MMC average by 1.4, 0.6 and 3.6 percentage points, respectively.
- One BH-MCO, PerformCare, met its seven-day and 30-day HEDIS Follow-Up After Hospitalization for Mental Illness goal for the 6-64 year age group; all other BH-MCOs failed to meet their interim MY 2014 goals for either rate.
- 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 58.2%. MBH and CCBH performed above the BH MMC average, while performance rates for CBH, PerformCare and VBH were below the average by 1.3, 1.3 and 0.6 percentage points, respectively.

- Three of five BH-MCOs (CCBH, PerformCare and VBH) had rates above the BH MMC average of 74.8% for the 30-Day Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness, whereas CBH and MBH were below the average by 3.1 and 1.3 percentage points, respectively.
- Rates ranged from 12.1% to 15.9% for the Readmission within 30 Days of Inpatient Psychiatric Discharge measure for the BH-MCOs. The lowest rate was observed for VBH at 12.1%, the highest for PerformCare at 15.9%. The BH MMC average for the rate was 14.3. The rates for three BH-MCOs, PerformCare, CCBH and MBH were higher than the BH MMC average. Please note that this is an inverted measure, in that lower rates indicate better performance.
- The BH MMC average for the Initiation of AOD Treatment measure (all ages) was 29.1%. CBH had the highest Initiation rate at 34.6%, while MBH had the lowest rate at 26.5%. Four of the five BH-MCOs were below the HEDIS 25th percentile for the Initiation numerator.
- The BH MMC average for the Engagement of AOD Treatment measure (all ages) was 19.1%. For this rate CBH and CCBH were above the BH MMC average while PerformCare, MBH and VBH were below the BH MMC average.

SECTION IV: 2014 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 2014 EQR Technical Reports, which were distributed in 2015. The 2015 EQR Technical Report is the eighth 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, 2015 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken, and
- The MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

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 2014, PH-MCOs were required to address those measures on the HEDIS 2014 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 2015 annual technical reports.

SECTION V: 2015 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.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2015. All 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.
- One BH-MCO, PerformCare, met its seven-day and 30-day HEDIS Follow-Up After Hospitalization for Mental Illness goal for the 6-64 year age group; all other BH-MCOs failed to meet their interim MY 2014 goals for either rate.
- All PH and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2014 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.
- 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.
- 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 8 displays the HEDIS measures for each PH-MCO requiring a root cause analysis and action plan:

Table 8: PH-MCO Root Cause Analysis Measures

	ABH	ACP	ACN	GHP	GH	HPP	KF	UHCP	UPMC
D	Comprehensive Diabetes Care – HbA1c Poor Control[1] Reducing Potentially Preventable Readmissions[2] Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received				Controlling High Blood Pressure Comprehensive Diabetes Care: HbA1c Poor Control	Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received	Reducing Potentially Preventable Readmissions	Comprehensive Diabetes Care: HbA1c Poor Control	
F	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Adolescent Well-Care Visits (Age 12-21 Years)	Annual Dental Visits	Annual Dental Visits	Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received	Emergency Department Utilization[3]	Frequency of Ongoing Prenatal Care:>=81% of Expected Prenatal Care Visits Received Prenatal and Postpartum Care: Timeliness of Prenatal Care	Controlling High Blood Pressure Frequency of Ongoing Prenatal Care: ≥81% of Expected Prenatal Care Visits Received	

Note: None of the selected measures required a root cause analysis and action plan from UPMC

For BH, measures requiring a root cause analysis and action plan were identified for each BH-MCO. 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.

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

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

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

Tables 9a and 9b display the performance measures for each BH-MCO identified as requiring a root cause analysis and action plan:

Table 9a: BH-MCO Root Cause Analysis Measures– PA specific Indicators

	CBH	PerformCare	CCBH	MBH	VBH
D		Readmission within 30 Days of Inpatient Psychiatric Discharge[1]		Readmission within 30 Days of Inpatient Psychiatric Discharge[4]	
F				Follow-up After Hospitalization for Mental Illness QI B (PA Specific 30 Day)	

Table 9b: 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 2 (HEDIS 30 Days) Ages 6 to 64	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) 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) Ages 6 to 64 Follow-up After Hospitalization for Mental Illness QI 2 (HEDIS 30 Days) Ages 6 to 64
Indicators that are less than the 50th percentile	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) Ages 6 to 64			

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

SECTION VI: 2015 ADULT COMMUNITY AUTISM PROGRAM (ACAP)

This waiver program is overseen by the Bureau of Autism Services (BAS) and is designed to me the needs of adults with an autism spectrum disorder. The program is administered by Keystone Autism Services (KAS). KAS provides ambulatory medical services and community and support services to the adults enrolled in the program. As of December 2015, 146 members were enrolled in the program.

Performance Improvement Project

In 2013, KAS undertook a performance improvement project. This project focused on increasing meaningful engagement outside the home for ACAP enrollees. Three areas were addressed

1. Increase job and employment retention rates for KAS ACAP enrollees
2. Improve the proportion of individuals receiving ACAP services who progress from educational and pre-vocational training to an employed status
3. Increase the proportion of non-engaged individuals who become engaged in some form of enrollment/pre-vocational related service

The first remeasurement period ended on 3/31/2015. KAS submitted a progress report to IPRO for review. Improvement was noted in employment placement over the baseline rates. Job retention, as defined by remaining in the same job, did not change over baseline. Employment retention was relatively unchanged. Community engagement was evaluated using the Scales of Independent Behavior – Revised (SIB-R) tool. Modest improvement was noted over baseline for community living measures.

The final report for the project will be submitted for review in 2016, showing baseline, Year 1 and Year 2 performance.

Performance Measures

KAS submitted documentation for the procedures used to track and report the following measures:

1. Annual Number of Law Enforcement Events
2. Psychiatric Emergency Room Care
3. Psychiatric Inpatient Hospitalization
4. Initial PCP visit within three weeks of enrollment or Annual PCP Visit
5. Annual Dental Exam

IPRO validated the data submitted and procedures used to report all 5 measures.

Annual Monitoring

BAS monitored compliance for 2015 and provided IPRO with a final monitoring report. Findings were presented under the following categories:

- Personnel Requirements
- Training
- Participant Records
- Incident Reports
- Fiscal Soundness
- Risk Reserve
- Insolvency

- Cost Avoidance
- Outreach and Marketing
- Individual Service Plan (ISP)
- Participant Rights, Responsibilities and Education
- Measuring Quality and Improvement
- Audits of Medical and Service Records
- Committees
- Participant Enrollment and Disenrollment
- Data Collection, Record Maintenance & Reporting
- Confidentiality
- Reporting Requirements

KAS responded to all recommendations and requests for remediation noted by BAS. All KAS responses were accepted as addressing the issues identified.

FINAL PROJECT REPORTS

Upon request, the following reports can be made available:

1. Individual PH-MCO BBA Reports for 2015
2. Individual BH-MCO BBA Reports for 2015
3. Follow-up After Hospitalization for Mental Illness External Quality Review Aggregate Data Tables – Measurement Year 2014 (BH-MCOs), and Report – Measurement Years 2013 and 2014
4. Readmission within 30 Days of Inpatient Psychiatric Discharge External Quality Review Aggregate Data Tables – Measurement Year 2013 (BH-MCOs)
5. HEDIS 2015 Member Level Data Reports, Data Analysis Trends (PH-MCOs)
6. HEDIS 2015 Member Level Data Reports, Data Findings by Measure (PH-MCOs)
7. HEDIS 2015 Member Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
8. HEDIS 2015 Member Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
9. HEDIS 2015 Member Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
10. HEDIS 2015 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.