

**Minnesota Department of Human Services**  
**2018 External Quality Review Annual Technical Report**  
**Issued April 29, 2020**

*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)*



Better healthcare,  
realized.

**Corporate Headquarters**  
**1979 Marcus Avenue**  
**Lake Success, NY 11042-1002**  
**(516) 326-7767**  
**[www.ipro.org](http://www.ipro.org)**

**2018 External Quality Review  
Annual Technical Report**

**Issued: April 29, 2020**

**Prepared by:**

**IPRO**

**1979 Marcus Avenue**

**Lake Success, NY 11042-1002**

**[www.ipro.org](http://www.ipro.org)**

**For More Information:**

**Mark Foresman, PhD, Supervisor, Quality Improvement**

**Health Care Research and Quality**

**Department of Human Services**

**P.O. Box 64986**

**St. Paul, MN 55164-0986**

**Telephone: (651) 431-6324**

**Fax: (651) 431-7422**

**E-mail: [mark.foresman@state.mn.us](mailto:mark.foresman@state.mn.us)**



For accessible formats of this publication and additional equal access to human services, write to [Minnesota State Department of Human Services Quality Improvement E-mail](#), call 651-461-2610 or use your preferred relay service. (ADA-1 [9-15])

**This document may be reproduced without restriction.  
IPRO reviewed and confirmed this document is 508-compliant.**

HEDIS® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). NCQA HEDIS® Compliance Audit™ is a trademark of the NCQA. NCQA™ is a trademark of the National Committee for Quality Assurance.

---

## TABLE OF CONTENTS

---

List of Figures .....	ii
List of Tables .....	iii
Acronyms Used in This Report .....	v
Executive Summary.....	1
Chapter 1: Introduction .....	2
Chapter 2: Summary of DHS Activities.....	8
2018 Health Care Disparities Report .....	8
State Targeted Response to the Opioid Crisis .....	9
Chapter 3: Evaluation of MCO Strengths and Opportunities .....	11
A. Evaluation Process.....	11
B. MCO Evaluations.....	18
Blue Plus .....	19
HealthPartners .....	32
Hennepin Health .....	44
Itasca Medical Care (IMCare).....	56
Medica.....	68
PrimeWest Health .....	76
South Country Health Alliance .....	91
UCare.....	104
C. Common Strengths and Opportunities across MHCP.....	119
Chapter 4: Follow-Up to 2017 ATR Recommendations .....	122
Chapter 5: MCO Feedback on 2018 ATR.....	170
Chapter 6: EQRO Recommendations to DHS.....	179

---

## LIST OF FIGURES

---

Figure 1: MHCP Enrollment by MCO – December 2018 .....	5
Figure 2: MHCP Enrollment Trends by MCO – December 2016, December 2017 and December 2018.....	6
Figure 3: Enrollment by Population Type – December 2018.....	7
Figure 4: Blue Plus 2019 HEDIS Measure Matrix .....	26
Figure 5: HealthPartners 2019 HEDIS Measure Matrix.....	39
Figure 6: Hennepin Health 2019 HEDIS Measure Matrix.....	51
Figure 7: IMCare 2019 HEDIS Measure Matrix .....	63
Figure 8: Medica 2019 HEDIS Measure Matrix.....	72
Figure 9: PrimeWest 2019 HEDIS Measure Matrix.....	85
Figure 10: SCHA 2019 HEDIS Measure Matrix .....	99
Figure 11: UCare 2019 HEDIS Measure Matrix.....	113

---

## LIST OF TABLES

---

Table 1: MCO Participation by Program in 2018 .....	3
Table 2: Blue Plus Enrollment as of December 2018.....	19
Table 3: Blue Plus Rates for the 2015-2017 PIP .....	20
Table 4: Blue Plus 2018 Financial Withhold.....	21
Table 5: Blue Plus HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	23
Table 6: Blue Plus CAHPS Performance – 2017, 2018 and 2019.....	27
Table 7: HealthPartners Enrollment as of December 2018 .....	32
Table 8: HealthPartners Performance Rates for the 2015-2017 PIP .....	33
Table 9: HealthPartners 2018 Financial Withhold .....	34
Table 10: HealthPartners HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	36
Table 11: HealthPartners CAHPS Performance – 2017, 2018 and 2019.....	40
Table 12: Hennepin Health Enrollment as of December 2018 .....	44
Table 13: Hennepin Health Performance Rates for the 2015-2017 PIP .....	45
Table 14: Hennepin Health 2018 Financial Withhold .....	46
Table 15: Hennepin Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	48
Table 16: Hennepin Health CAHPS Performance – 2017, 2018 and 2019.....	52
Table 17: IMCare Enrollment as of December 2018.....	56
Table 18: IMCare Performance Rates for the 2015-2017 PIP.....	57
Table 19: IMCare 2018 Financial Withhold.....	58
Table 20: IMCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	60
Table 21: IMCare CAHPS Performance – 2017, 2018 and 2019 .....	64
Table 22: Medica Enrollment as of December 2018.....	68
Table 23: Medica 2018 Financial Withhold.....	69
Table 24: Medica HEDIS Performance – Reporting Years 2017, 2018 and 2019.....	71
Table 25: Medica CAHPS Performance – 2017, 2018 and 2019 .....	73
Table 26: PrimeWest Enrollment as of December 2018.....	76
Table 27: PrimeWest Rates for the 2015-2017 PIP.....	77
Table 28: PrimeWest 2018 Financial Withhold.....	78

Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	81
Table 30: PrimeWest CAHPS Performance – 2017, 2018 and 2019 .....	86
Table 31: SCHA Enrollment as of December 2018.....	91
Table 32: SCHA Performance Rates for the 2015-2017 PIP.....	92
Table 33: SCHA 2018 Financial Withhold.....	93
Table 34: SCHA HEDIS Performance – Reporting Years 2017, 2018 and 2019 .....	95
Table 35: SCHA CAHPS Performance – 2017, 2018 and 2019.....	100
Table 36: UCare Enrollment as of December 2018.....	104
Table 37: UCare Performance Rates for the 2015-2017 PIP.....	105
Table 38: UCare 2018 Financial Withhold.....	106
Table 39: UCare HEDIS Performance – Reporting Years 2017, 2018 and 2019.....	109
Table 40: UCare CAHPS Performance – 2017, 2018 and 2019 .....	114
Table 41: MHCP HEDIS Performance – Reporting Years 2017, 2018 and 2019.....	120
Table 42: MHCP CAHPS Performance – 2019 .....	121

---

## ACRONYMS USED IN THIS REPORT

---

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
ACP:	American College of Physicians
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
ASAM:	American Society of Addiction Medicine (ASAM)
ATR:	Annual Technical Report
BBA:	Balanced Budget Act (of 1997)
BOC:	Board of Commissioners
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
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, Minnesota
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
JACC:	Journal of the American College of Cardiology
JAMA:	Journal of the American Medical Association
JNC 8:	Eighth Joint National Committee
JPB:	Joint Powers Board
MA:	Medical Assistance
MCO:	Managed Care Organization
MDH:	Minnesota Department of Health
MNCare:	MinnesotaCare
MNCM:	MN Community Measurement
MHCP:	Minnesota Health Care Programs
MSHO:	Minnesota Senior Health Options
MSC+:	Minnesota Senior Care Plus
MTM:	Medication Therapy Management
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
SNP:	Special Needs Plan
STR:	State Targeted Response
SWA:	Statewide Average
TCA:	Triennial Compliance Assessment
UR:	Utilization Review
URI:	Upper Respiratory Infection
USDHHS:	United States Department of Health and Human Services
USPSTF:	United States Preventive Services Task Force
VBP:	Value-Based Program

---

## 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 Minnesota 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 2018 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: the validation of performance measures, the validation of performance improvement projects (PIP), and compliance monitoring. Results of the most current Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>1</sup> reporting period and Consumer Assessment of Healthcare Providers and Systems (CAHPS)<sup>2</sup> survey are presented. IPRO's assessment also included a review of the PIPs that were in progress during the measurement year, the most current Quality Assurance Examination (QAE) and Triennial Compliance Assessment (TCA) findings, and MCO achievements under the Financial Withhold Program.

In 2018, MHCP performance in the area of adult access to care continued to be strong, while performance in the areas of quality of care and timeliness of care demonstrated opportunities for improvement. MHCP members continued to report high satisfaction with personal doctors, and high dissatisfaction with MCO customer service and overall health care.

Collectively, the MCOs continued to demonstrate strong performance in access to preventive and ambulatory care for adults. Related HEDIS rates met or exceeded the 75<sup>th</sup> percentile benchmark. MHCP demonstrated opportunities for improvement in the access to, quality of and timeliness of: women's preventive screenings, child and adolescent routine care, dental care for adults and children, and diabetes testing. Related HEDIS rates were below the 50<sup>th</sup> percentile benchmark. MHCP CAHPS results indicated that members were highly satisfied with provider communication, shared decision making and personal doctors. Satisfaction with health plans, customer service, overall health care and specialist seen most often were identified as opportunities for improvement.

---

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

<sup>2</sup> 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 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, and UCare. These 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. 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 the Medical Assistance and MinnesotaCare programs.<sup>3</sup>

Minnesota’s publicly funded managed care programs include:

- **Families & Children Medical Assistance (F&C-MA):** A program for low-income people, low-income families with children, and children who are in need.
- **MinnesotaCare (MNCare):** A 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 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 the Medical Assistance (Medicaid) program.

---

<sup>3</sup> <https://www.health.state.mn.us/facilities/insurance/managedcare/planinfo/hmo.html>

**Table 1: MCO Participation by Program in 2018**

Managed Care Program					
MCO	F&C-MA	MNCare	MSHO	MSC+	SNBC
Blue Plus	●	●	●	●	
HealthPartners	●	●	●	●	●
Hennepin Health	●	●			●
IMCare	●	●	●	●	
Medica			●	●	●
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 this 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 evaluation and review of activities in 2018.

The purpose of the 2018 ATR is to present the results of the quality evaluations performed in accordance with the BBA,<sup>4</sup> 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:

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

<sup>4</sup> Subpart E, 42 Code of Federal Regulations (CFR), Section 438.364

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 DHS 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:

- **Validation of 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.
- **Validation of 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 eligible people 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 assistance. 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:

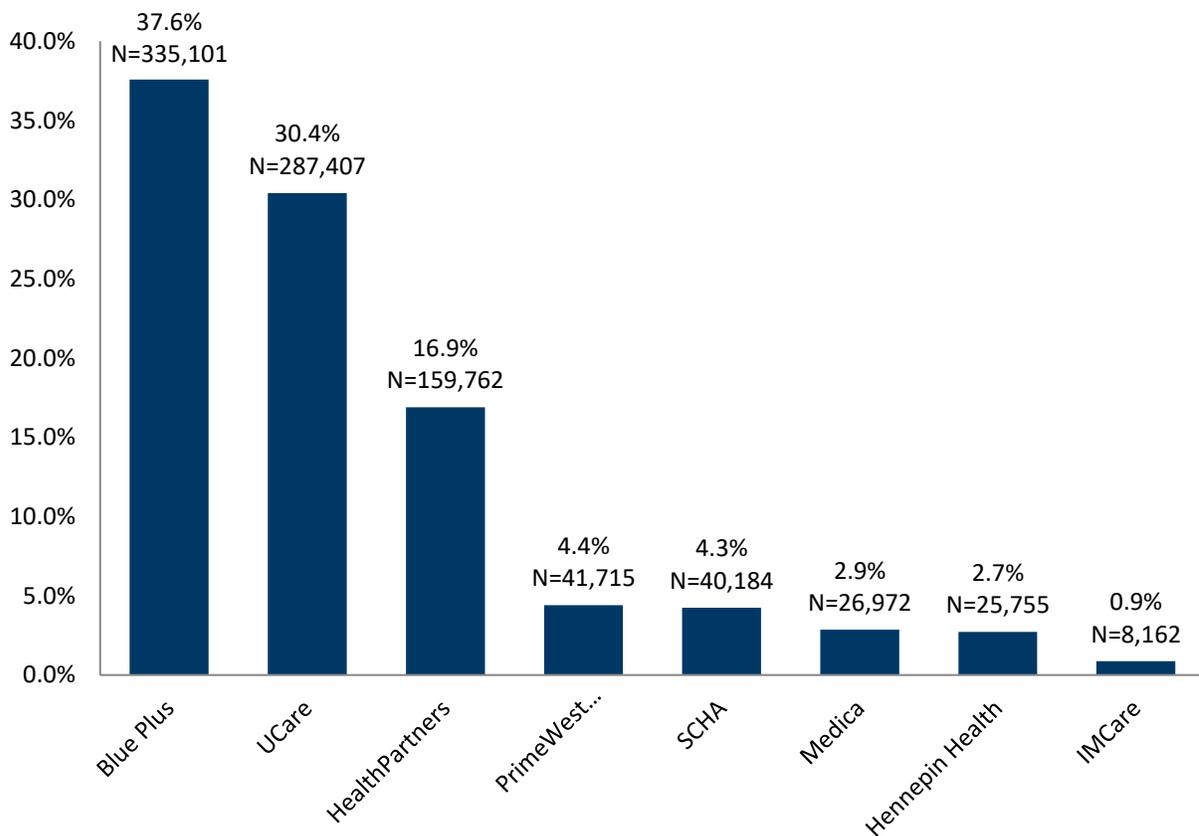
- Pregnant women
- Families and children
- Adults with disabilities
- Children with disabilities
- People 65 years or older
- Adults without children

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 Program<sup>5</sup>

In December 2018, total enrollment for MHCP was 945,058; a 1.4% decrease since the December 2017 enrollment of 958,284.<sup>6</sup> **Figure 1** displays December 2018 MHCP enrollment by MCO while **Figure 2** trends MHCP enrollment for December 2016, December 2017 and December 2018.

**Figure 1: MHCP Enrollment by MCO – December 2018**



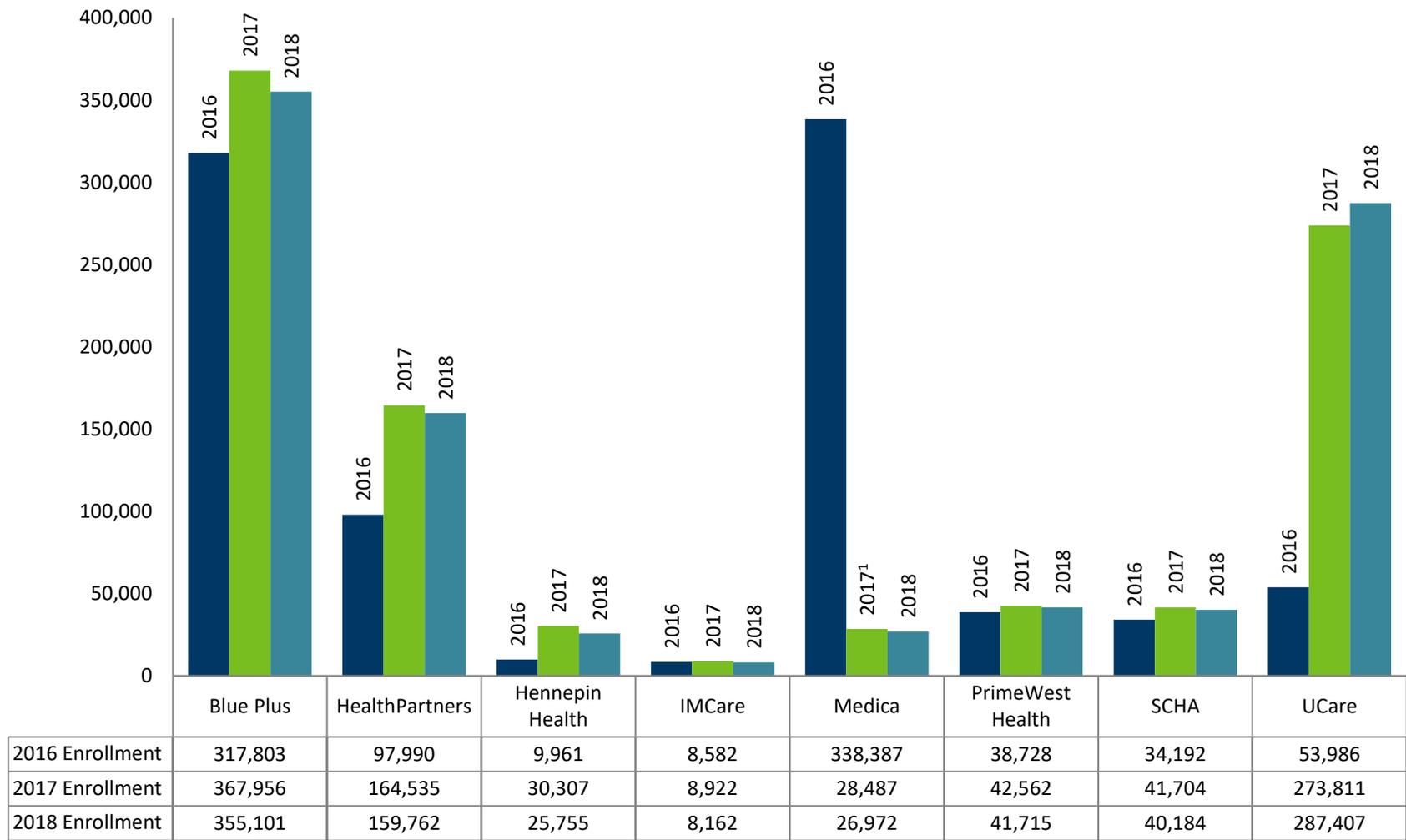
<sup>5</sup> Please visit the Minnesota Department of Health SAGE Screening Program.

<https://www.health.state.mn.us/diseases/cancer/sage/index.html>

<sup>6</sup> Enrollment data presented in Chapters 1 and 3 of this report derive from the DHS Managed Care Enrollment Figures for December 2018.

[https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_141529](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141529)

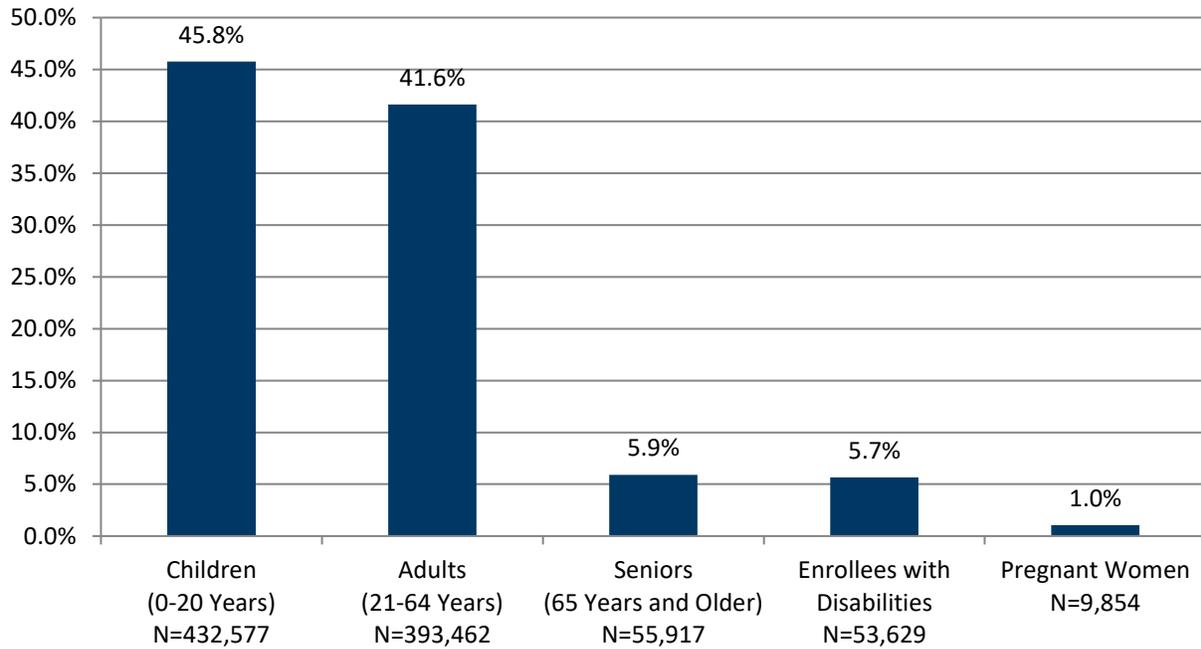
**Figure 2: MHCP Enrollment Trends by MCO – December 2016, December 2017 and December 2018**



<sup>1</sup> Medica’s enrollment significantly decreased between 2016 and 2017 due to Medica’s withdrawal from the F&C-MA contract.

As displayed in **Figure 3**, children are the largest population served by MHCP, accounting for almost 46% of the total enrollment. The overall December 2018 population breakdown is similar to that observed in December 2017.

**Figure 3: Enrollment by Population Type – December 2018**



---

## CHAPTER 2: SUMMARY OF DHS ACTIVITIES

---

### 2018 Health Care Disparities Report

In 2019, DHS contributed to the production of the MN Community Measurement<sup>®</sup> *2018 Minnesota HealthCare Disparities by Insurance Type*<sup>7</sup>. The data presented in the report was collected in 2018 for 2017 dates of service. The report focuses on statewide results for ten (10) quality measures across three overarching areas of care by race and ethnicity. The ten (10) quality measures are:

#### Preventive Health

1. Breast Cancer Screening
2. Colorectal Cancer Screening
3. Child Immunization Status (Combo 10)

#### Chronic Conditions

4. Optimal Diabetes Care
5. Optimal Vascular Care
6. Optimal Asthma Control – Adult
7. Optimal Asthma Control – Children
8. Controlling High Blood Pressure

#### Depression

9. Adult Depression Remission at Six Months
10. Adolescent Mental Health and/or Depression Screening

Key findings of the report include:

- Statewide MHCP results improved significantly since the 2017 reporting year for four (4) measures: Childhood Immunization Status, Optimal Asthma Control – Adults, Optimal Asthma Control – Children and Adult Depression Remission at Six Months.
- The Colorectal Cancer Screening measure had a statistically significant decrease in 2018 rates compared to 2017. However, the Colorectal Cancer Screening rate for MHCP patients increased by over eight (8) percentage points since 2011.
- Statewide MHCP rates are consistently and significantly lower than the Other Purchasers statewide rates for all ten (10) measures.
- American Indian/Alaskan Native patients were significantly below the MHCP statewide rate for eight (8) measures. This group did not perform significantly above any MHCP statewide rate.
- Black/African American patients were significantly below the MHCP statewide rate for eight (8) measures and above the MHCP statewide rate for one (1) measure.
- Asian patients were significantly above the MHCP statewide rate for five (5) measures and below the MHCP statewide average for one (1) measure.

---

<sup>7</sup> <https://mncm.org/wp-content/uploads/2020/01/2018-Disparities-Report-Final.pdf>

- White patients were significantly above the MHCP statewide rate for eight (8) measures. This group did not perform significantly below any MHCP statewide rate.
- Multi-Racial patients were significantly below the MHCP statewide rate for two (2) measures. This group did not perform significantly above any MHCP statewide rate.
- Hispanic patients were significantly above the MHCP statewide rate for two (2) measures. This group did not perform significantly below any MHCP statewide rate.

## State Targeted Response to the Opioid Crisis<sup>8</sup>

In 2017, Minnesota received a two-year grant from the Substance Abuse and Mental Health Services Administration. The State Targeted Response (STR) to the Opioid Crisis Grant program expands access to evidence-based prevention, treatment, and recovery support services, reduces unmet treatment needs, and helps to prevent opioid overdose deaths. The grant expires on July 1, 2019.

