Commonwealth Pennsylvania
Department of Human Services
Office of Medical Assistance Programs

2019 External Quality Review Report
Gateway Health

Final Report
April 2020
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HEDIS® and The Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA™ is a trademark of the National Committee for Quality Assurance.
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Introduction

Purpose and Background
The final rule of the Balanced Budget Act (BBA) of 1997 requires that State agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a MCO furnishes to Medicaid Managed Care recipients.

The EQR-related activities that must be included in detailed technical reports are as follows:

- review to determine MCO compliance with structure and operations standards established by the State (42 CFR §438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

HealthChoices Physical Health (PH) is the mandatory managed care program that provides Medical Assistance recipients with physical health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP) contracted with IPRO as its EQRO to conduct the 2019 EQRs for the HealthChoices PH MCOs and to prepare the technical reports. This technical report includes six core sections:

I. Structure and Operations Standards
II. Performance Improvement Projects
III. Performance Measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
IV. 2018 Opportunities for Improvement – MCO Response
V. 2019 Strengths and Opportunities for Improvement
VI. Summary of Activities

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

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

Section IV, 2018 Opportunities for Improvement – MCO Response, includes the MCO’s responses to the 2018 EQR Technical Report’s opportunities for improvement and presents the degree to which the MCO addressed each opportunity for improvement.

Section V has a summary of the MCO’s strengths and opportunities for improvement for this review period as determined by IPRO and a “report card” of the MCO’s performance as related to selected HEDIS® measures. Section VI provides a summary of EQR activities for the PH MCO for this review period.
I: Structure and Operations Standards
This section of the EQR report presents a review by IPRO of Gateway Health’s (GH’s) compliance with structure and operations standards. The review is based on information derived from reviews of the MCO that were conducted within the past three years.

Methodology and Format
The documents used by IPRO for the current review include the HealthChoices Agreement, the SMART database completed by PA DHS staff as of December 31, 2018, and the most recent NCQA Accreditation Survey for GH, effective December 2018.

The SMART items provided much of the information necessary for this review. The SMART items are a comprehensive set of monitoring items that PA DHS staff reviews on an ongoing basis for each Medicaid MCO. The SMART items and their associated review findings for each year are maintained in a database. The SMART database has been maintained internally at DHS since Review Year (RY) 2013. In 2018, upon receipt of the findings for RY 2017, IPRO and DHS discussed changes to the information included. First, the only available review conclusions were Compliant and non-Compliant. All other options previously available were re-designated in RY 2017 from review conclusion elements to review status elements and were therefore not included in the RY 2017 findings. Additionally, as of RY 2017, reviewers had the option to review zones covered by an MCO separately, and to provide multiple findings within a year (e.g., quarterly). As a result, there was an increase in the number of partially compliant items for RY 2017. These changes remained for the findings received in 2019. Upon review of the data elements from each version of database, IPRO merged the RY 2018, 2017, and 2016 findings for use in the current review. IPRO reviewed the elements in the SMART item list and created a crosswalk to pertinent BBA regulations. A total of 126 items were identified that were relevant to evaluation of MCO compliance with the BBA regulations. These items vary in review periodicity as determined by DHS.

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

<table>
<thead>
<tr>
<th>BBA Regulation</th>
<th>SMART Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subpart C: Enrollee Rights and Protections</strong></td>
<td></td>
</tr>
<tr>
<td>Enrollee Rights</td>
<td>7</td>
</tr>
<tr>
<td>Provider-Enrollee Communication</td>
<td>1</td>
</tr>
<tr>
<td>Marketing Activities</td>
<td>2</td>
</tr>
<tr>
<td>Liability for Payment</td>
<td>1</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>0</td>
</tr>
<tr>
<td>Emergency and Post-Stabilization Services – Definition</td>
<td>4</td>
</tr>
<tr>
<td>Emergency Services: Coverage and Payment</td>
<td>1</td>
</tr>
<tr>
<td>Solvency Standards</td>
<td>2</td>
</tr>
<tr>
<td><strong>Subpart D: Quality Assessment and Performance Improvement</strong></td>
<td></td>
</tr>
<tr>
<td>Availability of Services</td>
<td>14</td>
</tr>
<tr>
<td>Coordination and Continuity of Care</td>
<td>13</td>
</tr>
<tr>
<td>Coverage and Authorization of Services</td>
<td>9</td>
</tr>
<tr>
<td>Provider Selection</td>
<td>4</td>
</tr>
<tr>
<td>Provider Discrimination Prohibited</td>
<td>1</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
</tr>
<tr>
<td>Enrollment and Disenrollment</td>
<td>2</td>
</tr>
<tr>
<td>Grievance Systems</td>
<td>1</td>
</tr>
<tr>
<td>Subcontractual Relationships and Delegations</td>
<td>3</td>
</tr>
<tr>
<td>Practice Guidelines</td>
<td>2</td>
</tr>
</tbody>
</table>
Two categories, Cost Sharing and Effectuation of Reversed Resolutions, were not directly addressed by any of the SMART Items reviewed by DHS. Cost Sharing is addressed in the HealthChoices Agreements. Effectuation of Reversed Resolutions is evaluated as part of the most recent NCQA Accreditation review under Utilization Management (UM) Standard 8: Policies for Appeals and UM 9: Appropriate Handling of Appeals.

**Determination of Compliance**

To evaluate MCO compliance on individual provisions, IPRO grouped the monitoring standards by provision and evaluated the MCO’s compliance status with regard to the SMART Items. For example, all provisions relating to enrollee rights are summarized under Enrollee Rights 438.100. Each item was assigned a value of Compliant or non-Compliant in the Item Log submitted by DHS. If an item was not evaluated for a particular MCO, it was assigned a value of Not Determined. Compliance with the BBA requirements was then determined based on the aggregate results of the SMART Items linked to each provision within a requirement or category. If all items were Compliant, the MCO was evaluated as Compliant. If some were Compliant and some were non-Compliant, the MCO was evaluated as partially-Compliant. If all items were non-Compliant, the MCO was evaluated as non-Compliant. If no items were evaluated for a given category and no other source of information was available to determine compliance, a value of Not Determined was assigned for that category.

**Format**

The format for this section of the report was developed to be consistent with the subparts prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three subparts set out in the BBA regulations and described in the *MCO Monitoring Protocol*. Under each subpart heading fall the individual regulatory categories appropriate to those headings. IPRO’s findings are presented in a manner consistent with the three subparts in the BBA regulations explained in the Protocol, i.e., Enrollee Rights and Protections; Quality Assessment and Performance Improvement (including access, structure and operation, and measurement and improvement standards); and Federal and State Grievance System Standards.

In addition to this analysis of DHS’s MCO compliance monitoring, IPRO reviewed and evaluated the most recent NCQA accreditation report for each MCO.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO’s required assessment of the MCO’s compliance with BBA regulations as an element of the analysis of the MCO’s strengths and weaknesses.

**Findings**

Of the 126 SMART Items, 62 items were evaluated and 64 were not evaluated for the MCO in RY 2018, RY 2017, or RY 2016. For categories where items were not evaluated for compliance for RY 2018, results from reviews conducted within the two prior years (RY 2017 and RY 2016) were evaluated to determine compliance, if available.
Subpart C: Enrollee Rights and Protections
The general purpose of the regulations included in this category is to ensure that each MCO had written policies regarding enrollee rights and complies with applicable Federal and State laws that pertain to enrollee rights, and that the MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. [42 C.F.R. §438.100 (a), (b)]

Table 1.2: GH Compliance with Enrollee Rights and Protections Regulations

<table>
<thead>
<tr>
<th>Subpart C: Categories</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollee Rights</td>
<td>Compliant</td>
<td>7 items were crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 6 items and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on 6 items based on RY 2018.</td>
</tr>
<tr>
<td>Provider-Enrollee Communication</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 1 item and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Marketing Activities</td>
<td>Compliant</td>
<td>2 items were crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 2 items and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Liability for Payment</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 1 item and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>Compliant</td>
<td>Per HealthChoices Agreement</td>
</tr>
<tr>
<td>Emergency Services: Coverage and Payment</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 1 item and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Emergency and Post Stabilization Services</td>
<td>Compliant</td>
<td>4 items were crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 3 items and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on 3 items based on RY 2018.</td>
</tr>
<tr>
<td>Solvency Standards</td>
<td>Compliant</td>
<td>2 items were crosswalked to this category.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The MCO was evaluated against 2 items and was</td>
</tr>
<tr>
<td></td>
<td></td>
<td>compliant on 2 items based on RY 2018.</td>
</tr>
</tbody>
</table>

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

Subpart D: Quality Assessment and Performance Improvement Regulations
The general purpose of the regulations included under this heading is to ensure that all services available under the Commonwealth’s Medicaid managed care program are available and accessible to GH enrollees. [42 C.F.R. §438.206 (a)]

The SMART database includes an assessment of the MCO’s compliance with regulations found in Subpart D. Table 1.3 presents the findings by categories consistent with the regulations.
<table>
<thead>
<tr>
<th>Subpart D: Categories</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access Standards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of Services</td>
<td>Compliant</td>
<td>14 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Coordination and Continuity of Care</td>
<td>Compliant</td>
<td>13 items were crosswalked to this category. The MCO was evaluated against 13 items and was compliant on 13 items based on RY 2018.</td>
</tr>
<tr>
<td>Coverage and Authorization of Services</td>
<td>Compliant</td>
<td>9 items were crosswalked to this category. The MCO was evaluated against 7 items and was compliant on 7 items based on RY 2018.</td>
</tr>
<tr>
<td><strong>Structure and Operation Standards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Selection</td>
<td>Compliant</td>
<td>4 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Provider Discrimination Prohibited</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Enrollment and Disenrollment</td>
<td>Compliant</td>
<td>2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Grievance Systems</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Subcontractual Relationships and Delegations</td>
<td>Compliant</td>
<td>3 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 3 items based on RY 2018.</td>
</tr>
<tr>
<td><strong>Measurement and Improvement Standards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Guidelines</td>
<td>Compliant</td>
<td>2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on 1 item based on RY 2018.</td>
</tr>
<tr>
<td>Health Information Systems</td>
<td>Compliant</td>
<td>18 items were crosswalked to this category. The MCO was evaluated against 3 items and was compliant on 2 items and partially compliant on 1 item based on RY 2018.</td>
</tr>
</tbody>
</table>

GH was evaluated against 33 of 68 SMART Items that were crosswalked to Quality Assessment and Performance Improvement Regulations and was compliant on 32 items and partially compliant on 1 item. Of the 11 categories in Quality Assessment and Performance Improvement Regulations, GH was found to be compliant on all 11 categories.
Subpart F: Federal and State Grievance System Standards
The general purpose of the regulations included under this heading is to ensure that enrollees have the ability to pursue grievances.

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

Table 1.4: GH Compliance with Federal and State Grievance System Standards

<table>
<thead>
<tr>
<th>Subpart F: Categories</th>
<th>Compliance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Requirements</td>
<td>Compliant</td>
<td>8 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Notice of Action</td>
<td>Compliant</td>
<td>3 items was crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Handling of Grievances &amp; Appeals</td>
<td>Compliant</td>
<td>9 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Resolution and Notification</td>
<td>Compliant</td>
<td>7 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Expedited Resolution</td>
<td>Compliant</td>
<td>4 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Information to Providers and Subcontractors</td>
<td>Compliant</td>
<td>1 item was crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Recordkeeping and Recording</td>
<td>Compliant</td>
<td>6 items were crosswalked to this category. The MCO was evaluated against 2 items and was compliant on 2 items based on RY 2018.</td>
</tr>
<tr>
<td>Continuation of Benefits Pending Appeal and State Fair Hearings</td>
<td>Compliant</td>
<td>2 items were crosswalked to this category. The MCO was evaluated against 1 item and was compliant on this item based on RY 2018.</td>
</tr>
<tr>
<td>Effectuation of Reversed Resolutions</td>
<td>Compliant</td>
<td>Per NCQA Accreditation, 2017</td>
</tr>
</tbody>
</table>

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

Accreditation Status
GH underwent an NCQA Accreditation Survey effective through December 15, 2020 and was granted an Accreditation Status of Commendable.
II: Performance Improvement Projects

In accordance with current BBA regulations, IPRO undertook validation of Performance Improvement Projects (PIPs) for each Medicaid PH MCO. For the purposes of the EQR, PH MCOs were required to participate in studies selected by OMAP for validation by IPRO in 2019 for 2018 activities. Under the applicable HealthChoices Agreement with the DHS in effect during this review period, Medicaid PH MCOs are required to conduct focused studies each year. For all PH MCOs, two PIPs were initiated as part of this requirement. For all PIPs, PH MCOs are required to implement improvement actions and to conduct follow-up in order to demonstrate initial and sustained improvement or the need for further action.

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

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

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

For this PIP, OMAP has required all PH MCOs to submit the following core measures on an annual basis:

- Adapted from CMS form 416, the percentage of children ages 0-1 who received, in the last year:
  - any dental service,
  - a preventive dental service,
  - a dental diagnostic service,
  - any oral health service,
  - any dental or oral health service
- Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider
- Total Eligibles Receiving Preventive Dental Services
- The percentages of children, stratified by age (<1, 1-2, 3-5, 6-9, 10-14, 15-18, and 19-20 years) who received at least one topical application of fluoride.

Additionally, MCOs were encouraged to consider other performance measures such as:

- Percentage of children with ECC who are disease free at one year.
- Percentage of children with dental caries (ages 1-8 years of age).
- Percentage of oral health patients that are caries free.
- Percentage of all dental patients for whom the Phase I treatment plan is completed within a 12 month period.

“Reducing Potentially Preventable Hospital Admissions and Readmissions and Emergency Department Visits” was selected as the result of a number of observations. General findings and recommendations from the PA Rethinking Care Program (RCP) – Serious Mental Illness (SMI) Innovation Project (RCP-SMI) and Joint PH/BH Readmission projects, as well as overall Statewide readmission rates and results from several applicable Healthcare Effectiveness Data and Information Set (HEDIS) and PA Performance Measures across multiple years, have highlighted this topic as an area of concern to be addressed for improvement. The Aim Statement for the topic was “To reduce potentially avoidable ED
visits and hospitalizations, including admissions that are avoidable initial admissions and readmissions that are potentially preventable.” Five common objectives for all PH MCOs were selected:

1. Identify key drivers of avoidable hospitalizations, as specific to the MCO’s population (e.g., by specific diagnoses, procedures, comorbid conditions, and demographics that characterize high risk subpopulations for the MCO).
2. Decrease avoidable initial admissions (e.g., admissions related to chronic or worsening conditions, or identified health disparities).
3. Decrease potentially preventable readmissions (e.g., readmissions related to diagnosis, procedure, transition of care, or case management)
4. Decrease avoidable ED visits (e.g., resulting from poor ambulatory management of chronic conditions including BH/SA conditions or use of the ED for non-urgent care).
5. Demonstrate improvement for a number of indicators related to avoidable hospitalizations and preventable readmissions, specifically for Individuals with Serious Persistent Mental Illness (SPMI).

For this PIP, OMAP has required all PH MCOs to submit the following core measures on an annual basis:

**MCO-developed Performance Measures**

MCOS were required to develop their own indicators tailored to their specific PIP (i.e., customized to the key drivers of avoidable hospitalizations identified by each MCO for its specific population).

**DHS-defined Performance Measures**

- Ambulatory Care (AMB): ED Utilization. The target goal was 72 per 1,000 member months.
- Inpatient Utilization—General Hospital/Acute Care (IPU): Total Discharges. The target goal was 8.2 per 1,000 months.
- Reducing Potentially Preventable Readmissions (RPR). The target for the indicator was 8.5. This measure replaced the originally designated measure – Plan All-Cause Readmissions (PCR): 30-day Inpatient Readmission.
- Each of the five (5) BH-PH Integrated Care Plan (ICP) Program measures:
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Emergency Room Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
  - Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (SPMI)
  - Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI).

The PIPs extended from January 2015 through December 2018; with research beginning in 2015, initial PIP proposals were developed and submitted in first quarter 2016, and a final report was due in June 2019. The non-intervention baseline period was January 2015 to December 2015. Following the formal PIP proposal, the timeline defined for the PIPs included required interim reports in July 2016, June 2017 and June 2018, as well as a final report in June 2019. Based on validation findings in 2016, the timeline has undergone adjustments to require submission of interim reports in July of each year. For the current review year, 2019, final reports were also due in July.

The 2019 EQR is the sixteenth year to include validation of PIPs. For each PIP, all PH MCOs shared the same baseline period and timeline defined for that PIP. To introduce each PIP cycle, DHS provided specific guidelines that addressed the PIP submission schedule, the measurement period, documentation requirements, topic selection, study indicators, study design, baseline measurement, interventions, re-measurement, and sustained improvement. Direction was given with regard to expectations for PIP relevance, quality, completeness, resubmissions and timeliness.

All PH MCOs were required to submit their projects using a standardized PIP template form, which is consistent with the CMS protocol for *Conducting Performance Improvement Projects*. These protocols follow a longitudinal format and capture information relating to:

- Activity Selection and Methodology
- Data/Results
- Analysis Cycle
- Interventions
Validation Methodology

IPRO’s protocol for evaluation of PIPs is consistent with the protocol issued by the Centers for Medicare & Medicaid Services (CMS) (Validating Performance Improvement Projects, Final Protocol, Version 1.0, May 1, 2002) and meets the requirements of the final rule on EQR of Medicaid MCOs issued on January 24, 2003. IPRO’s review evaluates each project against ten review elements:

1. Project Topic And Topic Relevance
2. Study Question (Aim Statement)
3. Study Variables (Performance Indicators)
4. Identified Study Population
5. Sampling Methods
6. Data Collection Procedures
7. Improvement Strategies (Interventions)
8. Interpretation Of Study Results (Demonstrable Improvement)
9. Validity Of Reported Improvement
10. Sustainability Of Documented Improvement

The first nine elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement.

Review Element Designation/Weighting

For each review element, the assessment of compliance is determined through the weighted responses to each review item. Each element carries a separate weight. Scoring for each element is based on full, partial and non-compliance. Points can be awarded for the two phases of the project noted above and combined to arrive at an overall score. The overall score is expressed in terms of levels of compliance. For the current PIPs, compliance levels were assessed, but no formal scoring was provided.

Table 2.1 presents the terminologies used in the scoring process, their respective definitions, and their weight percentage.

Table 2.1: Element Designation

<table>
<thead>
<tr>
<th>Element Designation</th>
<th>Definition</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>Met or exceeded the element requirements</td>
<td>100%</td>
</tr>
<tr>
<td>Partial</td>
<td>Met essential requirements but is deficient in some areas</td>
<td>50%</td>
</tr>
<tr>
<td>Non-compliant</td>
<td>Has not met the essential requirements of the element</td>
<td>0%</td>
</tr>
</tbody>
</table>

Overall Project Performance Score

The total points earned for each review element are weighted to determine the MCO’s overall performance score for a PIP. For the EQR PIPs, the review elements for demonstrable improvement have a total weight of 80%. The highest achievable score for all demonstrable improvement elements is 80 points (80% x 100 points for Full Compliance; Table 2.2).

PIPs also are reviewed for the achievement of sustained improvement. For the EQR PIPs, this has a weight of 20%, for a possible maximum total of 20 points (Table 2.2). The MCO must sustain improvement relative to baseline after achieving demonstrable improvement. The evaluation of the sustained improvement area has two review elements.

Scoring Matrix

When the PIPs are reviewed, all projects are evaluated for the same elements. The scoring matrix is completed for those review elements where activities have occurred during the review year. At the time of the review, a project can be reviewed for only a subset of elements. It will then be evaluated for other elements at a later date, according to the PIP submission schedule. At the time each element is reviewed, a finding is given of “Met”, “Partially Met”, or “Not
Met”. Elements receiving a “Met” will receive 100% of the points assigned to the element, “Partially Met” elements will receive 50% of the assigned points, and “Not Met” elements will receive 0%.

Table 2.2: Review Element Scoring Weights

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

Findings

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

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

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

In 2017, reviews of the Project Year 1 Update documents submitted in late 2016 were completed. Upon initial review of the submissions, MCOs were provided findings for each PIP with request for clarification/revision as necessary. MCOs requiring additional discussion and potential modification were contacted for individual MCO conference calls. Upon completion of applicable resubmissions, MCOs were provided with their final Project Year 1 Update review findings. Following completion of Project Year 1 Update reviews, MCOs were asked to submit a Year 2 Interim Update providing information through June 30 for: 1) interventions implemented, 2) monitoring, or process measure, results, and 3) any performance measure outcome results. Review findings were incorporated into the form, and completed reviews were posted to IPRO’s FTP. For review year 2018, MCOs were requested to submit a full Project Year 3 Update with all updated Year 2 and applicable Year 3 activities, including: 1) final rates for all performance measures for Measurement Year (MY) 2016, 2) any available rates for MY 2017, 3) updated interventions grid, 4) rates/results as appropriate for the process measures utilized to evaluate interventions, and 5) any additional supporting analysis conducted for the PIP.

For the current review year, 2019, MCOs were requested to submit a Final Project submission. MCOs were asked to update their submission with the following information: 1) Final rates for all performance measures for MY 2017
(1/1/17-12/31/17)), including the rates provided to them for the ICP measures, 2) any available rates for the Sustainability Year, MY 2018 (1/1/18-12/31/18), 3) an updated interventions grid to show interventions completed in 2018, 4) rates/results as appropriate for the process measures utilized to evaluate each of the ongoing interventions, 5) any additional supporting analysis conducted for the PIP, and 6) the Abstract and Lessons Learned sections of the PIP submission form.

Improving Access to Pediatric Preventive Dental Care

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

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

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

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

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

The MCO conducted a barrier analysis utilizing claims data, 2015 CAHPS results, MCO call campaign data and the National Health and Nutrition Examination Survey (NHANES) data. Qualitative sources included GH’s dental benefit provider, participating PCPs, GH PHDHP and Care Management staff, community partners such as the Achieva Dental Task Force and the Allegheny County Health Department Task Force. Barriers were identified for members, dental and non-dental Providers, procedures and staff. Multiple interventions were developed to address each of the barriers.
identified for members, providers and staff. Examples of active interventions included Enhanced Public Health Dental Hygiene Practitioner (PHDHP) Program, Head Start/ Early Head Start Programming, Embedded Care Coordinators, Incentives, dental events and dashboard reports. The MCO listed a few passive interventions such as booklets, postcards, resource guides and recorded messages. With these interventions it can be hard to track success, as it is difficult to ensure each member received each postcard/phone call, and each provider read the booklets. Following review, the MCO specified efforts to ensure all contact information for each member is accurate.

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

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

Review Element 10 was reviewed in 2019 as part of the Final Project submission, and GH received full credit. GH noted that their interventions were successful in significantly increasing the number of pediatric members receiving dental care. Their strategy to strengthen member education and appointment scheduling first, and then to focus on access to care had proven effective. Although GH did not reach the target rates for all performance measure indicators, final rates improved over the baseline for all indicators.

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

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

Regarding performance measures, GH included all DHS-defined performance measures and MCO-specific measures in the methodology. Additionally, the MCO identified the at-risk population as targeted for the PIP, and noted that the entire eligible population was included for all measures, with no sampling. However, it was noted that the measures were not defined with sufficient detail. For all PIP measures, the specifications need to be defined, including the eligible populations and definitions of the numerators and denominators. It was noted that GH did not include process measures for monitoring/tracking the effectiveness of interventions with the outcome measures. Some process measures were defined and included in the Interventions section. The MCO provided additional information to address these issues in its 2019 Final Project submission and review element 3 was changed to full credit.

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

In its data analysis plan, GH explained that performance measure data are obtained from GH’s main medical claims data warehouse and based on specifications provided by the State. “Those that are aligned with HEDIS specifications utilize NCQA-certified software to calculate administrative rates. This information is validated weekly through the Finance Department to ensure completeness through a data matching process. An internal change control process is also in place to test and validate any changes to the process or logic which tests and validates data before being moved to production. Performance indicator rates are calculated monthly through a Key Performance Indicator report to track and trend variances in process. Additional Clinical Indicator data is obtained through the use of GH Health’s gDNA platform. This platform supports population health management, care-gap reporting, and a person-centered, holistic assessment tool that considers the member’s Behavioral, Economic, Environmental, Medical, Social and Spiritual (BEEMSS™) strengths and needs. [...] Data retrieval is completed by Decision Support Analysts/Senior Decision Support Analysts.”

