

**Minnesota Department of Human Services
2016 External Quality Review Annual Technical Report
Issued April 13, 2018**

*An independent external quality review of Minnesota publicly funded managed care programs in accordance with the Balanced Budget Act of 1997
(Subpart E, 42 Code of Federal Regulations Section 438.364)*



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**2016 External Quality Review
Annual Technical Report**

Issued: April 13, 2018

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Common Acronyms Used in This Report

(In alphabetical order)

AACAP:	American Academy of Child and Adolescent Psychiatry
AAFP:	American Academy of Family Physicians
AAP:	American Academy of Pediatrics
ACA:	Affordable Care Act
ACCF:	American College of Cardiology Foundation
ACIP:	Advisory Committee on Immunization Practices
ACOG:	American Congress of Obstetricians and Gynecologists
ACPM:	American College of Preventive Medicine
ADA:	American Diabetes Association
AHA:	American Heart Association
AHRQ:	Agency for Healthcare Research and Quality
APA:	American Psychiatric Association
ATR:	Annual Technical Report
BBA:	Balanced Budget Act (of 1997)
CAHPS®:	Consumer Assessment of Healthcare Providers and Systems
CBP:	County-Based Purchasing
CDC:	Centers for Disease Control and Prevention
CFR:	Code of Federal Regulation
CHW:	Community Health Worker
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
C&TC:	Child and Teen Checkups
DHS:	Department of Human Services
ED:	Emergency Department
EQR:	External Quality Review
EQRO:	External Quality Review Organization
ER:	Emergency Room
F&C-MA:	Families and Children Medical Assistance
GOLD:	Global Initiative for Chronic Obstructive Lung Disease
HEDIS®:	Healthcare Effectiveness Data and Information Set
HMO:	Health Maintenance Organization
ICHHS:	Itasca County Health and Human Services
ICSI:	Institute for Clinical Systems Improvement
IMCare:	Itasca Medical Care

JAMA: Journal of the American Medical Association

MA: Medical Assistance

MCO: Managed Care Organization

MDH: Minnesota Department of Health

MNCare: MinnesotaCare

MHCP: Minnesota Health Care Programs

MSHO: Minnesota Senior Health Options

MSC+: Minnesota Senior Care Plus

MY: Measurement Year

NCQA: National Committee for Quality Assurance

NHLBI: National Heart, Lung and Blood Institute

NIH: National Institutes of Health

OB/GYN: Obstetrician/Gynecologist

PCP: Primary Care Practitioner/Provider

PIP: Performance Improvement Project

QA: Quality Assurance

QAE: Quality Assurance Examination

QC®: Quality Compass®

QI: Quality Improvement

SNBC: Special Needs Basic Care

SWA: Statewide Average

TCA: Triennial Compliance Assessment

UR: Utilization Review

USDHHS: United States Department of Health and Human Services

USPSTF: United States Preventive Services Task Force

Executive Summary

The Centers for Medicare and Medicaid Services (CMS) require 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 (MCO). In order to comply with these requirements, the Department of Human Services (DHS) contracted with IPRO to assess and report the impact of its Minnesota Health Care Programs (MHCP) and each of the participating MCOs on the accessibility, timeliness, and quality of services. In accordance with Federal requirements, as set forth in the Balanced Budget Act (BBA) of 1997, this report summarizes the results of the 2016 External Quality Review (EQR).

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as State requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure validation, Performance Improvement Project (PIP) validation, and compliance audits. Results of the most current Healthcare Effectiveness Data and Information Set (HEDIS®)¹ reporting period and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)² survey are presented. IPRO's assessment also included a review of the PIPs that concluded during the measurement year and PIPs that are currently in progress, the most current Quality Assurance Examination (QAE) and Triennial Compliance Assessment (TCA) findings, and MCO achievements under the Financial Withhold Program.

In 2016, MHCP performance in the area of access to care was strong, while performance in the areas of quality of care and timeliness of care demonstrated opportunities for improvement. MHCP members reported high satisfaction with personal doctors, and high dissatisfaction with MCO customer service.

Collectively, the MCOs continued to demonstrate strong performance in adult access to preventive and ambulatory care; and demonstrated notable performance in access to primary care for adolescents aged 12-19 years. Related HEDIS® rates met or exceeded the 75th percentile benchmark. MHCP demonstrated opportunities for improvement in regard to the quality of and timeliness of: child and adolescent primary care, cancer screenings for women, and one aspect of diabetes care. Related HEDIS® rates were below the 50th percentile benchmark. MHCP CAHPS® performance indicated that members were highly satisfied with provider communication and personal doctors. Satisfaction with customer service continues to be an opportunity for improvement.

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

² CAHPS® is a product of the U.S. Agency for Healthcare Research and Quality (AHRQ).

Chapter 1: Introduction

DHS purchases medical care coverage through contracts with eight managed care organizations (MCOs) that receive a fixed, prospective monthly payment for each enrollee. The Minnesota Department of Health (MDH) licenses five of the entities as Health Maintenance Organizations (HMOs): Blue Plus, HealthPartners, Medica, Hennepin Health/Metropolitan Health Plan (MHP), and UCare. HMOs are non-profit corporations or government entities that provide comprehensive health maintenance services, or arrange for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee.³ The remaining three entities – Itasca Medical Care (IMCare), PrimeWest Health, and South Country Health Alliance (SCHA) – are licensed as County-Based Purchasing (CBP) organizations. CBP organizations are health plans operated by a county or group of counties, which purchase health care services for certain residents enrolled in Medical Assistance and MinnesotaCare.⁴

Minnesota’s publicly funded managed care programs include:

- **Families & Children Medical Assistance (F&C-MA):** A State-administered program for low-income people who are blind or disabled, low-income families with children, and children who are needy.
- **MinnesotaCare (MNCare):** A State-funded program for working families and people who do not have access to affordable health care coverage and meet certain income, asset, and residency requirements.
- **Minnesota Senior Health Options (MSHO):** A DHS program that combines Medicare and Medicaid financing and acute and long-term care service delivery systems for persons over 65 years of age who are dually eligible for both Medicare and Medicaid.
- **Minnesota Senior Care Plus (MSC+):** A Federal- and State-funded mandatory program for individuals age 65 years and older who qualify for Medical Assistance (Medicaid).
- **Special Needs Basic Care (SNBC):** A voluntary program for individuals, ages 18 – 64 years, who are certified disabled and qualify for Medical Assistance (Medicaid).

³ [Minnesota Department of Health Health Maintenance Organizations in Minnesota Website](#)

⁴ [Minnesota Department of Health Health Plan Information – County Based Purchasing Website](#)

Table 1: MCO 2016 Participation by Program

MCO	Managed Care Program				
	F&C-MA	MNCare	MSHO	MSC+	SNBC
Blue Plus	•	•	•	•	
HealthPartners	•	•	•	•	•
Hennepin Health	•	•			
IMCare	•	•	•	•	
Medica	•	•	•	•	•
MHP					•
PrimeWest Health	•	•	•	•	•
SCHA	•	•	•	•	•
UCare	•	•	•	•	•

The DHS/MCO Contract specifies the relationships between the purchaser and the MCOs and explicitly states compliance requirements for finances, service delivery, and quality of care terms and conditions. DHS and the MCOs meet throughout the year to ensure ongoing communication between the purchaser and the MCOs and to discuss Contract issues.

DHS contracts with IPRO to serve as its EQRO. As part of the agreement, IPRO performs an independent analysis of MCO performance relative to quality, access, and timeliness of health care services. This report is the result of IPRO’s 2016 evaluation and review.

The purpose of the 2016 ATR is to present the results of the quality evaluations performed in accordance with the BBA of 1997,⁵ review the strengths and weaknesses of each MCO, provide recommendations for improvement, and provide technical assistance to the MCOs. This report provides insight into the performance of the MCOs on key indicators of health care quality for enrollees in publicly funded programs.

Forming the foundation for improving care for the populations served by DHS is the Quality Strategy. CMS requires that each State Medicaid agency has a written strategy for evaluating the quality of care of its publicly funded managed care programs. The DHS Quality Strategy operationalizes the theories and precepts influencing the purchase of managed health care services for publicly funded programs. The strategy is designed to assess the quality and appropriateness of care and service provided by MCOs for all managed care contracts, programs, and enrollees. It is aimed at achieving seven essential outcomes:

⁵ Subpart E, 42 Code of Federal Regulations (CFR), Section 438.364

1. Purchasing quality health care services
2. Protecting the health care interests of managed care enrollees through monitoring
3. Assisting in the development of affordable health care
4. Reviewing and realigning DHS policy and procedures that act as unintended barriers to the effective and efficient delivery of health care services
5. Focusing on health care prevention and chronic disease improvements consistent with enrollee demographics and cultural needs
6. Improving the health care delivery system's capacity to deliver desired medical care outcomes through process standardization, improvement, and innovation
7. Strengthening the relationship between the patients and health care providers

Purchasing quality health care services is the primary outcome of the Quality Strategy. To achieve this outcome, there must be measurement of improvement in enrollee health status and satisfaction. DHS's Quality Strategy is framed on the key standards in Subpart D of the Medicaid Managed Care Regulation (*Quality Assessment and Performance Improvement*): Access, Structure and Operations, and Measurement and Improvement.

To facilitate and promote achievement of the Quality Strategy goals, DHS conducts yearly activities, including three (3) mandatory EQR-related activities for each contracted MCO pursuant to the BBA, Code of Federal Regulation (CFR) 438.358. IPRO, as the EQRO, provides analysis of the results. Mandatory EQR activities for each contracted MCO include the following:

- **Validate Performance Measures:** DHS contracts with MetaStar, a certified HEDIS® vendor, to evaluate the DHS information system's ability to collect, analyze, integrate, and report data. The evaluation includes extensive examinations of DHS's ability to monitor data for accuracy and completeness.
- **Validate Performance Improvement Projects (PIPs):** DHS validates that each MCO develops its proposed PIPs in a manner designed to achieve significant improvement that is sustainable over time and consistent with Federal protocols.
- **Review MCO Compliance with Federal and State Standards Established by DHS:** DHS uses MDH QAE and TCA audits to determine whether MCOs meet requirements relating to access to care, structure and operations, and quality measurement and improvement.

Minnesota Health Care Programs help people who live in Minnesota pay for all, or some, medical bills. The programs are generally for people who cannot get or afford health insurance elsewhere. Some people who already have insurance may also be eligible for help. To obtain coverage, there are rules about income, assets, insurance coverage, and other factors. Some rules vary for different people; for example, the income limit depends on age, living situation, and pregnancy or disability status.

Within the State of Minnesota, publicly funded medical assistance is available for:

- Pregnant women
- Families and children
- Adults with disabilities
- Children with disabilities
- People 65 years or older
- Adults without children

Coverage is also available for the following people who meet certain eligibility criteria:

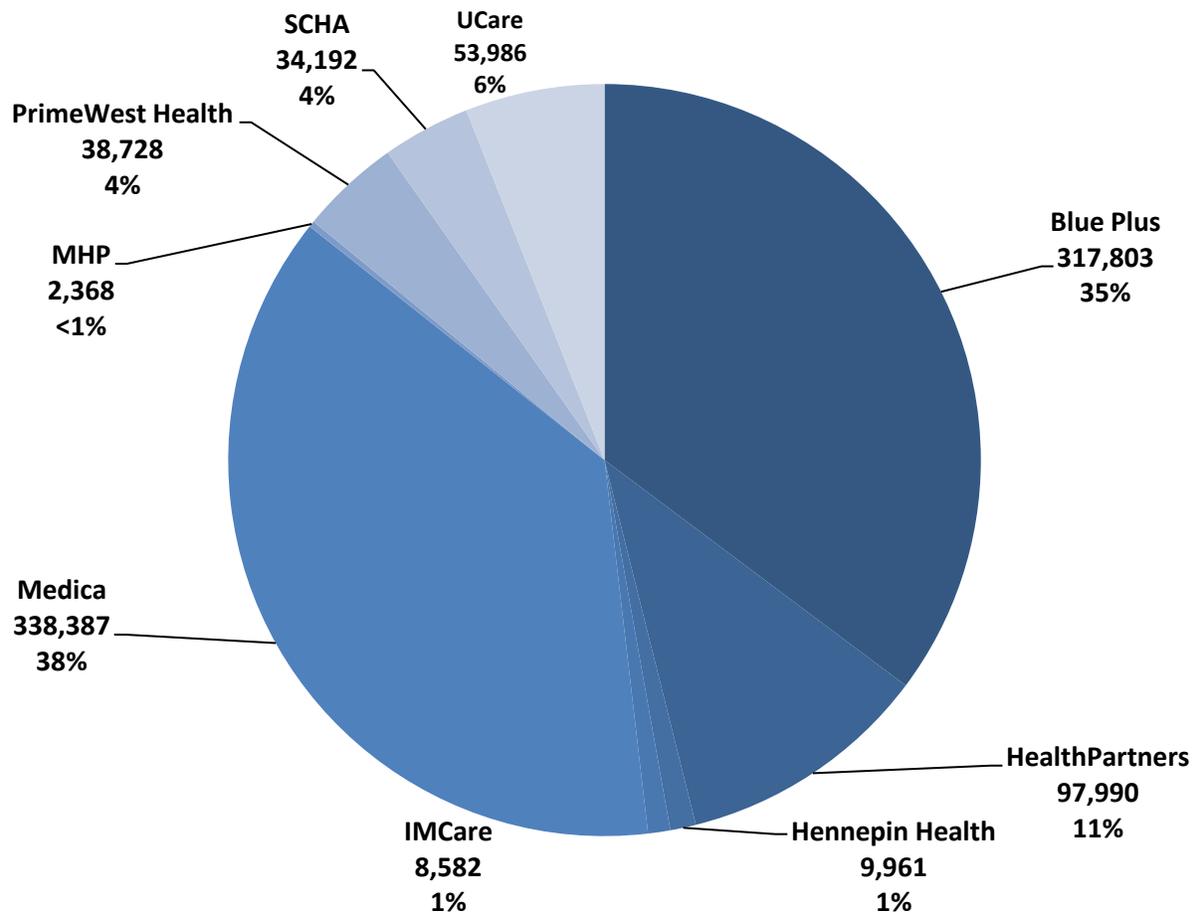
- People who need nursing home care or home care
- Employed persons with disabilities
- People who want only family planning coverage
- People who have breast or cervical cancer and have been screened by the Sage Program⁶

⁶ Please visit the Minnesota Department of Health SAGE Screening Program.

[Minnesota Department of Health Breast and Cervical Cancer Screening – Sage Program Website](#)

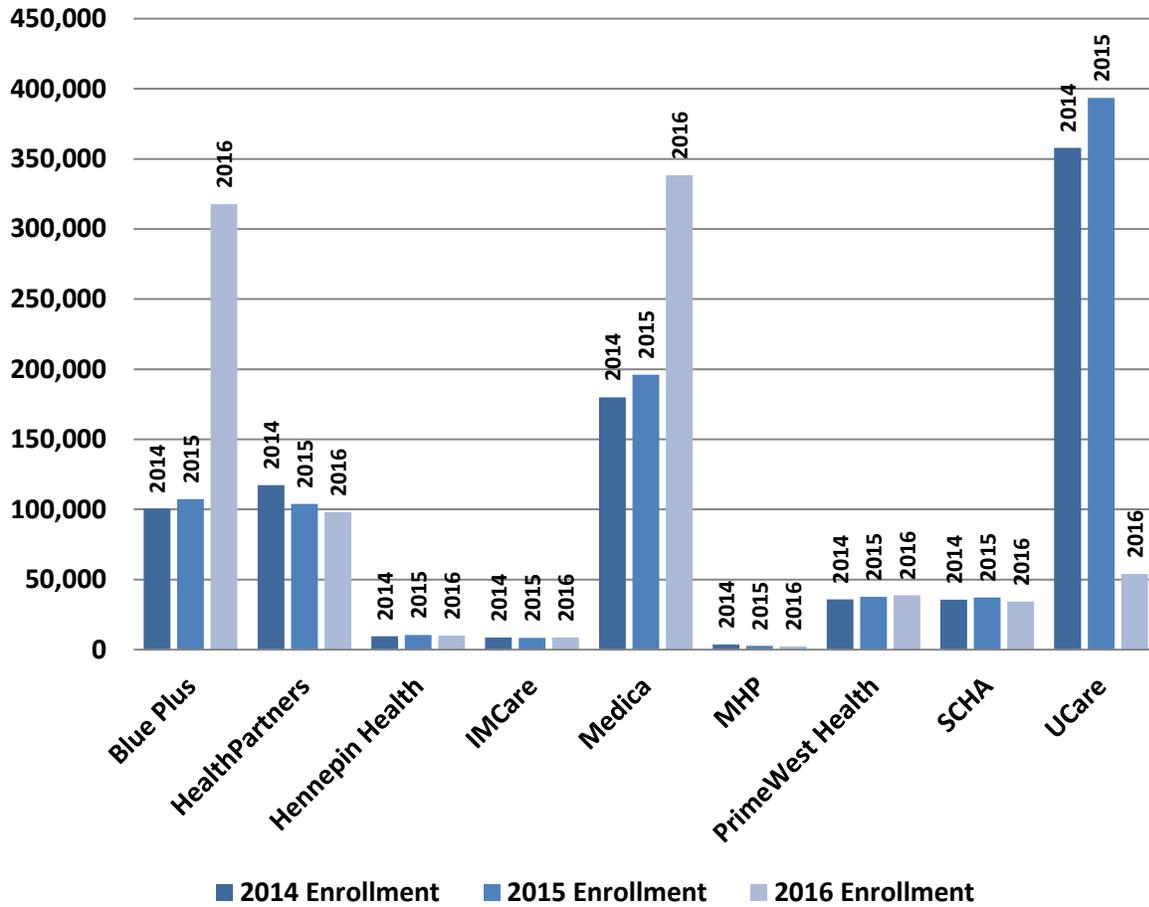
As of December 2016, total enrollment for MHCP was 901,997; a 0.5% increase since December 2015.⁷ Figure 1 displays December 2016 MHCP enrollment by MCO while Figure 2 trends MHCP enrollment for December 2014, December 2015 and December 2016.

Figure 1: MHCP Enrollment by MCO – December 2016



⁷ Enrollment data presented in Chapters 1 and 3 of this report derive from the [DHS MHCP Enrollment Totals December 2016 Report](#).

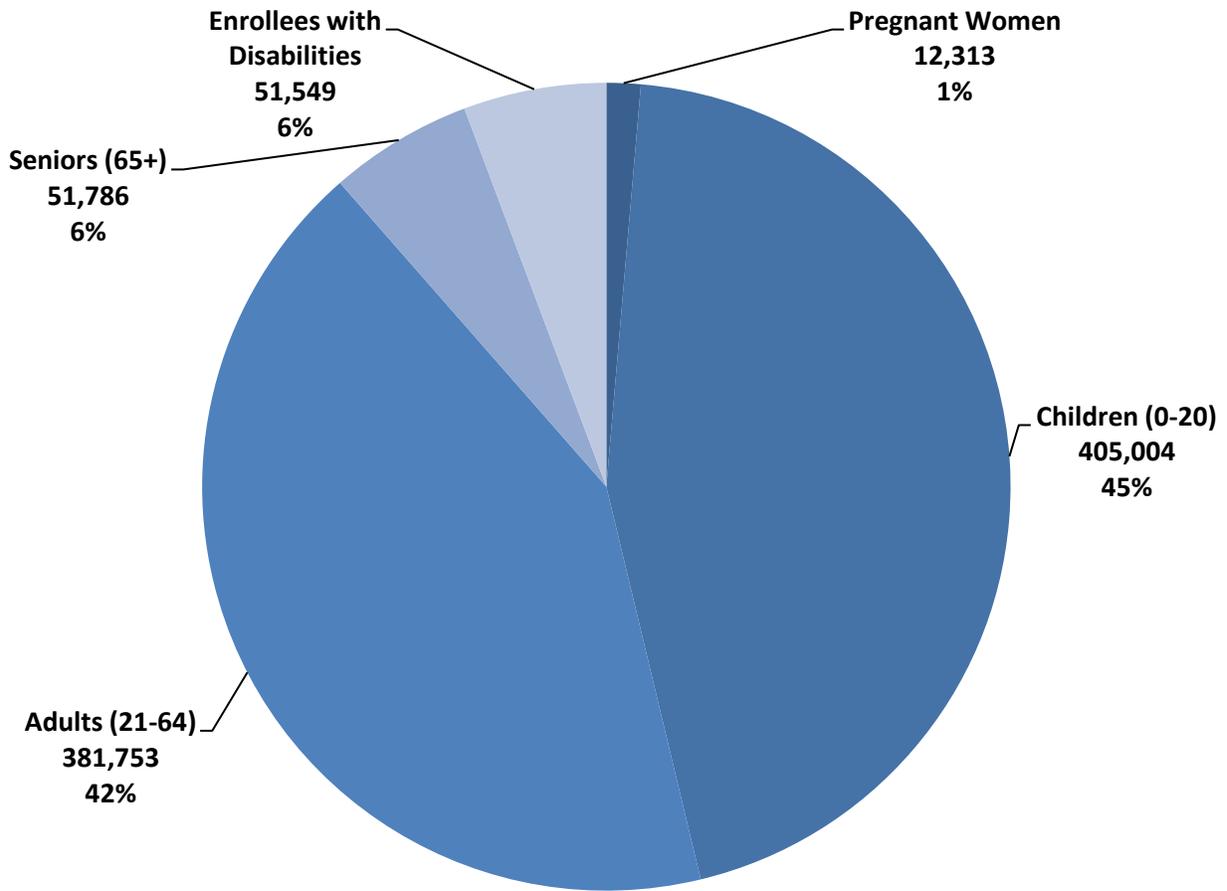
Figure 2: MHCP Enrollment Trends by MCO
 – December 2014, December 2015 and December 2016



Note: UCare’s enrollment decline from 2015 to 2016 is attributed to a reduction of its F&C-MA service area. In 2016, the MCO provided F&C-MA coverage in Olmstead County only.

As displayed in Figure 3, children are the largest population served by MHCP, accounting for 45% of the total enrollment. Despite the slight decline in adult enrollment, the overall December 2016 population breakdown is similar to that observed in December 2015.

Figure 3: Enrollment by Population Type – December 2016



Chapter 2: Summary of DHS Activities

2016 Health Care Disparities Report

In 2017, DHS contributed to the production of the MN Community Measurement[®] *2016 Health Care Disparities Report for Minnesota Health Care Programs*. The report provides health care performance rates for patients enrolled in managed care. Eight (8) of the nine (9) MHCP statewide measure have improved since last year, with five (5) of these improvements being statistically significant: Optimal Asthma Control – Children Ages 5-17, Childhood Immunization Status (Combo 3), Colorectal Cancer Screening, Appropriate Testing for Children with Pharyngitis and Appropriate Treatment for Children with URI. Chlamydia Screening in Women was the only measure to decline; however this change was not statistically significant.

This report also explores the difference in performance rates between patients enrolled in MHCP and patients enrolled in managed care programs of Other Purchasers (private, employer-based health care insurance, or Medicare managed care programs) at a statewide and medical group level. The report reveals that the largest gaps between MHCP and Other Purchaser patients occur on three (3) measures: Colorectal Cancer Screening, Breast Cancer Screening, and Optimal Vascular Care. Statewide gaps in performance between MHCP and Other Purchasers have narrowed over time for Chlamydia Screening in Women, Appropriate Treatment for Children with Pharyngitis, Controlling High Blood Pressure, Childhood Immunization Status (Combo 3), Optimal Asthma Control – Adults Ages 19-50, and Colorectal Cancer Screening.

Another topic in this report focuses on the differences between racial/ethnic groups within the MHCP population for seven (7) HEDIS[®] measures.

The American Indian/Alaskan Native racial group has the lowest rates for Childhood Immunization Status (Combo 3) and Breast Cancer Screening, which are significantly lower than the MHCP statewide rates. The Black or African American group has the highest rates for Appropriate Testing for Children with Pharyngitis and Chlamydia Screening in Women, which are significantly higher than the statewide MHCP rates. The multiracial group has the highest rate for Childhood Immunization Status (Combo 3) and the lowest rate for Controlling Blood Pressure. These rates are respectively significantly higher and lower than the statewide MHCP rates. The Asian group has the highest rate for Appropriate Treatment for Children with Upper Respiratory Infection (URI) which is significantly higher than the statewide MHCP rate. Lastly, the White racial group has the lowest rate for Appropriate Treatment for Children with URI which is significantly below the statewide MHCP rate, and performs significantly higher than the statewide MHCP rates for Breast Cancer Screening and the lowest Chlamydia Screening in Women.

A final element in the 2016 report is the regional analysis for the MHCP population. The Northwest region has the lowest rate for four (4) measures, all of which are significantly below the MHCP statewide rate: Optimal Diabetes Care, Depression Remission at Six Months, Optimal Asthma Care (children ages 5-17), and Optimal Asthma Care (adults ages 18-50). This region does not have the highest screening rate for any measure. The Northeast region had the lowest rate for the Optimal Vascular Care measure. This region

had the highest rate for one measure (Colorectal Cancer Screening). The rates were significantly above the MHCP statewide rate for two measures (Optimal Asthma Control – Adults Ages 18-50 and Colorectal Cancer Screening). The Metro region had the highest rate for four measures (Optimal Diabetes Care; Optimal Vascular Care; Depression Remission at Six Months; Optimal Asthma Control – Children Ages 5-17). The rates for Optimal Diabetes Care; Optimal Vascular Care; Depression Remission at Six Months; Optimal Asthma Control – Children Ages 5-17 were significantly above the MHCP statewide rate. This region had the lowest rate for Colorectal Cancer Screening which was significantly below the MHCP statewide rate. The Southern region had the highest rate for one measure (Optimal Asthma Control – Adults Ages 18-50). The rates for the Optimal Asthma Control – Adults Ages 18-50 and Colorectal Cancer Screening measures were significantly above the MHCP statewide rate. This region did not have the lowest rate for any measure.

The full report, as well as key findings, can be accessed [here](#).

Chapter 3: Evaluation of MCO Strengths and Opportunities

A. Evaluation Process

In order to assess the impact of MHCP on access, timeliness, and quality of health care services, IPRO reviewed pertinent MCO-specific information from a variety of sources including accreditation survey findings, member satisfaction surveys, performance measures, and State monitoring reports. Specifically, IPRO considered the following elements during the 2016 External Quality Review:

- HEDIS® 2017
- 2017 CAHPS® 5.0H Adult Medicaid Survey and 2016 Medicare Advantage and Prescription Drug Plan CAHPS®
- Performance Improvement Projects
- Minnesota Department of Health Quality Assurance Examination and Triennial Compliance Assessment
- 2016 Financial Withhold
- MCO Annual Quality Assurance Work Plan for 2016
- MCO Evaluation of the 2016 Quality Assessment and Performance Improvement Program
- MCO Provider Guidelines

HEDIS® Performance

HEDIS® allows for the standardized measurement of care received. All of the performance measures reported herein are derived from HEDIS® or CAHPS®. For these measures, statewide averages and national Medicaid benchmarks have been provided. HEDIS® benchmarks originate from the National Committee for Quality Assurance (NCQA) *Quality Compass*®⁸ 2017 for Medicaid and represent the performance of all MCOs (excluding PPOs and EPOs) that reported HEDIS® data to the NCQA for HEDIS® 2017 (Measurement Year (MY) 2016). *Note: The NCQA Quality Compass® 2017 did not include benchmarks for the Medication Management for People with Asthma – 50% (5-64 Years) measure.*

Included in this report is a combination of DHS-produced (administrative) and MCO-produced (hybrid) HEDIS® rates in the ATR. Administrative rates were calculated using encounter data and were audited by DHS's NCQA-certified HEDIS® auditor, MetaStar. Hybrid rates were calculated using a mix of claims data and data abstracted from medical records, and were also validated by NCQA-certified HEDIS® auditors. HEDIS® rates produced by the MCOs were reported to the NCQA.

To better identify MCO strengths and opportunities in this area, DHS continues to incorporate the Measure Matrix into the ATR. The Measure Matrix allows for the comparison of MCO performance year-over-year, as well as the comparison of MCO performance to the statewide average. It is a color-coded tool that visually indicates when an MCO's performance rates are notable or whether there is cause for action. For these year-over-year comparisons, the significance of the difference between two

⁸ Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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.

As seen below, boxes in the top row indicate that there was a statistically significant positive change in the rate from 2016, boxes in the middle row indicate no change from 2016, while those in the bottom row indicate a statistically significant negative change in the rate. Similarly, boxes in the right column indicate that the rate for the measure is higher than the statewide average, with those in the middle column being the same as the statewide average, and those in the left column indicating a rate that is lower than the statewide average.

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C	B	A	
	D	C	B	
	F	D	C	

The color of each box depends on its location in both the columns and rows and represents the recommended action:

 The green box (A) indicates notable performance. The MCO's HEDIS® 2017 rate is statistically significantly above the 2017 statewide average and trends up from HEDIS® 2016.

 The light green boxes (B) indicate a potential opportunity for improvement, but no immediate action is required. The MCO's HEDIS® 2017 rate is not different than the 2017 statewide average and is statistically above the HEDIS® 2016 rate or that the MCO's HEDIS® 2017 rate is statistically significantly above the 2017 statewide average but there is no change from HEDIS® 2016.

 The yellow boxes (C) indicate that the MCO should evaluate the measure for opportunities for improvement. The MCO's HEDIS® 2017 rate is statistically significantly below the 2017 statewide average and trends up from HEDIS® 2016 or that the MCO's HEDIS® 2017 rate is not different than the 2017 statewide average and there is no change from HEDIS® 2016 or that the MCO's HEDIS® 2017 rate is statistically significantly above the 2017 statewide average but trends down from HEDIS® 2016.

 The orange boxes (D) indicate poor performance and action based on the results of a root cause analysis. The MCO's HEDIS® 2017 rate is statistically significantly below the 2017 statewide average and there is no change from HEDIS® 2016 or that the MCO's HEDIS® 2017 rate is not different than the 2017 statewide average and trends down from HEDIS® 2016.

 The red box (F) indicates poor performance and action based on the results of a root cause analysis. The MCO's HEDIS® 2017 rate is statistically significantly below the 2017 statewide average and trends down from HEDIS® 2016.

HEDIS® measures selected for inclusion in the Measure Matrix cover three (3) overarching areas of care: chronic conditions, women's health, and child and adolescent care. Measures selected for these categories include:

- Chronic Conditions
 - HEDIS® *Comprehensive Diabetes Care: HbA1c Test*
 - HEDIS® *Comprehensive Diabetes Care: Eye Exam*
 - HEDIS® *Controlling High Blood Pressure*
 - HEDIS® *Medication Management for People with Asthma*
- Women's Health
 - HEDIS® *Breast Cancer Screening*
 - HEDIS® *Cervical Cancer Screening*
 - HEDIS® *Chlamydia Screening in Women*
- Child and Adolescent Care
 - HEDIS® *Adolescent Well-Care Visits*
 - HEDIS® *Childhood Immunization Status: Combo 3*
 - HEDIS® *Well-Child Visits in the First 15 Months of Life (6+ Visits)*
 - HEDIS® *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*

CAHPS® Performance

CAHPS® allows for the standardized measurement of member satisfaction with care received. All of the performance measures reported herein are derived from HEDIS® or CAHPS®. For these measures, statewide averages and national Medicaid benchmarks have been provided. CAHPS® benchmarks originate from the Agency for Healthcare Research and Quality's (AHRQ) CAHPS® Database and represent the performance of all health plans that reported CAHPS® data to the AHRQ for the 2017 Adult Medicaid Survey 5.0 (MY 2016). *Note: The CAHPS® Database did not include benchmarks for the Shared Decision Making composite measure.*

In 2016, DHS contracted with DataStat to conduct the 2017 CAHPS® 5.0H Adult Medicaid Survey on behalf of the participating MCOs who offer F&C-MA, MNCare, MSC+ and SNBC; and contracted with Health Services Advisory Group (HSAG) to analyze and summarize 2016 Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS® data obtained from CMS on behalf of the participating MCOs who offer MSHO. It is important to note that the MA & PDP CAHPS® results presented in this report for all participating MSHO plans represent the survey results calculated by HSAG. They are not official CMS survey results and should be used for QI purposes only.

In the CAHPS® tables that follow, scores for the following composite measures were calculated using responses of “yes” or “always”: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making; Getting Appointments and Care Quickly* (MSHO only), *Doctors Who Communicate Well* (MSHO only), *Getting Needed Prescription Drugs* (MSHO only), *Getting Information from Drug Plan* (MSHO only), and *Care Coordination* (MSHO only); while scores for the following rating measures were calculated using responses of “9” or “10”: *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of Health Plan, Rating of Health Care Quality* (MSHO only), and *Rating of Drug Plan* (MSHO only). MCO scores that were determined to be significantly higher than the statewide averages are indicated by ▲, while MCO scores that were significantly lower than the statewide averages are indicated by ▼. DataStat utilized difference-of-means tests to determine statistical significance. HSAG utilized two types of hypothesis tests to determine statistical significance. First, a global F-test was calculated, which determined whether the difference between MCO-level scores was statistically significant. If the F-test demonstrated MCO-level differences, then a T-test was performed for each MCO. The T-test determined whether each MCO's top-level response score was statistically significantly different from the overall scores of the other participating MCOs in the state. Scores that were significantly higher than the statewide averages were considered strengths, and scores that were significantly lower than the statewide averages were considered opportunities for improvement.

The 2017 Managed Care Public Programs: Consumer Satisfaction Survey Results Report can be accessed [here](#).

Performance Improvement Projects (PIPs)

MCOs are contractually required to conduct Performance Improvement Projects (PIPs) and to report annually on their progress. These PIPs use targeted interventions and ongoing measurements to significantly improve care quality. Ideally, these improvements in care are sustained over time. The PIPs must address clinical and non-clinical areas, and are expected to improve both enrollee health outcomes as well as enrollee satisfaction with their care and MCO. The measurement process includes a baseline, generally a three-year average of the measurement selected, and explicit and precisely defined goals. PIPs are considered completed when the goal has been reached and two more consecutive measurements sustain the improvement. PIPs reported in the ATR were validated by the DHS Health Program Quality Team to ensure MCO compliance with Federal protocols. DHS's assessments of the PIPs were considered during IPRO's evaluation of the MCO.

Starting with the 2015-2017 PIPs, the DHS PIP reporting requirements were modified to resemble the Medicare format. PIPs run for three (3) years and follow BBA guidelines for PIP protocols. MCO progress is monitored through the annual submission of interim reports. As DHS has identified disparities in care for enrollees with mental health conditions, DHS selected the following overarching PIP topic for 2015-2017 period, *Reduction of Race and Ethnic Disparities in the Management of Depression*.

Descriptions of MCO-specific PIP topics, PIP goals, and baseline and final measurement rates are reported in Section B: MCO Evaluations. Please note that reported PIP status is as of December 31, 2016.

Quality Assurance Examination and Triennial Compliance Assessment

Federal regulations require DHS to conduct triennial, on-site contract compliance validation assessments of each contracted MCO. DHS uses MDH Quality Assurance examinations (MDH-QA) and Triennial Compliance Assessment (TCA) audits to determine whether MCOs meet requirements relating to access to care, structure and operations, and quality measurement and improvement.

While the Quality Assurance examinations and Triennial Compliance Assessments are conducted every three (3) years, the process is staggered and is conducted at different times for each MCO. A summary of recommendations, mandatory improvements and deficiencies from the *most recent* exam is presented for each MCO and was considered during IPRO's evaluation of the MCO. Recommendations are areas where, although compliant with law, opportunities for improvement were identified. The MCO submits a Corrective Action Plan (CAP) to correct 'not-met' determinations, if necessary. If the MCO fails to submit a CAP within 30 days, and/or address contractual obligation compliance failures, then financial penalties will be assessed. Deficiencies are violations of law. (*The most recent Quality Assurance Examination and Triennial Compliance Assessment reports can be accessed [here](#).*)

2016 Financial Withhold

The overall purpose of the Financial Withhold is to emphasize and focus MCO and health care provider improvement efforts in the areas of prevention or early detection and screening of essential health care services. Specifically, the 2016 DHS-MCO contract allows the State to withhold a percentage of the capitation payments due to the MCO, only to be returned if the MCO meets performance targets determined by the State. MCO performance in the 2016 Financial Withhold is displayed in the following subsection of this report and was considered during IPRO's evaluation. *Note: MCO rates for the following programs are considered unreliable due small sample sizes and therefore excluded from total point calculations: HealthPartners' Annual Dental Visit rate for the SNBC program; Hennepin Health's Hospital 30-Day Readmission Rate for the F&C-MA and MNCare programs; IMCare's Well Child Visits in the First 15 Months of Life and Hospital 30-Day Readmission rates for the F&C-MA and MNCare programs; PrimeWest's Hospital 30-Day Readmission rate for the F&C-MA and MNCare programs; SCHA's Hospital 30-Day Readmission rate for the F&C-MA and MNCare programs; and UCare's rate for the Hospital 30-Day Readmission rate for the F&C-MA and MNCare programs.*

MCO Annual Quality Assurance Work Plan for 2016

Each MCO submits an annual written work plan that details proposed quality assurance and performance improvement projects for the year. At a minimum, the work plan must present a detailed description of the proposed quality evaluation activities, including proposed focused studies, and their respective timetables for completion. Summaries of all MCO Annual Quality Assurance Work Plans follow; however, these reports were not evaluated as part of the EQR process.