DHS has awarded grants to forty (40) state agencies, tribes and counties from the STR grant. The STR grants focus on:

- Supporting communities most impacted in order to offer elective, culturally relevant services
- Building on existing, proven efforts
- Offering new and innovative approaches

Overarching themes for grant activities include:

- Naloxone distribution
- Integrated care for high-risk pregnancies
- Community health worker mother's recovery training
- Care Coordination
- Parent child assistance program
- Rule 25 assessments
- Detox
- Office-based opioid treatment
- Improve access to treatment: fast-tracker
- Recently released from incarceration
- Peer recovery
- Extension from community healthcare outcomes (ECHO) hubs
- Prevention
- Innovation grants:
  - Strategies to decrease the burden of opioid misuse, abuse and overdose and address public awareness, provider education, and access to treatment
  - Syringe exchange program

---

<sup>8</sup><https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/str-opioid-crisis-grants/>

- Business plan that innovatively provides pretreatment, treatment, and post-treatment options
- Better identify and treat Neonatal Abstinence Syndrome
- Medication assisted treatment training program

---

## 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 compliance monitoring reports. Specifically, IPRO considered the following elements during the 2018 External Quality Review:

- HEDIS 2019
- 2019 CAHPS 5.0H Adult Medicaid Survey
- Performance Improvement Projects
- Minnesota Department of Health Quality Assurance Examination and Triennial Compliance Assessment
- 2018 Financial Withhold
- MCO Annual Quality Assurance Work Plan for 2018
- MCO Evaluation of the 2018 Quality Assessment and Performance Improvement Program
- MCO Clinical Practice 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*<sup>9</sup> 2019 for Medicaid and represent the performance of all MCOs (excluding PPOs and EPOs) that reported HEDIS data to the NCQA for HEDIS 2019 (Measurement Year (MY) 2018). *Note: The NCQA Quality Compass 2019 did not include benchmarks for the Medication Management for People with Asthma – 50% (Age 5-64 Years) measure.*

This report includes 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 independent proportions was determined by calculating the z-ratio. A z-ratio is a statistical measure that

---

<sup>9</sup> Quality Compass<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

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 2017, boxes in the middle row indicate no change from 2017, 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
2017 – 2018 Rate Change	C			
	D			
	F			

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

 The green box (or “A” box) indicates notable performance. The MCO’s HEDIS 2019 rate is statistically significantly above the 2019 statewide average and trends up from HEDIS 2018.

 The light green boxes (or “B” boxes) indicate a potential opportunity for improvement, but no immediate action is required. The MCO’s HEDIS 2019 rate is not different than the 2019 statewide average and is statistically above the HEDIS 2018 rate or that the MCO’s HEDIS 2019 rate is statistically significantly above the 2019 statewide average but there is no change from HEDIS 2018.

 The yellow boxes (or “C” boxes) indicate that the MCO should evaluate the measure for opportunities for improvement. The MCO’s HEDIS 2019 rate is statistically significantly below the 2019 statewide average and trends up from HEDIS 2018 or that the MCO’s HEDIS 2019 rate is not different than the 2019 statewide average and there is no change from HEDIS 2018 or that the MCO’s HEDIS 2019 rate is statistically significantly above the 2019 statewide average but trends down from HEDIS 2018.

 The orange boxes (or “D” boxes) indicate poor performance and action based on the results of a root cause analysis. The MCO’s HEDIS 2019 rate is statistically significantly below the 2019 statewide average and there is no change from HEDIS 2018 or that the MCO’s HEDIS 2019 rate is not different than the 2019 statewide average and trends down from HEDIS 2018.

 The red box (or “F” box) indicates poor performance and action based on the results of a root cause analysis. The MCO’s HEDIS 2019 rate is statistically significantly below the 2019 statewide average and trends down from HEDIS 2018.

HEDIS measures selected for inclusion in the measure matrix cover four (4) overarching areas of care: oral care, chronic conditions, women’s health, and child and adolescent care. Measures selected for these categories include:

- Oral Care
  - HEDIS *Annual Dental Visit*
- 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 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*

## CAHPS Performance

CAHPS allows for the standardized measurement of member satisfaction regarding healthcare services received. All of the performance measures reported herein are derived from the HEDIS or CAHPS reports. Statewide averages and national Medicaid benchmarks are provided for these measures. CAHPS benchmarks originate from the NCQA *Quality Compass*<sup>® 10</sup> 2019 for Medicaid and represent the performance of all Health Plans that reported CAHPS<sup>®</sup> data to the NCQA for HEDIS<sup>®</sup> 2019 (MY 2018).

In 2019, DHS contracted with Health Services Advisory Group (HSAG) to conduct the 2019 CAHPS 5.0H Adult Medicaid Survey on behalf of the participating MCOs who offer F&C-MA, MNCare, MSC+ and SNBC. In the CAHPS tables that follow, 2019 scores for the following composite measures were calculated using responses of “usually,” “always” or “yes”: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making*; 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, and Rating of Health Plan*. Historical data for 2018 and 2017 were recalculated using this scoring methodology as well. MCO scores that met or exceeded the 75<sup>th</sup> percentile were determined to be strengths, while scores below the 50<sup>th</sup> percentile were determined to be opportunities for improvement.

## Performance Improvement Projects

MCOs are contractually required to conduct 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 this ATR were validated by the DHS Quality Improvement 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 2016-2018 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

---

<sup>10</sup> Quality Compass<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

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: Improving Antidepressant Medication Adherence*.

During this cycle, Blue Plus, Hennepin Health, HealthPartners, Medica and UCare collaborated on the conduct of their PIPs, while IMCare, PrimeWest and SCHA conducted separate PIPs. Descriptions of MCO-specific topics, 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, 2018.

In 2018 DHS initiated a new PIP, *Reducing Chronic Opioid Use*. Initial PIP data will be reported in the 2019 ATR.

### **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.

### **2018 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 DHS-MCO contract allows DHS 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 2018 financial withhold is displayed in the following subsection of this report and was considered during IPRO's evaluation.

### **MCO Annual Quality Assurance Work Plan for 2018**

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 2018 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 Clinical Practice 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 clinical practice guidelines follow; however, this information was not evaluated as part of the EQR process.

## **MCO Quality Improvement Program Websites**

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. Additionally, the MCOs' most recent quality assurance work plan and evaluation of the quality assessment and performance improvement program can be accessed on these websites.<sup>11</sup> While the websites are evaluated by DHS for content and accessibility, the results of the evaluations were not considered as part of the EQR process.

---

<sup>11</sup> MCO Quality Improvement Program Websites can be accessed here under Quality, Outcomes and Performance Measures: <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/quality.jsp>

## 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 fourteen (14) DHS-produced rates are presented.
- For the MNCare program, a total of five (5) MCO-produced rates are presented, while twelve (12) 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 seven (7) DHS-produced rates are presented. *(Counts will vary if the MCO produced SNP and Non-SNP rates.)*

SPACE INTENTIONALLY LEFT BLANK

---

## BLUE PLUS

---

### Corporate Profile

Blue Plus, a wholly owned subsidiary of Blue Cross and Blue Shield of Minnesota, is a licensed HMO. Blue Plus contracts with DHS to deliver and administer F&C-MA, MNCare, MSC+ and MSHO programs and healthcare services. Blue Plus has provided managed care coverage for MHCP members since 1993. Blue Plus maintains a Commendable level of accreditation by NCQA under the Health Plan Accreditation status for its Medicaid lines of business. As of December 2018, the enrollment totaled 355,101. This accounted for 37.6% of the entire MHCP population. **Table 2** displays the enrollment total of Blue Plus in December 2018.

**Table 2: Blue Plus Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	308,923
MNCare	34,292
MSC+	3,216
MSHO	8,670
<b>Total Enrollment</b>	<b>355,101</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

In 2018, MDH conducted the most recent QAE and TCA on October 8, 2018 through October 12, 2018. The examination period covered December 1, 2015 to July 1, 2018, while the file review period covered July 1, 2017 to June 30, 2018. During this assessment, Blue Plus received a total of one (1) recommendation, five (5) mandatory improvements, and two (2) deficiencies for the QAE. The MCO received a total of three (3) “not met” designations for the TCA.

### Performance Improvement Project

In 2018 Blue Plus concluded its reporting on the following PIP:

- ***Reducing Race and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was 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 3** displays the MCO’s performance rates for this PIP.

**Table 3: Blue Plus Rates for the 2015-2017 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%
2017	43.12%	27.01%	-16.11%
2018	40.78%	27.92%	-12.86%
<b>Net Change</b>	<b>+0.79</b>	<b>-4.01</b>	<b>+4.80</b>

Member-focused interventions included:

- Targeted telephonic outreach by care coordinators or health coaches
- Outreach via mail, including educational materials, resources, and refill reminders
- Antidepressant refill reminder calls
- Referrals to case management services as needed

Provider-focused interventions included:

- Cultural competency training including issues specific to depression and antidepressant medication, health literacy, and communication
- Online “Provider Toolkit,” with patient resources, such as pharmacies with translation services and a shared-decision making tool

Community-focused interventions included:

- Collaborations with community organizations, such as NAMI-MN and local religious groups
- Sharing resources at local health fairs
- Promoting and attending community events during Minority Mental Health Month in July

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

### **2018 Financial Withhold**

Blue Plus achieved 2.20 points (of 100 points) for the F&C-MA and MNCare programs, and achieved 77.7 points (of 90 points) for the MSHO and MSC+ programs. **Table 4** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by Blue Plus.

**Table 4: Blue Plus 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (1-20 years)	55	0
Dental Service Utilization Rate for Adults (21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0
Emergency Department Utilization Rate	1	0.2
Hospital Admission Rate	1	0
No Repeat Deficiencies on the MDH QA Exam	2	2.0
<b>Total</b>	<b>100</b>	<b>2.20</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (65+ years)	15	2.7
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>77.7</b>

### Annual Quality Assurance Work Plan for 2018

The annual quality assurance work plan for Blue Plus is compliant with Minnesota Administrative Rule 4685.1130. The work plan outlines various quality improvement activities undertaken by the MCO throughout the year. Blue Plus conducted focused studies, performance improvement projects, and activities that targeted multiple facets of care and services, including chronic illnesses, opioid dependence, cancer screenings, and over- and under-utilization of services. For each activity, Blue Plus assigned responsible staff, listed a description of the activity, as well as identifying measure(s). Measures were used to evaluate improvement, interventions implemented, the target population of the activity, and the target or goal of the activity. Projects were presented in the same format throughout the work plan and clearly explained each project and the information within project(s).

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

The goal of Blue Plus' Quality Improvement (QI) Program is to "achieve the highest quality of care, resulting in the best value for members through an emphasis on health improvement and the clinical process of care". This was achieved by providing information and resources to stakeholders, emphasizing research and innovation, and dedication to the principles of continuous quality improvement. The QI Program for Blue Plus was designed to monitor various aspects of clinical care, clinical service, and organizational service for members and to identify opportunities for enhancements to existing programs and new program development. The scope of the QI Program included activities in the following areas: provider quality initiatives, population health improvement, health promotion/wellness, patient safety, behavioral health, service quality, NCQA delegated relationships and quality infrastructure.

Blue Plus also conducted multiple quality improvement projects throughout the year. The MCO was able to meet its established goals for about half of its projects, with the other half not meeting the goals. Blue

Plus continuously assesses its projects throughout the year and works diligently to resolve noted barriers and deficiencies. In 2018, Blue Plus reported that its Health Economics team experienced limited resources which caused delays in reporting. Moreover, other internal resources were used to meet two new requirements, which impacted survey responses rates. Overall, the QI Program for Blue Plus appears to be adequately designed to improve quality and services for members.

### **MCO Clinical Practice Guidelines**

Blue Plus recognizes the following sources for clinical practice guidelines:

- National Institutes of Health (NIH)
- Centers for Disease Control & Prevention
- American Academy of Pediatrics (AAP)
  - Diagnosis, evaluation, and treatment of ADHD in children and adolescents
- American Psychiatric Association (APA)
  - Treatment of individuals with major depressive disorder
- Institute for Clinical Systems Improvement (ICSI)
  - Treatment of individuals with major depressive disorder
- American Diabetes Association (ADA)
  - Prevention and management of diabetes
- National Heart, Lung and Blood Institute (NHLBI)
  - Diagnosis and management of asthma
- American Heart Association (AHA)
  - Management of heart failure
- Eighth Joint National Committee (JNC 8)
  - Management of High Blood Pressure
- National Osteoporosis Foundation (NOF)
  - Prevention and treatment of osteoporosis
- U.S. Preventive Services Task Force (USPSTF)
  - Preventive services for adults
  - Preventive services for children and adolescents
  - Routine prenatal care

### **HEDIS and CAHPS Performance**

The HEDIS and CAHPS rates for Blue Plus are displayed in **Table 5** and **Table 6**, respectively. The results of the MCO's Measure Matrix analysis are presented in **Figure 4**.

**Table 5: Blue Plus HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	Blue Plus HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	36.8%	41.6%	38.9%	10 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	90.3%	92.5%	94.4%	75 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	87.1%	84.1%	82.6%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	88.9%	87.7%	86.9%	50 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	Unavailable	46.5%	45.7%	10 <sup>th</sup>	47.1%
Breast Cancer Screening (52-74 Years) <sup>2</sup>	62.2%	60.7%	58.4%	33.33 <sup>rd</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	60.2%	58.3%	57.8%	33.33 <sup>rd</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	75.5%	71.8%	68.1%	33.33 <sup>rd</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	97.3%	96.8%	96.3%	50 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	90.4%	90.4%	88.6%	50 <sup>th</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	92.4%	92.5%	91.4%	50 <sup>th</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	93.2%	93.1%	92.3%	66.67 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	53.5%	51.0%	51.3%	25 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	65.6%	67.6%	71.8%	95 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	96.0%	91.2%	93.7%	90 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	66.9%	66.9%	72.5%	90 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	63.5%	64.6%	69.0%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	40.2%	40.4%	39.8%	50 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	67.7%	61.4%	64.4%	33.33 <sup>rd</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	63.8%	63.7%	63.1%	10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.					
<sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 5: Blue Plus HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	Blue Plus HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	23.4%	23.1%	26.5%	<10 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>	90.5%	94.2%	91.7%	50 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	83.4%	82.2%	82.0%	66.67 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	89.3%	88.5%	88.7%	66.67 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	Unavailable	38.8%	37.6%	<10 <sup>th</sup>	39.0%
Breast Cancer Screening (52-64 Years) <sup>2</sup>	68.7%	69.8%	66.3%	75 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	53.7%	55.3%	54.6%	10 <sup>th</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	93.5%	96.4%	50 <sup>th</sup>	94.2%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	92.6%	90.9%	88.4%	50 <sup>th</sup>	89.8%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	90.2%	90.4%	93.3%	75 <sup>th</sup>	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	52.3%	49.3%	52.1%	25 <sup>th</sup>	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	62.8%	74.2%	74.5%	95 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	95.9%	94.4%	95.6%	95 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	74.2%	73.0%	74.0%	90 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	82.3%	63.9%	79.6%	No Benchmark	77.5%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	53.2%	41.2%	55.8%	95 <sup>th</sup>	51.9%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	66.7%	63.5%	61.2%	<10 <sup>th</sup>	67.4%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 5: Blue Plus HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Blue Plus HEDIS 2017	Blue Plus HEDIS 2018	Blue Plus HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	98.2%	98.4%	98.1%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	67.5%	64.0%	65.3%	75 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	94.9%	95.1%	87.6%	33.33 <sup>rd</sup>	91.6%
<b>MSC+</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	93.1%	90.2%	90.8%	66.67 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	56.0%	55.3%	56.8%	33.33 <sup>rd</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	89.3%	86.2%	89.4%	50 <sup>th</sup>	74.2%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 4: Blue Plus 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	<b>C</b>		<b>B</b> <ul style="list-style-type: none"> <li>Medication Management for People with Asthma-50% (F&amp;C-MA)</li> <li>Well-Child Visits in the First 15 Months of Life (F&amp;C-MA)</li> </ul>	<b>A</b>
	<b>D</b> <ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (MNCare)</li> <li>Breast Cancer Screening (F&amp;C-MA)</li> <li>Cervical Cancer Screening (F&amp;C-MA, MNCare)</li> <li>Chlamydia Screening in Women (F&amp;C-MA)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>	<b>C</b> <ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>Breast Cancer Screening (MNCare, MSHO)</li> <li>Comprehensive Diabetes Care – HbA1c Testing (F&amp;C-MA, MNCare)</li> <li>Chlamydia Screening in Women (MNCare)</li> <li>Medication Management for People with Asthma-50% (MNCare)</li> <li>Medication Management for People with Asthma-75% (F&amp;C-MA, MNCare)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (MNCare)</li> </ul>	<b>B</b> <ul style="list-style-type: none"> <li>Breast Cancer Screening (MSC+)</li> <li>Comprehensive Diabetes Care – Eye Exam (F&amp;C-MA, MNCare)</li> </ul>	
	<b>F</b> <ul style="list-style-type: none"> <li>Annual Dental Visit (F&amp;C-MA, MNCare)</li> </ul>	<b>D</b>	<b>C</b>	

**Key to the Measure Matrix**

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

**Table 6: Blue Plus CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	Blue Plus CAHPS 2017	Blue Plus CAHPS 2018	Blue Plus CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	80.0%	89.4%	80.1%	10 <sup>th</sup>	84.1%
Getting Care Quickly*	84.0%	83.9%	79.1%	10 <sup>th</sup>	84.2%
How Well Doctors Communicate*	96.8%	96.8%	94.0%	75 <sup>th</sup>	95.1%
Customer Service*	82.7%	85.5%	85.8%	10 <sup>th</sup>	87.0%
Shared Decision Making*	82.2%	84.9%	85.3%	95 <sup>th</sup>	84.3%
Rating of All Health Care**	56.5%	63.2%	46.2%	<10 <sup>th</sup>	52.6%
Rating of Personal Doctor**	72.3%	73.0%	73.8%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	75.0%	71.3%	61.4%	10 <sup>th</sup>	61.9%
Rating of Health Plan**	58.2%	65.6%	57.7%	25 <sup>th</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	91.8%	88.0%	81.2%	25 <sup>th</sup>	84.1%
Getting Care Quickly*	89.4%	86.4%	88.5%	95 <sup>th</sup>	84.7%
How Well Doctors Communicate*	96.4%	93.4%	97.3%	95 <sup>th</sup>	95.2%
Customer Service*	78.4%	86.1%	77.9%	<10 <sup>th</sup>	84.0%
Shared Decision Making*	84.7%	82.4%	77.3%	10 <sup>th</sup>	79.4%
Rating of All Health Care**	50.7%	49.8%	52.2%	25 <sup>th</sup>	53.8%
Rating of Personal Doctor**	67.8%	66.2%	68.1%	50 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	71.0%	69.1%	73.1%	90 <sup>th</sup>	68.0%
Rating of Health Plan**	45.8%	54.7%	54.0%	10 <sup>th</sup>	56.5%
F&C-MA Response Rate = 7.93%. Sample Size =1,350. MNCare Response Rate = 14.20%. Sample size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 6: Blue Plus CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	Blue Plus CAHPS 2017	Blue Plus CAHPS 2018	Blue Plus CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>					
Getting Needed Care*	88.6%	83.4%	87.2%	90 <sup>th</sup>	85.5%
Getting Care Quickly*	90.1%	84.5%	86.1%	75 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.2%	94.5%	94.3%	75 <sup>th</sup>	94.4%
Customer Service*	80.6%	87.2%	87.7%	25 <sup>th</sup>	88.6%
Shared Decision Making*	80.2%	73.7%	81.7%	66.67 <sup>th</sup>	81.8%
Rating of All Health Care**	65.4%	65.4%	62.8%	90 <sup>th</sup>	57.8%
Rating of Personal Doctor**	77.5%	80.4%	76.3%	95 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	78.4%	76.8%	77.1%	95 <sup>th</sup>	69.3%
Rating of Health Plan**	72.1%	67.9%	71.1%	95 <sup>th</sup>	64.4%
MSC+ Response Rate = 24.70%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **NCQA Accreditation Survey** – Blue Plus maintained its NCQA commendable accreditation levels for its F&C-MA, MNCare and MSHO programs.
- **CAHPS (Member Satisfaction)** – Blue Plus performed well in the following areas of member satisfaction:
  - F&C-MA
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*
  - MNCare
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of Specialist Seen Most Often*
  - MSC+
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*

## Opportunities for Improvement

- **QAE and TCA (Compliance)** – Blue Plus was not fully compliant with all contractual standards. Blue Plus received a total of one (1) recommendation, five (5) mandatory improvements, and two (2) deficiencies for the QAE. The MCO received a total of three (3) “not met” designations for the TCA.
- **2018 Financial Withhold** – Blue Plus did not achieve full points for its 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
    - Dental Service Utilization Rate for Children (1-20 years)
    - Dental Service Utilization Rate for Adults (21-64 years)
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
    - Emergency Department Utilization Rate
    - Hospital Admission Rate
  - MSHO and MSC+
    - Annual Dental Visit Rate (65+ years)

- **HEDIS (Quality of Care)** – Blue Plus demonstrates an opportunity for improvement in the following areas of care:
  - F&C-MA
    - *Annual Dental Visit*
    - *Breast Cancer Screening*
    - *Cervical Cancer Screening*
    - *Chlamydia Screening in Women*
    - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
  - MNCare
    - *Annual Dental Visit*
    - *Adolescent Well-Care Visit*
    - *Cervical Cancer Screening*
  
- **CAHPS (Member Satisfaction)** – Blue Plus demonstrates an opportunity for improvement in the following areas of member satisfaction:
  - F&C-MA
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Customer Service*
    - *Rating of All Health care*
    - *Rating of Health Plan*
  - MNCare
    - *Getting Needed Care*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of Health Care*
    - *Rating of Health Plan*
  - MSC+
    - *Customer Service*

## Recommendations

- **2018 Financial Withhold –**
  - Blue Plus should continue its current improvement strategy and identify new (stronger, correlated) variables to reduce emergency department utilization, hospital admissions and hospital readmissions. Although Blue Plus has not met the withhold target for these measures, the health plan reported that rates for these measures were trending downwards.
  - Blue Plus indicates that there remains a shortage of dental providers in the state. To address this shortage, Blue Plus should consider training current network primary care providers to provide preventive oral health services for young members and encourage primary care clinics to add a dentist to the practice. Blue Plus should also outreach to all members who did not receive dental care within the past year to assist the member with identifying a dental provider who is accepting new patients and with making dental appointments.
  
- **HEDIS (Quality of Care) –**

- With regard to women’s health and well-visits for children and adolescents, Blue Plus should examine the adequacy of its provider network to determine if access and/or quality issues exist. Blue Plus should also enhance its quality improvement strategy to include multiple methods of member outreach, including community events, social media, direct contact via telephone, etc.
- **CAHPS (Member Satisfaction) -**
  - Blue Plus should conduct root cause analysis on all poorly performing CAHPS® measures and implement initiatives to address identified barriers.

---

# 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 2018, enrollment totaled 159,762, accounting for 16.9% of the entire MHCP population. **Table 7** displays HealthPartners' enrollment as of December 2018.

**Table 7: HealthPartners Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	126,589
MNCare	22,232
MSC+	2,393
MSHO	3,129
SNBC	5,419
<b>Total Enrollment</b>	<b>159,762</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

## Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA between March 5, 2018 and March 8, 2018. The evaluation period covered June 1, 2015 to December 31, 2017, while the file review period covered January 1, 2017 to December 31, 2017. The MCO received two (2) recommendations, two (2) mandatory improvements, and one (1) deficiency for the QAE. The MCO received one (1) "not met" designation for the TCA.

