Commonwealth of Pennsylvania
Department of Human Services
2016 External Quality Review Report
Statewide Medicaid Managed Care Annual Report

FINAL REPORT

Issue Date: January, 2018

IPRO
Better healthcare,
realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO
9001:2008
CERTIFIED

REPORT CONTENT

List of Tables

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 145 members enrolled as of June 2016, 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 more than 2.2 million recipients in 2016.

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, when it became mandatory statewide. For PH services in 2016, 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 2016 were:

Physical Health MCOs
- Aetna Better Health (ABH)
- AmeriHealth NorthEast (ACN)
- AmeriHealth Caritas Pennsylvania (ACP)
- Geisinger Health Plan (GEI)
- Gateway Health(GH)
- Health Partners Plan (HPP)
- Keystone First (KF)
- United Healthcare Community Plan (UHC)
- UPMC for You (UPMC)

Behavioral Health MCOs
- Community Behavioral Health (CBH)
- Community Care Behavioral Health (CCBH)
- Magellan Behavioral Health (MBH)
- PerformCare
- 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 2016.

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 2016 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 reviews 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) 2015, RY 2014 and RY 2013 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 2015, results from reviews conducted within the two prior review years, i.e., RY 2014 and RY 2013, 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 BH-MCOs by OMHSAS monitoring staff within the past three review years (RYs 2015, 2014, 2013). 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 2015. 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 2016 and entered into the PEPS Application as of October 2016 for RY 2015. 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 2015, RY 2014, and RY 2013 provided the information necessary for the 2016 assessment. Those standards not reviewed through the PEPS system in RY 2015 were evaluated on their performance based on RY 2014 and/or RY 2013 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	ACN	ACP	GEI	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	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
Enrollee Rights	P	C	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).

- CCBH was the only BH-MCO compliant with Enrollee Rights. The other four BH-MCOs were partially compliant.
- 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	ACN	ACP	GEI	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	C	C	C	C	C	C	C	C

- Each PH-MCO was compliant with all eleven categories of Quality Assessment and Performance Improvement Regulations.

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

Subpart D: Quality Assessment and Performance Improvement	CBH	CCBH	MBH	PerformCare	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	NC	P	P	P	P
Coverage and Authorization of Services	P	P	P	P	P	P
Structure and Operation Standards						
Provider Selection	C	C	C	C	C	C
Confidentiality	C	C	C	C	C	C
Subcontractual Relationships and Delegation	C	P	C	P	C	P
Measurement and Improvement Standards						
Practice Guidelines	P	P	P	P	P	P
Quality Assessment and Performance Improvement Program	C	P	P	P	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.
- CBH was the only BH-MCO compliant with Quality Assessment and Performance Improvement Regulations. The four other BH-MCOs were partially compliant.
- CBH, MBH, and VBH were compliant with Subcontractual Relationships and Delegation. The other two BH-MCOs were partially compliant.
- All five BH-MCOs were partially compliant with Availability of Services (Access to Care), Coverage and Authorization of Services, and Practice Guidelines.
- CCBH was non-compliant with Coordination and Continuity of Care. The other four BH-MCOs were partially compliant.

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	ACN	ACP	GEI	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	P	P	C	C	C	P	C	C	P
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 all compliant on eight of nine categories in Subpart F: Federal and State Grievance Standards.
- ACN, ACP, and KF were partially compliant for Recordkeeping and Recording Requirements. The other 6 PH-MCOs were compliant.
- 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	CCBH	MBH	PerformCare	VBH	TOTAL BH MMC
Statutory Basis and Definitions	P	P	P	P	P	P
General Requirements	P	P	P	P	P	P
Notice of Action	P	P	P	P	P	P
Handling of Grievances and Appeals	P	P	P	P	P	P
Resolution and Notification: Grievances and Appeals	P	P	P	P	P	P
Expedited Appeals Process/Resolution	P	P	P	P	P	P
Information to Providers & Subcontractors	P	C	P	C	P	P
Recordkeeping and Recording Requirements	C	C	C	C	C	C
Continuation of Benefits Pending Appeal and State Fair Hearings	P	P	P	P	P	P
Effectuation of Reversed Resolutions	P	P	P	P	P	P

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

- All five BH-MCOs were partially compliant with 8 of 10 categories of Subpart F: Federal and State Grievance System Standards.
- CCBH and PerformCare were compliant with Information to Providers and Subcontractors. The other three BH-MCOs were partially compliant.
- All BH-MCOs were compliant with 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, the multiple levels of activity and collaboration that occurred between DHS, the PH MCOs, and IPRO beginning in 2014 continued and progressed throughout the review year.

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 (OHI) 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 and following additional review of the research and the PIP topic, initiatives that appeared to have potential value for improving access to and delivery of quality oral healthcare services were included in the PIP proposal as areas in which PH MCOs could 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 refined 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. DHS requested the topic to 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 were 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 continue to 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. The PIP Submission Form that included instructions for each section for the proposal submissions was distributed to PH MCOs in February 2016, with a submission deadline for March 2016. Throughout 2016, subsequent to MCO proposal submissions, there were several levels of feedback provided to MCOs. In July, an overall summary document outlining common issues that were observed across most of the PIP proposal submissions was distributed to all PH MCOs. MCOs were asked to review the document and begin to discuss internally with appropriate staff for each of the topics. In July and August, each MCO received its MCO-specific review findings for each PIP and a request for a conference call to discuss, as well as an Update form to be completed following the calls. Throughout July and August, two conference calls were held with each MCO, to discuss the PIP proposal review findings with key MCO staff assigned to each PIP topic. MCOs were asked to complete the PIP Update form following the calls, in preparation for and to be submitted prior to, the MCO PIP Interactive Workshop scheduled by DHS. The Interactive Workshop was held with the MCOs at the end of August. MCOs were requested to come to the workshop with PIP project summaries that they were to present, which were later submitted to IPRO and distributed to all PH MCOs.

Following the workshop, in September, MCOs were given additional information to assist in preparing their next full PIP submission for the Project Year 1 Update. For the Readmission PIP, this included advising that DHS decided to replace the Plan All-Cause Readmissions (PCR) measure with the PAPM Reducing Potentially Preventable Readmissions (RPR) measure, particularly given that it is not reported for HEDIS by the Medicaid MCOs, as it is a HEDIS measure for commercial and Medicare products only. For the Dental PIP, MCOs were given the CMS instructions for State submission of the five core performance measures from the 416 form.

During October and November, additional information was provided to MCOs. For Dental, they were given instructions regarding the core performance measures that are related to the 416 form, and the corresponding line item reporting element to be used from the form. Also, given that there are no established benchmarks for the CMS-416, DHS provided three years of CMS-416 Reports with PA state aggregate data and the excerpt on oral health from the 2015 CMS Secretary's report with CMS OHI all-state data from FFY 2014, for the MCOs to calculate some appropriate benchmarks. For Readmission, MCOS were given the data for four of the five ICP measures. Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure data were not included, as they were not finalized. Data for this measure was sent to MCOs in December, subsequent to their Project Year 1 Update submission. Review of the Project Year 1 Update continued throughout December.

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 2016 for 2015 activities.

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

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

1. Reduce behavioral health and substance abuse readmissions post-inpatient discharge.

2. Increase kept ambulatory follow-up appointments post-inpatient discharge.

3. Improve medication adherence post-inpatient discharge.

Additionally, OMHSAS requires all BH-MCOs to submit the following core performance measures on an annual basis:

- **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Mental Health Discharges)**
  The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days without a substance abuse diagnosis during the initial stay.
- **Readmission Within 30 Days of Inpatient Psychiatric Discharge (Substance Abuse Discharges)**
  The percentage of members who were discharged from an acute inpatient facility to an ambulatory setting who were readmitted within 30 days with a substance abuse diagnosis (primary or secondary) during the initial stay.
- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
  The percentage of members diagnosed with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. This measure is based on the HEDIS measure of the same name.
- **Components of Discharge Management Planning**
  This measure is based on review of facility discharge management plans, and assesses the following:
  a. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers.
  b. The percentage of discharge plans including both medication reconciliation and all components of medication and therapy follow-up appointments: appointment dates, appointment times, provider names, provider addresses and provider phone numbers where at least one of the scheduled appointments occurred.