MCO Evaluation of the 2016 Quality Assessment and Performance Improvement Program

Each MCO conducts an annual quality assessment and performance improvement program evaluation consistent with State and Federal regulations, and current NCQA *Health Plan Accreditation* standards and requirements. The evaluation reviews the impact and effectiveness of the MCO's quality assessment and performance improvement program, including performance on standard measures and performance improvement projects. Summaries of all MCO Annual Quality Assessment and Performance Improvement Program Evaluation reports follow; however, these reports were not evaluated as part of the EQR process.

MCO Provider Guidelines

MCOs are required to adopt, disseminate, and apply practice guidelines consistent with current NCQA *Health Plan Accreditation Requirements – Practice Guidelines (QI 9)*. Adopted guidelines should be:

- Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Reflective of the needs of the MCO's enrollees
- Adopted in consultation with contracting health care professionals
- Reviewed and updated periodically as appropriate
- Disseminated to all affected providers and, upon request, to enrollees and potential enrollees
- Applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines

Summaries of all MCO provider guidelines follow; however, this information was not evaluated as part of the EQR process.

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B. MCO Evaluations

This section presents MCO-specific performance, as well as strengths, opportunities for improvement, and recommendations identified by IPRO during the external quality review process.

In regard to the HEDIS® performance measures, please note the following:

- As the MCOs were not required to report HEDIS® for the MSC+ program, there are no hybrid performance measures presented for the MSC+ program in this section of the report. However, a total of three (3) DHS administrative measures are presented.
- For the F&C-MA program, a total of six (6) MCO-produced rates are presented, while thirteen (13) DHS-produced rates are presented.
- For the MNCare program, a total of five (5) MCO-produced rates are presented, while eleven (11) DHS-produced rates are presented.
- For the MSHO program, a total of two (2) MCO-produced rates are presented, while two (2) DHS-produced rates are presented.
- For the SNBC program, a total of four (4) MCO-produced rates are presented, while six (6) DHS-produced rates are presented. *(Counts will vary if the MCO produced SNP and Non-SNP rates.)*

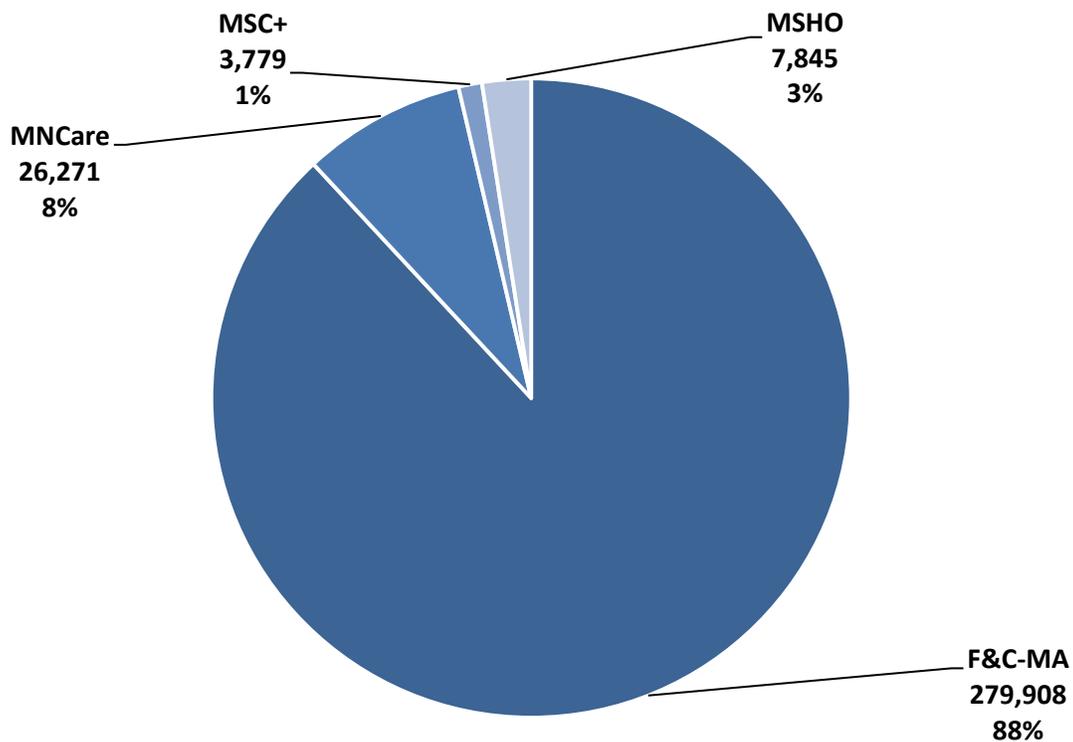
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Blue Plus

Corporate Profile

Blue Plus, a wholly owned subsidiary of BlueCross BlueShield of Minnesota, is a licensed HMO. In addition to offering a range of commercial products, Blue Plus contracts with DHS to deliver and administer F&C-MA, MNCare, MSC+ and MSHO. Blue Plus has provided managed care coverage for MHCP since 1993. The MCO achieved NCQA accreditation status for its Medicaid lines of business for the 2016-2017 NCQA rating period. As of December 2016, enrollment totaled 317,803, accounting for 35% of the entire MHCP population.

Figure 4: Blue Plus Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on November 16, 2015 through November 20, 2015. The examination period covered April 1, 2013 to September 30, 2015, while the file review period covered September 1, 2014 to August 31, 2015. While it was determined that the MCO was fully compliant with contractual standards reviewed for the TCA, the MCO received a total of three (3) recommendations, two (2) mandatory improvements, and two (2) deficiencies for the QAE.

Performance Improvement Project

The following PIP is in progress:

- **Reducing Race and Ethnic Disparities in the Management of Depression (2015-2017)** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP is to reduce, by 4 percentage points, the disparity between non-Hispanic White and non-White F&C-MA and MNCare members as indicated by the HEDIS® *Antidepressant Medication Management – Continuation Phase* measure. Table 2 displays the MCO’s baseline rates for this PIP.

Table 2: Blue Plus Baseline Rates – 2015 PIP

HEDIS® Year	Non-Hispanic White	Non-White	Disparity
2014	39.99%	31.93%	-8.06%
2015	41.59%	28.46%	-13.13%
2016	39.61%	27.77%	-11.84%
Change	-0.38	-4.16	+3.78

Member-focused interventions include:

- Member outreach via mail to members from racial and ethnic minority groups who recently filled new prescriptions for antidepressant medication. This mailing will include a letter and a “tip sheet” on depression and antidepressants. Targeted members will be identified monthly via pharmacy claims data.
- Telephonic outreach targeted at African American members who had been identified for the mailing intervention. Members will be prioritized for this intervention via medical claims for the diagnosis of major depression.

Provider-focused interventions include:

- In collaboration with the other MCOs listed above, development of provider training opportunities on cultural competency, depression, and its treatment. The MCOs anticipate conducting trainings in partnership with other organizations, such as the National Alliance on Mental Illness Minnesota (NAMI-MN), and promoting them to various health care providers.
- An electronic provider toolkit will be developed, which may include: a shared decision making tool to help providers educate and engage patients on depression and treatment options; a list of pharmacies that provide translators and/or medication instructions in different languages; and patient resources, such as brochures and resources within the community.

Community-focused interventions include:

- A community event to increase awareness during Minority Mental Health Month in July.
- Working with organizations, such as NAMI-MN, religious groups, targeted clinics, and other community organizations, to identify channels for promoting awareness.
- Sharing depression resources at local health fairs.
- Promoting culturally specific community events related to depression and mental health.

MCO-focused interventions include:

- In collaboration with other MCOs, development of common messaging for member and provider resources to ensure members and providers receive the same information with the same terminology.

2016 Financial Withhold

Blue Plus achieved 62.02 of 105 points for the F&C-MA and MNCare programs, and achieved 75 of 90 points for the MSHO and MSC+ programs. Table 3 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by Blue Plus.

Table 3: Blue Plus 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	0
Annual Dental Visit: Age 7-18 Years	5	0
Annual Dental Visit: Age 19-64 Years	5	2.02
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	0
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	15	0
Total	105	62.02
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75

Annual Quality Assurance Work Plan for 2016

Blue Cross Blue Shield submitted an annual Quality Assurance Work Plan that is fully compliant with Minnesota Administrative Rule 4685.1130. The MCO proposed focused studies for numerous topics; work plans for each activity are represented in a consistent and concise manner. The MCO chose to track milestones on a quarterly basis and perform yearly activity evaluations, which are included in the Program Evaluation. The MCO included an Evaluation Activities Calendar to track the process steps and timelines for evaluating different parts of the QI program. Process steps for each track include: survey preparation, survey/study in the field, quantitative and qualitative analysis, and leadership review. Work plans are formatted with the title of the topic to be studied, director(s) who approved the proposed study, rationale for the study topic, study methodology, sampling methodology, criteria that the MCO will use for evaluation, and benefits that the focused study will offer. Lastly, the MCO describes the benefits of each project for their members and how these benefits apply to NCQA and Minnesota State law standards.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

Blue Plus's quality improvement (QI) program aims to achieve the highest quality of care through emphasizing health improvement and the clinical process of care. The QI program monitors various aspects of clinical care, clinical and organizational service provided to members, and identifies opportunities for enhancing existing programs, as well as developing new programs. The scope of the 2016 QI program included activities in the following major areas: provider quality initiatives, population health improvement, health promotion/wellness, patient safety, behavioral health, service quality, oversight of delegated relationships and quality infrastructure. Blue Plus continues to commit to improving the quality of care and service delivered to MCO members.

In 2016, Blue Plus continued its program for in-house HEDIS® medical record review with the goal of transitioning vendor-provided HEDIS® abstraction nurses to permanent MCO employees. Blue Plus experienced some resource barriers during 2016, including budgetary restraints on Appointment Access and Accuracy of Provider Directory Surveys and multiple project demands, which caused some reporting delays. Overall, Blue Plus's QI program seems an effective means of improving quality of care and services provided to its members.

MCO Provider Guidelines

Blue Plus relies on the following sources for clinical practice guidelines related to behavioral health, chronic conditions and preventive care: the U.S. Preventive Services Task Force (USPSTF), the Health Resources and Services Administration, the Institute for Clinical Systems Improvement (ICSI), the American Psychiatric Association (APA), the American Academy of Pediatrics (AAP), the American Diabetes Association (ADA), the National Heart, Lung and Blood Institute (NHLBI), the Global Initiative For Chronic Obstructive Lung Disease (GOLD), the American Heart Association (AHA), the National Osteoporosis Foundation (NOF), and the Advisory Committee on Immunization Practices (ACIP) for the Centers for Disease Control and Prevention (CDC). Blue Plus recommended clinical guidelines include: diagnosis, evaluation, and treatment of ADHD in children and adolescents; treatment of major depressive disorder in adults; prevention and management of diabetes in adults; diagnosis and management of asthma; management of chronic obstructive pulmonary disease (COPD); management of heart failure;

management of high blood pressure; prevention and treatment of osteoporosis; preventive services for children, adolescents, and adults; and routine prenatal care.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 4 and 5, respectively. The results of the MCO's Measure Matrix analysis are presented in Figure 5.

Table 4: Blue Plus HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	Blue Plus HEDIS® 2015	Blue Plus HEDIS® 2016	Blue Plus HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	35.9%	39.4%	36.8%	10 th	39.1%
Adult BMI Assessment ¹	89.6%	90.7%	90.3%	66.67 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	88.8%	86.0%	87.1%	90 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	90.7%	88.7%	88.9%	66.67 th	88.6%
Breast Cancer Screening (50-64 Years) ²	60.4%	58.9%	62.2%	50 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	65.4%	58.0%	60.2%	50 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	79.4%	74.7%	75.5%	66.67 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.6%	97.5%	97.3%	75 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	90.7%	90.4%	90.4%	66.67 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	92.6%	92.8%	92.4%	66.67 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	92.9%	93.3%	93.2%	75 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	50.7%	50.2%	53.5%	33.33 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	90.7%	93.8%	96.0%	95 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	71.0%	71.5%	65.6%	75 th	70.4%
Controlling High Blood Pressure ¹	64.1%	68.6%	66.9%	75 th	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	57.5%	55.0%	63.5%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	34.4%	33.2%	40.2%	66.67 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	63.2%	63.5%	67.7%	66.67 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	61.4%	62.4%	63.8%	10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 4: Blue Plus HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	Blue Plus HEDIS® 2015	Blue Plus HEDIS® 2016	Blue Plus HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	28.6%	26.9%	23.4%	<10 th	28.6%
Adult BMI Assessment ¹	84.7%	90.0%	90.5%	75 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	82.8%	80.2%	83.4%	66.67 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	88.6%	87.0%	89.3%	75 th	88.0%
Breast Cancer Screening (50-64 Years) ²	68.2%	66.9%	68.7%	75 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	49.4%	50.3%	53.7%	25 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	98.2%	92.6%	75 th	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	97.1%	90.2%	50 th	91.1%
Chlamydia Screening in Women (16-24 Years) ²	48.3%	51.6%	52.3%	33.33 th	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	96.0%	94.5%	95.9%	95 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	71.4%	69.5%	62.8%	66.67 th	69.7%
Controlling High Blood Pressure ¹	66.2%	69.3%	74.2%	95 th	70.3%
Medication Management for People With Asthma – 50% (5-64 Years) ²	68.6%	70.3%	82.3%	Not Available	70.0%
Medication Management for People With Asthma – 75% (5-64 Years) ²	42.9%	41.8%	53.2%	90 th	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	58.1%	66.7%	25 th	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 4: Blue Plus HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	Blue Plus HEDIS® 2015	Blue Plus HEDIS® 2016	Blue Plus HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.7%	98.8%	98.2%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	61.8%	67.4%	67.5%	75 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	94.7%	96.5%	94.9%	95 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	81.9%	80.1%	81.0%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	92.7%	98.6%	93.1%	75 th	93.7%
Breast Cancer Screening (65-74 Years) ²	55.4%	55.3%	56.0%	33.33 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	89.1%	87.8%	89.3%	66.67 th	74.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 5: Blue Plus 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C	<ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) Chlamydia Screening in Women (F&C-MA) 	<ul style="list-style-type: none"> Cervical Cancer Screening (MNCare) Medication Management for People with Asthma-50% (F&C-MA) Well-Child Visits in the First 15 Months of Life (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	<ul style="list-style-type: none"> Medication Management for People with Asthma-75% (F&C-MA)
	D	<ul style="list-style-type: none"> Adolescent Well-Care Visit (MNCare) Comprehensive Diabetes Care – Eye Exam (F&C-MA) Chlamydia Screening in Women (MNCare) 	<ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA) Breast Cancer Screening (F&C-MA, MNCare) Controlling High Blood Pressure (F&C-MA, MNCare) Comprehensive Diabetes Care – Eye Exam (MSHO) Comprehensive Diabetes Care – HbA1c Testing (MNCare) Childhood Immunization Status – Combo 3 (F&C-MA) Medication Management for People with Asthma-75% (MNCare) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare) 	<ul style="list-style-type: none"> Breast Cancer Screening (MSC+, MSHO) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSC+, MSHO) Medication Management for People with Asthma-50% (MNCare)
	F	<ul style="list-style-type: none"> Comprehensive Diabetes Care – Eye Exam (MNCare) 		

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 5: Blue Plus CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	Blue Plus CAHPS® 2015	Blue Plus CAHPS® 2016	Blue Plus CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	54%	53%	50%	<25 th	54%
Getting Care Quickly	61%	62%	58%	25 th	58%
How Well Doctors Communicate	83%▲	78%	85%	90 th	81%
Customer Service	72%	74%	62%	<25 th	66%
Shared Decision Making	54%▲	86%▲	82%	Not Available	82%
Rating of All Health Care	60%▲	60%▲	56%	50 th	55%
Rating of Personal Doctor	74%▲	72%	72%	90 th	72%
Rating of Specialist Seen Most Often	63%	67%	75%▲	90 th	64%
Rating of Health Plan	64%▲	62%▲	58%	50 th	59%
MNCare					
Getting Needed Care	65%▲	53%	57%	50 th	57%
Getting Care Quickly	68%▲	53%	61%	50 th	60%
How Well Doctors Communicate	84%	78%	75%	50 th	79%
Customer Service	66%	59%	56%	<25 th	58%
Shared Decision Making	52%	82%	85%	Not Available	84%
Rating of All Health Care	62%▲	54%	51%	25 th	55%
Rating of Personal Doctor	76%▲	69%	68%	75 th	68%
Rating of Specialist Seen Most Often	73%	72%	71%	75 th	66%
Rating of Health Plan	57%	50%	46%▼	<25 th	52%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

Table 5: Blue Plus CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	Blue Plus CAHPS® 2015	Blue Plus CAHPS® 2016	Blue Plus CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	60%	59%	60%	90 th	61%
Getting Care Quickly	66%	66%	65%	90 th	67%
How Well Doctors Communicate	82%	78%	77%	75 th	77%
Customer Service	74% [▲]	63%	65%	25 th	70%
Shared Decision Making	51%	76%	80%	Not Available	78%
Rating of All Health Care	59%	63%	65%	90 th	62%
Rating of Personal Doctor	83% [▲]	79%	77%	90 th	76%
Rating of Specialist Seen Most Often	73%	72%	78%	90 th	75%
Rating of Health Plan	74% [▲]	69%	72% [▲]	90 th	69%
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	63%	Not Available	59%
Getting Appointments & Care Quickly			56%		53%
Doctors Who Communicate Well			75%		74%
Customer Service			72%		75%
Getting Needed Prescription Drugs			83%		80%
Getting Information from Drug Plan			66%		64%
Care Coordination			72%		72%
Rating of Health Plan			70%		71%
Rating of All Health Care Quality			54%		60%
Rating of Drug Plan			73%		73%

[▲] Rate is significantly higher than the statewide average.

Strengths

- **NCQA Accreditation Survey** – Blue Plus maintained its NCQA accreditation for the F&C-MA and MNCare programs.
- **HEDIS® (Quality of Care)** – Blue Plus performed well in regard to one area of care:
 - F&C-MA
 - *Medication Management for People with Asthma – 75%*
- **CAHPS® (Member Satisfaction)** – Blue Plus performed well in regard to the following areas of member satisfaction:
 - F&C-MA
 - *Rating of Specialist Seen Most Often*
 - MSC+
 - *Rating of Health Plan*
- **TCA** – Blue Plus was fully compliant with contractual standards reviewed for the TCA.
- **PIP** – The 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as a multifaceted intervention strategy that targets members, providers, the community, and the MCO.

Opportunities for Improvement

- **Financial Withhold** – Blue Plus did not achieve full points for the F&C-MA, MNCare, MSHO and MSC+ programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years, 7-18 years and 19-64 years
 - Emergency Department Utilization Rate
 - Hospital 30-Day Readmission Rate
 - MSHO and MSC+
 - Annual Dental Visits: Age group 65 years and older
- **HEDIS® (Quality of Care)** – Blue Plus demonstrates an opportunity for improvement in the following areas of care:
 - F&C MA
 - *Comprehensive Diabetes Care – Eye Exam*
 - MNCare
 - *Adolescent Well-Child Visit*
 - *Chlamydia Screening in Women*
 - *Comprehensive Diabetes Care – Eye Exam*
- **CAHPS® (Member Satisfaction)** – Blue Plus demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the statewide average for the following measure:
 - MNCare
 - *Rating of Health Plan*
- **QAE** – Blue Plus received a total of three (3) recommendations, two (2) mandatory improvements, and two (2) deficiencies for the QAE.

Recommendations

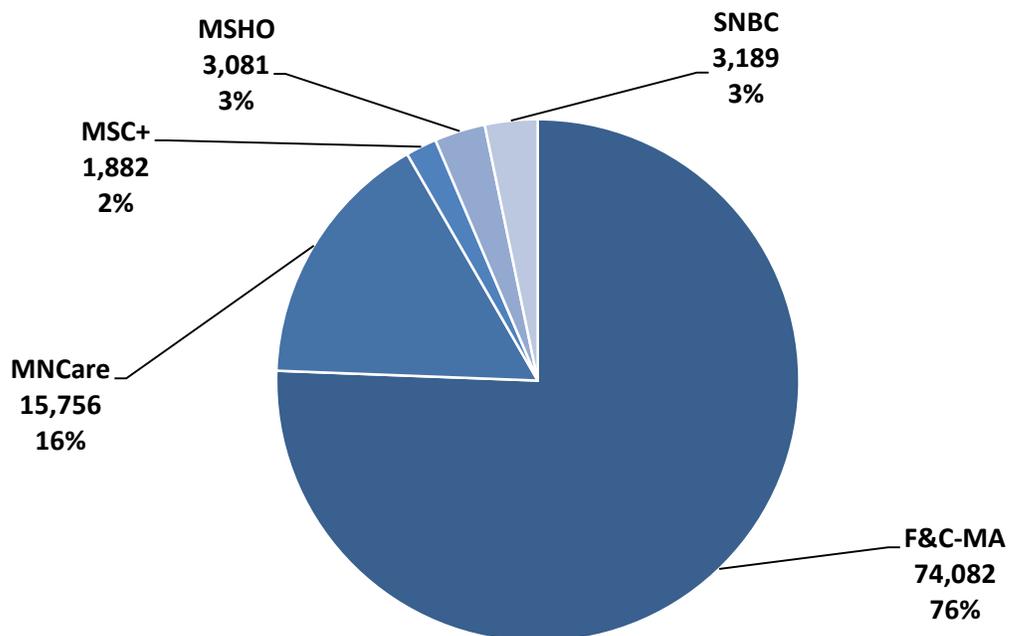
- **Financial Withhold** - Continue to work to address measures that failed to meet target goals. The MCO should ensure its Quality Work Plan is updated to address dental care for all age groups. Additionally, as the MCO continues to struggle with achieving points for the Emergency Department Utilization Rate, the MCO should assess the effectiveness of its current quality improvement strategy for this measure and modify its approach based on an updated root cause analysis.
- **HEDIS® (Quality of Care)** – As the MCO’s chlamydia screening rates trend upward, the MCO should continue with the intervention strategy outlined in the Health Plan’s response to the previous year’s recommendation, routinely monitor the effectiveness of the strategy and modify it as needed. The MCO should enhance its approach toward improving diabetes care and adolescent care to include provider- and system-level interventions.
- **CAHPS® (Member Satisfaction)** – Conduct a thorough root cause analysis for the measure listed above and implement interventions to address identified barriers. Additionally, identify best practices across programs and apply these practices to the MNCare program.

HealthPartners

Corporate Profile

HealthPartners became a managed care entity in 1992. HealthPartners provides services to enrollees in the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. As of December 2016, enrollment totaled 97,990, accounting for 11% of the entire MHCP population.

Figure 6: HealthPartners Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit between May 11, 2015 and May 15, 2015. The evaluation period covered April 1, 2012 to March 31, 2015, while the file review period covered April 1, 2014 to March 31, 2015. While it was determined that the MCO was fully compliant with contractual standards reviewed for the TCA, the MCO received six (6) recommendations, one (1) mandatory improvement, and one (1) deficiency for the QAE.

Performance Improvement Project

The following PIP is in progress:

- **Reducing Race Disparities in the Management of Depression (2015-2017)** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP is to reduce, by 20 percentage points, the disparity between White and non-White F&C-MA and MNCare members as indicated by the HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure. Table 6 displays the MCO’s baseline rates for this PIP.

Table 6: HealthPartners Baseline Rates – 2015 PIP

HEDIS® Year	White	Non-White	Disparity
2015	43.36%	24.65%	-18.71%
2016	44.82%	24.19%	-20.63%
Change	+1.46	-0.37	+1.92

Member-focused interventions include:

- Upon notification that a member has filled a new prescription for an antidepressant, the Behavioral Health team will complete an outreach call, which will include member education about the medication and information about the MCO’s Medication Therapy Management (MTM) program. Interpreters will be available for these calls.
- Members will receive a refill reminder letter when medication refills are due. If the medication is not filled, the members will receive a more specific letter, as well as a phone call. The provider will also receive a letter. HealthPartners will assess the need to translate these letters into different languages.

Provider-focused interventions include:

- In collaboration with the MCOs listed above and external agencies, develop training opportunities on cultural issues and beliefs related to depression and medication management. These trainings will be available to a variety of health care providers and disciplines. HealthPartners’ Behavioral Health staff will participate in cultural awareness activities and education to enhance their skills with outreach to different populations.
- The MCO collaboration will develop an electronic provider toolkit with resources for providers working with culturally diverse patients. The toolkit will include a shared decision making tool aimed at patient education.

- Behavioral Health staff will participate in the HealthPartners' Medical Group to discuss and create process changes to impact depression management in primary care.

Community-focused interventions include:

- A community event to create awareness during Minority Mental Health Month in July.
- Identifying communication channels to promote awareness of depression in minority communities.
- Sharing depression resources at local health fairs.
- Presenting cultural issues on mental health to health care organizations, church groups, community groups, etc.
- Promoting events and issues related to depression and mental health to our members.
- Joint development of posters or other educational materials for the community.

MCO-focused interventions include:

- In collaboration with the MCOs listed above, development of common messaging for member and provider resources to ensure members and providers receive the same information with the same terminology.

2016 Financial Withhold

HealthPartners achieved 80 of 105 points for the F&C-MA and MNCare programs, achieved 75 of 90 points for the MSHO and MSC+ programs and achieved 45 of 45 points for the SNBC program. Table 7 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by HealthPartners.

Table 7: HealthPartners 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	0
Annual Dental Visit: Age 7-18 Years	5	5
Annual Dental Visit: Age 19-64 Years	5	0
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	15	0
Total	105	80
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	Small Sample	Small Sample
Total	45	45

Annual Quality Assurance Work Plan for 2016

HealthPartners submitted an annual quality assurance work plan that is compliant with Minnesota Administrative Rule 4685.1130. The MCO developed a plan that contains quality evaluation activities, as well as focused studies on numerous topics; these activities and studies are represented in a simple and consistent format. The MCO chose to track the progress of each activity on a quarterly basis throughout the yearly period. The work plan includes focus studies that outline: the study topic, study methodology, evaluation criteria, expected benefits, and approval by a qualified representative. Additionally, the MCO lists the specific product lines that the activity will serve, as well as corresponding categories.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

Health Partners' Quality Improvement (QI) Program focused on improving the quality of health care for its members, member satisfaction with the MCO, and making health care affordable. MCO medical and executive leadership are actively involved in the QI Program through the publication of organization-wide performance scorecards, and the Quality Committee of the Board of Directors provides oversight for the QI Program through quarterly reports and meetings. Several committees report to the Quality Committee, including the Pharmacy Quality Utilization & Improvement (QUI), Quality Review Committee, and the Service Quality Council. Each committee has a charter outlining goals, objectives, and purpose statements that is reviewed each year. For 2016, the MCO continued its efforts in several areas, including pharmacy-related quality improvement to increase adherence and reduce cost, as well as reducing disparities in outcomes for members. In 2016, Health Partners planned the implementation of a new email reminder program for its members involved in the Beat the Blues Program for mild-to-moderate depression and anxiety disorders to increase participation.

Throughout 2016, Health Partners achieved many of the established improvement goals for various QI initiatives. The QI Program appears to be effective in achieving the MCO's overall goals of improving quality of care, member satisfaction, and affordability. Health Partners experienced a range of barriers to the successful implementation of the QI Program during 2016. Some barriers to improving health for members included the stigma associated with behavioral health treatment and the facilitation of smooth hand-offs in care to improve coordination of care. Other barriers the MCO encountered included, but were not limited to: challenging eligibility systems and re-procurement of MCO choices, price increases from pharmaceutical manufacturers, and limitations in addressing social determinants of health.

MCO Provider Guidelines

HealthPartners relies on the ICSI to provide a basis for clinical practice guidelines in the areas of preventive services, chronic care and acute conditions. Practitioners are expected to use ICSI guidelines, which are available to them via the MCO's website. Practitioner compliance with clinical guidelines is assessed annually.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 8 and 9, respectively, while Figure 7 displays the HEDIS® Measure Matrix.

Table 8: HealthPartners HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	Health Partners HEDIS® 2015	Health Partners HEDIS® 2016	Health Partners HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	45.0%	42.6%	46.2%	33.33 th	39.1%
Adult BMI Assessment ¹	91.5%	93.4%	94.9%	90 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	86.6%	83.5%	85.2%	75 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	88.5%	86.8%	88.8%	66.67 th	88.6%
Breast Cancer Screening (50-64 Years) ²	64.9%	63.6%	65.6%	75 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	69.1%	61.2%	63.2%	50 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	72.5%	76.9%	75.4%	66.67 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.2%	97.5%	97.7%	75 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	91.3%	90.4%	90.8%	75 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	93.0%	92.8%	92.0%	50 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	92.5%	93.3%	92.3%	66.67 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	69.0%	62.7%	68.9%	75 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	93.2%	92.7%	94.5%	90 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	63.1%	62.8%	65.0%	75 th	70.4%
Controlling High Blood Pressure ¹	73.5%	73.5%	72.3%	90 th	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	50.9%	52.5%	54.4%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	26.5%	28.6%	31.5%	33.33 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	63.8%	64.3%	65.8%	50 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	67.2%	66.7%	66.6%	25 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 8: HealthPartners HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	Health Partners HEDIS® 2015	Health Partners HEDIS® 2016	Health Partners HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	38.1%	26.3%	30.7%	<10 th	28.6%
Adult BMI Assessment ¹	92.0%	92.7%	93.7%	90 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	84.0%	80.5%	80.9%	50 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.7%	87.0%	87.2%	50 th	88.0%
Breast Cancer Screening (50-64 Years) ²	70.6%	71.0%	70.6%	90 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	55.2%	56.2%	53.5%	25 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	86.7%	97.5%	95 th	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	88.9%	Small Sample	Not Applicable	91.1%
Chlamydia Screening in Women (16-24 Years) ²	68.9%	61.4%	63.3%	66.67 th	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	98.6%	97.5%	96.7%	95 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	73.1%	71.6%	67.0%	75 th	69.7%
Controlling High Blood Pressure ¹	73.5%	77.9%	73.5%	90 th	70.3%
Medication Management for People With Asthma – 50% (5-64 Years) ²	Small Sample	57.1%	70.0%	Not Available	70.0%
Medication Management for People With Asthma – 75% (5-64 Years) ²	Small Sample	34.5%	40.0%	66.67 th	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	71.1%	69.4%	33.33 th	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 8: HealthPartners HEDIS® Performance – Reporting Years 2015, 2016 and 2016 (Continued)

HEDIS® Measures	Health Partners HEDIS® 2015	Health Partners HEDIS® 2016	Health Partners HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.1%	98.1%	98.3%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	70.7%	70.8%	62.4%	50 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	96.0%	97.1%	95.5%	95 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	76.0%	79.6%	79.2%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	89.9%	92.8%	90.9%	75 th	93.7%
Breast Cancer Screening (65-74 Years) ²	42.2%	41.8%	36.6%	<10 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	69.2%	64.7%	67.5%	<10 th	74.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 7: HealthPartners 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B	A <ul style="list-style-type: none"> ▪ Cervical Cancer Screening (F&C-MA) ▪ Chlamydia Screening in Women (F&C-MA)
	D <ul style="list-style-type: none"> ▪ Breast Cancer Screening (MSC+) ▪ Comprehensive Diabetes Care – Eye Exam (F&C-MA) ▪ Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	C <ul style="list-style-type: none"> ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSHO, MNCare) ▪ Controlling High Blood Pressure (MNCare) ▪ Comprehensive Diabetes Care – Eye Exam (MSHO, MNCare) ▪ Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MNCare) ▪ Chlamydia Screening in Women (MNCare) ▪ Childhood Immunization Status – Combo 3 (F&C-MA) ▪ Medication Management for People with Asthma-50% (F&C-MA, MNCare) ▪ Medication Management for People with Asthma-75% (F&C-MA, MNCare) ▪ Well-Child Visits in the First 15 Months of Life (F&C-MA) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare) 	B <ul style="list-style-type: none"> ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Controlling High Blood Pressure (F&C-MA) ▪ Comprehensive Diabetes Care – HbA1c Testing (MSHO) ▪ Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	
	F	D <ul style="list-style-type: none"> ▪ Cervical Cancer Screening (MNCare) 	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 9: HealthPartners CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	HealthPartners CAHPS® 2015	HealthPartners CAHPS® 2016	HealthPartners CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	57%	56%	53%	25 th	54%
Getting Care Quickly	58%	60%	60%	50 th	58%
How Well Doctors Communicate	75%	78%	83%	90 th	81%
Customer Service	75%	73%	78% [▲]	90 th	66%
Shared Decision Making	50%	76%	77% [▼]	Not Available	82%
Rating of All Health Care	61% [▲]	57%	61% [▲]	90 th	55%
Rating of Personal Doctor	74%	71%	72%	90 th	72%
Rating of Specialist Seen Most Often	70%	59%	60%	<25 th	64%
Rating of Health Plan	60%	59%	64% [▲]	90 th	59%
MNCare					
Getting Needed Care	55%	56%	52%	25 th	57%
Getting Care Quickly	53% [▼]	51%	60%	50 th	60%
How Well Doctors Communicate	77%	81%	82%	90 th	79%
Customer Service	65%	68%	67%	25 th	58%
Shared Decision Making	44% [▼]	82%	81%	Not Available	84%
Rating of All Health Care	52%	56%	56%	50 th	55%
Rating of Personal Doctor	75%	68%	73%	90 th	68%
Rating of Specialist Seen Most Often	60%	66%	67%	50 th	66%
Rating of Health Plan	54%	50%	50%	<25 th	52%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

Table 9: HealthPartners CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	HealthPartners CAHPS® 2015	HealthPartners CAHPS® 2016	HealthPartners CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Averages
MSC+					
Getting Needed Care	57%	59%	63%	90 th	61%
Getting Care Quickly	61%	66%	67%	90 th	67%
How Well Doctors Communicate	78%	77%	77%	75 th	77%
Customer Service	70%	69%	71%	75 th	70%
Shared Decision Making	49%	75%	75%	Not Available	78%
Rating of All Health Care	61%	59%	58%	75 th	62%
Rating of Personal Doctor	73%	82% [▲]	74%	90 th	76%
Rating of Specialist Seen Most Often	65%	65%	74%	90 th	75%
Rating of Health Plan	65%	73% [▲]	68%	90 th	69%
SNBC					
Getting Needed Care	Not Available	Not Available	51%	<25 th	54%
Getting Care Quickly			60%	50 th	60%
How Well Doctors Communicate			69% [▼]	<25 th	74%
Customer Service			67%	25 th	66%
Shared Decision Making			78%	Not Available	78%
Rating of All Health Care			50%	25 th	52%
Rating of Personal Doctor			62% [▼]	25 th	67%
Rating of Specialist Seen Most Often			64%	25 th	64%
Rating of Health Plan			52%	<25 th	56%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

Table 9: HealthPartners CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	HealthPartners CAHPS® 2015	HealthPartners CAHPS® 2016	HealthPartners CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Averages
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	64%	Not Available	59%
Getting Appointments & Care Quickly			56%		53%
Doctors Who Communicate Well			76%		74%
Customer Service			78%		75%
Getting Needed Prescription Drugs			80%		80%
Getting Information from Drug Plan			64%		64%
Care Coordination			72%		72%
Rating of Health Plan			75%		71%
Rating of All Health Care Quality			62%		60%
Rating of Drug Plan			73%		73%

Strengths

- **Financial Withhold** – HealthPartners earned all possible points for the SNBC program.
- **HEDIS® (Quality of Care)** – HealthPartners performed well in the following areas of care:
 - F&C-MA
 - *Cervical Cancer Screening*
 - *Chlamydia Screening in Women*
- **CAHPS® (Member Satisfaction)** – HealthPartners performed well in regard to the following areas of member satisfaction:
 - F&C-MA
 - *Customer Service*
 - *Rating of All Health Care*
 - *Rating of Health Plan*
- **TCA** – HealthPartners was fully compliant with contractual standards reviewed for the TCA.
- **PIP** – The 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as a multifaceted intervention strategy that targets members, providers, the community, and the MCO.