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

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

Review Element 10 was reviewed in 2019 as part of the Final Project submission, and GH received full credit. GH noted that many limitations regarding this project still exist, such as appointment availability immediately after discharge. However, GH is continuing collaboration with Readmissions and ED Reduction Strategy Workgroups to review and revise interventions. As a result of the interventions in place, GH saw improvements in rates for the given performance measure indicators.

GH’s Final Project compliance assessment by review element is presented in Table 2.3.

Table 2.3: GH PIP Compliance Assessments

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

**2019 External Quality Review Report: Gateway Health**
III: Performance Measures and CAHPS Survey

Methodology

IPRO validated PA specific performance measures and HEDIS data for each of the Medicaid PH MCOs.

The MCOs were provided with final specifications for the PA Performance Measures from December 2018 to June 2019. Source code, raw data and rate sheets were submitted by the MCOs to IPRO for review in 2019. A staggered submission was implemented for the performance measures. IPRO conducted an initial validation of each measure, including source code review and provided each MCO with formal written feedback. The MCOs were then given the opportunity for up to three resubmissions, if necessary. Additional resubmissions required discussion with and approval from DHS. Pseudo code was reviewed by IPRO. Raw data were also reviewed for reasonability and IPRO ran code against these data to validate that the final reported rates were accurate. Additionally MCOs were provided with comparisons to the previous year’s rates and were requested to provide explanations for highlighted differences. For measures reported as percentages, differences were highlighted for rates that were statistically significant and displayed at least a 3-percentage point difference in observed rates. For measures not reported as percentages (e.g. adult admission measures) differences were highlighted based only on statistical significance, with no minimum threshold.

For three PA performance Birth-related measures: Cesarean Rate for Nulliparous Singleton Vertex (CRS), Live Births Weighing Less Than 2,500 Grams (PLB), and Elective Delivery, rates for each of the measures were produced utilizing MCO Birth files in addition to the 2019 (MY 2018) Department of Health Birth File. IPRO requested, from each MCO, information on members with a live birth within the measurement year. IPRO then utilized the MCO file in addition to the most recent applicable PA Department of Health Birth File to identify the denominator, numerator and rate for the three measures.

HEDIS 2019 measures were validated through a standard HEDIS compliance audit of each PH MCO. This audit includes pre-onsite review of the HEDIS Roadmap, onsite interviews with staff and a review of systems, and post-onsite validation of the Interactive Data Submission System (IDSS). A Final Audit Report was submitted to NCQA for each MCO. Because the PA-specific performance measures rely on the same systems and staff, no separate onsite review was necessary for validation of the PA-specific measures. IPRO conducts a thorough review and validation of source code, data and submitted rates for the PA-specific measures.

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

Table 3.1: Performance Measure Groupings

<table>
<thead>
<tr>
<th>Source</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 12 - 24 months)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 25 months - 6 years)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 7-11 years)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 12-19 years)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 20-44 years)</td>
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<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 45-64 years)</td>
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<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 65+)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adult Body Mass Index Assessment</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)</td>
</tr>
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<td>PA EQR</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Well-Child Visits in the First 15 Months of Life (6+ Visits)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Age 3 to 6 Years)</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Childhood Immunizations Status by Age 2 (Combination 2)</td>
</tr>
<tr>
<td>Source</td>
<td>Measures</td>
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<tr>
<td>HEDIS</td>
<td>Childhood Immunizations Status by Age 2 (Combination 3)</td>
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<td>Adolescent Well-Care Visits (Age 12 to 21 years)</td>
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<td>HEDIS</td>
<td>Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 3-11 years)</td>
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<tr>
<td>HEDIS</td>
<td>Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index percentile: (Age 12-17 years)</td>
</tr>
<tr>
<td>HEDIS</td>
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### HEDIS Measures

- **Metabolic Monitoring for Children and Adolescents on Antipsychotics (Age 12 - 17 years)**
- **Use of Opioids at High Dosage**
- **Use of Opioids from Multiple Provider (4 or more prescribers)**
- **Use of Opioids From Multiple Providers - (4 or more pharmacies)**
- **Risk of Continued Opioid Use: New Episode Lasts at Least 15 Days**
- **Risk of Continued Opioid Use: New Episode Lasts at Least 31 Days**
- **Use of Opioids From Multiple Providers - (4 or more pharmacies & pharmacies)**
- **Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 1-3 Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Count of Index Hospital Stays (IHS) - 4+ Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 1-3 Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - 4+ Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Count of 30-Day Readmissions - Total Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 1-3 Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed Readmission Rate - 4+ Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed Readmission Rate - Total Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 1-3 Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Expected Readmission Rate - 4+ Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Expected Readmission Rate - Total Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 1-3 Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - 4+ Stays (Ages Total)**
- **Plan All-Cause Readmissions (PCR): Observed to Expected Readmission Ratio - Total Stays (Ages Total)**

### PA-Specific Performance Measure Selection and Descriptions

Several PA-specific performance measures were calculated by each MCO and validated by IPRO. In accordance with DHS direction, IPRO created the indicator specifications to resemble HEDIS specifications. Measures previously developed and added as mandated by CMS for children in accordance with the Children’s Health Insurance Program Reauthorization Act (CHIPRA) and for adults in accordance with the Affordable Care Act (ACA) were continued as applicable to revised CMS specifications. Additionally, new measures were developed and added in 2019 as mandated in accordance with the ACA. For each indicator, the eligible population is identified by product line, age, enrollment, anchor date, and event/diagnosis. Administrative numerator positives are identified by date of service, diagnosis/procedure code criteria, as well as other specifications, as needed. Indicator rates are calculated through one of two methods: (1) administrative, which uses only the MCO’s data systems to identify numerator positives and (2) hybrid, which uses a combination of administrative data and medical record review (MRR) to identify numerator “hits” for rate calculation.

A number of performance measures require the inclusion of PH and BH services. Due to the separation of PH and BH services for Medicaid, DHS requested that IPRO utilize encounter submitted by all PH and BH MCOs to DHS via the PROMISe encounter data system to ensure both types of services were included as necessary. For some measures, IPRO enhanced PH data submitted by MCOs with BH PROMISe encounter data, while for other measures, IPRO collected and reported the measures using PROMISe encounter data for both the BH and PH data required.

### PA Specific Administrative Measures

#### Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – CHIPRA Core Set

This performance measure assesses the percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. This
measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data.

Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication – CHIPRA Core Set

DHS enhanced this measure using Behavioral Health (BH) encounter data contained in IPRO’s encounter data warehouse. IPRO evaluated this measure using HEDIS 2019 Medicaid member level data submitted by the PH MCO.

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

**Initiation Phase:** The percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

**Continuation and Maintenance (C&M) Phase:** The percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

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

This performance measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. Four rates, one for each age group and a combined rate are to be calculated and reported for each numerator.

Follow-Up After Emergency Department Visit for Mental illness – Adult Core Set

This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit with a corresponding principal diagnosis for mental illness. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data. Two rates are reported:

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

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

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – Adult Core Set

This performance measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and who had a follow-up visit with a corresponding principal diagnosis for AOD abuse or dependence. This measure was collected and reported by IPRO using PROMISe encounter data for the required BH and PH data. Two rates are reported:

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

Per the CMS specifications, rates are reported for age cohorts 18 to 64 and 65 and older.
Annual Dental Visits For Enrollees with Developmental Disabilities

This performance measure assesses the percentage of enrollees with a developmental disability age two through 20 years of age, who were continuously enrolled and had at least one dental visit during the measurement year. This indicator utilizes the HEDIS 2019 measure Annual Dental Visit (ADV).

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

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

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

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

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

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

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

Frequency of Ongoing Prenatal Care

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

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

Cesarean Rate for Nulliparous Singleton Vertex – CHIPRA Core Set

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

Percent of Live Births Weighing Less than 2,500 Grams – CHIPRA Core Set

This performance measure is event-driven and identifies all live births during the measurement year in order to assess the number of live births that weighed less than 2,500 grams as a percent of the number of live births.

Elective Delivery – Adult Core Set

This performance measure assesses the percentage of enrolled women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed.
Asthma in Younger Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for asthma in adults ages 18 to 39 years per 100,000 Medicaid member months.

Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate – Adult Core Set

This performance measure assesses the number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid members 40 years and older. Three age groups will be reported: ages 40-64 years, age 65 years and older, and 40+ years.

Diabetes Short-Term Complications Admission Rate – Adult Core Set

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

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) – Adult Core Set

This performance measure assesses the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) in poor control (>9.0%). This measure was collected and reported by IPRO using PROMISE encounter data for the required BH and PH data.

Heart Failure Admission Rate – Adult Core Set

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

Reducing Potentially Preventable Readmissions

This performance measure assesses the percentage of inpatient acute care discharges with subsequent readmission to inpatient acute care within 30 days of the initial inpatient acute discharge. This measure utilized the 2019 HEDIS Inpatient Utilization – General Hospital/Acute Care measure methodology to identify inpatient acute care discharges. For this measure, a lower rate indicates better performance.

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

The percentage of members 19-64 years of age with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period during the measurement year. Members in hospice are excluded from eligible population.

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

Concurrent Use of Opioids and Benzodiazepines – Adult Core Set – New 2019

This performance measure assesses the percentage of members age 18 and older with concurrent use of prescription opioids and benzodiazepines.

PA Specific Hybrid Measures

Prenatal Screening for Smoking and Treatment Discussion During a Prenatal Visit

This performance measure assesses the percentage of pregnant enrollees who were:
1. Screened for smoking during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO.
2. Screened for smoking during the time frame of one of their first two prenatal visits (CHIPRA indicator).
3. Screened for environmental tobacco smoke exposure during the time frame of one of their first two prenatal visits or during the time frame of their first two visits on or following initiation of eligibility with the MCO.
4. Screened for smoking in one of their first two prenatal visits who smoke (i.e., smoked six months prior to or anytime during the current pregnancy), that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
5. Screened for environmental tobacco smoke exposure in one of their first two prenatal visits and found to be exposed, that were given counseling/advice or a referral during the time frame of any prenatal visit during pregnancy.
6. Screened for smoking in one of their first two prenatal visits and found to be current smokers (i.e., smoked at the time of one of their first two prenatal visits) that stopped smoking during their pregnancy.

This performance measure uses components of the HEDIS 2019 Prenatal and Postpartum Care Measure.

**Perinatal Depression Screening**

This performance measure assesses the percentage of enrollees who were:

1. Screened for depression during a prenatal care visit.
2. Screened for depression during a prenatal care visit using a validated depression screening tool.
3. Screened for depression during the time frame of the first two prenatal care visits (CHIPRA indicator).
4. Screened positive for depression during a prenatal care visit.
5. Screened positive for depression during a prenatal care visit and had evidence of further evaluation, treatment, or referral for further treatment.
6. Screened for depression during a postpartum care visit.
7. Screened for depression during a postpartum care visit using a validated depression screening tool.
8. Screened positive for depression during a postpartum care visit.
9. Screened positive for depression during a postpartum care visit and had evidence of further evaluation, treatment, or referral for further treatment.

This performance measure uses components of the HEDIS 2019 Prenatal and Postpartum Care Measure.

**Maternity Risk Factor Assessment**

This performance measure assesses, for each of the following risk categories, the percentage of pregnant enrollees who were:

1. Screened for alcohol use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
2. Screened for illicit drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
3. Screened for prescribed or over-the-counter drug use during the time frame of one of their first two prenatal visits (CHIPRA indicator).
4. Screened for intimate partner violence during the time frame of one of their first two prenatal visits (CHIPRA indicator).

This performance measure uses components of the HEDIS 2019 Prenatal and Postpartum Care Measure.

**HEDIS Performance Measure Selection and Descriptions**

Each MCO underwent a full HEDIS compliance audit in 2019. As indicated previously, performance on selected HEDIS measures is included in this year’s EQR report. Development of HEDIS measures and the clinical rationale for their inclusion in the HEDIS measurement set can be found in HEDIS2019, Volume 2 Narrative. The measurement year for HEDIS 2019 measures is 2018, as well as prior years for selected measures. Each year, DHS updates its requirements for
the MCOs to be consistent with NCQA’s requirement for the reporting year. MCOs are required to report the complete set of Medicaid measures, excluding behavioral health and chemical dependency measures, as specified in the HEDIS Technical Specifications, Volume 2. In addition, DHS does not require the MCOs to produce the Chronic Conditions component of the CAHPS 5.0 – Child Survey.

Children and Adolescents’ Access to Primary Care Practitioners

This measure assesses the percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Adults’ Access to Preventive/Ambulatory Health Services

This measure assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year (for Medicaid or Medicare). The following age groups are reported: 20-44, 45-64, 65+ and total.

Adult Body Mass Index (BMI) Assessment

This measure assessed the percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Well-Child Visits in the First 15 Months of Life

This measure assessed the percentage of members who turned 15 months old during the measurement year, who were continuously enrolled from 31 days of age through 15 months of age who received six or more well-child visits with a PCP during their first 15 months of life.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

This measure assessed the percentage of members who were 3, 4, 5, or 6 years of age during the measurement year, who were continuously enrolled during the measurement year and received one or more well-child visits with a PCP during the measurement year.

Childhood Immunization Status (Combos 2 and 3)

This measure assessed the percentage of children who turned two years of age in the measurement year who were continuously enrolled for the 12 months preceding their second birthday and who received one or both of the immunization combinations on or before their second birthday. Separate rates were calculated for each Combination. Combination 2 and 3 consists of the following immunizations:

- (4) Diphtheria, Tetanus, and Acellular Pertussis Vaccine/Diphtheria and Tetanus (DTaP/DT)
- (3) Injectable Polio Vaccine (IPV)
- (1) Measles, Mumps, and Rubella (MMR)
- (3) Haemophilus Influenza Type B (HiB)
- (3) Hepatitis B (HepB)
- (1) Chicken Pox (VZV)
- (4) Pneumococcal Conjugate Vaccine (PCV) – Combination 3 only

Adolescent Well-Care Visits

This measure assessed the percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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

1. BMI percentile documentation.
2. Counseling for nutrition.
3. Counseling for physical activity.

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

Immunization for Adolescents (Combo 1)

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

Lead Screening in Children

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

Follow-up Care for Children Prescribed ADHD Medication

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

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, which had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Annual Dental Visit

This measure assessed the percentage of children and adolescents between the ages of 2 and 20 years of age continuously enrolled in the MCO for the measurement year who had at least one dental visit during the measurement year.

Breast Cancer Screening

This measure assessed the percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

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

Cervical Cancer Screening

This measure assessed the percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:
• Women age 21-64 who had cervical cytology performed every 3 years.
• Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Chlamydia Screening in Women

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

Non-Recommended Cervical Cancer Screening in Adolescent Females

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

Prenatal and Postpartum Care

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

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

Appropriate Testing for Children with Pharyngitis

This measure assessed the percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Appropriate Treatment for Children with Upper Respiratory Infection

This measure assessed the percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measure assessed the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

Use of Spirometry Testing in the Assessment and Diagnosis of COPD

This measure assessed the percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

Pharmacotherapy Management of COPD Exacerbation

This measure assessed the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:
1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

**Medication Management for People with Asthma - 75% Compliance**

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

**Asthma Medication Ratio**

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

**Comprehensive Diabetes Care**

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

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

**Statin Therapy for Patients With Diabetes**

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

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

**Persistence of Beta-Blocker Treatment After a Heart Attack**

This measure assessed the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

**Controlling High Blood Pressure**

This measure assessed the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year.

**Statin Therapy for Patients With Cardiovascular Disease**

This measure assessed the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:
1. **Received Statin Therapy.** Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.

2. **Statin Adherence 80%.** Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.

Total rates for 1 and 2 are also reported.

**Cardiovascular Monitoring For People With Cardiovascular Disease and Schizophrenia**

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

**Adherence to Antipsychotic Medications for Individuals with Schizophrenia**

This measure assessed the percentage of members 19–64 years of age during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

**Use of Multiple Concurrent Antipsychotics in Children and Adolescents**

This measure assessed the percentage of children and adolescents 1–17 years of age who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Age groups 1-5, 6-11, 12-17 and total are reported.

For this measure, a lower rate indicates better performance.

**Metabolic Monitoring for Children and Adolescents on Antipsychotics**

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

**Use of Opioids at High Dosage**

This measure assessed the proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year at a high dosage (average milligram morphine dose [MME] >120 mg).

For this measure, a lower rate indicates better performance.

**Use of Opioids from Multiple Providers**

This measure assessed the proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

1. **Multiple Prescribers:** The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year
2. **Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
3. **Multiple Prescribers and Multiple Pharmacies:** The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).

A lower rate indicates better performance for all three rates.
Plan All-Cause Readmissions (PCR)

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

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

Risk of Continued Opioid Use – New 2019

This measure assessed the percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:

1. The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period.
2. The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.

For this measure, a lower rate indicates better performance.

CAHPS® Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is overseen by the Agency of Healthcare Research and Quality (AHRQ) and includes many survey products designed to capture consumer and patient perspectives on health care quality. NCQA uses the adult and child versions of the CAHPS Health Plan Surveys for HEDIS.

Implementation of PA-Specific Performance Measures and HEDIS Audit

The MCO successfully implemented all of the PA-specific measures for 2019 that were reported with MCO-submitted data. The MCO submitted all required source code and data for review. IPRO reviewed the source code and validated raw data submitted by the MCO. All rates submitted by the MCO were reportable. Rate calculations were collected via rate sheets and reviewed for all of the PA-specific measures. As previously indicated, for three PA Birth-related performance measures IPRO utilized the MCO Birth files in addition to the 2019 Department of Health Birth File to identify the denominator, numerator and rate for the Birth-related measures.

IPRO validated the medical record abstraction of the three PA-specific hybrid measures consistent with the protocol used for a HEDIS audit. The validation process includes a MRR process evaluation and review of the MCO’s MRR tools and instruction materials. This review ensures that the MCO’s MRR process was executed as planned and the abstraction results are accurate. A random sample of 16 records from each selected indicator across the three measures was evaluated. The indicators were selected for validation based on preliminary rates observed upon the MCO’s completion of abstraction. The MCO passed MRR Validation for the Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit, the Perinatal Depression Screening, and the Maternity Risk Factor Assessment measures.

Due to multiple implementation and validation issues that required additional follow-up over previous years for the Reducing Potentially Preventable Readmissions (RPR) measure, an attestation form was developed in 2019 to accompany the specifications. The attestation form listed the criteria for each review element in the measure. MCOs and if applicable their vendors were required to attest, or sign off, for each element that the element was addressed in the source code used to create the data file submitted for validation. The attestation form was in addition to the requirements for MCOs to use the final specifications to collect the measure data, submit the source code used to
produce the data file, and to pass validation of the data file. Completion of the form was required to complete validation and close out the measure.

During RPR validation, several MCOs advised that their vendors would not sign off on the form. One common vendor for most MCOs would not sign off on the form without a walkthrough of their systems. IPRO and DHS discussed that prior walkthroughs did not provide sufficient applicable information and utilized additional resources unnecessarily. Additionally, oversight of vendors to comply with requirements is part of the MCOs’ HealthChoices agreements. Because of this, DHS advised MCOs that the attestation form, in addition to all appropriate source code, must be provided or a corrective action and/or financial sanction would be imposed. As MCOs began working with their vendors to complete the form, questions arose regarding the types of data that were being utilized as well as how they were being designated and utilized for the measure.

For GH, the primary questions that arose regarding data used for RPR were 1) if fee-for-service (FFS) claims were inappropriately included and 2) if claims assigned as denied by the MCO included only claims allowed per the specification (i.e., claims when services were rendered regardless of MCO non-payment), or if other claims not covered by the specifications would be assigned as denied and would therefore also be included in the measure. GH confirmed that FFS claims were not being included for the measure. For denied claims, GH noted that there are a variety of denial codes in the claims processing system that account for various types of denied claims. GH advised that the duplicate claims are excluded via the vendor’s measure processing. Additionally, GH advised that claims denied for no service are voided and voided claims are not loaded into the vendor’s software, which means no claims would be used in measure creation. GH worked with the vendor as needed to submit corrected files, source code, and completed attestation form to pass validation.

The MCO successfully completed the HEDIS audit. The MCO received an Audit Designation of Report for all applicable measures.

**Findings**

MCO results are presented in Tables 3.2 through 3.11. For each measure, the denominator, numerator, and measurement year rates with 95% upper and lower confidence intervals (95% CI) are presented. Confidence intervals are ranges of values that can be used to illustrate the variability associated with a given calculation. For any rate, a 95% confidence interval indicates that there is a 95% probability that the calculated rate, if it were measured repeatedly, would fall within the range of values presented for that rate. All other things being equal, if any given rate were calculated 100 times, the calculated rate would fall within the confidence interval 95 times, or 95% of the time.

Rates for both the measurement year and the previous year are presented, as available [i.e., 2019 (MY 2018) and 2018 (MY 2017)]. In addition, statistical comparisons are made between the 2019 and 2018 rates. For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate populations. For comparison of 2019 rates to 2018 rates, statistically significant increases are indicated by “+”, statistically significant decreases by “−” and no statistically significant change by “n.s.”

In addition to each individual MCO’s rate, the MMC average for 2019 (MY 2018) is presented. The MMC average is a weighted average, which is an average that takes into account the proportional relevance of each MCO. Each table also presents the significance of difference between the plan’s measurement year rate and the MMC average for the same year. For comparison of 2019 rates to MMC rates, the “+” symbol denotes that the plan rate exceeds the MMC rate; the “−” symbol denotes that the MMC rate exceeds the plan rate and “n.s.” denotes no statistically significant difference between the two rates. Rates for the HEDIS measures were compared to corresponding Medicaid percentiles; comparison results are provided in the tables. The 90th percentile is the benchmark for the HEDIS measures.

Note that the large denominator sizes for many of the analyses led to increased statistical power, and thus contributed to detecting statistical differences that are not clinically meaningful. For example, even a 1-percentage point difference
between two rates was statistically significant in many cases, although not meaningful. Hence, results corresponding to each table highlight only differences that are both statistically significant, and display at least a 3-percentage point difference in observed rates. It should also be mentioned that when the denominator sizes are small, even relatively large differences in rates may not yield statistical significance due to reduced power; if statistical significance is not achieved, results will not be highlighted in the report. Differences are also not discussed if the denominator was less than 30 for a particular rate, in which case, “NA” (Not Applicable) appears in the corresponding cells. However, “NA” (Not Available) also appears in the cells under the HEDIS 2019 percentile column for PA-specific measures that do not have HEDIS percentiles to compare.

The tables below show rates up to one decimal place. Calculations to determine differences between rates are based upon unrounded rates. Due to rounding, differences in rates that are reported in the narrative may differ slightly from the difference between the rates as presented in the table.