This PIP project will extend from January 2014 through December 2017, with initial PIP proposals submitted in 2014 and a final report to be due in June 2018. In 2016, OMHSAS elected to add an additional intervention year to the PIP cycle to allow sufficient time for the demonstration of outcomes. The non-intervention baseline period was from January 2014 to December 2014. BH-MCOs were required to submit an initial PIP proposal during November 2014, with a final proposal

due in early 2015. BH-MCOs were required to submit interim reports in June 2016 and June 2017, as well as a final report to be submitted 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.

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

The 2016 EQR is the 13th review to include validation of PIPs. With this PIP cycle, all BH-MCOs/HC BH Contractors share the same baseline period and timeline. To initiate the PIP cycle in 2014, IPRO developed guidelines on behalf of OMHSAS that addressed the PIP submission schedule, the applicable study measurement periods, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given to the BH-MCOs/HC BH Contractors with regard to expectations for PIP relevance, quality, completeness, resubmission, and timeliness. The BH-MCOs were expected to implement the interventions that were planned in 2014, monitor the effectiveness of their interventions, and to improve their interventions based on their monitoring results.

The BH-MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with the Centers for Medicare & Medicaid Services (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

In 2016, OMHSAS elected to begin conducting quarterly PIP review calls with each BH-MCO. The purpose of these calls was to discuss ongoing monitoring of PIP activity, discuss the status of implementing planned interventions, and to provide a forum for technical assistance as necessary. Plans were asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, BH-MCOs were asked to submit only one PIP interim report in 2016, rather than two semi-annual submissions.

Findings

The BH-MCOs submitted their Year 1 PIP Update document for review in June 2016. As required by OMHSAS, the project topic was Successful Transitions from Inpatient Care to Ambulatory Care. IPRO provided feedback and comments to the BH-MCOs on these submissions.

Overall, study designs were improved. Better descriptions of data sources were provided; furthermore, changes from the initial proposal submission described steps taken to improve quality of source data as needed. Many procedural and structural changes were incurred to improve efficiency and effectiveness of each BH-MCO's PIP. To varying extents, the PIPs used monitoring of core interventions to identify additional barriers based on baseline year analysis. As applicable, existing interventions were expanded in scope, and new interventions were developed to account for a larger percentage of the population served.

Generally, indicators in the BH-MCOs' PIPs were outcome-oriented, measurable, and time-specific. Improvements were seen in defining and specifying target populations and measures of processes, outcomes, and intervention monitoring. The methodology sections identified the interventions linked to each measure, as

well as denominator and numerator criteria. Outcomes and processes were linked to objectives, and indicator scale was assessed for appropriateness and relevance to measure performance of each intervention.

Additionally, IPRO identified opportunities for improvement for some PIPs, including goal-setting, scaling up pilot interventions, barrier analyses, and sufficiently relating interventions to proposed study objectives.

Each BH-MCO presented preliminary findings from monitoring core interventions for baseline and Year 1. With varying success, barrier analyses were contextualized to identify target populations. However, results for some interventions and/or barrier analyses, as well as sufficient discussion, were missing from PIP updates.

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 2016, 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 2016. 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 2016: 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 nine PH-MCOs in 2016 as well as the PH MMC mean and the PH MMC weighted average. HEDIS performance for the five BH-MCOs is displayed in Table 7.

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 2016 measures.

Table 5 - PH-MCO HEDIS 2016 Measure Results

	ABH	ACN	ACP	GH	GEI	HPP	KF	UHC	UPMC	PADHS MEAN	Weighted Average	
Effectiveness of Care												
Prevention and Screening												
Adult BMI Assessment (ABA)												
ABA: Rate	69.91%	88.19%	94.33%	71.53%	85.85%	95.77%	86.08%	88.51%	92.54%	85.86%	86.06%	▲
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)												
WCC: BMI Percentile Ages 3 - 11 years	48.08%	69.06%	82.17%	60.14%	78.44%	75.09%	73.38%	63.94%	78.38%	69.85%	70.29%	▲
WCC: BMI Percentile Ages 12 - 17 years	51.03%	68.94%	79.82%	59.60%	75.97%	80.13%	74.26%	66.18%	78.68%	70.51%	70.86%	▲
WCC: BMI Percentile Total	49.07%	69.01%	81.45%	59.95%	77.64%	76.85%	73.68%	64.69%	78.48%	70.09%	70.52%	▲
WCC: Counseling for Nutrition Ages 3 - 11 years	51.92%	69.81%	74.81%	66.55%	71.00%	75.44%	74.90%	71.75%	73.36%	69.95%	70.73%	▲
WCC: Counseling for Nutrition Ages 12 - 17 years	48.28%	68.94%	73.68%	56.95%	55.04%	74.83%	71.32%	56.62%	70.59%	64.03%	64.22%	▼
WCC: Counseling for Nutrition Total	50.69%	69.48%	74.46%	63.19%	65.83%	75.23%	73.68%	66.67%	72.41%	67.96%	68.60%	▲
WCC: Counseling for Physical Activity Ages 3 - 11 years	43.55%	55.09%	58.53%	59.07%	65.43%	62.28%	60.08%	61.71%	69.88%	59.51%	61.03%	▼
WCC: Counseling for Physical Activity Ages 12 - 17 years	46.21%	66.46%	71.93%	56.95%	54.26%	71.52%	68.38%	55.15%	68.38%	62.14%	62.45%	▲
WCC: Counseling for Physical Activity Ages Total	44.44%	59.39%	62.63%	58.33%	61.81%	65.51%	62.91%	59.51%	69.37%	60.43%	61.61%	▲
Childhood Immunization Status (CIS)												
CIS: DtaP/DT	80.56%	76.16%	82.41%	76.85%	80.78%	85.65%	84.65%	80.29%	82.24%	81.06%	81.40%	▲
CIS: IPV	90.28%	90.74%	94.68%	89.35%	91.73%	94.91%	94.42%	91.97%	92.70%	92.31%	92.30%	▲
CIS: MMR	92.13%	88.89%	94.21%	92.82%	91.00%	96.76%	94.19%	91.73%	90.51%	92.47%	92.73%	▲
CIS: HiB	89.81%	89.35%	90.51%	86.57%	91.48%	95.14%	94.65%	92.21%	93.43%	91.46%	91.64%	▲
CIS: Hepatitis B	90.05%	93.06%	95.14%	91.20%	94.40%	97.22%	96.05%	93.19%	93.19%	93.72%	93.64%	▲
CIS: VZV	93.06%	88.19%	92.82%	92.82%	91.24%	96.76%	93.95%	91.97%	91.48%	92.48%	92.90%	▲
CIS: Pneumococcal Conjugate	82.41%	80.79%	85.42%	79.17%	84.18%	86.57%	82.79%	82.00%	84.91%	83.14%	83.10%	▲
CIS: Hepatitis A	87.50%	81.48%	86.34%	83.80%	82.00%	93.52%	89.77%	86.37%	85.64%	86.27%	86.76%	▲