Opportunities for Improvement

- **Financial Withhold** – HealthPartners did not achieve full points for the F&C-MA, MNCare, MSHO and MSC+ programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years and 19-64 years
 - Hospital 30-Day Readmission Rate
 - MSHO and MSC+
 - Annual Dental Visits: Age group 65 years and older
- **HEDIS® (Quality of Care)** – HealthPartners demonstrates an opportunity for improvement in the following area of care:
 - MSC+
 - *Breast Cancer Screening*
 - *Comprehensive Diabetes Care – HbA1c Testing*
 - F&C-MA
 - *Comprehensive Diabetes Care – Eye Exam*
 - MNCare
 - *Cervical Cancer Screening*

- **CAHPS® (Member Satisfaction)** – HealthPartners demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the statewide average for the following measure:
 - F&C-MA
 - *Shared Decision Making*
 - SNBC
 - *How Well Doctors Communicate*
 - *Rating of Personal Doctor*
- **QAE** – HealthPartners received six (6) recommendations, one (1) mandatory improvement and one (1) deficiency for the QAE.

Recommendations

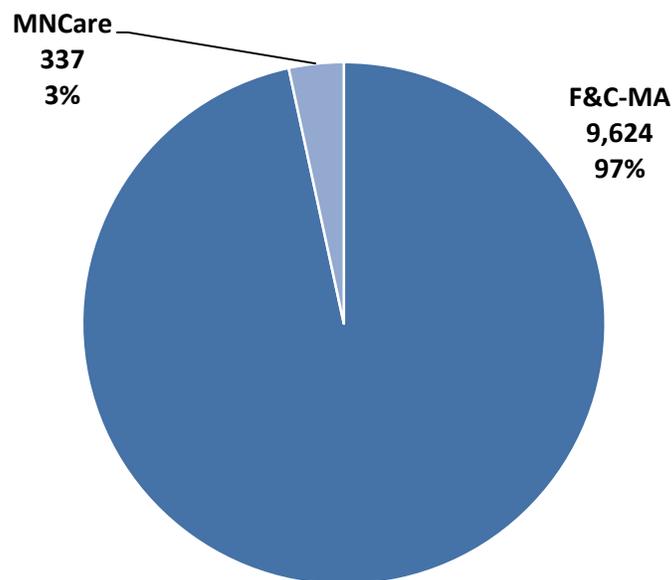
- **Financial Withhold** – The MCO should continue with the intervention strategy described in its response to the previous year’s recommendation, specifically the use of Community Health Workers, targeting “medium-risk” members and the use of internal member support resources. The MCO should also update the strategy to include dental care for children and adults. As the MCO achieved all possible points for Annual Dental for Visit for the 7-18 age group, best practices for this group should be identified and applied across the low performing age groups.
- **HEDIS® (Quality of Care)** – The MCO should consider including non-clinic providers in their quality improvement strategy to ensure the entire provider network benefits from the activities described in the MCO’s response to the previous year’s recommendation. The MCO should also consider developing member incentive programs for preventive screenings. Additionally, the MCO should routinely assess the effectiveness of its quality improvement activities, and modify these activities as needed.
- **CAHPS® (Member Satisfaction)** – Conduct thorough root cause analyses for the measures listed above and implement interventions to address identified barriers.

Hennepin Health

Corporate Profile

Hennepin Health was a Medicaid Expansion demonstration project contracted with DHS for single adults without children ages 19-64 in Hennepin County, which ran from January 1, 2012 through December 31, 2015. Metropolitan Health Plan (MHP) managed the Hennepin Health program under its HMO license. MHP has been a licensed HMO since 1983 and has provided medical assistance benefits to public program enrollees since 1984. The Hennepin Health service model combines a social service approach with behavioral health and medical services. Effective January 1, 2016, DHS awarded MHP/Hennepin Health an F&C-MA/MNCare contract; thus, changing from a Medicaid Expansion demonstration project to offering benefits to the F&C-MA and MNCare populations. Hennepin Health's F&C-MA and MNCare programs continue to combine a social service approach with behavioral health and medical services. When MHP changed its name to Hennepin Health in September 2016, the F&C-MA/MNCare program was renamed Hennepin Health - PMAP. The SNBC population continued to be served in 2016 (see MHP section for more information). As of December 2016, enrollment totaled 9,961, accounting for 1% of the entire MHCP population.

Figure 8: Hennepin Health Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QA Exam on May 12, 2014 through May 16, 2014. The examination period covered May 1, 2011 to February 28, 2014, while the file review period covered March 1, 2013 to February 28, 2014. The MCO received a total of one (1) recommendation, twelve (12) mandatory improvements, and one (1) deficiency for the QAE, and five (5) “Not Mets” for the TCA.

During the 2015 Mid-Cycle Review, MDH determined that MHP met its QAE corrective action plan with the exception of one (1) mandatory improvements and one (1) deficiency; and that MHP met its TCA corrective action plan. Of the initial five (5) “Not Mets” for the TCA, two (2) “Not Mets” were no longer applicable at the time of the mid-cycle review as MHP ended its CMS contract for the senior programs on December 31, 2014.

Performance Improvement Project

The following PIP is in progress:

- ***The Reduction of Racial Disparities in the Management of Depression (2015-2017)*** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP is to reduce, by 20 percentage points, the rate of disparity between Black and White members and between Native American and White members as indicated by the HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure. Table 10 displays the MCO’s baseline rates for this PIP.

Table 10: Hennepin Health Baseline Rates – 2015 PIP

HEDIS® Year	White	Black	Native American	White-Black Disparity	White-Native American Disparity
2014	46.47%	40.54%	35.89%	-5.93%	-10.58%
2015	42.66%	38.98%	17.39%	-3.68%	-25.27%
2016	47.46%	26.71%	25.00%	-20.75%	-22.46%
Change	+0.99	-13.83	-10.89	+14.82	-11.88

Provider-focused interventions include:

- In collaboration with the MCOs listed above, conduct training for providers in a variety of disciplines in partnership with other organizations, such as NAMI-MN and MDH.
- Develop resources, including a toolkit for providers, which will include a shared decision making tool, brochures, talking points, and a list of pharmacies that can print medication labels in multiple languages and that have language lines available for non-English speaking members.

Member-focused interventions include:

- Telephonic outreach conducted by care coordinators to members newly diagnosed with depression to address specific treatment barriers and teach strategies for managing side effects.
- Follow-up calls by nursing staff to educate and remind members of the importance of treating depression, the benefits of antidepressant therapy, and side effects.

2016 Financial Withhold

Hennepin Health achieved 75 of 75 points for the F&C-MA program, and achieved 51.06 of 60 points for the SNBC program. Table 11 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by Hennepin Health.

Table 11: Hennepin Health 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 19-64 Years	15	15
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	Small Sample	Small Sample
Total	75	75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Report	15	15
Maintaining a Local or Regional Stakeholders Group as Required in Section 7.4	15	15
Annual Dental Visit: Age 19-64 Years	15	6.06
Total	60	51.06

Annual Quality Assurance Work Plan for 2016

Hennepin Health submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The Hennepin Health work plan for 2016 is organized by the business area “domains” within Hennepin Health. The 2016 plan has 25 domains, and within each domain are multiple projects. Each project has a plan and standard to reference: goals, objectives, a timeline, staff-member(s) assigned, key strategic or foundational goals, and quality connections. Each project is expected to link one of the four key strategies of Hennepin Health, unless the project has a very specific business purpose. The four strategies are growth enrollment, financial stability, improved customer service, and improved operational infrastructure. Hennepin Health Plan has additional strategic goals for 2016, which are to increase and improve member relationships with care teams, improve connections with program areas and services outside of health care, improve “triple aim” outcomes for members with severe behavioral health conditions, actively participate in defining future state and national accountable care models, and

increase awareness of and commitment to Hennepin Health among partners. Each project is paired to the correlating health care quality characteristics that are described by the three definitions of quality, as defined by the Institute for Healthcare Improvement, the Institute of Medicine, and the National Association of Healthcare Quality. The work plan was approved by Hennepin Health's Quality Management Committee and Governing Board.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

The Hennepin QI program's mission is to continuously protect and improve the health care provided to MCO enrollees through high-quality, integrated, and cost-effective health delivery. The Hennepin County Board of Commissioners is the governing body for Hennepin and delegated responsibility for the QI program to the MCO's Quality Management Committee (QMC). In June 2016, leadership and staff from MHP and Hennepin Health merged, which allowed for staff to gain increased knowledge and experience. Hennepin Health also made every effort to contact members to engage them in care, including face-to-face encounters with members at the MCO's Walk-In Center or in homeless shelters.

During 2016, Hennepin Health reported many HEDIS® scores above both the statewide and national averages for several member populations. Hennepin Health's QI program appears to be an effective means for improving the health care of its members. The MCO also met several barriers to the successful implementation of the QI program. In 2015, the MCO switched to a new claims vendor, which caused disruptions and data errors when preparing data for HEDIS® 2016. Additionally, the MCO identified several areas in which improvement was warranted and has considered addressing these with PIPs.

MCO Provider Guidelines

Hennepin Health utilized guidelines established by ICSI, USPSTF, NIH, USDHHS, CDC, American Academy of Family Physicians (AAFP), AAP, MDH, NCQA, ACOG, APA, AACAP, and Minnesota Community Measurement, as well as recommendations from network physicians, in order to develop clinical practice guidelines. Hennepin Health adopted the following clinical guidelines in 2016: medical preventive services for adults, diabetes management, asthma medication management, childhood and adolescent immunizations, prenatal and postpartum care, follow-up care after hospitalization for mental illness, major depression in adults, and alcohol and other drug dependence. In order to assess provider compliance with clinical practice guidelines, Hennepin Health's HEDIS medical record reviewers review medical records for evidence of use of the guidelines during the HEDIS season.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 12 and 13, respectively, while Figure 9 displays the HEDIS® Measure Matrix.

Table 12: Hennepin Health HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	Hennepin Health HEDIS® 2015	Hennepin Health HEDIS® 2016	Hennepin Health HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adult BMI Assessment ¹	Not Reported	Not Reported	93.9%	90 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	69.0%	63.1%	73.0%	25 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	82.2%	78.9%	86.7%	33.33 th	88.6%
Breast Cancer Screening (50-64 Years) ²	70.4%	68.5%	48.1%	10 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	42.6%	41.9%	50.4%	10 th	61.0%
Chlamydia Screening in Women (16-24 Years) ²	84.6%	66.3%	78.0%	95 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	Not Reported	Not Reported	92.7%	75 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	Not Reported	Not Reported	64.7%	75 th	70.4%
Controlling High Blood Pressure ¹	Not Reported	Not Reported	62.4%	50 th	65.5%
Medication Management for People With Asthma – 50% (19-64 Years) ²	64.1%	63.9%	73.3%	Not Available	59.2%
Medication Management for People With Asthma – 75% (19-64 Years) ²	33.3%	30.6%	30.0%	33.33 th	34.0%

Note: In 2017, Hennepin Health’s CAHPS® survey results incorporated all Hennepin Health’s populations (F&C-MA, MNCare and SNBC); rather than separate CAHPS survey results for each population. Therefore, no conclusions to previous years’ data can be drawn. Additionally, Hennepin Health’s 2015 and 2016 CAHPS results included the Medicaid Expansion population of single adults ages 19 – 64 without families and children. For CAHPS 2017, F&C-MA and MNCare populations were included.

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 9: Hennepin Health 2017 HEDIS® Measure Matrix

	Statewide Average Statistical Significance Comparison	Statewide Average Statistical Significance Comparison	Statewide Average Statistical Significance Comparison
	Below Average	Statewide Average	Above Average
C ▪ Cervical Cancer Screening (F&C-MA)		B	A
D		C ▪ Medication Management for People with Asthma-50% (F&C-MA) ▪ Medication Management for People with Asthma-75% (F&C-MA)	B ▪ Chlamydia Screening in Women (F&C-MA)
F ▪ Breast Cancer Screening (F&C-MA)		D	C

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 13: Hennepin Health CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	Hennepin Health CAHPS® 2015	Hennepin Health CAHPS® 2016	Hennepin Health CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	48%	53%	61%	90 th	54%
Getting Care Quickly	58%	57%	61%	50 th	58%
How Well Doctors Communicate	73%	79%	82%	90 th	81%
Customer Service	64%	62%	69%	50 th	66%
Shared Decision Making	52%	84%	81%	Not Available	82%
Rating of All Health Care	45%	45%	55%	50 th	55%
Rating of Personal Doctor	64%	65%	66%	50 th	72%
Rating of Specialist Seen Most Often	69%	53%	70%	75 th	64%
Rating of Health Plan	55%	40%	56%	25 th	59%

Strengths

- **Financial Withhold** – Hennepin Health earned all possible points for the F&C-MA and MNCare programs.
- **PIP** – Hennepin Health’s 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as a mix of provider- and member-focused interventions.
- **TCA** – During the mid-cycle review, it was determined that Hennepin Health was fully compliant with its TCA corrective action plan.

Opportunities for Improvement

- **Financial Withhold** – Hennepin Health did not achieve full points for the SNBC program. The MCO did not meet the target goal for the following measure:
 - Annual Dental Visit: Age group 19-64 years
- **HEDIS® (Quality of Care)** – Hennepin Health demonstrates an opportunity for improvement in the following area of care:
 - F&C-MA
 - *Breast Cancer Screening*
- **QAE** – During the mid-cycle review, it was determined that Hennepin Health did not meet its QAE corrective action plan for one (1) mandatory improvement and one (1) deficiency.

Recommendations

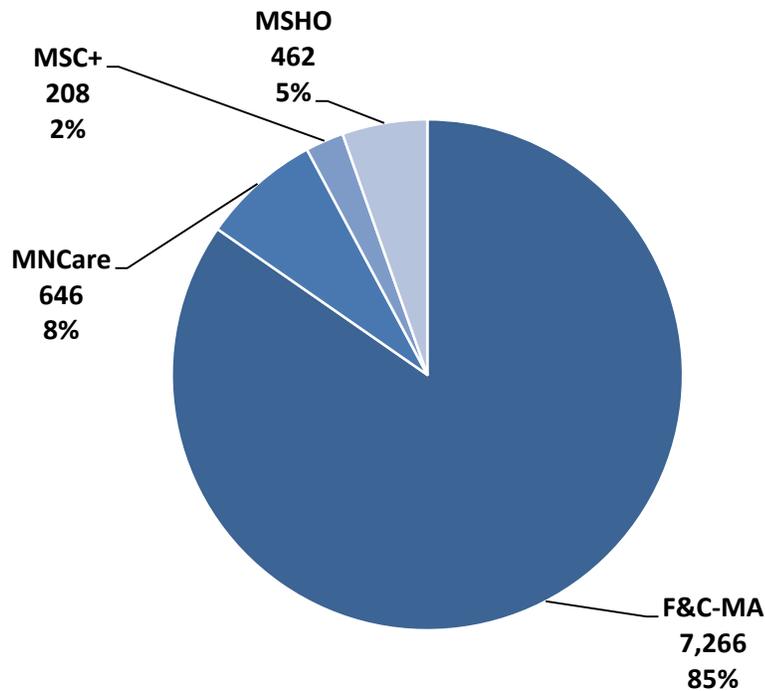
- **Financial Withhold**
 - The MCO should consider establishing partnerships with community dental clinics, such as Helping Hands, to obtain visit information in the absence of claims information.
 - The MCO should utilize primary care providers as champions of dental care to promote and encourage annual dental visits to patients.
 - In regard to the Dental Oral Health Center at HCMC, the MCO should communicate the availability of the clinic to its members and leverage its partnership with HCMC to establish data collection processes that allow the MCO determine the clinic’s impact on its membership.
- **HEDIS® (Quality of Care)** – Conduct root cause analysis to identify barriers to care and implement interventions to address these barriers. The MCO’s quality improvement strategy should include member-, provider- and system-level quality improvement initiatives.

Itasca Medical Care (IMCare)

Corporate Profile

Itasca County Health and Human Services administers IMCare, a CBP organization. Itasca County contracts with DHS to provide medical benefits through the IMCare program to the F&C-MA, MNCare, MSHO, and MSC+ populations. As of December 2016, enrollment totaled 8,582 accounting for 1% of the entire MHCP population.

Figure 10: IMCare Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on September 28, 2015 through October 2, 2015. The examination period covered August 1, 2012 to July 31, 2015, while the file review period covered August 1, 2014 to July 31, 2015. The MCO received a total of two (2) recommendations for the QAE and received one (1) “Not Met” for the TCA.

Performance Improvement Project

The following PIP is in progress:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression (2015-2017)*** – The goal of this project is to improve, by 8 percentage points, the HEDIS® *Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)* measure rate for F&C-MA and MNCare members who identified as a race other than White, and meet the HEDIS® specifications for the AMM measure (*note: denominator was four (4)*). Table 14 displays the MCO’s baseline rates for this PIP.

Table 14: IMCare Baseline Rates – 2015 PIP

HEDIS® Year	All
2014	0.0%
2015	25.0%
2016	50.0%
Change	+50.0

Member-focused interventions include:

- General member education regarding depression, medications, common side effects, and the importance of medication adherence will be included in the member newsletter each year. Resources for accessing this information in another language will also be available.
- IMCare will identify currently eligible members of the study population monthly, in order to account for the allowable gap in treatment in the NCQA specifications for the HEDIS® AMM measure, via prescription fill data. Members identified as not filling prescriptions will receive a reminder phone call concerning the importance of adherence and to address any barriers. Members can also be referred to case management during these phone calls.

Provider-focused interventions include:

- General network provider education via the provider newsletter, including information about: the design/goals of this PIP, practice guidelines, the provider’s role in the promotion of medication adherence, resources the provider can access for identified language barriers, and the Minnesota Mental Health Community Foundation online resource for connecting with community referral resources.

Pharmacy-focused interventions include:

- General network pharmacy education via provider update each year.
- Encouraging pharmacies to assess patients for language barriers, and to offer printed prescription labels and instructions in the patient’s primary language.

2016 Financial Withhold

IMCare achieved 67.37 of 75 points for the F&C-MA and MNCare programs and achieved 75 of 90 points for the MSHO and MSC+ programs. Table 15 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by IMCare.

Table 15: IMCare 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	0
Annual Dental Visit: Age 7-18 Years	5	5
Annual Dental Visit: Age 19-64 Years	5	2.37
Well-Child Visits in the First 15 Months of Life	Small Sample	Small Sample
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	Small Sample	Small Sample
Total	75	67.37
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75

Annual Quality Assurance Work Plan for 2016

IMCare submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The MCO proposed quality evaluation activities and studies related to numerous activities; work plan activities are represented in a consistent manner and separated by various categories. These categories include: Administration, Performance Improvement Projects, Quality Improvement Projects, Disease Management/Chronic Care Improvement Program, Community Outreach Programs, Affirmative Statement and Monitoring. Corresponding quality evaluation activities include: the identified population, objectives, goals, project tasks with target dates and corresponding responsible staff, timeline and review dates and status. The MCO's QA work plan was approved by the IMCare Provider Advisory Subcommittee, the IMCare QI/Utilization Management Committee, and the Itasca County Health and Human Services (ICHHS) Board of Commissioners (BOC).

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

IMCare's Quality Improvement (QI) Program is designed to support the mission, vision, and values of Itasca County and IMCare through ongoing improvement, evaluation, and monitoring of patient safety and delivery of services to members. QI goals and objectives are based upon information gathered through a variety of sources, including survey results, utilization and claims data, HEDIS® data, QAEs and TCAs. Accountability for the management and improvement of the quality of clinical care and services provided to enrollees rests on the ICHHS BOC. The ICHHS BOC delegates day-to-day operational responsibility to the IMCare Director. The IMCare Director, along with the Medical Director, Pharmacy Director, Quality Director, and Contract Compliance Director report QI activities and outcomes to the Provider Advisory Subcommittee (PAC), External Quality Improvement/Utilization Management Subcommittee (QI/UM), and the BOC.

Throughout 2016, IMCare met its established improvement goals for many of its QI projects. The MCO continued to identify opportunities for improvement throughout its QI initiatives, as well. IMCare utilized a variety of methods in order to improve quality measures, including, but not limited to: educating providers and members, redesigning the complex care management program, and utilizing reminder letters. The MCO has also improved its CaseTrakker system to better align with the claims system in order to improve documentation and achieve a higher adjudication rate for claims.

MCO Provider Guidelines

IMCare utilizes the ICSI as a source for its clinical practice guidelines, which include guidelines related to type 2 diabetes, hypertension, depression, follow-up after hospitalization for mental illness, and preventive care. To assess provider compliance with the clinical guidelines, IMCare analyzes data from several different sources, including: claims, hybrid and administrative HEDIS® data, and member reports.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 16 and 17, respectively, while Figure 11 displays the HEDIS® Measure Matrix.

Table 16: IMCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	IMCare HEDIS® 2015	IMCare HEDIS® 2016	IMCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	38.7%	29.4%	31.9%	<10 th	39.1%
Adult BMI Assessment ¹	91.0%	90.5%	89.3%	50 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	86.4%	84.4%	88.2%	95 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	89.7%	87.8%	90.5%	75 th	88.6%
Breast Cancer Screening (50-64 Years) ²	58.6%	45.7%	59.0%	50 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	61.9%	53.3%	53.3%	25 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	72.9%	68.9%	62.5%	10 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	98.3%	96.0%	97.7%	75 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	89.8%	89.4%	89.1%	50 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	91.6%	93.8%	92.0%	50 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	94.4%	92.9%	91.3%	50 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	45.5%	42.5%	43.3%	<10 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	92.6%	93.1%	91.2%	75 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	56.8%	65.6%	54.4%	33.33 th	70.4%
Controlling High Blood Pressure ¹	63.7%	59.0%	86.1%	95 th	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	72.7%	62.5%	67.4%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	40.9%	35.0%	37.2%	66.67 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	61.2%	56.3%	61.1%	33.33 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	65.2%	66.2%	65.7%	10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 16: IMCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	IMCare HEDIS® 2015	IMCare HEDIS® 2016	IMCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	Small Sample	Small Sample	23.3%	<10 th	28.6%
Adult BMI Assessment ¹	90.9%	91.7%	90.5%	75 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	84.9%	80.9%	87.2%	90 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.1%	88.0%	89.0%	66.67 th	88.0%
Breast Cancer Screening (50-64 Years) ²	65.9%	68.7%	60.8%	50 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	58.8%	54.2%	49.8%	10 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	No Data	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	91.1%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	Small Sample	90.5%	100.0%	95 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	Small Sample	64.3%	61.5%	66.67 th	69.7%
Controlling High Blood Pressure ¹	Small Sample	64.8%	89.8%	95 th	70.3%
Medication Management for People With Asthma – 50% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	70.0%
Medication Management for People With Asthma – 75% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	44.0%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 16: IMCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	IMCare HEDIS® 2015	IMCare HEDIS® 2016	IMCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	96.6%	98.2%	96.6%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	62.3%	58.7%	64.5%	66.67 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	96.1%	94.0%	95.9%	95 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	64.7%	58.0%	69.4%	90 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	87.9%	88.2%	90.4%	66.67 th	93.7%
Breast Cancer Screening (65-74 Years) ²	12.1%	29.7%	30.3%	<10 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	68.6%	67.6%	77.8%	<10 th	74.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 11: IMCare 2017 HEDIS® Measure Matrix

		Statewide Average Statistical		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B	A <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA, MNCare) Comprehensive Diabetes Care – HbA1c Testing (MNCare)
	D <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA) Cervical Cancer Screening (F&C-MA) Chlamydia Screening in Women (F&C-MA) Childhood Immunization Status – Combo 3 (F&C-MA) 	C <ul style="list-style-type: none"> Adolescent Well-Care Visit (MNCare) Breast Cancer Screening (F&C-MA, MSC+, MSHO, MNCare) Cervical Cancer Screening (MNCare) Comprehensive Diabetes Care – Eye Exam (MSHO, MNCare) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) Well-Child Visits in the First 15 Months of Life (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare) 	B	
	F <ul style="list-style-type: none"> Comprehensive Diabetes Care – Eye Exam (F&C-MA) 	D	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 17: IMCare CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	IMCare CAHPS® 2015	IMCare CAHPS® 2016	IMCare CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	58%	53%	60%	90 th	54%
Getting Care Quickly	62%	55%	61%	50 th	58%
How Well Doctors Communicate	79%	74%	83%	90 th	81%
Customer Service	64%	69%	66%	25 th	66%
Shared Decision Making	47%	86%	84%	Not Available	82%
Rating of All Health Care	50%	43%▼	56%	50 th	55%
Rating of Personal Doctor	64%	65%	72%	90 th	72%
Rating of Specialist Seen Most Often	68%	59%	70%	75 th	64%
Rating of Health Plan	58%	51%▼	55%	25 th	59%
MNCare					
Getting Needed Care	63%	58%	65%	90 th	57%
Getting Care Quickly	63%	62%▲	64%	90 th	60%
How Well Doctors Communicate	84%	79%	78%	75 th	79%
Customer Service	71%	62%	61%	<25 th	58%
Shared Decision Making	46%	84%	87%	Not Available	84%
Rating of All Health Care	55%	54%	54%	50 th	55%
Rating of Personal Doctor	66%	71%	64%	25 th	68%
Rating of Specialist Seen Most Often	68%	71%	64%	25 th	66%
Rating of Health Plan	57%	53%	53%	<25 th	52%

▼ Rate is significantly lower than the statewide average.
 ▲ Rate is significantly higher than the statewide average.

Table 17: IMCare CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	IMCare CAHPS® 2015	IMCare CAHPS® 2016	IMCare CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	60%	63%▲	64%	90 th	61%
Getting Care Quickly	50%▼	67%▲	67%	90 th	67%
How Well Doctors Communicate	83%	76%	75%	50 th	77%
Customer Service	59%	78%▲	77%	90 th	70%
Shared Decision Making	49%	77%	77%	Not Available	78%
Rating of All Health Care	67%	63%	66%	90 th	62%
Rating of Personal Doctor	74%	71%	75%	50 th	76%
Rating of Specialist Seen Most Often	67%	69%	74%	90 th	75%
Rating of Health Plan	69%	65%	71%	90 th	69%

▲ Rate is significantly higher than the statewide average.

▼ Rate is significantly lower than the statewide average.

Strengths

- **HEDIS® (Quality of Care)** – IMCare performed well in regard to the following areas of care:
 - MNCare
 - *Controlling High Blood Pressure*
 - *Comprehensive Diabetes Care – HbA1c Testing*
- **PIP** – IMCare’s 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as an intervention strategy that targets members, providers, and local pharmacies.

Opportunities for Improvement

- **Financial Withhold** – IMCare did not earn full points for the F&C-MA, MNCare, MSHO and MSC+ programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years and 19-64 years
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 years and older
- **HEDIS® (Quality of Care)** – IMCare demonstrates an opportunity for improvement in regard to the following areas of care:
 - F&C-MA
 - *Adolescent Well-Care Visit*
 - *Cervical Cancer Screening*
 - *Chlamydia Screening for Women*
 - *Childhood Immunization Status: Combo 3*
 - *Comprehensive Diabetes Care – Eye Exam*
- **TCA** – IMCare received one (1) “Not Met” for the TCA.
- **QAE** – IMCare received a total of two (2) recommendations for the QAE.

Recommendations

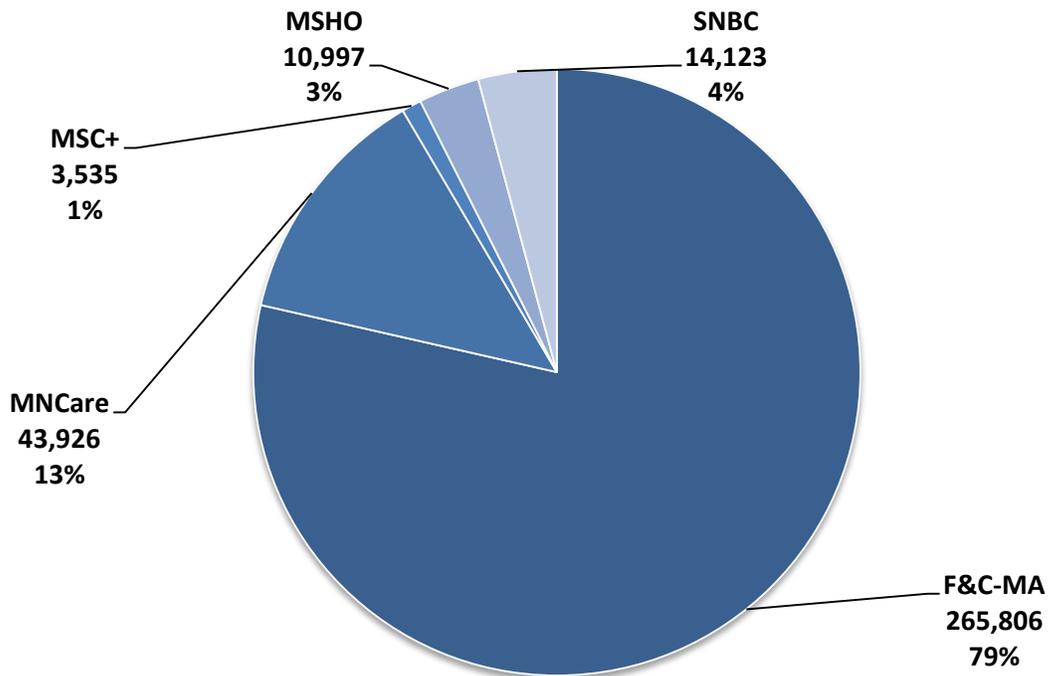
- **Financial Withhold** – The MCO should update its quality improvement strategy to include dental care for children and adults. As the MCO achieved all possible points for Annual Dental for Visit for the 7-18 age group, best practices for this group should be identified and applied across the low performing age groups.
- **HEDIS® (Quality of Care)**
 - The MCO’s process of contacting enrollees to “assess any potential barriers to accessing needed screenings” should be a formal process in which barriers are tracked and trended, and addressed by tailored interventions.
 - The MCO should consider increasing the frequency of the Stakeholder Advisory Committee, especially if this is the key method by which the MCO addresses quality initiatives.

Medica

Corporate Profile

Medica HMO is one of Minnesota's largest MCOs. The MCO achieved NCQA accreditation status for its F&C-MA line of business for the 2016-2017 NCQA rating period. Medica provided services to enrollees in the F&C-MA, MNCare, MSHO, MSC+, and SNBC programs. As of December 2016, enrollment totaled 338,387, accounting for 38% of the entire MHCP population.

Figure 12: Medica Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on March 16, 2015 through March 19, 2015. The examination period covered March 1, 2012 to December 31, 2014, while the file review period covered January 1, 2014 to December 31, 2014. The MCO received one (1) “Not Met” for the TCA, and received three (3) recommendations, four (4) mandatory improvements, and two (2) deficiencies for the QAE.

Performance Improvement Projects

The following PIPs are in progress:

- **Racial and Ethnic Disparities in the Management of Depression (2015-2017)** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Medica, MHP and UCare. The goal of this PIP is to reduce, by 5.38 percentage points, the disparity between White and non-White F&C-MA and MNCare members as indicated by the HEDIS® *Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)* measure. Table 18 displays the MCO’s baseline rates for this PIP.

Table 18: Medica Baseline Rates – 2015 PIP

HEDIS® Year	White	Non-White	Disparity
2014	55.20%	36.06%	-19.14%
2015	44.47%	32.56%	-11.91%
Baseline	49.83%	34.31%	-15.52%
2016	43.94%	38.60%	-5.34%
Change	-5.89	+4.29	-10.18

Member-focused interventions include:

- Distribution of member educational materials to members newly prescribed an antidepressant twice per year with information that may include depression signs, symptoms, and treatment, as well as the availability of confidential behavioral health services.
- Nurse care coordinators will conduct telephonic outreach quarterly to non-White members identified through claims data. Bilingual Care Coordination staff will be utilized when available, or a translation service will be used. Calls will address education on depression, medications, side effects, symptoms, importance of medication adherence, referrals to behavioral health services, and providing culturally appropriate resources.

Provider-focused interventions include:

- In partnership with the MCOs listed above, development of educational opportunities, which may include cultural issues/beliefs related to depression and medication management best practices. These trainings will be made available to a variety of providers and health care disciplines.
- In collaboration with the MCOs listed above, an electronic provider toolkit will be developed with resources including: mental health resources for providers, culturally appropriate resources, pharmacy resources, and a shared decision making tool aimed at helping providers with patient education.

Community-based interventions include:

- A community event to increase awareness during Minority Mental Health Month in July.
- Working with organizations, such as the National Alliance on Mental Illness – Minnesota (NAMI-MN), religious groups, targeted clinics, etc. to identify channels for promoting awareness of depression in diverse communities.
- Sharing depression resources at local health fairs.
- Promoting culturally specific community events related to depression and mental health.

Follow-Up after Hospitalization for Mental Illness (2015-2017) – This PIP is a collaborative comprised of two (2) MCOs: Medica and UCare. The goals of this project are to increase the HEDIS® *Follow-up After Hospitalization for Mental Illness –7 Days* and *–30 Days* measure rates by 5.40 percentage points and 4.50 percentage points, respectively, for the SNBC population. Rates for the SNBC population will be compared to rates for the Medica commercial population to determine the rate of disparity between the two populations. Table 19 displays the MCO’s baseline rates for this PIP.

Table 19: Medica Baseline Rates – 2015 PIP

HEDIS® Year	7 Days	30 Days
2014	57.22%	75.28%
2015	62.60%	81.00%
Baseline	59.91%	78.14%
2016	63.66%	84.37%
Change	+3.75	+6.23

Member-focused interventions include:

- Twice per year, members identified as having been hospitalized for mental illness within the last year will receive educational materials concerning follow-up care, depression signs, symptoms, treatments, and availability of behavioral health services. Care coordinators will also share educational materials during visits with members.
- Care coordination staff will conduct telephonic outreach to help schedule follow-up appointments, educate members on signs of depression, explain the importance of medication adherence, and provide culturally appropriate resources.

Provider-focused interventions include:

- In partnership with the MCO listed above, development of educational opportunities to address cultural issues, educating patients on follow-up care, MCO resources, etc. These trainings will be available to primary and behavioral health specialists, clinical nurses, etc.
- In collaboration with the MCO listed above, development of an electronic provider toolkit with resources for behavioral health; best practices; cultural competency; MCO resources, such as transportation; etc.
- Identification of major hospitals/clinics with the highest volumes of this population and targeted support for these hospitals/clinics through educational materials and trainings.

Community-focused interventions include:

- A community event to increase awareness during Minority Mental Health Month in July.
- Working with organizations, such as the National Alliance on Mental Illness – Minnesota (NAMI-MN), religious groups, targeted clinics, etc. to identify channels for promoting awareness of depression.
- Sharing depression resources at local health fairs.
- Promoting culturally specific community events related to behavioral health.

2016 Financial Withhold

Medica achieved 65.27 of 105 points for the F&C-MA and MNCare programs, 75.55 of 90 points for the MSHO and MSC+ programs, and 45 of 60 points for the SNBC program. Table 20 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by Medica.