## Performance Improvement Project

In 2018 HealthPartners concluded its reporting on the following PIP:

- ***Reducing Race Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was 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 8** displays the MCO's rates for this PIP.

**Table 8: HealthPartners Performance Rates for the 2015-2017 PIP**

HEDIS Year	White	Non-White	Disparity
2015	43.36%	24.65%	-18.71%
2016	44.82%	24.19%	-20.63%
2017	43.46%	24.49%	-18.97%
2018	41.62%	28.83%	-12.79%
<b>Change</b>	<b>-1.74</b>	<b>+4.18</b>	<b>-5.92</b>

Member-focused interventions included:

- Targeted telephonic outreach by care coordinators or health coaches
- Outreach via mail, including educational materials, resources, and refill reminders
- Antidepressant refill reminder calls
- Referrals to case management services as needed

Provider-focused interventions included:

- Cultural competency training including issues specific to depression and antidepressant medication, health literacy, and communication
- Online “Provider Toolkit,” with patient resources, such as pharmacies with translation services and a shared-decision making tool

Community-focused interventions included

- Collaborations with community organizations, such as NAMI-MN and local religious groups
- Sharing resources at local health fairs
- Promoting and attending community events during Minority Mental Health Month in July

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

### **2018 Financial Withhold**

HealthPartners achieved 3.27 points (of 100 points) for the F&C-MA and MNCare programs, achieved 75 points (of 90 points) for the MSHO and MSC+ programs and achieved 53.31 points (of 60 points) for the SNBC program. **Table 9** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by HealthPartners.

**Table 9: HealthPartners 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (1-20 years)	55	0
Dental Service Utilization Rate for Adults (21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0
Emergency Department Utilization Rate	1	1
Hospital Admission Rate	1	0.27
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>100</b>	<b>3.27</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (65+ years)	15	0
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>75</b>
<b>SNBC</b>		
Annual Dental Visit Rate (19-64 years)	15	8.31
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>53.31</b>

### Annual Quality Assurance Work Plan for 2018

The annual quality assurance work plan developed by HealthPartners was compliant with Minnesota Administrative Rule 4685.1130. The work plan outlines the various quality improvement activities planned for the reporting year, which cover a wide variety of health care areas, including compliance, network adequacy, enrollee satisfaction, HEDIS performance, and delegation oversight, among others. Detailed information is included for each project, including the key priority area(s) and action plans, goals and measures of success, staff responsible for the project, and quarterly outcomes. The work plan clearly describes each project in a consistent format.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

HealthPartners' QI Program is based on the Triple Aim values of health, experience, and affordability, and is designed to improve the health and well-being of its members through partnership with members, patients, and the community. Through integrating quality improvement and utilization management, HealthPartners can better serve members by ensuring quality and experience are considered in utilization management. HealthPartners annually evaluates the adequacy of the resources available for the QI Program in order to ensure appropriate staff and technology are available.

During the reporting year, HealthPartners engaged in a variety of projects aimed at improving clinical quality, patient safety, health disparities, and affordability. The MCO was able to meet many of its established goals for these projects through intervention strategies aimed at members, providers, and health plan systems and processes. While the MCO did meet goals for many projects, there were some areas where goals were not met and the MCO noted barriers faced throughout the projects and identified opportunities for improvement. Overall, HealthPartners' QI Program appears to be well established.

### **MCO Clinical Practice Guidelines**

HealthPartners recognizes the following source for clinical practice guidelines:

- ISCI

### **HEDIS AND CAHPS Performance**

The MCO's HEDIS and CAHPS rates are displayed in **Table 10** and **Table 11**, respectively, while **Figure 5** displays the HEDIS Measure Matrix.

**Table 10: HealthPartners HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	Health Partners HEDIS 2017	Health Partners HEDIS 2018	Health Partners HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	46.2%	43.1%	44.5%	25 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	94.9%	95.6%	93.9%	75 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	85.2%	84.0%	83.7%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	88.8%	87.8%	87.5%	50 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	Unavailable	48.4%	48.1%	10 <sup>th</sup>	47.1%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	65.6%	64.9%	64.0%	75 <sup>th</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	63.2%	62.8%	63.3%	50 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	75.4%	78.1%	74.7%	75 <sup>th</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	97.7%	96.7%	96.9%	66.67 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	90.8%	91.8%	90.2%	66.67 <sup>th</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	92.0%	92.8%	92.9%	66.67 <sup>th</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	92.3%	93.5%	93.4%	75 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	68.9%	68.1%	68.8%	75 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	65.0%	68.8%	64.2%	66.67 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	94.5%	93.1%	92.0%	75 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	72.3%	67.2%	73.2%	90 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	54.4%	56.0%	58.8%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	31.5%	35.6%	30.7%	10 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	65.8%	72.4%	70.9%	75 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	66.6%	68.0%	69.4%	33.33 <sup>rd</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.					
<sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 10: HealthPartners HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Health Partners HEDIS 2017	Health Partners HEDIS 2018	Health Partners HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	30.7%	24.3%	32.9%	<10 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>	93.7%	94.2%	94.7%	75 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	80.9%	81.6%	81.7%	66.67 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	87.2%	86.8%	87.8%	66.67 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	Unavailable	39.0%	40.1%	10 <sup>th</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	70.6%	71.3%	67.6%	75 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	53.5%	57.1%	60.0%	33.33 <sup>rd</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	Small Sample	92.9%	10 <sup>th</sup>	94.2%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	97.5%	90.5%	90.7%	75 <sup>th</sup>	89.8%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	Small Sample	90.1%	94.2%	75 <sup>th</sup>	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	63.3%	60.1%	66.6%	75 <sup>th</sup>	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	67.0%	69.0%	70.3%	90 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	96.7%	95.3%	94.9%	95 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	73.5%	75.9%	74.5%	95 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	70.0%	68.5%	68.2%	No Benchmark	77.5%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	40.0%	41.1%	43.2%	75 <sup>th</sup>	51.9%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	69.4%	51.5%	74.3%	50 <sup>th</sup>	67.4%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.					
<sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 10: HealthPartners HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Health Partners HEDIS 2017	Health Partners HEDIS 2018	Health Partners HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	98.3%	98.1%	98.3%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	62.4%	61.2%	64.5%	75 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	95.5%	95.4%	92.5%	75 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	90.9%	91.0%	92.7%	75 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	36.6%	34.4%	39.9%	<10 <sup>th</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	67.5%	57.5%	69.9%	<10 <sup>th</sup>	74.2%
<b>SNBC</b>					
Adult BMI Assessment <sup>1</sup> (Non-SNP)	Small Sample	100%	92.2%	50 <sup>th</sup>	93.7%
Adults’ Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	No Data	94.3%	94.1%	95 <sup>th</sup>	92.4%
Adults’ Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	Small Sample	96.4%	96.3%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	No Data	Small Sample	51.1%	10 <sup>th</sup>	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	No Data	41.7%	46.8%	10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	No Data	48.0%	48.8%	10 <sup>th</sup>	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	No Data	70.8%	69.9%	90 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (Non-SNP)	No Data	92.0%	92.0%	75 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	Small Sample	80.1%	75.4%	95 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	No Data	Small Sample	70.0%	No Benchmark	74.8%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	No Data	Small Sample	50.0%	90 <sup>th</sup>	47.5%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.					
<sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 5: HealthPartners 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	<b>C</b>		<b>B</b> <ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>Cervical Cancer Screening (SNBC)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (MNCare)</li> </ul>	<b>A</b> <ul style="list-style-type: none"> <li>Cervical Cancer Screening (MNCare)</li> </ul>
	<b>D</b> <ul style="list-style-type: none"> <li>Medication Management for People with Asthma-50% (F&amp;C-MA)</li> <li>Medication Management for People with Asthma-75% (F&amp;C-MA)</li> </ul>	<b>C</b> <ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>Breast Cancer Screening (MNCare, MSC+, MSHO)</li> <li>Controlling High Blood Pressure (F&amp;C-MA, MNCare, SNBC)</li> <li>Comprehensive Diabetes Care – Eye Exam Screening (F&amp;C-MA, MNCare)</li> <li>Comprehensive Diabetes Care – HbA1c Testing Screening (F&amp;C-MA, MNCare)</li> <li>Medication Management for People with Asthma-50% (MNCare)</li> <li>Medication Management for People with Asthma-75% (MNCare)</li> </ul>	<b>B</b> <ul style="list-style-type: none"> <li>Annual Dental Visit (F&amp;C-MA, MNCare)</li> <li>Breast Cancer Screening (F&amp;C-MA)</li> <li>Cervical Cancer Screening (F&amp;C-MA)</li> <li>Chlamydia Screening in Women (F&amp;C-MA, MNCare)</li> <li>Childhood Immunization Status – Combo 3 (F&amp;C-MA)</li> <li>Well-Child Visits in the First 15 Months of Life (F&amp;C-MA)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>	
	<b>F</b>	<b>D</b>	<b>C</b>	

**Key to the Measure Matrix**

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

**Table 11: HealthPartners CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	HealthPartners CAHPS 2017	HealthPartners CAHPS 2018	HealthPartners CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	87.3%	84.4%	85.2%	66.67 <sup>th</sup>	84.1%
Getting Care Quickly*	82.9%	83.7%	85.1%	75 <sup>th</sup>	84.2%
How Well Doctors Communicate*	96.1%	97.2%	95.7%	95 <sup>th</sup>	95.1%
Customer Service*	97.3%	88.3%	85.4%	10 <sup>th</sup>	87.0%
Shared Decision Making*	76.5%	80.6%	85.4%	90 <sup>th</sup>	84.3%
Rating of All Health Care**	61.4%	61.8%	57.1%	66.67 <sup>th</sup>	52.6%
Rating of Personal Doctor**	71.7%	74.8%	69.7%	50 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	59.5%	73.6%	68.5%	50 <sup>th</sup>	61.9%
Rating of Health Plan**	64.0%	62.0%	61.2%	33.33 <sup>rd</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	86.6%	85.7%	86.4%	75 <sup>th</sup>	84.1%
Getting Care Quickly*	82.7%	83.1%	86.1%	75 <sup>th</sup>	84.7%
How Well Doctors Communicate*	96.3%	96.0%	92.9%	50 <sup>th</sup>	95.2%
Customer Service*	84.2%	93.0%	90.0%	50 <sup>th</sup>	84.0%
Shared Decision Making*	80.9%	83.2%	80.9%	66.67 <sup>th</sup>	79.4%
Rating of All Health Care**	56.1%	53.7%	55.0%	50 <sup>th</sup>	53.8%
Rating of Personal Doctor**	73.2%	70.7%	69.1%	50 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	67.1%	68.3%	67.9%	50 <sup>th</sup>	68.0%
Rating of Health Plan**	50.4%	57.1%	58.5%	33.33 <sup>rd</sup>	56.5%
F&C-MA Response Rate = 11.98%. Sample Size = 1,350. MNCare Response Rate = 15.03%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 11: HealthPartners CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	HealthPartners CAHPS 2017	HealthPartners CAHPS 2018	HealthPartners CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Averages
<b>MSC+</b>					
Getting Needed Care*	84.3%	82.4%	82.3%	33.33 <sup>rd</sup>	85.5%
Getting Care Quickly*	85.8%	77.8%	83.3%	50 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.1%	93.1%	94.1%	75 <sup>th</sup>	94.4%
Customer Service*	89.6%	86.4%	88.5%	33.33 <sup>rd</sup>	88.6%
Shared Decision Making*	74.5%	75.2%	82.0%	75 <sup>th</sup>	81.8%
Rating of All Health Care**	58.2%	59.3%	55.6%	50 <sup>th</sup>	57.8%
Rating of Personal Doctor**	73.7%	75.1%	69.3%	50 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	73.7%	65.6%	66.4%	33.33 <sup>rd</sup>	69.3%
Rating of Health Plan**	68.4%	67.9%	61.1%	33.33 <sup>rd</sup>	64.4%
<b>SNBC</b>					
Getting Needed Care*	80.9%	84.6%	80.6%	25 <sup>th</sup>	82.5%
Getting Care Quickly*	81.2%	89.1%	81.6%	33.33 <sup>rd</sup>	83.8%
How Well Doctors Communicate*	88.6%	94.2%	94.7%	90 <sup>th</sup>	93.0%
Customer Service*	85.5%	91.1%	93.9%	95 <sup>th</sup>	89.2%
Shared Decision Making*	78.2%	79.7%	79.1%	33.33 <sup>rd</sup>	82.2%
Rating of All Health Care**	49.5%	52.7%	56.1%	50 <sup>th</sup>	53.5%
Rating of Personal Doctor**	61.6%	69.3%	71.3%	75 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	63.5%	63.2%	68.0%	50 <sup>th</sup>	65.4%
Rating of Health Plan**	51.8%	64.0%	59.8%	33.33 <sup>rd</sup>	60.6%
MSC+ Response Rate = 26.45%. Sample Size = 1,350. SNBC Response Rate = 18.56%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **HEDIS (Quality of Care)** – HealthPartners performed well in the following areas of care:
  - MNCare
    - *Cervical Cancer Screening*
  
- **CAHPS (Member Satisfaction)** – HealthPartners performed well in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
  - MNCare
    - *Getting Needed Care*
    - *Getting Care Quickly*
  - MSC+
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
  - SNBC
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Rating of Personal Doctor*

## Opportunities for Improvement

- **QAE and TCA (Compliance)** - HealthPartners was not fully compliant with the contractual standards. HealthPartners received two (2) recommendations, two (2) mandatory improvements, and one (1) deficiency for the QAE. The MCO received one (1) “not met” designation for the TCA.
  
- **2018 Financial Withhold** – HealthPartners did not achieve full points for the F&C-MA, MNCare, MSHO, MSC+, and SNBC programs. The MCO did not meet the target goal for the following measures:
  - F&C-MA and MNCare
    - Dental Service Utilization Rate for Children (1-20 years)
    - Dental Service Utilization Rate for Adults (21-64 years)
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
    - Hospital Admission Rate
  - MSHO and MSC+
    - Annual Dental Visit Rate (65+ years)
  - SNBC
    - Annual Dental Visit Rate (19-64 years)

- **HEDIS (Quality of Care)** – HealthPartners demonstrates an opportunity for improvement in the following area of care:
  - F&C-MA
    - *Medication Management for People with Asthma – 50%*
    - *Medication Management for People with Asthma – 75%*
  
- **CAHPS (Member Satisfaction)** – HealthPartners demonstrates an opportunity for improvement in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Customer Service*
    - *Rating of Health Plan*
  - MNCare
    - *Rating of Health Plan*
  - MSC+
    - *Getting Needed Care*
    - *Customer Service*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - SNBC
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Shared Decision Making*
    - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold –**
  - In regard to hospital admissions and readmissions, HealthPartners should continue with the interventions strategy described in the Health Plan’s response to the previous year’s recommendation. HealthPartners should identify the most effective interventions and identify ways in which these interventions can be expanded upon.
  - HealthPartners indicates access to dental providers is an ongoing issue for MHCP members. To address this gap in care, HealthPartners should consider training current network primary care providers to provide preventive oral health services for young members.
- **HEDIS (Quality of Care)** – HealthPartners should evaluate the effectiveness of the Asthma Management Program on member medication management. HealthPartners should expand its approach to include members who are not enrolled in the Asthma Management Program.
- **CAHPS (Member Satisfaction)** – HealthPartners should conduct root cause analysis and implement interventions to address identified barriers. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

---

## 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/MNCare. Cornerstone, Hennepin Health's SNBC program, was renamed Hennepin Health – SNBC. As of December 2018, enrollment totaled 25,755, accounting for 2.7% of the entire MHCP population. **Table 12** displays Hennepin Health's enrollment as of December 2018.

**Table 12: Hennepin Health Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	21,847
MNCare	1,918
SNBC	1,990
<b>Total Enrollment</b>	<b>25,755</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on February 27, 2017 through March 2, 2017. The examination period covered June 1, 2014 to December 31, 2016, while the file review period covered January 1, 2016 to November 30, 2016. The MCO received a total of six (6) recommendations, four (4) mandatory improvements, and six (6) deficiencies for the QAE. The MCO received nineteen (19) "not met" designations for the TCA.

### Performance Improvement Project

In 2018 Hennepin Health concluded its reporting on the following PIP:

- ***The Reduction of Racial Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Hennepin Health, Medica, and UCare. The goal of this PIP was 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 13** displays the MCO’s performance rates for this PIP.

**Table 13: Hennepin Health Performance Rates for the 2015-2017 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%
2017	44.14%	23.91%	28.57%	-20.23%	-15.57%
<b>Change</b>	<b>-2.33</b>	<b>-16.63</b>	<b>-7.32</b>	<b>+14.30</b>	<b>+4.99</b>

Member-focused interventions included:

- Targeted telephonic outreach by care coordinators or health coaches
- Outreach via mail, including educational materials, resources, and refill reminders
- Antidepressant refill reminder calls
- Referrals to case management services as needed

Provider-focused interventions included:

- Cultural competency training including issues specific to depression and antidepressant medication, health literacy, and communication
- Online “Provider Toolkit,” with patient resources, such as pharmacies with translation services and a shared-decision making tool

Community-focused interventions included:

- Collaborations with community organizations, such as NAMI-MN and local religious groups
- Sharing resources at local health fairs
- Promoting and attending community events during Minority Mental Health Month in July

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

**2018 Financial Withhold**

Hennepin Health achieved 26 points (of 100 points) for the F&C-MA and MNCare programs, and achieved 49.19 points (of 60 points) for the SNBC program. **Table 14** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by Hennepin Health.

**Table 14: Hennepin Health 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>	-	-
Dental Service Utilization Rate for Children (aged 1-20 years)	55	22
Dental Service Utilization Rate for Adults (aged 21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0
Emergency Department Utilization Rate	1	1
Hospital Admission Rate	1	1
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>100</b>	<b>26.0</b>
<b>SNBC</b>	-	-
Annual Dental Visit Rate (aged 19-64 years)	15	4.19
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>49.19</b>

### Annual Quality Assurance Work Plan for 2018

Hennepin Health’s quality assurance work plan was compliant with Minnesota Administrative Rule 4685.1130. The work plan is designed around the Institute for Healthcare Improvement’s Triple Aim, the Institute of Medicine’s Quality Definition, and the National Association of Healthcare Quality, referred to as “quality connections”, as well as the MCO’s five strategic goals. Each activity included in the work plan is directly linked to at least one of the aspects of the quality connections, as well as at least one strategic goal. Detailed descriptions of the goals and objectives, outcome measures, actions to be taken, timelines, responsible staff, and project status are provided for each activity. Activities are organized into overarching categories, such as compliance, appeals and grievances, case and disease management, and member and provider satisfaction, among others.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

The mission of Hennepin’s Quality Management (QM) Program is “to continuously protect and improve the health care provided its enrollees through a high-quality, integrated, and cost-effective health delivery system” with personalized service. The QM Program is based on the Institute for Healthcare Improvement (IHI) Triple Aim, which is focused on improving satisfaction and health outcomes while reducing cost. Additionally, Hennepin focuses on the Institute of Medicine’s definition of quality, which includes patient-centered care, efficiency, and equitability and timeliness, as well as the National Association of Healthcare Quality (NAHQ), which defines quality as safe, effective, accessible, fair, and accountable. Hennepin uses these principles (Triple Aim, Institute of Medicine, and NAHQ) in order to inform its quality activities.

Throughout the reporting year, Hennepin conducted multiple quality improvement efforts focused on a variety of areas, such as access to care, member experience, and care coordination. For each activity,

Hennepin defines the tasks and responsible staff, as well as establishing connections to the principles outlined by the Triple Aim, the Institute of Medicine, and NAHQ. Hennepin met many of its established goals across its improvement projects and noted areas that continue to be opportunities for further improvement. Overall, the MCO's QM Program is designed adequately to improve the quality of patient care.

### **MCO Clinical Practice Guidelines**

Hennepin Health recognizes the following source for clinical practice guidelines:

- ADA
  - Diabetes Management
- AHRQ
  - Evidence-Based Psychotherapies
- American Academy of Child and Adolescent Psychiatry (AACAP)
- APA
  - Depression
- ICSI
  - Diagnosis and Management of Asthma
  - Immunization Update and Preventive Services for Children and Adolescents
  - Routine Prenatal Care
  - Depression, Major, in Adults in Primary Care
  - Health Lifestyles
- MN Community Measurement (MNCM)
  - D5 Goals for Diabetes Mellitus
- USPSTF
  - Preventive Screenings
  - Children and Asthma
  - Immunization for Adults and Children
  - Maternal and Child Health Measures
  - Screening for Depression in Adults
  - Recommendation for Alcohol Misuse

### **HEDIS AND CAHPS Performance**

The MCO's HEDIS and CAHPS rates are displayed in **Table 15** and **Table 16**, respectively, while **Figure 6** displays the HEDIS Measure Matrix.