CIS: Rotavirus	68.52%	66.90%	75.00%	68.52%	70.56%	75.46%	68.37%	67.64%	73.24%	70.47%	70.64%	▼
CIS: Influenza	53.24%	42.82%	58.10%	49.77%	48.91%	59.95%	63.72%	59.37%	52.55%	54.27%	55.08%	▼
CIS: Combination 2	77.08%	72.69%	78.94%	70.83%	77.62%	84.49%	82.56%	77.86%	76.89%	77.66%	77.76%	▲
CIS: Combination 3	74.54%	70.14%	77.55%	68.52%	76.16%	80.79%	78.37%	75.43%	74.70%	75.13%	75.11%	▲
CIS: Combination 4	71.30%	66.20%	73.84%	63.43%	70.32%	79.63%	76.74%	72.26%	71.29%	71.67%	71.75%	▲
CIS: Combination 5	59.95%	54.86%	65.51%	55.56%	61.31%	68.98%	61.40%	59.12%	61.56%	60.92%	61.02%	▲
CIS: Combination 6	46.30%	38.19%	51.85%	41.67%	43.55%	54.86%	58.14%	50.12%	45.74%	47.83%	48.41%	▼
CIS: Combination 7	58.10%	52.08%	62.73%	52.78%	57.18%	68.06%	60.23%	57.18%	58.88%	58.58%	58.78%	▲
CIS: Combination 8	44.91%	37.04%	50.23%	39.12%	41.36%	54.40%	57.44%	49.15%	44.04%	46.41%	46.94%	▼
CIS: Combination 9	39.35%	31.94%	44.91%	35.42%	36.25%	46.53%	45.12%	42.09%	40.39%	40.22%	40.70%	▼
CIS: Combination 10	38.66%	31.02%	43.52%	34.26%	34.55%	46.30%	44.65%	41.36%	38.69%	39.22%	39.70%	▼
Immunizations for Adolescents (IMA)												
IMA: Meningococcal	79.17%	84.50%	80.06%	84.95%	84.43%	92.71%	85.89%	84.23%	88.65%	84.95%	85.69%	▲
IMA: Tdap/Td	80.09%	85.71%	86.17%	87.27%	87.10%	94.27%	89.21%	84.59%	89.52%	87.10%	87.79%	▲
IMA: Combination #1	76.85%	82.07%	78.14%	83.33%	83.45%	91.67%	85.06%	82.08%	87.77%	83.38%	84.30%	▲
Lead Screening in Children (LSC)												
LSC: Rate	83.80%	79.86%	75.23%	77.78%	83.70%	79.40%	82.33%	80.78%	83.70%	80.73%	81.00%	▲
Breast Cancer Screening (BCS)												
BCS: Rate	52.21%	57.92%	63.60%	53.83%	60.58%	69.25%	64.70%	53.17%	59.63%	59.43%	60.78%	▲
Cervical Cancer Screening (CCS)												
CCS: Rate	46.39%	60.31%	69.60%	57.85%	64.32%	71.61%	66.20%	59.85%	62.80%	62.10%	62.80%	▼
Chlamydia Screening in Women (CHL)												
CHL: Ages 16 - 20 years	51.15%	44.25%	48.73%	49.12%	45.19%	77.83%	66.11%	57.04%	46.49%	53.99%	55.24%	▼
CHL: Ages 21 - 24 years	60.94%	50.08%	56.74%	58.44%	53.16%	78.50%	71.28%	68.29%	55.32%	61.42%	63.20%	▼
CHL: Total Rate	55.42%	46.94%	52.02%	52.96%	48.22%	78.17%	68.28%	61.45%	50.42%	57.10%	58.65%	▲
Human Papillomavirus Vaccine for Female Adolescents (HPV)												
HPV: Rate	16.44%	24.07%	34.34%	25.93%	27.98%	34.11%	27.84%	22.63%	29.20%	26.95%	27.33%	▼
Non-Recommended Cervical Cancer Screening in Adolescent Females												
NCS: Rate	1.79%	2.46%	1.79%	1.79%	4.03%	0.96%	0.97%	1.21%	1.95%	1.88%	1.74%	▼
Respiratory Conditions												
Appropriate Testing for Children with Pharyngitis (CWP)												
CWP: Rate	66.58%	69.29%	65.60%	70.99%	74.67%	77.39%	67.58%	72.89%	77.80%	71.42%	71.94%	▲
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
URI: Rate	91.41%	86.99%	90.37%	90.09%	90.67%	94.35%	93.10%	90.17%	87.61%	90.53%	90.55%	▲
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)												
AAB: Rate	24.23%	22.13%	18.94%	26.60%	27.77%	37.08%	31.42%	24.34%	20.04%	25.84%	25.47%	▼
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)												
SPR: Rate	30.21%	27.16%	35.63%	31.67%	42.05%	36.96%	24.14%	28.24%	35.68%	32.41%	31.82%	▲
Pharmacotherapy Management of COPD Exacerbation (PCE)												
PCE: Systemic Corticosteroid	72.31%	73.31%	82.79%	74.06%	83.96%	76.99%	76.85%	72.20%	79.04%	76.83%	76.60%	▼
PCE: Bronchodilator	84.40%	84.06%	88.78%	86.11%	86.23%	90.42%	91.77%	81.95%	88.26%	86.89%	87.52%	▼
Cardiovascular Conditions												
Controlling High Blood Pressure (CBP)												
CBP: Total Rate	60.63%	67.32%	67.78%	34.06%	74.93%	67.92%	57.50%	63.75%	66.67%	62.28%	61.02%	▼
Persistence of Beta Blocker Treatment After a Heart Attack (PBH)												