Access to/Availability of Care

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

- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
  - Adults’ Access to Preventive/Ambulatory Health Services (Age 20-44 years) – 3.9 percentage points

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

Table 3.2: Access to/Availability of Care

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<th>Indicator Source</th>
<th>Indicator</th>
<th>Denom</th>
<th>Num</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
<th>2018 (MY2017) Rate</th>
<th>2019 Rate Compared to 2018</th>
<th>2019 Rate Compared to MMC</th>
<th>HEDIS 2019 Percentile</th>
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<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 12-24 months)</td>
<td>7,542</td>
<td>7,309</td>
<td>96.9%</td>
<td>96.5%</td>
<td>97.3%</td>
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<td>96.4%</td>
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<td>Children and Adolescents’ Access to PCPs (Age 25 months-6 years)</td>
<td>30,595</td>
<td>27,188</td>
<td>88.9%</td>
<td>88.5%</td>
<td>89.2%</td>
<td>89.3%</td>
<td>n.s.</td>
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<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 7-11 years)</td>
<td>26,767</td>
<td>24,856</td>
<td>91.8%</td>
<td>91.5%</td>
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<tr>
<td>HEDIS</td>
<td>Children and Adolescents’ Access to PCPs (Age 12-19 years)</td>
<td>36,992</td>
<td>33,969</td>
<td>91.8%</td>
<td>91.5%</td>
<td>92.1%</td>
<td>92.0%</td>
<td>n.s.</td>
<td>92.2%</td>
<td>-</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 20-44 years)</td>
<td>65,683</td>
<td>53,685</td>
<td>81.7%</td>
<td>81.4%</td>
<td>82.0%</td>
<td>82.3%</td>
<td>-</td>
<td>77.8%</td>
<td>+</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 45-64 years)</td>
<td>33,188</td>
<td>29,280</td>
<td>88.2%</td>
<td>87.9%</td>
<td>88.6%</td>
<td>89.2%</td>
<td>-</td>
<td>85.6%</td>
<td>+</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adults’ Access to Preventive/Ambulatory Health Services (Age 65+ years)</td>
<td>737</td>
<td>614</td>
<td>83.3%</td>
<td>80.6%</td>
<td>86.1%</td>
<td>88.0%</td>
<td>-</td>
<td>81.5%</td>
<td>n.s.</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adult BMI Assessment (Age 18-74 years)</td>
<td>411</td>
<td>377</td>
<td>91.7%</td>
<td>88.9%</td>
<td>94.5%</td>
<td>89.5%</td>
<td>n.s.</td>
<td>93.2%</td>
<td>n.s.</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 1 to 5)</td>
<td>6</td>
<td>4</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>50.9%</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 6 to 11)</td>
<td>217</td>
<td>158</td>
<td>72.8%</td>
<td>66.7%</td>
<td>79.0%</td>
<td>77.4%</td>
<td>n.s.</td>
<td>73.3%</td>
<td>n.s.</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Ages 12 to 17)</td>
<td>363</td>
<td>255</td>
<td>70.3%</td>
<td>65.4%</td>
<td>75.1%</td>
<td>72.6%</td>
<td>n.s.</td>
<td>67.3%</td>
<td>n.s.</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total ages 1 to 17)</td>
<td>586</td>
<td>417</td>
<td>71.2%</td>
<td>67.4%</td>
<td>74.9%</td>
<td>74.2%</td>
<td>n.s.</td>
<td>69.3%</td>
<td>n.s.</td>
</tr>
</tbody>
</table>
Well-Care Visits and Immunizations

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

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Adolescent Well-Care Visits (Age 12 to 21 Years) – 5.0 percentage points
  - Body Mass Index: Percentile (Age 3 - 11 years) – 7.6 percentage points
  - Body Mass Index: Percentile (Total) – 6.5 percentage points
  - Counseling for Nutrition (Age 3-11 years) – 6.3 percentage points
  - Counseling for Nutrition (Total) – 4.2 percentage points

Table 3.3: Well-Care Visits and Immunizations

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denom</td>
<td>Num</td>
<td>Rate</td>
<td>Lower 95% Confidence Interval</td>
<td>Upper 95% Confidence Interval</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Well Child Visits in the First 15 Months of Life (≥ 6 Visits)</td>
<td>411</td>
<td>289</td>
<td>70.3%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Age 3 to 6 years)</td>
<td>411</td>
<td>319</td>
<td>77.6%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Childhood Immunizations Status (Combination 2)</td>
<td>411</td>
<td>299</td>
<td>72.7%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Childhood Immunizations Status (Combination 3)</td>
<td>411</td>
<td>288</td>
<td>70.1%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adolescent Well Care Visits (Age 12 to 21 Years)</td>
<td>411</td>
<td>236</td>
<td>57.4%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Body Mass Index: Percentile (Age 3 - 11 years)</td>
<td>259</td>
<td>197</td>
<td>76.1%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Body Mass Index: Percentile (Age 12 - 17 years)</td>
<td>152</td>
<td>120</td>
<td>78.9%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Body Mass Index: Percentile (Total)</td>
<td>411</td>
<td>317</td>
<td>77.1%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Nutrition (Age 3 - 11 years)</td>
<td>259</td>
<td>182</td>
<td>70.3%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Nutrition (Age 12 - 17 years)</td>
<td>152</td>
<td>112</td>
<td>73.7%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Nutrition (Total)</td>
<td>411</td>
<td>294</td>
<td>71.5%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Physical Activity (Age 3 - 11 years)</td>
<td>259</td>
<td>170</td>
<td>65.6%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Physical Activity (Age 12 - 17 years)</td>
<td>152</td>
<td>108</td>
<td>71.1%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Counseling for Physical Activity (Total)</td>
<td>411</td>
<td>278</td>
<td>67.6%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Immunization for Adolescents (Combo 1)</td>
<td>411</td>
<td>369</td>
<td>89.8%</td>
</tr>
</tbody>
</table>

EPSDT: Screenings and Follow-up

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

- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
  - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase – 5.1 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase – 6.6 percentage points
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase – 5.3 percentage points
Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase – 6.7 percentage points

Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days) – 3.9 percentage points

No opportunities for improvement are identified for EPSDT: Screenings and Follow-up performance measures.

Table 3.4: EPSDT: Screenings and Follow-up

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Denom</td>
<td>Num</td>
<td>Rate</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Lead Screening in Children (Age 2 years)</td>
<td>411</td>
<td>326</td>
<td>79.3%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Follow up Care for Children Prescribed ADHD Medication Initiation Phase</td>
<td>2,089</td>
<td>1,006</td>
<td>48.2%</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Follow up Care for Children Prescribed ADHD Medication Continuation Phase</td>
<td>603</td>
<td>340</td>
<td>56.4%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Initiation Phase</td>
<td>2,089</td>
<td>1,019</td>
<td>48.8%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow up Care for Children Prescribed ADHD Medication (BH Enhanced) Continuation Phase</td>
<td>573</td>
<td>340</td>
<td>59.3%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Developmental Screening in the First Three Years of Life Total</td>
<td>19,513</td>
<td>10,624</td>
<td>54.4%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Developmental Screening in the First Three Years of Life 1 year</td>
<td>6,910</td>
<td>3,341</td>
<td>48.4%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Developmental Screening in the First Three Years of Life 2 years</td>
<td>6,625</td>
<td>3,875</td>
<td>58.5%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Developmental Screening in the First Three Years of Life 3 years</td>
<td>5,978</td>
<td>3,408</td>
<td>57.0%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 - ED visits for mental illness, follow up within 7 days)</td>
<td>1,468</td>
<td>603</td>
<td>41.1%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 - ED visits for mental illness, follow up within 30 days)</td>
<td>1,468</td>
<td>811</td>
<td>55.3%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow up within 7 days)</td>
<td>1,843</td>
<td>268</td>
<td>14.5%</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, or Mental Illness (Ages: 18 to 64 - ED visits for AOD abuse or dependence, follow up within 30 days)</td>
<td>1,843</td>
<td>422</td>
<td>22.9%</td>
</tr>
</tbody>
</table>
Dental Care for Children and Adults

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

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

Table 3.5: EPSDT: Dental Care for Children and Adults

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Denom</th>
<th>Num</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
<th>2018 (MY2017) Rate</th>
<th>2019 Rate Compared to 2018</th>
<th>MMC 2019 Rate Compared to MMC</th>
<th>HEDIS 2019 Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Dental Visit (Age 2-20 years)</td>
<td>HEDIS</td>
<td>106,352</td>
<td>68,104</td>
<td>64.0%</td>
<td>63.7%</td>
<td>64.3%</td>
<td>63.7%</td>
<td>n.s.</td>
<td>64.0%</td>
<td>&gt;= 50th and &lt; 75th percentile</td>
</tr>
<tr>
<td>Annual Dental Visits for Members with Developmental Disabilities (Age 2-20 years)</td>
<td>PA EQR</td>
<td>8,628</td>
<td>5,521</td>
<td>64.0%</td>
<td>63.0%</td>
<td>65.0%</td>
<td>63.8%</td>
<td>n.s.</td>
<td>62.4%</td>
<td>+</td>
</tr>
<tr>
<td>Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk</td>
<td>PA EQR</td>
<td>13,757</td>
<td>3,346</td>
<td>24.3%</td>
<td>23.6%</td>
<td>25.0%</td>
<td>23.8%</td>
<td>n.s.</td>
<td>21.9%</td>
<td>+</td>
</tr>
<tr>
<td>Dental Sealants for 6-9 Year Of Children At Elevated Caries Risk (Dental Enhanced)</td>
<td>PA EQR</td>
<td>13,885</td>
<td>3,393</td>
<td>24.4%</td>
<td>23.7%</td>
<td>25.2%</td>
<td>23.8%</td>
<td>n.s.</td>
<td>23.1%</td>
<td>+</td>
</tr>
</tbody>
</table>

Women’s Health

No strengths are identified for Women’s Health performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Chlamydia Screening in Women (Age 16-20 years) – 3.1 percentage points
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20) – 3.3 percentage points
### Table 3.6: Women's Health

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>Denom</th>
<th>Num</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
<th>2018 (MY2017) Rate</th>
<th>2019 Rate Compared to 2018</th>
<th>MMC</th>
<th>2019 Rate Compared to MMC</th>
<th>HEDIS 2019 Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS Breast Cancer Screening (Age 50-74 years)</td>
<td>10,052</td>
<td>5,531</td>
<td>55.0%</td>
<td>54.0%</td>
<td>56.0%</td>
<td>54.5%</td>
<td>n.s.</td>
<td>57.3%</td>
<td>-</td>
<td>&gt;= 25th and &lt; 75th percentile</td>
<td></td>
</tr>
<tr>
<td>HEDIS Cervical Cancer Screening (Age 21-64 years)</td>
<td>411</td>
<td>253</td>
<td>61.6%</td>
<td>56.7%</td>
<td>66.4%</td>
<td>56.4%</td>
<td>n.s.</td>
<td>63.0%</td>
<td>n.s.</td>
<td>&gt;= 50th and &lt; 75th percentile</td>
<td></td>
</tr>
<tr>
<td>HEDIS Chlamydia Screening in Women (Total)</td>
<td>11,540</td>
<td>6,743</td>
<td>58.4%</td>
<td>57.5%</td>
<td>59.3%</td>
<td>58.0%</td>
<td>n.s.</td>
<td>60.9%</td>
<td>-</td>
<td>&gt;= 50th and &lt; 75th percentile</td>
<td></td>
</tr>
<tr>
<td>HEDIS Chlamydia Screening in Women (Age 16-20 years)</td>
<td>6,483</td>
<td>3,520</td>
<td>54.3%</td>
<td>53.1%</td>
<td>55.5%</td>
<td>53.7%</td>
<td>n.s.</td>
<td>57.4%</td>
<td>-</td>
<td>&gt;= 25th and &lt; 50th percentile</td>
<td></td>
</tr>
<tr>
<td>HEDIS Chlamydia Screening in Women (Age 21-24 years)</td>
<td>5,057</td>
<td>3,223</td>
<td>63.7%</td>
<td>62.4%</td>
<td>65.1%</td>
<td>63.5%</td>
<td>n.s.</td>
<td>65.1%</td>
<td>n.s.</td>
<td>&gt;= 25th and &lt; 50th percentile</td>
<td></td>
</tr>
<tr>
<td>HEDIS Non Recommended Cervical Cancer Screening in Adolescent Females</td>
<td>11,087</td>
<td>62</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.7%</td>
<td>0.9%</td>
<td>-</td>
<td>0.8%</td>
<td>-</td>
<td>&gt;= 50th and &lt; 75th percentile</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 15 to 20)</td>
<td>13,125</td>
<td>4,554</td>
<td>34.7%</td>
<td>33.9%</td>
<td>35.5%</td>
<td>35.2%</td>
<td>n.s.</td>
<td>32.7%</td>
<td>+</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for All Women: Provision of LARC (Ages 15 to 20)</td>
<td>13,125</td>
<td>541</td>
<td>4.1%</td>
<td>3.8%</td>
<td>4.5%</td>
<td>5.4%</td>
<td>-</td>
<td>3.6%</td>
<td>+</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for All Women: Provision of most or moderately effective contraception (Ages 21 to 44)</td>
<td>37,171</td>
<td>10,803</td>
<td>29.1%</td>
<td>28.6%</td>
<td>29.5%</td>
<td>28.7%</td>
<td>n.s.</td>
<td>28.7%</td>
<td>n.s.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for All Women: Provision of LARC (Ages 21 to 44)</td>
<td>37,171</td>
<td>1,702</td>
<td>4.6%</td>
<td>4.4%</td>
<td>4.8%</td>
<td>6.3%</td>
<td>-</td>
<td>4.3%</td>
<td>+</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 15 to 20)</td>
<td>637</td>
<td>44</td>
<td>6.9%</td>
<td>4.9%</td>
<td>9.0%</td>
<td>4.5%</td>
<td>n.s.</td>
<td>9.8%</td>
<td>-</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 15 to 20)</td>
<td>637</td>
<td>264</td>
<td>41.4%</td>
<td>37.5%</td>
<td>45.3%</td>
<td>40.1%</td>
<td>n.s.</td>
<td>42.2%</td>
<td>n.s.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: LARC 3 days (Ages 15 to 20)</td>
<td>637</td>
<td>17</td>
<td>2.7%</td>
<td>1.3%</td>
<td>4.0%</td>
<td>0.9%</td>
<td>+</td>
<td>4.8%</td>
<td>-</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: LARC 60 days (Ages 15 to 20)</td>
<td>637</td>
<td>68</td>
<td>10.7%</td>
<td>8.2%</td>
<td>13.2%</td>
<td>11.2%</td>
<td>n.s.</td>
<td>14.0%</td>
<td>-</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: Most or moderately effective contraception 3 days (Ages 21 to 44)</td>
<td>4,397</td>
<td>628</td>
<td>14.3%</td>
<td>13.2%</td>
<td>15.3%</td>
<td>13.1%</td>
<td>n.s.</td>
<td>14.7%</td>
<td>n.s.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: Most or moderately effective contraception 60 days (Ages 21 to 44)</td>
<td>4,397</td>
<td>1,877</td>
<td>42.7%</td>
<td>41.2%</td>
<td>44.2%</td>
<td>42.6%</td>
<td>n.s.</td>
<td>41.9%</td>
<td>n.s.</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: LARC 3 days (Ages 21 to 44)</td>
<td>4,397</td>
<td>59</td>
<td>1.3%</td>
<td>1.0%</td>
<td>1.7%</td>
<td>0.9%</td>
<td>n.s.</td>
<td>2.6%</td>
<td>-</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PA EQR Contraceptive Care for Postpartum Women: LARC 60 days (Ages 21 to 44)</td>
<td>4,397</td>
<td>398</td>
<td>9.1%</td>
<td>8.2%</td>
<td>9.9%</td>
<td>9.7%</td>
<td>n.s.</td>
<td>10.3%</td>
<td>-</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

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

### Obstetric and Neonatal Care

Strengths are identified for the following Obstetric and Neonatal Care performance measures.
- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
  - Prenatal Screening Positive for Depression – 8.7 percentage points

Opportunities for improvement are identified for the following measures:
- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care – 3.6 percentage points
  - Prenatal and Postpartum Care – Postpartum Care – 4.7 percentage points
  - Prenatal Screening for Smoking – 8.9 percentage points
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator) – 9.0 percentage points
  - Prenatal Screening for Environmental Tobacco Smoke Exposure – 37.3 percentage points
- Prenatal Counseling for Smoking – 20.8 percentage points
- Prenatal Counseling for Environmental Tobacco Smoke Exposure – 20.1 percentage points
- Prenatal Screening for Depression – 19.1 percentage points
- Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator) – 25.9 percentage points
- Postpartum Screening for Depression – 8.3 percentage points
- Prenatal Screening for Alcohol use – 17.4 percentage points
- Prenatal Screening for Illicit drug use – 17.0 percentage points
- Prenatal Screening for Prescribed or over-the-counter drug use – 9.9 percentage points
- Prenatal Screening for Intimate partner violence – 29.3 percentage points
- Prenatal Screening for Behavioral Health Risk Assessment – 37.3 percentage points

Table 3.7: Obstetric and Neonatal Care

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>Denom</th>
<th>Num</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
<th>2018 (MY2017) Rate</th>
<th>2019 Rate Compared to 2018</th>
<th>MMC</th>
<th>2019 Rate Compared to MMC</th>
<th>HEDIS 2019 Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA EQR</td>
<td>Frequency of Ongoing Prenatal Care Greater than or Equal to 61% of Expected Prenatal Care Visits Received</td>
<td>411</td>
<td>364</td>
<td>88.6%</td>
<td>85.4%</td>
<td>91.8%</td>
<td>86.9%</td>
<td>n.s.</td>
<td>87.2%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Frequency of Ongoing Prenatal Care Greater than or Equal to 81% of Expected Prenatal Care Visits Received</td>
<td>411</td>
<td>318</td>
<td>77.4%</td>
<td>73.2%</td>
<td>81.5%</td>
<td>73.0%</td>
<td>n.s.</td>
<td>73.4%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Prenatal and Postpartum Care Timeliness of Prenatal Care</td>
<td>411</td>
<td>343</td>
<td>83.5%</td>
<td>79.7%</td>
<td>87.2%</td>
<td>81.5%</td>
<td>n.s.</td>
<td>87.0%</td>
<td>-</td>
<td>&gt;= 25th and &lt; 50th percentile</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Prenatal and Postpartum Care Postpartum Care</td>
<td>411</td>
<td>259</td>
<td>63.0%</td>
<td>58.2%</td>
<td>67.8%</td>
<td>66.2%</td>
<td>n.s.</td>
<td>67.7%</td>
<td>-</td>
<td>&gt;= 25th and &lt; 50th percentile</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Smoking</td>
<td>428</td>
<td>333</td>
<td>77.8%</td>
<td>73.7%</td>
<td>81.9%</td>
<td>66.3%</td>
<td>+</td>
<td>86.7%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)</td>
<td>428</td>
<td>332</td>
<td>77.6%</td>
<td>73.5%</td>
<td>81.6%</td>
<td>65.5%</td>
<td>+</td>
<td>86.6%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Environmental Tobacco Smoke Exposure</td>
<td>428</td>
<td>63</td>
<td>14.7%</td>
<td>11.2%</td>
<td>18.2%</td>
<td>18.2%</td>
<td>n.s.</td>
<td>52.1%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Counseling for Smoking</td>
<td>121</td>
<td>70</td>
<td>57.9%</td>
<td>48.6%</td>
<td>67.1%</td>
<td>81.1%</td>
<td>-</td>
<td>78.6%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Counseling for Environmental Tobacco Smoke Exposure</td>
<td>34</td>
<td>21</td>
<td>61.8%</td>
<td>44.0%</td>
<td>79.6%</td>
<td>NA</td>
<td>NA</td>
<td>81.9%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Smoking Cessation</td>
<td>119</td>
<td>23</td>
<td>19.3%</td>
<td>11.8%</td>
<td>26.8%</td>
<td>7.8%</td>
<td>+</td>
<td>18.5%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Depression</td>
<td>428</td>
<td>235</td>
<td>54.9%</td>
<td>50.1%</td>
<td>59.7%</td>
<td>45.1%</td>
<td>+</td>
<td>74.0%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)</td>
<td>428</td>
<td>189</td>
<td>44.2%</td>
<td>39.3%</td>
<td>49.0%</td>
<td>37.9%</td>
<td>n.s.</td>
<td>70.0%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening Positive for Depression</td>
<td>233</td>
<td>65</td>
<td>27.7%</td>
<td>21.7%</td>
<td>33.6%</td>
<td>30.6%</td>
<td>n.s.</td>
<td>19.0%</td>
<td>+</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Counseling for Depression</td>
<td>65</td>
<td>53</td>
<td>81.5%</td>
<td>71.3%</td>
<td>91.7%</td>
<td>71.4%</td>
<td>n.s.</td>
<td>79.8%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Postpartum Screening for Depression</td>
<td>320</td>
<td>221</td>
<td>69.1%</td>
<td>63.8%</td>
<td>74.3%</td>
<td>74.8%</td>
<td>n.s.</td>
<td>77.3%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Postpartum Screening Positive for Depression</td>
<td>221</td>
<td>42</td>
<td>19.0%</td>
<td>13.6%</td>
<td>24.4%</td>
<td>17.3%</td>
<td>n.s.</td>
<td>15.7%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Postpartum Counseling for Depression</td>
<td>42</td>
<td>40</td>
<td>95.2%</td>
<td>87.6%</td>
<td>100.0%</td>
<td>84.6%</td>
<td>n.s.</td>
<td>88.9%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Cesarean Rate for Nulliparous Singleton Vertex</td>
<td>1,220</td>
<td>274</td>
<td>22.5%</td>
<td>20.1%</td>
<td>24.8%</td>
<td>25.8%</td>
<td>n.s.</td>
<td>22.6%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Percent of Live Births Weighing Less than 2,500 Grams (Positive)</td>
<td>5,844</td>
<td>544</td>
<td>9.3%</td>
<td>8.6%</td>
<td>10.1%</td>
<td>10.4%</td>
<td>-</td>
<td>9.1%</td>
<td>n.s.</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Alcohol use</td>
<td>428</td>
<td>283</td>
<td>66.1%</td>
<td>61.5%</td>
<td>70.7%</td>
<td>46.8%</td>
<td>+</td>
<td>83.6%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Illicit drug use</td>
<td>428</td>
<td>285</td>
<td>66.6%</td>
<td>62.0%</td>
<td>71.2%</td>
<td>48.0%</td>
<td>+</td>
<td>83.6%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Prescribed or over the counter drug use</td>
<td>428</td>
<td>328</td>
<td>76.6%</td>
<td>72.5%</td>
<td>80.8%</td>
<td>67.7%</td>
<td>+</td>
<td>86.5%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Intimate partner violence</td>
<td>428</td>
<td>144</td>
<td>33.6%</td>
<td>29.1%</td>
<td>38.2%</td>
<td>24.4%</td>
<td>+</td>
<td>63.0%</td>
<td>-</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Prenatal Screening for Behavioral Health Risk Assessment</td>
<td>428</td>
<td>67</td>
<td>15.7%</td>
<td>12.1%</td>
<td>19.2%</td>
<td>10.8%</td>
<td>+</td>
<td>52.9%</td>
<td>-</td>
<td>NA</td>
</tr>
</tbody>
</table>
Respiratory Conditions

Strengths are identified for the following Respiratory Conditions performance measures.

- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – 3.3 percentage points

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months – 16.1 admissions per 100,000 member months
  - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months – 16.3 admissions per 100,000 member months

Table 3.8: Respiratory Conditions

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>2019 (MY 2018)</th>
<th>2019 (MY 2018) Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Denom</td>
<td>Num</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>4,811</td>
<td>4,077</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection</td>
<td>6,408</td>
<td>567</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>2,234</td>
<td>1,238</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>1,116</td>
<td>310</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Pharmacotherapy Management of COPD Exacerbation: Systemic Corticosteroid</td>
<td>1,347</td>
<td>993</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Pharmacotherapy Management of COPD Exacerbation: Bronchodilator</td>
<td>1,347</td>
<td>1,122</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Medication Management for People with Asthma 75% Compliance (Age 5 11 years)</td>
<td>1,045</td>
<td>380</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Medication Management for People with Asthma 75% Compliance (Age 12 18 years)</td>
<td>877</td>
<td>333</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Medication Management for People with Asthma 75% Compliance (Age 19 50 years)</td>
<td>1,459</td>
<td>664</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Medication Management for People with Asthma 75% Compliance (Age 51 64 years)</td>
<td>478</td>
<td>261</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Medication Management for People with Asthma 75% Compliance (Total Age 5 64 years)*</td>
<td>3,859</td>
<td>1,658</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Asthma Medication Ratio (5 11 years)</td>
<td>1,158</td>
<td>858</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Asthma Medication Ratio (12 18 years)</td>
<td>1,004</td>
<td>700</td>
</tr>
</tbody>
</table>
HEDIS Asthma Medication Ratio (19-50 years) 1,842 1,056 57.3% 55.0% 59.6% 57.3% n.s. 58.0% 57.3% n.s. >= 50th and < 75th percentile
HEDIS Asthma Medication Ratio (51-64 years) 626 380 60.7% 56.8% 64.6% 62.3% n.s. 61.1% n.s. >= 50th and < 75th percentile
HEDIS Asthma Medication Ratio (Total) 4,630 2,994 64.7% 63.3% 66.1% 64.5% n.s. 65.9% n.s. >= 50th and < 75th percentile

PA EQR Asthma in Younger Adults Admission Rate (Age 18-39 years) per 100,000 member months 1,001,989 78 7.8 6.1 9.5 7.0 n.s. 9.3 n.s. NA

PA EQR Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months 625,696 550 87.9 80.6 95.2 101.9 - 71.8 + NA

PA EQR Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 65 years and older) per 100,000 member months 11,059 8 72.3 22.2 122.5 73.2 n.s. 47.8 n.s. NA

PA EQR Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months 636,755 558 87.6 80.4 94.9 101.4 - 71.3 + NA

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

### Comprehensive Diabetes Care

No strengths are identified for Comprehensive Diabetes Care performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - HbA1c Control (<8.0%) – 9.8 percentage points
  - HbA1c Good Control (<7.0%) – 7.2 percentage points
  - Blood Pressure Controlled <140/90 mm Hg – 5.9 percentage points
  - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age) – 18.0 percentage points
  - HbA1c Poor Control (>9.0%) – 7.7 percentage points
  - Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months – 6.3 admissions per 100,000 member months
  - Diabetes Short-Term Complications Admission Rate (Total Age 18+ years) per 100,000 member months – 6.3 admissions per 100,000 member months

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>2019 (MY 2018)</th>
<th>2019 (MY 2018) Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denom</td>
<td>Num</td>
<td>Rate</td>
</tr>
<tr>
<td>HEDIS Hemoglobin A1c (HbA1c) Testing</td>
<td>564</td>
<td>501</td>
<td>88.8%</td>
</tr>
<tr>
<td>HEDIS HbA1c Poor Control (&gt;9.0%)</td>
<td>564</td>
<td>239</td>
<td>42.4%</td>
</tr>
<tr>
<td>HEDIS HbA1c Control (&lt;8.0%)</td>
<td>564</td>
<td>243</td>
<td>43.1%</td>
</tr>
</tbody>
</table>

Table 3.9: Comprehensive Diabetes Care

2019 External Quality Review Report: Gateway Health
Cardiovascular Care

No strengths are identified for Cardiovascular Care performance measures.

Opportunities for improvement are identified for the following measures:

- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months – 2.5 admissions per 100,000 member months
  - Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months – 2.8 admissions per 100,000 member months

Table 3.10: Cardiovascular Care

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>Denom</th>
<th>Num</th>
<th>Rate</th>
<th>Lower 95% Confidence Interval</th>
<th>Upper 95% Confidence Interval</th>
<th>2018 Rate (MY2017)</th>
<th>2019 Rate Compared to 2018</th>
<th>MMC 2019 Rate Compared to MMC</th>
<th>HEDIS 2019 Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>Persistence of Beta Blocker Treatment After Heart Attack</td>
<td>175</td>
<td>146</td>
<td>83.4%</td>
<td>77.6%</td>
<td>89.2%</td>
<td>84.5%</td>
<td>n.s.</td>
<td>83.3%</td>
<td>=&gt; 75th and &lt; 90th percentile</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Controlling High Blood Pressure (Total Rate)</td>
<td>411</td>
<td>269</td>
<td>65.5%</td>
<td>60.7%</td>
<td>70.2%</td>
<td>52.3%</td>
<td>+</td>
<td>66.4%</td>
<td>=&gt; 50th and &lt; 75th percentile</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months</td>
<td>1,627,685</td>
<td>410</td>
<td>25.2</td>
<td>22.8</td>
<td>27.6</td>
<td>23.5</td>
<td>n.s.</td>
<td>22.7</td>
<td>+</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Heart Failure Admission Rate (Age 65+ years) per 100,000 member months</td>
<td>11,059</td>
<td>14</td>
<td>126.6</td>
<td>60.3</td>
<td>192.9</td>
<td>118.9</td>
<td>n.s.</td>
<td>75.3</td>
<td>n.s.</td>
</tr>
</tbody>
</table>

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

Strengths are identified for the following Utilization performance measures.
- The following rates are statistically significantly above/better than the 2019 MMC weighted average:
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia − 4.6 percentage points
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced) − 5.1 percentage points

Opportunities for improvement are identified for the following measures:
- The following rates are statistically significantly below/worse than the 2019 MMC weighted average:
  - Use of Opioids From Multiple Providers (4 or more prescribers) − 4.6 percentage points

Table 3.11: Utilization

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>2019 (MY 2018)</th>
<th>2019 (MY 2018) Rate Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Denom</td>
<td>Num</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Reducing Potentially Preventable Readmissions</td>
<td>19,833</td>
<td>2,122</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>936</td>
<td>644</td>
</tr>
<tr>
<td>PA EQR</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)</td>
<td>2,286</td>
<td>1,900</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 1–5 years</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 6–11 years</td>
<td>503</td>
<td>8</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Ages 12–17 years</td>
<td>1,034</td>
<td>22</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Use of Multiple Concurrent Antipsychotics in Children and Adolescents: Total Rate</td>
<td>1,542</td>
<td>30</td>
</tr>
<tr>
<td>Indicator Description</td>
<td>2018 Count</td>
<td>2019 Count</td>
<td>Rate Comparison</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>PCR: 30 Day Readmissions 13 Stays (Ages Total)</td>
<td>545</td>
<td>784</td>
<td>1,626</td>
</tr>
<tr>
<td>PCR: Observed Readmission Rate 13 Stays (Ages Total)</td>
<td>7.1%</td>
<td>8.9%</td>
<td>NA</td>
</tr>
<tr>
<td>PCR: Observed Readmission Rate 4+ Stays (Ages Total)</td>
<td>50.0%</td>
<td>50.6%</td>
<td>NA</td>
</tr>
<tr>
<td>PCR: Expected Readmission Rate 13 Stays (Ages Total)</td>
<td>14.4%</td>
<td>16.1%</td>
<td>NA</td>
</tr>
<tr>
<td>PCR: Expected Readmission Rate 4+ Stays (Ages Total)</td>
<td>16.6%</td>
<td>16.6%</td>
<td>NA</td>
</tr>
<tr>
<td>HEDIS PCR: Count of 30 Day Readmissions Total Stays (Ages Total)</td>
<td>7,637</td>
<td>8,367</td>
<td>NA</td>
</tr>
<tr>
<td>HEDIS PCR: Count of Index Hospital Stays (IHS) 4+ Stays (Ages Total)</td>
<td>1,568</td>
<td>1,736</td>
<td>NA</td>
</tr>
<tr>
<td>HEDIS PCR: Count of Index Hospital Stays (IHS) Total Stays (Ages Total)</td>
<td>9,205</td>
<td>10,103</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)</td>
<td>6,319</td>
<td>1,346</td>
<td>24.1%</td>
</tr>
<tr>
<td>PA EQR Concurrent Use of Opioids and Benzodiazepines (Age 18-64 years)</td>
<td>6,295</td>
<td>1,345</td>
<td>24.2%</td>
</tr>
<tr>
<td>PA EQR Concurrent Use of Opioids and Benzodiazepines (Age 65 years and older)</td>
<td>24</td>
<td>1</td>
<td>NA</td>
</tr>
<tr>
<td>PA EQR Concurrent Use of Opioids and Benzodiazepines (Total Ages 18 years and older)</td>
<td>6,319</td>
<td>1,346</td>
<td>24.1%</td>
</tr>
</tbody>
</table>

2019 (MY 2018) 2019 (MY 2018) Rate Comparison

<table>
<thead>
<tr>
<th>Indicator Source</th>
<th>Indicator</th>
<th>Count</th>
<th>Rate</th>
<th>2018 (MY2017) Rate</th>
<th>2019 Rate Compared to 2018</th>
<th>HEDIS 2019 Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR: 30 Day Readmissions 13 Stays (Ages Total)</td>
<td>7,637</td>
<td>8,367</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PCR: Observed Readmission Rate 13 Stays (Ages Total)</td>
<td>7.1%</td>
<td>8.9%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PCR: Observed Readmission Rate 4+ Stays (Ages Total)</td>
<td>50.0%</td>
<td>50.6%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PCR: Expected Readmission Rate 13 Stays (Ages Total)</td>
<td>14.4%</td>
<td>16.1%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>PCR: Expected Readmission Rate 4+ Stays (Ages Total)</td>
<td>16.6%</td>
<td>16.6%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>HEDIS</td>
<td>PCR: Expected Readmission Rate Total Stays (Ages Total)</td>
<td>20.0%</td>
<td>20.1%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>HEDIS</td>
<td>PCR: Observed to Expected Readmission Ratio 1-3 Stays (Ages Total)</td>
<td>43.1%</td>
<td>53.9%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>HEDIS</td>
<td>PCR: Observed to Expected Readmission Ratio 4+ Stays (Ages Total)</td>
<td>136.1%</td>
<td>136.8%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>HEDIS</td>
<td>PCR: Observed to Expected Readmission Ratio Total Stays (Ages Total)</td>
<td>72.2%</td>
<td>80.2%</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

1 For the Reducing Potentially Preventable Readmissions measure, lower rates indicate better performance.
2 For the Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure, lower rates indicate better performance.
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Satisfaction with the Experience of Care

The following tables provide the survey results of four composite questions by two specific categories for GH across the last three measurement years, as available. The composite questions will target the MCOs performance strengths as well as opportunities for improvement.

Due to differences in the CAHPS submissions from year to year, direct comparisons of results are not always available. Questions that are not included in the most recent survey version are not presented in the tables.

2019 Adult CAHPS 5.0H Survey Results

Table 3.12: CAHPS 2019 Adult Survey Results

<table>
<thead>
<tr>
<th>Survey Section/Measure</th>
<th>2019 Rate Compared to 2018</th>
<th>2018 Rate Compared to 2017</th>
<th>2017 Rate Compared to 2016</th>
<th>2019 MMC Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Health Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Adult’s Health Plan (Rating of 8 to 10)</td>
<td>▲ 85.30%</td>
<td>▼ 77.50%</td>
<td>▼ 79.23%</td>
<td>80.72%</td>
</tr>
<tr>
<td>Getting Needed Information (Usually or Always)</td>
<td>▼ 87.58%</td>
<td>▲ 88.57%</td>
<td>▲ 84.50%</td>
<td>84.19%</td>
</tr>
<tr>
<td>Your Healthcare in the Last Six Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Health Care (Rating of 8-10)</td>
<td>▲ 74.43%</td>
<td>▼ 72.82%</td>
<td>▼ 73.54%</td>
<td>77.03%</td>
</tr>
<tr>
<td>Appointment for Routine Care When Needed (Usually or Always)</td>
<td>▼ 82.67%</td>
<td>▲ 84.08%</td>
<td>▲ 83.57%</td>
<td>82.42%</td>
</tr>
</tbody>
</table>

▲▼ = Performance compared to prior years’ rate
Shaded boxes reflect rates above the 2019 MMC Weighted Average.

2019 Child CAHPS 5.0H Survey Results

Table 3.13: CAHPS 2019 Child Survey Results

<table>
<thead>
<tr>
<th>CAHPS Items</th>
<th>2019 Rate Compared to 2018</th>
<th>2018 Rate Compared to 2017</th>
<th>2017 Rate Compared to 2016</th>
<th>2019 MMC Weighted Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Child’s Health Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Child’s Health Plan (Rating of 8 to 10)</td>
<td>▲ 87.06%</td>
<td>▼ 84.45%</td>
<td>▼ 85.65%</td>
<td>87.41%</td>
</tr>
<tr>
<td>Information or Help from Customer Service (Usually or Always)</td>
<td>▼ 80.13%</td>
<td>▲ 85.22%</td>
<td>▲ 81.55%</td>
<td>83.11%</td>
</tr>
<tr>
<td>Your Healthcare in the Last Six Months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction with Health Care (Rating of 8-10)</td>
<td>▲ 89.47%</td>
<td>▼ 81.50%</td>
<td>▼ 83.07%</td>
<td>87.51%</td>
</tr>
<tr>
<td>Appointment for Routine Care When Needed (Usually or Always)</td>
<td>▼ 89.49%</td>
<td>▲ 93.00%</td>
<td>▲ 89.08%</td>
<td>88.68%</td>
</tr>
</tbody>
</table>

▲▼ = Performance compared to prior years’ rate
Shaded boxes reflect rates above the 2019 MMC Weighted Average.
IV: 2018 Opportunities for Improvement MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each PH MCO has addressed the opportunities for improvement made by IPRO in the 2018 EQR Technical Reports, which were distributed June 2019. The 2019 EQR is the eleventh to include descriptions of current and proposed interventions from each PH MCO that address the 2018 recommendations.

DHS requested that MCOs submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the MCOs. These activities follow a longitudinal format, and are designed to capture information relating to:

- Follow-up actions that the MCO has taken through June 30, 2019 to address each recommendation;
- Future actions that are planned to address each recommendation;
- When and how future actions will be accomplished;
- The expected outcome or goals of the actions that were taken or will be taken; and
- The MCO’s process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the response submitted to IPRO as of September 209, as well as any additional relevant documentation provided by GH.

Table 4.1 presents GH’s responses to opportunities for improvement cited by IPRO in the 2018 EQR Technical Report, detailing current and proposed interventions.

<table>
<thead>
<tr>
<th>Reference Number: [GH] 2018.01: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Body Mass Index: Percentile (Age 3 - 11 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow Up Actions Taken Through 06/30/19:</td>
</tr>
<tr>
<td>Care Gap Button (October 2014 – ongoing). All Gateway Health member-facing representatives utilize the “Care Gap” function made available in current software configuration. The function displays actionable open gaps, including Annual Body Mass Index (BMI) Assessment. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.</td>
</tr>
<tr>
<td>Pediatric Obesity Toolkit (March 2016 – ongoing). The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.</td>
</tr>
<tr>
<td>Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.</td>
</tr>
<tr>
<td>Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.</td>
</tr>
<tr>
<td>Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.</td>
</tr>
<tr>
<td>Quality Gap Closure (Q3 2018 – ongoing). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records.</td>
</tr>
</tbody>
</table>
The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 75.49% for the Body Mass Index: Percentile (Age 3 - 11 years).

Future Actions Planned:
Member Care Plan (July 2019): Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

Partnership with low performing providers (Q3 – Q4 2019): Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

Reference Number: [GH] 2018.02: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Body Mass Index: Percentile (Age 12-17 years)

Follow Up Actions Taken Through 06/30/19:
**“Care Gap” Button (October 2014 – ongoing).** All Gateway Health member-facing representatives utilize the “Care Gap” function made available in current software configuration. The function displays actionable open gaps, including Annual Body Mass Index (BMI) Assessment. Members may not be aware that they have specific gaps in care and this offers an opportunity for them to receive a reminder.

**Pediatric Obesity Toolkit (March 2016 – ongoing).** The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

**Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing).** Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

**Appointment Reminder Outreach Campaign (April 2017 – ongoing).** IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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

**Well-child Days (April 2019-ongoing)** Participating providers assess members for well-child screenings, immunizations and weight assessment counseling for nutrition and physical activity.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 74.19% for the Body Mass Index: Percentile (Age 12-17 years).

Future Actions Planned:
Member Care Plan (July 2019): Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

Partnership with low performing providers (Q3 – Q4 2019): Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.
Follow Up Actions Taken Through 06/30/19:

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

Pediatric Obesity Toolkit (March 2016 – ongoing). The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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


The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 75.55% for the Body Mass Index: Percentile (Total).

Future Actions Planned:

Member Care Plan (July 2019): Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

Partnership with low performing providers (Q3 – Q4 2019): Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

Reference Number: [GH] 2018.03: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Body Mass Index: Percentile (Total)

Reference Number: [GH] 2018.04: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Nutrition (Age 3-11 years)
Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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


The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 70.73% for the Counseling for Nutrition (Age 3-11 years).

Future Actions Planned:

Member Care Plan (July 2019): Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

Partnership with low performing providers (Q3 – Q4 2019): Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

Reference Number: [GH] 2018.05: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Nutrition (Age 12-17 years)

Follow Up Actions Taken Through 06/30/19:

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

Pediatric Obesity Toolkit (March 2016 – ongoing). The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing). Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are
recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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

**Well-child Days (April 2019-ongoing)** Participating providers assess members for well-child screenings, immunizations and weight assessment counseling for nutrition and physical activity.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 69.96% for the Counseling for Nutrition (Age 12-17 years).

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**Future Actions Planned:**

**Member Care Plan (July 2019):** Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

**Partnership with low performing providers (Q3 – Q4 2019):** Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

**Reference Number: [GH] 2018.06:** The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Nutrition (Total).

**Follow Up Actions Taken Through 06/30/19:**

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

**Pediatric Obesity Toolkit (March 2016 – ongoing).** The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

**Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing).** Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

**Appointment Reminder Outreach Campaign (April 2017 – ongoing).** IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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

**Well-child Days (April 2019-ongoing)** Participating providers assess members for well-child screenings, immunizations and weight assessment counseling for nutrition and physical activity.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 69.57% for the Counseling for Nutrition (Total).
Future Actions Planned:

**Member Care Plan (July 2019):** Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

**Partnership with low performing providers (Q3 – Q4 2019):** Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

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**Reference Number: [GH] 2018.07: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Physical Activity (Age 3-11 years)**

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Follow Up Actions Taken Through 06/30/19:

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

**Pediatric Obesity Toolkit (March 2016 – ongoing):** The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

**Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing):** Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

**Appointment Reminder Outreach Campaign (April 2017 – ongoing):** IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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

**Well-child Days (April 2019-ongoing):** Participating providers assess members for well-child screenings, immunizations and weight assessment counseling for nutrition and physical activity.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 61.80% for the Counseling for Physical Activity (Age 3-11 years).

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Future Actions Planned:

**Member Care Plan (July 2019):** Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

**Partnership with low performing providers (Q3 – Q4 2019):** Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

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**Reference Number: [GH] 2018.08: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Physical Activity (Age 12-17 years)**
Follow Up Actions Taken Through 06/30/19:

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

**Pediatric Obesity Toolkit (March 2016 – ongoing).** The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

**Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing).** Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.

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

**Appointment Reminder Outreach Campaign (April 2017 – ongoing).** IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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

**Well-child Days (April 2019-ongoing)** Participating providers assess members for well-child screenings, immunizations and weight assessment counseling for nutrition and physical activity.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 65.33% for the weighted average for Counseling for Physical Activity (Age 12-17 years).

Future Actions Planned:

**Member Care Plan (July 2019):** Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

**Partnership with low performing providers (Q3 – Q4 2019):** Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

**Reference Number: [GH] 2018.09: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Counseling for Physical Activity (Total)**

Follow Up Actions Taken Through 06/30/19:

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

**Pediatric Obesity Toolkit (March 2016 – ongoing).** The toolkit’s purpose is to promote awareness of the pediatric provider’s role in both prevention and treatment of childhood obesity and to provide tools for providers that enhance their treatment of pediatric obesity. In 2016, the toolkit was distributed by Provider Engagement and Provider Relations staffs.

**Omnichannel Preventative Well Child Visit Program (May 2016 – ongoing).** Program consists of a blend of telephone calls, email and/or SMS messages (for members who opt in). The Target Population is Pediatric Members with one or more open care gaps. The purpose of the program is to encourage Well Child visits, including Weight, Nutrition and Physical Activity Counseling. Live agents are also available to assist with scheduling appointments or resolving barriers to care.
Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Appointment Reminder Outreach Campaign (April 2017 – ongoing). IVR calls are made to members who have been identified as historically compliant as an enhancement to the existing Omnichannel Preventative Well Child Visit Program. Members who are recently due for a Well Child Visits are contacted ahead of the expected date of their next appointment to remind them to schedule one, if they have not already. This visit is an opportunity to have to address Weight, Nutrition and Physical Activity Counseling.

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


The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 63.50% for the weighted average for Counseling for Physical Activity (Total).

Future Actions Planned:
Member Care Plan (July 2019): Gateway will send members a care plan indicating whether the member has completed their Preventative Well-care or still needs to receive it. The care plan also includes education on a Well-Care, including guidelines and its importance.

Partnership with low performing providers (Q3 – Q4 2019): Identification of high volume practices with low Preventative Well-Care rates will include looking at historical data to determine trends in performance over time. Gateway will reach out to providers for an onsite visit that will include discussion of best practices, looking at current recommendations used by clinicians and discussion about targeted outreach to members for assistance with scheduling appointments.

Reference Number: [GH] 2018.10: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Lead Screening in Children (Age 2 years)

Follow Up Actions Taken Through 06/30/19:
Provider Education (November 2015 – ongoing). Gateway Health published a section on the provider website that provided links to EPSDT information, including both the Bright Futures/AAP and Pennsylvania Periodicity Schedules. The Pennsylvania Periodicity Schedule includes coding specifics on the matrix. The Gateway Health website has been reorganized to highlight the Lead Screenings clearly in the EPSDT section of the website. Additionally, a coding and billing guide began being distributed to all pediatric practices beginning in January 2018 with an additional handout specific to billing Lead Screenings. The EPSDT coordinator also makes visits to providers focusing on low performing, high volume providers to review specific screenings including the lead screening and proper coding and billing of this screening.

Omni-channel Well-Baby Education Program (May 2016 – ongoing). Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to encourage new parents to follow the periodicity schedule by educating on well-baby visits, immunizations, and lead screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

EPSDT Coordinator Position (January 2017 – ongoing). The EPSDT Coordinator is responsible to ensure enterprise wide compliance with Early Periodic Screening, Diagnosis and Treatment of members under 21 in accordance with the Federal Medicaid Program (Title XIX of the Social Security Act) and multi-state level requirements to screen, diagnose, track and follow up for individuals under 21, including those in substitute care, those in residential facility placement, and those with special needs.

EPSDT Dashboard (Q2 2017 – ongoing). The EPSDT Dashboard allows the EPSDT Coordinator to monitor both the member and the provider level for completion of the Lead Screenings at each indicated age on the periodicity schedule.

Member Newsletter Article (Fall 2018, Spring 2019). An article in the Fall and Spring member newsletters provided education on the importance of Lead Testing as well as additional information on current recommendations for all EPSDT Screenings and addressing lead in schools.
Provider Webinar (2018). A provider webinar focusing on when to complete and how to properly bill for Structured Developmental screenings was held in February 2018. It was recorded and posted to the Gateway Health website for additional viewing at providers’ convenience. This webinar also addressed correct billing and coding of Developmental Screenings. This webinar remains available on the Gateway Website as an educational tool for providers to watch at their convenience.

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

Future Actions Planned:

Member Newsletter (Summer 2019). An article addressing the importance of environmental lead investigation will be included in the Summer 2019 member newsletter.

Payment Policy - Gateway is currently in process of assessing system capabilities for a payment policy that will require complete claim submission for EPSDT services for providers to receive full payment for EPSDT visits.

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including lead screening care gaps and related EPSDT education was mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on lead testing guidelines and importance on completing the testing. The care plan is sent at least annually.

Reference Number: [GH] 2018.11: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Developmental Screening in the First Three Years of Life - 1 year

Follow Up Actions Taken Through 06/30/19:

Provider Education (November 2015 – ongoing). Gateway Health published a section on the provider website that provided links to EPSDT information, including both the Bright Futures/AAP and Pennsylvania Periodicity Schedules. The Pennsylvania Periodicity Schedule includes coding specifics on the matrix. The Gateway Health website has been reorganized to highlight the Structured Developmental Screenings clearly in the EPSDT section of the website. An updated list of validated screening tools that providers can use to complete formal developmental screenings was added in Q2 of 2018. Additionally, a coding and billing guide began being distributed to all pediatric practices beginning in January 2018 with an additional handout specific to billing Developmental Screenings. The EPSDT coordinator also makes visits to providers focusing on low performing, high volume providers to review specific screenings including the developmental screening and proper coding and billing of this screening.

Omni-channel Well-Baby Education Program (May 2016 – ongoing). Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to encourage new parents to follow the periodicity schedule by educating on well-baby visits, immunizations, and lead screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

EPSDT Coordinator Position (January 2017 – ongoing). The EPSDT Coordinator is responsible to ensure enterprise wide compliance with Early Periodic Screening, Diagnosis and Treatment of members under 21 in accordance with the Federal Medicaid Program (Title XIX of the Social Security Act) and multi-state level requirements to screen, diagnose, track and follow up for individuals under 21, including those in substitute care, those in residential facility placement, and those with special needs.