**Table 15: Hennepin Health HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	Hennepin Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	No Data	42.7%	47.5%	25 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	93.9%	96.4%	91.7%	50 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	73.0%	67.0%	66.3%	10 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	86.7%	80.8%	78.7%	10 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	No Data	29.6%	34.0%	<10 <sup>th</sup>	47.1%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	48.1%	52.9%	53.2%	10 <sup>th</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	50.4%	44.3%	50.3%	10 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	No Data	53.3%	65.1%	10 <sup>th</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	No Data	85.1%	90.2%	<10 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	No Data	83.8%	80.5%	10 <sup>th</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	No Data	Small Sample	72.2%	<10 <sup>th</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	No Data	Small Sample	73.0%	<10 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	78.0%	70.4%	69.9%	75 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	64.7%	52.0%	51.6%	10 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	92.7%	87.7%	88.9%	50 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	62.4%	69.8%	65.2%	50 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	73.3%	66.7%	66.0%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	30.0%	39.4%	35.8%	33.33 <sup>rd</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	No Data	34.4%	43.0%	<10 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	No Data	56.0%	61.4%	<10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 15: Hennepin Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	Hennepin Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	No Data	Small Sample	26.3%	<10 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>		98.0%	98.1%	95 <sup>th</sup>	92.4%
Adults’ Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>		78.9%	75.8%	33.33 <sup>rd</sup>	81.4%
Adults’ Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>		94.3%	84.2%	33.33 <sup>rd</sup>	88.2%
Annual Dental Visit <sup>2</sup>		30.3%	34.4%	<10 <sup>th</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>		Small Sample	Small Sample	Not Applicable	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>		44.9%	54.7%	10 <sup>th</sup>	56.9%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>		Small Sample	Small Sample	Not Applicable	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>		Small Sample	55.3%	33.33 <sup>rd</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>		Small Sample	94.2%	95 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>		61.3%	63.2%	50 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>		No Data	Small Sample	Not Applicable	77.5%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>		Unavailable	Small Sample	Not Applicable	51.9%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 15: Hennepin Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	Hennepin Health HEDIS 2017	Hennepin Health HEDIS 2018	Hennepin Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>SNBC</b>					
Adult BMI Assessment <sup>1</sup> (Non-SNP)	92.5%	93.7%	96.4%	90 <sup>th</sup>	93.7%
Adults’ Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	88.4%	88.6%	89.2%	95 <sup>th</sup>	92.4%
Adults’ Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	94.5%	94.2%	93.7%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	51.5%	42.6%	Small Sample	Not Applicable	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	48.5%	46.5%	49.7%	10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	61.7%	63.5%	62.9%	66.67 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (Non-SNP)	92.5%	93.4%	96.1%	95 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	64.7%	72.4%	70.6%	75 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	74.8%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	47.5%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 6: Hennepin Health 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	<b>C</b>	<ul style="list-style-type: none"> <li>Annual Dental Visit (F&amp;C-MA)</li> <li>Cervical Cancer Screening (F&amp;C-MA)</li> </ul>	<b>B</b>	<b>A</b>
	<b>D</b>	<ul style="list-style-type: none"> <li>Annual Dental Visit (MNCare)</li> <li>Breast Cancer Screening (F&amp;C-MA)</li> <li>Controlling High Blood Pressure (MNCare)</li> <li>Comprehensive Diabetes Care – Eye Exam (F&amp;C-MA)</li> <li>Comprehensive Diabetes Care – HbA1c Testing (F&amp;C-MA)</li> <li>Well-Child Visits in the First 15 Months of Life (F&amp;C-MA)</li> </ul>	<ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>Controlling High Blood Pressure (F&amp;C-MA)</li> <li>Cervical Cancer Screening (MNCare, SNBC)</li> <li>Medication Management for People with Asthma-50% (F&amp;C-MA)</li> <li>Medication Management for People with Asthma-75% (F&amp;C-MA)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>	<ul style="list-style-type: none"> <li>Chlamydia Screening in Women (F&amp;C-MA)</li> </ul>
	<b>F</b>		<b>D</b>	<b>C</b>

**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.
- E** Conduct root cause analysis and develop action plan.

**Table 16: Hennepin Health CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	Hennepin Health CAHPS 2017	Hennepin Health CAHPS 2018	Hennepin Health CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	77.2%	79.6%	81.5%	33.33 <sup>rd</sup>	84.1%
Getting Care Quickly*	73.6%	74.25	85.6%	75 <sup>th</sup>	84.2%
How Well Doctors Communicate*	93.6%	93.4%	94.5%	75 <sup>th</sup>	95.1%
Customer Service*	86.2%	83.6%	83.0%	<10 <sup>th</sup>	87.0%
Shared Decision Making*	81.0%	77.1%	88.2%	95 <sup>th</sup>	84.3%
Rating of All Health Care**	47.1%	39.7%	51.3%	10 <sup>th</sup>	52.6%
Rating of Personal Doctor**	61.8%	66.4%	71.8%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	63.9%	62.1%	61.5%	10 <sup>th</sup>	61.9%
Rating of Health Plan**	51.3%	44.0%	44.0%	<10 <sup>th</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	87.8%	86.1%	86.3%	75 <sup>th</sup>	84.1%
Getting Care Quickly*	83.6%	87.7%	86.2%	75 <sup>th</sup>	84.7%
How Well Doctors Communicate*	95.0%	96.1%	95.8%	95 <sup>th</sup>	95.2%
Customer Service*	82.7%	89.8%	82.7%	<10 <sup>th</sup>	84.0%
Shared Decision Making*	81.7%	83.9%	76.7%	10 <sup>th</sup>	79.4%
Rating of All Health Care**	54.3%	51.9%	50.5%	10 <sup>th</sup>	53.8%
Rating of Personal Doctor**	63.8%	69.2%	71.1%	75 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	64.7%	65.6%	65.5%	33.33 <sup>rd</sup>	68.0%
Rating of Health Plan**	52.3%	53.8%	56.1%	10 <sup>th</sup>	56.5%
F&C-MA Response Rate = 9.64%. Sample Size = 1,350. MNCare Response Rate= 15.08%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 16: Hennepin Health CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	Hennepin Health CAHPS 2017	Hennepin Health CAHPS 2018	Hennepin Health CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>SNBC</b>					
Getting Needed Care*	94.2%	80.3%	81.3%	33.33 <sup>rd</sup>	82.5%
Getting Care Quickly*	83.8%	81.4%	82.4%	50 <sup>th</sup>	83.8%
How Well Doctors Communicate*	98.3%	95.1%	93.7%	75 <sup>th</sup>	93.0%
Customer Service*	91.7%	89.0%	85.1%	10 <sup>th</sup>	89.2%
Shared Decision Making*	80.8%	78.7%	81.8%	75 <sup>th</sup>	82.2%
Rating of All Health Care**	68.9%	53.1%	56.8%	50 <sup>th</sup>	53.5%
Rating of Personal Doctor**	73.9%	72.0%	70.6%	75 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	78.0%	61.4%	61.8%	10 <sup>th</sup>	65.4%
Rating of Health Plan**	69.0%	57.4%	59.5%	33.33 <sup>rd</sup>	60.6%
SNBC Response Rate = 21.50%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **CAHPS (Member Satisfaction)** – Hennepin Health performed well in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*
  - MNCare
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
  - SNBC
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*

## Opportunities for Improvement

- **2018 Financial Withhold** – Hennepin Health did not achieve full points for the F&C-MA, MNCare, 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
    - Dental Service Utilization Rate for Children (aged 1-20 years)
    - Dental Service Utilization Rate for Adults (aged 21-64 years)
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
  - SNBC
    - Annual Dental Visit Rate (aged 19-64 years)
- **HEDIS (Quality of Care)** – Hennepin Health demonstrates an opportunity for improvement in the following areas of care:
  - F&C-MA
    - *Breast Cancer Screening*
    - *Comprehensive Diabetes Care – Eye Exam*
    - *Comprehensive Diabetes Care – HbA1c Testing*
  - MNCare
    - *Annual Dental Visit*
    - *Controlling High Blood Pressure*
    - *Well-Child Visits in the First 15 Months of Life*
- **CAHPS (Member Satisfaction)** – Hennepin Health demonstrates an opportunity for improvement in regard to the following areas of member satisfaction:

- F&C-MA
  - *Getting Needed Care*
  - *Customer Service*
  - *Rating of All Health Care*
  - *Rating of Specialist Seen Most Often*
  - *Rating of Health Plan*
- MNCare
  - *Customer Service*
  - *Shared Decision Making*
  - *Rating of All Health Care*
  - *Rating of Specialist Seen Most Often*
  - *Rating of Health Plan*
- SNBC
  - *Getting Needed Care*
  - *Customer Service*
  - *Rating of Specialist Seen Most Often*
  - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold** – Hennepin Health work to address measures that failed to meet target goals, routinely monitor the effectiveness of current improvement activities and modify them as needed.
- **HEDIS (Quality of Care)** –
  - Hennepin Health should 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.
  - Hennepin Health should leverage its relationship with county case managers and delegated care guide agency staff to reconnect with members.
- **CAHPS (Member Satisfaction)** –
  - In regard to customer service, Hennepin Health should identify methods for capturing member feedback on the helpfulness of the Member Services Representative with whom the member made contact with. Hennepin Health should monitor Member Services calls for quality improvement.
  - Hennepin Health should reeducate members and providers on appointment timeframe standards.
  - If the addition of the Fairview Health System to the network demonstrates a positive impact, Hennepin Health should identify additional options for network expansion.

---

## ITASCA MEDICAL CARE (IMCARE)

---

### Corporate Profile

Itasca County Health and Human Services (ICHHS) administers IMCare, a County-Based Purchasing (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 2018, enrollment totaled 8,162 accounting for 0.9% of the entire MHCP population. **Table 17** displays IMCare’s enrollment as of December 2018.

**Table 17: IMCare Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	662
MNCare	6,814
MSC+	225
MSHO	461
<b>Total Enrollment</b>	<b>8,162</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

In 2018, MDH conducted the most recent QAE and TCA examination on August 13, 2018 through August 17, 2018. The examination period covered November 1, 2015 to August 1, 2018, while the file review period covered June 1, 2017 to May 31, 2018. The MCO received a total of three (3) mandatory improvements and two (2) deficiencies for the QAE. The MCO received three (3) “not met” designations for the TCA.

### Performance Improvement Project

In 2018 IMCare concluded its reporting on the following PIP:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – The goal of this project was 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 18** displays the MCO’s rates for this PIP.

**Table 18: IMCare Performance Rates for the 2015-2017 PIP**

HEDIS Year	All
2014	0.0%
2015	25.0%
2017	35.0%
<b>Net Change</b>	<b>+35.0</b>

Member interventions:

- Education outreach via the 1<sup>st</sup> quarter member newsletter
- Telephonic outreach to those with a gap in antidepressant medication refill
- Referrals for case management or additional assistance as needed

Provider interventions:

- Education outreach via the 1<sup>st</sup> quarter provider newsletter
- Encourage collaboration between providers and pharmacies

Pharmacy interventions:

- Education outreach via the 1<sup>st</sup> quarter provider newsletter
- Encourage blister-packing of member medications
- Print prescription labels and medication instructions in members' preferred language

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

## **2018 Financial Withhold**

IMCare achieved 13 points (of 99 points) for the F&C-MA and MNCare programs and achieved 90 points (of 90 points) for the MSHO and MSC+ programs. **Table 19** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by IMCare.

**Table 19: IMCare 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (aged 1-20 years)	55	0
Dental Service Utilization Rate for Adults (aged 21-64 years)	30	0
Dental Network Provider Equity	10	10
Hospital 30-Day Readmission Rate	Not Applicable	Not Applicable
Emergency Department Utilization Rate	1	1
Hospital Admission Rate	1	0
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>99</b>	<b>13</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (aged 65+ years)	15	15
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>90</b>

Note: The F&C-MA and MNCare Hospital 30-Day Readmission Rate was eliminated from the point calculation due to low claims rate in the county.

### Annual Quality Assurance Work Plan for 2018

IMCare developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. Activities reported in the work plan are organized by topics, and cover many areas of care and services. Some of these include network adequacy and provider accessibility, credentialing, enrollee and provider satisfaction, and populations with special health care needs, as well as performance improvement projects and focused studies. The work plan details the activities, objectives and goals, tasks for completion, outcome measures, data sources, responsible staff, timelines, and progress for each activity consistently throughout.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

IMCare’s QI Program is designed to support Itasca County’s mission, vision, and values through continuous improvement, evaluation, and monitoring of patient safety and delivery of services to its enrollees for both medical and behavioral health. Partnerships with providers, public and private community organizations, and delegated entities are leveraged to support the QI Program. Goals for the Program are established through information from survey results, utilization and claims data, HEDIS data, QAEs, and TCAs.

The MCO conducted quality improvement projects in a variety of areas including clinical care, special health care needs, enrollee experience, care coordination, and disease management. Goals were established for each project and interventions were developed to foster improvement. IMCare met most

of its established goals across its projects during the reporting year. Overall, IMCare's QI Program appears to be well-established and designed to promote continuous quality improvement for its members.

### **MCO Clinical Practice Guidelines**

IMCare recognizes the following sources for clinical practice guidelines:

- AAFP
  - Clinical Preventive Services
- UpToDate
  - Overview of Hypertension in Adults
  - Overview of Medical Care in Adults with Diabetes Mellitus
  - Unipolar Depression in Adults: Assessment and Diagnosis
  - Establishing and Maintaining a Therapeutic Relationship in Psychiatric Practice
  - Prenatal Care: Initial Assessment
  - Prenatal Care: Second and Third Trimesters
  - Screening Test in Children and Adolescents
  - Guidelines for Adolescent Preventive Services
  - Preventive care in Adults: Recommendations

### **HEDIS AND CAHPS Performance**

The HEDIS and CAHPS rates for IMCare are displayed in **Table 20** and **Table 21**, respectively, while **Figure 7** displays the HEDIS Measure Matrix.

**Table 20: IMCare HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	IMCare HEDIS 2017	IMCare HEDIS 2018	IMCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	31.9%	39.2%	40.4%	10 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	89.3%	92.2%	95.1%	75 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	88.2%	83.8%	84.0%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	90.5%	88.1%	87.4%	50 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	No Data	56.8%	58.5%	50 <sup>th</sup>	47.1%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	59.0%	52.6%	60.1%	50 <sup>th</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	53.3%	53.3%	52.8%	10 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	62.5%	74.8%	71.4%	50 <sup>th</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	97.7%	96.5%	96.6%	50 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	89.1%	88.7%	90.6%	75 <sup>th</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	92.0%	89.2%	91.0%	33.33 <sup>rd</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	91.3%	91.7%	92.2%	66.67 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	43.3%	42.5%	49.2%	10 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	54.4%	61.2%	61.9%	50 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	91.2%	90.5%	91.7%	75 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	86.1%	67.4%	75.1%	95 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	67.4%	60.0%	73.9%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	37.2%	40.0%	50.0%	90 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	61.1%	59.7%	56.5%	10 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	65.7%	60.9%	59.7%	<10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 20: IMCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	IMCare HEDIS 2017	IMCare HEDIS 2018	IMCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	23.3%	Small Sample	Small Sample	Not Applicable	31.4%
Adult BMI Assessment <sup>1</sup>	90.5%	91.9%	95.7%	75 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	87.2%	81.4%	82.9%	75 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	89.0%	90.4%	90.3%	75 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	No Data	55.3%	55.8%	33.33 <sup>rd</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	60.8%	68.3%	63.8%	66.67 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	49.8%	52.2%	57.8%	33.33 <sup>rd</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	94.2%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	61.5%	65.0%	64.4%	66.67 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	100.0%	95.0%	93.3%	90 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	89.8%	67.4%	76.8%	95 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	77.5%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	51.9%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 20: IMCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	IMCare HEDIS 2017	IMCare HEDIS 2018	IMCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	96.6%	98.2%	98.5%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	64.5%	60.6%	67.3%	75 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	95.9%	94.4%	100.0%	95 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	90.4%	89.9%	88.6%	50 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	30.3%	31.6%	57.5%	33.33 <sup>rd</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	77.8%	91.7%	83.9%	10 <sup>th</sup>	74.2%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 7: IMCare 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change		<b>C</b>	<b>B</b>	<b>A</b> ▪ Breast Cancer Screening (MSC+)
		<b>D</b> ▪ Cervical Cancer Screening (F&C-MA) ▪ Chlamydia Screening in Women (F&C-MA) ▪ Well-Child Visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> and 6 <sup>th</sup> Years of Life (F&C-MA)	<b>C</b> ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Breast Cancer Screening (F&C-MA, MSHO, MNCare) ▪ Controlling High Blood Pressure (MNCare) ▪ Cervical Cancer Screening (MNCare) ▪ Comprehensive Diabetes Care – Eye Exam (F&C-MA, MNCare) ▪ Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MNCare) ▪ 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 First 15 Months of Life (F&C-MA)	<b>B</b> ▪ Annual Dental Visit (F&C-MA, MNCare) ▪ Controlling High Blood Pressure (F&C-MA)
		<b>F</b>	<b>D</b>	<b>C</b>

**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 21: IMCare CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	IMCare CAHPS 2017	IMCare CAHPS 2018	IMCare CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	87.5%	87.0%	84.2%	50 <sup>th</sup>	84.1%
Getting Care Quickly*	86.2%	81.4%	79.4%	10 <sup>th</sup>	84.2%
How Well Doctors Communicate*	95.6%	96.3%	94.6%	75 <sup>th</sup>	95.1%
Customer Service*	91.6%	83.9%	82.6%	<10 <sup>th</sup>	87.0%
Shared Decision Making*	84.4%	86.1%	79.7%	50 <sup>th</sup>	84.3%
Rating of All Health Care**	56.5%	48.6%	48.8%	10 <sup>th</sup>	52.6%
Rating of Personal Doctor**	72.2%	71.3%	74.1%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	70.0%	74.2%	54.5%	<10 <sup>th</sup>	61.9%
Rating of Health Plan**	55.1%	56.9%	53.8%	10 <sup>th</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	87.8%	86.1%	86.3%	75 <sup>th</sup>	84.1%
Getting Care Quickly*	83.6%	87.7%	86.2%	75 <sup>th</sup>	84.7%
How Well Doctors Communicate*	95.0%	96.1%	95.8%	95 <sup>th</sup>	95.2%
Customer Service*	82.7%	89.8%	82.7%	<10 <sup>th</sup>	84.0%
Shared Decision Making*	87.1%	83.9%	76.7%	10 <sup>th</sup>	79.4%
Rating of All Health Care**	54.3%	51.9%	50.5%	10 <sup>th</sup>	53.8%
Rating of Personal Doctor**	63.8%	69.2%	71.1%	75 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	64.7%	65.6%	65.5%	33.33 <sup>rd</sup>	68.0%
Rating of Health Plan**	52.3%	53.8%	56.1%	10 <sup>th</sup>	56.5%
F&C-MA Response Rate = 10.30%. Sample Size = 1,350. MNCare Response Rate = 15.08%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 21: IMCare CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	IMCare CAHPS 2017	IMCare CAHPS 2018	IMCare CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>					
Getting Needed Care*	89.3%	88.6%	89.5%	95 <sup>th</sup>	85.5%
Getting Care Quickly*	88.9%	90.9%	88.9%	95 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.8%	96.3%	95.4%	95 <sup>th</sup>	94.4%
Customer Service*	91.4%	94.4%	92.3%	75 <sup>th</sup>	88.6%
Shared Decision Making*	76.6%	78.1%	80.2%	50 <sup>th</sup>	81.8%
Rating of All Health Care**	65.9%	60.3%	60.7%	75 <sup>th</sup>	57.8%
Rating of Personal Doctor**	74.8%	77.0%	73.7%	75 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	73.5%	72.6%	68.7%	50 <sup>th</sup>	69.3%
Rating of Health Plan**	71.5%	71.9%	64.0%	66.67 <sup>th</sup>	64.4%
MSC+ Response Rate = 24.09%. Sample Size = 1,200. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **2018 Financial Withhold** – IMCare earned full points for the MSHO and MSC+ programs. The MCO met the target goal for the following measures:
  - MSC+
    - Annual Dental Visit Rate
    - Initial Health Risk Screening/Assessment
    - No Repeat Deficiencies on the MDH QA Exam
    - Care Plan Audit
    - MCO Stakeholder Group
- **HEDIS (Quality of Care)** – IMCare performed well in regard to the following area of care:
  - MSC+
    - *Breast Cancer Screening*
- **CAHPS (Member Satisfaction)** – IMCare performed well in regard to the following areas of member satisfaction:
  - F&C-MA
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
  - MNCare
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
  - MSC+
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Rating of All Health care*
    - *Rating of Personal Doctor*

## Opportunities for Improvement

- **2018 Financial Withhold** – IMCare did not earn full points for its F&C-MA and MNCare 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
    - Dental Service Utilization Rate for Children
    - Dental Service Utilization Rate for Adults
    - Hospital Admission Rate
- **HEDIS (Quality of Care)** – IMCare demonstrated an opportunity for improvement in regard to the following areas of care:

- F&C-MA
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
- **CAHPS (Member Satisfaction)** – IMCare demonstrated an opportunity for improvement in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Getting Care Quickly*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - MNCare
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold** –
  - In regard to dental care, IMCare should continue with the improvement strategy described in the Health Plan’s response to the previous year’s recommendation. IMCare should routinely evaluate the effectiveness of each intervention and modify them as needed.
  - IMCare should develop a robust strategy aimed at decreasing hospital admissions.
- **HEDIS (Quality of Care)** –
  - As IMCare continues to demonstrate an opportunity for improvement in regard to women’s health, IMCare should evaluate the effectiveness of its current improvement strategy. Member education on the importance of preventive screenings should be conducted using a multifaceted approach. Additionally, the improvement strategy should be enhanced to include provider-level interventions.
- **CAHPS (Member Satisfaction)** –
  - IMCare should conduct root cause analysis and implement interventions to address identified barriers in the CAHPS. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

---

## MEDICA

---

### Corporate Profile

Medica HMO contracts with DHS to provide services to enrollees in the MSC+, MSHO and SNBC programs. As of December 2018, enrollment totaled 28,487, accounting for 3% of the entire MHCP population. **Table 22** displays Medica’s enrollment as of December 2018.

**Table 22: Medica Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
MSC+	4,129
MSHO	10,830
SNBC	13,528
<b>Total Enrollment</b>	<b>28,487</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on October 2, 2017 through October 6, 2017. The examination period covered January 1, 2015 to August 31, 2017, while the file review period covered January 1, 2016 to August 31, 2017. The MCO received two (2) mandatory improvements for the QAE and one (1) “not met” designation for the TCA.

### Performance Improvement Projects

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

### 2018 Financial Withhold

Medica achieved 90 points (of 90 points) for the MSHO and MSC+ programs, and 45 points (of 60 points) for the SNBC program. **Table 23** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by Medica.

**Table 23: Medica 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (aged 65+ years)	15	15
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>90</b>
<b>SNBC</b>		
Annual Dental Visit Rate (aged 19-64 years)	15	0
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>45</b>

### Annual Quality Assurance Work Plan for 2018

Medica’s quality assurance work plan, compliant with Minnesota Administrative Rule 4685.1130, outlines the significant, measurable quality improvement activities planned. Activities were meant to address one or more of the following areas: clinical quality, service quality/member experience, provider quality, patient safety, and regulatory/accreditation requirements. Activities are also categorized as assessment/research, design/development, implementation, improvement, or evaluation. For each project, a description of the activity, the project lead, objective and rationale, expected quality improvement impact, milestones, and outcomes are provided consistently throughout the work plan.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

Medica’s QI Program is designed to identify, implement, and measure results from activities to achieve improvement in member care, service, access, and/or safety; service to providers, employers, brokers, and other customers and partners; and Medica’s internal operations. The MCO selected opportunities for improvement based on several factors: 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.

During the reporting year, Medica conducted multiple quality improvement activities and achieved the established target goals for the majority. Due to a company-wide restructuring in 2017 and a reduction in the work force, some 2017 quality improvement activities could not be completed or were discontinued. The MCO evaluated each project to determine if the project would continue as a new project or as an ongoing part of standard business practice. Overall, Medica’s QI Program appears to be adequately designed to enable continuous quality improvement.

## MCO Clinical Practice Guidelines

Medica recognizes the following sources for clinical practice guidelines:

- AAP
  - Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents
  - Guidelines for Adolescent Depression in Primary Care: Part I. Assessment and Initial Management
  - Guidelines for Adolescent Depression in Primary Care: Part II. Treatment and Ongoing Management
- ADA
  - Diabetes care
- APA
  - Bipolar Disorder: Adults
  - Schizophrenia
- American College of Cardiology (ACC) and AHA
  - Cholesterol management
  - Management of heart failure
  - Prevention, detection, evaluation, and management of high blood pressure in adults
  - Lifestyle management to reduce cardiovascular risk
  - Management of overweight and obesity in adults
- American College of Physicians (ACP)
  - Prevention and treatment of osteoporosis
- ASAM
  - Substance use disorders
- CDC
  - Prescribing opioids for chronic pain
- Global Initiative for Chronic and Obstructive Lung Disease
  - Chronic obstructive lung disease
- Minnesota DHS
  - Child and Teen Checkups
- NHLBI
  - Screening, prevention, diagnosis and treatment of asthma
- Tobacco Use and Dependence Guideline Panel
  - Treating tobacco use and dependence
- USPSTF
  - Preventive services

## HEDIS and CAHPS Performance

The MCO's HEDIS and CAHPS rates are displayed in **Table 24** and **Table 25**, respectively, while **Figure 8** displays the HEDIS Measure Matrix.