PBH: Rate	87.30%	97.14%	93.67%	88.62%	92.06%	94.17%	93.14%	77.94%	91.48%	90.61%	90.91%	▲
Statin Therapy for Patients With Cardiovascular Disease (SPC)												
SPC: Received Statin Therapy - 21-75 years (Male)	79.51%	76.88%	78.33%	75.75%	79.95%	76.49%	76.71%	78.13%	72.04%	77.09%	76.12%	
SPC: Received Statin Therapy - 40-75 years (Female)	74.88%	79.46%	80.37%	75.70%	80.84%	75.22%	72.86%	68.85%	70.89%	75.45%	74.38%	
SPC: Received Statin Therapy - Total Rate	77.51%	77.94%	79.30%	75.73%	80.37%	75.82%	74.83%	73.85%	71.56%	76.32%	75.32%	
SPC: Statin Adherence 80% - 21-75 years (Male)	85.78%	89.43%	87.23%	72.16%	70.80%	84.81%	89.42%	62.80%	72.57%	79.44%	78.47%	
SPC: Statin Adherence 80% - 40-75 years (Female)	89.44%	84.27%	83.72%	66.91%	68.18%	80.07%	85.37%	60.18%	69.73%	76.43%	75.68%	
SPC: Statin Adherence 80% - Total Rate	87.31%	87.26%	85.56%	69.87%	69.55%	82.33%	87.50%	61.67%	71.39%	78.05%	77.19%	
Diabetes												
Comprehensive Diabetes Care (CDC)												
CDC: HbA1c Testing	82.72%	83.85%	87.33%	84.65%	87.88%	89.38%	83.85%	84.48%	87.59%	85.75%	86.25%	▲
CDC: HbA1c Poor Control (>9.0%)	39.87%	41.32%	35.42%	48.94%	28.75%	30.09%	40.45%	43.36%	33.58%	37.97%	37.47%	▲
CDC: HbA1c Control (<8.0%)	49.34%	47.92%	50.69%	40.88%	59.31%	57.52%	50.35%	46.56%	53.47%	50.67%	51.12%	▼
CDC: HbA1c Control (<7.0%)	33.71%	35.48%	34.66%	31.31%	43.55%	39.81%	39.12%	35.87%	39.66%	37.02%	37.56%	▲
CDC: Eye Exam	46.35%	53.99%	62.50%	59.73%	65.64%	61.50%	52.43%	59.52%	62.59%	58.25%	59.17%	▲
CDC: Medical Attention for Nephropathy	86.21%	87.50%	91.15%	90.12%	90.60%	90.41%	90.97%	91.36%	89.05%	89.71%	89.96%	▲
CDC: Blood Pressure Controlled (<140/90 mm Hg)	54.15%	68.92%	69.97%	57.75%	80.83%	68.44%	63.02%	64.96%	74.09%	66.90%	67.06%	▲
Statin Therapy for Patients With Diabetes (SPD)												
SPD: Total Rate	64.41%	64.36%	64.51%	62.78%	66.68%	64.07%	61.48%	62.31%	60.07%	63.41%	62.80%	
Musculoskeletal												
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (ART)												
ART: Rate	77.59%	74.68%	87.66%	81.65%	78.57%	75.29%	72.07%	72.40%	69.84%	76.64%	75.43%	▲
Use of Imaging Studies for Low Back Pain (LBP)												
LBP: Rate	74.08%	71.68%	74.62%	74.13%	76.88%	80.33%	78.49%	71.92%	72.83%	75.00%	75.66%	▲
Behavioral Health												
Follow-up Care for Children Prescribed ADHD Medication (ADD)												
ADD: Initiation Phase	27.37%	25.90%	21.92%	24.76%	33.66%	16.84%	18.11%	39.98%	60.21%	29.86%	30.83%	▲
ADD: Continuation and Maintenance Phase	29.20%	20.18%	24.25%	26.46%	35.28%	22.03%	19.70%	46.99%	67.54%	32.40%	37.41%	▲
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)												
SSD: Rate	88.64%	86.56%	83.73%	88.26%	89.30%	84.24%	78.97%	85.06%	88.60%	85.93%	84.60%	▲
Diabetes Monitoring for People With Diabetes And Schizophrenia (SMD)												
SMD: Rate	65.75%	76.67%	73.68%	71.00%	75.00%	76.34%	70.88%	66.49%	72.85%	72.07%	71.93%	▲
Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia (SMC)												
SMC: Rate	75.00%	66.67%	68.75%	87.18%	81.82%	74.24%	81.11%	88.46%	69.77%	77.00%	78.15%	▲
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)												
SAA: Rate	55.34%	82.71%	77.73%	66.84%	72.06%	57.60%	77.19%	61.48%	71.53%	69.16%	70.46%	▼
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)												
APC: Ages 1 - 5 years	0.00%	0.00%	2.86%	0.00%	4.35%	0.00%	0.00%	0.00%	0.00%	0.80%	1.49%	▲
APC: Ages 6 - 11 years	0.38%	0.78%	0.83%	0.72%	2.04%	0.00%	0.37%	0.69%	0.91%	0.75%	0.85%	▼
APC: Ages 12 - 17 years	2.95%	2.67%	1.76%	1.97%	2.58%	1.05%	1.33%	1.69%	2.81%	2.09%	2.11%	▼
APC: Total Rate	2.05%	1.87%	1.38%	1.51%	2.39%	0.66%	0.97%	1.30%	2.19%	1.59%	1.64%	▼
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)												
APM: Ages 1 - 5 years	28.57%	12.50%	28.57%	22.58%	27.78%	21.43%	31.58%	20.83%	36.36%	25.58%	29.76%	
APM: Ages 6 - 11 years	37.69%	26.89%	33.14%	36.08%	33.37%	42.31%	36.27%	32.76%	54.53%	37.00%	37.52%	
APM: Ages 12 - 17 years	37.15%	35.52%	38.51%	38.49%	39.43%	44.44%	43.35%	41.60%	40.54%	39.89%	40.07%	

APM: Total Rate	37.21%	31.59%	35.98%	37.51%	36.88%	43.28%	40.68%	38.08%	44.76%	38.44%	38.96%	
Medication Management												
Annual Monitoring for Patients on Persistent Medications (MPM)												
MPM: ACE inhibitors or ARBs	87.12%	87.13%	88.84%	87.17%	89.25%	90.35%	86.32%	87.19%	87.14%	87.83%	87.78%	▲
MPM: Digoxin *	54.72%	45.83%	55.32%	56.39%	61.90%	60.36%	51.92%	57.75%	56.19%	55.60%	56.10%	▲
MPM: Diuretics	88.03%	89.17%	89.30%	86.59%	89.46%	89.09%	85.49%	87.45%	87.47%	88.00%	87.52%	▲
MPM: Total Rate	87.19%	87.37%	88.83%	86.65%	88.96%	89.64%	85.74%	87.01%	86.95%	87.59%	87.41%	▲
Medication Management for People With Asthma (MMA)												
MMA: 50% Ages 5 - 11 years	65.36%	71.43%	69.19%	60.05%	65.09%	47.31%	64.07%	51.00%	58.61%	61.35%	60.25%	▲
MMA: 50% Ages 12 - 18 years	61.11%	66.67%	68.99%	57.92%	62.85%	49.31%	59.54%	47.95%	61.65%	59.55%	58.60%	▲
MMA: 50% Ages 19 - 50 years	68.93%	72.62%	73.92%	64.50%	67.41%	63.45%	67.65%	57.98%	62.63%	66.57%	66.28%	▲
MMA: 50% Ages 51 - 64 years	74.75%	84.75%	80.63%	78.76%	79.68%	77.86%	79.32%	61.31%	76.86%	77.10%	77.94%	▲
MMA: 50% Total	66.07%	71.65%	72.03%	62.31%	66.43%	56.77%	65.11%	52.22%	62.22%	63.87%	63.17%	▲
MMA: 75% Ages 5 - 11 years	38.76%	54.19%	47.27%	34.43%	42.09%	24.97%	40.66%	26.95%	33.43%	38.08%	36.57%	▲
MMA: 75% Ages 12 - 18 years	37.96%	46.46%	47.04%	34.17%	39.01%	27.30%	38.64%	24.22%	35.39%	36.69%	35.86%	▲
MMA: 75% Ages 19 - 50 years	44.65%	50.19%	54.90%	43.30%	45.33%	40.31%	48.73%	34.74%	41.41%	44.84%	45.16%	▲
MMA: 75% Ages 51 - 64 years	41.41%	62.71%	64.76%	56.48%	56.15%	56.06%	60.54%	39.42%	57.25%	54.98%	57.23%	▲
MMA: 75% Total	40.51%	51.31%	51.75%	38.73%	43.42%	34.33%	43.76%	28.57%	38.43%	41.20%	40.72%	▲
Asthma Medication Ratio (AMR)												
AMR: 5-11 years	72.85%	70.00%	73.50%	74.00%	81.34%	68.64%	65.54%	71.40%	77.92%	72.80%	70.83%	▲
AMR: 12-18 years	65.45%	60.57%	67.68%	65.76%	71.37%	59.96%	63.20%	62.98%	67.30%	64.92%	64.76%	▲
AMR: 19-50 years	55.49%	48.32%	55.30%	53.80%	55.94%	57.63%	51.01%	48.36%	55.09%	53.44%	53.81%	▲
AMR: 51-64 years	59.02%	63.64%	59.76%	61.88%	59.92%	56.40%	48.23%	57.22%	63.61%	58.85%	56.49%	▲
AMR: Total Rate	64.26%	58.40%	64.33%	64.50%	67.35%	61.51%	59.57%	62.45%	66.27%	63.18%	62.71%	▲
Access/Availability of Care												
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
AAP: Ages 20 - 44 years	70.87%	83.63%	84.98%	82.20%	87.25%	81.48%	81.88%	77.66%	84.43%	81.60%	81.82%	▼
AAP: Ages 45 - 64 years	81.36%	89.92%	92.88%	90.36%	93.98%	92.10%	91.00%	85.19%	91.79%	89.84%	90.42%	▼
AAP: Ages 65 years and older	72.25%	90.68%	90.87%	87.41%	88.51%	87.73%	86.64%	78.11%	87.41%	85.51%	85.66%	▼
AAP: Total Rate	73.99%	85.66%	87.56%	84.75%	89.50%	85.54%	85.19%	80.15%	86.96%	84.37%	84.75%	▼
Children and Adolescents' Access to Primary Care Practitioners (CAP)												
CAP: Ages 12 - 24 months	94.57%	97.68%	97.59%	97.29%	97.33%	95.73%	96.91%	96.73%	97.49%	96.81%	96.83%	▼
CAP: Ages 25 months - 6 years	86.79%	91.87%	88.86%	87.94%	91.52%	87.43%	88.80%	89.31%	90.37%	89.21%	88.97%	▼
CAP: Ages 7 - 11 years	90.40%	93.94%	92.62%	91.72%	94.11%	92.61%	94.25%	93.25%	92.30%	92.80%	92.84%	▲
CAP: Ages 12 - 19 years	88.40%	93.81%	91.46%	90.14%	93.42%	90.84%	92.79%	92.72%	90.55%	91.57%	91.44%	▲
Annual Dental Visits (ADV)												
ADV: Ages 2 - 3 years	45.99%	37.74%	41.19%	40.21%	37.37%	56.75%	58.79%	43.47%	33.01%	43.84%	44.96%	▲
ADV: Ages 4 - 6 years	66.08%	64.24%	67.29%	63.52%	63.66%	74.79%	74.87%	68.06%	62.20%	67.19%	67.79%	▲
ADV: Ages 7 - 10 years	66.81%	67.18%	69.95%	62.68%	64.81%	74.38%	74.16%	68.71%	62.71%	67.93%	68.02%	▲
ADV: Ages 11 - 14 years	62.05%	62.55%	65.92%	58.46%	59.91%	69.45%	70.49%	63.80%	58.57%	63.47%	63.49%	▲
ADV: Ages 15 - 18 years	53.20%	57.02%	58.81%	52.96%	51.31%	58.53%	59.71%	55.04%	52.75%	55.48%	55.35%	▲
ADV: Ages 19 - 20 years	36.04%	43.54%	42.66%	38.50%	38.05%	42.03%	43.19%	38.45%	38.55%	40.11%	39.97%	
ADV: Total Rate	57.87%	58.45%	61.44%	55.76%	55.91%	65.89%	67.13%	59.86%	54.46%	59.64%	59.91%	▲
Prenatal and Postpartum Care (PPC)												
PPC: Timeliness of Prenatal Care	81.07%	91.46%	92.63%	78.47%	90.02%	89.07%	83.88%	82.73%	94.40%	87.08%	86.89%	▲