EPSDT Dashboard (Q2 2017 – ongoing). The EPSDT Dashboard allows the EPSDT Coordinator to monitor both the member and the provider level for completion of the Developmental Screenings at each indicated age on the periodicity schedule.

Member Newsletter Article (August 2017, Spring 2018, Summer 2018, Spring 2019). An article in the August and Spring member newsletters provided education on current recommendations for EPSDT Screenings, including Developmental Screenings.

Provider Webinar (2018). A provider webinar focusing on when to complete and how to properly bill for Structured Developmental screenings was held in February 2018. It was recorded and posted to the Gateway Health website for additional viewing at providers’ convenience. This webinar also addressed correct billing and coding of Developmental Screenings. This webinar remains available on the Gateway Website as an educational tool for providers to watch at their convenience.

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

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

Future Actions Planned:

Member Newsletter (Summer 2019). An article addressing the importance of developmental screenings will be included in the
Payment Policy - Gateway is currently in process of assessing system capabilities for a payment policy that will require complete claim submission for EPSDT services for providers to receive full payment for EPSDT visits.

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including developmental screening care gaps and related EPSDT education was mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on developmental screening guidelines and importance of screening. The care plan is sent at least annually.

Follow Up Actions Taken Through 06/30/19:

Provider Education (November 2015 – ongoing). Gateway Health published a section on the provider website that provided links to EPSDT information, including both the Bright Futures/AAP and Pennsylvania Periodicity Schedules. The Pennsylvania Periodicity Schedule includes coding specifics on the matrix. The Gateway Health website has been reorganized to highlight the Structured Developmental Screenings clearly in the EPSDT section of the website. An updated listed of validated screening tools that providers can use to complete formal developmental screenings was added in Q2 of 2018. Additionally, a coding and billing guide began being distributed to all pediatric practices beginning in January 2018 with an additional handout specific to billing Developmental Screenings. The EPSDT coordinator also makes visits to providers focusing on low performing, high volume providers to review specific screenings including the developmental screening and proper coding and billing of this screening.

Omnichannel Well-Baby Education Program (May 2016 – ongoing). Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to encourage new parents to follow the periodicity schedule by educating on well-baby visits, immunizations, and lead screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

EPSDT Coordinator Position (January 2017 – ongoing). The EPSDT Coordinator is responsible to ensure enterprise wide compliance with Early Periodic Screening, Diagnosis and Treatment of members under 21 in accordance with the Federal Medicaid Program (Title XIX of the Social Security Act) and multi-state level requirements to screen, diagnose, track and follow up for individuals under 21, including those in substitute care, those in residential facility placement, and those with special needs.

EPSDT Dashboard (Q2 2017 – ongoing). The EPSDT Dashboard allows the EPSDT Coordinator to monitor both the member and the provider level for completion of the Developmental Screenings at each indicated age on the periodicity schedule.

Member Newsletter Article (August 2017, Spring 2018, Summer 2018, Spring 2019). An article in the August and Spring member newsletters provided education on current recommendations for EPSDT Screenings, including Developmental Screenings.

Provider Webinar (2018). A provider webinar focusing on when to complete and how to properly bill for Structured Developmental screenings was held in February 2018. It was recorded and posted to the Gateway Health website for additional viewing at providers’ convenience. This webinar also addressed correct billing and coding of Developmental Screenings. This webinar remains available on the Gateway Website as an educational tool for providers to watch at their convenience.

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

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

Future Actions Planned:

Member Newsletter (Summer 2019). An article addressing the importance of developmental screenings will be included in the Summer 2019 member newsletter.

Payment Policy - Gateway is currently in process of assessing system capabilities for a payment policy that will require complete claim submission for EPSDT services for providers to receive full payment for EPSDT visits.

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including developmental screening care gaps and related EPSDT education was mailed to members to provide education on open care gaps as well as the importance of gap closure.
The document also provides reinforcement to members who have closed care gaps. It includes education on developmental screening guidelines and importance of screening. The care plan is sent at least annually.

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

Gateway Clinical Staff Education Day on Women’s Health (May 23, 2019). Clinical staff were educated on disparities and barriers to women receiving mammograms across LGBTQ, socioeconomic, and racial groups. Increasing awareness of disparities across various groups can help staff to recognize barriers and even biases when interacting with certain members and motivate members to complete their screenings.

Breast Cancer Screening Education (September 10, 2018 – ongoing). Members were educated on mammograms through Gateway’s health education website. It includes an interactive quiz that helps to dispel myths around breast cancer.

Breast Cancer Awareness Month (October 2018). Gateway Health promoted breast cancer screening during Breast Cancer Awareness Month through social media messaging.

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

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

Breast Cancer Mailer (October – November 2018). Members due for a mammogram received a mailer encouraging them to complete their screening.

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

Mammography Scheduling Campaigns (Q4 2018, Q2 2019). Gateway partnered with radiology facilities to schedule members for mammograms and assist them in scheduling transportation and contacting their providers for a referral if needed.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 58.04% for the Breast Cancer Screening measure.
Future Actions Planned:

**Breast Cancer Awareness Month (October 2019).** Gateway Health will promote breast cancer screening during Breast Cancer Awareness Month through social media messaging.

**Clinical Quality Care Gap Care Plan (July 2019).** A comprehensive document including hypertension and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on mammography guidelines and importance of completing the screening. The care plan is sent at least annually.

**Mobile Community events (Q4 2018-present):** Targeting members through a series of mobile community events to have the opportunity to close open care gaps for breast cancer screening.

**Quality Provider Outreach Program (Q4 2019)** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to identify someone as needing a mammogram and what method they use to better understand potential barriers. Based on discussion, Gateway will work with providers to develop best practices within the office.

**Faith Based Organization Partnership (Q3-Q4 2019):** Partner with community faith based organizations to provide awareness and education on breast cancer screening.

**Reference Number: [GH] 2018.14: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Chlamydia Screening in Women (Age 16-20 years)**

**Follow Up Actions Taken Through 06/30/19:**

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

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

**Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015—ongoing).** The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75th and 90th percentile Quality Compass thresholds. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities.

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

**Gateway Clinical Staff Education Day on Women’s Health (May 23, 2019).** Clinical staff were educated on importance of women completing chlamydia screening. Increasing awareness of screening guidelines helps to provide consistent messaging to members.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark for the following components of the Chlamydia Screening in Women measure:

- 52.75% (ages 16-20)
- 63.61% (ages 21-24)
- 56.07% (total)

Future Actions Planned:

**Quality Provider Outreach Program (Q4 2019)** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to identify someone as needing a chlamydia test and what method they use to better understand potential barriers. Based on discussion, Gateway will work with providers to develop best practices within the office.
MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.
Monitoring Effectiveness via Monthly HEDIS Surveillance Report (May 2015 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. Report includes the total number of gaps needed to reach 75\textsuperscript{th} and 90\textsuperscript{th} percentile Quality Compass thresholds. This report enables the Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff meets monthly to review rates, problem solve any barriers or opportunities. This method applies both to actions implemented previously and those planned in the future.

Mobile Maternity App (May 2019 – Ongoing). A mobile application is available to perinatal and postpartum women and provides them with tools to reach their Case Manager, contact the 24-hour Nurseline, and video conference with a lactation consultant with any questions or concerns. It also sends push notifications to the member’s phone that educates and reminds members on ways to ensure a healthy pregnancy and baby.

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Contraceptive Care for Postpartum Women: Most or moderately effective contraception - 3 days (Ages 15 to 20).

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to prescribing contraception to postpartum women and what method they use to better understand potential barriers. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019– Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.16: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal and Postpartum Care – Timeliness of Prenatal Care

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.
Prenatal and Postpartum Education Programs (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about early and frequent prenatal care, and timely postpartum care. The program runs the length of members’ pregnancies with contact occurring at least once per month. Provides reminders on frequency for prenatal visits as pregnancy progresses and on the timing of postpartum care. Provides live agent assistance to schedule appointments and resolve barriers/SDoH impediments to care.

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prenatal and Postpartum Care – Timeliness of Prenatal Care.

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women complete a first trimester visit and accurately capture the visit through retroactive billing (or other means). Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.17: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Smoking

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prenatal Screening for Smoking.
**Quality Provider Outreach Program (Q4 2019).** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screening for smoking and offered resources to quit. Based on discussion, Gateway will work with providers to develop best practices within the office.

**Reference Number: [GH] 2018.18: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)**

**Follow Up Actions Taken Through 06/30/19:**

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

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

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

**Provider Education (July 2016 – ongoing).** Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

**Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing).** CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.
Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

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

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screening for smoking and offered resources to quit. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.19: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Environmental Tobacco Smoke Exposure

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

**Provider Education Materials (May 2018 – Ongoing).** Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Bilingual Guide and Medicaid Provider Manual.

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

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

**Future Actions Planned:**

**Quality Provider Outreach Program (Q4 2019).** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for environmental tobacco smoke exposure. Based on discussion, Gateway will work with providers to develop best practices within the office.

**Data Coordination (Q3 2019 – Q4 2019).** Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

**Reference Number: [GH] 2018.20: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Depression**

**Follow Up Actions Taken Through 06/30/19:**

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

Member Interventions (based on risk stratification levels):

- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, family planning and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes
assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking status

- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prenatal Screening for Depression.

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for depression and offered available resources. Based on discussion, Gateway will work with providers to develop best practices within the office.
Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.21: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.
Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on prenatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

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

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for depression during one of the first two visits and offered available resources. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.22: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Alcohol use

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

**Provider Education Materials (May 2018 – Ongoing).** Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prenatal Screening for Alcohol use.

**Future Actions Planned:**

**Quality Provider Outreach Program (Q4 2019).** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for alcohol use. Based on discussion, Gateway will work with providers to develop best practices within the office.

**Data Coordination (Q3 2019 – Q4 2019).** Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

**Reference Number: [GH] 2018.23: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Illicit drug use**

**Follow Up Actions Taken Through 06/30/19:**

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

**Member Interventions (based on risk stratification levels):**

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

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Illicit drug use.

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for illicit drug use. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management.
and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.24: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Prescribed or over-the-counter drug use

Follow Up Actions Taken Through 06/30/19:

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

Member Interventions (based on risk stratification levels):

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

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

**Provider Education (July 2016 – ongoing).** Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

**Provider Education Materials (May 2018 – Ongoing).** Gateway Health continues to offer guidance on perinatal care and provides...
Information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prescribed or over-the-counter drug use.

**Future Actions Planned:**

**Quality Provider Outreach Program (Q4 2019).** Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for over-the-counter drug use. Based on discussion, Gateway will work with providers to develop best practices within the office.

**Data Coordination (Q3 2019 – Q4 2019).** Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

**Reference Number: [GH] 2018.25: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Intimate partner violence**

**Follow Up Actions Taken Through 06/30/19:**

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

**Member Interventions (based on risk stratification levels):**

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

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

**Provider Education (July 2016 – ongoing).** Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

**Prenatal and Postpartum Education Programs (May 2016 - ongoing).** Includes IVR Call/Email/SMS & Live agent assistance components to educate members about early and frequent prenatal care, and timely postpartum care. The program runs the length of members’ pregnancies with contact occurring at least once per month. Provides reminders on frequency for prenatal visits as pregnancy progresses and on the timing of postpartum care. Provides live agent assistance to schedule appointments and resolve
Member Incentive (November 2016 – ongoing). Through Gateway Health’s Goodness Rewards Program members who obtain timely and ongoing prenatal care and timely postpartum care are eligible for incentives after attending prenatal appointments.

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Prenatal Screening for Intimate partner violence.

Future Actions Planned:
Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for intimate partner violence. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.26: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Prenatal Screening for Behavioral Health Risk Assessment

Follow Up Actions Taken Through 06/30/19:
MOM Matters® Program (prior to 2014 – ongoing). MOM Matters is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions. MOM Matters supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies.

Member Interventions (based on risk stratification levels):
- Prenatal welcome packet for all members qualified for MOM Matters Program, includes a welcome letter, Prenatal Rewards brochure, an educational booklet related to pregnancy, family planning and information related to alcohol and smoking cessation, depression during pregnancy and domestic violence.
- Maternity related education delivered through a variety of mechanisms (e.g., member handbook, newsletter articles, educational mailings, telephone on-hold messaging, Gateway Health website)
- Antepartum and/or postpartum home health visit, if requested
- Comprehensive telephonic and/or face to face assessment, ongoing care management, and treatment plans which includes assessment of co-morbid medical/behavioral health conditions and psychosocial issues, depression screening and smoking
status

- Pharmacy review of all medications
- Reminder call for postpartum visit
- Postpartum Mailer sent two weeks after delivery to support telephonic postpartum outreach
- Assistance with barriers to seeking care
- Needs assessment and connection to community resources

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

Provider Education (July 2016 – ongoing). Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone number for future questions.

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

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

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

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

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

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

Provider Education Materials (May 2018 – Ongoing). Gateway Health continues to offer guidance on perinatal care and provides information on contraceptives available to members in the Obstetrical Billing Guide and Medicaid Provider Manual.

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

The expected outcomes/goals of these collective actions are to meet or exceed the 2018 MMC weighted average for Screening for Behavioral Health Risk Assessment.

Future Actions Planned:

Quality Provider Outreach Program (Q4 2019). Staff from the quality department will visit low performing provider practices face to face to assess provider policies and procedures to ensuring pregnant women are screened for behavioral risk assessment. Based on discussion, Gateway will work with providers to develop best practices within the office.

Data Coordination (Q3 2019 – Q4 2019). Data will be monitored to identify opportunities to refer members to Care Management.
and Community Health Workers who will assist pregnant members in getting perinatal care. Additionally, chart collection opportunities will be identified.

Reference Number: [GH] 2018.27: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Pharmacotherapy Management of COPD Exacerbation: Bronchodilator

Follow Up Actions Taken Through 06/30/19:

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

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

**Clinical Practice Guidelines (January 2016 – ongoing).** Clinical Practice Guidelines are published on Gateway Health’s website for providers to access and review. The Clinical Practice Guideline for the “Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease” was formed through the collaborative efforts of the National Heart, Lung, and Blood Institute, National Institutes of Health, USA and the World’s Health Organization.

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

**Website and Social Media Promotion (September 2018 - Ongoing):** Articles about COPD, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

**Care Management Staff Education (January 2019).** Education provided to member facing staff on COPD management to create consistent messaging when speaking with members who have COPD.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 75th percentile benchmark of 87.6%.

Future Actions Planned:

**In-Home Community Health Worker (2020):** Community Health Workers (CHW) will visit members diagnosed with COPD to link the member to community resources and follow-up care. Members who recently had an exacerbation will be encouraged to take their prescribed medication for management.

**COPD Awareness Month Materials (November 2019):** Inclusion of COPD management materials for educating members on prevention of exacerbation will be added to the Health and Wellness website for COPD Awareness Month.

Reference Number: [GH] 2018.28: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Medication Management for People with Asthma - 75% Compliance (Age 5-11 years)

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

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

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

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

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

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

Website and Social Media Promotion (September 2018 - Ongoing). Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

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

Enhanced Care Management Outreach (June 2019 - Ongoing). Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 90th percentile benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:
- 42.97% (ages 5-11)

Future Actions Planned:
Pharmacist Outreach (Q3 2019). Pharmacies and prescribers of members who are non-compliant for asthma controller medications will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.

Asthma Medication Kiosk (Q1 2020). Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.

Reference Number: [GH] 2018.29: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Medication Management for People with Asthma - 75% Compliance (Age 12-18 years)

Follow Up Actions Taken Through 06/30/19:
Self-Management Education (Prior to 2014-Ongoing). Asthma “sticker letters” were mailed on a rolling basis to members newly identified as having asthma. This mailing contains education and stickers to help members differentiate between their rescue and controller inhalers.

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

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

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

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

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

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

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

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

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

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

**Website and Social Media Promotion (September 2018 - Ongoing).** Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

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

**Enhanced Care Management Outreach (June 2019 - Ongoing).** Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 90th percentile benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:

- 43.38% (ages 12-18)

**Future Actions Planned:**

**Pharmacist Outreach (Q3 2019).** Pharmacies and prescribers of members who are non-compliant for asthma controller medications will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.

**Asthma Medication Kiosk (Q1 2020).** Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.

**Reference Number: [GH] 2018.30:** The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Medication Management for People with Asthma - 75% Compliance (Age 19-50 years)

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

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

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

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

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

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

**Website and Social Media Promotion (September 2018 - Ongoing).** Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

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

**Enhanced Care Management Outreach (June 2019 - Ongoing).** Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 90th percentile benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:

- 53.68% (ages 19-50)

**Future Actions Planned:**

**Pharmacist Outreach (Q3 2019).** Pharmacies and prescribers of members who are non-compliant for asthma controller medications will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.

**Asthma Medication Kiosk (Q1 2020).** Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.
Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

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

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

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

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

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

**Website and Social Media Promotion (September 2018 - Ongoing).** Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

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

**Enhanced Care Management Outreach (June 2019 - Ongoing).** Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 90th percentile benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:

- 65.53% (ages 51-64)

Future Actions Planned:

**Pharmacist Outreach (Q3 2019).** Pharmacies and prescribers of members who are non-compliant for asthma controller medications
will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.

**Asthma Medication Kiosk (Q1 2020).** Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.

**Reference Number: [GH] 2018.32: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Medication Management for People with Asthma - 75% Compliance (Total - Age 5-64 years)**

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

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

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

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

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

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

**Website and Social Media Promotion (September 2018 - Ongoing).** Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website.

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

**Enhanced Care Management Outreach (June 2019 - Ongoing).** Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis.

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 90th percentile.
benchmark for the following components of the Medication Management for People with Asthma – 75% Compliance measure:
- 51.22% (Total 5-64 years)

<table>
<thead>
<tr>
<th>Future Actions Planned:</th>
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<tbody>
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<td><strong>Pharmacist Outreach (Q3 2019).</strong> Pharmacies and prescribers of members who are non-compliant for asthma controller medications will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.</td>
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<td><strong>Asthma Medication Kiosk (Q1 2020).</strong> Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.</td>
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<tr>
<th>Reference Number: [GH] 2018.33: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for HbA1c Control (&lt;8.0%)</th>
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<tbody>
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<td>Follow Up Actions Taken Through 06/30/19:</td>
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<td><strong>Gateway to Lifestyle Management® (GTLM) Diabetes program (prior to 2014 – ongoing).</strong> GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence-based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care.</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

| Member Incentive (November 2016 – ongoing). Through Gateway Health’s Goodness Rewards Program, members who obtain diabetes care are eligible to obtain incentives for HbA1c testing up to two times per year. |
Wellness Coaches (2015-ongoing): Members who are identified as having uncontrolled diabetes or are in need of additional support in effectively managing their diabetes have the opportunity to receive wellness coaching from an internal dietitian and/or certified diabetes educator.

Gateway to Practitioner Excellence (GPE®) 2018 Program (January 2018 – ongoing). The HbA1c poor control measure is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

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

Diabetes Care Plan (August 2017 – September 2018). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic anti-diabetic medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

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

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

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 51.34% for HbA1c Control (<8.0%).

Future Actions Planned:
Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including diabetes and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.
In home A1c test kits (Q4 2019): Mailing of A1c test kits to member homes for completion and return to close A1c test gap and obtain result.

Mobile Community events (Q4 2018-present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.
IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care

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

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

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

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

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

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

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

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

**Wellness Coaches (2015- ongoing):** Members who are identified as having uncontrolled diabetes or are in need of additional support in effectively managing their diabetes have the opportunity to receive wellness coaching from an internal dietitian and/or certified diabetes educator

**Gateway to Practitioner Excellence (GPE®) 2018 Program (January 2018 – ongoing).** The HbA1c poor control measure is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

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

**Diabetes Care Plan (August 2017 – September 2018).** The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

**Direct EHR Feeds (Q4 2017- ongoing).** Secure EHR exchanges with select practices allow for the ongoing capture of medical record data relevant to clinical care and quality measures.
**90 day medication fills (July 2018-ongoing)** Members being prescribed select generic anti-diabetic medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

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

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

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 35.07% for HbA1c Good Control (<7.0%).

### Future Actions Planned:

**Clinical Quality Care Gap Care Plan (July 2019).** A comprehensive document including diabetes and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

**In home A1c test kits (Q4 2019):** Mailing of A1c test kits to member homes for completion and return to close A1c gap as well as obtain A1c result.

**Mobile Community events (Q4 2018- present):** Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

**Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.**

**Quality Provider Outreach Program (Q4 2019)** Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.

### Reference Number: [GH] 2018.35: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Blood Pressure Controlled <140/90 mm Hg

**Follow Up Actions Taken Through 06/30/19:**

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

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

**Wellness Coaches (2015- ongoing):** Members who are identified as having uncontrolled diabetes or high blood pressure are in need of additional support in effectively managing their diabetes and/or high blood pressure have the opportunity to receive wellness coaching from an internal dietitian and/or certified diabetes educator.

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

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

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

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

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

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

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

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

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

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

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic antihypertensive medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

The expected outcome/goal of these collective actions is to meet or exceed the 2017 NCQA Quality Compass 50th percentile benchmark of 63.02% for Blood Pressure Controlled <140/90 mm Hg.

Future Actions Planned:
Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including hypertension and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on blood pressure screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.
Mobile Community events (Q4 2018 - present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program completes member home visits and provides blood pressure screenings and obtains result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.

Reference Number: [GH] 2018.36: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Statin Therapy for Patients With Diabetes: Statin Adherence 80%

Follow Up Actions Taken Through 06/30/19:

- 90 day benefit change
  - Gateway Health Plan* designed and implemented a 90-day benefit offering on 8/15/2018 which allows members to receive 90-day supply of commonly used medications for chronic disease states, including several Statin medications.
  - Embedded pharmacists
    - Gateway Health Plan* placed 2 pharmacists into physician practices for the measurement year who meet with patients face to face to discuss medications and address adherence issues.
  - Multi-dose packaging
    - Small pilot of non-adherent members who take multiple chronic medications have been offered a multi-dose packaging service for the measurement year which delivers packaged medications to their homes at no additional cost to members.

Future Actions Planned:

- Fax campaign to providers to encourage utilization of the 90 day benefit (Q3 2019 – ongoing)
  - The purpose of the fax campaign to prescribing providers is to encourage utilization of the 90 day benefit for members who are stable on their prescribed statins. This campaign will be launched by the end of September 2019 and adherence rates for members taking statins are expected to improve by the end of 2019 as a result of reduction in the number of times needed for members to go to the pharmacy to pick up their prescriptions. Lesser number of times necessary to call pharmacies for medication refills and also the number of trips to the pharmacy to pick up prescriptions can improve medication adherence, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the 90 day benefit and compare them to the population who are not utilizing the benefit.

- Call campaign to pharmacies to switch prescriptions from 30 day to 90 day fill (Q3 2019 – ongoing)
  - The purpose of the call campaign is to make outbound calls to pharmacies where statins are being filled and having the pharmacy staff request 90 day prescription from prescribing providers via fax; the goal of this campaign is to simplify switching statin prescriptions from 30 day to 90 day supply for members for whom prescribers determine can benefit from this switch. This campaign will be launched by the end of September 2019 and adherence rates for members taking statins are expected to improve by the end of 2019 as a result of reduction in the number of times needed for members to go to the pharmacy to pick up their prescriptions. Lesser number of times necessary to call pharmacies for medication refills and also the number of trips to the pharmacy to pick up prescriptions can improve medication adherence, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the 90 day benefit and compare them to the population who are not utilizing the benefit.

- Expansion of the utilization of multi-dose packaging pharmacy services (Q3 2019 – ongoing)
  - A larger population of members who take multiple chronic medications for different disease states, with emphasis on those who are experiencing low adherence, are going to be offered multi-dose packaging services. Through the use of multi-dose packaging pharmacy services, medication are going to be filled and packaged on a monthly basis and delivered to members at no additional cost to members. This service will be available to members by the end of September 2019 and the adherence rates for members taking statins are expected to improve by the end of 2019 as a result of eliminating the need to make trips to the pharmacy to pick up prescriptions for non-adherent members who experience trips to pharmacies an adherence barrier and by eliminating the likelihood for forgetfulness as the multi-dose packaging pharmacy reminds members when their medications are due for a refill; elimination of these barriers can improve adherence and the
overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the multi-dose packaging pharmacy service and compare them to the population who are not utilizing the benefit.