**Table 24: Medica HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	Medica HEDIS 2017	Medica HEDIS 2018	Medica HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	98.2%	98.5%	98.1%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	55.7%	57.8%	60.9%	50 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	93.4%	94.2%	93.3%	90 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	93.5%	93.8%	92.4%	75 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	29.8%	27.9%	25.1%	<10 <sup>th</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	45.7%	62.7%	51.4%	<10 <sup>th</sup>	74.2%
<b>SNBC</b>					
Adult BMI Assessment <sup>1</sup> (Non-SNP)	94.9%	94.4%	97.3%	95 <sup>th</sup>	93.7%
Adults’ Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	92.6%	91.6%	90.4%	95 <sup>th</sup>	92.4%
Adults’ Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	96.5%	96.2%	96.1%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	37.8%	36.1%	34.5%	<10 <sup>th</sup>	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	41.4%	42.7%	41.2%	<10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	53.5%	47.3%	47.2%	10 <sup>th</sup>	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	72.3%	76.4%	75.1%	95 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (Non-SNP)	92.5%	93.3%	92.8%	75 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	74.2%	72.8%	69.3%	75 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	68.1%	68.9%	74.2%	No Benchmark	74.8%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	45.6%	43.7%	44.6%	75 <sup>th</sup>	47.5%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 8: Medica 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	C		<b>B</b> ▪ Breast Cancer Screening (MSHO)	<b>A</b>
	D	<b>D</b> ▪ Breast Cancer Screening (MSC+, SNBC) ▪ Cervical Cancer Screening (SNBC)	<b>C</b> ▪ Controlling High Blood Pressure (SNBC)	<b>B</b>
	F		<b>D</b>	<b>C</b>

**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 25: Medica CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	Medica CAHPS 2017	Medica CAHPS 2018	Medica CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>					
Getting Needed Care*	89.6%	84.9%	84.6%	66.67 <sup>th</sup>	85.5%
Getting Care Quickly*	91.7%	84.8%	84.4%	66.67 <sup>th</sup>	85.0%
How Well Doctors Communicate*	97.0%	94.3%	96.0%	95 <sup>th</sup>	94.4%
Customer Service*	90.8%	93.6%	85.7%	10 <sup>th</sup>	88.6%
Shared Decision Making*	78.8%	77.1%	80.7%	50 <sup>th</sup>	81.8%
Rating of All Health Care**	58.9%	60.8%	57.1%	66.67 <sup>th</sup>	57.8%
Rating of Personal Doctor**	75.6%	80.7%	77.6%	95 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	72.4%	73.4%	68.4%	50 <sup>th</sup>	69.3%
Rating of Health Plan**	65.1%	67.6%	65.3%	75 <sup>th</sup>	64.4%
<b>SNBC</b>					
Getting Needed Care*	83.4%	82.4%	83.8%	50 <sup>th</sup>	82.5%
Getting Care Quickly*	80.4%	80.2%	86.7%	90 <sup>th</sup>	83.8%
How Well Doctors Communicate*	94.0%	92.6%	93.4%	75 <sup>th</sup>	93.0%
Customer Service*	90.7%	88.7%	89.5%	50 <sup>th</sup>	89.2%
Shared Decision Making*	77.2%	79.7%	84.7%	90 <sup>th</sup>	82.2%
Rating of All Health Care**	49.8%	54.1%	52.6%	25 <sup>th</sup>	53.5%
Rating of Personal Doctor**	73.0%	71.8%	72.1%	75 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	66.1%	66.0%	63.4%	25 <sup>th</sup>	65.4%
Rating of Health Plan**	56.9%	58.5%	60.4%	33.33 <sup>rd</sup>	60.6%
MSC+ Response Rate = 25.25%. Sample Size = 1,350. SNBC Response Rate = 21.72%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **2018 Financial Withhold** – Medica achieved full points for the MSHO and MSC+ programs. Medica met the target for the following measures:
  - MSHO and MSC+
    - Annual Dental Visit Rate (aged 65+ years)
    - Initial Health Risk Screening/Assessment
    - No Repeat Deficiencies on the MDH QA Exam
    - Care Plan Audit
    - MCO Stakeholder Group
- **CAHPS (Member Satisfaction)** – Medica performed well in the following areas of member satisfaction:
  - MSC+
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
    - *Rating of Health Plan*
  - SNBC
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*

## Opportunities for Improvement

- **2018 Financial Withhold** – Medica did not achieve full points for the SNBC program. The MCO did not meet the target goal for the following measures:
  - SNBC
    - Annual Dental Visit Rate (aged 19-64 years)
- **HEDIS (Quality of Care)** – Medica demonstrates an opportunity for improvement in the following areas of care:
  - MSC+
    - *Breast Cancer Screening*
  - SNBC
    - *Breast Cancer Screening*
    - *Cervical Cancer Screening*
- **CAHPS (Member Satisfaction)** – Medica demonstrates an opportunity for improvement in regard to the following areas of member satisfaction:
  - MSC+
    - *Customer Service*
  - SNBC
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold** – Medica should continue the dental care improvement strategy described in the Health Plan’s response to the previous year’s recommendation. Medica should routinely measure the effectiveness of the interventions and modify them as needed.
- **HEDIS (Quality of Care)** – As women’s health continues to be an opportunity for improvement for Medica, Medica’s Quality Improvement Program should increase its member and provider education and outreach efforts.
- **CAHPS (Member Satisfaction)** – Medica’s CAHPS Committee should conduct root cause analysis and implement interventions to address identified barriers. The MCO should also evaluate the effectiveness of existing interventions and update and modify them as needed.

---

## PRIMEWEST HEALTH

---

### Corporate Profile

Organized through a Joint Powers Board (JPB) 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. PrimeWest maintains the Commendable level of accreditation by NCQA under the Health Plan Accreditation status for its Medicaid lines of business. As of December 2018, enrollment totaled 41,715, accounting for 4.4% of the entire MHCP population. **Table 26** displays PrimeWest’s enrollment as of December 2018.

**Table 26: PrimeWest Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	33,251
MNCare	3,394
MSC+	848
MSHO	1,949
SNBC	2,273
<b>Total Enrollment</b>	<b>41,715</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on July 17, 2017 through July 20, 2017. The examination period covered November 1, 2014 to March 31, 2017, while the file review period covered May 1, 2016 to April 30, 2017. The MCO received a total of four (4) mandatory improvements for the QAE and four (4) “not met” designations for the TCA.

### Performance Improvement Projects

In 2018 PrimeWest concluded its reporting on the following PIP:

- ***Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – The goal for this PIP was to increase, by 6 percentage points, the HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for the F&C-MA population. **Table 27** displays the MCO’s rates for this PIP.

**Table 27: PrimeWest Rates for the 2015-2017 PIP**

HEDIS Year	Rates
2013	34.43%
2014	37.43%
<b>Baseline</b>	<b>35.89%</b>
2015	39.63%
2016	37.17%
2017	37.92%
2018	40.82%
<b>Net Change</b>	<b>+4.93</b>

Member interventions:

- Health coach calls to Non-White members filling a new antidepressant prescription
- Weekly health coach calls and motivational interviewing for all members who are late in filling their antidepressant medication
- Reminder letters to all members who are late in filling their antidepressant medication

Provider interventions:

- Electronically distributed provider toolkit
- Provider follow-up by phone to all members who pose specific medical questions in health coach calls
- Letters to providers when any member misses an antidepressant medication refill

Community interventions:

- General outreach through PSA postings, website postings, and email blasts

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

## 2018 Financial Withhold

PrimeWest achieved 3.03 points (of 100 points) for the F&C-MA and MNCare programs, 80.77 points (of 90 points) for the MSHO and MSC+ programs, and 45 points (of 60 points) for the SNBC program. **Table 28** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by PrimeWest.

**Table 28: PrimeWest 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (aged 1-20 years)	55	0
Dental Service Utilization Rate for Adults (aged 21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0.03
Emergency Department Utilization Rate	1	1
Hospital Admission Rate	1	0
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>100</b>	<b>3.03</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (aged 65+ years)	15	5.77
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>80.77</b>
<b>SNBC</b>		
Annual Dental Visit Rate (aged 19-64 years)	15	0
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>45</b>

### Annual Quality Assurance Work Plan for 2018

PrimeWest submitted an annual QA work plan compliant with Minnesota Administrative Rule 4685.1130. The work plan clearly outlines each project’s scope, objectives, responsible persons, and timelines to achieve project goals. The work plan also delineates when projects are in development, and when data will be collected, aggregated, reported, and analyzed. The work plan covers a variety of topics, including quality of services, availability of practitioners, accessibility of services, member experience, quality of clinical care, safety of clinical care, utilization management, and quality program administration. Additionally, the MCO clearly denotes activities that affect the safety of its members.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

PrimeWest’s Quality Program is designed to promote the MCO’s mission, vision, and values through continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services. The system-wide program integrates and coordinates services throughout the organization and its partners, providers, and delegated entities. For the reporting year (2018), PrimeWest established three goals for the Quality Program: 1) ensure access to safe, quality health care services; 2)

improve the health status of PrimeWest members and counties; and 3) operate PrimeWest as a model business while embracing and fulfilling the public service responsibilities of a government agency. PrimeWest relies on the Triple Aim of population health, experience of care, and cost in order to inform its Quality Strategy.

PrimeWest executed quality improvement projects designed to improve the quality and safety of clinical care, as well as the overall quality of services, throughout the year. Descriptions of the projects include the topic and rationale, the process for conducting the project, quantitative and qualitative analysis, and recommendations for continuous quality improvement, regardless of whether the project goals were met. PrimeWest was able to meet many of its established project goals throughout the year and continues to work to improve quality and services for its members. Overall, the Quality Program appears to adequately address continuous quality improvement.

### **MCO Clinical Practice Guidelines**

PrimeWest recognizes the following source for clinical practice guidelines:

- AACAP
  - Assessment and treatment of children and adolescents with attention deficit hyperactivity disorder
  - Assessment and treatment of children and adolescents with depressive disorders
- ACCF/AHA
  - Management of patients with chronic heart failure
- ACOG
  - Preconception, prenatal and postpartum care
- ADA
  - Standards of medical care in diabetes
- AHRQ
  - Treating tobacco use and dependence
- APA
  - Pharmacological treatment of patients with alcohol use disorder
- CDC
  - Immunization schedule for adults
  - Child and adolescent immunization schedules
- Journal of the American College of Cardiology (JACC)
  - Prevention, detection, evaluation and management of high blood pressure in adults
- ICSI
  - Diagnosis and management of chronic obstructive pulmonary disease
  - Treating adult depression
- MN DHS
  - Child and Teen Checkups
  - Children's Therapeutic Services and Supports

- Dental services
- Minnesota FFS and Managed Care Uniform Preferred Drug List
- NHLBI
  - Diagnosis and management of asthma
- USPSTF
  - Preventive services for adults, including breast cancer, cervical cancer, chlamydia screening and BMI assessment

### **HEDIS and CAHPS Performance**

The HEDIS and CAHPS rates for PrimeWest Health are displayed in **Table 29** and **Table 30**, respectively, while **Figure 9** displays the HEDIS Measure Matrix.

**Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	PrimeWest Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	44.8%	59.6%	52.1%	33.33 <sup>rd</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	79.3%	90.0%	92.7%	50 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	87.0%	85.3%	84.9%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	88.2%	87.4%	87.0%	50 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	No Data	50.9%	50.4%	25 <sup>th</sup>	47.1%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	65.5%	69.4%	68.3%	75 <sup>th</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	57.0%	57.1%	56.2%	25 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	66.9%	64.7%	67.4%	33.33 <sup>rd</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	95.7%	95.4%	95.6%	50 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	89.1%	87.7%	87.2%	33.33 <sup>rd</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	91.7%	92.2%	90.4%	33.33 <sup>rd</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	93.1%	93.7%	92.7%	75 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	40.4%	39.9%	40.9%	<10 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	69.6%	72.5%	71.1%	90 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	92.1%	89.4%	90.4%	66.67 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	62.0%	68.6%	70.3%	75 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	67.9%	76.1%	77.5%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	45.1%	55.4%	46.3%	75 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	58.0%	60.3%	59.5%	25 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	56.9%	56.7%	56.9%	<10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	PrimeWest Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	43.8%	56.4%	56.5%	50 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>	83.7%	88.6%	88.8%	33.33 <sup>rd</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	85.0%	85.8%	85.6%	90 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	89.0%	89.9%	88.6%	66.67 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	No Data	44.9%	45.0%	10 <sup>th</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	72.4%	76.1%	72.2%	95 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	53.9%	58.5%	57.8%	33.33 <sup>rd</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	94.2%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	89.8%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	Small Sample	Small Sample	98.3%	95 <sup>th</sup>	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	41.5%	42.0%	41.4%	<10 <sup>th</sup>	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	74.6%	80.6%	75.9%	95 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	94.1%	89.2%	92.4%	75 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	63.4%	74.3%	75.5%	95 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	77.5%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	51.9%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	67.4%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	PrimeWest Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	99.4%	99.1%	98.8%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	64.6%	64.5%	64.1%	75 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	94.1%	94.4%	93.0%	90 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	97.4%	97.6%	98.1%	95 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	61.8%	54.9%	56.8%	33.33 <sup>d</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	88.9%	83.1%	83.0%	10 <sup>th</sup>	74.2%

<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.

<sup>2</sup> Rate calculated by DHS using the administrative methodology.

**Table 29: PrimeWest Health HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	PrimeWest Health HEDIS 2017	PrimeWest Health HEDIS 2018	PrimeWest Health HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>SNBC</b>					
Adult BMI Assessment <sup>1</sup> (SNP)	93.8%	97.9%	97.1%	95 <sup>th</sup>	96.61
Adult BMI Assessment <sup>1</sup> (Non-SNP)	87.8%	92.5%	92.5%	50 <sup>th</sup>	93.7%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	90.0%	92.2%	92.9%	95 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	94.8%	96.0%	95.6%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	61.6%	58.0%	67.9%	75 <sup>th</sup>	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	45.7%	45.2%	49.9%	10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (SNP)	89.7%	92.5%	97.9%	95 <sup>th</sup>	86.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	67.2%	64.4%	68.6%	75 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (SNP)	86.2%	92.5%	95.7%	95 <sup>th</sup>	95.7%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Year) <sup>1</sup> (Non-SNP)	88.2%	83.5%	89.3%	50 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (SNP)	74.0%	85.7%	80.4%	95 <sup>th</sup>	76.7%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	61.4%	71.3%	74.4%	90 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	74.8%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	47.5%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 9: PrimeWest 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change		<b>C</b>	<b>B</b>	<b>A</b> ▪ Breast Cancer Screening (SNBC)
		<b>D</b> ▪ Cervical Cancer Screening (F&C-MA) ▪ Chlamydia Screening in Women (F&C-MA, MNCare) ▪ Well-Child Visits in the First 15 Months of Life (F&C-MA) ▪ Well-Child Visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> and 6 <sup>th</sup> Years of Life (F&C-MA)	<b>C</b> ▪ Breast Cancer Screening (MSHO, MNCare) ▪ Controlling High Blood Pressure (F&C-MA, MNCare, SNBC SNP, SNBC Non-SNP) ▪ Cervical Cancer Screening (MNCare, SNBC) ▪ Comprehensive Diabetes Care – Eye Exam (MNCare, SNBC Non-SNP) ▪ Comprehensive Diabetes Care – HbA1c Testing (F&C-MA, MNCare, SNBC SNP, SNBC Non-SNP) ▪ Childhood Immunization Status – Combo 3 (F&C-MA)	<b>B</b> ▪ Annual Dental Visit (F&C-MA, MNCare) ▪ Adolescent Well-Care Visit (MNCare) ▪ Breast Cancer Screening (F&C-MA, MSC+) ▪ Comprehensive Diabetes Care – Eye Exam (F&C-MA, SNBC SNP) ▪ Medication Management for People with Asthma-50% (F&C-MA)
		<b>F</b>	<b>D</b>	<b>C</b> ▪ Adolescent Well-Care Visit (F&C-MA) ▪ Medication Management for People with Asthma-75% (F&C-MA)

**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.
- E Conduct root cause analysis and develop action plan.

**Table 30: PrimeWest CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	PrimeWest CAHPS 2017	PrimeWest CAHPS 2018	PrimeWest CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	84.5%	84.3%	82.1%	33.33 <sup>rd</sup>	84.1%
Getting Care Quickly*	78.7%	84.4%	84.2%	50 <sup>th</sup>	84.2%
How Well Doctors Communicate*	96.7%	96.5%	94.7%	90 <sup>th</sup>	95.1%
Customer Service*	84.5%	88.2%	95.2%	95 <sup>th</sup>	87.0%
Shared Decision Making*	85.6%	79.1%	82.6%	75 <sup>th</sup>	84.3%
Rating of All Health Care**	51.4%	54.8%	57.5%	66.67 <sup>th</sup>	52.6%
Rating of Personal Doctor**	69.2%	69.7%	70.7%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	56.8%	64.2%	61.5%	10 <sup>th</sup>	61.9%
Rating of Health Plan**	53.6%	59.5%	67.0%	75 <sup>th</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	87.8%	86.1%	86.3%	75 <sup>th</sup>	84.1%
Getting Care Quickly*	83.6%	87.7%	86.2%	75 <sup>th</sup>	84.7%
How Well Doctors Communicate*	95.0%	96.1%	95.8%	95 <sup>th</sup>	95.2%
Customer Service*	82.7%	89.8%	82.7%	<10 <sup>th</sup>	84.0%
Shared Decision Making*	87.1%	83.9%	76.7%	10 <sup>th</sup>	79.4%
Rating of All Health Care**	54.3%	51.9%	50.5%	10 <sup>th</sup>	53.8%
Rating of Personal Doctor**	63.8%	69.2%	71.1%	75 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	64.7%	65.6%	65.5%	33.33 <sup>rd</sup>	68.0%
Rating of Health Plan**	52.3%	53.8%	56.1%	10 <sup>th</sup>	56.5%
F&C-MA Response Rate = 8.92%. Sample Size = 1,350. MNCare Response Rate = 15.08%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 30: PrimeWest CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	PrimeWest CAHPS 2017	PrimeWest CAHPS 2018	PrimeWest CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>	-	-	-	-	-
Getting Needed Care*	89.3%	88.6%	89.5%	95 <sup>th</sup>	85.5%
Getting Care Quickly*	88.9%	90.9%	88.9%	95 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.8%	96.3%	95.4%	95 <sup>th</sup>	94.4%
Customer Service*	91.4%	94.4%	92.3%	75 <sup>th</sup>	88.6%
Shared Decision Making*	76.6%	78.1%	80.2%	50 <sup>th</sup>	81.8%
Rating of All Health Care**	65.9%	60.3%	60.7%	75 <sup>th</sup>	57.8%
Rating of Personal Doctor**	74.8%	77.0%	73.7%	75 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	73.5%	72.6%	68.7%	50 <sup>th</sup>	69.3%
Rating of Health Plan**	71.5%	71.9%	64.0%	66.67 <sup>th</sup>	64.4%
<b>SNBC</b>					
Getting Needed Care*	86.1%	88.3%	84.0%	50 <sup>th</sup>	82.5%
Getting Care Quickly*	84.5%	87.2%	84.5%	66.67 <sup>th</sup>	83.8%
How Well Doctors Communicate*	93.4%	94.0%	91.0%	25 <sup>th</sup>	93.0%
Customer Service*	83.3%	94.6%	89.6%	50 <sup>th</sup>	89.2%
Shared Decision Making*	76.8%	83.5%	82.2%	75 <sup>th</sup>	82.2%
Rating of All Health Care**	51.1%	60.4%	50.3%	10 <sup>th</sup>	53.5%
Rating of Personal Doctor**	69.7%	74.9%	68.6%	50 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	63.2%	68.8%	70.4%	66.67 <sup>th</sup>	65.4%
Rating of Health Plan**	54.5%	68.3%	60.4%	66.67 <sup>th</sup>	60.6%
MSC+ Response Rate = 24.09%. Sample Size = 1,200. SNBC Response Rate = 18.25%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **NCQA Accreditation Survey** – PrimeWest maintained NCQA accreditation for the F&C-MA and MNCare programs.
- **HEDIS (Quality of Care)** – PrimeWest demonstrates an opportunity for improvement in the following area of care:
  - SNBC
    - *Breast Cancer Screening*
- **CAHPS (Member Satisfaction)** – PrimeWest performed well in the following areas of member satisfaction:
  - F&C-MA
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*
    - *Rating of Health Plan*
  - MNCare
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Rating of Personal Doctor*
  - MSC+
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Personal Doctor*
  - SNBC
    - *Shared Decision Making*

## Opportunities for Improvement

- **Financial Withhold** – PrimeWest did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
  - F&C-MA and MNCare
    - Dental Service Utilization Rate for Children (aged 1-20 years)
    - Dental Service Utilization Rate for Adults (aged 21-64 years)
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
    - Hospital Admission Rate
  - MSHO and MSC+
    - Annual Dental Visit Rate (aged 65+ years)

- SNBC
  - Annual Dental Visit Rate (aged 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*
    - *Well-Child Visits in the First 15 Months of Life*
    - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
  - MNCare
    - *Chlamydia Screening in Women*
- **CAHPS (Member Satisfaction)** – PrimeWest demonstrates an opportunity for improvement in in the following areas of member satisfaction:
  - F&C-MA
    - *Getting Needed care*
    - *Rating of Specialist Seen Most Often*
  - MNCare
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold** –
  - Dental care: PrimeWest Health should continue with the quality improvement strategy described in the Health Plan’s response to the previous year’s recommendation [refer to page 144]. However, PrimeWest Health should investigate dental measures to determine why they remain flat despite the robust improvement strategy.
  - Hospital admissions and readmissions: PrimeWest should conduct root cause analysis, implement interventions based on identified barriers, and routinely monitor the effectiveness of improvement activities.
- **HEDIS (Quality of Care)** –
  - Women’s health: PrimeWest Health should expand its current program to include cervical cancer screenings. PrimeWest Health should also expand its chlamydia screening improvement strategy to include member education.
  - Well-child Visits: PrimeWest Health should consider leveraging its child immunization improvement strategy to increase well-child visit rates [refer to page 146]. For example, when personalized immunization reminder letters are sent to members, this can be used as an opportunity to reminder members about the importance of completing well-child visits.

PrimeWest Health should evaluate the adequacy of its pediatric provider network to determine if access issues exist for members.

- **CAHPS (Member Satisfaction)** – In addition to the results of the CAHPS survey, PrimeWest Health should identify other means of collecting member feedback and use this information to conduct a thorough root cause analysis. The Health Plan should also evaluate the effectiveness of existing interventions and update and modify them as needed.

---

## SOUTH COUNTRY HEALTH ALLIANCE

---

### Corporate Profile

South Country Health Alliance (SCHA) is a partnership of eleven (11) Minnesota counties formed in 2001 as a CBP. SCHA participates in the F&C-MA, MNCare, MSC+, MSHO and SNBC programs. As of December 2018, enrollment totaled 40,184, accounting for 4.3% of the entire MHCP population. **Table 31** displays SCHA's enrollment as of December 2018.

**Table 31: SCHA Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	31,128
MNCare	3,477
MSC+	829
MSHO	1,838
SNBC	2,912
<b>Total Enrollment</b>	<b>40,184</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA 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 total of two (2) recommendations, three (3) mandatory improvements, and three (3) deficiencies for the QAE. The MCO received one (1) "not met" designation for the TCA.

### Performance Improvement Projects

In 2018 SCHA concluded its reporting on the following PIP:

- ***Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – The goal of this PIP was 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 was to increase, by 6 percentage points, the overall F&C-MA and MNCare HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* rate for all members. This goal was met. **Table 32** displays the MCO's performance rates for this PIP.