PPC: Postpartum Care	59.35%	62.93%	68.06%	48.15%	74.45%	73.61%	67.29%	58.64%	66.91%	64.38%	64.06%	▼
Call Answer Timeliness (CAT)												
CAT: Rate	89.90%	89.59%	89.37%	51.08%	89.85%	56.61%	88.87%	90.10%	84.23%	81.07%	77.23%	▼
Use of Services												
Frequency of Ongoing Prenatal Care (FPC)												
FPC: <21 percent	5.84%	1.71%	1.72%	9.72%	2.68%	1.65%	4.44%	4.87%	1.46%	3.79%	4.06%	▼
FPC: 21 - 40 percent	5.61%	2.68%	1.97%	6.02%	4.62%	3.71%	5.84%	4.14%	2.19%	4.09%	4.20%	▼
FPC: 41 - 60 percent	11.21%	4.88%	5.16%	5.56%	6.57%	7.42%	8.88%	10.71%	4.62%	7.22%	7.00%	▼
FPC: 61 - 80 percent	15.42%	13.41%	9.83%	13.66%	12.65%	12.16%	16.12%	18.49%	9.98%	13.53%	13.24%	▼
FPC: >= 81 percent	61.92%	77.32%	81.33%	65.05%	73.48%	75.05%	64.72%	61.80%	81.75%	71.38%	71.50%	▲
Well-Child Visits in the First 15 Months of Life (W15)												
W15: 0 Visits	0.93%	0.00%	0.00%	1.62%	0.60%	1.26%	0.97%	0.83%	0.00%	0.69%	0.79%	▼
W15: 1 Visit	2.78%	0.73%	1.08%	1.16%	0.60%	1.26%	0.97%	1.94%	0.66%	1.24%	1.22%	▲
W15: 2 Visits	3.70%	1.21%	0.54%	2.55%	0.60%	3.54%	1.46%	2.22%	0.33%	1.79%	1.84%	▼
W15: 3 Visits	5.32%	2.43%	5.11%	4.17%	2.09%	4.80%	4.13%	5.00%	2.62%	3.96%	3.98%	▼
W15: 4 Visits	8.56%	8.98%	5.65%	3.70%	6.27%	9.34%	10.44%	6.67%	7.54%	7.46%	7.35%	▼
W15: 5 Visits	14.12%	16.02%	13.71%	15.51%	15.52%	13.13%	18.93%	14.17%	15.41%	15.17%	15.32%	▼
W15: >= 6 Visits	64.58%	70.63%	73.92%	71.30%	74.33%	66.67%	63.11%	69.17%	73.44%	69.68%	69.50%	▲
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)												
W34: Rate	69.44%	74.60%	73.37%	74.07%	73.48%	82.70%	77.47%	77.96%	75.68%	75.42%	75.84%	▼
Adolescent Well-Care Visits (AWC)												
AWC: Rate	50.69%	54.55%	51.74%	56.48%	52.66%	63.81%	55.69%	53.83%	56.30%	55.08%	55.68%	▼
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	0.01	0.00		
FSP: Bariatric Weight Loss Surgery F Ages 20-44 Procs/1000 MM	0.07	0.08	0.22	0.08	0.09	0.13	0.05	0.08	0.09	0.10		
FSP: Bariatric Weight Loss Surgery F Ages 45-64 Procs/1000 MM	0.02	0.08	0.26	0.11	0.12	0.08	0.10	0.13	0.15	0.12		
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	0.02	0.00	0.07	0.01	0.04	0.03	0.02	0.01	0.02	0.02		
FSP: Bariatric Weight Loss Surgery M Ages 45-64 Procs/1000 MM	0.02	0.00	0.03	0.02	0.04	0.02	0.03	0.05	0.03	0.03		
FSP: Tonsillectomy MF Ages 0-9 Procs/1000 MM	0.54	0.56	0.65	0.57	0.61	0.68	0.53	0.63	0.63	0.60		
FSP: Tonsillectomy MF Ages 10-19 Procs/1000 MM	0.27	0.34	0.27	0.24	0.31	0.21	0.21	0.23	0.33	0.27		
FSP: Hysterectomy Abdominal F Ages 15-44 Procs/1000 MM	0.13	0.13	0.10	0.15	0.14	0.11	0.11	0.11	0.15	0.13		
FSP: Hysterectomy Abdominal F Ages 45-64 Procs/1000 MM	0.27	0.46	0.32	0.30	0.34	0.34	0.28	0.25	0.24	0.31		
FSP: Hysterectomy Vaginal F Ages 15-44 Procs/1000 MM	0.09	0.11	0.22	0.15	0.09	0.08	0.06	0.11	0.16	0.12		
FSP: Hysterectomy Vaginal F Ages 45-64 Procs/1000 MM	0.15	0.06	0.26	0.18	0.10	0.20	0.15	0.12	0.15	0.15		
FSP: Cholecystectomy, Open M Ages 30-64 Procs/1000 MM	0.06	0.05	0.02	0.04	0.04	0.04	0.04	0.02	0.04	0.04		
FSP: Cholecystectomy, Open F Ages 15-44 Procs/1000 MM	0.02	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.02	0.01		
FSP: Cholecystectomy Open F Ages 45-64 Procs/1000 MM	0.02	0.05	0.03	0.04	0.06	0.03	0.07	0.07	0.04	0.04		
FSP: Cholecystectomy Closed M Ages 30-64 Procs/1000 MM	0.30	0.43	0.36	0.36	0.38	0.16	0.15	0.30	0.44	0.32		
FSP: Cholecystectomy Closed F Ages 15-44 Procs/1000 MM	0.58	0.92	0.72	0.70	0.79	0.49	0.41	0.60	0.86	0.67		
FSP: Cholecystectomy Closed F Ages 45-64 Procs/1000 MM	0.62	0.88	0.69	0.84	0.78	0.46	0.43	0.48	0.83	0.67		
FSP: Back Surgery M Ages 20-44 Procs/1000 MM	0.19	0.33	0.28	0.23	0.30	0.15	0.17	0.24	0.41	0.26		
FSP: Back Surgery F Ages 20-44 Procs/1000 MM	0.16	0.15	0.25	0.23	0.24	0.09	0.10	0.21	0.29	0.19		
FSP: Back Surgery M Ages 45-64 Procs/1000 MM	0.61	0.90	0.54	0.77	0.86	0.43	0.38	0.58	1.13	0.69		
FSP: Back Surgery F Ages 45-64 Procs/1000 MM	0.49	0.56	0.77	0.91	0.75	0.32	0.30	0.59	0.79	0.61		