- **Point-of-sale interventions**
  - Independent pharmacies will be provided data on Gateway Health Plan® members with open statin gaps in Q1 2020. Pharmacies will then work with Gateway Health Plan® to offer the most appropriate tools to members to help with improvement of medication adherence. Identification of the reason for low adherence at point-of-sale and offering appropriate tools to members are expected to improve adherence for members, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who have been intervened on at point-of-sale by the pharmacy staff and compare them to the population who are not have this type of intervention.

**Reference Number: [GH] 2018.37: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18-64 Years of Age)**

**Follow Up Actions Taken Through 06/30/19:**

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

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

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

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

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

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

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

**Omnichannel Medication Adherence Education Program (July 2016 – ongoing).** Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.
Member Incentive (November 2016 – ongoing). Through Gateway Health’s Goodness Rewards Program, members who obtain diabetes care are eligible to obtain incentives for HbA1c testing up to two times per year.

Wellness Coaches (2015- ongoing): Members who are identified as having uncontrolled diabetes or are in need of additional support in effectively managing their diabetes have the opportunity to receive wellness coaching from an internal dietitian and/or certified diabetes educator.

Gateway to Practitioner Excellence (GPE®) 2018 Program (January 2018 – ongoing). The HbA1c poor control measure is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

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

Diabetes Care Plan (August 2017 – September 2018). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

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

Integrated Care Plans (Q3 2018-ongoing) Members who are identified as having a serious mental illness as well as diabetes are identified through case management efforts to have an integrated care plan developed with their BH MCO and physical and behavioral health providers to address member health needs including open care gaps and diabetic care needs as well as factors related to SDoH.

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic anti-diabetic medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

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

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 70.96% for Diabetes Care for People with Serious Mental Illness.

Future Actions Planned:

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including diabetes and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

In home A1c test kits (Q4 2019): Mailing of A1c test kits to member homes for completion and return to close A1c gap as well as obtain A1c result.

Mobile Community events (Q4 2018-present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues.
that may impact their ability to effectively and efficiently close care gaps.

Reference Number: [GH] 2018.38: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for HbA1c Poor Control (>9.0%)

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

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

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

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

Wellness Coaches (2015- ongoing): Members who are identified as having uncontrolled diabetes or are in need of additional support in effectively managing their diabetes have the opportunity to receive wellness coaching from an internal dietitian and/or certified diabetes educator.

Gateway to Practitioner Excellence (GPE®) 2018 Program (January 2018 – ongoing). The HbA1c poor control measure is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.
Continuous Clinical Transformation Consultant Outreach (January 2017 – ongoing). CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015.

Diabetes Care Plan (August 2017 – September 2018). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic anti-diabetic medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

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

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

The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 38.2% for HbA1c Poor Control (>9.0%)

Future Actions Planned:

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including diabetes and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

In home A1c test kits (Q4 2019): Mailing of A1c test kits to member homes for completion and return to close A1c gap as well as obtain A1c result.

Mobile Community events (Q4 2018- present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.

Reference Number: [GH] 2018.39: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months

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

Care Management Staff Training (ongoing). Staff receive in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Diabetes Clinical Specialist, Pharmacist, Medical Director, or external partners as warranted.
Transition Management Program (2014 – ongoing). Gateway Health’s Transition Management (TM) Program focuses on a subset of diagnoses, which includes but is not exclusive to diabetes, COPD, and asthma. Cases are created for members for the Transition Management team when they are authorized for inpatient admissions related to specific diagnoses. The Transition Management team receives cases for members who are admitted regardless of diagnosis if they have been identified as being at risk for an inpatient admission. Both of these referral sources could include members with diabetes, COPD, and asthma, in addition to other diagnosis. The Transition Management Case Manager initiates outreach during the inpatient stay at the earliest point when the member is able to engage. They follow the Eric Coleman Transition Management Guidelines triangle and maintain contact with the member through a series of interventions. The interventions focus on medications, appointments, home health, transportation, durable medical equipment, and care gaps.

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

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

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

Clinical Practice Guidelines (January 2016 – ongoing). The Clinical Practice Guideline “Standards of Medical Care in Diabetes-2019”, produced by the American Diabetes Association, is published on Gateway Health’s website for providers to access and review

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

Diabetes Care Plan (August 2017 – September 2018). The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

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

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

Future Actions Planned:

Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including diabetes and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

In home A1c test kits (Q4 2019): Mailing of A1c test kits to member homes for completion and return to close A1c gap as well as obtain A1c result.

Mobile Community events (Q4 2018- present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.
Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

**Clinical Practice Guidelines (January 2016 – ongoing).** The Clinical Practice Guideline “Standards of Medical Care in Diabetes-2019”, produced by the American Diabetes Association, is published on Gateway Health’s website for providers to access and review.

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

**Diabetes Care Plan (August 2017 – September 2018).** The care plan is a mailing which provides members with the dates and/or results of diabetes-related exams and refill dates for medication. It includes education on HbA1c screenings and the most recent lab/test results for diabetes. The care plan is sent at least annually.

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

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

**Clinical Actions Planned:**

**Clinical Quality Care Gap Care Plan (July 2019).** A comprehensive document including diabetes and adult preventative care gaps and...
related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on HbA1c screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

In home A1c test kits (Q4 2019): Mailing of A1c test kits to member homes for completion and return to close A1c gap as well as obtain A1c result.

Mobile Community events (Q4 2018- present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for A1c and obtain A1c result.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provide in-home lab draws to close A1c test gap and obtain result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.

Reference Number: [GH] 2018.41: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Controlling High Blood Pressure (Total Rate)

Follow Up Actions Taken Through 06/30/19:

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

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

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

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

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

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

Omnichannel Condition Management Education Program (May 2016 - ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about diabetes and high blood pressure screenings, including HbA1c and favorable values, as well as on the importance of regular screenings. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.
Omnichannel Medication Adherence Education Program (July 2016 – ongoing). Includes IVR Call/Email/SMS & Live agent assistance components to educate members about the importance of continuing to take ACE/ARBs, antihypertensives, and statins as prescribed. Live agent assistance is available to schedule appointments and resolve barriers/SDoH impediments to care.

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

Wellness Coaches (2015- ongoing): Members who are identified as having uncontrolled hypertension or are in need of additional support in effectively managing their blood pressure have the opportunity to receive wellness coaching from an internal dietitian regarding healthy eating.

Gateway to Practitioner Excellence (GPE®) 2018 Program (January 2018 – ongoing). The Controlling High blood pressure measure is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic antihypertensive medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

Quality Gap Closure (Q3 2018). A web-based platform that allows for exchange of patient service and results data to inform gap closure and support submission of medical records. The expected outcome/goal of these collective actions is to meet or exceed the 2018 NCQA Quality Compass 50th percentile benchmark of 58.64% for Controlling High Blood Pressure.

Future Actions Planned:
Clinical Quality Care Gap Care Plan (July 2019). A comprehensive document including hypertension and adult preventative care gaps and related education mailed to members to provide education on open care gaps as well as the importance of gap closure. The document also provides reinforcement to members who have closed care gaps. It includes education on blood pressure screenings and the most recent lab/test result known to Gateway Health via claims. The care plan is sent at least annually.

Mobile Community events (Q4 2018- present): Targeting members through a series of mobile community events to have the opportunity to close open care gaps for blood pressure screening.

Community Paramedicine Program (Q4 2019) Through partnership with a local community paramedicine program complete member home visits and provides in-home blood pressure checks and obtains result.

Quality Provider Outreach Program (Q4 2019) Staff from the quality department will be going and visiting low performing provider practices face to face to identify opportunities for improvement of practice outcomes and to discuss and resolve practice level issues that may impact their ability to effectively and efficiently close care gaps.

Reference Number: [GH] 2018.42: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - 40-75 years (Female)

Follow Up Actions Taken Through 06/30/19:
- 90 day benefit change
  - Gateway Health Plan® designed and implemented a 90-day benefit offering on 8/15/2018 which allows members to receive 90-day supply of commonly used medications for chronic disease states, including several statin medications.
- Embedded pharmacists
  - Gateway Health Plan® placed 2 pharmacists into physician practices for the measurement year who meet with patients face to face to discuss medications and address adherence issues.
- Multi-dose packaging
Small pilot of non-adherent members who take multiple chronic medications have been offered a multi-dose packaging service for the measurement year which delivers packaged medications to their homes at no additional cost to members.

Future Actions Planned:

- **Fax campaign to providers to encourage utilization of the 90 day benefit (Q3 2019 – ongoing)**
  - The purpose of the fax campaign to prescribing providers is to encourage utilization of the 90 day benefit for members who are stable on their prescribed statins. This campaign will be launched by the end of September 2019 and adherence rates for members taking statins are expected to improve by the end of 2019 as a result of reduction in the number of times needed for members to go to the pharmacy to pick up their prescriptions. Lesser number of times necessary to call pharmacies for medication refills and also the number of trips to the pharmacy to pick up prescriptions can improve medication adherence, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the 90 day benefit and compare them to the population who are not utilizing the benefit.

- **Call campaign to pharmacies to switch prescriptions from 30 day to 90 day fill (Q3 2019 – ongoing)**
  - The purpose of the call campaign is to make outbound calls to pharmacies where statins are being filled and having the pharmacy staff request 90 day prescription from prescribing providers via fax; the goal of this campaign is to simplify switching statin prescriptions from 30 day to 90 day supply for members for whom prescribers determine can benefit from this switch. This campaign will be launched by the end of September 2019 and adherence rates for members taking statins are expected to improve by the end of 2019 as a result of reduction in the number of times needed for members to go to the pharmacy to pick up their prescriptions. Lesser number of times necessary to call pharmacies for medication refills and also the number of trips to the pharmacy to pick up prescriptions can improve medication adherence, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the 90 day benefit and compare them to the population who are not utilizing the benefit.

- **Expansion of the utilization of multi-dose packaging pharmacy services (Q3 2019 – ongoing)**
  - A larger population of members who take multiple chronic medications for different disease states, with emphasis on those who are experiencing low adherence, are going to be offered multi-dose packaging services. Through the use of multi-dose packaging pharmacy services, medication are going to be filled and packaged on a monthly basis and delivered to members at no additional cost to members. This service will be available to members by the end of September 2019 and the adherence rates for members taking statins are expected to improve by the end of 2019 as a result of eliminating the need to make trips to the pharmacy to pick up prescriptions for non-adherent members who experience trips to pharmacies an adherence barrier and by eliminating the likelihood for forgetfulness as the multi-dose packaging pharmacy reminds members when their medications are due for a refill; elimination of these barriers can improve adherence and the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the multi-dose packaging pharmacy service and compare them to the population who are not utilizing the benefit.

- **Point-of-sale interventions**
  - Independent pharmacies will be provided data on Gateway Health Plan® members with open statin gaps in Q1 2020. Pharmacies will then work with Gateway Health Plan® to offer the most appropriate tools to members to help with improvement of medication adherence. Identification of the reason for low adherence at point-of-sale and offering appropriate tools to members are expected to improve adherence for members, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who have been intervened on at point-of-sale by the pharmacy staff and compare them to the population who are did not have this type of intervention.

Reference Number: [GH] 2018.43: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Statin Therapy for Patients With Cardiovascular Disease: Statin Adherence 80% - Total Rate

Follow Up Actions Taken Through 06/30/19:

- 90 day benefit change
  - Gateway Health Plan® designed and implemented a 90-day benefit offering on 8/15/2018 which allows members to receive 90-day supply of commonly used medications for chronic disease states, including several statin medications.

- Embedded pharmacists
• Gateway Health Plan® placed 2 pharmacists into physician practices for the measurement year who meet with patients face to face to discuss medications and address adherence issues.

Future Actions Planned:

- **Fax campaign to providers to encourage utilization of the 90 day benefit (Q3 2019 – ongoing)**
  - The purpose of the fax campaign to prescribing providers is to encourage utilization of the 90 day benefit for members who are stable on their prescribed statins. This campaign will be launched by the end of September 2019 and adherence rates for members taking statins are expected to improve by the end of 2019 as a result of reduction in the number of times needed for members to go to the pharmacy to pick up their prescriptions. Lesser number of times necessary to call pharmacies for medication refills and also the number of trips to the pharmacy to pick up prescriptions can improve medication adherence, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who utilize the 90 day benefit and compare them to the population who are not utilizing the benefit.

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  - Independent pharmacies will be provided data on Gateway Health Plan® members with open statin gaps in Q1 2020. Pharmacies will then work with Gateway Health Plan® to offer the most appropriate tools to members to help with improvement of medication adherence. Identification of the reason for low adherence at point-of-sale and offering appropriate tools to members are expected to improve adherence for members, resulting in improvement of the overall health outcomes for members. To monitor the effectiveness of this action, there will be a monthly report created to include real-time adherence rates for members who have been intervened on at point-of-sale by the pharmacy staff and compare them to the population who are did not have this type of intervention.

**Reference Number: [GH] 2018.44: The MCO’s rate was statistically significantly below the 2018 (MY 2017) MMC weighted average for Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months**

**Follow Up Actions Taken Through 06/30/19:**

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

Care Management Staff Training (ongoing). Staff receive in-services on cardiovascular disease protocols, new medications, and changes to clinical practice guidelines. Trainings can be conducted by the Clinical Specialists, Pharmacist, Medical Director, or external partners as warranted. September, 2018 Care Management received a focused training on “Heart Failure”. The goal of this educational program was to provide an overview of heart failure and strategies to prevent readmissions.

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

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

Provider Webinar (November 2018 - ongoing). A webinar on Heart Disease and Women: Recognizing Risk factors and Appropriate Treatment was conducted in November 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

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

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

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

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

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

90 day medication fills (July 2018-ongoing) Members being prescribed select generic statin medications are able to obtain a 90 day supply of the medication at a retail pharmacy.

Omni Scale – Digital scales and education provided to members diagnosed with heart failure to monitor fluid-retention weight gain.

Direct EHR Feeds (Q4 2017 - ongoing). Secure EHR exchanges with select practices will allow for the ongoing capture of medical record data relevant to clinical care and quality measures.
American Heart Association & Gateway Health Partnership (June 2018 – ongoing). Partnership that is aimed at blood pressure management at the member and provider level. Through Check. Change. Control program members track their blood pressure readings. Target BP program allows providers to also track blood pressures and deliver evidenced based care to members. Enhanced outreach strategy in June 2018 for providers including the use of CTCs and program materials to better assist with registration and monitoring.

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

Future Actions Planned:
Gateway has developed an Innovation and Strategy work group to do detailed population analysis as it relates to heart failure admissions. The analysis includes admission drivers such as member composition, co-morbidities, and overall utilization patterns. There will be specialized interventions targeting each group developed and implemented by Q2 2020.

Reference Number: [GH] 2018.45: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months

Follow Up Actions Taken Through 06/30/19:
Gateway to Lifestyle Management® (GTLM) Cardiac program (prior to 2014 – ongoing). GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including cardiovascular disease. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence-based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care.

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

**Future Actions Planned:**
Gateway has developed an Innovation and Strategy work group to do detailed population analysis as it relates to heart failure admissions. The analysis includes admission drivers such as member composition, co-morbidities, and overall utilization patterns. There will be specialized interventions targeting each group developed and implemented by Q2 2020.

**Reference Number: [GH] 2018.46: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for Use of Opioids from Multiple Providers (4 or more prescribers)**

**Follow Up Actions Taken Through 06/30/19:**

**Recipient Restriction Program (2005-present, ongoing).** The program aims to identify members who are utilizing >2 prescribers for controlled substances and other commonly abused medications in a 30 day or less timeframe. The Pharmacy Claims Analysis Team queries and reviews data monthly and recommends members to the State for final approval. Once approved, members may be restricted to a single prescriber for care and service coordination for a period of five years. Internal partners, such as Care Management, Payment Integrity or Utilization Management may refer cases to the Team for review and submission. External partners, such as dispensing pharmacies and providers may also refer cases to the Team for review and submission. In addition to the criteria established by the State, Gateway looks for other patterns of abuse that may appear based on market trends or fluctuations in medical events. For example, a spike in heroin overdoses in members utilizing buprenorphine/naloxone or an increase in Emergency Department visits by a member will prompt submission to the State for review and potential enrollment into the Recipient Restriction Program.

**Opioid Prior authorization (2017-ongoing).** In 2017, Gateway Health Pharmacy Services implemented prior authorization criteria for opioids based on the Centers for Disease Control Guideline for Prescribing Opioids for Chronic Pain, published and released in 2016. Prior authorization criteria included limitations on milligram morphine equivalent (MME), age and length of prescription in support of the CDC guidelines. The criteria also encouraged coordination of care, cautioned of concurrent use of drug types and that could be dangerous when used together and stressed the importance of monitoring using screening techniques as well as the Prescription Drug Monitoring Program (PDMP).

**Prescription Drug Monitoring Program (PDMP) (August 2017).** Pennsylvania’s Prescription Drug Monitoring Program (PDMP) collects information on all filled prescriptions for controlled substances. This information helps health care providers safely prescribe controlled substances. Prescribers and dispensing Pharmacists have the ability to view the PDMP and review a patient’s controlled substance prescribing and dispensing history. Gateway, as part of our opioid prior authorization process noted above requires prescribers and pharmacists check the PDMP prior to writing or filling a prescription for a controlled substance.
Opioid Integrated Care Pod (December 2017 – ongoing). In response to the opioid epidemic and subsequent guidance from our governing agencies Gateway Health has implemented a number of safety protocols. In addition to mitigating risk via medication management programs, Gateway Health created a program focused on patient safety. A holistic approach is utilized to enhance the quality of care and improve health outcomes for our members. The Opioid Integrated Care Pod (OICP) at Gateway Health is a multidisciplinary team which includes physicians, pharmacists, nurses, social workers and care managers who focus on providing comprehensive treatment plans for our members. All members who have a continued >50 MME and are not currently tapering will be prioritized for clinical review based on risk stratification using five criteria: Continued >50 MME with no evidence of tapering six weeks post initial authorization, Medication Assisted Treatment (MAT) claims in member history, history of overdose, multiple prescribers (three or more) of opioid prescription(s), and concomitant use of benzodiazepines.

Provider education (2018 and ongoing). To coordinate efforts related to the opioid prior authorization criteria, notification and education was provided to prescribers in advance of the initiative to allow for questions and comments. The Gateway Health provider website contains helpful information related to prior authorization criteria, CDC guidelines, referral process to Centers of Excellence and resources for substance use disorder treatment and recovery.

Member education (2018 and ongoing). To coordinate efforts related to the opioid prior authorization criteria, notification and education was provided to members in advance of the initiative to allow for discussion with their prescriber or prescribers on the best course of treatment. The Gateway Health member website contains helpful information related to opioid/substance use disorder and offers a resource center for abuse topics such as prevention, addiction, treatment and recovery, pain medicine, naloxone and prescription drug disposal programs.

Staff education (2018 and ongoing). To coordinate efforts related to the opioid prior authorization criteria, the opioid integrated care pod, and other activities related to opioid management, a multidisciplinary team presented information on all aspects of addiction and programs available for pharmacy, care management and other areas within Gateway Health.

Pennsylvania Pharmacists Care Network (PPCN) (2017 and ongoing). Since 2017, Gateway Health members using a PPCN pharmacy have been able to have a sit down, face-to-face appointment with the PPCN pharmacist to help them manage their medications with the focus on better overall health. As it relates to the opioid epidemic, PPCN utilizes an Opioid Risk Tool (ORT) to identify and assist members who are in need of pain management counseling. The ORT is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

AxialHealthcare (December 2017 and ongoing) AxialHealthcare is a health IT and care solutions company leveraging technology and analytics in combination with clinician-to-clinician outreach to identify trends within a pain management and opioid utilizing populations. They work to identify both high-performing and high-risk providers within a given network and engage said providers either telephonically or face-to-face in order to provide specialized assistance and guidance relevant to pain management and mitigate opioid-related patient risk.

Dental initiatives (2019 and ongoing). Standing section titled “Opioids Spotlight” in the quarterly provider newsletter that highlights links to useful articles relating to opioid prescribing as well as continuing education courses that are available. Gateway’s Dental Director reviews trends in Emergency Department (ED) visits, opioid and medication assisted treatment (MAT) use in dental procedures. Gateway also collaborates with other MCOs via the Dental Directors meeting, last held on May 6, 2019. This group strategizes on multi-pronged approaches to manage opioid prescribing and opioid use as it relates to dental.

Monitoring Effectiveness via Monthly HEDIS Surveillance Report (March 2018 – ongoing). The HEDIS surveillance report monitors monthly administrative data for all HEDIS measures to identify trends. The report utilizes rolling year data and includes a one-year lookback to provide the most accurate picture of current HEDIS measure performance. This report enables the assigned Gateway Health Operational Lead to monitor monthly rate changes/trends, assess impact of activities released into the market, and to plan future intervention activities. A multi-disciplinary group of Gateway Health staff also meet monthly to review rates and problem solve around barriers and opportunities. This method applies both to actions implemented previously and those planned in the future.

Future Actions Planned:
Provider education (August 2019). Transitioning Towards Safer Opioid Prescribing and Pain Management. Hosted by Gateway Health and presented by Gateway Health Medical Director who is actively involved in opioid management and the opioid integrated care pod (OICP).
Provider education (October 2019). Presentation on safe opioid prescribing, tapering and safer alternatives presented by embedded care management pharmacist to medical residents and other healthcare professionals in a large practice in the northwest region of Gateway Health’s service area.

Enhanced reporting (2019 and ongoing). Continued development and enhancements to the internal opioid dashboard to allow for efficient tracking of member and prescriber trends to aid in developing targeted strategies for opioids and other controlled substances.

Integrated Pain Management collaboration with MCOs

Dental initiatives. Addition of a helpline link to Gateway Health website where providers can call or refer members who may exhibit opioid addiction.

Reference Number: [GH] 2018.47: The MCO’s rate was statistically significantly below/worse than the 2018 (MY 2017) MMC weighted average for Use of Opioids From Multiple Providers (4 or more prescribers & pharmacies)

Follow Up Actions Taken Through 06/30/19: DUPLICATE – SEE ABOVE

Future Actions Planned:

Root Cause Analysis and Action Plan

The 2019 EQR is the tenth year MCOs were required to prepare a Root Cause Analysis and Action Plan for measures on the HEDIS 2018 P4P Measure Matrix receiving either “D” or “F” ratings. Each P4P measure in categories “D” and “F” required that the MCO submit:

- A goal statement;
- Root cause analysis and analysis findings;
- Action plan to address findings;
- Implementation dates; and
- A monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

For the 2019 EQR, GH was required to prepare a Root Cause Analysis and Action Plan for the following performance measures:

1. Comprehensive Diabetes Care: HbA1c Poor Control (Table 4.2)
2. Controlling High Blood Pressure (Table 4.3)
3. Prenatal Care in the First Trimester (Table 4.4)
4. Medication Management for People With Asthma: 75% Total (Table 4.5)


Table 4.2: RCA and Action Plan: Comprehensive Diabetes Care: HbA1c Poor Control

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

<table>
<thead>
<tr>
<th>Managed Care Organization:</th>
<th>Gateway Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Date:</td>
<td>9/12/19</td>
</tr>
<tr>
<td>Measure:</td>
<td>Comprehensive Diabetes Care: HbA1c Poor Control</td>
</tr>
<tr>
<td>Reason for Root Cause Analysis:</td>
<td>Comprehensive Diabetes Care: HbA1c Poor Control is statistically significantly lower/worse than the 2018 MMC weighted average.</td>
</tr>
</tbody>
</table>
**Goal Statement:** Please specify goal(s) for measure

**Improve Diabetes Care: HbA1c Control, as well as improve year over year**

### Part A: Identify Factors via Analysis

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.
- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.