Table 20: Medica 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	0
Annual Dental Visit: Age 7-18 Years	5	0
Annual Dental Visit: Age 19-64 Years	5	0.27
Well-Child Visits in the First 15 Months of Life	15	15
Child and Teen Checkups Referral Code	15	5
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	15	0
Total	105	65.27
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0.55
Total	90	75.55
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Annual Quality Assurance Work Plan for 2016

Medica submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The MCO’s QA work plan identifies significant, measureable quality activities that address at

least one or more of the following: clinical quality, service quality, member experience, provider quality, and patient safety. Each plan project is categorized by type, such as assessment or research, design or development, implementation, improvement, and evaluation. The work plan also provides a detailed explanation of Medica's activities related to measurement and monitoring, community collaboratives, and delegated quality improvement outcomes related to quality improvement efforts. Each of the QA projects applies to all the Medica legal entities and market business segments. If a project is population- or project-specific, it is specified in the project objectives. The MCO performed two focused studies with efforts to improve antidepressant medication adherence, reduce disparity in antidepressant medication management between White and non-White enrollees, and improve depression management and antidepressant medication adherence in the senior population. For each project in the work plan, there is a project owner or lead. Each project is clearly and comprehensively laid out to show the project objective, project rationale, expected quality improvement impact, project type, project focus, if it is a new or continuing project, key project outputs including deliverables or milestones, and project goals and outcomes inclusive of baseline/current state, partial, target and stretch. The work plan for the MCO was approved by the Director of Quality Improvement, the Vice President and Senior Medical Director, the Quality Improvement Subcommittee, the Medical Committee of Medical Board of directors, and the Medica Board of Directors.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

Medica's Quality Improvement (QI) Program aims to identify, implement, and measure results from activities designed to achieve improved member care, service, access, and safety; service to providers, employers, brokers, and other partners; and internal operations. Medica selected opportunities for clinical and service improvement based on factors such as potential for improved clinical quality or service utilization; regulatory and accreditation requirements and contractual obligations; member and provider satisfaction and complaint data; and feasibility with available staff, resources, and capital. Progress was monitored by the QI Department and the Quality Improvement Subcommittee. The QI Program is governed by the Medica Board of Directors and the Medical Committee, and is integrated throughout the organization and across departments through various committees, including, but not limited to: the Utilization Management Subcommittee, Medical Policy Committee, Quality Indicators Review Committee, and the Delegation Committee.

Throughout 2016, the QI Program engaged in a total of 34 activities, of which 19 fully met the target goals and 5 partially met the target goals. Among the other 9 projects, two projects were scored not applicable (N/A), one project was cancelled, and six were pending final reports due to pending HEDIS®/CAHPS® data and departmental restructuring. Overall strengths of the 2016 QI Program included the collaboration of cross-functional teams with internal and external stakeholders, as well as the development and maintenance of vendor partnerships. Medica continued to face several barriers to the success of its QI Program. One barrier the MCO continued to cite was obtaining timely data, as several projects relied on HEDIS®/CAHPS® data, which were not available at year-end 2016. Competing priorities also affected resources and project timelines, such as the hiring and training of new staff and the acquisition of a new pharmacy vendor. Seasonal spikes in workload were also cited as a barrier to the success of the QI Program.

MCO Provider Guidelines

Since 2002, Medica has adopted 56 ICSI-developed clinical guidelines and conducts consistency reviews to ensure policies and initiatives are aligned with these guidelines.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 21 and 22, respectively, while Figure 13 displays the HEDIS® Measure Matrix.

Table 21: Medica HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	Medica HEDIS® 2015	Medica HEDIS® 2016	Medica HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	43.1%	41.6%	Not Reported	Not Applicable	39.1%
Adult BMI Assessment ¹	90.0%	91.2%	Not Reported	Not Applicable	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	87.9%	83.9%	86.5%	75 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	90.5%	87.4%	88.7%	66.67 th	88.6%
Breast Cancer Screening (50-64 Years) ²	60.7%	60.5%	62.3%	50 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	65.2%	57.5%	62.4%	50 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	70.8%	72.0%	Not Reported	Not Applicable	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.4%	95.5%	96.7%	66.67 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	91.7%	87.6%	90.3%	66.67 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	94.1%	93.6%	93.5%	75 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.8%	92.5%	93.2%	75 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	61.7%	60.3%	61.8%	66.67 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	92.0%	93.1%	Not Reported	Not Applicable	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	67.5%	66.1%	Not Reported	Not Applicable	70.4%
Controlling High Blood Pressure ¹	70.6%	68.1%	Not Reported	Not Applicable	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	48.8%	50.2%	53.8%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	27.5%	27.9%	26.1%	10 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	65.6%	49.4%	65.7%	50 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	67.6%	66.2%	65.8%	10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 21: Medica HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	Medica HEDIS® 2015	Medica HEDIS® 2016	Medica HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	26.1%	25.8%	Not Reported	Not Applicable	28.6%
Adult BMI Assessment ¹	88.8%	89.3%	Not Reported	Not Applicable	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	78.6%	76.8%	80.2%	50 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	86.6%	84.7%	87.6%	50 th	88.0%
Breast Cancer Screening (50-64 Years) ²	65.2%	65.5%	65.6%	75 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	43.2%	48.0%	51.6%	10 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	85.7%	79.5%	90.8%	75 th	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	91.8%	90.2%	50 th	91.1%
Chlamydia Screening in Women (16-24 Years) ²	61.1%	62.3%	62.7%	66.67 th	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	96.7%	92.9%	Not Reported	Not Applicable	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	69.5%	69.9%	Not Reported	Not Applicable	69.7%
Controlling High Blood Pressure ¹	72.5%	74.2%	Not Reported	Not Applicable	70.3%
Medication Management for People With Asthma – 50% (19-64 Years) ²	67.6%	66.4%	65.3%	Not Available	70.0%
Medication Management for People With Asthma – 75% (19-64 Years) ²	41.2%	36.4%	40.0%	66.67 th	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	64.5%	Small Sample	59.7%	<10 th	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 21: Medica HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	Medica HEDIS® 2015	Medica HEDIS® 2016	Medica HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.2%	98.2%	98.2%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	58.3%	57.1%	55.7%	33.33 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	94.4%	95.1%	93.4%	90 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	75.2%	79.3%	80.5%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	94.8%	94.0%	93.5%	75 th	93.7%
Breast Cancer Screening (65-74 Years) ²	33.7%	30.2%	29.8%	<10 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	71.6%	70.2%	45.7%	<10 th	74.3%
SNBC					
Adult BMI Assessment ¹ (Non-SNP)	92.9%	90.5%	94.9%	90 th	90.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	94.1%	93.3%	92.6%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.4%	96.5%	96.5%	95 th	96.3%
Breast Cancer Screening (50-64 Years) ²	43.8%	40.8%	37.8%	<10 th	53.4%
Cervical Cancer Screening (24-64 Years) ²	45.1%	42.7%	41.4%	<10 th	46.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	91.4%	92.5%	92.5%	75 th	91.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	71.4%	71.9%	72.3%	95 th	70.5%
Controlling High Blood Pressure ¹ (Non-SNP)	78.1%	74.9%	74.2%	95 th	70.2%
Medication Management for People With Asthma – 50% (19-64 Years) ²	63.9%	69.3%	68.1%	Not Available	67.0%
Medication Management for People With Asthma – 75% (19-64 Years) ²	40.5%	49.7%	45.6%	75 th	46.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 13: Medica 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C	<ul style="list-style-type: none"> Cervical Cancer Screening (MNCare) 	<ul style="list-style-type: none"> Well-Child Visits in the First 15 Months of Life (F&C-MA) 	<ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA)
	D	<ul style="list-style-type: none"> Breast Cancer Screening (MSC+) Cervical Cancer Screening (SNBC) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) 	<ul style="list-style-type: none"> Breast Cancer Screening (F&C-MA, MNCare) Controlling High Blood Pressure (SNBC) Comprehensive Diabetes Care – Eye Exam (MSHO, SNBC) Comprehensive Diabetes Care – HbA1c Testing (MSHO, SNBC) Chlamydia Screening in Women (MNCare) Medication Management for People with Asthma-50% (MNCare) Medication Management for People with Asthma-75% (MNCare) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (MNCare) 	<ul style="list-style-type: none"> Chlamydia Screening in Women (F&C-MA)
	F	<ul style="list-style-type: none"> Breast Cancer Screening (MSHO, SNBC) Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	D	C

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 22: Medica CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	Medica CAHPS® 2015	Medica CAHPS® 2016	Medica CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	53%	49%	53%	25 th	54%
Getting Care Quickly	56%	57%	60%	50 th	58%
How Well Doctors Communicate	79%	82%	78%	75 th	81%
Customer Service	59%	62%	58%	<25 th	66%
Shared Decision Making	48%	78%	84%	Not Available	82%
Rating of All Health Care	45%▼	50%	55%	50 th	55%
Rating of Personal Doctor	65%	68%	79%▲	90 th	72%
Rating of Specialist Seen Most Often	68%	66%	66%	50 th	64%
Rating of Health Plan	54%	57%	55%	25 th	59%
MNCare					
Getting Needed Care	59%	57%	52%	25 th	57%
Getting Care Quickly	67%	58%	57%	25 th	60%
How Well Doctors Communicate	79%	77%	81%	90 th	79%
Customer Service	72%	59%	52%	<25 th	58%
Shared Decision Making	56%	79%	83%	Not Available	84%
Rating of All Health Care	59%	49%	54%	50 th	55%
Rating of Personal Doctor	63%	68%	68%	75 th	68%
Rating of Specialist Seen Most Often	63%	68%	70%	75 th	66%
Rating of Health Plan	56%	55%	55%	25 th	52%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

Table 22: Medica CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	Medica CAHPS® 2015	Medica CAHPS® 2016	Medica CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	61%	53%	58%	50 th	61%
Getting Care Quickly	61%	55%	67%	90 th	67%
How Well Doctors Communicate	82%	75%	80%	90 th	77%
Customer Service	62%	63%	67%	25 th	70%
Shared Decision Making	55%	83% [▲]	79%	Not Available	78%
Rating of All Health Care	59%	56%	59%	90 th	62%
Rating of Personal Doctor	75%	66% [▼]	76%	90 th	76%
Rating of Specialist Seen Most Often	67%	67%	72%	90 th	75%
Rating of Health Plan	63%	59%	65%	90 th	69%
SNBC					
Getting Needed Care	56% [▲]	52%	55%	25 th	54%
Getting Care Quickly	62% [▲]	54%	56%	25 th	60%
How Well Doctors Communicate	74%	75%	78% [▲]	75 th	74%
Customer Service	63%	71%	64%	25 th	66%
Shared Decision Making	49%	80%	77%	Not Available	78%
Rating of All Health Care	47%	51%	50%	25 th	52%
Rating of Personal Doctor	67%	73% [▲]	73% [▲]	90 th	67%
Rating of Specialist Seen Most Often	67%	64%	66%	50 th	64%
Rating of Health Plan	58%	64% [▲]	57%	25 th	56%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

Table 22: Medica CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	Medica CAHPS® 2015	Medica CAHPS® 2016	Medica CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	58%	Not Available	59%
Getting Appointments & Care Quickly			56%		53%
Doctors Who Communicate Well			76%		74%
Customer Service			70%		75%
Getting Needed Prescription Drugs			81%		80%
Getting Information from Drug Plan			72%		64%
Care Coordination			75%		72%
Rating of Health Plan			72%		71%
Rating of All Health Care Quality			63%		60%
Rating of Drug Plan			74%		73%

Strengths

- **HEDIS® (Quality of Care)** – Medica performed well in regard to the following areas of care:
 - F&C-MA
 - *Cervical Cancer Screening*
 - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
- **CAHPS® (Member Satisfaction)** – Medica performed well in the following areas of member satisfaction:
 - F&C-MA
 - *Rating of Personal Doctor*
 - SNBC
 - *How Well Doctors Communicate*
 - *Rating of Personal Doctor*

Opportunities for Improvement

- **Financial Withhold** – Medica did not achieve full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. This was also noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years, 7-18 years and 19-64 years
 - Child and Teen Checkups Referral Code
 - Hospital 30-Day Readmission Rate
 - MSHO and MSC+
 - Annual Dental Visit: Age 65 years and older
 - SNBC
 - Annual Dental Visit: Age group 19-64 years
- **HEDIS® (Quality of Care)** – Medica demonstrates an opportunity for improvement in the following areas of care:
 - MSHO
 - *Breast Cancer Screening*
 - SNBC
 - *Breast Cancer Screening*
 - *Cervical Cancer Screening*
 - MSC+
 - *Comprehensive Diabetes Care – HbA1c Testing*
 - *Breast Cancer Screening*
 - F&C MA
 - *Medication Management for People with Asthma-50%*
 - *Medication Management for People with Asthma-75%*

Recommendations

- **Financial Withhold** – As the MCO continues to struggle with the Hospital 30-Day Readmission measure, the MCO should reevaluate the effectiveness of its current strategy to decrease readmissions. In addition to performing root cause analyses to identify barriers, the subgroup created to address dental care should consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.
- **HEDIS® (Quality of Care)**
 - Despite having a multifaceted intervention approach, Medica continues to struggle with improving cancer screening rates for women across multiple programs. The MCO should analyze the effectiveness of related interventions and expand upon those determined to be most effective.
 - The MCO should update its quality improvement strategy to include asthma medication management.

Metropolitan Health Plan (MHP)

Corporate Profile

Metropolitan Health Plan (MHP) has been a licensed HMO since 1983 and has provided medical assistance benefits to public program enrollees since 1984. MHP operates under the sponsorship of Hennepin County and serves enrollees in the SNBC program. The MCO ended its participation in the MSHO and MSC+ programs as of January 1, 2015. Effective September 2, 2016, MHP changed its name to Hennepin Health, and will be reported under Hennepin Health in future ATR publications. As of December 2016, enrollment totaled 2,368, accounting for less than 1% of the entire MHCP population.

Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QA Exam on May 12, 2014 through May 16, 2014. The examination period covered May 1, 2011 to February 28, 2014, while the file review period covered March 1, 2013 to February 28, 2014. The MCO received a total of one (1) recommendation, twelve (12) mandatory improvements, and one (1) deficiency for the QAE, and five (5) “Not Mets” for the TCA.

During the 2015 Mid-Cycle Review, MDH determined that MHP met its QAE corrective action plan with the exception of one (1) mandatory improvements and one (1) deficiency; and that MHP met its TCA corrective action plan. Of the initial five (5) “Not Mets” for the TCA, two (2) “Not Mets” were no longer applicable at the time of the mid-cycle review as MHP ended its CMS contract for the senior programs on December 31, 2014.

Performance Improvement Project

The following PIP is in progress:

- **Reduction of Racial Disparities in the Management of Depression (2015-2017)** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Medica, MHP, and UCare. The goal of this PIP is to increase the use of antidepressant medication treatment for depression within the SNBC population and to reduce the existing gaps within the critical racial groups with regard to antidepressant medication adherence. Specifically, the goal is to reduce, by 20 percent, the rate of disparity between White SNBC members and Black SNBC members as by indicated the HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure. Rates will be calculated separately for White members and Black members and then compared to determine the rate of disparity between the two populations. Table 23 displays the MCO’s baseline rates for this PIP.

Table 23: MHP Baseline Rates – 2015 PIP

HEDIS® Year	White	Non-White	Disparity
2014	35.13%	31.66%	-3.47%
2015	33.33%	33.73%	+0.04%
Change	-1.8	+2.07	-3.51

Provider-focused interventions include:

- In collaboration with the MCOs listed above, conduct training for providers in a variety of disciplines in partnership with other organizations, such as NAMI-MN and MDH.
- Develop resources, including a toolkit for providers, which will include a shared decision making tool, brochures, talking points, and a list of pharmacies that can print medication labels in multiple languages and that have language lines available for non-English speaking members.

Member-focused interventions include:

- Telephonic outreach conducted by care coordinator staff to members newly diagnosed with depression to address specific treatment barriers and teach strategies for managing side effects.
- Follow-up calls by nursing staff to educate and remind members of the importance of treating depression, the benefits of antidepressant therapy, and best practices for managing side effects.

2016 Financial Withhold

See Hennepin Health.

Annual Quality Assurance Work Plan for 2016

See Hennepin Health.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

See Hennepin Health.

MCO Provider Guidelines

See Hennepin Health.

HEDIS® AND CAHPS® Performance

The MCO's HEDIS® rates are displayed in Table 24, while Figure 14 displays the HEDIS® Measure Matrix. During this reporting period, CAHPS® data was not reported for MHP's SNBC program.

Table 24: MHP HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	MHP HEDIS® 2015	MHP HEDIS® 2016	MHP HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
SNBC					
Adult BMI Assessment ¹ (Non-SNP)	81.3%	84.9%	92.5%	75 th	90.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	89.6%	90.8%	88.4%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	95.2%	94.1%	94.5%	95 th	96.3%
Breast Cancer Screening (50-64 Years) ²	48.0%	55.8%	51.5%	10 th	53.4%
Cervical Cancer Screening (24-64 Years) ²	52.3%	50.1%	48.5%	10 th	46.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	93.3%	86.9%	92.5%	75 th	91.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	54.9%	62.5%	61.7%	66.67 th	70.5%
Controlling High Blood Pressure ¹ (Non-SNP)	67.6%	60.2%	64.7%	66.67 th	70.2%
Medication Management for People With Asthma – 50% (19-64 Years) ²	47.1%	59.4%	Small Sample	Not Applicable	67.0%
Medication Management for People With Asthma – 75% (19-64 Years) ²	9.8%	28.1%	Small Sample	Not Applicable	46.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 14: MHP 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B Comprehensive Diabetes Care – HbA1c Testing (SNBC)	A
	D	D Comprehensive Diabetes Care – Eye Exam (SNBC)	C Breast Cancer Screening (SNBC) Controlling High Blood Pressure (SNBC) Cervical Cancer Screening (SNBC)	B
	F		D	C

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Strengths

- **PIP** – MHP’s 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as an intervention approach that targets members and providers.

Opportunities for Improvement

- **HEDIS® (Quality of Care)** – MHP demonstrates an opportunity for improvement in the following area of care:
 - SNBC
 - *Comprehensive Diabetes Care: Eye Exam*
- **QAE** – MHP met its QAE corrective action plan with the exception of one (1) mandatory improvement and one (1) deficiency.

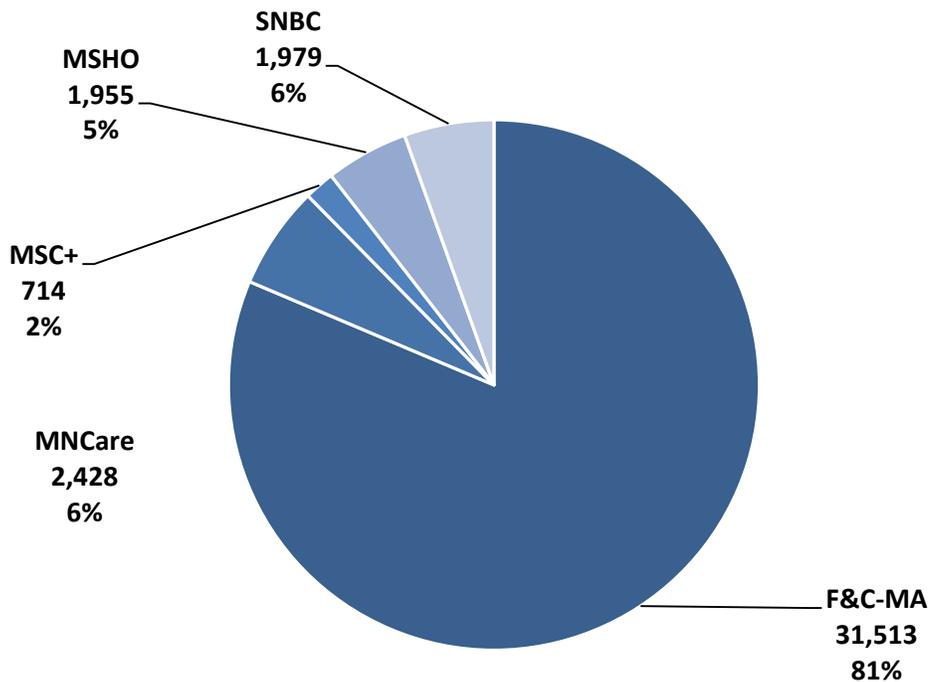
Recommendations

- **HEDIS® (Quality of Care)** – Conduct root cause analysis for the measure listed above and implement quality improvement initiatives to address identified barriers. The MCO should expand the reach of interventions to ensure members who are not in the Diabetes Disease Management Program also benefit from implemented interventions.

Corporate Profile

Organized through a Joint Powers Board of thirteen (13) local county governments as a CBP, PrimeWest is a publicly funded MCO. The MCO began enrollment in July 2003 for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO achieved NCQA accreditation status for its Medicaid lines of business for the 2016-2017 NCQA rating period. As of December 2016, enrollment totaled 38,728, accounting for 4% of the entire MHCP population.

Figure 15: PrimeWest Health Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on October 20, 2014 through October 23, 2014. The examination period covered June 1, 2011 to August 31, 2014, while the file review period covered September 1, 2013 to August 31, 2014. The MCO received a total of two (2) recommendations and two (2) mandatory improvements for the QAE, and one (1) not met for the TCA.

Performance Improvement Projects

The following PIP is in progress:

- **Antidepressant Medication Management with a Special Focus on Racial/Ethnic Disparities, F&C-MA (2015-2017)** – The goal for this PIP is to increase, by 6 percentage points, the HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for the F&C-MA population. Table 25 displays the MCO’s baseline rates for this PIP.

Table 25: PrimeWest Baseline Rates – 2015 PIP

HEDIS® Year	All
2013	34.43%
2014	37.43%
Baseline	35.89%
2015	39.63%
2016	37.17%
Change	+1.28

Member-focused interventions include:

- Using pharmacy claims data, health coaches will identify members who are late with filling prescriptions and call these members each week to provide assistance, encourage follow-up appointments and medication adherence, provide general health education, and address barriers for members.
- If health coaches cannot reach members by phone, reminder letters will be mailed on a weekly basis. These letters will contain information on coping with side effects, follow-up visits, adherence, etc., as well as a number to call with questions.

Provider-focused interventions include:

- Create a provider toolkit for all providers, including pharmacists, to be distributed electronically, containing resources including: how to approach depression, motivational interviewing techniques, and cultural considerations.
- Providers will receive a letter when members miss a prescription fill. MCO staff will also reach out to providers after health coach calls to members are made to coordinate care between providers, pharmacies, and the MCO.

Community-focused interventions include:

- General community outreach will be completed, including public service announcement postings, training opportunities, website postings, etc., as needed.

2016 Financial Withhold

PrimeWest achieved 65.85 of 90 points for the F&C-MA and MNCare programs, 78.84 of 90 points for the MSHO and MSC+ programs, and 45 of 60 points for the SNBC program. Table 26 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by PrimeWest.

Table 26: PrimeWest 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	0.22
Annual Dental Visit: Age 7-18 Years	5	1.71
Annual Dental Visit: Age 19-64 Years	5	3.92
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	Small Sample	Small Sample
Total	90	65.85
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	3.84
Total	90	78.84
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Annual Quality Assurance Work Plan for 2016

PrimeWest Health submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The work plan identifies the quality improvement program scope, objectives, persons responsible, and timeframe to achieve each activity. The MCO has a wide variety of programs addressing topics, such as the quality of services, quality of clinical care, safety of clinical care, and quality program administration. Each project has its own timeline for when the MCO will develop a process, collect data, aggregate data, report findings, analyze findings, intervene, and monitor previously identified issues for each measure, if any. With efforts to focus on patient safety, projects with a safety component were specifically noted. The MCO had three focused studies with the following topics: Timeliness of Behavioral Health Care and Medical Health Care Information, 2016 Increase in Pharmacy Appeals, and Chiropractic Billing.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

The 2016 QI program goals included the following: ensuring access to safe, quality health care services for Medicaid and low-income populations; improving the health status of PrimeWest members and its member counties; and operating PrimeWest as a model business. The PrimeWest QI program is administered and implemented by the following staff: Chief Senior Medical Director, Director of Care Management, Director of Quality and Utilization Management, Behavioral Health Medical Director, Family Medicine Medical Director, Manager of Quality Management, Manager of Reporting and Data Analytics, Data Specialist, Quality Specialist, Complaints/Appeals and Grievances Specialist, Quality Coordinator, Site Visit and Utilization Management Coordinator, HEDIS® and Site Visit Specialist, Pharmacy Manager, and Provider Contracting and Network Manager. Specific responsibilities are delegated to a variety of MCO committees and subcommittees, which are comprised of departmental leadership, staff members, and practitioners.

During 2016, the MCO engaged in improvement initiatives in areas encompassing several areas of health care, including continuity and coordination of physical and behavioral health care, access and availability of providers, member satisfaction, and patient safety. Overall, PrimeWest achieved many of its established goals across the majority of its improvement initiatives. The MCO identified several opportunities for improvement through its various QI initiatives, as well. PrimeWest Health readjusted its improvement goals for these initiatives and, moving forward, will consider continuing these projects in order to facilitate improvement.

MCO Provider Guidelines

PrimeWest adopted clinical practice guidelines related to preventive care, chronic disease, prenatal care, tobacco use and dependency, chemical dependency, and special needs population-specific conditions. Sources for PrimeWest's clinical practice guidelines included ICSI, the Eighth Joint National Committee, ADA, American College of Cardiology Foundation (ACCF), AHA, Journal of American Medical Association (JAMA), AACAP, NHLBI, AHRQ, APA, Mayo Clinic and Stratis Health. Provider compliance with guidelines is measured annually via related HEDIS® measures. The goal for each guideline was to maintain or improve the previous year's corresponding HEDIS® measure rates.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 27 and 28, respectively, while Figure 16 displays the HEDIS® Measure Matrix.

Table 27: PrimeWest Health HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	PrimeWest Health HEDIS® 2015	PrimeWest Health HEDIS® 2016	PrimeWest Health HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	34.1%	32.1%	44.8%	33.33 th	39.1%
Adult BMI Assessment ¹	85.2%	84.9%	79.3%	25 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	87.0%	85.0%	87.0%	90 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.7%	85.9%	88.2%	50 th	88.6%
Breast Cancer Screening (50-64 Years) ²	57.5%	65.0%	65.5%	75 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	63.7%	56.0%	57.0%	33.33 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	68.4%	68.9%	66.9%	25 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	96.3%	95.2%	95.7%	50 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	88.6%	89.9%	89.1%	50 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	91.3%	91.2%	91.7%	50 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	93.9%	93.6%	93.1%	75 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	40.9%	37.3%	40.4%	<10 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	89.3%	90.1%	92.1%	75 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	61.6%	69.0%	69.6%	90 th	70.4%
Controlling High Blood Pressure ¹	66.7%	62.5%	62.0%	50 th	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	65.0%	66.2%	67.9%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	43.1%	43.9%	45.1%	75 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	61.3%	61.6%	58.0%	25 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	56.6%	58.2%	56.9%	<10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 27: PrimeWest Health HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2015	PrimeWest Health HEDIS® 2016	PrimeWest Health HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	Small Sample	19.0%	43.8%	25 th	28.6%
Adult BMI Assessment ¹	86.6%	87.3%	83.7%	33.33 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	78.9%	78.3%	85.0%	75 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	85.2%	86.4%	89.0%	66.67 th	88.0%
Breast Cancer Screening (50-64 Years) ²	66.1%	68.0%	72.4%	90 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	49.4%	48.9%	53.9%	25 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	91.1%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	37.9%	41.5%	<10 th	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	96.7%	90.0%	94.1%	90 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	56.7%	66.9%	74.6%	95 th	69.7%
Controlling High Blood Pressure ¹	53.3%	70.4%	63.4%	66.67 th	70.3%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	70.0%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	Small Sample	Small Sample	Not Applicable	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology

Table 27: PrimeWest Health HEDIS® Performance – Reporting Years 2014, 2015 and 2016 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2015	PrimeWest Health HEDIS® 2016	PrimeWest Health HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.5%	98.8%	99.4%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	64.1%	66.5%	64.6%	66.67 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	93.6%	95.2%	94.1%	90 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	75.9%	83.5%	75.7%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	87.7%	95.0%	97.4%	95 th	93.7%
Breast Cancer Screening (65-74 Years) ²	58.9%	57.5%	61.8%	50 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	88.1%	89.7%	88.9%	66.67 th	74.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 27: PrimeWest Health HEDIS® Performance – Reporting Years 2014, 2015 and 2016 (Continued)

HEDIS® Measures	PrimeWest Health HEDIS® 2015	PrimeWest Health HEDIS® 2016	PrimeWest Health HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
SNBC					
Adult BMI Assessment ¹ (SNP)	82.5%	87.6%	93.8%	90 th	92.0%
Adult BMI Assessment ¹ (Non-SNP)	82.2%	84.5%	87.8%	50 th	90.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	91.8%	91.0%	90.0%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.4%	96.5%	94.8%	95 th	96.3%
Breast Cancer Screening (50-64 Years) ²	67.7%	66.2%	61.6%	50 th	53.4%
Cervical Cancer Screening (24-64 Years) ²	46.8%	46.1%	45.7%	10 th	46.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (SNP)	86.6%	95.0%	86.2%	33.33 th	89.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Year) ¹ (Non-SNP)	86.6%	85.7%	88.2%	50 th	91.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (SNP)	82.1%	85.0%	89.7%	95 th	84.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	76.1%	68.6%	67.2%	75 th	70.5%
Controlling High Blood Pressure ¹ (SNP)	56.6%	73.5%	74.0%	90 th	82.4%
Controlling High Blood Pressure ¹ (Non-SNP)	56.5%	67.1%	61.4%	50 th	70.2%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	67.0%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	46.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 16: PrimeWest 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Cervical Cancer Screening (MNCare) 	A <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA, MNCare)
	D <ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) Chlamydia Screening in Women (F&C-MA, MNCare) Childhood Immunization Status – Combo 3 (F&C-MA) Well-Child Visits in the First 15 Months of Life (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	C <ul style="list-style-type: none"> Breast Cancer Screening (F&C-MA, MSHO, MNCare) Controlling High Blood Pressure (F&C-MA, MNCare, SNBC Non-SNP, SNBC SNP) Cervical Cancer Screening (SNBC) Comprehensive Diabetes Care – Eye Exam (F&C-MA, MSHO, MNCare, SNBC Non-SNP, SNBC SNP) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO, MNCare, SNBC Non-SNP, SNBC SNP) 	B <ul style="list-style-type: none"> Breast Cancer Screening (MSC+, SNBC) Comprehensive Diabetes Care – HbA1c Testing (MSC+) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) 	
	F	D	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 28: PrimeWest CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	PrimeWest CAHPS® 2015	PrimeWest CAHPS® 2016	PrimeWest CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	56%	48%	53%	25 th	54%
Getting Care Quickly	60%	54%	58%	25 th	58%
How Well Doctors Communicate	79%	81%	80%	90 th	81%
Customer Service	64%	73%	64%	25 th	66%
Shared Decision Making	50%	80%	86%	Not Available	82%
Rating of All Health Care	49%	47%	51%	25 th	55%
Rating of Personal Doctor	63%	67%	69%	75 th	72%
Rating of Specialist Seen Most Often	58%	63%	57%	<25 th	64%
Rating of Health Plan	50%▼	52%	54%▼	25 th	59%
MNCare					
Getting Needed Care	49%▼	58%	65%	90 th	57%
Getting Care Quickly	50%▼	62%▲	64%	90 th	60%
How Well Doctors Communicate	77%	79%	78%	75 th	79%
Customer Service	74%	62%	61%	<25 th	58%
Shared Decision Making	45%	84%	87%	Not Available	84%
Rating of All Health Care	51%	54%	54%	50 th	55%
Rating of Personal Doctor	67%	71%	64%	25 th	68%
Rating of Specialist Seen Most Often	60%	71%	64%	25 th	66%
Rating of Health Plan	50%	53%	53%	<25 th	52%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

Table 28: PrimeWest CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	PrimeWest CAHPS® 2015	PrimeWest CAHPS® 2016	PrimeWest CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	63%▲	63%▲	64%	90 th	61%
Getting Care Quickly	72%▲	67%▲	67%	90 th	67%
How Well Doctors Communicate	77%	76%	75%	50 th	77%
Customer Service	68%	78%▲	77%	90 th	70%
Shared Decision Making	50%	77%	77%	Not Available	78%
Rating of All Health Care	67%	63%	66%	90 th	62%
Rating of Personal Doctor	75%	71%	75%	90 th	76%
Rating of Specialist Seen Most Often	74%	69%	74%	90 th	75%
Rating of Health Plan	73%▲	65%	71%	90 th	69%
SNBC					
Getting Needed Care	52%	57%▲	53%	25 th	54%
Getting Care Quickly	59%	58%	58%	25 th	60%
How Well Doctors Communicate	71%	75%	73%	25 th	74%
Customer Service	67%	73%▲	67%	25 th	66%
Shared Decision Making	50%	82%	77%	Not Available	78%
Rating of All Health Care	49%	49%	51%	25 th	52%
Rating of Personal Doctor	70%	71%	70%	75 th	67%
Rating of Specialist Seen Most Often	62%	69%	63%	25 th	64%
Rating of Health Plan	55%	58%	54%	25 th	56%

▲ Rate is significantly higher than the statewide average.

Table 28: PrimeWest CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	PrimeWest CAHPS® 2015	PrimeWest CAHPS® 2016	PrimeWest CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	61%	Not Available	59%
Getting Appointments & Care Quickly			52%		53%
Doctors Who Communicate Well			72%		74%
Customer Service			79%		75%
Getting Needed Prescription Drugs			82%		80%
Getting Information from Drug Plan			71%		64%
Care Coordination			67%		72%
Rating of Health Plan			72%		71%
Rating of All Health Care Quality			63%		60%
Rating of Drug Plan			76%		73%

Strengths

- **HEDIS® (Quality of Care)** – PrimeWest performed well in regard to the following areas of care:
 - F&C-MA
 - *Adolescent Well-Care Visit*
 - MNCare
 - *Adolescent Well-Care Visit*
- **PIP** – The MCO’s 2015-2017 PIP includes the use of a standardized HEDIS® measure to evaluate improvement, as well as a multicultural intervention strategy that targets members, providers, and the community.

Opportunities for Improvement

- **Financial Withhold** – PrimeWest did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. This was noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years, 7-18 years, and 19-64 years
 - Well-Child Visits in the First 15 Months of Life
 - MSHO and MSC+
 - Annual Dental Visit: Age group 65 years and older
 - SNBC
 - Annual Dental Visit: Age group 19-64 years
- **HEDIS® (Quality of Care)** – PrimeWest demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Cervical Cancer Screening*
 - *Chlamydia Screening in Women*
 - *Childhood Immunization Status: Combo 3*
 - *Well-Child Visits in the First 15 Months of Life*
 - *Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*
 - MNCare
 - *Chlamydia Screening in Women*
- **CAHPS® (Member Satisfaction)** – PrimeWest demonstrates an opportunity for improvement in regard to member satisfaction. The MCO performed below the statewide average for the following measure:
 - F&C-MA
 - *Rating of Health Plan*
- **QAE** – The MCO received a total of two (2) recommendations and two (2) mandatory improvements for the QAE.
- **TCA** – The MCO received a total of one (1) “Not Met” for the TCA.

Recommendations

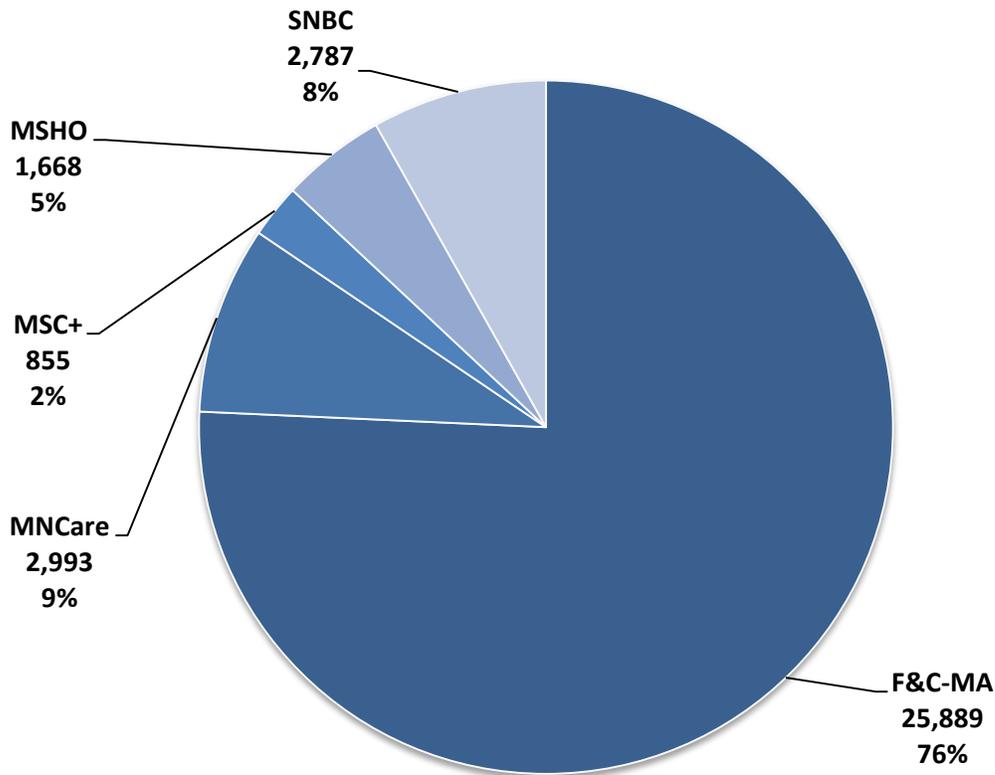
- **Financial Withhold** – As dental care is an area of concern across all programs, the MCO should ensure that the Annual Dental Visit measure is included in its five year strategic improvement plan. The MCO should also consider adding annual dental visit as an Accountable Rural Community Health facility outcome measure; as well as consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.
- **HEDIS® (Quality of Care)** – As the MCO continues to struggle with child health and women’s health, the MCO should ensure that these areas of care are priorities in its five year strategic improvement plan. The MCO should leverage its “in house” HEDIS® process to perform frequent data analysis, and to drive quality improvement actions.