**Table 32: SCHA Performance Rates for the 2015-2017 PIP**

HEDIS Year	All
2013/2014	33.60%
2015	37.64%
2016	38.84%
2017	40.38%
<b>Net Change</b>	<b>+6.78</b>

Member-focused interventions included:

- Mailings to members at 1 month, 3 months, and 6 months following their first antidepressant prescription fill -- to offer general education, positive affirmation, and any additional support needed to adhere to their treatment plan
- Health coach phone calls to members following the 1<sup>st</sup> mailing
- Develop simple and engaging member communications

Provider-focused interventions included:

- Cultural competency training for Member Services and Health Services staff, as well as to other interested departments
- Extend cultural competency training opportunities to County partners in Public Health and Human Services
- Provide additional support and resources to high-volume pharmacies and inform them of interpreter services
- Provide data and additional support to clinics with low performance scores related to depression remission
- Partner with healthcare coordinators to provide additional support to members

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

### **2018 Financial Withhold**

SCHA achieved 3 points (of 100 points) for the F&C-MA and MNCare programs, 80.99 points (of 90 points) for the MSHO and MSC+ programs and 45 points (of 60 points) for the SNBC program. **Table 33** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by SCHA.

**Table 33: SCHA 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (aged 1-20 years)	55	0
Dental Service Utilization Rate for Adults (aged 21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0
Emergency Department Utilization Rate	1	1
Hospital Admission Rate	1	0
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>100</b>	<b>3</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (aged 65+ years)	15	5.99
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>80.99</b>
<b>SNBC</b>		
Annual Dental Visit Rate (aged 19-64 years)	15	0
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>45</b>

### Annual Quality Assurance Work Plan for 2018

SCHA developed a quality assurance work plan compliant with Minnesota Administrative Rule 4685.1130. The work plan categorizes quality-related activities by topic, such as delegation oversight, compliance, care coordination, and populations with special needs. The following information is provided for each activity included within the work plan: objectives, actions planned, resources, responsible staff, timeline, and project status.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

South Country's QI Program is designed to support the MCO's mission of empowering and engaging members to be as healthy as they can be, build connections with local agencies and providers, and be an accountable partner to the counties served. The MCO uses its Diamond Values of collaboration, stewardship, communication, and excellence in order to inform business operations and improve the quality of care and services.

The QI Program has several overarching goals, including:

- establishing effective partnerships with providers, health systems, and networks across disciplines committed to delivering quality care;
- establishing and measuring performance expectations that include clinical outcomes and processes, functional outcomes, satisfaction, access to care, and resource utilization;
- improving the clinical and functional outcomes of members;
- improving member experience and understanding which factors contribute to satisfaction;
- ensuring appropriate access to care and services; and
- exceeding regulatory requirements.

Throughout the year, South Country conducted various performance improvement projects aimed at achieving the goals of the QI Program. Each project had its own improvement goals and methodology to attain those goals. South Country met many of the established project goals, while falling short of its goals for some projects. Next steps were outlined for the projects in order to promote continuous quality improvement. Overall, the QI Program is well-developed and adequately designed to improve the quality of services for members.

### **MCO Clinical Practice Guidelines**

SCHA recognizes the following sources for clinical practice guidelines:

- USPSTF
  - Preventive services for adults
  - Preventative services for children and adolescents
- AAFP
  - Prenatal Care
- ICSI
  - Diabetes, Type 2
  - Asthma
  - Hypertension diagnosis and treatment
  - Depression in adults
- AACAP
  - Children and adolescents with attention-deficit hyperactivity disorder

### **HEDIS and CAHPS Performance**

The HEDIS and CAHPS rates for South Country Health Alliance are displayed in **Table 34** and **Table 35**, respectively, while **Figure 10** displays the HEDIS Measure Matrix.

**Table 34: SCHA HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	SCHA HEDIS 2017	SCHA HEDIS 2018	SCHA HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	37.3%	38.4%	38.4%	10 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	85.2%	88.8%	83.5%	10 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	86.5%	84.7%	83.5%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	87.2%	85.9%	86.7%	50 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	No Data	46.3%	46.0%	10 <sup>th</sup>	47.1%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	68.1%	68.5%	62.2%	50 <sup>th</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	59.5%	60.1%	56.6%	25 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	79.4%	76.9%	75.2%	75 <sup>th</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	96.0%	97.2%	97.6%	75 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	90.8%	89.5%	87.3%	33.33 <sup>rd</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	92.3%	92.5%	91.1%	50 <sup>th</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	93.1%	93.6%	92.2%	66.67 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	45.7%	46.1%	48.3%	10 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	64.0%	66.1%	67.3%	75 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	92.6%	92.3%	92.5%	75 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	60.6%	65.2%	64.7%	66.67 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	67.3%	68.8%	70.8%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	44.2%	47.7%	40.2%	50 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	63.9%	64.7%	67.4%	50 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	64.4%	62.1%	61.5%	10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 34: SCHA HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	SCHA HEDIS 2017	SCHA HEDIS 2018	SCHA HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>	-	-	-	-	-
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	27.8%	28.1%	25.4%	<10 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>	83.1%	88.3%	84.4%	25 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	81.9%	81.9%	81.1%	50 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	88.1%	87.9%	86.6%	50 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	No Data	35.7%	35.3%	<10 <sup>th</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	70.9%	71.4%	70.3%	90 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	53.8%	54.1%	54.6%	10 <sup>th</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	94.2%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	89.8%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	Small Sample	Small Sample	88.9%	33.33 <sup>rd</sup>	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	64.1%	50.0%	44.8%	10 <sup>th</sup>	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	63.3%	61.0%	69.0%	75 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	96.7%	96.5%	95.3%	95 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	66.8%	69.6%	71.4%	75 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	77.5%
Medication Management for People With Asthma – 75% (19-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	51.9%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	67.4%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 34: SCHA HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	SCHA HEDIS 2017	SCHA HEDIS 2018	SCHA HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	98.0%	97.9%	98.4%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	67.9%	70.6%	71.9%	90 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	95.9%	96.4%	96.6%	95 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults’ Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	93.0%	94.8%	93.7%	75 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	52.6%	52.6%	57.7%	33.33 <sup>rd</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	85.9%	85.8%	92.5%	75 <sup>th</sup>	74.2%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 34: SCHA HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	SCHA HEDIS 2017	SCHA HEDIS 2018	SCHA HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>SNBC</b>	-	-	-	-	-
Adult BMI Assessment <sup>1</sup> (SNP)	91.2%	96.4%	96.6%	90 <sup>th</sup>	96.61
Adult BMI Assessment <sup>1</sup> (Non-SNP)	85.6%	89.5%	90.3%	50 <sup>th</sup>	93.7%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	95.4%	93.0%	94.3%	95 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	97.2%	97.6%	97.7%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	71.0%	70.0%	69.8%	90 <sup>th</sup>	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	49.7%	50.5%	52.1%	10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (SNP)	82.2%	85.1%	85.3%	95 <sup>th</sup>	86.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	71.1%	70.8%	74.6%	95 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (SNP)	95.8%	97.9%	96.7%	95 <sup>th</sup>	95.7%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (Non-SNP)	95.4%	93.1%	92.2%	75 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (SNP)	87.0%	83.0%	80.7%	95 <sup>th</sup>	76.7%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	71.2%	72.0%	72.0%	75 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	74.8%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	47.5%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

Figure 10: SCHA 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	<b>C</b>	<b>B</b>	<b>A</b>	
	<b>D</b> <ul style="list-style-type: none"> <li>▪ Annual Dental Visit (F&amp;C-MA, MNCare)</li> <li>▪ Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>▪ Chlamydia Screening in Women (F&amp;C-MA, MNCare)</li> <li>▪ Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>	<b>C</b> <ul style="list-style-type: none"> <li>▪ Adolescent Well-Care Visit (MNCare)</li> <li>▪ Breast Cancer Screening (MNCare)</li> <li>▪ Controlling High Blood Pressure (F&amp;C-MA, MNCare, SNBC Non-SNP)</li> <li>▪ Cervical Cancer Screening (MNCare)</li> <li>▪ Comprehensive Diabetes Care – Eye Exam (F&amp;C-MA, MNCare, SNBC Non-SNP, SNBC SNP)</li> <li>▪ Comprehensive Diabetes Care – HbA1c Testing (F&amp;C-MA, MNCare, SNBC Non-SNP, SNBC SNP)</li> <li>▪ Medication Management for People with Asthma-50% (F&amp;C-MA)</li> <li>▪ Medication Management for People with Asthma-75%(F&amp;C-MA)</li> <li>▪ Well-Child Visits in the First 15 Months of Life (F&amp;C-MA)</li> </ul>	<b>B</b> <ul style="list-style-type: none"> <li>▪ Breast Cancer Screening (MSC+, MSHO, SNBC)</li> <li>▪ Controlling High Blood Pressure (SNBC SNP)</li> <li>▪ Cervical Cancer Screening (SNBC)</li> <li>▪ Childhood Immunization Status – Combo 3 (F&amp;C-MA)</li> </ul>	
	<b>F</b> <ul style="list-style-type: none"> <li>▪ Cervical Cancer Screening (F&amp;C-MA)</li> </ul>	<b>D</b> <ul style="list-style-type: none"> <li>▪ Breast Cancer Screening (F&amp;C-MA)</li> </ul>	<b>C</b>	

**Key to the Measure Matrix**

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

**Table 35: SCHA CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	SCHA CAHPS 2017	SCHA CAHPS 2018	SCHA CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	86.1%	86.6%	92.2%	95 <sup>th</sup>	84.1%
Getting Care Quickly*	82.8%	86.4%	88.7%	95 <sup>th</sup>	84.2%
How Well Doctors Communicate*	97.8%	97.9%	98.0%	95 <sup>th</sup>	95.1%
Customer Service*	87.8%	92.2%	92.2%	75 <sup>th</sup>	87.0%
Shared Decision Making*	86.2%	86.1%	85.7%	95 <sup>th</sup>	84.3%
Rating of All Health Care**	48.7%	53.8%	55.4%	50 <sup>th</sup>	52.6%
Rating of Personal Doctor**	73.8%	68.6%	73.8%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	64.4%	68.2%	65.0%	33.33 <sup>rd</sup>	61.9%
Rating of Health Plan**	62.4%	62.0%	60.6%	33.33 <sup>rd</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	87.8%	86.1%	86.3%	75 <sup>th</sup>	84.1%
Getting Care Quickly*	83.6%	87.7%	86.2%	75 <sup>th</sup>	84.7%
How Well Doctors Communicate*	95.0%	96.1%	95.8%	95 <sup>th</sup>	95.2%
Customer Service*	82.7%	89.8%	82.7%	<10 <sup>th</sup>	84.0%
Shared Decision Making*	87.1%	83.9%	76.7%	10 <sup>th</sup>	79.4%
Rating of All Health Care**	54.3%	51.9%	50.5%	10 <sup>th</sup>	53.8%
Rating of Personal Doctor**	63.8%	69.2%	71.1%	75 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	64.7%	65.6%	65.5%	33.33 <sup>rd</sup>	68.0%
Rating of Health Plan**	52.3%	53.8%	56.1%	10 <sup>th</sup>	56.5%
F&C-MA Response Rate = 10.89%. Sample Size = 1,350. MNCare Response Rate = 15.08%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 35: SCHA CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	SCHA CAHPS 2017	SCHA CAHPS 2018	SCHA CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>					
Getting Needed Care*	89.3%	88.6%	89.5%	95 <sup>th</sup>	85.5%
Getting Care Quickly*	88.9%	90.9%	88.9%	95 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.8%	96.3%	95.4%	95 <sup>th</sup>	94.4%
Customer Service*	91.4%	94.4%	92.3%	75 <sup>th</sup>	88.6%
Shared Decision Making*	76.6%	78.1%	80.2%	50 <sup>th</sup>	81.8%
Rating of All Health Care**	65.9%	60.3%	60.7%	75 <sup>th</sup>	57.8%
Rating of Personal Doctor**	74.8%	77.0%	73.7%	75 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	73.5%	72.6%	68.7%	50 <sup>th</sup>	69.3%
Rating of Health Plan**	71.5%	71.9%	64.0%	66.67 <sup>th</sup>	64.4%
<b>SNBC</b>					
Getting Needed Care*	86.1%	88.3%	84.0%	50 <sup>th</sup>	82.5%
Getting Care Quickly*	84.5%	87.2%	84.5%	66.67 <sup>th</sup>	83.8%
How Well Doctors Communicate*	93.4%	94.0%	91.0%	25 <sup>th</sup>	93.0%
Customer Service*	83.3%	94.6%	89.6%	50 <sup>th</sup>	89.2%
Shared Decision Making*	76.8%	83.5%	82.2%	75 <sup>th</sup>	82.2%
Rating of All Health Care**	51.1%	60.4%	50.3%	10 <sup>th</sup>	53.5%
Rating of Personal Doctor**	69.7%	74.9%	68.6%	50 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	63.2%	68.8%	70.4%	66.67 <sup>th</sup>	65.4%
Rating of Health Plan**	54.5%	68.3%	60.4%	33.33 <sup>rd</sup>	60.6%
MSC+ Response Rate = 24.09%. Sample Size = 1,200. SNBC Response Rate = 18.25%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **CAHPS (Member Satisfaction)** – SCHA performed well in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of Personal Doctors*
  - MNCare
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *Howe Well Doctors Communicate*
    - *Rating of Personal Doctor*
  - MSC+
    - *Getting Needed Care*
    - *Getting Care Quickly*
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Rating of Health Care*
    - *Rating of Personal Doctor*
  - SNBC
    - *Shared Decision Making*

## Opportunities for Improvement

- **2018 Financial Withhold** – SCHA did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
  - F&C-MA and MNCare
    - Dental Service Utilization Rate for Children (aged 1-20 years)
    - Dental Service Utilization Rate for Adults (aged 21-64 years)
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
    - Hospital Admission Rate
  - MSHO and MSC+
    - Annual Dental Visit Rate (aged 65+ years)
  - SNBC
    - Annual Dental Visit Rate (aged 19-64 years)
- **HEDIS (Quality of Care)** – SCHA demonstrates an opportunity for improvement in the following areas of care:
  - F&C-MA

- *Cervical Cancer Screening*
- *Annual Dental Visit*
- *Adolescent Well-Care Visit*
- *Chlamydia Screening in Women*
- *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
- *Breast Cancer Screening*
- MNCare
  - *Annual Dental Visit*
  - *Chlamydia Screening in Women*
- **CAHPS (Member Satisfaction)** – SCHA demonstrates an opportunity for improvement in regard to the following areas of member satisfaction:
  - F&C-MA
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - MNCare
    - *Customer Service*
    - *Shared Decision Making*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - SNBC
    - *How Well Doctors Communicate*
    - *Rating of All Health Care*
    - *Rating of Health Plan*

## Recommendations

- **2018 Financial Withhold** –
  - Dental Care: SCHA should continue with the improvement strategy described in the Health Plan’s response to the previous year’s recommendation [refer to page 148]. SCHA should continue to expand its dental network and utilize the results of the member survey to identify barriers to care.
  - Hospital readmissions: SCHA should leverage the hospital admissions reduction strategy to include readmissions [refer to page 155]. SCHA should ensure that members with readmissions are targeted for care management.
- **HEDIS (Quality of Care)** – As women’s health and child and adolescent care continue to be opportunities for improvement, SCHA should conduct evaluate the effectiveness of its current quality improvement strategy and modify it as needed.
- **CAHPS (Member Satisfaction)** – SCHA should conduct root cause analysis on all poorly performing CAHPS® measures and implement initiatives to address identified barriers.

---

## UCARE

---

### 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, MSC+, MSHO and SNBC programs. As of December 2018, enrollment totaled 287,407, accounting for 30.4% of the entire MHCP population. **Table 36** displays UCare’s enrollment as of December 2018.

**Table 36: UCare Enrollment as of December 2018**

Program	Enrollment (as of December 2018)
F&C-MA	212,895
MNCare	28,440
MSC+	4,908
MSHO	12,386
SNBC	28,778
<b>Total Enrollment</b>	<b>287,407</b>

Source: Minnesota Health Care Enrollment Totals December 2018 Report

### Quality Assurance Examination and Triennial Compliance Assessment

MDH conducted the most recent QAE and TCA on May 7, 2018 through May 11, 2018. The examination period covered December 1, 2015 to February 28, 2018. During this cycle there were two file review periods: November 1, 2017 to March 1, 2018 and December 1, 2017 to March 1, 2018. The MCO received a total of one (1) recommendation and five (5) deficiencies on the QAE. The MCO was fully compliant with contract elements reviewed for the TCA.

### Performance Improvement Projects

In 2018 UCare concluded its reporting on the following PIP:

- ***Elimination of Race and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)*** – This PIP was a collaborative comprised of five (5) MCOs: Blue Plus, HealthPartners, Medica, MHP, and UCare. The goal for this PIP was to increase, by 6 percentage points, the HEDIS *Antidepressant Medication Management – Effective Continuation Phase Treatment* measure rate for Olmstead County members. **Table 37** displays the MCO’s performance rates for this PIP.

**Table 37: UCare Performance Rates for the 2015-2017 PIP**

HEDIS Year	All
2014	23.08%
2015	16.67%
2016	18.75%
2017	23.91%
2018	22.22%
<b>Net Change</b>	<b>-1.15</b>

Member-focused interventions included:

- Targeted telephonic outreach by care coordinators or health coaches
- Outreach via mail, including educational materials, resources, and refill reminders
- Antidepressant refill reminder calls
- Referrals to case management services as needed

Provider-focused interventions included:

- Cultural competency training including issues specific to depression and antidepressant medication, health literacy, and communication
- Online “Provider Toolkit,” with patient resources, such as pharmacies with translation services and a shared-decision making tool

Community-focused interventions included:

- Collaborations with community organizations, such as NAMI-MN and local religious groups
- Sharing resources at local health fairs
- Promoting and attending community events during Minority Mental Health Month in July

The following PIP was in progress:

- **Reducing Chronic Opioid Use (2018):** Initial PIP data will be reported in the 2019 ATR.

## 2018 Financial Withhold

UCare achieved 3.01 points (of 100 points) for the F&C-MA and MNCare programs, 75 points (of 90 points) for the MSHO and MSC+ programs and 51.82 points (of 60 points) for the SNBC program. **Table 38** displays the results of the 2018 Financial Withhold, including performance measures, point values, and points earned by UCare.

**Table 38: UCare 2018 Financial Withhold**

Performance Measure	Point Value	Points Earned
<b>F&amp;C-MA and MNCare</b>		
Dental Service Utilization Rate for Children (aged 1-20 years)	55	0
Dental Service Utilization Rate for Adults (aged 21-64 years)	30	0
Dental Network Provider Equity	10	0
Hospital 30-Day Readmission Rate	1	0
Emergency Department Utilization Rate	1	0.01
Hospital Admission Rate	1	1
No Repeat Deficiencies on the MDH QA Exam	2	2
<b>Total</b>	<b>100</b>	<b>3.01</b>
<b>MSHO and MSC+</b>		
Annual Dental Visit Rate (aged 65+ years)	15	0
Initial Health Risk Screening/Assessment	30	30
No Repeat Deficiencies on the MDH QA Exam	15	15
Care Plan Audit	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>90</b>	<b>75</b>
<b>SNBC</b>		
Annual Dental Visit Rate (aged 19-64 years)	15	6.82
No Repeat Deficiencies on the MDH QA Exam	15	15
Service Accessibility (Dental)	15	15
MCO Stakeholder Group	15	15
<b>Total</b>	<b>60</b>	<b>51.82</b>

### Annual Quality Assurance Work Plan for 2018

UCare’s annual quality assurance work plan is compliant with Minnesota Administrative Rule 4685.1130. Quality activities are organized into five categories: administrative, member experience, quality of clinical care, quality of service, and safety of clinical care. For each activity included, the work plan details the category the activity falls under, the population(s) the activity applies to, yearly objectives, actions planned, and the owner of each project. Additionally, regulatory requirements for each activity are defined, as well as the quality improvement committees involved and where the results would be reported.

### Evaluation of the 2018 Annual Quality Assessment and Performance Improvement Program

The UCare QI Program utilizes a multidimensional approach that allows the MCO to focus on improving processes, as well as health outcomes and satisfaction for members and providers. The Program emphasizes accountability and responsibility of all MCO employees and affiliates for quality of care and services and ensures that all medical care and service needs of members are being met and continuous improvement occurs. UCare established goals for the QI Program which include: maintaining NCQA

accreditation levels; continued focus on maintaining and improving member health through innovative initiatives; coordination of quality improvement activities to achieve efficiencies and reduce duplication; continuous improvement of quality, appropriateness, availability accessibility, coordination, and continuity of services; defining, demonstrating, and communicating an organization-wide commitment to improving quality of patient safety; partnering with members, caregivers, providers, and the community to promote health management and education and encourage appropriate use of care; ensuring a high quality, easily accessible, and accurate network; collaboration with providers; improving and managing member outcomes, satisfaction, and safety; compliance with local, state, and federal regulatory requirements; oversight of delegated entities; ensuring organizational initiatives related to cultural competency and diversity meet member needs; and improving member and provider satisfaction while improving the MCO's understanding of the key factors that contribute to satisfaction.

Throughout the reporting year, UCare engaged in multiple performance improvement projects designed to accomplish the goals of the QI Program. The MCO was able to achieve its goals for many projects, with some measures demonstrating significant improving. Conversely, some projects did not achieve the improvement goals and UCare noted that these projects will be considered for continuation into the next year. Overall, UCare's QI Program appears adequate to promote continuous quality improvement in the areas of quality care and patient safety.

### **MCO Clinical Practice Guidelines**

UCare recognizes the following sources for clinical practice guidelines:

- Global Initiative for Asthma
  - Diagnosis and management of asthma
- ADA
  - Diagnosis and management of type 2 diabetes
- JACC
  - Management of heart failure in adults
- AAFP
  - Prevention and management of obesity in adults
  - Prenatal care
  - Preventive services for adults
- AAP
  - Preventive services for children and adolescents
- AACAP
  - Assessment and treatment of children with attention-deficit hyperactivity disorder
  - Assessment and treatment of children and adolescents with depressive disorders
- APA
  - Treatment of patients with major depressive disorder
  - Treatment of patients with schizophrenia

- Treatment of patients with substance use disorders

### **HEDIS and CAHPS Performance**

The MCO's HEDIS and CAHPS rates are displayed in **Table 39** and **Table 40**, respectively, while **Figure 11** displays the HEDIS Measure Matrix.