FSP: Mastectomy F Ages 15-44 Procs/1000 MM	0.02	0.02	0.04	0.04	0.05	0.01	0.02	0.03	0.03	0.03		
FSP: Mastectomy F Ages 45-64 Procs/1000 MM	0.13	0.19	0.14	0.14	0.15	0.14	0.14	0.21	0.15	0.15		
FSP: Lumpectomy F Ages 15-44 Procs/1000 MM	0.08	0.17	0.14	0.12	0.14	0.14	0.15	0.15	0.13	0.14		
FSP: Lumpectomy F Ages 45-64 Procs/1000 MM	0.38	0.48	0.41	0.39	0.55	0.44	0.44	0.45	0.38	0.44		
Ambulatory Care: Total (AMBA)												
AMBA: Outpatient Visits/1000 MM	270.80	408.04	369.78	344.49	427.70	331.53	307.02	332.50	393.85	353.97	349.41	▼
AMBA: Emergency Department Visits/1000 MM	74.94	79.55	84.33	82.00	67.01	78.94	67.01	74.34	67.45	75.06	73.99	▲
Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)												
IPUA: Total Discharges/1000 MM	6.19	7.24	6.76	7.15	6.77	11.09	7.82	6.86	7.86	7.53		
IPUA: Medicine Discharges/1000 MM	2.75	3.29	2.88	3.37	3.09	5.98	4.02	3.17	3.19	3.53		
IPUA: Surgery Discharges/1000 MM	1.52	1.55	1.47	1.88	1.39	2.38	1.84	1.68	2.30	1.78		
IPUA: Maternity Discharges/1000 MM	2.82	3.43	3.67	2.84	3.32	3.92	2.96	2.99	3.41	3.26		
Antibiotic Utilization: Total (ABXA)												
ABXA: Total # of Antibiotic Prescriptions M&F	133,594	79,536	110,234	282,922	188,235	153,965	226,785	138,645	365,411	186,592		
ABXA: Average # of Antibiotic Prescriptions PMPY M&F	0.85	1.22	0.93	0.99	1.26	0.77	0.81	0.83	1.16	0.98		
ABXA: Total Days Supplied for all Antibiotic Prescriptions M&F	1,255,192	737,298	1,022,627	2,725,232	1,804,264	1,397,344	2,118,634	1,326,886	3,556,482	1,771,551		
ABXA: Average # Days Supplied per Antibiotic Prescription M&F	9.40	9.27	9.28	9.63	9.59	9.08	9.34	9.57	9.73	9.43		
ABXA: Total # of Prescriptions for Antibiotics of Concern M&F	53,115	35,378	41,981	112,203	85,235	55,450	83,016	54,229	155,420	75,114		
ABXA: Average # of Prescriptions for Antibiotics of Concern M&F	0.34	0.54	0.35	0.39	0.57	0.28	0.30	0.33	0.49	0.40		
ABXA: Percent Antibiotics of Concern of all Antibiotic Prescriptions	39.76%	44.48%	38.08%	39.66%	45.28%	36.01%	36.61%	39.11%	42.53%	40.17%		
Health Plan Descriptive Information												
Board Certification (BCR)												
BCR: % of Family Medicine Board Certified	48.95%	78.53%	87.39%	80.39%	82.29%	81.95%	84.64%	72.20%	85.63%	78.00%		
BCR: % of Internal Medicine Board Certified	59.73%	76.56%	83.60%	61.03%	81.68%	77.92%	80.07%	79.15%	86.93%	76.30%		
BCR: % of OB/GYNs Board Certified	53.39%	70.11%	80.66%	73.96%	80.23%	74.00%	78.91%	82.08%	78.55%	74.65%		
BCR: % of Pediatricians Board Certified	39.31%	84.62%	85.39%	63.88%	80.82%	81.35%	86.53%	86.02%	89.36%	77.48%		
BCR: % of Geriatricians Board Certified	45.32%	100.00%	83.82%	78.38%	76.67%	87.50%	84.51%	64.71%	81.72%	78.07%		
BCR: % of Other Physician Specialists Board Certified	51.34%	81.05%	87.02%	85.61%	82.06%	85.80%	85.81%	82.53%	87.97%	81.02%		

▲ ▼ : Comparisons to HEDIS 2015 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 which takes into account the proportional relevance of each MCO.

Table 6 - PH-MCO PA Performance Measure 2016 Results

	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Annual Dental Visits for Members with Developmental Disabilities (Age 2-21 years)											
Rate	61.8%	62.8%	61.2%	55.1%	48.2%	62.2%	64.6%	63.0%	48.7%	58.6%	55.7%
Cesarean rate for Nulliparous Singleton Vertex											
Rate[1]	22.7%	24.5%	25.1%	22.1%	24.0%	22.6%	21.2%	21.3%	22.7%	22.9%	22.8%
Percent of Live Births weighing less than 2,500 grams (Positive)											
Rate[1]	8.7%	8.6%	8.2%	7.9%	9.5%	9.5%	10.3%	10.4%	8.7%	9.1%	9.2%
Elective Delivery (Adult Core Measure PC01-AD)											
Rate[1]	14.1%	16.8%	18.0%	13.0%	16.5%	10.3%	17.9%	14.4%	15.6%	15.2%	15.1%
Reducing Potentially Preventable Readmissions											
Rate[2]	7.9%	7.3%	7.0%	9.8%	9.9%	11.6%	11.1%	13.4%	9.4%	9.7%	10.2%
Prenatal Screening for Smoking											
Rate 1 - Prenatal Screening for Smoking	55.2%	86.1%	86.0%	87.3%	57.4%	94.3%	85.8%	89.6%	95.4%	81.9%	82.1%
CHIPRA Rate 1 - Prenatal Screening for Smoking during one of the first two visits	54.2%	85.9%	85.5%	81.9%	56.1%	90.3%	85.8%	87.9%	93.2%	80.1%	80.2%
Rate 2 - Prenatal Screening for Environmental Tobacco Smoke Exposure	15.9%	35.6%	23.8%	36.4%	20.6%	64.8%	25.0%	44.1%	47.6%	34.9%	34.9%
Rate 3 - Prenatal Counseling for Smoking*	72.2%*	89.5%	79.5%*	76.0*	85.3%*	80.0%*	81.3%*	75.9*	90.7%	81.1%	83.0%
Rate 4 - Prenatal Counseling for Environmental Tobacco Smoke*	48.4%*	53.6%*	35.3%*	75.0%*	46.7%*	80.0%*	55.2*	60.6%*	87.1%*	60.2%	64.1%
Rate 5 - Prenatal Smoking Cessation*	4.4%*	14.3%	9.6%*	10.9%	17.9%*	23.3%*	14.1%*	23.3%	8.5%	14.0%	13.6%
Perinatal Depression Screening											
Rate 1 – Prenatal Screen for Depression	29.7%	70.3%	67.8%	71.6%	27.2%	92.3%	77.0%	83.3%	80.7%	66.7%	66.8%
CHIPRA Rate 1 – Prenatal Screening for Depression during one of the first two visits	25.3%	65.6%	62.8%	62.1%	21.1%	78.5%	74.8%	75.9%	77.6%	60.4%	60.6%
Rate 2 – Prenatal Screening Positive for Depression	26.7%	15.5%	13.3%	18.1%	27.9%	10.6%	13.3%	22.7%	21.5%	18.8%	17.4%
Rate 3 - Prenatal Counseling for Depression*	74.2%*	68.2%*	97.2%*	73.6%*	82.8*	87.2%*	87.8%*	71.0%*	84.5%*	80.7%	79.9%
Rate 4 – Postpartum Screening for Depression	40.9%	64.7%	79.9%	80.8%	45.6%	64.3%	64.0%	89.8%	88.7%	68.7%	68.3%
Rate 5 – Postpartum Screening Positive for Depression	23.9%	17.3%	14.5%	12.1%	15.7%	6.1%	9.7%	17.3%	16.5%	14.8%	14.1%
Rate 6 – Postpartum Counseling for Depression*	70.4*	90.9%*	94.1%*	70.8*	72.2*	78.6*	100.0*	87.5%*	95.5%*	84.4%	86.2%
Maternity Risk Factor Assessment											
CHIPRA Rate 1 - Prenatal Screening for Alcohol use	50.4%	81.2%	84.0%	89.0%	53.0%	88.3%	84.8%	87.1%	90.5%	78.7%	78.9%
CHIPRA Rate 2 - Prenatal Screening for Illicit drug use	51.4%	82.2%	83.0%	89.2%	49.9%	88.5%	85.0%	84.9%	90.5%	78.3%	78.5%
CHIPRA Rate 3 - Prenatal Screening for Prescribed or over-the-counter drug use	47.8%	84.2%	78.0%	92.4%	48.6%	93.0%	84.0%	88.5%	93.4%	78.9%	79.1%
CHIPRA Rate 4 - Prenatal Screening for Intimate partner violence	22.5%	47.0%	52.5%	71.1%	24.3%	69.3%	53.3%	52.3%	59.3%	50.2%	50.4%
Behavioral Health Risk Assessment (BHRA-CH)											
CHIPRA Rate - Prenatal Screening for Behavioral Health Risk Assessment	12.3%	34.9%	36.3%	41.8%	7.6%	56.5%	40.3%	42.5%	52.4%	36.1%	36.2%