South Country Health Alliance (SCHA)

Corporate Profile

South Country Health Alliance (SCHA) is a partnership of eleven (11) Minnesota counties formed in 2001 as a CBP. The MCO participates in the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. As of December 2016, enrollment totaled 34,192, accounting for 4% of the entire MHCP population.

Figure 17: SCHA Health Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on May 16, 2016 through May 20, 2016. The examination period covered May 1, 2013 to February 29, 2016, while the file review period covered March 1, 2015 to February 29, 2016. The MCO received one (1) “Not Met” for the TCA and a total of two (2) recommendations, three (3) mandatory improvements, and three (3) deficiencies for the QAE.

Performance Improvement Projects

The following PIP is in progress:

- ***Elimination of Racial and Ethnic Disparities in the Management of Depression (2015-2017)*** – The goal of this PIP is to improve the rate of compliance with antidepressant medications among both White and non-White members, thereby supporting efforts to eliminate racial and ethnic disparities in the treatment of depression. Specifically, the goal is to increase, by 4.64 percentage points, the overall F&C-MA and MNCare HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* rate for the first measurement year. Table 29 displays the MCO’s baseline rates for this PIP.

Table 29: SCHA Baseline Rates – 2015 PIP

HEDIS® Year	All
2013/2014	33.60%
2015	37.64%
2016	38.84%
Change	+5.24

Member-focused interventions include:

- Targeted, personalized mailings to identified members concerning: general education about the importance of follow up (one month), medication adherence and a reminder to continue (three months), and offering these members continued support in following treatment plans (six months).
- Call center service, telephonic outreach to remind members to fill prescriptions, provide education and address barriers for members. A script will be developed, which will include talking points aimed at follow-up appointments and medication adherence. Interpreter services will be available.

Provider-focused interventions include:

- Contact high-volume pharmacies to inform them of the project, offer assistance and resources to support adherence, determine which pharmacies have language services and which do not, and offer information regarding telephonic interpreter services.
- Identify prescribing physicians and network clinic systems to collaborate on depression care and best practices, as well as share pharmacy claims data with providers regarding adherence.

MCO-focused interventions include:

- Obtain a cultural competency training series via a vendor and make it available for all Member Services and Health Services staff.

2016 Financial Withhold

SCHA achieved 71.08 of 90 points for the F&C-MA and MNCare programs, 76.88 of 90 points for the MSHO and MSC+ programs and 45 of 60 points for the SNBC program. Table 30 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by SCHA.

Table 30: SCHA 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	2.33
Annual Dental Visit: Age 7-18 Years	5	5
Annual Dental Visit: Age 19-64 Years	5	3.75
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	15
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	Small Sample	Small Sample
Total	90	71.08
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	1.88
Total	90	76.88
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	0
Total	60	45

Annual Quality Assurance Work Plan for 2016

SCHA submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The work plan focuses on the structure of the MCOs quality program, including descriptions of the MCO's mission and values, scope of activities, systems for communication, activities and programs. The MCO's goals and objectives for its quality program include establishing effective partnerships with providers, primary care clinics and provider networks committed to quality care; establishing and measuring performance expectations; improving the clinical and functional outcomes of members over time;

improving member satisfaction; ensuring appropriate access; and meeting or exceeding regulatory requirements.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

SCHA's mission is to empower and engage members to be healthy, build connections with local agencies and providers, and be an accountable partner to the counties served. In order to achieve this mission, SCHA utilizes its Diamond Values to guide the QI program. These values include collaboration, stewardship, communication, and excellence. The QI Program aims to improve clinical outcomes and processes, functional outcomes, satisfaction, access to care, and resource utilization. The Program is comprised of multiple committees, which include SCHA staff members, Joint Powers Board (JPB) representatives, county representatives, providers, and other stakeholders. Some key committees include the Quality Assurance Committee (QAC), Compliance Committee, Member Advisory Committee, and the Public Health & Human Services Advisory Committee (PH/HSAC). The QAC provides direct input and recommendations as SCHA carries out the goals of the QI Program and the overall organizational goal. The PH/HSAC facilitates relationships between county agencies and the MCO in order to improve the quality of care for MCO members.

During 2016, SCHA continued to target a variety of areas of health care, including clinical and non-clinical aspects of health care. The MCO continued to reduce emergency department utilization among F&C-MA and MNCare members, and achieved a 25% reduction. Additionally, process improvements to the Grievances and Appeals Program appear to show a downward trend in pharmacy and dental benefits coverage appeals. The MCO's Health Pathways Program, which provides funding for the provision of prevention and early intervention mental health services for members who do not meet the Mental Health Targeted Case Management criteria, grew by 50%, as well. The MCO also continued to expand upon its communication with members and providers by increasing its presence on social media platforms.

MCO Provider Guidelines

SCHA identifies and reviews clinical guidelines with support from clinical and mental health staff, as well as Medical Directors. SCHA's clinical practice guidelines included preventive services for adults, preventive services for children and adolescents, routine prenatal care, diagnosis and management of asthma, diagnosis and treatment of hypertension, treatment of depression in adults, and assessment and treatment of ADHD for children and adolescents. Sources for clinical guidelines included ICSI, USPTF, DHS, ACOG, AAP, USDHHS, ACPM and AACAP. Guidelines are distributed to providers through the Provider Manual, newsletters, and MCO website. Provider compliance to clinical practice guidelines is assessed annually.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 31 and 32, respectively, while Figure 18 displays the HEDIS® Measure Matrix.

Table 31: SCHA HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	SCHA HEDIS® 2015	SCHA HEDIS® 2016	SCHA HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	41.7%	43.5%	37.3%	10 th	39.1%
Adult BMI Assessment ¹	91.7%	88.9%	85.2%	33.33 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	88.1%	83.1%	86.5%	75 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	87.9%	85.2%	87.2%	50 th	88.6%
Breast Cancer Screening (50-64 Years) ²	63.6%	61.7%	68.1%	75 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	62.6%	55.5%	59.5%	50 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	80.7%	77.7%	79.4%	90 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	96.8%	96.7%	96.0%	50 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	89.5%	90.4%	90.8%	75 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	90.0%	91.5%	92.3%	50 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	91.8%	93.1%	93.1%	75 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	43.0%	47.1%	45.7%	10 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	94.0%	93.8%	92.6%	75 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	65.0%	64.7%	64.0%	75 th	70.4%
Controlling High Blood Pressure ¹	69.8%	65.9%	60.6%	50 th	65.5%
Medication Management for People With Asthma – 50% (12-64 Years) ²	73.8%	63.7%	67.3%	Not Available	59.2%
Medication Management for People With Asthma – 75% (12-64 Years) ²	47.6%	45.1%	44.2%	75 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	65.5%	62.9%	63.9%	50 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	62.6%	62.6%	64.4%	10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 31: SCHA HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	SCHA HEDIS® 2015	SCHA HEDIS® 2016	SCHA HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	23.3%	32.4%	27.8%	<10 th	28.6%
Adult BMI Assessment ¹	90.5%	90.0%	83.1%	33.33 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	76.6%	77.4%	81.9%	50 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	83.3%	84.4%	88.1%	50 th	88.0%
Breast Cancer Screening (50-64 Years) ²	65.6%	68.9%	70.9%	90 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	40.9%	49.5%	53.8%	25 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	No Data	No Data	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	91.1%
Chlamydia Screening in Women (16-24 Years) ²	Small Sample	49.2%	64.1%	75 th	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	Small Sample	95.3%	96.7%	95 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	Small Sample	57.5%	63.3%	66.67 th	69.7%
Controlling High Blood Pressure ¹	67.5%	74.2%	66.8%	75 th	70.3%
Medication Management for People With Asthma – 50% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	70.0%
Medication Management for People With Asthma – 75% (19-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	Small Sample	Small Sample	Small Sample	Not Applicable	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 31: SCHA HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	SCHA HEDIS® 2015	SCHA HEDIS® 2016	SCHA HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	97.7%	97.8%	98.0%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	58.9%	65.6%	67.9%	75 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	96.7%	93.9%	95.9%	95 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	81.7%	75.0%	81.7%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	91.0%	92.3%	93.0%	75 th	93.7%
Breast Cancer Screening (65-74 Years) ²	47.0%	50.4%	52.6%	10 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	88.4%	80.5%	85.9%	33.33 th	74.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 31: SCHA HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	SCHA HEDIS® 2015	SCHA HEDIS® 2016	SCHA HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
SNBC					
Adult BMI Assessment ¹ (SNP)	94.7%	95.1%	91.2%	75 th	92.0%
Adult BMI Assessment ¹ (Non-SNP)	90.5%	93.1%	85.6%	33.33 th	90.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	94.9%	93.3%	95.4%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	97.1%	97.4%	97.2%	95 th	96.3%
Breast Cancer Screening (50-64 Years) ²	73.4%	72.5%	71.0%	90 th	53.4%
Cervical Cancer Screening (24-64 Years) ²	51.0%	48.5%	49.7%	10 th	46.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (SNP)	98.5%	96.9%	95.8%	95 th	89.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	96.3%	96.6%	95.4%	95 th	91.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (SNP)	86.9%	86.2%	82.2%	95 th	84.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	73.8%	68.7%	71.1%	95 th	70.5%
Controlling High Blood Pressure ¹ (SNP)	89.7%	88.5%	87.0%	95 th	82.4%
Controlling High Blood Pressure ¹ (Non-SNP)	72.7%	75.1%	71.2%	75 th	70.2%
Medication Management for People With Asthma – 50% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	67.0%
Medication Management for People With Asthma – 75% (12-64 Years) ²	Small Sample	Small Sample	Small Sample	Not Applicable	46.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 18: SCHA 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Cervical Cancer Screening (F&C-MA) 	A
	D <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA) Comprehensive Diabetes Care – Eye Exam (F&C-MA) Chlamydia Screening in Women (F&C-MA) 	C <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA, MNCare) Breast Cancer Screening (MNCare) Controlling High Blood Pressure (MNCare, SNBC Non-SNP, SNBC SNP) Cervical Cancer Screening (MNCare, SNBC) Comprehensive Diabetes Care – Eye Exam (MSHO, MNCare, SNBC Non-SNP, SNBC SNP) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MNCare) Chlamydia Screening in Women (MNCare) Well-Child Visits in the First 15 Months of Life (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	B <ul style="list-style-type: none"> Breast Cancer Screening (F&C-MA, MSC+, MSHO, SNBC) Comprehensive Diabetes Care – HbA1c Testing (MSC+, MSHO, SNBC Non-SNP, SNBC SNP) Childhood Immunization Status – Combo 3 (F&C-MA) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) 	
	F	D	C	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 32: SCHA CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	SCHA CAHPS® 2015	SCHA CAHPS® 2016	SCHA CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	52%	47%	56%	50 th	54%
Getting Care Quickly	54%	54%	58%	25 th	58%
How Well Doctors Communicate	78%	83%	82%	90 th	81%
Customer Service	62%	73%	66%	25 th	66%
Shared Decision Making	50%	77%	86%	Not Available	82%
Rating of All Health Care	57%	46%▼	49%	<25 th	55%
Rating of Personal Doctor	73%	66%	74%	90 th	72%
Rating of Specialist Seen Most Often	59%	58%	64%	25 th	64%
Rating of Health Plan	58%	54%	62%	75 th	59%
MNCare					
Getting Needed Care	63%	58%	65%	90 th	57%
Getting Care Quickly	63%	62%▲	64%	90 th	60%
How Well Doctors Communicate	84%	79%	78%	75 th	79%
Customer Service	71%	62%	61%	<25 th	58%
Shared Decision Making	46%	84%	87%	Not Available	84%
Rating of All Health Care	55%	54%	54%	50 th	55%
Rating of Personal Doctor	66%	71%	64%	25 th	68%
Rating of Specialist Seen Most Often	68%	71%	64%	25 th	66%
Rating of Health Plan	57%	53%	53%	<25 th	52%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

Table 32: SCHA CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	SCHA CAHPS® 2015	SCHA CAHPS® 2016	SCHA CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	63%▲	63%▲	64%	90 th	61%
Getting Care Quickly	72%▲	67%▲	67%	90 th	67%
How Well Doctors Communicate	77%	76%	75%	50 th	77%
Customer Service	68%	78%▲	77%	90 th	70%
Shared Decision Making	50%	77%	77%	Not Available	78%
Rating of All Health Care	67%	63%	66%	90 th	62%
Rating of Personal Doctor	75%	71%	75%	90 th	76%
Rating of Specialist Seen Most Often	74%	69%	74%	90 th	75%
Rating of Health Plan	73%▲	65%	71%	90 th	69%
SNBC					
Getting Needed Care	51%	57%▲	53%	25 th	54%
Getting Care Quickly	53%	57%	58%	25 th	60%
How Well Doctors Communicate	73%	75%	73%	25 th	74%
Customer Service	67%▲	73%▲	67%	25 th	66%
Shared Decision Making	52%	82%	77%	Not Available	78%
Rating of All Health Care	49%	49%	51%	25 th	52%
Rating of Personal Doctor	69%	71%	70%	75 th	67%
Rating of Specialist Seen Most Often	61%	69%	63%	25 th	64%
Rating of Health Plan	61%	58%	54%	25 th	56%

▲ Rate is significantly higher than the statewide average.

Table 32: SCHA CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	SCHA CAHPS® 2015	SCHA CAHPS® 2016	SCHA CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	58%	Not Available	59%
Getting Appointments & Care Quickly			54%		53%
Doctors Who Communicate Well			73%		74%
Customer Service			79%		75%
Getting Needed Prescription Drugs			80%		80%
Getting Information from Drug Plan			68%		64%
Care Coordination			75%		72%
Rating of Health Plan			70%		71%
Rating of All Health Care Quality			60%		60%
Rating of Drug Plan			75%		73%

Strengths

- **PIPs** – SCHA’s 2015-2017 PIPs include the use of standardized HEDIS® measures to evaluate improvement, as well as an intervention strategy that targets members, providers, and the MCO.

Opportunities for Improvement

- **Financial Withhold** – SCHA did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. This was noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age groups 2-6 years and 19-64 years
 - Well-Child Visits in the First 15 Months of Life
 - MSHO and MSC+
 - Annual Dental Visit: Age group 65 years and older
 - SNBC
 - Annual Dental Visit: Age group 19-64 years
- **HEDIS® (Quality of Care)** – SCHA demonstrates an opportunity for improvement in the following areas of care:
 - F&C-MA
 - *Controlling High Blood Pressure*
 - *Comprehensive Diabetes Care – Eye Exam*
 - *Chlamydia Screening in Women*
- **QAE** – The MCO received a total of two (2) recommendations, three (3) mandatory improvements, and three (3) deficiencies for the QAE.

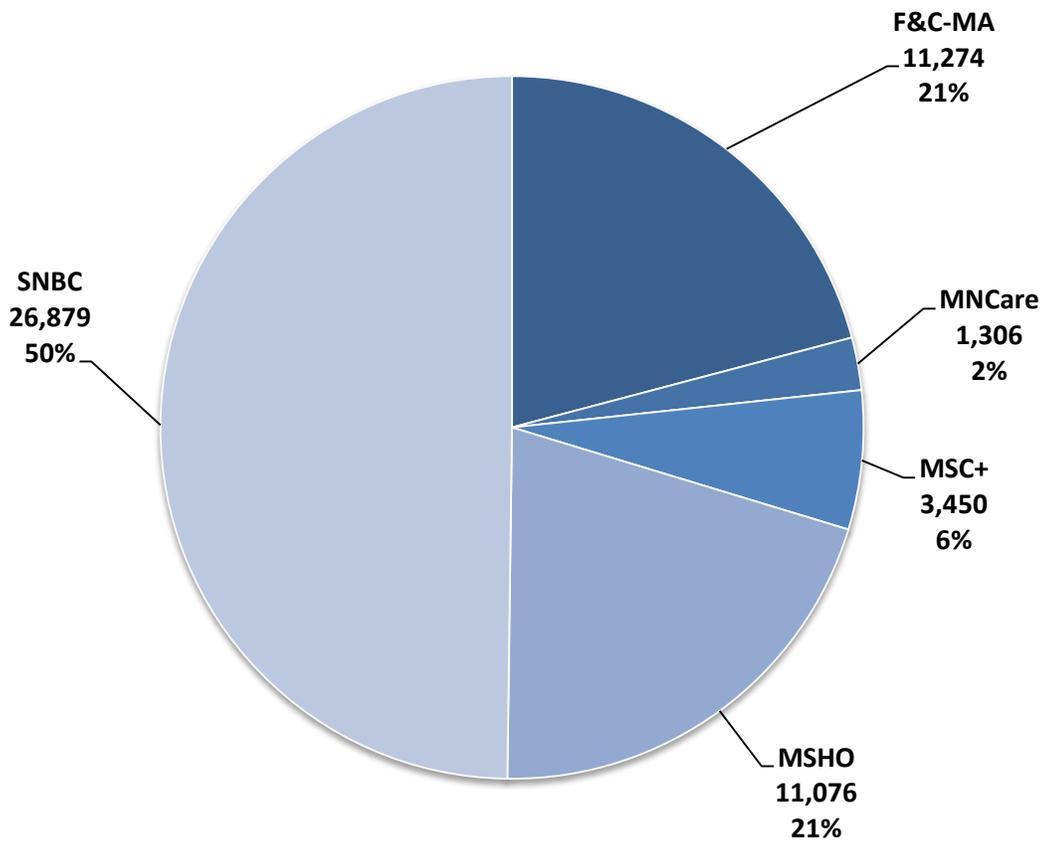
Recommendations

- **Financial Withhold**
 - In regard to the HEDIS® Well-Child Visits in the First 15 Months of Life Measure, the MCO should develop specific interventions to address the barriers described in its response to the previous year’s recommendation. For example, work with in-network clinics to enhance EMR systems to capture necessary documentation.
 - Conduct root cause analysis for annual dental visits by age group and by program, and development interventions to address identified barriers. The MCO should also consider collaborating with other MCOs to identify and address community issues, such as free dental clinics that do not submit claims.
- **HEDIS® (Quality of Care)** –
 - In regard to chlamydia screening, evaluate the effectiveness of the interventions described in the MCO’s response to the previous year’s recommendation and modify the interventions as needed. The MCO should expand all provider initiatives to include gynecologists as well.
 - Conduct root cause analysis for measures newly identified as opportunities for improvement and develop interventions to address identified barriers to care.

Corporate Profile

UCare is an independent, non-profit MCO founded in 1984 by the Department of Family Practice at the University of Minnesota Medical School. UCare serves enrollees in the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. As of December 2016, enrollment totaled 53,985, accounting for 6% of the entire MHCP population.

Figure 19: UCare Health Enrollment by Program – December 2016



Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent compliance audit on March 14, 2016 through March 18, 2016. The examination period covered July 1, 2013 to November 30, 2015, while the file review period covered December 1, 2014 to November 30, 2015. The MCO received one (1) “Not Met” for the TCA and a total of three (3) recommendations, two (2) mandatory improvements, and six (6) deficiencies on the QAE.

Performance Improvement Projects

The following PIPs are in progress:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression (2015-2017)*** – This PIP is a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Medica, MHP, and UCare. The goal for this PIP is to increase, by 6 percentage points, the HEDIS® *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for non-White F&C-MA and MNCare members. Table 33 displays the MCO’s baseline rates for this PIP.

Table 33: UCare Baseline Rates – 2015 PIP

HEDIS® Year	Non-White
2014	27.33%
2015	27.41%
2016	27.75%
Change	+0.42

Member-focused interventions include:

- Telephonic outreach to members regarding education on depression, medications and their side effects, and symptoms, in addition to checking in with members on medication adherence, assisting in scheduling follow-up appointments, and referring members to behavioral health services, as needed.
- Through Beacon Health Strategies, a behavioral health delegate, institute a health coaching program, which consists of an initial health coach phone call to offer enrollment in this program. If members agree to enroll, they receive educational materials, such as a depression brochure (currently available in English and Spanish), a list of resources and contact information, and support for medication adherence.

Provider-focused interventions include:

- In collaboration with other MCOs, development of training opportunities on cultural issues related to depression diagnosis and treatment. These will be available to primary and specialty care providers, pharmacists, clinical nurses, etc.
- In collaboration with other MCOs, development of a provider toolkit aimed at patient education, which will include resources, such as information on pharmacies that have the ability to print medication labels in different languages.

- Partner with pharmacies to employ Medication Therapy Management (MTM). MTM may include: pharmacists reviewing members’ medications, identifying and synchronizing medications on a 30-day schedule, pharmacists consulting with members and physicians, etc.

Community-focused interventions include:

- A community event to create awareness during Minority Mental Health Month in July.
 - Partnerships with organizations such as the NAMI-MN, religious groups, targeted clinics, etc. to raise awareness of depression.
 - Sharing depression resources at local health fairs.
 - Promoting culturally specific community events related to depression and mental health.
- **Increasing Follow-up after Hospitalization Rates (2015-2017)** – This PIP is a collaborative comprised of two (2) MCOs: Medica and UCare. The goal of this PIP is to increase the HEDIS® *Follow-up After Hospitalization for Mental Illness –30 Days* rate by 6 percentage points and the – *7 Days* rate by 7 percentage points for the SNBC population. Table 34 displays the MCO’s baseline rates for this PIP.

Table 34: UCare Baseline Rates – 2015 PIP

HEDIS® Year	7 Days	30 Days
2014	41.40%	67.63%
2015	43.87%	69.66%
2016	43.50%	69.59%
Change	+2.1	+1.96

Provider-focused interventions include:

- In collaboration with the MCO listed above, identify hospitals and/or clinics serving high volumes of members to pilot best practices.
- Development of educational opportunities/trainings to address topics including: mental health in the SNBC population, cultural issues related to psychiatric disorders, MCO resources, and best practices.
- Development of a provider toolkit that may include resources for: mental health; best practices; cultural competency; MCO resources, such as transportation; etc. A postcard with toolkit information will be distributed to providers at events.

Member-focused interventions include:

- Implementation of Beacon Health Strategies After Care Coordination program, which provides outreach to members post-discharge in order to assist members in scheduling a follow-up appointment at seven (7) and/or thirty (30) days and to provide additional support to members who did not adhere to appointments, in addition to calls and mailings reminding members of appointments.

- Partner with internal care coordinators for outreach to members to ensure they receive follow-up care, to assist in scheduling appointments and transportation, and to provide education on mental health/medication adherence, etc.

Community-focused interventions include:

- Collaborate with community agencies, such as the NAMI-MN, religious groups, targeted clinics, etc. to identify channels for promoting awareness of mental health resources.

2016 Financial Withhold

UCare achieved 58.89 of 90 points for the F&C-MA and MNCare programs, 75 of 90 points for the MSHO and MSC+ programs and 47.47 of 60 points for the SNBC program. Table 35 displays the results of the 2016 Financial Withhold, including performance measures, point values, and points earned by UCare.

Table 35: UCare 2016 Financial Withhold

Performance Measure	Point Value	Points Earned
F&C-MA and MNCare		
Annual Dental Visit: Age 2-6 Years	5	5
Annual Dental Visit: Age 7-18 Years	5	5
Annual Dental Visit: Age 19-64 Years	5	3.89
Well-Child Visits in the First 15 Months of Life	15	0
Child and Teen Checkups Referral Code	15	15
Repeat Deficiencies on the MDH QA Exam	15	15
Emergency Department Utilization Rate	15	0
Hospital Admission Rate	15	15
Hospital 30-Day Readmission Rate	Small Sample	Small Sample
Total	90	58.89
MSHO and MSC+		
Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
Initial Health Risk Screening/Assessment	30	30
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 65+	15	0
Total	90	75
SNBC		
Repeat Deficiencies on the MDH QA Exam	15	15
Compliance with Service Accessibility Requirements Reports	15	15
MCO Stakeholder Group	15	15
Annual Dental Visit: Age 19-64 Years	15	2.47
Total	60	47.47

Annual Quality Assurance Work Plan for 2016

UCare submitted an annual QA work plan that is compliant with Minnesota Administrative Rule 4685.1130. The MCO's proposed activities are separated into three categories: Service, Clinical, and Patient. The activities were then placed into specific focus areas, which include: Administrative, Member Experience, Quality of Clinical Care, Quality of Service, and Safety of Clinical Care. Additionally, corresponding activities include: products, yearly objective and planned activities. In the report, the MCO also included: the regulatory requirement for each activity, the report in which the results will be presented, owner of the activity, as well as the committees that are involved. The MCO's report was approved by the Quality Improvement Advisory and Credentialing Committee (QIACC), the Quality Improvement Committee, and the Board of Directors.

Evaluation of the 2016 Annual Quality Assessment and Performance Improvement Program

UCare's Quality Improvement (QI) Program is designed to objectively and systematically monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and services. UCare's multidimensional approach to clinical, organizational, and consumer components enable the MCO to focus on opportunities for improving processes, as well as health outcomes, and provider and member satisfaction. For 2016, the QI Program established several goals, which included, but were not limited to, the following: coordinate quality improvement activities throughout the organization; continuously improve the quality, appropriateness, availability, accessibility, coordination, and continuity of care; improve and manage member outcomes, satisfaction, and safety; and foster a partnership among members, caregivers, providers, and the community. The MCO's QI Program is overseen by the Board of Directors, which delegates operational activities to various committees, including the Quality Improvement Advisory and Credentialing Committee, Medical Management Committee, Member Experience Steering Committee, and the Quality Measures Improvement Committee.

Overall, the MCO's QI Program achieved many of its established goals. Some accomplishments included, but were not limited to: improvements in the *Improving or Maintaining Mental Health* and *Improving Bladder Control* for certain populations; obtaining results at or above the national average for several CAHPS measures, particularly in the *Rating of MCO* metric; and achievement of lower rates of high-risk medication use. UCare commits to continuous improvement and will continue to address identified opportunities for improvement to ensure optimal member experience.

MCO Provider Guidelines

The MCO adopts and utilizes clinical practice guidelines to enhance patient and professional decision-making. UCare's preferred source for clinical practice guidelines is ICSI. Guidelines are reviewed, at a minimum, every two years. In 2015, UCare adopted guidelines related to preventive services for adults, preventive services for children and adolescents, routine prenatal care, diagnosis and management of type 2 diabetes in adults, diagnosis and management of asthma, prevention and management of obesity in adults, heart failure in adults, and treatment of depression in adults. UCare audits a sample of its provider clinics and systems in order to assess compliance with these guidelines and to identify barriers.

HEDIS® and CAHPS® Performance

The MCO's HEDIS® and CAHPS® rates are displayed in Tables 36 and 37, respectively, while Figure 20 displays the HEDIS® Measure Matrix.

Table 36: UCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures	UCare HEDIS® 2015	UCare HEDIS® 2016	UCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Adolescent Well-Care Visit (12-21 Years) ¹	38.7%	41.1%	37.0%	10 th	39.1%
Adult BMI Assessment ¹	92.5%	88.8%	85.6%	33.33 th	88.3%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	88.0%	84.0%	81.6%	50 th	86.3%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	89.7%	86.9%	86.0%	33.33 th	88.6%
Breast Cancer Screening (50-74 Years) ²	65.3%	63.7%	60.4%	50 th	63.3%
Cervical Cancer Screening (24-64 Years) ²	66.0%	58.7%	61.1%	50 th	61.0%
Childhood Immunization Status: Combo 3 (2 Years) ¹	67.6%	69.6%	75.6%	66.67 th	73.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	97.6%	97.0%	96.0%	50 th	97.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	91.2%	90.1%	87.6%	33.33 th	90.3%
Children and Adolescents' Access to PCPs (7-11 Years) ²	93.0%	92.1%	85.3%	10 th	92.3%
Children and Adolescents' Access to PCPs (12-19 Years) ²	91.9%	92.0%	87.5%	33.33 th	92.7%
Chlamydia Screening in Women (16-24 Years) ²	60.4%	59.2%	48.6%	10 th	57.1%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	93.4%	92.5%	93.7%	90 th	93.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	62.2%	64.4%	70.2%	90 th	70.4%
Controlling High Blood Pressure ¹	67.6%	60.8%	48.1%	25 th	65.5%
Medication Management for People With Asthma – 50% (5-64 Years) ²	52.1%	52.9%	59.5%	Not Available	59.2%
Medication Management for People With Asthma – 75% (5-64 Years) ²	27.0%	27.4%	30.4%	33.33 th	34.0%
Well-Child Visits in the First 15 Months of Life (6+ Visits) ²	63.3%	63.1%	57.9%	25 th	65.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	66.0%	64.5%	62.9%	10 th	64.5%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 36: UCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	UCare HEDIS® 2015	UCare HEDIS® 2016	UCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MNCare					
Adolescent Well-Care Visit (12-21 Years) ¹	27.7%	26.8%	26.8%	<10 th	28.6%
Adult BMI Assessment ¹	91.7%	87.8%	84.2%	33.33 th	87.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	78.6%	75.9%	78.8%	33.33 th	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	85.7%	84.9%	79.9%	10 th	88.0%
Breast Cancer Screening (50-64 Years) ²	70.8%	70.6%	71.8%	90 th	68.2%
Cervical Cancer Screening (24-64 Years) ²	44.4%	46.8%	57.6%	33.33 th	52.8%
Children and Adolescents' Access to PCPs (12-24 Months) ²	Small Sample	Small Sample	Small Sample	Not Applicable	95.0%
Children and Adolescents' Access to PCPs (25 Months-6 Years) ²	84.6%	82.2%	Small Sample	Not Applicable	93.0%
Children and Adolescents' Access to PCPs (12-19 Years) ²	Small Sample	90.4%	Small Sample	Not Applicable	91.1%
Chlamydia Screening in Women (16-24 Years) ²	60.5%	59.4%	Small Sample	Not Applicable	58.8%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹	96.5%	92.9%	95.8%	95 th	96.3%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹	65.0%	65.9%	66.7%	75 th	69.7%
Controlling High Blood Pressure ¹	71.8%	62.3%	31.1%	<10 th	70.3%
Medication Management for People With Asthma – 50% (12-64 Years) ²	60.0%	64.7%	Small Sample	Not Applicable	70.0%
Medication Management for People With Asthma – 75% (12-64 Years) ²	45.5%	38.8%	Small Sample	Not Applicable	44.0%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life ²	58.5%	53.4%	Small Sample	Not Applicable	63.9%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Table 36: UCare HEDIS® Performance – Reporting Years 2015, 2016 and 2017 (Continued)

HEDIS® Measures	UCare HEDIS® 2015	UCare HEDIS® 2016	UCare HEDIS® 2017	QC® 2017 National Medicaid Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	98.2%	98.2%	98.0%	95 th	98.2%
Breast Cancer Screening (65-74 Years) ²	64.5%	64.7%	62.3%	50 th	61.2%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ¹	94.2%	95.1%	94.4%	90 th	92.3%
Comprehensive Diabetes Care: Eye Exam (65-75 Years) ¹	76.9%	77.6%	80.8%	95 th	79.9%
MSC+					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) ²	96.0%	94.6%	95.6%	95 th	93.7%
Breast Cancer Screening (65-74 Years) ²	48.1%	46.3%	42.2%	<10 th	43.6%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) ²	89.8%	86.9%	84.9%	25 th	74.3%
SNBC					
Adult BMI Assessment ¹ (Non-SNP)	91.5%	90.0%	91.7%	75 th	90.5%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) ²	93.0%	92.9%	92.8%	95 th	92.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) ²	96.4%	96.7%	96.5%	95 th	96.3%
Breast Cancer Screening (50-64 Years) ²	63.3%	62.9%	61.3%	50 th	53.4%
Cervical Cancer Screening (24-64 Years) ²	52.8%	51.4%	50.1%	10 th	46.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) ¹ (Non-SNP)	94.0%	91.8%	92.0%	75 th	91.1%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) ¹ (Non-SNP)	72.3%	67.0%	69.2%	90 th	70.5%
Controlling High Blood Pressure ¹ (Non-SNP)	64.2%	59.9%	69.6%	75 th	70.2%
Medication Management for People With Asthma – 50% (12-64 Years) ²	65.1%	63.3%	64.6%	Not Available	67.0%
Medication Management for People With Asthma – 75% (12-64 Years) ²	38.8%	38.8%	44.4%	75 th	46.3%

¹ Rate calculated by the MCO using the hybrid methodology.

² Rate calculated by DHS using the administrative methodology.

Figure 20: UCare 2017 HEDIS® Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2016 – 2017 Rate Change	C		B <ul style="list-style-type: none"> Controlling High Blood Pressure (SNBC) Cervical Cancer Screening (MNCare) 	A
	D <ul style="list-style-type: none"> Well-Child Visits in the First 15 Months of Life (F&C-MA) 	C <ul style="list-style-type: none"> Adolescent Well-Care Visit (F&C-MA, MNCare) Breast Cancer Screening (F&C-MA, MSC+, MSHO, MNCare) Cervical Cancer Screening (F&C-MA) Comprehensive Diabetes Care – Eye Exam (F&C-MA, MSHO, MNCare, SNBC) Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MSHO, MNCare, SNBC) Childhood Immunization Status – Combo 3 (F&C-MA) Medication Management for People with Asthma-50% (F&C-MA) Medication Management for People with Asthma-75% (F&C-MA) Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (F&C-MA) 	B <ul style="list-style-type: none"> Breast Cancer Screening (SNBC) Cervical Cancer Screening (SNBC) 	
	F <ul style="list-style-type: none"> Controlling High Blood Pressure (F&C-MA, MNCare) Chlamydia Screening in Women (F&C-MA) 	D	C <ul style="list-style-type: none"> Comprehensive Diabetes Care – HbA1c Testing (MSC+) 	

Key to the Measure Matrix

- A** Notable performance. MCO may continue with internal goals.
- B** MCOs may identify continued opportunities for improvement, but no required action.
- C** MCOs should identify opportunities for improvement, but no immediate action required.
- D** Conduct root cause analysis and develop action plan.
- F** Conduct root cause analysis and develop action plan.

Table 37: UCare CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures	UCare CAHPS® 2015	UCare CAHPS® 2016	UCare CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
F&C-MA					
Getting Needed Care	54%	55%	57%	50 th	54%
Getting Care Quickly	55%	58%	54%	<25 th	58%
How Well Doctors Communicate	80%	82%	75%▼	50 th	81%
Customer Service	72%	60%	62%	<25 th	66%
Shared Decision Making	49%	85%	80%	Not Available	82%
Rating of All Health Care	54%	64%▲	57%	75 th	55%
Rating of Personal Doctor	74%	74%	67%▼	50 th	72%
Rating of Specialist Seen Most Often	66%	68%	63%	25 th	64%
Rating of Health Plan	57%	58%	63%	75 th	59%
MNCare					
Getting Needed Care	58%	63%	61%	90 th	57%
Getting Care Quickly	58%	53%	59%	25 th	60%
How Well Doctors Communicate	75%	83%	81%	90 th	79%
Customer Service	68%	56%	52%	<25 th	58%
Shared Decision Making	48%	88%	85%	Not Available	84%
Rating of All Health Care	52%	62%	62%▲	90 th	55%
Rating of Personal Doctor	68%	77%	67%	50 th	68%
Rating of Specialist Seen Most Often	67%	69%	52%	<25%	66%
Rating of Health Plan	52%	52%	57%	25 th	52%

▼ Rate is significantly lower than the statewide average.
 ▲ Rate is significantly higher than the statewide average.