**Table 39: UCare HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	UCare HEDIS 2017	UCare HEDIS 2018	UCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	37.0%	32.4%	43.8%	10 <sup>th</sup>	43.7%
Adult BMI Assessment <sup>1</sup>	85.6%	91.7%	92.9%	66.67 <sup>th</sup>	92.0%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	81.6%	79.8%	83.4%	75 <sup>th</sup>	82.5%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	86.0%	83.8%	87.9%	66.67 <sup>th</sup>	86.8%
Annual Dental Visit <sup>2</sup>	No Data	53.3%	49.1%	10 <sup>th</sup>	47.1%
Breast Cancer Screening (50-74 Years) <sup>2</sup>	60.4%	56.5%	56.8%	33.33 <sup>rd</sup>	60.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	61.1%	62.2%	61.1%	50 <sup>th</sup>	59.4%
Childhood Immunization Status: Combo 3 (2 Years) <sup>1</sup>	75.6%	74.5%	63.5%	10 <sup>th</sup>	69.7%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	96.0%	97.4%	95.7%	50 <sup>th</sup>	96.1%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	87.6%	85.3%	89.2%	50 <sup>th</sup>	88.9%
Children and Adolescents' Access to PCPs (7-11 Years) <sup>2</sup>	85.3%	87.0%	84.2%	10 <sup>th</sup>	91.4%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	87.5%	87.7%	87.4%	25 <sup>th</sup>	92.4%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	48.6%	44.2%	60.2%	50 <sup>th</sup>	56.6%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	70.2%	66.9%	61.1%	50 <sup>th</sup>	64.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	93.7%	91.1%	93.4%	90 <sup>th</sup>	91.7%
Controlling High Blood Pressure <sup>1</sup>	48.1%	60.9%	62.8%	50 <sup>th</sup>	68.9%
Medication Management for People With Asthma – 50% (5-64 Years) <sup>2</sup>	59.5%	61.9%	65.9%	No Benchmark	67.6%
Medication Management for People With Asthma – 75% (5-64 Years) <sup>2</sup>	30.4%	41.0%	38.8%	50 <sup>th</sup>	38.5%
Well-Child Visits in the First 15 Months of Life (6+ Visits) <sup>2</sup>	57.9%	65.9%	60.4%	25 <sup>th</sup>	64.3%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	62.9%	61.4%	66.0%	10 <sup>th</sup>	64.6%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 39: UCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	UCare HEDIS 2017	UCare HEDIS 2018	UCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MNCare</b>					
Adolescent Well-Care Visit (12-21 Years) <sup>1</sup>	26.8%	33.3%	26.0%	<10 <sup>th</sup>	31.4%
Adult BMI Assessment <sup>1</sup>	84.2%	91.7%	93.4%	66.67 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	78.8%	78.4%	80.1%	50 <sup>th</sup>	81.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	79.9%	82.5%	88.2%	66.67 <sup>th</sup>	88.2%
Annual Dental Visit <sup>2</sup>	No Data	39.1%	39.5%	10 <sup>th</sup>	39.0%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	71.8%	57.7%	62.5%	66.67 <sup>th</sup>	67.1%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	57.6%	60.7%	57.7%	33.33 <sup>rd</sup>	56.9%
Children and Adolescents' Access to PCPs (12-24 Months) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	94.2%
Children and Adolescents' Access to PCPs (25 Months-6 Years) <sup>2</sup>	Small Sample	Small Sample	89.5%	66.67 <sup>th</sup>	89.8%
Children and Adolescents' Access to PCPs (12-19 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	93.0%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	Small Sample	56.4%	33.33 <sup>rd</sup>	55.5%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup>	66.7%	77.2%	65.3%	75 <sup>th</sup>	69.2%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup>	95.8%	94.7%	94.8%	95 <sup>th</sup>	94.8%
Controlling High Blood Pressure <sup>1</sup>	31.1%	59.2%	64.0%	50 <sup>th</sup>	71.1%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	77.5%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	Small Sample	Small Sample	Small Sample	Not Applicable	51.9%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life <sup>2</sup>	Small Sample	Small Sample	69.5%	33.33 <sup>rd</sup>	67.4%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 39: UCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	UCare HEDIS 2017	UCare HEDIS 2018	UCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSHO</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	98.0%	98.0%	98.2%	95 <sup>th</sup>	98.2%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	62.3%	61.6%	62.5%	66.67 <sup>th</sup>	63.0%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	94.4%	95.9%	90.8%	75 <sup>th</sup>	91.6%
<b>MSC+</b>					
Adults' Access to Preventive/Ambulatory Health Services (65+ Years) <sup>2</sup>	95.6%	95.6%	94.0%	75 <sup>th</sup>	92.9%
Breast Cancer Screening (65-74 Years) <sup>2</sup>	42.2%	42.2%	39.7%	<10 <sup>th</sup>	40.9%
Comprehensive Diabetes Care: HbA1c Testing (65-75 Years) <sup>2</sup>	84.9%	85.0%	81.0%	<10 <sup>th</sup>	74.2%
<sup>1</sup> Rate calculated by the MCO using the hybrid methodology. <sup>2</sup> Rate calculated by DHS using the administrative methodology.					

**Table 39: UCare HEDIS Performance – Reporting Years 2017, 2018 and 2019 (Continued)**

HEDIS Measures	UCare HEDIS 2017	UCare HEDIS 2018	UCare HEDIS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>SNBC</b>					
Adult BMI Assessment <sup>1</sup> (SNP)	No Data	95.9%	96.1%	90 <sup>th</sup>	96.61
Adult BMI Assessment <sup>1</sup> (Non-SNP)	91.7%	92.2%	93.7%	75 <sup>th</sup>	93.7%
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years) <sup>2</sup>	92.8%	92.8%	92.9%	95 <sup>th</sup>	92.4%
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years) <sup>2</sup>	96.5%	96.5%	96.4%	95 <sup>th</sup>	96.3%
Breast Cancer Screening (50-64 Years) <sup>2</sup>	61.3%	59.2%	57.1%	33.33 <sup>rd</sup>	51.3%
Cervical Cancer Screening (24-64 Years) <sup>2</sup>	50.1%	48.6%	50.4%	10 <sup>th</sup>	47.8%
Chlamydia Screening in Women (16-24 Years) <sup>2</sup>	Small Sample	43.2%	43.1%	<10 <sup>th</sup>	44.4%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (SNP)	No Data	73.8%	76.9%	95 <sup>th</sup>	86.7%
Comprehensive Diabetes Care: Eye Exam (18-64 Years) <sup>1</sup> (Non-SNP)	69.2%	70.8%	68.2%	75 <sup>th</sup>	69.9%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (SNP)	No Data	94.4%	94.7%	95 <sup>th</sup>	95.7%
Comprehensive Diabetes Care: HbA1c Testing (18-64 Years) <sup>1</sup> (Non-SNP)	92.0%	93.5%	92.4%	75 <sup>th</sup>	92.5%
Controlling High Blood Pressure <sup>1</sup> (SNP)	No Data	64.7%	69.1%	75 <sup>th</sup>	76.7%
Controlling High Blood Pressure <sup>1</sup> (Non-SNP)	69.6%	67.4%	68.1%	75 <sup>th</sup>	71.3%
Medication Management for People With Asthma – 50% (12-64 Years) <sup>2</sup>	64.6%	70.3%	75.8%	No Benchmark	74.8%
Medication Management for People With Asthma – 75% (12-64 Years) <sup>2</sup>	44.4%	48.0%	48.1%	75 <sup>th</sup>	47.5%

<sup>1</sup> Rate calculated by the MCO using the hybrid methodology.

<sup>2</sup> Rate calculated by DHS using the administrative methodology.

Figure 11: UCare 2019 HEDIS Measure Matrix

		Statewide Average Statistical Significance Comparison		
		Below Average	Statewide Average	Above Average
2017 – 2018 Rate Change	<b>C</b>		<b>B</b> <ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (F&amp;C-MA)</li> <li>Controlling High Blood Pressure (SNBC SNP)</li> <li>Comprehensive Diabetes Care – Eye Exam (SNBC SNP)</li> <li>Comprehensive Diabetes Care – HbA1c Testing (SNBC SNP, SNBC Non-SNP)</li> </ul>	<b>A</b> <ul style="list-style-type: none"> <li>Cervical Cancer Screening (SNBC SNP)</li> <li>Chlamydia Screening in Women (F&amp;C-MA)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>
	<b>D</b>	<ul style="list-style-type: none"> <li>Adolescent Well-Care Visit (MNCare)</li> <li>Controlling High Blood Pressure (F&amp;C-MA, MNCare)</li> <li>Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life (F&amp;C-MA)</li> </ul>	<b>C</b> <ul style="list-style-type: none"> <li>Annual Dental Visit (MNCare)</li> <li>Breast Cancer Screening (F&amp;C-MA, MNCare, MSHO, MSC+)</li> <li>Controlling High Blood Pressure (SNBC Non-SNP)</li> <li>Cervical Cancer Screening (MNCare)</li> <li>Comprehensive Diabetes Care – Eye Exam (F&amp;C-MA, SNBC Non-SNP)</li> <li>Comprehensive Diabetes Care – HbA1c Testing (F&amp;C-MA, MNCare)</li> <li>Medication Management for People with Asthma-50% (F&amp;C-MA)</li> <li>Medication Management for People with Asthma-75%(F&amp;C-MA)</li> </ul>	<b>B</b> <ul style="list-style-type: none"> <li>Breast Cancer Screening (SNBC SNP)</li> <li>Cervical Cancer Screening (F&amp;C-MA)</li> </ul>
	<b>F</b>	<ul style="list-style-type: none"> <li>Childhood Immunization Status – Combo 3 (F&amp;C-MA)</li> </ul>	<b>D</b> <ul style="list-style-type: none"> <li>Comprehensive Diabetes Care – Eye Exam (MNCare)</li> </ul>	<b>C</b> <ul style="list-style-type: none"> <li>Annual Dental Visit (F&amp;C-MA)</li> </ul>

**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.
- E** Conduct root cause analysis and develop action plan.

**Table 40: UCare CAHPS Performance – 2017, 2018 and 2019**

CAHPS Measures	UCare CAHPS 2017	UCare CAHPS 2018	UCare CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>F&amp;C-MA</b>					
Getting Needed Care*	85.5%	84.2%	83.0%	33.33 <sup>rd</sup>	84.1%
Getting Care Quickly*	83.1%	80.5%	85.7%	75 <sup>th</sup>	84.2%
How Well Doctors Communicate*	90.9%	93.3%	93.3%	66.67 <sup>th</sup>	95.1%
Customer Service*	87.1%	87.1%	87.0%	10 <sup>th</sup>	87.0%
Shared Decision Making*	80.3%	82.2%	83.8%	75 <sup>th</sup>	84.3%
Rating of All Health Care**	57.0%	55.5%	48.7%	<10 <sup>th</sup>	52.6%
Rating of Personal Doctor**	67.0%	69.7%	72.8%	75 <sup>th</sup>	72.4%
Rating of Specialist Seen Most Often**	62.7%	74.7%	59.5%	<10 <sup>th</sup>	61.9%
Rating of Health Plan**	62.6%	63.8%	58.8%	33.33 <sup>rd</sup>	57.7%
<b>MNCare</b>					
Getting Needed Care*	85.7%	83.9%	82.4%	33.33 <sup>rd</sup>	84.1%
Getting Care Quickly*	76.8%	84.0%	79.1%	10 <sup>th</sup>	84.7%
How Well Doctors Communicate*	96.5%	95.9%	94.6%	75 <sup>th</sup>	95.2%
Customer Service*	77.6%	77.6%	85.0%	10 <sup>th</sup>	84.0%
Shared Decision Making*	84.9%	86.4%	82.7%	75 <sup>th</sup>	79.4%
Rating of All Health Care**	62.0%	60.4%	57.5%	66.67 <sup>th</sup>	53.8%
Rating of Personal Doctor**	66.7%	72.7%	68.6%	50 <sup>th</sup>	69.3%
Rating of Specialist Seen Most Often**	51.9%	68.2%	65.2%	33.33 <sup>rd</sup>	68.0%
Rating of Health Plan**	56.6%	55.1%	57.1%	25 <sup>th</sup>	56.5%
F&C-MA Response Rate = 9.74%. Sample Size = 1,350. MNCare Response Rate = 14.71%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

**Table 40: UCare CAHPS Performance – 2017, 2018 and 2019 (Continued)**

CAHPS Measures	UCare CAHPS 2017	UCare CAHPS 2018	UCare CAHPS 2019	QC 2019 National Medicaid Benchmark Met/Exceeded	2019 Statewide Average
<b>MSC+</b>					
Getting Needed Care*	88.6%	80.1%	84.3%	50 <sup>th</sup>	85.5%
Getting Care Quickly*	88.7%	79.7%	82.8%	50 <sup>th</sup>	85.0%
How Well Doctors Communicate*	94.0%	91.6%	91.3%	33.33 <sup>rd</sup>	94.4%
Customer Service*	85.9%	79.7%	88.6%	33.33 <sup>rd</sup>	88.6%
Shared Decision Making*	81.7%	80.8%	85.1%	90 <sup>th</sup>	81.8%
Rating of All Health Care**	60.9%	51.1%	51.4%	10 <sup>th</sup>	57.8%
Rating of Personal Doctor**	78.8%	60.5%	70.1%	66.67 <sup>th</sup>	73.7%
Rating of Specialist Seen Most Often**	75.8%	64.4%	65.3%	33.33 <sup>rd</sup>	69.3%
Rating of Health Plan**	68.3%	52.5%	59.0%	33.33 <sup>rd</sup>	64.4%
<b>SNBC</b>					
Getting Needed Care*	84.6%	86.0%	82.3%	33.33 <sup>rd</sup>	82.5%
Getting Care Quickly*	87.8%	82.9%	83.6%	50 <sup>th</sup>	83.8%
How Well Doctors Communicate*	93.0%	94.2%	92.2%	50 <sup>th</sup>	93.0%
Customer Service*	85.6%	88.9%	88.4%	33.33 <sup>rd</sup>	89.2%
Shared Decision Making*	78.6%	79.9%	82.6%	75 <sup>th</sup>	82.2%
Rating of All Health Care**	59.6%	48.5%	51.3%	10 <sup>th</sup>	53.5%
Rating of Personal Doctor**	65.1%	71.2%	68.3%	50 <sup>th</sup>	70.2%
Rating of Specialist Seen Most Often**	60.9%	75.0%	64.7%	33.33 <sup>rd</sup>	65.4%
Rating of Health Plan**	61.0%	59.6%	62.8%	50 <sup>th</sup>	60.6%
MSC+ Response Rate = 19.11%. Sample Size = 1,350. SNBC Response Rate = 20.51%. Sample Size = 1,350. * Measure represents the percent of members who responded “yes,” “usually” or “always.” ** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”					

## Strengths

- **TCA (Compliance)** – UCare was fully compliant with the contractual standards reviewed for the TCA.
- **HEDIS (Quality of Care)** – UCare performed well in regard to the following areas of care:
  - F&C-MA
    - *Adolescent Well-Care Visit*
    - *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life*
  - SNBC SNP
    - *Chlamydia Screening for Women*
- **CAHPS (Member Satisfaction)** – UCare performed well in the following areas of member satisfaction:
  - F&C-MA
    - *Getting Care Quickly*
    - *Shared Decision Making*
    - *Rating of Personal Doctor*
  - MNCare
    - *How well Doctors Communicate*
    - *Shared Decision Making*
  - MSC+
    - *Shared Decision Making*
  - SNBC
    - *Shared Decision Making*

## Opportunities for Improvement

- **QAE (Compliance)** – UCare was not fully compliant with the contractual standards reviewed for the QAE. UCare received a total of one (1) recommendation and five (5) deficiencies.
- **2018 Financial Withhold** – UCare did not earn full points for the F&C-MA, MNCare, MSHO, MSC+ and SNBC programs. The MCO did not meet the target goal for the following measures:
  - F&C-MA and MNCare
    - Dental Service Utilization Rate for Children
    - Dental Service Utilization Rate for Adults
    - Dental Network Provider Equity
    - Hospital 30-Day Readmission Rate
    - Emergency Department Utilization Rate
  - MSHO and MSC+
    - Annual Dental Visit Rate
  - SNBC
    - Annual Dental Visit Rate
- **HEDIS (Quality of Care)** – UCare demonstrates an opportunity for improvement in regard to the following areas of care:

- F&C-MA
  - *Childhood Immunization Status*
  - *Controlling High Blood Pressure*
  - *Well-Child Visits in the First 15 Months of Life*
- MNCare
  - *Adolescent Well-Care Visit*
  - *Controlling High Blood Pressure*
  - *Breast Cancer Screening*
  - *Comprehensive Diabetes Care – Eye Exam*
- **CAHPS (Member Satisfaction)** – UCare demonstrates an opportunity for improvement the following areas of member satisfaction:
  - F&C-MA
    - *Getting Needed Care*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - MNCare
    - *Getting Care Quickly*
    - *Customer Service*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - MSC+
    - *How Well Doctors Communicate*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*
    - *Rating of Health Plan*
  - SNBC
    - *Getting Needed Care*
    - *Customer Service*
    - *Rating of All Health Care*
    - *Rating of Specialist Seen Most Often*

## Recommendations

- **2018 Financial Withhold** – UCare should continue with the robust improvement strategy described in the Health Plan’s response to the previous year recommendation to address dental care and hospital readmissions. UCare should routinely evaluate the effectiveness of the improvement strategy and modify it as needed.
- **HEDIS (Quality of Care)** – UCare should continue with its current strategy to address areas of care that continue to perform poorly. UCare should expand this strategy to include diabetes and childhood immunizations.

- **CAHPS (Member Satisfaction)** – In addition to the results of the CAHPS survey, UCare should identify other means of collecting member feedback and use this information to conduct a thorough root cause analysis.

## 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 and CAHPS statewide averages to the national Medicaid benchmarks presented in the *Quality Compass 2019*. Measures performing at or above the 75<sup>th</sup> percentile were considered strengths; measures performing at the 50<sup>th</sup> percentile were considered average, while measures performing below the 50<sup>th</sup> 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 **Table 41** and **Table 42**, respectively.

### MHCP Common Strengths and Opportunities for Improvement

Common strengths of the MHCP include: access to primary care for adults, and member satisfaction with personal doctor. MHCP rates for the following HEDIS and CAHPS measures met or exceeded the 75<sup>th</sup> percentile:

- *Adults' Access to Preventive/Ambulatory Health Services* (all age groups)
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Common MHCP opportunities for improvement include: child/adolescent care, women's health screenings, and member satisfaction with of health plan. MCHP rates for the following HEDIS and CAHPS measures were below the 50<sup>th</sup> percentile:

- *Adolescent Well-Care Visit* (12-21 Years)
- *Annual Dental Visit*
- *Breast Cancer Screening* (50-74 Years)
- *Cervical Cancer Screening* (24-64 Years)
- *Childhood Immunization Status: Combo 3* (2 Years)
- *Children and Adolescents' Access to Primary Care Practitioners* (12-24 Months, 25 Months-6 Years and 7-11 Years)
- *Chlamydia Screening in Women* (16-24 Years)
- *Comprehensive Diabetes Care: HbA1c Testing* (18-75 Years)
- *Well-Child Visits in the First 15 Months of Life* (6+ Visits)
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* (3-6 Years)
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

**Table 41: MHCP HEDIS Performance – Reporting Years 2017, 2018 and 2019**

HEDIS Measures	MHCP HEDIS 2017	MHCP HEDIS 2018	MHCP HEDIS 2019	Performance Assessment based on QC 2019 National Medicaid Benchmarks
Adolescent Well-Care Visit (12-21 Years)	38.8%	35.0%	36.8%	Opportunity
Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)	86.1%	84.5%	83.4%	Strength
Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)	90.1%	90.2%	90.1%	Strength
Adults' Access to Preventive/Ambulatory Health Services (65+ Years)	96.7%	95.1%	94.6%	Strength
Annual Dental Visit	No Data	45.6%	47.6%	Opportunity
Breast Cancer Screening (50-74 Years)	58.3%	56.2%	57.8%	Opportunity
Cervical Cancer Screening (24-64 Years)	57.6%	56.1%	55.8%	Opportunity
Childhood Immunization Status: Combo 3 (2 Years)	59.6%	63.5%	56.6%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	97.0%	96.6%	95.1%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	90.3%	90.2%	87.1%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (7-11 Years)	92.3%	92.3%	90.1%	Opportunity
Children and Adolescents' Access to Primary Care Practitioners (12-19 Years)	92.7%	93.0%	91.2%	Average
Chlamydia Screening in Women (16-24 Years)	57.2%	52.3%	54.2%	Opportunity
Comprehensive Diabetes Care: HbA1c Testing (18-75 Years)	85.2%	85.8%	85.8%	Opportunity
Medication Management for People with Asthma – 50% Compliance (5-64 Years)	61.2%	65.2%	68.9%	No Benchmark
Medication Management for People with Asthma – 75% Compliance (5-64 Years)	36.7%	42.7%	40.4%	Average
Well-Child Visits in the First 15 Months of Life (6+ Visits)	65.0%	63.8%	59.4%	Opportunity
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (3-6 Years)	64.5%	63.6%	60.2%	Opportunity
MHCP rates were calculated by DHS using the administrative methodology.				

**Table 42: MHCP CAHPS Performance – 2019**

CAHPS Measures	MHCP CAHPS 2019 <sup>1</sup>	Performance Assessment based QC 2019 National Medicaid Benchmark Met/Exceeded <sup>2</sup>
Getting Needed Care*	83.9%	Average
Getting Care Quickly*	84.4%	Average
How Well Doctors Communicate*	94.1%	Strength
Customer Service*	87.7%	Opportunity
Shared Decision Making*	82.3%	Strength
Rating of All Health Care**	54.6%	Opportunity
Rating of Personal Doctor**	71.4%	Strength
Rating of Specialist Seen Most Often**	66.4%	Opportunity
Rating of Health Plan**	60.1%	Opportunity
<p>MHCP Response Rate = 29,550. Response Rate = 16.14%.</p> <p><sup>1</sup> MHCP rates were calculated by HSAG.</p> <p><sup>2</sup> Performance Assessment: Strength = at or above the 75<sup>th</sup> percentile; Average = at or between the 74<sup>th</sup> and 50<sup>th</sup> percentiles; Opportunity = below the 50<sup>th</sup> percentile.</p> <p>* Measure represents the percent of members who responded “yes,” “always” or “usually.”</p> <p>** Ratings range from 0 to 10. This measure represents the percent of members who responded “9” or “10.”</p>		

---

## **CHAPTER 4: FOLLOW-UP TO 2017 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 2017 improvement recommendations including verbatim responses from each MCO.

SPACE INTENTIONALLY LEFT BLANK

---

## BLUE PLUS

---

- **2017 Recommendation: Financial Withhold –**

- In regard to ED utilization, hospital admissions and readmissions, Blue Plus should continue with the improvement strategy described in the MCO's response to the previous year's recommendation. Blue Plus should leverage the successes of its health connectors, value-based programs (VBPs) and health coaches to encourage members to utilize the health care system appropriately.
- Blue Plus indicates that there are significant barriers to improving access to dental services across the state. As such, Blue Plus should consider utilizing a mobile dental service in remote areas of the state, as well as consider organizing a series of local dental fairs in which members can receive dental care. The MCO should also encourage primary care providers to remind members to receive dental care

**MCO Response:**

**Emergency Department Utilization:** Blue Plus is committed to reducing unnecessary emergency department (ED) utilization and helping members access the care they need. Our goal is for members to receive the right care, at the right time, in the right place. We are tackling this goal through multiple avenues, including member education, program design, and provider value-based programs.

Member Education and Program Design

In 2016, Blue Plus launched the Health Connections Program, which centers on a team of Health Connectors that specialize in helping F&C-MA and MNCare (collectively, "Medicaid") members navigate the complex health care system. The goal of the Health Connections Program is to empower Medicaid members through education and information to make the best decisions possible to meet individual health care needs. This model fosters high quality interactions that create a positive customer experience while guiding members to the most appropriate services, promoting quality, and managing the total cost of care. In 2017 and 2018, Health Connectors did targeted outreach to Medicaid members that used the ED in the previous month for non-urgent conditions. The Health Connectors educated members on alternatives to the ED for non-urgent conditions, including a new telehealth benefit through Doctor on Demand® and nurse line services. They also helped connect the member to a primary care provider, where applicable.