	ABH	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC	PH MMC Average	PH MMC Weighted Average
Follow-Up for Care Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (include the BH data) (CHIPRA 21) – 2013											
Rate 1 – Initiation Phase	27.4%	25.9%	21.9%	33.7%	24.8%	16.8%	18.1%	40.0%	60.2%	29.9%	30.8%
Rate 2 – Continuation Phase	29.2%	20.2%	24.3%	35.3%	26.5%	22.0%	19.7%	47.0%	67.5%	32.4%	37.4%
Rate 1 BH ED Enhanced Initiation Phase	29.1%	27.7%	22.9%	35.8%	26.3%	17.2%	18.9%	41.7%	60.3%	31.1%	31.9%
Rate 2 BH ED Enhanced Continuation Phase	37.3%	30.3%	29.0%	38.4%	30.2%	24.4%	24.1%	49.7%	71.4%	37.2%	41.8%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA Rate: MCO Defined	55.3%	82.7%	77.7%	72.1%	66.8%	57.6%	77.2%	61.5%	71.5%	69.1%	70.5%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)											
SAA Rate: BH ED Enhanced	57.4%	76.9%	71.6%	74.7%	71.3%	59.9%	74.5%	67.1%	71.7%	69.5%	69.4%
Adult Asthma Admission Rate (PQI 15)											
Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months[3]	13.3	9.5	11.2	6.9	10.3	21.8	19.7	13.4	5.4	12.4	12.7
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 05)											
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Age 40+ years) per 100,000 member months[3]	77.99	83.5	94.4	84.9	104.9	145.8	137.1	109.7	44.1	98.0	100.6
Diabetes Short- Term Complications Admission Rate (PQI 01)											
Age Cohort 1 (18–64 Years) - Admission rate per 100,000 member months[3]	23.4	18.0	24.8	21.2	23.3	25.2	24.6	18.7	20.9	22.2	22.6
Age Cohort 2 (65+ Years) - Admission rate per 100,000 member months[3]	0.0	0.0	0.0	0.0	10.3	15.1	13.9	10.6	0.0	5.5	8.2
Total 3 (Age 18+ Years) - Admission rate per 100,000 member months[3]	23.2	17.9	24.6	21.1	23.2	25.1	24.4	18.6	20.7	22.1	22.5
Congestive Heart Failure Admissions Rate (PQI 08)											
Age Cohort 1 (18-64 Years) Admission rate per 100,000 member months[3]	17.2	13.5	12.0	13.4	15.2	27.3	24.8	17.9	16.5	17.5	18.5
Age Cohort 2 (65+ Years) Admission rate per 100,000 member months[3]	94.4	0.0	41.5	67.8	102.9	75.5	92.5	63.7	65.8	67.1	77.2
Total 3 (Age 18+ Years) Admission rate per 100,000 member months[3]	17.8	13.5	12.2	13.7	15.7	27.9	25.5	18.3	16.8	17.9	19.0
Developmental Screening in the First Three Years of Life (CHIPRA Measure DEV-CH)											
Rate 1: Total	56.6%	57.2%	45.6%	60.8%	46.7%	30.8%	46.0%	50.2%	65.0%	51.0%	51.1%
Rate 2: 1 year	52.7%	51.8%	38.5%	59.2%	41.2%	24.8%	39.7%	44.4%	61.5%	46.0%	46.6%
Rate 3: 2 years	59.5%	62.9%	48.3%	63.6%	49.0%	36.4%	51.6%	54.5%	66.6%	54.7%	54.4%
Rate 4: 3 years	57.2%	57.2%	51.2%	60.0%	49.9%	31.2%	46.6%	52.1%	67.6%	52.6%	52.4%

* 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.

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

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

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

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 2016 (MY 2015), 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 2015 performance measure results are presented in Table 7 for each BH-MCO along with the BH MMC Average and BH MMC Weighted Average which takes into account the proportional relevance of each MCO.

Table 7 - BH-MCO Performance Measure Results

	CBH	CCBH	MBH	PerformCare	VBH	BH MMC Average	BH MMC Weighted Average
HEDIS Follow-up After Hospitalization for Mental Illness							
Within 7 Days – Ages 6-64	41.8%	47.6%	46.8%	42.7%	46.5%	45.1%	45.7%
Within 30 Days – Ages 6-64	60.1%	68.0%	63.8%	66.6%	70.2%	65.8%	66.1%
Within 7 Days – All Ages	41.6%	47.4%	46.7%	42.4%	46.2%	44.7%	45.5%
Within 30 Days – All Ages	59.7%	67.7%	63.7%	66.2%	69.8%	65.4%	65.8%
Within 7 Days – Ages 6-20	57.5%	58.6%	52.5%	55.1%	57.0%	56.1%	56.7%
Within 30 Days – Ages 6-20	75.8%	79.1%	69.9%	77.8%	79.3%	76.4%	77.0%
Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness							
Within 7 Days – All Ages	51.1%	59.7%	55.8%	56.9%	55.7%	55.8%	56.6%
Within 30 Days – All Ages	67.4%	75.3%	69.9%	75.6%	75.2%	72.7%	73.0%
Readmission within 30 Days of Inpatient Psychiatric Discharge							
Rate	13.7%	14.0%	15.2%	15.6%	11.7%	14.4%	14.0%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment							
Initiation of AOD Treatment – Ages 13-17	47.6%	40.7%	24.2%	29.3%	26.2%	33.6%	36.8%
Engagement of AOD Treatment – Ages 13-17	35.5%	28.2%	17.7%	17.9%	16.2%	23.1%	25.7%
Initiation of AOD Treatment – Ages 18+	25.8%	27.7%	23.5%	27.7%	28.8%	26.7%	26.7%
Engagement of AOD Treatment – Ages 18+	18.5%	18.6%	16.5%	16.0%	22.1%	18.3%	18.6%
Initiation of AOD Treatment – Ages 13+	27.0%	28.9%	23.5%	27.9%	28.7%	27.2%	27.5%
Engagement of AOD Treatment – Ages 13+	19.4%	19.5%	16.6%	16.2%	21.8%	18.7%	19.1%