Table 37: UCare CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	UCare CAHPS® 2015	UCare CAHPS® 2016	UCare CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSC+					
Getting Needed Care	50%▼	46%▼	61%	90 th	61%
Getting Care Quickly	64%	51%▼	68%	90 th	67%
How Well Doctors Communicate	79%	79%	78%	75 th	77%
Customer Service	59%	63%	69%	50 th	70%
Shared Decision Making	53%	78%	82%	Not Available	78%
Rating of All Health Care	60%	49%▼	61%	90 th	62%
Rating of Personal Doctor	72%	73%	79%	90 th	76%
Rating of Specialist Seen Most Often	69%	64%	76%	90 th	75%
Rating of Health Plan	65%	61%	68%	90 th	69%
SNBC					
Getting Needed Care	52%	52%	57%	50 th	54%
Getting Care Quickly	55%	55%	67%▲	90 th	60%
How Well Doctors Communicate	69%	69%	76%	50 th	74%
Customer Service	54%	60%	67%	25 th	66%
Shared Decision Making	52%	79%	79%	Not Available	78%
Rating of All Health Care	54%	41%	60%	90 th	52%
Rating of Personal Doctor	63%	58%▼	65%	25 th	67%
Rating of Specialist Seen Most Often	58%	57%	61%	<25 th	64%
Rating of Health Plan	54%	56%	61%	50 th	56%

▼ Rate is significantly lower than the statewide average.

▲ Rate is significantly higher than the statewide average.

Table 37: UCare CAHPS® Performance – 2015, 2016 and 2017 (Continued)

CAHPS® Measures	UCare CAHPS® 2015	UCare CAHPS® 2016	UCare CAHPS® 2017	2017 CAHPS® Database Benchmark Met/Exceeded	2017 Statewide Average
MSHO					
Getting Needed Care	No Data to Report	No Data to Report	49%▼	No Available	59%
Getting Appointments & Care Quickly			45%▼		53%
Doctors Who Communicate Well			72%		74%
Customer Service			72%		75%
Getting Needed Prescription Drugs			74%		80%
Getting Information from Drug Plan			51%		64%
Care Coordination			70%		72%
Rating of Health Plan			68%		71%
Rating of All Health Care Quality			57%		60%
Rating of Drug Plan			66%		73%

▼ Rate is significantly lower than the statewide average.

Strengths

- **PIPs** – UCare’s 2015-2017 PIPs include the use of standardized HEDIS® measures to evaluate improvement, as well as an intervention strategy that targets members, providers, and the community.
- **CAHPS® (Member Satisfaction)** – UCare performed well in regard to the following areas of member satisfaction:
 - MNCare
 - *Rating of All Health Care*
 - SNBC
 - *Getting Care Quickly*

Opportunities for Improvement

- **Financial Withhold** – UCare did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. This was noted as an opportunity for improvement in the previous year’s report. The MCO did not meet the target goal for the following measures:
 - F&C-MA and MNCare
 - Annual Dental Visit: Age group 19-64 years
 - Well-Child Visits in the First 15 Months of Life
 - Emergency Department Utilization
 - MSHO and MSC+
 - Annual Dental Visit: Age group 65 years and older
 - SNBC
 - Annual Dental Visit: Age group 19-64 years
- **HEDIS® (Quality of Care)** – IMCare demonstrates an opportunity for improvement in regard to the following areas of care:
 - F&C-MA
 - *Well-Child Visits in the First 15 Months of Life*
 - *Controlling High Blood Pressure*
 - *Chlamydia Screening for Women*
 - MNCare
 - *Controlling High Blood Pressure*
- **CAHPS® (Member Satisfaction)** – UCare demonstrates an opportunity for improvement the following areas of member satisfaction:
 - F&C-MA
 - *How Well Doctors Communicate*
 - *Rating of Personal Doctor*
 - MSHO
 - *Getting Needed Care*
 - *Getting Appointments & Care Quickly*

Recommendations

▪ **Financial Withhold**

- As the MCO continues to struggle with emergency department utilization and well-child visits, the MCO should evaluate the effectiveness of its current improvement strategy and modify it based on updated root cause analyses.
- To address annual dental visits, the MCO should modify and expand upon its current dental outreach program described in the MCO's response to the previous year's recommendation. At a minimum, a modified approach should be based on root cause analysis and should address barriers across the various age groups and programs.

▪ **HEDIS® (Quality of Care)**

- As the MCO continues to struggle with improving the controlling high blood pressure rates, the MCO should intensify the improvement strategy described in the MCO's response to the previous year's recommendation. The MCO should consider an approach that includes a variety of member- and provider-level interventions.
- For measures newly identified as opportunities for improvement, the MCO should conduct root cause analyses to identify barriers and update its overall quality improvement strategy to include these measures.

▪ **CAHPS® (Member Satisfaction) – To enhance member experience with their personal doctors:**

- Continue to share survey results with providers and continue to work with providers to improve member-provider experience.
- Consider developing metrics that allow the MCO to routinely evaluate the member-provider experience; as well as increase the frequency of the Quality Management Department and Member Experience Manager's review of member satisfaction.
- Utilize complaints and grievances as a source to identify and address trends that may impact the member-provider experience.

C. Common Strengths and Opportunities across MHCP

Annually, DHS evaluates statewide performance using the HEDIS® administrative methodology for select measures. DHS also contracts with a certified-CAHPS® vendor to annually assess statewide member satisfaction. To determine common strengths and opportunities for improvement across all MCOs participating in the MHCP, IPRO compared the HEDIS® statewide averages to the national Medicaid benchmarks presented in the *Quality Compass*® 2017 and compared the CAHPS® statewide averages to the benchmarks published in the 2017 CAHPS® Database. Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement. Common strengths and opportunities for improvement are discussed below. Statewide HEDIS® and CAHPS® performance, as well as IPRO's assessment, are displayed in Tables 38 and 39, respectively.

MHCP Common Strengths and Opportunities for Improvement

Common strengths among all MCOs participating in the MHCP include: access to primary care for adults and adolescents, and member satisfaction with personal doctor. MHCP rates for the following HEDIS® and CAHPS® measures met or exceeded the 75th percentile:

- *Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)*
- *Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)*
- *Adults' Access to Preventive/Ambulatory Health Services (65+ Years)*
- *Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)*
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*

Common MHCP opportunities for improvement include: child/adolescent care, women's health screenings, and member satisfaction with MCO customer service. MCHP rates for the following HEDIS® and CAHPS® measures were below the 50th percentile:

- *Adolescent Well-Care Visit (12-21 Years)*
- *Breast Cancer Screening (50-74 Years)*
- *Cervical Cancer Screening (24-64 Years)*
- *Childhood Immunization Status: Combo 3 (2 Years)*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)*
- *Customer Service*

Table 38: MHCP HEDIS® Performance – Reporting Years 2015, 2016 and 2017

HEDIS® Measures ¹	MHCP HEDIS® 2015	MHCP HEDIS® 2016	MHCP HEDIS® 2017	Performance Assessment based on QC® 2017 National Medicaid Benchmarks
Adolescent Well-Care Visit (12-21 Years)	35.2%	35.3%	38.8%	Opportunity
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	87.1%	82.9%	86.1%	Strength
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	90.6%	88.4%	90.1%	Strength
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	96.9%	96.6%	96.7%	Strength
Breast Cancer Screening (50-74 Years)	59.5%	59.3%	58.3%	Opportunity
Cervical Cancer Screening (24-64 Years)	60.6%	54.5%	57.6%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	97.5%	96.7%	97.0%	Average
Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	91.0%	89.8%	90.3%	Average
Children and Adolescents' Access to Primary Care Practitioners (7-11 Years)	92.9%	92.4%	92.3%	Average
Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)	92.6%	92.5%	92.7%	Strength
Childhood Immunization Status: Combo 3 (2 Years)	67.6%	65.6%	59.6%	Opportunity
Chlamydia Screening in Women (16-24 Years)	58.7%	57.0%	57.2%	Average
Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)	88.4%	86.8%	85.2%	Opportunity
Medication Management for People with Asthma – 50% Compliance (5-64 Years)	55.0%	56.1%	61.2%	Not Available ²
Medication Management for People with Asthma – 75% Compliance (5-64 Years)	31.0%	32.1%	36.7%	Average
Well-Child Visits in the First 15 Months of Life (6+ Visits)	63.8%	60.6%	65.0%	Average
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)	65.3%	62.6%	64.5%	Opportunity

¹ HEDIS® rates were calculated by DHS using the administrative methodology.

² Performance cannot be assessed because NCQA *Quality Compass*® benchmarks for this measure are unavailable.

Table 39: MHCP CAHPS® Performance – 2015, 2016 and 2017

CAHPS® Measures ¹	MHCP CAHPS® 2015	MHCP CAHPS® 2016	MHCP CAHPS® 2017	Performance Assessment based on 2017 CAHPS® Database Benchmarks
Getting Needed Care	56%	54%	57%	Average
Getting Care Quickly	60%	58%	61%	Average
How Well Doctors Communicate	77%	78%	79%	Strength
Customer Service	67%	65%	66%	Opportunity
Shared Decision Making	50%	81%	81%	Not Available ²
Rating of All Health Care	54%	52%	56%	Average
Rating of Personal Doctor	70%	69%	70%	Strength
Rating of Specialist Seen Most Often	67%	63%	68%	Average
Rating of Health Plan	61%	54%	58%	Average

¹ MHCP rates were calculated by IPRO using DataStat data.

² Performance cannot be assessed because CAHPS® Database benchmarks for this measure are unavailable.

D. MCO Quality Improvement and Service Innovations

Each MCO submits annual quality program updates to demonstrate how their quality improvement programs identify, monitor and work to improve service and clinical quality issues related to MHCP enrollees. These updates are publicly presented on each MCO's corresponding website and highlight what the MCO considers to be significant quality improvement activities that have resulted in measurable, meaningful and sustained improvement. Some of these activities, which IPRO identifies as best practices, are presented below. (*MCO quality improvement program website URLs can be accessed [here](#).*)

Bridging Gaps between Members and Providers

More recently the health care industry has been raising keen awareness about the crucial need for better care transitions. There has been a great push to bridge gaps between members and providers by improving constant communication and connectivity through all network activities.

MCOs across Minnesota have established committees and councils that work together to enhance collaborative efforts to ensure that all voices are being heard and community relationships are being expanded. These meetings develop, monitor, and evaluate the several initiatives that are being put in place to improve the quality of health on a population scale. The workgroups enhance community outreach and development, and even work to tailor programs that cater to member and employee special needs.

In addition to community engagement, the implementation of printed newsletters and various sources of social media have encouraged both members and providers to be on the same page. Discussing topics that include health and safety education, wellness programming, benefits, health plan updates, practice guidelines for providers, effectiveness of quality and care, and improvement for the delivery of health care services and wellness of members.

Performance Improvement Projects and Programs

Another key area of focus for several MCOS is the development and execution of PIPs that encompass active interventions for members and providers and are designed to provide support for health and wellness.

Many of the PIPs and programs use health education as an important driver to the wellness activities. An example of this is a fully integrated pregnancy program that incorporates health coaching and support networks to meet each member's special needs. This program would connect eligible individuals to various community-based resources that would be beneficial to the prenatal and postpartum care and any necessary preventive services.

The PIPs and programs aim to improve the quality of patient care, care transitions and coordination, treatment adherence, and overall patient and team satisfaction.

Data analytics and Informatics

In addition to community engagement and program development, there is an increasing concentration on data and information support. Work plans assist many MCOs to manage several quality metrics along with provider, enrollment, and claims data. MCOs use relevant software systems to track and monitor the effectiveness of patient care and provider activities, as well as to support clinical practices. Data from satisfaction surveys and several focus studies are also used to gain insight on member and provider needs. These data play a vital role in improving quality of care and service.

System-Wide Approach

The main target for all the MCOs is to build a connected system to work collaboratively. Consistent flow of communication allows MCOs to achieve goals and values such as access to health care services, patient safety, member and provider satisfaction, and delegation oversight. Some MCOs use the “customer-driven” quality strategy, in which members’ well-being is the first and foremost goal, while others use the motto “the key to improving quality is transparency” for *all* parties involved. These MCOs have become integrated health care models that work to continuously put the puzzle pieces of quality health care together.

Chapter 4: Follow-Up to 2015 ATR Recommendations

As in the past and in accordance with the BBA, Section 42 CFR 438.364(a)(5), IPRO requested the MCOs describe how they plan to address, or have addressed, the EQR recommendations. This chapter presents IPRO's 2015 improvement recommendations including verbatim responses from each MCO.

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- **2015 Recommendation: Financial Withhold** - Continue to work to address measures that failed to meet target goals, routinely monitor the effectiveness of current improvement activities and modify them as needed.

Plan Response: Blue Plus identifies multiple health care improvement activities conducted throughout the organization within our annual Quality Work Plans. Each Work Plan project has measurable goals and planned interventions with quarterly milestones identified which, along with data status reports, facilitates regular reporting of progress. DHS withhold measures are incorporated into projects within the Quality Work Plan that are geared to help prevent illness and manage chronic disease. In 2015, root cause analyses were done on HEDIS measures identified in Work Plan projects that were showing slow or no improvement, it was determined that quarterly HEDIS data reports were not frequent enough to be helpful in our ability to adjust interventions in time to meet project goals. Our Health Economics department moved to publishing monthly reports instead of quarterly. In addition, our Quality department established a user friendly HEDIS Improvement database that displays the monthly HEDIS rates along with comparative data from the prior year and calculations for how many data points are needed to move the measure to the next National percentile bracket.

Withhold measures are evaluated within their respective Quality Work Plan projects and, while we have given attention to improve results, there have been other challenges we have had the last two years. In 2016, Blue Plus saw a substantial increase in membership within our Medicaid populations including a broader area of service into rural counties. This increase stretched our capabilities to expand our member outreach interventions, particularly in rural areas. Along with the increase in membership, a heightened emphasis has been placed on meeting financial withholds. Quality department leadership will work with members of our government programs department to evaluate what interventions we could do to achieve favorable ratings in all of the Withhold measures.

Antidepressant Medication Management: Effective Continuation Phase Treatment

Blue Plus has an active Performance Improvement Project (PIP) in place to address disparities in antidepressant medication adherence in our Medicaid population. Interventions include telephonic and mail outreach to members from racial and ethnic minority groups who have had an initial prescription fill of antidepressant medication. The goal of the outreach is to educate members about depression and its treatment and help address barriers to adherence. If appropriate, members are referred to our Depression Disease Management program. In addition to member interventions, Blue Plus has implemented provider interventions that include notification by fax of attributed members who are identified as having a gap in antidepressant refills. In 2016 and 2017, Blue Plus participated in a collaborative of Minnesota health plans and offered educational webinars for health care providers on ethnic and cultural considerations for treatment of depression. The webinars are recorded and posted on a public website for future reference by Health Coaches and other health

care providers. Blue Plus and the other members of the collaborative conducted a health fair that was held in a community location where a concentration of Latino members reside. The event promoted overall health preventive care along with 'Make it OK' messaging and education on depression. Materials were available in English and Spanish.

Analysis of process and outcome measurement results to date suggest that the HEDIS measure for continuous medication management in members with depression in all populations has not seen much improvement. In data analysis by ethnicity or race we did not see improvement either. One of our biggest challenges is an inability to reach members by telephone and/or mail. Blue Plus is continuing to work on identifying the most effective channels of communication for the F&C-MA and MNCare population. Among members we could reach, we have learned that side effects, transportation and language continue to be barriers to medication adherence. Blue Plus Health Coaches try to help members address these barriers by providing education and referring members to appropriate resources. We will continue to provide targeted mailings that include Antidepressant Management tip sheets in English and either Spanish and Somali for members who have an initial file of an antidepressant.

Well-Child Visits in the First 15 Months of Life (W15)

Blue Plus has implemented a multi-pronged approach to improving preventive care among its members. This has included member education and incentives for healthy behavior, provider incentives and quality improvement support, and community outreach to better understand barriers to preventive care.

The W15 HEDIS measure is one of the quality metrics in this program. To help support participating providers in their efforts to improve well-child care among their youngest patients, Blue Plus provides member and provider-level reporting. In addition, in 2016, Blue Plus created a new clinical consultant team that consists of clinicians dedicated to working with providers on quality improvement efforts. Child preventive care is one area of focus for this team. Results for the 2016 Withholds, which will be reported in the 2016 ATR, show that the W15 measure has improved and Blue Plus has met the withhold measure.

Community Outreach

Blue Plus is committed to engaging communities in all aspects of health care services and delivery. In 2016, Blue Plus continued to provide a Community Outreach Program to establish Innovative partnerships with local communities to help meet the needs of our diverse membership. Community Health fairs and events were held that included speakers who addressed the multi-cultural considerations in asking for and receiving healthcare. These events were positively received and welcomed in our Latino, African American, Somali, and Asian communities. The primary goal for our community outreach staff is to encourage good health and promote health screenings.

Member Education and Healthy Rewards Program

Blue Plus continues to offer a Rewards Program for F&C-MA and MNCare members. Members are eligible to earn a financial reward if they complete six well child visits within the first 15 months of life (as verified by a qualified provider). Members are provided education about the importance of annual check-ups and regular well child visits. The rewards program is highlighted within enrollment packets mailed annually members are encouraged to go to their Blue Cross website to download vouchers for gift card rewards when preventive care services are received. Also, Blue Plus continues to utilize a software program for customer service staff called the “Family Aggregator”. After completing members’ requests for assistance, the customer service representative can provide important health messages or reminders for preventive care visits and screenings that are due or overdue for that member and/or dependents.

Clinical Consultants for Provider and Member Support

Blue Plus continues to increase our partnerships with providers through our Clinical Consultant roles. The Clinical Consultants provide child preventive care education to providers quarterly via onsite provider meetings, Skype meetings or email. Also, in 2016, the clinical consultants made outbound calls to members regarding receiving their preventive care visit. Members received assistance with finding a primary care provider (PCP) if needed and provided preventive care education materials if requested.

The clinical consultants provide child preventive care education to providers quarterly via onsite provider meetings, Skype meetings or email. A reporting package is presented to the providers that includes the following child preventive care measures:

- Childhood Immunizations
- Adolescent Immunizations
- Well Child Check 15 months
- Well Child Check 3-6 years

The report presented to providers shows the performance rates for the child preventive care HEDIS measures. This includes the care system rate, plan rate and the goal of each HEDIS measure. The provider is also given a report showing the performance by each individual clinic. This allows the provider to focus on rate improvement at a clinic level.

The provider may also request a gap report. This is a member list that includes performance by physician to help identify and connect with patients who may have gaps in care. During the HEDIS abstraction season, our Clinical Consultants identify areas that the providers can improve child preventive care. The Clinical Consultants set up meetings and present the identified provider education opportunities. This includes sharing medical record chart examples with the providers.

Hospital Admission and Readmission Rates

Blue Plus believes that the earlier our health coaches can intervene with members who are hospitalized to ensure they have the tools and resources they need, the more likely they can experience a smooth transition to home or other care setting. Both of these measures continue to be included in our Aligned Incentive Program and both measures are quality metrics in our Medicaid Value-Based Contracting program. As noted below, this program launched in 2015 with the goal of working with our network providers to improve health outcomes and quality of care in our F&C-MA and MNCare populations. Blue Plus works closely with participating providers to identify opportunities for improvement. This includes reviewing regular member and provider-level reporting on admissions and readmissions.

In 2016, Blue Plus initiated innovative partnerships with some community-based medical and behavioral health providers. These partnerships involve an enhanced care coordination model, with the goal of better addressing the needs of some of our most complex and high-risk F&C-MA and MNCare members, who often have high rates of admissions and readmissions. Blue Plus also continues to have an internal Transitions of Care program, in which Health Coaches help ensure that members who have been hospitalized are armed with the resources they need for a successful transition home. Members are identified for outreach based on hospital length of stay, high complexity of care, and admitting diagnosis. Health Coaches reach out to members within two days of notification of inpatient discharge. The Health Coaches use a “Transitions of Care” assessment tool that is based on evidence-based models to reduce avoidable readmissions. It is noted that Blue Plus did meet the withhold measure for Readmissions within 30 days but did not for Hospital Admissions.

Provider Incentives and Quality Improvement Support

Blue Plus has continued to provide a Medicaid Value-Based Contracting program to focus specifically on improving health outcomes and quality of care in our F&C-MA and MNCare populations. The following are all included as quality metrics within our Medicaid (PMAP/MNCare) Value-Based Programs. These programs serve over 60% of attributed members and have been in place since 2015. In 2016, program was somewhat successful.

For emergency room utilization, 10% of care systems achieved partial to full achievement towards goal by effectively closing the gap between their baseline performance and goal by at least 50% during the 2016 program year.

For all cause readmissions, 33% of care systems achieved partial to full achievement towards goal by effectively closing the gap between their baseline performance and goal by at least 50% during the 2016 program year.

For all cause admissions, 33% of care systems achieved partial to full achievement towards goal by effectively closing the gap between their baseline performance and goal by at least 50% during the 2016 program year.

For well-child visits at 15 months, 64% of care systems achieved partial to full achievement towards goal by effectively closing the gap between their baseline performance and goal by at least 50% during the 2016 program year.

For antidepressant medication management - continuous treatment, 21% of care systems achieved partial to full achievement towards goal by effectively closing the gap between their baseline performance and goal by at least 50% during the 2016 program year. Due to low attainment for this measure in particular, a new report was created to alert participating providers of first fills and missed refills for antidepressant medication for their attributed members. Distribution of this report began in first quarter of 2017.

For all measures, quarterly member detail reporting was provided, but wasn't available at the start of the program year. In addition, large increases in population size, which were not realized in reporting until mid-year reporting due to attribution requirements for continuous enrollment made it challenging for care systems to manage population.

The following quality measures will be added to our **Aligned Incentive Contracts** (value-based agreement focusing on large integrated care delivery systems) and Patient-Centered Medical Home programs beginning in 2018. Medicaid (PMAP/MNCare) members are included in measuring performance on quality measures.

- Chlamydia Screening in Women
- Cervical Cancer Screening

- **2015 Recommendation: HEDIS® (Quality of Care)** – In regard to women’s health, continue with the enhanced intervention strategy outlined in the Health Plan’s response to the previous year’s recommendation, routinely monitor the effectiveness of the strategy and modify it as needed. As the Health Plan has noted that chlamydia rates have increased statewide, Blue Plus should consider spearheading a collaborative devised of other MCOs and community programs to strengthen and broaden the reach of the improvement strategy.

Plan Response: Blue Plus has implemented several health and wellness programs to promote preventive care and support best practice guidelines in the management of women’s health and prevention of diseases. Blue Plus has seen substantial growth in our F&C-MA and MNCare membership and are now in almost all counties throughout the state of Minnesota. With an expanded geographical reach, Blue Plus has had the opportunity to partner with more rural communities and an ever-increasing diverse population to raise awareness of the importance of preventive care and screenings. A root cause analysis of our 2014 performance in women’s health screenings laid the groundwork for how we could push the needle of success forward. The following programs describe the activities we have done and plan to continue to increase chlamydia and cervical cancer screening rates.

Minnesota Chlamydia Partnership

Blue Plus participates on a state-wide community-based task force called the Minnesota Chlamydia Partnership (MCP) to raise awareness of the increasing numbers of young people contracting sexually transmitted infections (STI) throughout the state. A large component of the work done by MCP is to promote annual STI testing and treatment. MCP, along with community clinics and organizations, sponsors events that offer confidential and free/low cost testing. One such event is called the Annual STI Testing Day which is led by the Community Restoring Urban Youth Sexual Health (CRUSH) group. Privacy has been a barrier for young people in getting tested. Another barrier is the stigma associated with sexual health so MCP cosponsored an event by an organization of young people to promote testing - "Pee for Pizza" party at a community college was successful.

A collaborative of health plans, namely Blue Plus, HealthPartners, Medica and UCare, have assisted the MCP in the promotion of these events and is a resource to the MCP task force for how health plans reach out to providers to encourage chlamydia screening. Community organizations and clinics are often unaware of the efforts by health plans to improve quality of care and how the use of quality performance measures can impact provider engagement in this and many other areas of health wellness and disease management. The collaborative does annual updates to a provider resource manual (Chlamydia Screening Provider Toolkit) developed by the group in 2013. The toolkit is a wealth of information and helps providers by offering such things an interview guide to what can be an uncomfortable discussion with a young person about their sexual activity. There are resources and information concerning the legal requirements on confidentiality and suggestions on how tests and results can be protected and kept confidential. A link to the tool kit is available via a public website of our Quality Improvement organization partner, Stratis Health: [PIP: Chlamydia Screening for Women](#).

Healthy Rewards Program for Cervical Cancer and Chlamydia Screening

Blue Plus continued to offer a Rewards Program for F&C-MA and MNCare members in 2015 and 2016. As described in the 'Financial Withhold' section above, Members were informed about the Rewards Program within their enrollment packets. Blue Plus also continues to utilize a software program for customer service staff called the "Family Aggregator." After completing members' requests for assistance, the customer service representative can provide important health messages or reminders for preventive care visits and screenings that are due or overdue for that member and/or dependents. Gift card incentives offered to Medicaid members in 2015 and 2016 included the following:

CHILDREN

[Well Child Visit: Before age 15 months \(PDF\)](#)

[Childhood Immunization: Before Age 2 \(PDF\)](#)

[Annual Dental Visit: Ages 2-20 \(PDF\)](#)

[Well Child Visit: Ages 3-17 \(PDF\)](#)

[Adolescent immunizations: Turning age 13 \(PDF\)](#)

WOMEN

[Chlamydia Screening: Ages 16-24 \(PDF\)](#)

[Cervical Cancer Screening: Ages 21-64 \(PDF\)](#)

[Prenatal Care Visit \(PDF\)](#)

[Post-Delivery Visit \(PDF\)](#)

DIABETES

[Diabetes Control Tests \(PDF\)](#)

Clinical Consultants for Provider Support

The Clinical Consultants provide women's health education to providers quarterly via onsite provider meetings, Skype meetings or email. A reporting package is presented to the providers that include the following Women's Health measures:

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening

The report presented shows the performance rates for chlamydia screening, breast cancer screening and cervical cancer screening measures. This includes the care system rate, plan rate and the goal of each measure. The provider is also given a report showing the performance by each individual clinic. This allows the provider to focus on rate improvement at a clinic level.

The provider may also request a gap report. This is a member list that includes performance by physician to help identify and connect with patients who may have gaps in care. Cervical cancer screening is a HEDIS hybrid measure, therefore, during the HEDIS abstraction season the clinical consultants identify areas that the providers can improve health outcomes and HEDIS rates for cervical cancer screening. The Clinical Consultants set up meetings and present the education opportunities related to improving health outcomes for cervical cancer screening. This includes sharing medical record chart examples with the providers related to cervical cancer screening. HEDIS rates for Cervical Cancer Screening rates have shown very little improvement. Both Cervical Cancer Screening and Chlamydia Screening measures will be incorporated into our Provider Aligned Incentive contracting program in 2018.

- **2015 Recommendation: Financial Withhold** – As the same measures continue to miss target goals, the Health Plan should evaluate the effectiveness of the current improvement strategy and modify it to include provider, member and process interventions.

Plan Response: HealthPartners has an internal work group that meets regularly and closely monitors the status of the withhold measures for our DHS contracts and seeks opportunities for improvement in our performance on these withholds. Individual measures have smaller work groups that develop and implement interventions specific to that measure. We continue to seek improved results and outcomes through data analysis, and the refinement and addition of interventions.

While some withhold measures have been slower to respond, we have been making positive improvements in most of these measures. For example, while we only received partial points for our Emergency Department Utilization rate withhold in multiple years, we saw steady progress on this measure over the past several years and ultimately achieved the overall 25% reduction goal. We continue to actively work on this issue and monitor the status of this withhold.

Similarly, Well-Child Visits in the First 15 Months started out with slow performance, but root-cause analysis showed which visits were being missed by members, gaps in our data analytics to monitor the measures, language and cultural barriers, and member confusion over the need for these visits. This analysis allowed us to focus outreach efforts, clean up our data, and refine messages to members about the importance of preventive care for our youngest members. Partnerships with care delivery and other areas within our organization were optimized to create a program to address the identified barriers to success. Significant resources were dedicated to this withhold measure in 2015 and 2016. The result has been to achieve full withhold points for 2016, and we are on track to perform well again in 2017.

Efforts to decrease hospital admissions and readmissions have continued to be a challenge for HealthPartners. In 2016, HealthPartners senior leadership established a workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement, and determine next steps.

Our findings show that the causes for both admissions and 30-day readmissions fluctuate each year. For example, one year, respiratory issues were a leading driver of admissions. The next year, respiratory declined and was replaced by circulatory issues. This fluctuation makes it difficult to create a clinical intervention that may impact the measure. These analyses continue and are shared at the Medical Director level where recommendations on clinical operational changes to care can be pursued.

One finding of the analysis completed in 2016 is that social determinants of health directly impact utilization of services, including admissions and readmissions. There has been significant research in this area and the workgroup felt it is important to note that impact, especially among our Medicaid membership. As a result, one of the recommendations of the sub-group was to increase Community Health Worker (CHW) support for our Medicaid members. This has proven to be an effective intervention in a pilot program, resulting in a statistically significant reduction in admissions among members working with a CHW. This increase in CHW time is being developed internally by additional full time staff and externally via contracting.

It has been difficult to engage the highest medically at-risk members. Lack of good contact information, resistance to interventions, and other priorities make engagement a challenge. However, our analysis showed there was opportunity to impact these measures by including medium-risk members in interventions. Collaboration with our care system allowed us to identify data elements to enhance risk stratification and prioritize outreach to those medium-risk members for care coordination services and offer support for social issues when needed as well.

As a health plan, we under-utilize our own internal member support resources such as care coordination and Medication Therapy Management (MTM) services, so those are among the services being promoted and enhanced. For example, we have added a full-time employee to offer complex case management support for our busiest hospital to enhance discharge planning including referrals to MTM services as appropriate.

- **2015 Recommendation: HEDIS® (Quality of Care)** – The Health Plan should enhance its improvement strategy to include provider outreach that is based on extensive root cause analysis. HealthPartners should consider conducting retroactive analysis to identify and target for outreach, providers who missed opportunities to provide care according to clinical guidelines.

Plan Response: HealthPartners analyzes our HEDIS results every year and focuses specific attention on measures which we feel are clinical priorities for our members. For those measures, extensive root cause analysis is conducted and evaluation of potential interventions is assessed and implemented as appropriate. HealthPartners has implemented several strategies to impact our HEDIS rates which include deep analytic examination of drivers behind measures, provider focused and member focused strategies to lift these measures.

We have an internal cross-discipline group which includes project managers, informatics, quality and provider relations leaders and representatives from both the health plan and our care delivery system. This group meets monthly to examine our rates and strategize performance. Health Informatics provides this group and other stakeholders a monthly monitoring report which compares our current rates on HEDIS measures to the same time in the last reporting year. This allows us to be nimble with interventions as we assess which measures may need attention or intervention enhancement mid-year.

The monthly monitoring report utilizes our internal claims data, so hybrid measures lack that data, but we feel it is still a valid reflection of how those rates are trending. The monitoring report includes analysis of the performance of our own care delivery system as well as a breakdown of contracted care groups and how they are performing on the measures for our health plan members. We can see the number of Minnesota Health Care Programs (MHCP) members that each care group is serving who are in the HEDIS measure denominator, and of those how many are currently a positive HEDIS hit for that measure. This identifies partnership opportunities to collaborate with care groups and have an immediate impact on rates.

HealthPartners has implemented several layers of provider interventions with care groups including:

- Provider Registries - HealthPartners provides a claims-based registry report to our contracted clinics on a quarterly basis to identify members who have gaps in their preventive screenings and chronic disease care.
 - Clinics receive notification each time that the registries are updated with new member information.
 - HealthPartners utilizes our provider newsletter to share updates or changes to the registry as well as highlight measures that we identify as a priority.
- Quality Consultations - HealthPartners offers consultative services through the Quality Improvement and Compliance Department to clinic groups to support their quality improvement initiatives. Clinics may choose technical assistance on clinic processes, or they may benefit from analysis of data specific to their clinic.
 - The Quality Consultant (QC) may identify specific measures that a clinic has an opportunity to improve or the clinic may seek assistance with a measure or a clinic process.
 - The QC tailors their level of involvement to the needs of the participating care group. Data analytics may be an important element of information for the care group or a plan Medical Director may be involved to offer support or elevate the importance of action.
- Quality Connections Forums – Quality Connections Forum is a gathering of key quality improvement leaders from major contracted clinics which meets three times per year to share initiatives, best practices, successes, and failures in efforts to improve publicly reported quality measures. Participants share the latest science and best practice methods and share successes and challenges related to their quality improvement efforts.

Surveys of the Quality Connections group has shown that care groups value the collaborative nature of the group and most systems have implemented improvements or strategies discussed in the group.

- Clinic incentive programs – Many of our care systems participate in HealthPartners incentive programs based on the three dimensions of the Triple Aim: health, experience and

affordability. These incentives do not specifically target MHCP members, however those members benefit from the efforts that the clinics implement across their patient population.

The Partners in Excellence (PIE) awards program recognizes excellence, innovation and sustainable change to impact quality improvement measures. PIE goals are aligned with HEDIS.

In addition to these provider-based interventions, HealthPartners utilizes numerous member focused interventions such as member mailings for preventive screenings, social media messaging, and alerts that Disease and Case Management, health coaching staff and Member Services can deliver when a member contacts the health plan. When a measure is both a HEDIS measure and a Medicaid withhold, particular focus is given to that measure.

Hennepin Health

- **2015 Recommendation: Financial Withhold** – Hennepin’s response to the previous year’s recommendation indicates that the Health Plan has analyzed its performance on behavioral health measures from a data perspective. It is recommended that the Health Plan use this data analysis as a starting point only and proceed with formal, in-depth root cause and barrier analyses to develop an intervention strategy that specifically targets this population despite it being in “survival mode”.

Plan Response: Hennepin Health is a Medicaid Expansion program established in CY 2012; therefore, long-term data, including accurate behavioral characteristics of the population, is not available. A formal, in-depth root cause and barrier analyses has been completed for all three withhold measures not met – Initiation of Alcohol & Other Drug Dependence Treatment, Follow-up After Hospitalization for Mental Illness 30 Days Post-Discharge and the Annual Dental Visit. Characteristics of Hennepin Health’s Medicaid Expansion population reveal that 91% are single adults without children whose median age is 37. Males represent 61% of the population and 89% identify their preferred spoken language as English. The ethnicity breakdowns as follows: white 42%, Black/African-American 36%, American Indian 3% and Other 19%. Eight-nine percent (89%) of Hennepin Health’s population have a behavioral health diagnosis with 41% having a mental illness (MI) diagnosis, 27% having a substance use disorder (SUD) diagnosis and 21% have both a MI and SUD diagnoses.

Individuals with substance abuse and/or mental illness diagnosis often lack adequate shelter, food, transportation and financial supports. Their basic needs required for survival are not met. There is a high rate of homelessness for this population. Involvement in the criminal justice system is not uncommon for this population as well. The main areas of focus for Hennepin Health members are addressing these basic survival needs in addition to their psychosocial and medical needs. It is documented in current literature that successfully addressing an individual’s basic survival needs first allows the individual to focus on their psychosocial and medical needs.

Services provided through Hennepin County can be divided into four sectors: health care utilization, human services, criminal justice and housing. Analysis reveals 93% of Hennepin Health’s members have contact with at least one of these sectors. Additional breakdown reveals:

- 21% involved in health care only;
- 30% involved in health care and human services;
- 19% were involved in health care, human services and criminal justice;
- 4% involved in health care, human services and housing; and
- 8% involved in all sectors.

Initiation of Alcohol & Other Drug Dependence Treatment

In order to meet this requirement, the member must initiate an alcohol or other drug dependency treatment within the 14 days from diagnosis through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization. Additionally, baseline data calculations can change dramatically due to enrollment changes throughout the calendar year. Enrollment increased from December 2014 to December 2015 by 10% (9,532 to 10,544) which is a moderate increase. Withhold goal rates are based on enrollment; thus with an enrollment increase, the goal rate can change considerably. Having a constantly moving target rate and not knowing what the final target rate is until mid-year are factors which influence the success of meeting the withhold measure rate.