<table>
<thead>
<tr>
<th>Factor categories</th>
<th>Factors</th>
</tr>
</thead>
</table>
| **Policies?** (e.g., data systems, delivery systems, provider facilities) | - While able to identify that member had A1c testing completed, unable to obtain A1c result via electronic data feeds.  
- Provider completes A1c test in office, but does not bill for service or code result.  
- Vendor for lab data currently captures values from a specific set of labs resulting in less than 100% of reported lab values  
- Inaccurate member demographics negatively impacts member outreach |
| **Procedures?** (e.g., payment/reimbursement, credentialing/collaboration) | - Deficient success rates in chart retrieval during HEDIS medical record review process capture.  
- Most recent lab values not always available to Care Management staff when speaking with members  
- Providers may not offer in-office HbA1c tests which would require members to make a separate lab visit |
| **People?** (e.g., personnel, provider network, patients) | - Provider does not leverage CPT II codes to report A1c result administratively  
- Member does not have A1c test completed during the measurement year and as a result is captured as being uncontrolled.  
- Primary care providers may not collaborate with member’s specialists to ensure testing is completed annually.  
- Member does not understand difference between A1c and blood glucose and believes test has been completed when it was not.  
- Provider may review result with member but not provide support/ intervention to positively impact A1c results.  
- Provider office billing staff remove CPT II codes from billing because of lack of understanding of importance.  
- Member is medication non-compliant and has uncontrolled blood sugars  
- Member knowledge deficit regarding: the diabetes disease process, complications, and (ADA) American Diabetes Association guideline recommendations  
- Members not compliant with ADA guidelines recommendations for self-management  
- Member may not return within calendar year for follow-up on a lab of >9.0%  
- Members can be difficult to reach due to nonworking phone numbers and/or outdated addresses  
- Provider may not personalize treatment options in a manner than promotes adherence for members |
| **Provisions?** (e.g., screening tools, medical record forms, provider and enrollee educational materials) | - Provider may not have office protocol for members with diabetes to address open care gaps  
- Provider office may not have means to complete A1c test while member is in the office.  
- Poor coordination between endocrinologists and PCPs |
### Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2019

<table>
<thead>
<tr>
<th>Actions</th>
<th>Which factor(s) are addressed by this action?</th>
<th>Implementation Date</th>
<th>Monitoring Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateway to Lifestyle Management® (GTLM) Diabetes program - GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations with chronic medical conditions, including diabetes. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence-based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions and gaps in care.</td>
<td>Member education opportunities</td>
<td>Prior to 2014 - ongoing</td>
<td>Effectiveness is monitored at via participation rates. An analysis will be completed at year-end year to determine if members included in the HEDIS sample and engaged with GTLM were more often seen to have HbA1c values of less than 8.0 as compared to those members in the HEDIS sample who chose not to engage with GTLM. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
</tr>
<tr>
<td>Care Management Staff Training – Staff received in-services on diabetes disease process and protocols, new medications, and changes to clinical practice guidelines.</td>
<td>Member education opportunities</td>
<td>Prior to January 2016 - Ongoing</td>
<td>Effectiveness of the action is monitored via attendance rosters to specific trainings and</td>
</tr>
<tr>
<td>Application of new material as assessed during routine call audits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gateway to Practitioner Excellence (GPE®) 2018-2019 Program – The HbA1c poor control measure is a component of Gateway Health’s provider pay-for-performance program. The 2019 program structure offers a percentage based incentive to [opt] in PCPs for each member whose HbA1c level is ≤ 9% via evidence of submission of CPT II codes on the encounter claim.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Education January 2016 - ongoing Effectiveness is measured by monthly provider dashboard reports. Individual practices will be reviewed quarterly to assess performance improvements and to identify/resolve barriers to improvement. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focused Provider Education &amp; Practice Reference Guide - The Gateway Health Provider Engagement Team began visiting participating providers in July 2015 in an ongoing outreach effort. During the visits, the team educates providers about the importance of HbA1c control and current clinical practice guidelines. An overview of CDC measure components is included in the 2018 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information on HEDIS coding, and tips to improve HEDIS CDC scores.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Education January 2016 - ongoing Effectiveness is measured by monthly provider dashboard reports. Individual practices will be reviewed quarterly to assess performance improvements and to identify/resolve barriers to improvement. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
</tr>
<tr>
<td>Program Name</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Diabetes Care Plan</td>
</tr>
<tr>
<td>Quality Care Gap Member Care Plan</td>
</tr>
<tr>
<td>Omnichannel Education Program</td>
</tr>
</tbody>
</table>
### Medical Record Review Process Enhancements – Gateway will be devoting resources to year-round medical record capture and review.

In addition to directly impacting the HEDIS® hybrid project, these activities will enhance provider processes and documentation through a rigorous feedback loop of education and monitoring. For CDC, this initiative will enhance Gateway’s ability to track members who with HbA1c >9 closer to real time.

<table>
<thead>
<tr>
<th>Internal process for record review</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness will [be] monitored through key performance indicators that are currently under development, as well as through metrics related to the hybrid medical record review process. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
<td></td>
</tr>
</tbody>
</table>

### EHR Data – Gateway is engaged in an initiative to enhance our capture of member-level detail directly from EHRs. Data will include labs, transition of care documentation, and continuity of care documentation.

<table>
<thead>
<tr>
<th>Internal processes</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness will [be] monitored through key performance indicators that are currently under development. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
<td></td>
</tr>
<tr>
<td>Member Incentives – Gateway Health will be combining the omnichannel education program with innovative member incentives around HbA1c control. In 2019, the focus will be on testing gaps.</td>
<td>Member gap closure</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>90 day pharmacy fills for select generic medications, including diabetic medications, to promote better A1c control through medication adherence.</td>
<td>Member medication adherence</td>
</tr>
<tr>
<td>Embedded Care managers - Provider practice based in high volume practices and community based case managers to support member gap closure through face to face education and intervention. These case managers also have the opportunity to collaborate and coordinate with providers to address open care gaps</td>
<td>Member and provider education, inability to contact members</td>
</tr>
</tbody>
</table>
Mobile Community events- Members with diabetes will be targeted and invited to participate in community events designed to promote gap closure through the availability of onsite testing.

Member education
Member access to care

Q3 2019

Effectiveness will [be] monitored based on rate of which the events are able to close open care gaps and member participation.

Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.

Factors not addressed by Actions

Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.

N/A

Table 4.3: RCA and Action Plan: Controlling High Blood Pressure

<table>
<thead>
<tr>
<th>Managed Care Organization:</th>
<th>Gateway Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Date:</td>
<td>9/12/19</td>
</tr>
<tr>
<td>Measure:</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>Reason for Root Cause Analysis:</td>
<td>Controlling High Blood Pressure is statistically significantly lower/worse than the 2018 MMC weighted average.</td>
</tr>
<tr>
<td>Goal Statement: Please specify goal(s) for measure</td>
<td>Improve Diabetes Care: HbA1c Control, as well as improve year over year</td>
</tr>
</tbody>
</table>

Part A: Identify Factors via Analysis

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.
- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.
<table>
<thead>
<tr>
<th>Factor categories</th>
<th>Factors</th>
</tr>
</thead>
</table>
| Policies? (e.g., data systems, delivery systems, provider facilities) | - Lack of an internal database to store blood pressure results  
- Deficient success rates in chart retrieval during HEDIS medical record review process capture.  
- Difficult to track members trending toward readings outside of normal limits  
- Inaccurate member demographics negatively impacts member outreach |
| Procedures? (e.g., payment/reimbursement, credentialing/collaboration) | - Insufficient rate of CPT II code submission that indicate blood pressure readings  
- No current mechanism to extract blood pressure readings from EHRs |
| People? (e.g., personnel, provider network, patients) | - Member may not understand normal blood pressures readings, the importance of regular screenings/self-monitoring, lifestyle management techniques, and medication adherence  
- Members may not be aware clinical guideline recommendations regarding blood pressure reading limits.  
- Members may not report untoward side effects from hypertension medication to providers resulting in non-adherence with medication  
- Members can be difficult to reach due to nonworking phone numbers and/or outdated addresses |
| Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials) | - Providers may lack hypertension educational materials that are consistent with health literacy best practice standards  
- Providers may lack adequate resources for member support and education |
| Other? (specify) | - Members seek care in the emergency department for hypertensive episodes which may result in a lack of coordination between ED and PCP and impede blood pressure control  
- SDoH factors and other barriers may negatively impact management of condition, access to care, and access to resources |

### Part B: Identify Actions – implemented and planned

**For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2019**

**Actions**

Include those planned as well as already implemented.

Actions should address factors contributing to poor performance compared to MMC average and/or previous year.

**Add rows if needed.**

| Gateway to Lifestyle Management® (GTLM) Cardiac program - GTLM is a multidisciplinary, continuum-based holistic approach to health care delivery that proactively identifies populations | Member education | Prior to 2014 - ongoing | Effectiveness is monitored via participation rates. An analysis will be |

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with chronic medical conditions, including cardiovascular disease. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence-based guidelines and patient empowerment strategies. Member-facing activities include a welcome packet for all newly identified members; relevant member newsletter articles at least twice a year; educational information available on the website and member portal; periodic member education focusing on self-management delivered via IVR, newsletter, outbound calls, and/or pre-queue messaging; comprehensive telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care.

### Care Management Staff Training
- **Staff received in-services** on cardiovascular disease process and protocols, new medications, and changes to clinical practice guidelines.

### Gateway to Practitioner Excellence (GPE®) 2019 Program
- The blood pressure control measure is a component of Gateway Health’s provider pay-for-performance program. The 2016 program structure offers a percentage of gaps closed incentive to opted in PCPs for each member whose blood pressure reading is <140/90. The incentive is paid for a maximum of one new date of service in each quarter of 2018 via submission of CPT II codes on the encounter claim. The maximum payout is four times per program year per member.

### Focused Provider Education & Practice Reference Guide
- The Gateway Health Provider Engagement Team began visiting participating providers in July 2015 in an ongoing outreach effort. During the visits, the team educates providers about the importance of blood pressure control and current clinical practice guidelines. An overview of CBP measure components is included in the 2018 Practice Reference Guide used during on-site visits and distributed to providers. The Practice Reference Guide includes measure definition, information of completed at year-end year to determine if members included in the HEDIS sample and engaged with GTLM were more often seen to have favorable blood pressure readings as compared to those members in the HEDIS sample who chose not to engage with GTLM.

<table>
<thead>
<tr>
<th>Staff education</th>
<th>Prior to January 2016 - Ongoing</th>
<th>Effectiveness of the action is monitored via attendance rosters to specific trainings and application of new material as assessed during routine call audits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider education</td>
<td>January 2016 - ongoing</td>
<td>Effectiveness is measured by monthly provider dashboard reports. Individual practices will be reviewed quarterly to assess performance improvements and to identify/resolve barriers to improvement.</td>
</tr>
<tr>
<td>Provider Education</td>
<td>January 2016 - ongoing</td>
<td>Effectiveness is measured by monthly provider dashboard reports. Individual practices will be reviewed quarterly to assess performance improvements and to identify/resolve barriers to improvement.</td>
</tr>
<tr>
<td>Omnichannel Education Program – Includes IVR Call/Email/SMS &amp; Live agent assistance components to educate members about blood pressure reading limits and the importance of regular screenings. Provides reminders to get screened. Provides live agent assistance to schedule appointment and resolve barriers/SDoH impediments to care.</td>
<td>Member education</td>
<td>May 2016 - Ongoing</td>
</tr>
<tr>
<td>Medical Record Review Process Enhancements – Gateway began devoting resources to year-round medical record capture and review. In addition to directly impacting the HEDIS® hybrid project, these activities will enhance provider processes and documentation through a rigorous feedback loop of education and monitoring. For CBP, this initiative will enhance Gateway’s ability to track members who with abnormal blood pressure readings closer to real time.</td>
<td>Record review</td>
<td>June 2018- ongoing</td>
</tr>
<tr>
<td>EHR Data – Gateway is engaged in an initiative to enhance our capture of member-level detail directly from EHRs. Data will include labs, transition of care documentation, and continuity of care documentation.</td>
<td>Internal processes</td>
<td>June 2018- ongoing</td>
</tr>
<tr>
<td>Member Incentives – Gateway Health will be combining the omnichannel education program with innovative member incentives around blood pressure control. Incentives will wrap together health education activities, medication adherence, and regular provider visits to enhance members’ compliance with evidence-based clinical practice guidelines</td>
<td>Member completion</td>
<td>2017- ongoing</td>
</tr>
<tr>
<td>90 day pharmacy fills for select generic medications, including diabetic medications, to promote better A1c control through medication adherence.</td>
<td>Member medication adherence</td>
<td>Q3 2018</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Embedded Care managers- Provider practice based in high volume practices and community based case managers to support member gap closure through face to face education and intervention. These case managers also have the opportunity to collaborate and coordinate with providers to address open care gaps.</td>
<td>Member and provider education, inability to contact members</td>
<td>2018- ongoing</td>
</tr>
<tr>
<td>Mobile Community events- Members will be targeted and invited to participate in community events designed to promote gap closure through the availability of onsite testing.</td>
<td>Member education Member access to care</td>
<td>Q3 2019</td>
</tr>
</tbody>
</table>
Target BP- Provider facing program offered in collaboration with the American Heart Association. Providers receive access to the latest guidelines, clinical tools and support to help providers optimize how patients with hypertension are diagnosed and managed through empowered care teams helping to achieve better health outcomes.

Check, Change, Control: Gateway Health partnered with the American Heart Association is an evidence-based hypertension management program offer through the American Heart Association that utilizes blood pressure self-monitoring to empower participants to take ownership of their cardiovascular health. The program incorporates the concepts of remote monitoring, online tracking and recruiting local volunteer health mentors to encourage participants.

| Factors not addressed by Actions | N/A |

Table 4.4: RCA and Action Plan: Prenatal Care in the First Trimester

<table>
<thead>
<tr>
<th>Managed Care Organization:</th>
<th>Gateway Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Date:</td>
<td>9/12/19</td>
</tr>
<tr>
<td>Measure:</td>
<td>Prenatal Care in the First Trimester</td>
</tr>
</tbody>
</table>
**Reason for Root Cause Analysis:** Prenatal Care in the First Trimester is statistically significantly lower/worse than the 2018 MMC weighted average.

**Goal Statement:** Please specify goal(s) for measure

Reach or exceed the MMC WA for Prenatal Care in the First Trimester, as well as improve year over year

**Part A: Identify Factors via Analysis**

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.
- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.

<table>
<thead>
<tr>
<th>Factor categories</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies?</td>
<td>Providers typically have patients come in for their first visit at 12 weeks to confirm pregnancy. If the woman misses the 12 weeks appointment, it may be difficult to schedule within the first trimester.</td>
</tr>
<tr>
<td></td>
<td>Enrollment files change on a daily basis and Gateway only gets updates once a week which impacts the ability to reach out to members and get them in for their prenatal visits.</td>
</tr>
<tr>
<td></td>
<td>Gateway is unable to capture prenatal visit dates when providers submit for bundled services.</td>
</tr>
<tr>
<td>Procedures?</td>
<td>Providers bill incorrectly</td>
</tr>
<tr>
<td></td>
<td>Hospitals containing clinics bill under hospital ID and isn’t recognized.</td>
</tr>
<tr>
<td>People?</td>
<td>Members don’t have health insurance and wait until they are enrolled with a MCO before visiting their OB.</td>
</tr>
<tr>
<td></td>
<td>Women don’t understand or trust that their coverage can be backdated and fear they will be left with the bill.</td>
</tr>
<tr>
<td></td>
<td>Women don’t know they are pregnant until after their first trimester.</td>
</tr>
<tr>
<td></td>
<td>Women with addictions don’t get frequent prenatal care.</td>
</tr>
<tr>
<td></td>
<td>Women with previous healthy pregnancies don’t feel that they need prenatal care</td>
</tr>
<tr>
<td></td>
<td>Women don’t have child care</td>
</tr>
<tr>
<td></td>
<td>Women don’t have transportation</td>
</tr>
<tr>
<td></td>
<td>Women can’t take off from work</td>
</tr>
<tr>
<td></td>
<td>Providers all operate differently and may recommend that members come in at different times.</td>
</tr>
<tr>
<td>Provisions?</td>
<td>EDC is often based on self-reported last menstrual cycle and providers don’t confirm until the ultrasound is completed during their first prenatal visit.</td>
</tr>
<tr>
<td>Other? (specify)</td>
<td>Window is small for member to realize she is pregnant and get care.</td>
</tr>
</tbody>
</table>
### Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2019

<table>
<thead>
<tr>
<th>Actions</th>
<th>Which factor(s) are addressed by this action?</th>
<th>Implementation Date</th>
<th>Monitoring Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateway Clinical Staff Education Day on Women’s Health. Clinical staff were educated on the importance of perinatal care and its impact on maternal health and birth outcomes. Racial and ethnic disparities were addressed to increase awareness and help staff to recognize barriers and biases when interacting with members and assist them in getting perinatal care.</td>
<td>Women don’t know they are pregnant until after their first trimester</td>
<td>May 23, 2019</td>
<td>Effectiveness is monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year</td>
</tr>
<tr>
<td>Mobile Maternity App. A mobile application is available to pregnant and postpartum women that provides them with tools to reach their Case Manager, contact the 24-hour Nurseline, and video conference with a lactation consultant with any questions or concerns. It also sends push notifications to the member’s phone that educates and reminds members on ways to ensure a healthy pregnancy and baby.</td>
<td>Women with addictions don’t get frequent prenatal care</td>
<td>May 2019 – Ongoing</td>
<td>Effectiveness will be monitored based on rate of which members using the app are able to close their open care gap.</td>
</tr>
<tr>
<td></td>
<td>Women with previous healthy pregnancies don’t feel that they need prenatal care</td>
<td></td>
<td>Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS</td>
</tr>
<tr>
<td></td>
<td>Women don’t have child care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women don’t have transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women can’t take off from work</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Women can’t take off from work

**Member incentive.** Through Gateway Health’s Goodness Rewards Program, members who obtain timely prenatal care are eligible for incentives after attending their first trimester prenatal visit.

<table>
<thead>
<tr>
<th>Women with addictions don’t get frequent prenatal care</th>
<th>November 2016 – Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women with previous healthy pregnancies don’t feel that they need prenatal care</td>
<td></td>
</tr>
</tbody>
</table>

Effectiveness will be monitored based on rate of which involved members are able to close open care gap.

Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year

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

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

<table>
<thead>
<tr>
<th>Women with addictions don’t get frequent prenatal care</th>
<th>Prior to 2014 – Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women with previous healthy pregnancies don’t feel that they need prenatal care</td>
<td></td>
</tr>
<tr>
<td>Women don’t have child care</td>
<td></td>
</tr>
<tr>
<td>Women don’t have transportation</td>
<td></td>
</tr>
<tr>
<td>Women can’t take off from work</td>
<td></td>
</tr>
<tr>
<td>Providers typically have patients come in for their first visit at 12 weeks to confirm pregnancy. If the woman misses the 12 weeks appointment, it may be difficult to schedule within the first trimester visit.</td>
<td></td>
</tr>
<tr>
<td>Window is small for member to realize she is pregnant and get care</td>
<td></td>
</tr>
</tbody>
</table>

Effectiveness will be monitored based on rate of which involved members are able to close open care gap.

Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year
Needs assessment and connection to community resources

**Data Optimization.** Gateway Health developed a proprietary platform used to drive early identification of pregnant members. This platform forms the basis for all member outreach to pregnant members.

- Enrollment files change on a daily basis and Gateway only gets updates once a week which impacts the ability to reach out to members and get them in for their prenatal visits.
- Women with addictions don’t get frequent prenatal care.
- Women with previous healthy pregnancies don’t feel that they need prenatal care.
- Women don’t have child care.
- Women don’t have transportation.
- Women can’t take off from work.
- EDC is often based on self-reported last menstrual cycle and providers don’t confirm until the ultrasound is completed during their first prenatal visit.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016 – Ongoing</td>
<td>Effectiveness will be monitored based on the ability to identify pregnant members from the platform compared to members in the HEDIS denominator. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.</td>
</tr>
</tbody>
</table>

**Provider Education.** Gateway Health began educating high-volume OB/GYN providers in August 2015 about timely and accurate claims/billing, and how they can earn incentives by providing first trimester prenatal visits, as well as ongoing prenatal visits and a postpartum visit. Gateway Health is identifying providers who are untimely in billing or who are using incorrect codes, which is impeding the tracking of prenatal or postpartum care visits. Ongoing education includes face-to-face visits with high volume offices; discussing coding issues and promotion, a leave-behind tip sheet and contact phone.

- Providers typically have patients come in for their first visit at 12 weeks to confirm pregnancy. If the woman misses the 12 weeks appointment, it may be difficult to schedule within the first trimester visit.
- Providers bill incorrectly.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016 – Ongoing</td>
<td>Effectiveness will be monitored based on provider incentive performance. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final</td>
</tr>
<tr>
<td>Number for future questions.</td>
<td>Members don’t have health insurance and wait until they are enrolled with a MCO before visiting their OB. Women don’t understand or trust that their coverage can be backdated and fear they will be left with the bill. Providers all operate differently and may recommend that members come in at different times. EDC is often based on self-reported last menstrual cycle and providers don’t confirm until the ultrasound is completed during their first prenatal visit.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Prenatal and Postpartum Education Programs.</strong> Includes IVR Call/Email/SMS &amp; Live agent assistance components to educate members about early and frequent prenatal care, and timely postpartum care. The program runs the length of members’ pregnancies with contact occurring at least once per month. Provides reminders on frequency for prenatal visits as pregnancy progresses and on the timing of postpartum care. Provides live agent assistance to schedule appointments and resolve barriers/SDoH impediments to care.</td>
<td>Women with addictions don’t get frequent prenatal care. Women with previous healthy pregnancies don’t feel that they need prenatal care. Women don’t have child care. Women don’t have transportation.</td>
</tr>
</tbody>
</table>

**Effectiveness will [be] monitored based on rate of members reached.**

Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year.

| **Community Health Workers.** Community health workers meet with members face to face to assess the member for their needs related to supporting a healthy pregnancy and obtaining appropriate prenatal and postpartum care. | Women with addictions don’t get frequent prenatal care. Women with previous healthy pregnancies don’t feel that they need prenatal care. | October 2016 – Ongoing |

**Effectiveness will [be] monitored based on rate of which involved members are engaged and are able to close open care gap.**

Effectiveness is also
<table>
<thead>
<tr>
<th>Women don’t have child care</th>
<th>monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women don’t have transportation</td>
<td></td>
</tr>
<tr>
<td>Women can’t take off from work</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Gateway is unable to capture prenatal visit dates when providers submit for bundled services</th>
<th>Effectiveness will be monitored based on rate of which ONAFs are submitted during the first trimester.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers bill incorrectly</td>
<td>Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year</td>
</tr>
<tr>
<td>Hospitals containing clinics bill under hospital ID and isn’t recognized.</td>
<td></td>
</tr>
</tbody>
</table>

**Internal Medical Record Capture.** Gateway Health nurses began to collect maternity medical records to better leverage the organization’s member-level data and coordinate record retrieval with our providers.