- BH-MCOs had interim goals to increase HEDIS Follow-up After Hospitalization for Mental Illness by 1% over the previous year (MY 2014) for ages 6-64. These goals were not met by any BH-MCO for 7 and 30 day rates.
- The BH MMC weighted average (HealthChoices Aggregate of all BH-MCOs) was between the NCQA 50th and 75th. Consequently the OMHSAS goal of meeting or exceeding the HEDIS 75th percentile for ages 6-64 for both 7 and 30 days was not achieved.
- HEDIS Follow-up After Hospitalization for Mental Illness rates for ages 6-20 did not change significantly from the previous year, with the exception of the VBH 30 day rate, which significantly decreased.
- For the Pennsylvania-Specific Follow-up After Hospitalization for Mental Illness rates, CBH and MBH had significantly lower 7 and 30 day follow-ups than MY 2014, CCBH and PerformCare showed no significant difference from MY 2014, and VBA had significantly lower 7 day, and similar 30 day rates to MY 2014.
- Readmission rates did not significantly change from the previous year for any BH-MCO, with the exception of CCBH which significantly decreased.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment rates for 13-17 year olds did not significantly differ from the previous year for any BH-MCO.
- For Initiation and Engagement of Alcohol and Other Drug Dependence Treatment rates (Ages 18+), CBH and MBH rates decreased significantly from MY 2014 for both initiation and engagement, CCBH rates decreased for initiation but not engagement, PerformCare rates did not differ for initiation but did decrease for engagement, and finally VBH showed improvement for both initiation and engagement compared to the previous year.
- For Initiation and Engagement of Alcohol and Other Drug Dependence Treatment rates (Ages 13+), CBH and MBH rates decreased significantly from MY 2014 for initiation and engagement, CCBH rates remained the same, PerformCare rates did not change for initiation but increased for engagement, and VBH rates increased for both initiation and engagement.

Section IV: 2015 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 2015 EQR Technical Reports, which were distributed in April 2016. The 2016 EQR Technical Report is the ninth 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 May 30 (BH-MCOs) and June 30 (PH-MCOs), 2016 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.

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 2015, PH-MCOs were required to address those measures on the HEDIS 2015 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 P4P measure in categories "D" and "F":

- 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 2016 annual technical reports.

Section V: 2016 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 Subpart D: Quality Assessment and Performance Improvement Regulations.
- All PH-MCOs successfully completed NCQA HEDIS Compliance Audits in 2016. 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.
- All PH and BH-MCOs provided responses to the Opportunities for Improvements issued in the 2014 annual technical reports.

Overall Opportunities

- Most BH-MCOs were only partially compliant with most of the categories of Subpart D: Quality Assessment and Performance Improvement Regulations.
- Most BH-MCOs were only partially compliant with most of the categories of 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 2015 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	ACN	ACP	GEI	GH	HPP	KF	UHC	UPMC
D	Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Prenatal Care in the First Trimester Postpartum Care[1] Adolescent Well-Care Visits			Annual Dental Visit (Ages 2 – 20 years) Adolescent Well-Care Visits	Prenatal Care in the First Trimester Postpartum Care[1] Reducing Potentially Preventable Readmissions[3]		Well-Child Visits in the First 15 Months of Life, 6 or more[5] Adolescent Well-Care Visits	Comprehensive Diabetes Care – HbA1c Poor Control[4] Prenatal Care in the First Trimester Postpartum Care[1]	Annual Dental Visit (Ages 2 – 20 years)
F	Emergency Department Utilization[2]	Emergency Department Utilization[2]	Emergency Department Utilization[2]		Comprehensive Diabetes Care: HbA1c Poor Control[4] Controlling High Blood Pressure Emergency Department Utilization[2]			Reducing Potentially Preventable Readmissions[3] Emergency Department Utilization[2]	

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

[1] Postpartum Care was added as a P4P measure in 2016 (MY 2015).
[2] A lower rate, indicating better performance, is preferable for Emergency Department Utilization
[3] Reducing Potentially Preventable Readmissions was a first year PA specific performance measure in 2012 (MY 2011). Lower rates are preferable, indicating better performance. This measure was added as a P4P measure in 2013 (MY 2012).
[4] Comprehensive Diabetes Care – HbA1c Poor Control is an inverted measure. Lower rates are preferable, indicating better performance.
[5] Well-Child Visits in the First 15 Months of Life, 6 or more was added as a P4P measure in 2016 (MY 2015).

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.

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	CCBH	MBH	PerformCare	VBH
D			Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day)		Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day)
F	Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day) Follow-up After Hospitalization for Mental Illness QI B (PA Specific 30 Day)		Follow-up After Hospitalization for Mental Illness QI A (PA Specific 7 Day)		

Table 9b: BH-MCO Root Cause Analysis Measures – HEDIS Indicators

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

Section VI: 2016 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 June 2016, 145 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

Review in 2016 examined year 1 and year 2 comparisons to baseline. Results were varied. There were modest improvements in job placement. Results for job retention, defined by remaining in the same job, were mixed across the retention periods studied. Retention improved for year 1, but declined for the shorter retention periods in year 2 and declined back to baseline for the 1-yr retention period. Meaningful engagement was largely unchanged, with rates of 80%, 80% and 77% for baseline and year 1 and year 2 respectively.

Community engagement was evaluated using the Scales of Independent Behavior – Revised (SIB-R) tool. SIB-R results showed modest improvement for the community living measures but no change was noted for the social skills component. BAS noted issues with reliance on the SIB-R as a good indicator of improvements in adaptive skills. KAS reported that although it was a contractual obligation, an appropriate alternative measure of adaptive skills should be investigated. KAS noted this as a limitation of the project. Additionally, KAS documented planned or implemented changes that could impact the project and its measurement, such as introducing video modeling into employee orientation, and the use of modeling prompts. Given the limitations and program modifications, it was unclear if the project should be continued to the sustainability phase.

Performance Measures

In accordance with their contract, KAS was to submit data to BAS for the following measures. No additional documentation for the procedures used to track and report the measures was provided to IPRO.

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

Annual Monitoring

BAS monitored compliance for 2016 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

The category “Contracted Services” was introduced in 2016, but was not assessed by IPRO for BBA compliance. At the time of submission of the monitoring report, KAS had not yet responded to all recommendations and requests for remediation noted by BAS, as the deadline for response was pending.

Final Project Reports

Upon request, the following reports can be made available:

1. Individual PH-MCO BBA Reports for 2016
2. Individual BH-MCO BBA Reports for 2016
3. Follow-up After Hospitalization for Mental Illness External Quality Review Aggregate Data Tables – Measurement Year 2015 (BH-MCOs), and Report – Measurement Years 2014 and 2015
4. Readmission within 30 Days of Inpatient Psychiatric Discharge External Quality Review Aggregate Data Tables – Measurement Year 2014 (BH-MCOs)
5. HEDIS 2016 Member Level Data Reports, Data Analysis Trends (PH-MCOs)
6. HEDIS 2016 Member Level Data Reports, Data Findings by Measure (PH-MCOs)
7. HEDIS 2016 Member Level Data Reports, Year-to-Year Data Findings – Southeast Zone/Region (PH-MCOs)
8. HEDIS 2016 Member Level Data Reports, Year-to-Year Data Findings – Southwest Zone/Region (PH-MCOs)
9. HEDIS 2016 Member Level Data Reports, Year-to-Year Data Findings – Lehigh/Capital Zone/Region (PH-MCOs)
10. HEDIS 2016 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.