Hennepin Health's HEDIS rate for this measure cannot be compared to other health plans' rates as Hennepin Health's population has a higher rate of mental health and/or substance abuse diagnosis and is a demonstration project; therefore, no comparable data is available. Between HEDIS® 2013 and HEDIS® 2014, Hennepin Health improved in this measure by 0.49 %. In HEDIS® 2015, the rate decreased by 3.29%; however, in HEDIS® 2016, the rate increased by 3.30% which was the rate consistent with HEDIS 2014. The 2015 rate decrease could be due to factors such as the behavior characteristics of individuals who have a mental illness diagnosis and use alcohol and/or other drugs. For HEDIS® 2017, the initiation rate of alcohol and/or substance abuse treatment increased by 11.26%.

The individual's mental illness symptoms can influence the decision-making regarding the need for an alcohol and/or drug treatment program. Developing a trusting relationship with health care practitioners/programs who are outside of their usual "trusted" support system can be difficult for individuals with mental illness; one that is not easily established. Additionally, this population typically does not have an adequate social support system available to them; often having lost contact and/or alienating their family/friends. Regardless if the individual has a mental illness diagnosis or not, often the existence of an alcohol and/or drug use problem is denied; thus refusing the need for any treatment. These individuals generally only seek medical care when an acute medical illness arises. Once the acute medical illness has been addressed, they generally do not seek ongoing primary and preventive care services so traditional interventions used to improve this rate cannot be routinely initiated and/or completed.

In addition to the issues identified above, many of the Hennepin Health members live in what some might call "survival mode." This survival mode ultimately means that members think only of the present day and what their needs are in that moment. What they might need a month, a year, or multiple years from now is not something in the forefront of many members' thoughts. This aversion to thinking long term is often a major barrier to members seeking out appropriate treatment programs or receiving primary/preventive health care services.

Meeting the requirement of the member initiating an alcohol or other drug dependency treatment within the 14 day timeframe from diagnosis is not realistic for the reasons identified above and the

availability of the appropriate treatment program (an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization) at that particular time. If the appropriate program is not available immediately when the member is ready to seek treatment, the member may choose not to follow-up in a few days with the provider arranging treatment. The ability of the provider to contact the member to inform them when a treatment facility is available can also be impeded due to a non-permanent address for the homeless member or the lack of access to communication methods such as a cell phone.

Hennepin Health, in conjunction with Health and Human Services and Hennepin County Medical Center, have implemented initiatives such as care coordination services, employment initiative, Access Clinic initiative and housing navigation in order to help its members meet their basic needs which allows the member to address other psychosocial and medical needs.

Although Hennepin Health did not achieve its CY2015 target financial withhold goal, Hennepin Health has made progress in improving this rate. As evidenced above, Hennepin Health has made significant progress in improving this rate in CY2016. Every additional resource of investment made by Hennepin Health goes into increasing the level of service and care provided to members to ultimately address the many variables which may contribute to the individual not seeking medical services such as alcohol and/or drug use treatment. This includes access to transportation and/or providing a cell phone to the member. Encouraging and supporting the member to seek appropriate alcohol and/or drug treatment is an ongoing process that Hennepin Health as a plan works on through innovative initiatives with the goal to have success one member at a time. This measure will be an ongoing and ever present focus for Hennepin Health, although, as of 2016, this is no longer a withhold measure for Hennepin Health.

Follow-up After Hospitalization for Mental Illness 30 Days Post-Discharge

As stated above, long-term trending data is not available for programs recently started such as Hennepin Health. Additionally, baseline data calculations can change dramatically due to enrollment changes throughout the calendar year. As an example, the Department of Human Services (DHS) calculated the CY 2012 withhold baseline rate for this measure initially using data from CY 2011 which had a numerator of 7 with a denominator of 23 for a rate of 30.43%. The final CY 2012 withhold baseline calculated on July 25, 2013 revealed a numerator of 48 and a denominator of 104 for a withhold rate of 46.15% - over a 15% increase. The rate change was mainly due to the enrollment increases experienced throughout CY 2012. Hennepin Health's CY 2013 rate was calculated by July 2014 with DHS publishing revisions of this withhold rate for CY 2014 in September 2014. Enrollment increased from December 2013 to December 2014 by slightly over 34% (6,250 to 9,532) which is a significant increase. Enrollment increased 10% by December 2015. Having a constantly moving target rate and not knowing what the final target rate is until mid-year are factors which influence the success of meeting the withhold measure rate.

Between HEDIS® 2013 and HEDIS® 2014 season, Hennepin Health improved in this measure by 2.74%. Hennepin Health's 2015 HEDIS® rate was 63.12% - an increase of 5.33%. Hennepin Health 2016 HEDIS rate did drop to 27.94% with the rate increasing to 51.02% in HEDIS 2017. Hennepin Health's rate cannot not be compared to other health plans as a comparable program does not exist within other health plans. As with the initiation of the alcohol/drug treatment needing to be completed within 14 days of the diagnosis, this withhold measure also requires the individual to be seen by a mental health practitioner as defined by the HEDIS® technical specifications or have a mental health follow-up visit with a primary care provider within 30 days after an outpatient visit, intensive outpatient encounter, partial hospitalization or a mental illness hospital admission. As with other withhold measures, Hennepin Health relies on the practitioner to accurately code the follow-up visit and using the correct defined set of CPT codes and ICD-10-CM diagnosis codes in the correct order in order for the encounter to be included in this measure.

Review of the Hennepin Health's members' clinic records reveal that the follow-up appointment is usually made within the required 30 day timeframe. Even with Hennepin Health's open mental health network, access to the appropriate mental health practitioners within the 30 days can be an issue. Addition review finds that the member often cancels these appointments or are a "no-show" for the appointment. If the member chooses to reschedule the appointment, it is generally scheduled after the 30 day timeframe. Meeting the 30 day timeframe is not important to the member. The ability of the provider to contact the member to remind them of the upcoming appointment can also be impeded due to the lack of access to communication methods such as a cell phone. Hennepin Health's population generally seeks acute episodic care and do not see the need for ongoing primary and preventive care, especially if they feel "better". Transportation for the member may also play a part in the need to reschedule appointments.

Many members are often resistant to allowing a mental health practitioner and/or primary care physician into their personal health. In addition to that resistance, many of the Hennepin Health members live in the "survival mode" as discussed above; thinking only of present day and what their needs are in that moment. The lack of long-term thinking is another major barrier to members receiving ongoing and preventive health care services.

Implementing quality improvement initiatives to overcome the barriers identified above is a challenge as changing member's behavior patterns and beliefs is a long-term process. To address the transportation issue, Hennepin Health now provides a monthly bus pass for members having four or more health care system appointments; thus, allowing the member to ride free numerous times during the month. Hennepin Health will continue to work with its members to encourage them to receive the necessary follow-up care that can lead better behavioral care management. Hennepin Health, in conjunction with Health and Human Services and Hennepin County Medical Center, have implemented initiatives such as care coordination services, employment initiative, Access Clinic initiative and housing navigation in order to help its members meet their basic needs which allows

the member to address other psychosocial and medical needs. Encouraging and supporting the members' behavior change to seek timely ongoing follow-up care is an ongoing process that Hennepin Health as a plan works on through innovative initiatives. Success is obtained one member at a time. This measure will be an ongoing and ever present focus for Hennepin Health, although, as of 2016, this is no longer a withhold measure for Hennepin Health.

Annual Dental Visit

There are multiple barriers to members receiving their annual dental visit. The Hennepin Health population has high levels of alcohol and/or other drug use, mental illness, and stress due to a lack of basic needs such as housing and food. There is also a high rate of homelessness for this population and lack of transportation can also be a barrier. The fears of going to a dentist or having a dental procedure are as common in this population as in other populations. Due to the member's mental illness and/or the fear of the dentist, members are often resistant to allowing a dental provider to provide any dental services. There is also the fear that dentists is only going to pull the tooth rather than providing services in which the tooth may be saved. In addition to that resistance, many of the Hennepin Health members live in the "survival mode" as discussed above; thinking only of present day and what their needs are in that moment. They often wait until their dental pain is severe, seeking acute episodic care in the Emergency Room Department. Waiting to seek dental treatment often leads to more severe dental issues such as abscesses; thus, making the dental visit even more traumatic for the member. Some members choose to receive their dental services at free dental clinics offered throughout the community such as at Helping Hands; therefore, the member's dental visit is not recorded as there is no claim submitted.

Adding to these barriers is the dental access issue with dental offices often reaching their capacity so they are not taking new patients. Many dental offices choose not to accept any additional Medicaid patients once they have reached the required Medicaid capacity percentage due to the high rate of "no-shows" in this population. Due to the access issue, non-availability of same day or next day dental appointments which could address an acute dental issue is also a barrier. Lack of dental services coverage and low dental reimbursement rates, especially in the seven-county metro area in comparison to the greater Minnesota area, does not incentivize the dental community to provide services to this population.

The Hennepin Health Partnership has implemented many strategies to address these barriers. Strategies have included higher dental reimbursement rates, providing community health worker (CHW) services in the Emergency Department (ED) to provide assistance to members in finding dental providers and making same day, next day or in the future dental appointments. Next business day follow-up phone calls to members who received dental services in the ED are completed, offering assistance in locating dental providers for the member. If the member cannot be reach, a letter outlining how Hennepin Health can assist the member in finding dental services is sent. NorthPoint Dental Providers work closely with Hennepin Health in providing needed dental services on a one-on-

one basis, including same day or next day dental appointments. Hennepin Health Member Services and CHWs work closely with Delta Dental in finding dental providers. Bus passes, including monthly bus allowing unlimited rides during the month for members having four or more health care system appointments, are provided. Hennepin Health also arranges transportation with various transportation companies throughout the metro area for the member.

HCMC, a partner of Hennepin Health, recently received a grant from Delta Dental of Minnesota Foundation to establish a dental health clinic within HCMC's Ambulatory Outpatient Specialty Center to open in 2018. It is anticipated that this new facility will see and treat the 85% of HCMC's dental patients who are covered by public programs, are uninsured, or qualify as low income residents. Currently in the planning stages, this clinic will provide enhanced patient-centered care for all patients, especially children and individuals with special needs. It is anticipated that the Delta Dental Oral Health Center at HCMC will increase oral health care by approximately 60%, or an estimated additional 11, 000 visits annually, for a total of 27, 500 patient visits per year.

Hennepin Health has implemented many quality improvement initiatives to improve the annual dental visit rate, including easier and more convenient access to medical, behavioral and dental services through office relocation. NorthPoint has established an orientation program where new patient orientation to the services available is conducted through a group. However, for the member to benefit from these initiatives, the members need to know about the services, be educated on their health care benefits and showing up for appointments. Perhaps, the toughest challenges are overcoming the member's behavior patterns and beliefs and locating the members. A communication method in order to reach the members consistently is also lacking. Locating the member is a challenge as member contact information received is generally inaccurate by the time it is received through the enrollment files. Many members do not have a permanent address and receive mail through General Delivery. They do not regularly receive their mail. Additionally, many members do not have access to a cell phone. Hennepin Health does provide cell phones and transportation; however, informing members of these services is a challenge as the traditional methods to communicate with members are not consistently available. To address the transportation issue, Hennepin Health now provides a monthly bus pass for members having four or more health care system appointments; thus, allowing the member to ride free numerous times during the month.

Hennepin Health will continue to work on improving the number of members receiving an annual dental visit which can lead to better overall health for the member. A monetary incentive in the form of a gift card has been implemented in 2017 which a member can receive after completing a dental visit. Success of increasing the annual dental visit may only occur through a one to one interaction with one member at a time, which is resource intensive. Locating the member can be difficult. Encouraging and supporting the members' behavior change to seek dental care is an ever ongoing process. This withhold measure will be an ongoing and ever present focus for Hennepin Health.

- **2015 Recommendation: HEDIS® (Quality of Care)** – Prior to implementing any of the interventions outlined in the Health Plan’s response to the previous year’s recommendation, Hennepin should conduct formal, in-depth root-cause and barrier analyses to ensure that interventions are appropriately constructed and targeted. Additionally, Hennepin should ensure that selected interventions address the needs of members in “survival mode”.

Plan Response:

Cervical Cancer Screening

Hennepin Health is a relatively small product (10,544 members as of December 2015). When continuous enrollment requirements are applied for data such as HEDIS® measures (especially for female-only measures since Hennepin Health is approximately two-thirds male), the sample size becomes small and potentially unreliable. IPRO stated that Hennepin Health’s 2014 HEDIS® was 48.5%; whereas Hennepin Health’s audited HEDIS® data displayed a higher rate of 54.26%. Hennepin Health’s 2015 cervical cancer screening rate was stated as 42.6% per IPRO; Hennepin Health’s audited HEDIS® data was again higher and at a rate of 45.26%. Hennepin Health’s 2016 cervical cancer screening rate was stated as 41.9% per IPRO; Hennepin Health’s audited HEDIS® data was again higher and at a rate of 45.26%. Hennepin Health’s 2017 HEDIS® cervical cancer screening rate was 53.77% - an increase of 8.51%.

Based on the Hennepin Health derived rate for cervical cancer, the rate was consistent from HEDIS® 2015; although the rate is lower than desired for this population or compared to the statewide rate. More than two-thirds of Hennepin Health members are male and thus some female only measures such as cervical cancer screening are often not as widely focused on from a system perspective. Females in the general population avoid having pap smears for cervical cancer screening for various reasons. It is one thing that a female often does not look forward to having during the preventive care visit. The mental attitude also exists within Hennepin Health’s female population.

The Hennepin Health population has high levels of alcohol and/or other drug use, mental illness, and stress due to a lack of basic needs such as housing and food. There is also a high rate of homelessness for this population. Many members are often resistant to allowing a primary care physician into their personal health and find the concept of preventive care services unnecessary and sometimes invasive unless the member has a strong trusting relationship with the practitioner. Developing a trusting relationship with health care practitioners who are outside of their usual “trusted” support system can be difficult for individuals with mental illness; one that is not easily established. Review of the medical records reveal that members tend to seek care for acute medical issues and refuse a pap smear when offered by the practitioner. Reasons for refusal include beliefs that a pap smear is not necessary as the member is not sexually active or the procedure is uncomfortable. Members also self-report that they had a “normal” pap smear within the previous 5 years; results from other clinics are not always received when requested or the member doesn’t recall specifically where the pap smear was completed.

In addition to that resistance and lack of trust, many of the Hennepin Health members live in the “survival mode” as discussed above; thinking only of present day and what their needs are in that moment. The lack of long-term thinking is another major barrier to members receiving preventive health care services as members do not feel preventive health care services are important at that time. The member wants to deal with their immediate concerns, such as their acute medical condition, a family crisis, food, shelter, etc.

Hennepin Health does not offer a member or a provider cervical cancer screening incentive. Cervical Cancer Screening rates have also been on the decline due to changing practice guidelines regarding the frequency and risk factors that warrant screening. Practitioners’ practice patterns have not changed quickly in response to the changed practice guidelines requiring cervical cytology and human papillomavirus (HPV) co-testing for women age 30 – 64 if cervical cancer screening is performed less than every 2 years. Often, HPV testing will be performed only if the cervical cancer screening is positive; otherwise, the lab test states that the woman has aged out of the HPV test. Provider education on the cervical cancer screening requirements have been provided by Hennepin Health.

Hennepin Health has supported the MDH cancer screening incentive program to boost colorectal, breast and cervical cancer screening rates implemented in late 2014. The greatest opportunity for Hennepin Health to address cervical cancer screening is to approach it in conjunction with trying to increase general preventive care services; along with practitioner education of the requirements. Although member education and incentives will be investigated as possible interventions, this may not produce the results intended due to the member’s “survival mode” mentality and the inability to locate many members as a large portion of Hennepin Health members are homeless with no consistent means of reaching them.

Itasca Medical Care (IMCare)

- **2015 Recommendation: Financial Withhold** – Conduct root cause analysis for the measures listed above for which the MCO failed to achieve target goals and implement quality improvement initiatives to address identified barriers. Additionally, the Health Plan should leverage the Disease Management Coordinator and the Northeast C&TC partnership to address identified barriers.

Plan Response: IMCare did not earn full points to obtain financial withhold for F&C- MA and MNCare contracts. The measures that did not earn full points include Well-Child Visits, Emergency Department Utilization Rate and Hospital Admission Rate. IMCare recognizes the continued opportunity to increase the number of enrollees who receive a Well-Child screening within the first 15 months of life. In review of the data the State average for Well-Child visits within the first 15 months of life was 60.6%, in comparison, IMCare was slightly below the States rate at 56.3%. IMCare will continue the member incentive program for current participants, which is aimed at improving the rate of Well-Child visits within the first 15 months of life. The IMCare’s Disease Management Coordinator continues to partner with the Northeast C&TC partnership and outreach groups. IMCare has done outreach to facilities whose visits do not consistently meet the elements of a well-child visit. Additionally, IMCare has provided both enrollee and provider education about the updated well child visit schedules. IMCare Emergency Department (ED) Utilization is identified as an area needing improvement. IMCare has evaluated and modified the Emergency Department Focus Study to further identify enrollees who frequent the emergency for non-emergency purposes. Early enrollee education and intervention is intended to decrease overall utilization. ED Utilization is monitored monthly to identify any fluctuations in utilization. IMCare also recognizes that there is an opportunity to work towards lowering hospital admission rates. IMCare Disease Management Program is evaluating the opportunity to expand outreach measures to offer information to enrollees regarding preventative wellness. Additionally, IMCare has made efforts to collaborate with network facilities to include care coordinators and case managers in the discharge planning of enrollees to prevent hospital readmissions and assist enrollees with obtaining needed care and services while in the community.

- **2015 Recommendation: HEDIS® (Quality of Care)** – As the Health Plan continues to struggle in regard to women’s health, the effectiveness of the current improvement strategy should be assessed and be modified based on thorough Root-cause Analysis. IMCare should expand its quality improvement strategy to include newly identified poor performing HEDIS® measures.

Plan Response: HEDIS Quality of Care results demonstrate an opportunity for IMCare to improve in the following areas: Adolescent Well-Care Visits, Cervical Cancer Screening, and Chlamydia Screening for Women for PMAP enrollees, Breast Cancer Screening for PMAP and MSC+ enrollees and Comprehensive Diabetes Care –Eye Exams for MSHO enrollees. IMCare monitors preventive screening HEDIS measures for women, which includes breast cancer screenings, cervical cancer screenings and chlamydia screenings. Based on a review of the F&C- MA data 58.6% of enrollees aged 50 to 64 years

completed breast cancer screenings in 2015 and 45.7% in 2016, which is lower than the State's 2016 average of 62.2%. Based on a review of the MSC+ data 12.1% of enrollee aged 65-74 years completed breast cancer screenings in 2015 and 29.7% in 2016, compared to the State's 2016 average of 44.8%; while this is below the state average significant increase from year-to-year was observed. With regard to cervical cancer screening for enrollees aged 24 to 64, 61.9% in 2015 and 53.3% in 2016 completed their screenings compared to the States 2016 average of 58.2%. IMCare member's age 16-24 years completed chlamydia screenings at a rate of 45.5% in 2015 and 42.5% in 2016 in comparison to the States 2016 average of 57.0%. With regard to Adolescent Well-Care Visits for enrollees 12-21 years 38.7% in 2015 and 29.4% in 2016 completed their visits in comparison to the 2016 state average of 38.6%. Due to the low number of enrollees that meet the denominator criteria for each measure, IMCare's HEDIS rates may be volatile, fluctuating annually and may not always adequately reflect performance. IMCare continues to utilize the Care Management system to capture screening information and contacts enrollees to provide member education about the benefits of early preventative screenings and assess any potential barriers to accessing needed screenings. In addition, IMCare also provides member and provider education through newsletters and individualized mailings. To address all Quality of Care areas IMCare has evaluated the current audit process and identified additional avenues to obtain needed information. IMCare has included educational materials on all of the above topics in both the member and provider newsletters. IMCare restructured the biannual Stakeholder Advisory Committee with the goal of identifying additional opportunities to work collaboratively with enrollee representatives and network facilities to address quality initiatives.

- **2015 Recommendation: CAHPS® (Member Satisfaction)** – Conduct thorough root cause analyses for the measures listed above.

Plan Response: IMCare monitors and evaluates CAHPS survey results, the following measures have been reviewed:

- Rating of all Health Care (F&C MA) – In 2015 the rate was 50% and in 2016 the rate was 43%, which is below States rate of 52% for 2016.
- Rating of Health Plan (F&C MA) – In 2015 the rate was 58% and in 2016 the rate was 51%, which is lower than the States rate of 56% for 2016.

IMCare historically has low participation in the CAHPS survey with a 30% response rate. Due to the small number of participants the data is less weighted and difficult to conduct an analysis on. IMCare continues to maintain an adequate primary care provider, specialty services, and behavioral health network in relationship to member numbers and geographic distribution. Enrollees have the availability to access all MHCP providers. IMCare will evaluate opportunities for member outreach to assess enrollee satisfaction and identify areas for improvement.

- **2015 Recommendation: Financial Withhold** – Continue to work to address withhold measures that fail to achieve target goals. Additionally, the Health Plan should ensure that the various committees and subgroups that have been created to monitor and improve withhold measure performance are working collaboratively to execute a uniform improvement strategy.

Plan Response: Medica continued work in 2016 to address the opportunity for improvement in its Financial Withhold measures, including the reduction of emergency department (ED) utilization and reduction in hospital readmissions under the DHS Families & Children contract. The Anti-depressant Medication Management withhold was discontinued by DHS in 2016. However, Medica efforts to improve this HEDIS measure continued in 2016 and included member outreach, provider education and Care Coordinator education.

Medica staff meet regularly to review utilization metrics, including Emergency Department. Staff believes one root cause for members' use of emergency department is lack of understanding about primary care and preventive benefits. Medica's community health team increased community outreach and education in 2016 to encourage members to use their benefits and avoid emergency department visits when appropriate. Medica also included articles in member newsletters about preventive care and appropriate use of emergency department. Total cost of care clinic quality measures included Emergency Room utilization and hospital readmissions.

The effort to address evidence based management gaps in care also continued, with gaps in care shared with case management and care coordination teams. In addition, Medica continued with the integrated care coordination program, which worked with PMAP and MNCare members. This program included a focus on addressing inappropriate utilization. Medica partnered with an external organization to address social barriers to improving member's health, and has implemented a hospital discharge review process to ensure transition to appropriate levels of care with a focus on preventing readmission.

Medica has an internal committee that meets regularly to review performance on withhold measures. The committee evaluates ongoing performance and identifies strategies to improve performance. Subgroups have been created to address individual withhold measures. Beginning in 2016, this included a subgroup focused on the new dental utilization withhold measure. In addition, Medica has a workgroup Utilization Management Subcommittee, which reviews utilization rates, including ED use, admission, and readmissions. The Utilization Committee reports to the Quality Improvement Subcommittee of the Medical Committee of the Medica Board of Directors. Medica's Quality Improvement Subcommittee, directs, oversees, and evaluates the Medica quality improvement program with the goal of promoting and continually improving clinical quality, service quality, provider quality, and patient safety. The workgroup has and will continue to conduct its root cause analysis to identify appropriate interventions to reduce ED and Readmission utilization.

Medica implemented quality metrics for select Care Coordination delegates in 2016 for MSHO and SNBC members. This included the plan all cause readmission measure. The goal was to decrease hospital readmission rates through increased transition of care work by Care Coordinators.

- **2015 Recommendation: CAHPS® (Member Satisfaction)** – Conduct root cause analysis for the CAHPS® measure listed above, and modify the current improvement plan to address this area of member satisfaction. Additionally, Medica should consider adding a provider component to its company-wide initiative aimed at understanding the health care experience from the members’ perspective.

Plan Response: Medica’s CAHPS Workgroup reviews the CAHPS results across all programs and identifies barriers and possible interventions to help improve member satisfaction with their health care. Medica chose to complete an off cycle CAHPS survey in 2016 to better understand the specific issues driving member satisfaction. Results were used to drive 2017 improvement activities.

Medica’s Model of Care for MSC+ relies on the Care Coordinator as the primary source for member education and support. Medica’s Care Coordinators discuss member’s primary care needs annually as part of their health risk assessment. As needed the Coordinator is available to assist members in choosing a new provider if the member is unhappy with their care. The care plan used by Care Coordinators was updated in 2016 to include more information about the member’s interdisciplinary care team. Training was completed with Care Coordinators at the time to encourage use of this section and discussion with the member about the importance of their care team.

The Quality Indicators Review Committee reviews CAHPS results and actions annually and reports findings to the Quality Improvement Subcommittee. Results are reported from the Quality Improvement Subcommittee to the Medical Committee of the Medica Board of Directors.

- **2015 Recommendation: HEDIS® (Quality of Care)** – As the Health Plan continues to demonstrate opportunities for improvement in regard to children and women’s health despite its multifaceted intervention approach, Medica should evaluate the effectiveness of the current improvement strategy and modify interventions as needed.

Plan Response: Medica closely monitors its HEDIS performance through the HEDIS/Stars Clinical Quality Improvement Committee, and the Quality Improvement Subcommittee of the Board. The HEDIS/Stars Clinical Quality Improvement Committee works with internal stakeholders to analyze HEDIS and other clinical quality data to identify trends and areas for concern; propose possible interventions; set implementation priorities; and implement and monitor interventions to improve low performing HEDIS measures.

In 2016, Medica staff continued efforts to improve select HEDIS metrics through use of an internal action plan. Cervical Cancer Screening, Breast Cancer Screening, Well Child visits and Comprehensive Diabetes Care: HbA1c testing was included in this action plan. Actions implemented include member

education, care coordinator education and provider interventions. Medica included education on all of the metrics in the hold messaging members listen to when they call in to our member services area. In addition, Medica completed a mailing to all members identified as having a gap in their Breast Cancer Screening. The mailing included education on the importance of screening and resources to help the member schedule an appointment.

Medica continues to partner with the American Cancer Society to implement initiatives with provider clinics and to provide education for Care Coordinators who work with the SNBC and Senior populations. Breast Cancer Screening and Cervical Cancer screening were both included in Medica's EBM Gaps in Care initiative, with both considered priority gaps in care, addressed by Medica Care Coordination and Health Management staff working with members. In addition, Medica implemented quality metrics for select Care Coordination delegates in 2016 which included Breast Cancer Screening.

Other interventions continued in 2016 include: total cost of care clinic quality measures; provider newsletter articles including information about adolescent immunizations and well care; and member newsletter articles twice per year highlighting the importance of well child visits and childhood immunizations.

Medica's annual Quality Improvement (QI) Work Plan highlights the key quality improvement initiatives Medica undertakes each year. The QI Work Plan lists significant, measurable quality activities and highlights significant activities with potential to influence clinical quality, service quality, provider quality, and safety for our members.

The Quality Improvement department compiles the QI Work Plan with input from business units and stakeholders throughout Medica. The Quality Improvement Subcommittee (QIS) reviews and approves the plan annually. The Quality Improvement department monitors overall work plan progress and presents quarterly status reports to QIS. QIS reports quality improvement activities to the Medical Committee of the Medica Board of Directors, which reports quality improvement activities to the full Medica Board of Directors on a quarterly basis. In addition, the Medical Committee and the Board of Directors annually review and approve the Quality Improvement Program Description, Work Plan, and Program Evaluation.

Metropolitan Health Plan (MHP)

Note: Effective September 2, 2016, MHP changed its name to Hennepin Health.

- **2015 Recommendation: CAHPS® (Member Satisfaction)** – Conduct a thorough root cause analysis for the measures listed above and implement interventions to address identified barriers.

Plan Response: Getting Needed Care - Hennepin Health's CAHPS rate of 50% for Getting Needed Care met or exceeded the 25th percentile and was only 3% lower than the statewide average of 53%. A significant challenge for Hennepin Health's SNBC members when accessing care is often with Mental Health and Chemical Dependency categories of service. There is a general shortage of Mental Health and Chemical Dependency providers in the State of Minnesota. Hennepin Health keeps the network to these services as open access. Hennepin Health will provide transportation to and from appointments wherever the members are able to get in. However, these measures have not been enough to ensure that all of our members get their needed care, when they need it. Many of the members with mental and/or chemical health issues who cannot get the care that they need will often present at the nearest hospital emergency department.

Some unique benefits come along with Hennepin Health's relationship to the county Health and Human Services Department and to the Hennepin County Medical Center (HCMC) for members in need of mental or chemical health care. Hennepin Health is better able to connect members to services available through the county or county partners. The Acute Psychiatric Services (APS) at HCMC is uniquely positioned psychiatric emergency room that serves the primary area where many of Hennepin Health's members reside. Even with the arrangement of Hennepin Health's mental Health and chemical dependency services, there is still a shortage of providers making it difficult for members to receive needed care.

Hennepin Health conducts an annual assessment of appointment availability as a component of a network adequacy review in addition to GeoAccess maps for physical access. Appointment availability is determined through a provider survey process and is measured against a set of clinically viable standards for appointment wait times. Hennepin Health has set the internal benchmark of providers being able to meet those clinical standards at least 85% of the time or greater. The various appointment types reviewed in the survey fall into four categories of services: primary care, ob/gyn care, mental Health care and specialty care. Under these four categories is a wide array of appointment types that the survey questions address. For 2016, the number of primary care and ob/gyn care clinics who met the preventive care appointments standard of 45 days was 100%. Specialty care clinics who met the appointment standard of 60 days was 95%. Behavioral Health clinics who met the appointment standard of 10 business days was 92%. Hennepin Health does not require SNBC members to obtain referrals for specialty care or behavioral health care and has an extensive

provider network. Hennepin Health also provides transportation services for members who need it, either by taxi, bus or through specialty transportation.

The provider network for Hennepin Health's Families and Children program is more limited than the provider network for Hennepin Health's SNBC program. Hennepin Health's Families and Children members can be seen at Hennepin County Medical Center, NorthPoint and North Memorial; whereas, SNBC members can be seen at Fairview Clinics, University of Minnesota Clinics, Allina, HealthEast, etc. There is some confusion within the SNBC provider network that they can see Hennepin Health's SNBC members. The providers will convey to the member incorrectly that they cannot see the member which frustrates the member.

Effective April 1, 2015, Hennepin Health transitioned to a new claims processing vendor. As with any change, this led to some improvement opportunities which were addressed during the remainder of 2015 and into 2016. In some cases, processing of claims and claims payment was delayed, which led to provider dissatisfaction. Some providers informed patients that they could not be seen until claims were paid. Hennepin Health and the claims processing vendor worked closely with these providers and all providers to ensure that members would be seen timely and when appropriate so that care would not be interrupted.

Hennepin Health's Provider Services Department actively continues to educate the SNBC providers on how to identify correctly Hennepin Health's SNBC members. Hennepin Health continues to address and monitor claims processing issues. Hennepin Health will continue to monitor this measure.

Customer Service – Hennepin Health's CAHPS Customer Service score of 61% ranked below the 25th percentile and was 5% below the statewide average of 66%. This rate is consistent with Hennepin Health's CAHPS rate of 61%. Effective April 1, 2015, Hennepin Health transitioned to a new claims processing vendor. As with any change, this led to some improvement opportunities which were addressed during the remainder of 2015 and into 2016. In some cases, processing of claims and claims payment was delayed, which led to provider dissatisfaction. Some providers informed patients that they could not be seen until claims were paid. This in turn would frustrate the members. Hennepin Health and the claims processing vendor worked closely with these providers and all providers to ensure that members would be seen timely and when appropriate so that care would not be interrupted.

Hennepin Health maintains a high number of members physically coming into Hennepin Health's front lobby for customer service assistance rather than calling in. The number of walk-in members averages about 800 members per month. It is highly unusual for a health plan to offer walk-in customer services at its location. Hennepin Health has implemented multiple changes to its walk-in customer service approach. Hennepin Health has a professional nurse or social worker care guide available to assist members in the front lobby. The front desk is staffed by a Community Health Worker (CHW) to provide better assistance to members regarding their coverage and eligibility needs. CHWs are also available

in the various Hennepin Health clinics to create better coordination from the coverage environment to the point of care and better communication across organizations at a level directly serving members.

A significant cause of dissatisfaction amongst Hennepin Health members is the scheduling of transportation which is handled through Hennepin Health's Customer Service Department. Arranging transportation can be a frustrating process as it requires meticulously verifying appointments and logistical details. Many member grievances are related to transportation issues as members expect cabs to be there at a specified time, although the members are told window of time within 10 minutes is given. Additionally, members have expressed dissatisfaction to Hennepin Health's Customer Service representatives that they only want to use certain cab companies and do not like the "round robin" process. Hennepin Health does regular training with customer service representatives regarding transportation, including how to provide individual member assistance in order to de-escalate conflicts.

Additional actionable recommendations to be implemented in 2016 and 2017 include the development of a post customer service call survey in efforts to capture and identify member concerns/experiences and conducting a Customer Service Kaizen event to obtain a better understanding of concerns our members have with Hennepin Health and any barriers they face to getting assistance. These activities will help to focus Hennepin Health's efforts and generate new ideas for improving customer services experiences for our members.

Rating of the Specialist Seen Most Often – Hennepin Health's CAHPS Rating of the Specialist Seen Most Often score of 47% ranked below the 25th percentile tile and was 13% below the statewide average. Effective January 1st, 2015, Hennepin Health discontinued its CMS Medicare Managed Care contract for the SNBC product; thus, Hennepin Health manages only the Medicaid benefit for its SNBC members. The CAHPS 2016 survey is the first year Hennepin Health has had only non-dual members participating in the survey which may account for the decrease rating of the specialist seen most often. Hennepin Health has noted that its SNBC non-dual members are not as actively engaged in care coordination which may impact their overall satisfaction with their physicians managing their care. Hennepin Health's provider network for SNBC remains unchanged from previous years. Hennepin Health will continue to monitor this rate.

- **2015 Recommendation: HEDIS® (Quality of Care)** – Enhance Diabetes Disease Management Program to include HbA1c testing. Additionally, expand quality improvement strategy to address the HEDIS® *Comprehensive High Blood Pressure* measure.

Plan Response: Hennepin Health's Diabetes Disease Management Program does include HbA1c testing and the Disease Management Coordinators do encourage all members who opt in to Hennepin Health's Diabetes Disease Management Program to see their attending health care professional for management of their diabetes.

Effective January 1st, 2015, Hennepin Health discontinued its CMS Medicare Managed Care contract for the SNBC product; thus, Hennepin Health manages only the Medicaid benefit for its SNBC members. Hennepin Health's SNBC population does include members who are dual-eligible but whose Medicare benefits are managed through either Medicare fee-for-service or other health plans. In those cases, Hennepin Health does not receive all Medicare claims for these members. For HEDIS 2016, both dual-eligible and non-dual SNBC members were included in the HEDIS measures. As Hennepin Health did not have access to Medicare claims for its members, this impacted the accurate identification of provider location and retrieval of data which had an impact on the above HEDIS measures. On the recommendation of Hennepin Health's HEDIS auditor, dual eligible members will not be included in the HEDIS measures for 2017 and beyond. Hennepin Health will continue to monitor these rates.

- **2015 Recommendation: Financial Withhold** – Continue to work to address withhold measures that fail to achieve target goals.

Plan Response: IPRO recommends that PrimeWest continue to examine measures that fail to meet the withhold requirements. For 2015, PrimeWest Health met all the requirements for MSHO/MS C+ and SNBC. The measures that did not meet were AMM (2.86/5 points) and Hospital Admission Rate (0/10) in our F&C-MA and MNCare populations. Our comments on these measures are below.

AMM

PrimeWest Health received 2.86/5 points for the AMM continuation phase measure. During 2015, PrimeWest Health began a Performance Improvement Project (PIP) for the F&C-MA population on this measure. Interventions for this project include the following:

- Member outreach calls and letters when claims data indicates a late pharmacy fill for antidepressants
- Provider letters to the prescribing practitioner when claims data indicates a late pharmacy fill for antidepressants
- Proactive outreach to minority members any time a new antidepressant prescription is filled
- Electronic provider tool kit
- Other cultural considerations or outreach as applicable such as webinars, newsletter articles, community events, email blasts, etc.

Measurement one of this project was received in June 2016. The PMAP AMM rate for HEDIS 2016 was 37.34 percent, which is an almost two percentage point increase over the baseline. This is a promising increase, and if this rate of growth continues, we should reach our goal of a six percentage point improvement by 2018. The MinnesotaCare rate was 40 percent, which is close to a 5 percentage point increase. However, this population also has smaller numbers in the denominator, which can affect the percentage changes.