<table>
<thead>
<tr>
<th>Gateway is unable to capture prenatal visit dates when providers submit for bundled services</th>
<th>Effectiveness will [be] monitored based on rate of which involved members are able to close open care gap through medical record review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers bill incorrectly</td>
<td></td>
</tr>
<tr>
<td>Hospitals containing clinics bill under hospital ID and isn’t recognized.</td>
<td></td>
</tr>
<tr>
<td>Members don’t have health insurance and wait until they are enrolled with a MCO before visiting their OB</td>
<td></td>
</tr>
<tr>
<td>Women don’t understand or trust that their coverage can be backdated and fear they will be left with the bill</td>
<td></td>
</tr>
<tr>
<td>December 2016 – Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
**Gateway to Practitioner Excellence (GPE®) 2018 Program.** Timeliness of Prenatal Care and Postpartum Care measures are a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.

| Continuous Clinical Transformation Consultant Outreach. CTCs increased outreach to practices based on patient panel size and FQHC designation. Contacts include office visits, phone, or electronic outreach. The goal of the follow-up visits is to reinforce shared reference guides and address problems at the practice level including documentation of HEDIS and PAPM measures. This is an enhancement to an action started in August 2015. | Providers typically have patients come in for their first visit at 12 weeks to confirm pregnancy. If the woman misses the 12 weeks appointment, it may be difficult to schedule within the first trimester visit. Providers bill incorrectly Providers all operate differently and may recommend that members come in at different times | January 2018 – Ongoing | Effectiveness will be monitored based on rate of which involved members are able to close open care gap. Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year |
| Revised Provider Materials (May 2018). Gateway Health completed revisions to all provider-facing maternity documents to ensure alignment with HEDIS specifications. New content was approved for the Obstetrical Billing Guide and Medicaid Provider Manual. | Providers typically have patients come in for their first visit at 12 weeks to confirm pregnancy. If the woman misses the 12 weeks appointment, it may be difficult to schedule within the first trimester visit. Providers bill incorrectly | May 2018 – Ongoing | Effectiveness is also monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year |
Providers all operate differently and may recommend that members come in at different times

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

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

<table>
<thead>
<tr>
<th>All factors</th>
<th>May 2015 – ongoing</th>
<th>Effectiveness is monitored via review of monthly surveillance reporting of administrative HEDIS data with month-over-month comparisons and final HEDIS measure rates year-over-year</th>
</tr>
</thead>
</table>

Gateway is unable to capture prenatal visit dates when providers submit for bundled services

Providers bill incorrectly

Hospitals containing clinics bill under hospital ID and isn’t recognized.

Members don't have health insurance and wait until they are enrolled with a MCO before visiting their OB

Women don’t understand or trust that their coverage can be backdated and fear they will be left with the bill

Effectiveness will [be] monitored based on rate of which involved members are able to close open care gap through medical record review.
Provider Webinar. A webinar on Prenatal and Postpartum Best Practices was conducted in January 2018 for our provider network as part of the Learning and Earning with Gateway Professional Education CME/CEU Webinar Series. Eligible attendees were able to receive 1 CME for attending. The webinar was recorded and posted to the Gateway Health website for additional viewing.

<table>
<thead>
<tr>
<th>Factors not addressed by Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why.</td>
</tr>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 4.5: RCA and Action Plan: Medication Management for People With Asthma: 75% Total

<table>
<thead>
<tr>
<th>Managed Care Organization:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateway Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/12/19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Management for People With Asthma: 75% Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Root Cause Analysis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Management for People With Asthma: 75% Total is statistically significantly lower/worse than the 2018 MMC weighted average.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal Statement: Please specify goal(s) for measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach or exceed the MMC WA for Medication Management for People With Asthma: 75% Total, as well as improve year over year</td>
</tr>
</tbody>
</table>

Part A: Identify Factors via Analysis

Please identify which factors contributed to poor performance compared to the MMC average and/or the previous measurement year.

- If performance is worse than the MMC average, please identify factors that explain why performance is worse than the MMC average.
  and/or
- If performance is worse than the previous measurement year, please identify factors that explain why performance is worse than the previous measurement year. Factors that are not new or have not changed this measurement year are unlikely to explain yearly decline in performance.

<table>
<thead>
<tr>
<th>Factor categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies? (e.g., data systems, delivery systems, provider facilities)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter &quot;N/A&quot; if a factor category does not apply</td>
</tr>
</tbody>
</table>

- Retail pharmacies may not capture the appropriate number of days covered on long-term controller (LTC) fills
| Procedures? (e.g., payment/reimbursement, credentialing/collaboration) | - Members may receive samples or extra LTC medication from inpatient (IP), emergency department (ED), or primary care provider (PCP) visits  
- Identification of non-adherent members may occur too late to intervene during the year.  
- Medication fill may have a co-pay |
|---|---|
| People? (e.g., personnel, provider network, patients) | - Pharmacist may not be aware of poor compliance when member presents for a different medication fill  
- Member may not follow-up for care with PCP after ED or IP event for asthma  
- Provider unaware of medication compliance, except by member self-report. Self-report may be falsely elevated due to misunderstanding of LTC vs rescue medications.  
- Member may not understand the difference between LTC and rescue medications or the need to take LTC daily |
| Provisions? (e.g., screening tools, medical record forms, provider and enrollee educational materials) | - Providers may not have streamlined asthma protocol for adherence screening |
| Other? (specify) | - Providers may not prescribe a spacer device which leads to medication delivery errors for children |

### Part B: Identify Actions – implemented and planned

For the factors identified in Part A please indicate what Actions have been planned and/or taken since June 2019

<table>
<thead>
<tr>
<th>Actions</th>
<th>Which factor(s) are addressed by this action?</th>
<th>Implementation Date</th>
<th>Monitoring Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transition Management Program.</strong> Gateway Health’s Transition Management (TM) Program focuses on a subset of diagnoses, including asthma. Through daily admission reports, members without an open Care Management case are referred to the TM Team; members with an open case are referred to their existing Case Manager who completes the TM process to ensure continuity of care. The TM Care Coordinator initiates outreach during the inpatient stay at the earliest point when the member is able to engage and maintains contact with the member through a series of interactions.</td>
<td>Member may not follow-up for care with PCP after IP event for asthma</td>
<td>2014-Ongoing</td>
<td>Effectiveness is monitored via participation rates in the program. Members who [interact with] the TM team are monitored to determine if additional emergency care has been required or if a PCP visit occurred post-discharge. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.</td>
</tr>
</tbody>
</table>
**Embedded Care Managers.** Gateway Health has embedded care managers located at a variety of high-volume PCP practices. Embedded CMs work with members living with asthma to resolve barriers to medication compliance and assist with care coordination.

**Coordination of care**

**November 2015-Ongoing**

Members identified as having asthma who interact with the embedded Care Managers are monitored quarterly to determine if the percentage of days covered (PDC) is above 75%.

The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.

<table>
<thead>
<tr>
<th>Clinical Practice Guidelines. Clinical Practice Guidelines are published on Gateway Health’s website for providers to access and review. “Guidelines for the Diagnosis and Management of Asthma” is a National Guideline developed by the National Heart, Lung and Blood Institute as part of the National Asthma Education and Prevention Program.</th>
<th>Providers may not have a streamlined asthma protocol</th>
<th>January 2016-Ongoing</th>
<th>The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gateway to Practitioner Excellence (GPE®). Asthma management is a component of Gateway Health’s provider pay-for-performance program. In addition to the provider incentive, Gateway Health continues the practice developed in 2016 to deliver member-level gap information to providers on a monthly basis.</th>
<th>Providers may not be aware of member medication adherence</th>
<th>January 2017-Ongoing</th>
<th>Effectiveness is monitored via monthly provider dashboard reports. Individual practices are reviewed quarterly to assess performance improvements. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.</th>
</tr>
</thead>
</table>

| Self-Management Educational. Asthma “sticker letters” were mailed on a rolling basis to members newly identified as having asthma. This mailing contains education and stickers to help members differentiate between their rescue and controller inhalers. | Members may not understand the differences between rescue and controller medications or the need to take LTC daily | Prior to 2014-Ongoing | The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |
**Omnichannel Asthma Medication Adherence and Education Program.** Program consists of a blend of outbound telephone calls, email and/or SMS messages (for members who opt in). The purpose is to increase asthma medication adherence among members and to educate on the difference between controller and rescue medications. Live agent assistance available to schedule appointments and resolve barriers/SDoH impediments to care.

Members may not understand the differences between rescue and controller medications or the need to take LTC daily

May 2016- Ongoing

Effectiveness is monitored on a monthly basis through key performance metrics including reach rates, expression of intent to see provider, rate of transfer to live agents for assistance, proportion of members who achieve compliance.

The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.

---

**Interdisciplinary Asthma Workgroup.** The purpose of the workgroup is to identify asthma initiatives and barriers across departments, as well as examine asthma clinical quality trends.

Addresses process improvements for data and systems barriers

January 2017- Ongoing

The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.

---

**ED Utilization Dashboard.** Member level report on ED utilization sent to provider via Secure Messaging on a monthly basis.

Member may not follow-up for care with PCP after ED or IP event for asthma

May 2017- Ongoing

Dashboard utilization is monitored on an ongoing basis to determine the impact of the intervention.

The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.

---

**Asthma Medication Adherence Dashboard.** The provider dashboard now includes member level adherence information.

Providers may not be aware of member medication adherence

May 2018 - Ongoing

Dashboard utilization is monitored on a monthly basis to determine impact.

The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.
<p>| <strong>Retail Pharmacy Collaboration.</strong> | The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. | Member may not understand the difference between LTC and rescue medications or the need to take LTC daily | November 2017-Ongoing | Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |
| <strong>Embedded Pharmacist Collaboration.</strong> | Pharmacists embedded at practices receive lists of members who are patients at the practice and are currently in the MMA denominator or have a high likelihood of falling into the denominator. The pharmacist uses the information in face-to-face discussions with members or heads of households for education and to assist with getting prescriptions filled. | Pharmacist may not be aware of poor compliance when member presents for a different medication fill | March 2018-Ongoing | Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |
| <strong>Data Optimization.</strong> | Automated report created to identify members for asthma intervention. This report now identifies members with exclusions like COPD. | Identification of non-adherent members may occur too late to intervene during the year. | February 2018-Ongoing | Utilized for intervention purposes only |
| <strong>Website and Social Media Promotion.</strong> | Articles about Asthma, including proper management, were added to the new Gateway to Better Health portion of Gateway Health’s website. | Member may not understand the difference between LTC and rescue medications or the need to take LTC daily | September 2018-Ongoing | The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |
| <strong>Report on Days Covered.</strong> | Identification of non-adherent members may occur too late to intervene during the year. | Retail pharmacies may not capture that appropriate number of days covered on long-term controller (LTC) fills | Q2 2019 | Evaluation of volume of claims correctly identified and reversed on a quarterly basis. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |
| <strong>Enhanced Care Management Outreach.</strong> | Care Managers outreach to members with low asthma controller medication compliance, or historically low compliance, on a bi-monthly basis. | Member may not understand the difference between LTC and rescue medications or the need to take LTC daily | June 2019-Ongoing | Member engagement with the program and medication fill rate are monitored quarterly. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness. |</p>
<table>
<thead>
<tr>
<th><strong>Pharmacist Outreach.</strong> Pharmacies and prescribers of members who are non-compliant for asthma controller medications will be contacted by Gateway Health’s Pharmacy Department to notify and assist in getting the prescription filled for the member.</th>
<th>Providers may not have a streamlined asthma protocol</th>
<th>Q3 2019 - Ongoing</th>
<th>Members identified for the program are included in the report on days covered and the PDC for controller medications will be monitored to determine if they are compliant. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma Medication Kiosk.</strong> Partnering provider offices will have the opportunity to have a medication dispensation kiosk to allow members to fill new prescriptions for certain medications, including asthma controllers.</td>
<td>Providers may not have a streamlined asthma protocol</td>
<td>Q1 2020 - Ongoing</td>
<td>Members who are newly prescribed asthma controller medications at participating provider offices will be monitored through the report on days covered to determine PDC. The MMA HEDIS rate is monitored through monthly surveillance reporting to determine effectiveness.</td>
</tr>
</tbody>
</table>
| **Factors not addressed by Actions** Please list factors identified in Part A that are not addressed by the above actions and if known, the reason why. | - Co-pay may be member barrier  
- Providers may not prescribe spacer device which leads to medication delivery errors for children | | |
V: 2019 Strengths and Opportunities for Improvement
The review of MO’s performance against structure and operations standards, performance improvement projects and performance measures identified strengths and opportunities for improvement in the quality outcomes, timeliness of, and access to services for Medicaid members served by this MCO.

Strengths
- GH was found to be fully compliant on Subparts C, D, and F of the structure and operations standards.
- The MCO’s performance was statistically significantly above/better than the MMC weighted average in 2019 (MY 2018) on the following measures:
  - Adults’ Access to Preventive/Ambulatory Health Services (Age 20-44 years)
  - Follow-up Care for Children Prescribed ADHD Medication - Initiation Phase
  - Follow-up Care for Children Prescribed ADHD Medication - Continuation Phase
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Initiation Phase
  - Follow-up Care for Children Prescribed ADHD Medication (BH Enhanced) - Continuation Phase
  - Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (Ages: 18 to 64 - ED visits for mental illness, follow-up within 30 days)
  - Prenatal Screening Positive for Depression
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (BH Enhanced)
- The following strengths were noted in 2019 (MY 2018) for Adult and Child CAHPS survey items:
  - Of the four Adult CAHPS composite survey items reviewed, three items were above the 2019 MMC Weighted average. Two items increased in 2019 (MY 2018) as compared to 2018 (MY 2017).
  - Of the four Child CAHPS composite survey items reviewed, two items were above the 2019 MMC Weighted average. Two items increased in 2019 (MY 2018) as compared to 2018 (MY 2017).

Opportunities for Improvement
- For approximately 20 percent of reported measures the MCO’s performance was statistically significantly below/worse than the MMC weighted average in 2019 (MY 2018) on the following measures:
  - Adolescent Well-Care Visits (Age 12 to 21 Years)
  - Body Mass Index: Percentile (Age 3 - 11 years)
  - Body Mass Index: Percentile (Total)
  - Counseling for Nutrition (Age 3-11 years)
  - Counseling for Nutrition (Total)
  - Chlamydia Screening in Women (Age 16-20 years)
  - Contraceptive Care for Postpartum Women: LARC - 60 days (Ages 15 to 20)
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care
  - Prenatal and Postpartum Care – Postpartum Care
  - Prenatal Screening for Smoking
  - Prenatal Screening for Smoking during one of the first two visits (CHIPRA indicator)
  - Prenatal Screening for Environmental Tobacco Smoke Exposure
  - Prenatal Counseling for Smoking
  - Prenatal Counseling for Environmental Tobacco Smoke Exposure
  - Prenatal Screening for Depression
  - Prenatal Screening for Depression during one of the first two visits (CHIPRA indicator)
  - Postpartum Screening for Depression
  - Prenatal Screening for Alcohol use
  - Prenatal Screening for Illicit drug use
  - Prenatal Screening for Prescribed or over-the-counter drug use
  - Prenatal Screening for Intimate partner violence
Prenatal Screening for Behavioral Health Risk Assessment

Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Age 40 to 64 years) per 100,000 member months

Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Total Age 40+) per 100,000 member months

HbA1c Control (<8.0%)

HbA1c Good Control (<7.0%)

Blood Pressure Controlled <140/90 mm Hg

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (Age Cohort: 18 - 64 Years of Age)

HbA1c Poor Control (>9.0%)

Diabetes Short-Term Complications Admission Rate (Age 18-64 years) per 100,000 member months

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

Heart Failure Admission Rate (Age 18-64 years) per 100,000 member months

Heart Failure Admission Rate (Total Age 18+ years) per 100,000 member months

Use of Opioids From Multiple Providers (4 or more prescribers)

The following opportunities were noted in 2019 (MY 2018) for Adult and Child CAHPS survey items:

- Of the four Adult CAHPS composite survey items reviewed, one item was below the 2019 MMC weighted average. Two items decreased between 2019 (MY 2018) and 2018 (MY 2017).
- Of the four Child CAHPS composite survey items reviewed, two items were below the 2019 MMC weighted average. Two items decreased between 2019 (MY 2018) and 2018 (MY 2017).

Additional targeted opportunities for improvement are found in the MCO-specific HEDIS 2019 P4P Measure Matrix that follows.
The Pay-for-Performance (P4P) Matrix Report Card provides a comparative look at all measures in the Quality Performance Measures component of the “HealthChoices MCO Pay for Performance Program.” Nine measures are Healthcare Effectiveness Data Information Set (HEDIS®) measures, and the remaining two are PA specific measures. The matrix:

1. Compares the Managed Care Organization’s (MCO’s) own Pankan measure performance over the two most recent reporting years (2019 and 2018); and
2. Compares the MCO’s 2019 P4P measure rates to the 2019 Medicaid Managed Care (MMC) Weighted Average.

The table is a three by three matrix. The horizontal comparison represents the MCO’s current performance as compared to the most recent MMC weighted average. When comparing a MCO’s rate to the MMC weighted average for each respective measure, the MCO rate can be either above average, average or below average. Whether or not a MCO performed above or below average is determined by whether or not that MCO’s 95% confidence interval for the rate included the MMC Weighted Average for the specific indicator. When noted, the MCO comparative differences represent statistically significant differences from the MMC weighted average.

The vertical comparison represents the MCO’s performance for each measure in relation to its prior year’s rates for the same measure. The MCO’s rate can trend up (↑), have no change, or trend down (↓). For these year-to-year comparisons, the significance of the difference between two independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that quantifies the difference between two percentages when they come from two separate study populations.

The matrix is color-coded to indicate when a MCO’s performance rates for these P4P measures are notable or whether there is cause for action:

- The green box (A) indicates that performance is notable. The MCO’s 2019 rate is statistically significantly above/better than the 2019 MMC weighted average and above/better than the MCO’s 2018 rate.
- The light green boxes (B) indicate either that the MCO’s 2019 rate does not differ from the 2019 MMC weighted average and is above/better than 2018 or that the MCO’s 2019 rate is statistically significantly above/better than the 2019 MMC weighted average but there is no change from the MCO’s 2018 rate.
- The yellow boxes (C) indicate that the MCO’s 2019 rate is statistically significantly below/worse than the 2019 MMC weighted average and is above/better than the 2018 rate, or the MCO’s 2019 rate does not differ from the 2019 MMC weighted average and there is no change from 2018, or the MCO’s 2019 rate is statistically significantly above/better than the 2019 MMC weighted average but is lower/worse than the MCO’s 2018 rate. No action is required although MCOs should identify continued opportunities for improvement.
- The orange boxes (D) indicate either that the MCO’s 2019 rate is statistically significantly lower/worse than the 2019 MMC weighted average and there is no change from 2018, or that the MCO’s 2019 rate is not different than the 2019 MMC weighted average and is lower/worse than the MCO’s 2018 rate. A root cause analysis and plan of action is therefore required.
- The red box (F) indicates that the MCO’s 2019 rate is statistically significantly below/worse than the 2019 MMC weighted average and is below/worse than the MCO’s 2018 rate. A root cause analysis and plan of action is therefore required.
GH Key Points

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

- No P4P measures fell into this comparison category.

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

Measures that in 2019 are statistically significantly above/better than 2018, but are not statistically significantly different from the 2019 MMC weighted average are:

- Controlling High Blood Pressure
- Medication Management for People With Asthma: 75% Total

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

Measures that in 2019 did not statistically significantly change from 2018, and are not statistically significantly different from the 2019 MMC weighted average are:

- Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits
- Prenatal Care in the First Trimester
- Annual Dental Visit (Ages 2 – 20 years)
- Well-Child Visits in the First 15 Months of Life, 6 or more
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Measures that in 2019 are statistically significantly below/worse than 2018, and are statistically significantly above/better than the 2019 MMC weighted average are:

- Reducing Potentially Preventable Readmissions

**D - Root cause analysis and plan of action required**

Measures that in 2019 did not statistically significantly change from 2018, but are statistically significantly lower/worse than the 2019 MMC weighted average are:

- Adolescent Well-Care Visits
- Comprehensive Diabetes Care: HbA1c Poor Control
- Postpartum Care

**F - Root cause analysis and plan of action required**

- No P4P measures fell into this comparison category.

---

1 Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
2 Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
### Medicaid Managed Care Weighted Average Statistical Significance Comparison

<table>
<thead>
<tr>
<th>Trend</th>
<th>Below/Worse than Average</th>
<th>Average</th>
<th>Above/Better than Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Change</td>
<td>C</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Upward Trend</td>
<td>D</td>
<td><strong>B</strong></td>
<td><strong>A</strong></td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Controlling High Blood Pressure Medication Management for People With Asthma: 75% Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **D**          | Adolescent Well-Care Visits Comprehensive Diabetes Care: HbA1c Poor Control
|                | Postpartum Care          |         |                           |
| **C**          | Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Prenatal Care in the First Trimester Annual Dental Visit (Ages 2 – 20 years)
|                | Well-Child Visits in the First 15 Months of Life, 6 or more Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life |
| **F**          |                          | **D**   | **C**                     |
| **C**          | Reducing Potentially Preventable Readmissions |

---

3 Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance
4 Lower rates for Reducing Potentially Preventable Readmissions indicate better performance
P4P performance measure rates for 2016, 2017, 2018, and 2019 as applicable are displayed in Figure 5.2. Whether or not a statistically significant difference was indicated between reporting years is shown using the following symbols:

▲ Statistically significantly higher than the prior year,
▼ Statistically significantly lower than the prior year or
═ No change from the prior year.

Table 5.1: P4P Measure Rates

<table>
<thead>
<tr>
<th>Quality Performance Measure – HEDIS®</th>
<th>HEDIS® 2016 Rate</th>
<th>HEDIS® 2017 Rate</th>
<th>HEDIS® 2018 Rate</th>
<th>HEDIS® 2019 Rate</th>
<th>HEDIS® 2019 MMC WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Well Care Visits (Age 12-21 Years)</td>
<td>56.5% ▼ 58.4% ▼ 61.6% ▼ 57.4% ▼ 62.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care HbA1c Poor Control</td>
<td>48.9% ▲ 43.1% ▼ 39.9% ▼ 42.4% ▼ 34.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>34.1% ▼ 56.3% ▲ 52.3% ▲ 65.5% ▲ 66.4%</td>
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<tr>
<td>Prenatal Care in the First Trimester</td>
<td>78.5% ▼ 86.2% ▲ 81.5% ▲ 83.5% ▲ 87.0%</td>
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<tr>
<td>Postpartum Care</td>
<td>48.1% ▼ 63.4% ▲ 66.2% ▲ 63.0% ▲ 67.7%</td>
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<tr>
<td>Annual Dental Visits (Ages 2-20 years)</td>
<td>55.8% ▲ 56.4% ▲ 63.7% ▲ 64.0% ▲ 64.0%</td>
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<tr>
<td>Well Child Visits in the First 15 Months of Life, 6 or more</td>
<td>71.3% ▲ 66.6% ▼ 68.4% ▼ 70.3% ▼ 71.6%</td>
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<tr>
<td>Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life</td>
<td>74.1% NA 78.1% ▼ 76.4% ▼ 77.6% ▼ 77.7%</td>
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<tr>
<td>Medication Management for People with Asthma: 75% Total</td>
<td>38.7% NA 37.7% ▼ 38.0% ▼ 43.0% ▲ 44.3%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Performance Measure – PA</th>
<th>2016 Rate</th>
<th>2017 Rate</th>
<th>2018 Rate</th>
<th>2019 Rate</th>
<th>2019 MMC WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Ongoing Prenatal Care: ≥ 81% of Expected Prenatal Care Visits Received</td>
<td>65.0% ▲ 73.2% ▲ 73.0% ▲ 77.4% ▲ 73.4%</td>
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<tr>
<td>Reducing Potentially Preventable Readmissions</td>
<td>9.1% ▲ 12.1% ▲ 9.5% ▼ 10.7% ▲ 11.9%</td>
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</tbody>
</table>

5 Lower rates for Comprehensive Diabetes Care: HbA1c Poor Control indicate better performance.
6 Lower rates for Reducing Potentially Preventable Readmissions indicate better performance.
VI: Summary of Activities

Structure and Operations Standards
• GH was found to be fully compliant on Subparts C, D, and F. Compliance review findings for GH from RY 2018, RY 2017, and RY 2016 were used to make the determinations.

Performance Improvement Projects
• As previously noted, GH’s Dental and Readmission PIP Final Project submissions were validated. The MCO received feedback and subsequent information related to these activities from IPRO.

Performance Measures
• GH reported all HEDIS, PA-Specific, and CAHPS Survey performance measures in 2019 for which the MCO had a sufficient denominator.

2018 Opportunities for Improvement MCO Response
• GH provided a response to the opportunities for improvement issued in the 2018 annual technical report and a root cause analysis and action plan for those measures on the HEDIS 2018 P4P Measure Matrix receiving either “D” or “F” ratings.

2019 Strengths and Opportunities for Improvement
• Both strengths and opportunities for improvement have been noted for GH in 2019. A response will be required by the MCO for the noted opportunities for improvement in 2020.