AMM Measurement

N: Members who remained on their antidepressant medications for 6 months

D: Members in the study populations

	Baseline (HEDIS 2013 & 2014)	Measurement 1 (HEDIS 2016)		
		N	D	Rate
PMAP	35.89%	197	530	37.35%
Minnesota Care	35.89%*	14	35	40%

PrimeWest Health will continue to monitor this project and seek to improve member adherence to their antidepressants.

Hospital Admission Rate

PrimeWest Health received 0/10 withhold points for the F&C-MA and MNCare contracts. PrimeWest Health had several population changes throughout this time and the year prior due to the Affordable Care Act. PrimeWest Health had a large increase in membership in first quarter 2014, with more Minnesotans qualifying for Medical Assistance. Due to these population shifts, historical data is less comparable to current utilization, as we are serving a new demographic. However, PrimeWest Health has ongoing initiatives to decrease hospital admission rates. These include utilizing our disease management program to target educational outreach, working with clinics to receive timely data reports to better identify those needing support, and utilizing risk lists to encourage members to receive preventive screenings and care. PrimeWest Health also works with Accountable Rural Community Health (ARCH) clinics to improve quality outcomes and reduce hospital admissions. ARCH clinics are part of a value based payment system via collaborative efforts with PrimeWest Health to achieve Triple Aim and create shared accountability. PrimeWest Health will continue to monitor trends in our new population and adjust interventions as necessary.

- **2015 Recommendation: HEDIS® (Quality of Care)** – Continue to modify interventions based on data analysis and continue to use Care Analyzer to create “risk lists”. PrimeWest should consider options for monitoring HEDIS performance in real-time and consider increasing the frequency for which the HEDIS/Star group assesses effectiveness of interventions.

Plan Response: IPRO recommends that PrimeWest Health should continue to modify HEDIS interventions as needed and attempt to measure effectiveness more frequently. IPRO also recommends seeking ways to measure HEDIS in ‘real time’ throughout the year. In 2017 the HEDIS/Star Strategy group created a 5 year strategic plan for improvement organizational wide. Many of the goals included in this plan are related to HEDIS measures. This process included prioritizing different measures based on PrimeWest Health NCQA Accreditation for our Medicaid population, including additional staff across the organization for input into the strategic plan, and modifying prior interventions based on data analysis. Risk lists continue to be utilized for various HEDIS measures, and PrimeWest Health has performed several focus studies that use Care Analyzer for HEDIS improvement. For example, PrimeWest Health retrieved chlamydia Screening rates in real time by individual clinics and shared these results with each clinic so that they were able see their performance in relation to other clinics. PrimeWest Health also provided risk lists to these facilities to perform outreach on members that were missing this important screening. PrimeWest Health will continue to use Care Analyzer in seeking improvement opportunities based on real time data.

In 2017, PrimeWest Health made a change and took HEDIS in house instead of contracting out for reporting and data services. Due to this, PrimeWest Health was able to utilize our internal data staff to perform monthly reporting of rates throughout the year and to improve processes. PrimeWest

Health will continue to pull HEDIS rates more frequently than in the past with this new process and capability.

PrimeWest Health is taking collaborative action with its Accountable Rural Community Health (ARCH) facilities. ARCH is an alternative model of health care financing and delivery transformation to better pursue Triple Aim (improving patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per capita cost of health care) for our members. At ARCH facilities, members have a care coordinator who helps with integration of medical, behavioral health, public health, social services, and community support services. As part of these ARCH agreements, facilities must meet certain outcome measures for payment conditions to be met. These outcome measures are typically related to HEDIS measures. As part of this process, PrimeWest Health sends monthly data to each ARCH provider so they may be notified of their current HEDIS rates in real time. This process allows the clinics to take action on the most current data available and improve quality of care.

PrimeWest Health will continue to seek opportunities to use Care Analyzer, and will consider reconvening the Star/Strategy group on a more frequent basis. Although the Star/Strategy group currently only meets annually, based on the information described above, HEDIS rates are continually being examined in real time, and this process will continue into 2018.

South Country Health Alliance (SCHA)

- **2015 Recommendation: Financial Withhold** – Continue with the interventions described in the Health Plan’s response to the previous year’s recommendation and modify these intervention as needed. SCHA should conduct root cause analyses for new withhold measures that failed to meet target goals, and should implement interventions that address identified barriers.

Plan Response:

Antidepressant Medication Management Performance Improvement Project

The topic of Antidepressant Medication Management (AMM) was a Financial Withhold performance measure under the DHS Families & Children contract for calendar years 2014 and 2015. This measure was later selected by DHS for the 2015-2017 F&C Performance Improvement Project (PIP) topic. The intended outcome of the PIP was to increase the percentage of members who had a diagnosis of major depression, were being treated with antidepressant medication, and remained on an antidepressant medication for at least 180 days.

The following AMM interventions strategies were initially implemented in 2015 and remain in place through at least 2017:

- Member Outreach and Education: South Country’s Member Services staff conduct supportive outreach telephone calls to members 21 to 27 days after a newly prescribed antidepressant prescription fill. Follow-up letters and educational materials (medication tip sheets, calendars with doctor appointment reminder and prescription refill stickers) are provided to both contacted members and members that are unreachable by phone.

Member Services staff also conduct “gap fill” outreach telephone calls to members who are 4 to 10 days late in refilling their anti-depressant medication prescription; supportive reminder letters are mailed to members who could not be reached by phone. In addition, treatment gap notifications are provided to members experiencing second and third gaps in treatment.

Congratulatory, positive affirmation letters and a 7-day pill organizer are mailed to members who meet the criteria for medication adherence during the *Acute Phase of Treatment* (84 days of continuous treatment). A self-care booklet is mailed along with a congratulatory letter to identified members who meet the criteria for anti-depressant medication adherence at the completion of the *Effective Continuation Phase of Treatment* (180 days of continuous treatment). The booklet, developed by South Country, provides suggestions on dealing with stress when faced with physical and mental health conditions that may affect an individual’s sense of well-being.

- Provider Outreach: News articles introducing any updates on the project are published in county- and provider-focused newsletters. Network pharmacy providers also received notification of the project along with an updated *Pharmacy Provider Toolkit* that includes strategies for increasing antidepressant medication adherence and sharing best practices. Lessons learned and next steps for continued improvement were incorporated into the 2017 toolkit.
- Staff Training on Cultural Competency: The cultural competency intervention was revised to focus on cultural sensitivity considerations for South Country’s Member Services staff and pharmacy providers. Member Services staff received training on Major Depressive Disorder and on Sensitivity Awareness regarding stigma, labeling, attitudes and beliefs often associated with diagnosis of mental illness. The *Pharmacy Provider Toolkit* mailed to network pharmacies included a section on cultural considerations when providing pharmaceutical care for individuals.

The baseline rate for this measure in 2014 was 33.60% and the performance outcome rate for HEDIS 2017 was 40.56%. The HEDIS 2017 rate denotes the first full year of intervention implementation for this measure as the measurement year was from May 1, 2015 to April 30, 2016. Rates for process measures are evaluated on an annual basis to assess the effectiveness of the intervention strategies and to determine modifications accordingly.

Well-Child Visits in the First 15 Months of Life Withhold Measure: Root Cause Analysis

South Country implemented a comprehensive strategy to promote and improve compliance with recommended infant well-child visits. This included a reward program that offers parents a gift card reward if their child completes 6 well-child visits by 15 months of age. Parents of eligible children are mailed information about the importance of the well-child visits alongside a reward program voucher; the topic is also heavily promoted by South Country’s partnering public health agencies. In addition, a clinic system pay-for-performance program has been in place since 2014 to improve compliance with well-child visits. Through this program, key clinic systems are provided with member “risk lists” identifying children due for the services and incentive dollars for achieving clinic-specific well-child visit goal rates. This arrangement has allowed clinics and South Country to strive for better coordinated member care and document utilization for future data collection and reporting purposes.

A root cause analysis for this measure was conducted during HEDIS 2016 and 2017 using the hybrid specifications outlined for medical record review. The following themes were noted:

- Many children receive the recommended number of well-child visits during infancy; however, the sixth visit commonly falls outside the parameters of the practice guidelines, generally within a range of one to 60 days after the child turns 15 months.
- Many clinics use a checklist in their electronic medical record (EMR) system as evidence of providing anticipatory guidance, with no notation of further education or recommendations offered to the child’s parent or guardian. While clinics often report education is provided, the

lack of documentation of discussion/education makes the record non-compliant for this portion of the measure, according to the regulatory standards.

- Similarly, lack of or inadequate health history documentation in the patient's chart (particularly for children seen for ongoing acute and/or chronic medical conditions) causes many well-child visits to be deemed incomplete.
- Infants with ongoing acute or chronic conditions are seen on a frequent basis by their provider for follow-up care. However, components for well-child preventive services are not necessarily included as part of the provider visit.

These findings were published in our provider newsletter and shared during strategic planning meetings with our network providers and partnering public health agencies as a means of addressing causal factors and collaboratively aligning performance improvement strategies for infant well-care visits. Collaborative initiatives with primary care providers such as pay-for-performance and frequent touch point meetings have provided the opportunity to learn and share best practices, as well as gain a better understanding of the challenges providers experience in delivering well-child services to our members.

Hospital Admission Rate: Root Cause Analysis

South Country has implemented pay-for-performance programs and utilization management efforts to reduce hospital admissions for several years. Activities from these programs help South Country achieve its goals for this measure over time. Our target rate for hospital admissions was not achieved in 2015, however South Country met its performance target rates in 2014 and 2016. Utilization reports for hospital admissions are monitored daily, with trending and evaluation done on a quarterly basis - by assessing the potential for over-utilization trends and identifying opportunities for improvement. A review of potential causal factors and admission trends during 2015 did not reveal any significant findings for this population.

- **2015 Recommendation: HEDIS® (Quality of Care)** – Continue with the interventions, both current and proposed, described in the Health Plan's response to the previous year's recommendation and consider adding a provider outreach component to the Chlamydia screening improvement strategy.

Plan Response:

Chlamydia Screening: Quality Improvement Strategies

South Country's *Be Rewarded!* member wellness program continues to promote evidence-based health care guidelines and is designed to improve the health status of members through education and rewards. In 2017 a bonus reward was added to the existing young adult well-care visit reward for all eligible members, ages 18-21, for completing chlamydia screening during their well-care exam. A monthly outreach campaign was implemented, targeting members who did not have an annual well-child visit in the previous six months. Members receive a supportive outreach letter, an educational flyer describing facts about chlamydia, information on screening and treatment, and a rewards program voucher to take with them to their next well-care exam. This information is also made

available to county public health agencies to distribute and provide education to eligible members who use services provided by their agencies.

In 2016, South Country began partnering with public health agencies for conducting annual Child and Teen Checkup (C&TC) meetings with key primary care providers and their clinic staff. The purpose of these meetings was to promote C&TCs, discuss implementation of preventive screening practices (including coding and maximization of accurate billing practices), share educational materials and provide information on preventive care rewards. This included promoting chlamydia screening for both male and female young adults. The partnership was expanded during 2017 and South Country plans to continue this collaborative approach of conducting annual provider clinic outreach meetings for 2018.

Additional outreach strategies for 2016-2017 have included provider network newsletter articles on best practices in rewarding preventive care, as well as information on the *Be Rewarded!* incentive programs offered to eligible South Country members. South Country's member newsletter also includes articles focused on the importance of preventive care services, including chlamydia education and screening.

Cervical Cancer Screening: Quality Improvement Strategies

Although Cervical Cancer Screening (CCS) was offered as a potential Pay for Performance measure with specific provider groups in 2017, none opted to include it as one of four quality of care measures tied to a financial incentive. This measure is challenging from both the provider and member perspective, as there have been several changes in the screening guidelines for initial testing, recommended screening tests and the frequency of testing over the past several years, creating contradictions and confusion, as one provider pointed out.

In 2017 South Country implemented an outreach campaign (supportive initial/reminder outreach letters and educational information) targeting all female members ages 21-64, promoting annual preventive care exams and member initiated discussions with providers on completing CCS during the exam. Plans for 2018 include the addition of a CCS gift card reward program, specifically directed at members needing to complete an initial CCS and members who are identified as non-compliant with the recommended screening requirements.

- **2015 Recommendation: CAHPS® (Member Satisfaction)** – Conduct a thorough root cause analysis for the measure listed above and implement interventions to address identified barriers.

Plan Response:

CAHPS (Member Satisfaction)-Rating of All Health Care: Root Cause Analysis

Overall composite scores for PMAP members responding to the 2016 CAHPS survey demonstrated a decline in member satisfaction compared to the average scores of all Minnesota health plans, with Rating of All Health Care being significantly lower than the state average. South Country’s Leadership Team and Quality Assurance Committee reviewed the data and concurred that underlying factors contributing to the lower rating included the influx of new members as a result of the Affordable Care Act and confusion as to their Medicaid status and enrollment in a health plan, implementation of Families & Children managed care procurement resulting in significant shifts between managed care plans for enrollees in 2015 and 2016, shortage of healthcare providers in rural clinics and corresponding longer wait times for needed appointments, disruption of care with a designated primary provider as a result of provider turnover in rural clinic systems, and newly implemented team-based approaches in service delivery among health systems that require time for adaptation.

Identified strategies to improve member satisfaction for 2017 include implementation of a consumer awareness plan focused on marketing and education to new and current members (recognizing South Country as their managed care plan), outreach and collaboration with provider and clinic systems in addressing consumer concerns directed at service delivery and provider continuity of care, and enhancing member assistance in locating primary care providers.

▪ **2015 Recommendation: Financial Withhold**

- Enhance the improvement strategy to include new withhold measures that failed to meet target goals.
- Continually evaluate the effectiveness of the improvement strategy and modify interventions as needed.

Plan Response:

Antidepressant Medication Management: Effective Continuation Phase Treatment

We note that this withhold measure was in effect only for the 2014 and 2015 DHS F&C-MA contracts.

2015 UCare Interventions

UCare utilized an antidepressant medication management specialist available through Beacon Health Strategies, UCare's behavioral health delegate, to offer enrollment in a health coaching program to members 7-14 days after their first antidepressant medication fill. The Psychotropic Drug Intervention Program – Antidepressant Medication Management provides education and support to members to assist them in filling their antidepressant medication on a monthly basis. The voluntary program's features include:

- An prospective, proactive, and educational approach
- Support for the member in order to have a successful outcome with their medication
- Consistently educating the member to call his or her prescriber about lack of response or therapy side effects
- The same antidepressant medical management specialist throughout
- Prescriber Referral Program that allows the prescriber to refer the member to the Psychotropic Drug Intervention Program – Antidepressant Medication Management
- English and Spanish programming
- Optional educational materials

AMM was discontinued as a withhold, but was continued as a Performance Improvement Project (PIP).

Emergency Department Utilization Rate

UCare has adopted a multi-prong approach to reducing avoidable emergency room utilization. We have a cross-organizational team that designs, implements, and oversees our efforts. We routinely review emergency room utilization on a quarterly basis via our Utilization Management Work Group and Medical Management Committee, paying particular attention to identifying members with frequent utilization, facilities with high volume of avoidable visits, and primary care clinics with high volume emergency room patients.

Following is a description of a few key strategies UCare employed in 2016 to address the state mandated emergency room withhold.

- Nurse advice services: UCare collaborates with a national vendor to provide on-demand health guidance and support to our members seeking health advice, telephonic triage services, and easy access to medical information and treatment recommendations. This service is available 24/7/365 and immediately connects members to a nurse with each call. UCare also offers members the option of a secure on-line WebNurse as another way to make care more accessible and convenient for members. The web-based non-emergent nurse advice service is accessed through our member portal any time of the day, and members receive a response to general health questions within 24 hours. UCare analyzed our nurse advice line data and found we have a >65% emergency room avoidance rate, and more than 30% of our nurse triage line calls are resolved with in-home treatment.
- Health coaching: UCare offers a telephonic health coaching program based on a therapeutic intervention model called Dynamic Somato-Social Theory delivered by cross-trained clinicians to break down psychological and social barriers, then address specific medical needs. This program targets members with multi-chronic conditions with exacerbating behavioral comorbidities and psychosocial challenges. In 2016, almost 10,000 members participated in this program. Overall, validated outcomes showed a reduction in both emergency room visits and inpatient admissions and a significant reduction in member costs.
- Dental outreach: UCare continues to work with metropolitan hospitals to ensure follow up with members who present with dental conditions, one of our top conditions for seeking emergent care in the 19-27 year old age range. To address this, UCare worked with our dental delegate that contacts members who went to the hospital and then arranged for primary dental care assignment and follow up care. The goal of the dental outreach program is to support members in establishing dental homes, thus avoiding future emergency room use for such care.
- Minnesota Restricted Recipient Program: UCare maintained a high rate of enrollment of members in this program throughout calendar year 2016. Analysis of member utilization and costs both showed significant reduction in emergency room utilization by members in this program, along with significant reduction in the use of narcotics and pharmacy costs.
- UCare works closely with provider groups and care management entities to support interventions via a care manager or primary care provider.

Hospital Admission Rate and Hospital 30-Day Readmission Rate

UCare employs a multifaceted approach to control *avoidable* hospital admissions and readmissions. However, due to significant changes in demographics of members in UCare during late 2015 through early 2016, we experienced substantial changes in the rate of admissions and associated readmissions, especially as members in older age ranges joined UCare and the membership fell in a differential pattern across UCare's smaller service area.

During 2015, UCare continued the building of the Utilization Management Workgroup to bring key staff (especially clinically-focused data analysts) and leaders together to address all aspects of utilization, including over and under-utilization of inpatient services.

Other interventions included:

- Targeting of high emergency room utilizers - including support by culturally-competent Community Health Workers and identification of members at high risk via predictive modeling software
 - Referral of appropriate potential members to the UCare Restricted Recipient Program
- **2015 Recommendation: HEDIS® (Quality of Care)**
- In regard to cervical cancer screenings, the Health Plan should identify and address barriers to care that are specific to its membership rather than only addressing barriers identified in literature.
 - In regard to chronic conditions, conduct root cause analysis to identify barriers to care and develop a multifaceted approach that includes both member- and provider- targeted interventions.

Plan Response: The recommendation is that UCare: (1) evaluate the effectiveness of the child and adolescent care improvement strategy described in UCare’s response to the 2014 ATR recommendation and modify it as needed; and (2) expand UCare’s quality improvement strategy to include cervical cancer screenings, controlling high blood pressure and comprehensive diabetes care.

Annually, a cross-departmental team reviews and analyzes all of UCare’s HEDIS data based on our comparison to the previous year, statistical significance of increases and decreases, comparison to NCQA national percentiles, and comparison to the Minnesota state average (which UCare leads and coordinates with the other health plans). UCare uses this analysis to set priorities for the year.

A committee is dedicated to the improvement of priority HEDIS measures and assigns responsibility for improving the measures to Quality Improvement Specialists who work with content experts throughout the organization. These specialists conduct focused studies following the Plan-Do-Study-Act model for improvement taught by ICSI staff. They perform a root-cause analysis for all identified measures, which includes an understanding of the issue/measure, an environmental scan and literature review, barrier analysis, intervention planning and implementation, and analysis of the intervention. If the intervention is successful, it is operationalized within UCare.

Childhood Immunization Status

UCare has an internal workgroup dedicated to improving childhood immunizations status, and in 2016, UCare conducted a number of different initiatives to increase childhood immunizations. These were:

- Conducting automated calls in English, Somali, Hmong and Spanish to remind members about immunizations and well-child visits
- Collaborating with community groups for various C&TC initiatives and educational opportunities
- Articles in our provider newsletter, [health lines](#)
- Articles in our member newsletter, in the [Zerkalo](#), a Russian newspaper and community services directory
- Mailing our Management of Maternity Services (MOMs) [booklet](#) to all expecting members, which includes information on immunizations
- Providing the [Parent's Guide](#) after delivery, which includes information on immunizations

Well-Child Visits (12-24 months and 3-6 years)

UCare has an internal workgroup dedicated to improving the access to primary care provider (PCP) measure, and in 2016, UCare conducted a number of different initiatives to improve this rate and the care for our young members. Please see our response to the childhood immunization status measure, above. Additional efforts for child access to PCPs included:

- Offering a \$50 incentive for completing six well child visits by 15 months of life
- A member engagement specialist who made specific calls to members to provide education over the phone (specifically on the importance of a well-child visit), assisted in scheduling well child visits, and assisted with scheduling transportation and an interpreter as needed.

Child/Adolescent Well-Care Visit (7-11 years, 12-21 years)

UCare has an internal workgroup dedicated to improving the access to PCP measure, and in 2016, UCare used a number of different initiatives to improve this rate and the care for adolescents. These were:

- Conducting automated calls in English, Somali, Hmong and Spanish to remind members about immunizations and adolescent well care visits
- Collaborating with community groups for various C&TC initiatives and educational opportunities
- Articles in our provider newsletter, [health lines](#)
- Offering a \$25 incentive for completing an adolescent well care visit

Cervical Cancer Screening

UCare has an internal workgroup dedicated to improving cervical cancer screening, and in 2016, UCare conducted a number of initiatives to improve this rate and the care for our members. Interventions were designed based on identified barriers from the literature on cervical cancer screening that included lack of awareness and knowledge on the importance of getting a cervical cancer screen, cultural beliefs, and access issues. Interventions were:

- Providing training to care coordinators to help educate and schedule members for preventive screens (barriers addressed: lack of awareness and knowledge, cultural beliefs, and access issues)
- Promoting the transportation benefit to assist members in getting to their medical appointment (barrier addressed: access issues)
- Targeting primary care providers by partnering with the American Cancer Society to present a cervical cancer webinar (barriers addressed: lack of awareness and knowledge and cultural beliefs)
- Collaborating with the American Cancer Society to send a member mailing discussing the importance of cervical cancer screenings (barriers addressed: lack of awareness and knowledge and cultural beliefs)

Controlling High Blood Pressure

UCare has an internal workgroup dedicated to improving controlling high blood pressure, and in 2016, UCare used a number of different initiatives to improve this rate. These were:

- Creating educational materials for providers on monitoring member's blood pressure who is not controlling their blood pressure. Providing education to providers about ongoing monitoring of member's blood pressure

Comprehensive Diabetes Care

UCare has an internal workgroup dedicated to improving diabetes care, and in 2016, UCare used a number of different initiatives to improve this rate. These were:

- Creating educational materials for providers on diabetes care including A1c testing, blood sugar control, eye exam and kidney disease monitoring
- Providing education to providers about ongoing monitoring of member's diabetes care and appropriate screens

- **2015 Recommendation: CAHPS® (Member Satisfaction)** – To enhance member experience with the health care system:
 - Use the results of the annual secret shopper calls to identify and educate providers who are not compliant with MCO appointment standards.
 - Routinely communicate appointment standards to members.
 - Use complaints and grievances as a source to identify issues members face when attempting to access care.

- Identify best practices across programs and apply these practices to the MSC+ and SNBC programs.

Plan Response: The recommendation is to conduct root cause analysis and implement interventions to address identified barriers, as well as evaluate the effectiveness of existing interventions, updating and modifying them as needed.

Annually, UCare establishes a cross-departmental team to review all of our CAHPS survey results. The data is analyzed and reviewed based on our comparison to the previous year, statistical significance of increases and decreases, comparison to national benchmarks, and comparison to the Minnesota state average. UCare takes that analysis and sets priorities for the year.

UCare's Quality Management Department and our Member Experience Workgroup are dedicated to the improvement of these priority CAHPS measures. Responsibility for improving the measures is assigned to the appropriate UCare team that works with content experts throughout UCare. The Quality Management Department conducts a root-cause analysis of all identified measures, which includes an understanding of the issue/measure, environmental scan and literature review, barrier analysis, intervention planning and implementation, and analysis of the intervention. If the intervention is successful UCare operationalizes it within the organization.

UCare also monitors member experience through other methods such as additional member surveys, focus groups, secret shopper calls, number and types of complaints/appeals/grievances, customer service call analytics, and Member Advisory Committee feedback.

Getting Needed Care

UCare identified the issue of access to timely care as an improvement area from the 2015 CAHPS survey. When members call for non-urgent or specialist appointments, members expect to be seen within their expected time frame. UCare has in place access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret-shopper calls. This measure is part of the NCQA Quality Improvement and Network Standards, which includes an annual GeoAccess analysis. In addition, we conduct a semi-annual service area analysis for MSHO, MSC+ and SNBC to identify opportunities for improvement. UCare identified those areas and is working on strategies to better address the needs of our members. UCare are conducted member focus groups to identify other needs improvement opportunities to provide overall improved member experiences. This measure was identified as one of our top priorities for the 2016 Member Experience Workgroup.

Priority areas that are being worked on to support this CAHPS measure include:

- Analyze UCare’s provider network access across primary care, specialty and behavioral health to determine gaps and the need for additional contracts especially in rural counties
- Provider Services and Contracting Department to contract directly with behavioral health providers that were previously contracted through UCare’s former delegate for expansion of behavioral health services
- Work with internal stakeholders for consideration on benefit design making member material language clearer, so members can understand what services are covered and what services have cost sharing
- Review members’ requests for new providers that are not in-network.
- Internal education on grievance and appeal trends
- Provider Relations and Contracting Department to continually monitor network adequacy

Further, the Clinical Services Department continues to annually publish and apply authorization and notification requirements for providers as an integral component of our medical management strategy. Utilization review compliance continues to be exceptionally high due to the multiple procedures in place to ensure authorization requests are received, reviewed and results communicated to providers and members in a timely manner. The prior authorization and notification requirements continue to be extensively reviewed throughout the year via many channels, including workgroups and committees. UCare looks at multiple data points such as utilization, cost, local trends and patterns, and national studies as a basis for these decisions.

Getting Care Quickly

UCare identified the issue of access to timely care as an improvement area from the 2015 CAHPS survey. When members call for non-urgent or specialist appointments, members expect to be seen within their time frame expectations.

UCare has established access and availability standards for providers. To ensure these standards are met, UCare conducts annual secret shopper calls. This measure is part of the NCOA Network Standard reports for accessing the provider network, and we perform a yearly analysis of this area and identify opportunities for improvement. UCare identified these areas and is working on strategies to better address the needs of our members. We also conducted member focus groups to identify other needs and areas where there is room for improvement.

Priority areas that are being worked on to support this CAHPS measure include:

- Analyze UCare’s provider network access across primary care, specialty and behavioral health to determine gaps and the need for additional contracts especially in rural counties
- Provider Services and Contracting Department to contract directly with behavioral health providers that were previously contracted through UCare’s former delegate for expansion of behavioral health services

- Work with internal stakeholders for consideration on benefit design making the member material language clearer, so members can understand what services are covered and what services have cost sharing
- Review members' requests for new providers that are not in-network.
- Internal education on grievance and appeal trends
- Provider Relations and Contracting Department to continually monitor network adequacy

To help members receive care quickly, UCare does not:

- Require prior authorization for inpatient stays, although notification is required within one business day of admission; this notification is shared with case managers to assist with transition of care management
- Require members to obtain a referral to see specialty providers within the provider network
- Require authorization for emergency or urgent care
- Require a three day hospital inpatient admission before skilled nursing facility coverage is accessed for MSHO when a qualifying event occurs

Customer Service

- UCare developed a soft skills training on the special needs of our dual eligible MSHO members. The goal of the training was to provide UCare Customer Services representatives with the skills and thought processes to help these members in a more kind, considerate and focused way. UCare Customer Services representatives receive ongoing soft skills training for our MSHO population to better understand the membership and meet the needs of our members.
- Customer Services shifted its training emphasis from purely knowledge-based to knowledge + problem resolution. Using speech analytic software, managers identify common problems Customer Service representatives have difficulty solving. Managers work with Customer Service representatives on providing additional training and education.
- UCare's Customer Services Quality Assurance Team monitors post calls. Members who score a Customer Service representative low on the post call survey or who appear to be dissatisfied with the call receive a follow up call by a Customer Service Supervisor within 24 hours. The Quality Assurance Team also closely monitors Customer Service calls for accuracy to ensure members are treated with courtesy and respect. Customer Service Managers provide feedback to representatives based on the call performance to improve member satisfaction.
- Customer Services Managers continue to provide ongoing refresher trainings for Customer Services representatives regarding products' benefits, answering member questions effectively and efficiently, as well as treating members with courtesy and respect. Additional training is provided for Customer Services representatives on oral grievances. Training includes understanding how to address people who need to file a grievance, how to try and problem solve and provide a resolution for these members, as well as learning how to deescalate complaints. In addition, a centralized group of Customer Services representatives are trained specifically to handle oral grievances for members.

- A core group of Customer Services representatives are specifically trained on pharmacy benefits.

Rating of All Health Care

UCare provided education to providers on the overlap and crossover of Health Plan (HP) CAHPS and Clinician and Group (CG) CAHPS to help improve rating of all health care. UCare provided education through onsite visits with our Provider Relations and Contracting and Provider Services Departments, as well as through provider communications.

UCare's Quality Management Department and Member Experience Manager review on an annual basis HP CAHPS and CG CAHPS to see how UCare can better partner with providers to improve overall scores for members' ratings of all health care.

Rating of Personal Doctor

UCare provided education to providers on the overlap and crossover of HP CAHPS and CG CAHPS, and to help improve this rating, UCare has provided education through onsite visits from our Provider Relations and Contracting Department as well as through provider communications.

UCare's Quality Management Department and Member Experience Manager review on an annual basis HP CAHPS and CG CAHPS on how we can better partner with providers to improve overall scores for MSHO members' ratings of personal doctor.

Rating of Health Plan

UCare has many initiatives in place to support our members and enhance the care and services they receive. We constantly seek out feedback from our members on how we can improve and work diligently to meet their needs. We host numerous focus groups along with our quarterly Member Advisory Committee to ensure the voice of our members is heard, and our Quality Management Department, Member Experience Manager and Member Experience Workgroup work to improve our programs accordingly.

UCare sent a UCare CAHPS survey to the entire MSHO population in the fall of 2016 to gather more information on members' feedback. UCare will use this information to better design interventions to help address members' concerns and improve delivery of care.

UCare's Marketing Team incorporated CAHPS questions regarding Getting Needed Care, Customer Service and Care Coordination in the MSHO member feedback survey. This will give UCare specific information on areas of improvement, how to improve quality of care, as well as how to design interventions to improve these CAHPS scores.

Chapter 5: MCO Feedback on 2016 ATR

The DHS/MCO Contract, Section 7.5.3, states that each MCO shall be provided with the opportunity to review and comment on the final draft of the ATR prior to publication. This chapter presents MCO feedback on the final draft of the 2016 ATR. MCO comment resulting in modification to the ATR is noted as “addressed”.

Blue Plus

No comment.

HealthPartners

- F&C-MA's 2017 Shared Decision Making score is 76%, but is reported at 76.5% in the Minnesota Managed Care Public Programs Consumer Satisfaction Survey Results report. Should the score be rounded to 75%? **Addressed.**
- MSC+'s 2017 Shared Decision Making score is 74% but is reported at 74.5% in the Minnesota Managed Care Public Programs Consumer Satisfaction Survey Results report. Should the score be rounded to 75%? **Addressed.**
- SNBC's 2017 Rating of Specialist score of 63% is reported at 63.5% in the Minnesota Managed Care Public Programs Consumer Satisfaction Survey Results report. Should the score be rounded to 64%? **Addressed.**

Hennepin Health

- MCO requested edits to the Corporate Profile. **Addressed**
- MCO requested revisions to the Quality Assurance Examination and Triennial Compliance Assessment section to be consistent with other MCO summaries. **Addressed**
- MCO requested edits to the Provider Guidelines section. **Addressed**
- Hennepin Health’s CAHPS results section: As the sampling methodology and results reported incorporated all three of Hennepin Health’s products – PMAP, MNCare and SNBC, I would recommend adding a note that comparison to previous years cannot be made. **Addressed**
- Additionally, CAHPS 2015 and 2016 results captured only Hennepin Health’s Medicaid Expansion population as Hennepin Health did not have a PMAP or MNCare population; therefore, a comparison to CAHPS 2017 cannot be made. **Addressed**
- There is not a SNBC CAHPS® results section either under Hennepin Health or MHP. ***The DataStat CAHPS® report did not include reportable results for the Hennepin Health SNBC program as the sample size was considered too small to report. Since there was no data to report for this period, the SNBC table was removed.***

Itasca Medical Care (IMCare)

No comment.

Medica

- On page 63, it states “Medica *provides* services to enrollees.....”. While that was true for 2016, it is not currently true as the MCO is not providing services in F&C MA or MNCare. **Addressed**

Metropolitan Health Plan (MHP)

- MHP's Corporate Profile, Figure 14: the enrollment data of December 2016 includes enrollment for MSC+ and MSHO. Hennepin Health/MHP has not had any MSC+ or MSHO enrollment since January 1, 2016 as the CMS contract ended on December 31, 2015. **Addressed**
- In MHP's PIP section, it states this PIP is a collaborative comprised of 3 MCOs. It should be changed to reflect 5, instead of 3. **Addressed**
- There is not a SNBC CAHPS® results section either under MHP or Hennepin Health. ***The DataStat CAHPS® report did not include reportable results for the Hennepin Health SNBC program as the sample size was considered too small to report. Since there was no data to report for this period, the SNBC table was removed.***

PrimeWest Health

- Page 83, there is a statement that indicates PrimeWest Health is accredited for the 2016-2017 NCQA rating period. Technically, our accreditation is good until January 19, 2019. Additionally, there is a statement that says that PrimeWest Health achieved NCQA accreditation for the MNCare line of business but omitted Medicaid. We have NCQA accreditation for both F&C-MA and MNCare.
Addressed

South Country Health Alliance (SCHA)

We identified one concern in the use of the Measure Matrix for comparing MCO performance year-over-year and to the statewide average pertaining to placement of the MNCare Breast Cancer Screening measure in the yellow (C) matrix box. We continue to experience continued improvement in the rate for this measure from 65.6% in 2015 to 68.9% in 2016 and 70.9% for 2017. This puts us above the statewide average and at the 90th for the national benchmark. According to the methodology used for the ATR Matrix, described in Chapter 3 of the ATR, we believe this measure should be placed in the light green (B) middle matrix box (identify opportunities for improvement, but no required improvement). **Based on additional review, the MN HEDIS® Breast Cancer Screening measure will remain in its current location on the Measure Matrix. The color coded cell description has been modified for clarification.**

Under the Performance Improvement Project section of the report, *Home-Base Medication Reconciliation Post-Hospital Discharge* (2015-17) was listed as a PIP for SingleCare and SharedCare. Rates for HEDIS 2015 were listed as “Not Available” and for HEDIS 2016 as “Not Yet Reported.” DHS discontinued this PIP before interventions were fully implemented, and replaced it with the Antidepressant Management PIP which became effective January 1, 2016. A final report was not required to be submitted to DHS because of the transition to the new PIP/QIP alignment process and AMM topic selection by DHS. Therefore we recommend omitting the Medication Reconciliation project from the ATR, as the PIP was not implemented during the 2015-2017 timeframe; only the AMM project was in place, similar to the process followed by other MCOs and CBPs. **Addressed**

Please review the QAE summary for South Country on page 109 of the ATR report. It should be corrected to read as follows: “The MCO received a total of two (2) recommendations, three (3) mandatory improvements and three (3) deficiencies for the QAE.” It currently reads one (3) deficiencies for QAE. **Addressed**

UCare

- The following note on the bottom of page seven is incorrect: “Note: UCare’s enrollment decline from 2015 to 2016 is attributed to the loss of its F&C-MA contract.” Please update this note to reflect our presence in Olmstead County for the F&C-MA contract in 2016. **Addressed.**

Chapter 6: EQRO Recommendations to DHS

ATR Recommendations

- As DHS's Withhold program now includes annual dental visit rates for all MHCP programs, DHS should consider reporting in future ATRs, the HEDIS® *Annual Dental Visit* measure in MCO-level HEDIS® tables to allow for comprehensive analysis of the MCOs' performance as it relates to dental care.
- As the national opioid epidemic continues, DHS should consider including in future ATRs, state initiatives aimed at addressing the opioid crisis in Minnesota. Specifically, a summary of DHS's "Minnesota State Targeted Response to the Opioid Crisis" project narrative would provide CMS and other stakeholders with an outstanding overview of Minnesota's efforts to reduce opioid use in the Medicaid population. DHS should also consider the reporting of related HEDIS® measures in future ATRs.
- Size and breadth of provider networks can impact access to, quality of and timeliness of care. As such, IPRO continues to recommend the inclusion of provider network data in future ATRs. These data will allow for a more detailed level of analysis of MCO performance, as well as more tailored suggestions for improvement.