In 2017, Blue Plus launched a High Complexity Case Unit (HCCU) Program to meet the needs of our most complex members. The HCCU Program uses an interdisciplinary care team approach that includes a comprehensive, holistic assessment, an individualized plan of care, and provider collaboration. Analysis from the first cohort of members to participate in the program was positive and showed statistically significant reductions in inpatient admissions for members engaged in HCCU

versus standard health coaching. Results also indicated shorter lengths of stay and fewer ED visits for these members.

#### Provider Value-Based Programs

Blue Plus first launched its Medicaid Provider Value-Based Program (VBP) in 2015 to focus specifically on improving health outcomes, increasing quality of care and managing costs in our F&C-MA and MNCare populations. Currently, the program serves over 60% of attributed members. ED utilization has been a metric in the Medicaid VBP since its inception. As part of the Medicaid VBP, Blue Plus regularly reviews performance with participating care systems and provides member-level reporting on at least a quarterly basis. Blue Plus and the care system work together to identify opportunities for improvement.

Despite not achieving the withhold, Blue Plus's ED utilization rates are trending down, indicating our work is having a positive impact in helping members access the appropriate level of care. In 2018, 33% of care systems participating in the Medicaid VBP achieved partial to full achievement towards goal by closing the gap between their baseline performance and goal by at least 50%. This reflects considerable improvement compared to 2016, when only 10% of participating care systems closed that gap by at least 50%. Emergency department utilization will continue to be included in 2019 VBPs. Blue Plus's HEDIS® rate for Emergency Department Utilization (AMB-EDU) also has shown an improvement. The number of ED visits per 1,000-member months decreased for both F&C-MA and MNCare members from HEDIS 2017 (calendar year (CY) 2016) to HEDIS 2018 (CY 2017).

**Hospital Readmission Rates:** Blue Plus also is committed to reducing unnecessary readmissions by working to ensure members who have been hospitalized have the tools and resources they need to experience a smooth transition to home or other care setting. As with ED utilization, we are addressing this through a multi-pronged approach.

#### Provider Value-Based Programs

All cause readmissions has been a metric in our Medicaid VBP since its inception in 2015. As noted above, Blue Plus works closely with care systems participating in the Medicaid VBP to identify opportunities for improvement. This includes reviewing regular member and provider-level reporting on both admissions and readmissions. In 2018, 71% of care systems achieved partial to full achievement towards goal by closing the gap between their baseline performance and goal by at least 50%. This reflects considerable improvement compared to 2016, when only 33% of participating care systems closed that gap by at least 50%. All cause readmissions will continue to be included in 2019 VBPs.

#### Program Design

A consistent barrier to our clinicians effectively assisting members with transitions of care has been lack of timely notification of admission and discharge. In 2017, Blue Plus enhanced its admission

notification process, which feeds our case and disease management platform. 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.

Although our efforts to date have not resulted in meeting the withhold, we are seeing improvement in the reduction of readmissions among the providers participating in our Medicaid VBP. In the near future, Blue Plus plans to initiate member outbound calls to provide utilization education to members that recently used the emergency room. We will also continue to promote our 24-hour nurse line that members can use free of charge.

**Dental Care for All Age Groups:** Blue Plus recognizes the importance of annual dental care for all age groups. Regular dental visits are essential for the maintenance of healthy teeth and gums and can identify oral health issues early when treatment is most successful. Blue Plus has initiated member interventions across all ages to encourage an annual dental visit, as outlined below. However, significant barriers remain to improving dental access for Medicaid members across the state.

---

## HEALTHPARTNERS

---

- **2017 Recommendation: Financial Withhold** – As HealthPartners continues to struggle with increasing annual dental visits and decreasing hospital admissions, the MCO should continue to identify additional ways to positively impact these areas of care. As the use of community health (CHW) workers has proven to be an effective intervention in reducing admissions and readmissions, HealthPartners should consider additional ways that CHWs can be integrated into the system to reach more members and to support other areas of care. For the less managed, low-risk population, HealthPartners should identify the drivers of readmissions for this population and develop targeted interventions that address these drivers. HealthPartners should evaluate the effectiveness of the placement of the full-time employee within the hospital setting and determine whether or not other hospitals would benefit from this intervention. In regard to dental, the HealthPartners Patient Dental Call Center should expand telephonic outreach to all age groups. HealthPartners should also run gaps in care reports within multiple times a year and use these reports to drive outreach.

### **MCO Response:**

**Admissions and Readmissions:** Efforts to decrease hospital admissions and readmissions continue to be a challenge for HealthPartners. 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 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 this impact, especially among our Minnesota Health Care Programs (MHCP) membership. In addition, as a health plan, our MHCP members under-utilize our internal member support resources such as care coordination and Medication Therapy Management (MTM) services.

We conducted chart reviews for a selection of members who were readmitted in an effort to identify missed opportunities for intervention prior to the readmission. Some of the findings include:

- These are very complex, high-risk patients.
- Patients often were already receiving high-risk Case Management services.
- Some patients with a history of Mental Health /Chemical Dependency issues may have an opportunity to be directed to appropriate treatment services; however patients have been struggling with these conditions for long periods of time.
- No significant opportunities or trends were identified.

The workgroup recommended systematically focusing on increasing the use of existing programs and looking for opportunities to address social determinants of health. Overall, the collaboration between

the health plan and our care system to identify high risk members who may be at risk for hospitalization or re-hospitalization is an opportunity to impact this measure.

**Community Health Navigators:** MHCP members have unique social and cultural-specific needs. Community Health Navigators (CHNs) are a proven strategy to effectively address various socioeconomic determinants of health for MHCP and other hard-to-reach populations. Two CHNs located onsite at our Midway and Maplewood clinics, provide face-to-face visits (both onsite and in the home) to HealthPartners PMAP members attributed to our St. Paul, Midway, Center for International Health, and Maplewood clinics. With an emphasis on improving connections between MHCP members and their Primary Care Provider (PCP), this program aims to decrease avoidable ER use, increase use of Primary Care Clinics, and increase adherence to Primary Care follow-up. In 2018, HealthPartners focused our efforts on model improvements based on lessons learned from the 2016 CHN pilot and 2017 CHN expansion to the Maplewood Clinic. Program monitoring in 2018 revealed a 68% enrollment rate and an increase in education interventions and community resource connections completed for members.

**Disease & Case Management (DCM) Services:** Members identified for DCM services include those with complex medical conditions or poorly managed chronic conditions that are at high risk of future hospitalization. Our goal is to improve member self-management of their complex or chronic conditions, thereby reducing risk of future admissions including readmissions. DCM uses the following targeted interventions:

- Post-discharge support for all members participating in DCM services who have a hospital admission.
- Connection to MTM services for members with complex medication regimens or medication adherence concerns.
- Assessment and care planning with interventions tailored to address the member's unique needs, barriers, and identified clinical gaps in care.
- Close collaboration with care team members including PCPs, health care home nurses, home care providers, MTM/pharmacy resources, and community based providers.
- Collaboration with Regions Care Management to facilitate identification and engagement of members hospitalized at Regions Hospital. The Regions Case Management department increased referral goals for HealthPartners members to a goal of 60 referrals per month. In 2018, this goal was met in nine months.
- Inpatient Case Management services to support real time identification and engagement of high risk members to ensure milestones and care plans are implemented before discharge.
- Hospital Case Managers refer members to MTM for medication review when appropriate following discharge to ensure medication reconciliation and patient understanding of any medication changes.

**Provider Interventions:** HealthPartners Medical Group (HPMG) and Park Nicollet Clinics receive daily discharge notifications from hospitals. They implemented outreach processes for post-discharge calls with patients. Care delivery uses an algorithm to identify those who may be at especially high risk for readmission to prioritize patient calls and ensure they are scheduled for follow-up with their clinic in a timely manner. Engagement with the highest risk members continues to be a challenge.

- Park Nicollet care system implemented a text-first communication approach to reach patients following discharge. A text message is sent via a texting platform and asks a series of automated questions to help assess a patient’s risk for readmission. Based on the patient’s answers, the platform automatically notifies the care team of their responses and nurses prioritize those who need attention.
- The HPMG/Park Nicollet care system embedded a predictive analytics tool into EPIC in May 2018. Risk of Unplanned Readmission alerts assist in identifying patients who are at risk of readmission by looking at the following components: age, demographics, diagnosis, medications, order type lookback, lab lookback and utilization. Inpatient case managers document readmission risk in a note prior to discharge for access by the clinic team.
- Network clinics and hospitals are using Community Paramedics (CPs) and Emergency Medical Technicians (EMTs) to conduct home visits to support the member after discharge and reduce the likelihood of readmission. CPs are experienced 911 paramedics with additional education to provide non-emergency care to patients and help manage chronic conditions.

At Regions and Lakeview hospitals, orders for the CP Program are made through the EPIC system. The current diagnoses that can be referred to the CP Program include CHF, COPD, AMI, pneumonia and stroke. As the benefits of these visits are recognized, the diagnoses that are targeted for visits continue to expand. Priority is given to HealthPartners insured members. CP Home visits include:

- Measurement of vital signs
- Performing physical exams
- Reviewing upcoming appointments or assistance with scheduling follow up
- Medication reconciliation, education, and compliance checks
- Connecting patients to community resources
- Conducting home safety assessments
- Reinforcement of dietary recommendations

Methodist Hospital’s “Good to be Home” program partners with several local fire departments for a one-time post-discharge visit by an EMT.

- Perform blood pressure check, and ask basic health questions
- Review medications and physician instructions
- Review upcoming appointments or provide assistance with scheduling follow up
- Ensure access to food and transportation
- Conduct home safety assessments

- Replace smoke alarms or batteries as needed
- o HealthPartners Community Senior Care program offers care for seniors where the patient is located – in their home, a nursing home, transitional care center or assisted living center.
- o Care at Home sends medical teams to the home of Minnesota Senior Health Options (MSHO) and Medicare Advantage patients at risk of readmission. The care team includes both an advance practice nurse as well as MDs.
- o To reduce readmissions due to symptom management, care teams ensure that comfort care is provided after discharge at the member’s location to reduce the likelihood of readmission for symptom or pain management. The medical team works with the staff at the transitional care center or nursing home to provide the appropriate level of symptom management.

**Dental Withhold:** Access to dental providers has been identified as an ongoing issue for MHCP members in Minnesota. HealthPartners has a State Public Programs Navigator role within Member Services to help members locate a dentist who is accepting new patients. Member Services representatives look to the Navigator for assistance with complex dental benefits, provider access, resources for community services when non-plan benefits are needed.

We created an outreach plan for members who were overdue for preventive dental care. In 2018, electronic member communications were sent in two large outreach pushes. Members who get dental care within our care group received the HealthPartners Dental Group (HPDG) call center number. Members who were seen at a contracted clinic received that clinic’s number, and members who did not have a dental clinic history were encouraged to call Member Services for assistance finding a clinic.

- o In July 2018, we deployed 13,921 emails 2018 encouraging members to schedule dental care. Of those 11,873 were directed to the dental call center for assistance and 2,048 were directed to their own dental clinic.
- o In November 2018, we sent a follow-up e-mail to 6,299 members who had not responded to the initial email or were newly eligible.
- o This strategy was revised so smaller outreaches are now done on a monthly basis encouraging members to seek dental care if they are due.
- o Approximately 10% of members who received this outreach message receive dental care in the 6 months following the message.

Our dental clinic group hired two additional call center staff to manage the increased volume of calls and to conduct outreach to MHCP members. Protocols for scheduling MHCP members within the HPDG clinics was updated to maximize access opportunities and call center staff received training to schedule accordingly.

HPDG strategically recruited and hired additional dental staff to serve members at high-MHCP dental clinics to increase access to appointments. In addition to the call center staff, HPDG added more than 12 FTEs including dentists, dual license ADT/hygienists and hygienists to improve appointment availability.

Health Informatics created an outreach list which is distributed to the call center on a monthly basis to conduct outbound calls to members who are due for preventive dental care.

Analysis of our own dental clinics service of MHCP members, identified that the volume of MHCP patient visits increased, but the number of unique members did not increase at the same rate. More members receiving preventive care identified issues that resulted in more appointments slots being taken up by restorative care, potentially causing the unintended consequence of limiting access to more new patients.

HealthPartners is evaluating the impact of all these strategies in 2019.

- **2017 Recommendation: HEDIS (Quality of Care)** – HealthPartners should identify providers with large Medicaid panels and implement the same interventions provided to contracted clinic providers. Specifically, the Health Plan should ensure that providers who provide care for a large number of members also receive gaps in care reports, receive support from the Quality Consultants, participate in the Quality Connections Forum and participate in incentive programs. HealthPartners should consider including dental care into the member incentive program.

**MCO Response:** HealthPartners provides a claim-based Gaps in Care Registry Report to our contracted clinics on a quarterly basis. The Gaps in Care Reports include members of all products, including MHCP, and are available on line via a secure login to our Provider Portal. The report includes data on preventive services and chronic disease.

A Registered Nurse from the Quality Improvement & Compliance (QIC) department is available to consult with medical groups about their quality improvement processes and assist with interpreting data. This can be especially helpful for small clinics or smaller systems without a fully developed Quality Improvement department.

Quality Connections Forums is a strategy to share best practice for quality improvement initiatives across our provider network. We convene quality improvement representatives from clinics to meet for relationship building and sharing of successes, learnings, best practices, experiences and results. The stated purpose of the group is to share and learn so that we can take action to benefit our patients and our organizations as we mutually strive to achieve high performance results on publicly reported measures. This group has grown from five provider groups in 2012 to 16 in 2018 and includes both

large network clinics, and smaller, community-based clinics (FQHCs) who see a large number of MHCP members.

In addition to these network level interventions, HealthPartners engages in many activities to improve HEDIS rates for our members. Here are examples of those activities for the measures where HealthPartners showed the greatest opportunities:

- HbA1c Testing, Minnesota Senior Care Plus (MSC+) – messages were sent to members with diabetes who were coming due for HbA1c testing and/or retinal eye exam. Of the members who received the message approximately 50% subsequently received the service. In 2019, HealthPartners added HbA1c testing to our home test kit project.
- Breast Cancer Screening, MSC+ - Preventive screening messages for breast cancer are customized using predictive analytics to improve member engagement in getting screening tests. Our care group's Mammo-a-go-go bus attends numerous community screening events across the state to promote breast cancer screening and offer mammograms to women who might not otherwise have access or don't go to their PCP for screening.
- Medication Management for people with Asthma, Families & Children (F&C-MA) – HealthPartners utilizes Health Informatics analysis to identify members who appear to have asthma based on claims. These members receive information about our Disease and Case Management program for asthma. Members who engage with our Asthma Management Program receive a \$25 incentive. This has resulted in increased engagement with the Asthma Management Program.
- Annual Dental Visit, MinnesotaCare (MNCare) – HealthPartners initiated multiple interventions as described above to increase access to dental care and to encourage members to complete dental visits.
- Adolescent well-care visits, MNCare – HealthPartners sends outreach communications to parents of adolescents encouraging them to seek preventive care and offers an incentive for adolescents to receive the full combo 2 series of immunizations required by age 13. We conducted social media campaigns around adolescent immunizations (including HPV) promoted educational blogs, and boosted social media messages from other organizations such as the MN Department of Health on this topic. Our 2019 HEDIS (2018 dates of service) shows a statistically significant 8.5 point increase in adolescent well care visits for MNCare members. We continue to analyze our performance on this measure and develop initiatives to strengthen our interventions.

---

## HENNEPIN HEALTH

---

- **2017 Recommendation: HEDIS (Quality of Care) –**
  - Hennepin Health should identify non-traditional methods for communicating with members.
  - Despite not finding a resource to establish a mobile mammogram center, Hennepin Health should consider other options for mobilizing care, especially since a large majority of their membership lack a health home.
  - Hennepin Health should reconsider the use of monetary incentives for members.

**MCO Response:** Hennepin Health analyzes its HEDIS results each year and identifies measures which not only provide opportunities for improvement, but which are clinical priorities for our members and our external partners – Hennepin Healthcare System (HHS) and NorthPoint Health and Wellness Center. For the identified measures, root cause analysis is conducted, and potential interventions are assessed and implemented, as appropriate. Hennepin Health has implemented several strategies during 2018 – 2019 to impact the HEDIS rates. These strategies include, but are not limited to, the analysis of the drivers behind the measures as well as provider and member strategies.

Medicaid Expansion members comprise a high percentage of the Hennepin Health membership. A high percentage (>85%) of the Medicaid Expansion members 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. Members may also lack transportation. Involvement in the criminal justice system is not uncommon for this population as well. Many Hennepin Health members live in what some may call the “survival mode”; thinking only of 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 primary/preventive health care services as evidenced by the HEDIS preventive services visit utilization rate. The focus areas for Hennepin Health members are addressing these basic survival needs in addition to their psychosocial and medical needs. The Medicaid Expansion population generally seeks acute episodic care and do not see the need for ongoing primary and preventive care, especially if they feel “better.” Many members are resistant to allowing a primary care physician (PCP) into their personal health. 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.

Hennepin Health employs several different communication methods for member outreach. Many members do not have a permanent home address or cell phone. Some members cannot be located.

Hennepin Health Community Outreach staff attend many community health fairs or other community events to provide information about Hennepin health and the various health care rewards programs.

In addition, Hennepin Health reaches out to county case managers and delegated care guide agencies' staff who work with our members to encourage our members to obtain preventive care exams and complete preventive health screenings/activities. In collaboration with HHS, a readmission project was implemented in January 2019 to work specifically with members who are homeless when admitted to HHS hospital. Through this initiative, the Hennepin Health Social Service Navigation team staff meets with the member while the member is hospitalized. If the member accepts case management services, the Social Service Navigation team staff will work on a 1:1 basis with members to address social determinants of health, such as homelessness, as well as assisting members in establishing a health care home. This is a resource intensive initiative.

Email communication, when available, is also used to reach out to members to encourage preventive care exams as well as preventive health screenings/ activities. Hennepin Health Social Service Navigation team will work with members on an individual basis to establish a health care home and obtain appropriate healthcare screenings. Information regarding health care screenings is also available at the Hennepin Health Walk-In Center which currently provides services such as bus card passes. The Walk-In Center sees about 800 members per month.

Hennepin Health is in the process of implementing a new case management software system which includes a Population Health Module. The Population Health module will allow Hennepin Health to implement "healthcare campaigns" to promote appropriate healthcare activities such as breast cancer screening. In addition, Hennepin Health has added to its member website a vendor based link to Healthwise.com which is a community standard and leader in providing detailed, easy to understand information about health conditions and preventive screenings in both English and Spanish.

F&C- MA and MNCare Annual Dental Visit: In late 2016 and throughout 2017, the Hennepin Health Dental Strategy Workgroup developed strategies to address the low annual dental rates for children and adults. Hennepin Health developed a voucher program for this measure in 2017. Any member, age 1 and up who completed an annual dental visit could earn a \$15.00 gift card. This voucher incentive program is ongoing. The gift card amount will increase to \$25.00 in 2020.

Hennepin Health hired a Dental Coordinator in May 2018. The Dental Coordinator's responsibilities include developing the dental program, contacting members/families to educate members on the importance of dental care, and provide assistance in scheduling a dental visit, if requested. Hennepin Health also works closely with their external partners, Hennepin Healthcare System Dental Clinic and NorthPoint Health and Wellness Clinic Dental Clinic, in scheduling dental visits. The Dental Coordinator can directly schedule dental visit, using the respective electronic medical record system.

Through these efforts, Hennepin Health realized an almost 7 percent increase in dental utilization for children ages 1 – 20 in 2018. The MNCare HEDIS Annual Dental Visit measure increased to 42.31 percent and the F&C-MA HEDIS Annual Dental Visit measure increased to 52.71 percent in HEDIS 2019 season (2018 data)

F&C – MA and MNCare Cervical Cancer Screening: Hennepin Health continues to focus on encouraging members to establish health care homes and to complete annual preventive health exams. As stated above, members can be reluctant to establish relationships with health care professionals. Hennepin Health has also provided provider education regarding the HEDIS requirements for cervical cancer screening via the Hennepin Health provider website. During HEDIS medical record chart abstraction, it was identified that the provider would often provide education regarding the importance of cervical cancer screening, but the member would refuse the pap smear sometimes for the reasons such as they were not sexually active or it was not culturally appropriate.

Hennepin Health has implemented a member cervical cancer screening incentive, effective 4<sup>th</sup> quarter 2019 and ongoing. Postcards will be mailed to eligible women who have not received a cervical cancer screening in 2019 informing them of the gift card incentive. The incentive information will be posted on the Hennepin Health website as of January 1, 2020.

F&C- MA and SNBC Breast Cancer Screening: The Hennepin Health F&C-MA HEDIS 2018 Breast Cancer Screening rate was 52.9% which is approximately 4 percent higher than the HEDIS 2017 rate. The Hennepin Health HEDIS SNBC Breast Cancer Screening rate was 42.6% which is lower than the 2017 HEDIS rate of 51.5%.

The eligible population for the 2019 HEDIS Breast Cancer Screening measure, women ages 50 – 64, for both F&C- MA and SNBC population was significantly less than the NCQA required sample size 411. For 2019 HEDIS season, the F&C-MA and SNBC population was 208 and 141, respectively. 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. Data limitations included, but were not limited to, not having the claims data for women who were enrolled with Hennepin Health for 2018 or claims information indicating the woman had a bilateral mastectomy.

Hennepin Health reviewed 162 medical records of women ages 50-64 enrolled in the F&C-MA and SNBC product in 2018 who did not have a mammogram claim. Of the 162 medical records reviewed, the Primary Care Physician had provided education regarding the importance of having a mammogram to thirty-four members in 2017 or 2018. Seventeen women either refused having a mammogram, cancelled or forgot about the scheduled mammogram appointment. There were two members who should have not been part of the sample as they had a diagnosis of breast cancer. With

such a small sample size, having even a few members refuse or cancel the mammogram appointments can have a significant impact on the overall rate.

In discussion with some primary care providers (PCP), it appears PCPs have a different perspective regarding the process women could use to obtain a mammogram. Some PCPs prefer having a discussion with the member prior to ordering a mammogram; other PCPs allow members to obtain a mammogram without an order and have the results sent to the PCP. Mammogram Service Centers also have different protocols. Some require the member to have a PCP within the respective healthcare system; others do not have this requirement and will send the mammogram results to the designated PCP. Some allow walk-in mammograms; others do not.

Hennepin Health encourages PCPs to stress to their patients the importance of having a mammogram. This has been communicated through the Hennepin Health provider website, including the provider bulletin. The greatest opportunity for Hennepin Health to address breast cancer screening is to encourage members to seek preventive health care services and establish a primary care relationship. Hennepin Health continues to work with its providers on strategies to increase preventive health visits for this population.

As stated above, Hennepin Health continues to implement communication strategies to encourage members to seek preventive health care visits and receive appropriate screenings. Hennepin Health has implemented a member breast cancer screening incentive, effective 4<sup>th</sup> quarter 2019 and ongoing. Postcards will be mailed to eligible women who have not received a mammogram in 2019 informing them of the gift card incentive. The incentive information will be posted on the Hennepin Health website as of January 1, 2020.

F&C – MA and SNBC Comprehensive Diabetes Care – Eye Exam: Hennepin Health has placed specific focus on diabetes care in recent years, in particular focusing on the diabetic eye exam. Hennepin Health continues to work with HHS and NorthPoint providers aimed at improving health for those living with diabetes. Provider education regarding the importance of encouraging members to have an annual eye exam via the Hennepin Health Provider website has been conducted. During HEDIS medical record chart abstraction for HHS, it was identified that frequently the eye exam appointment has been scheduled for the member and the member is either a “no-show” or cancels the eye exam without rescheduling the eye exam. HHS provides eye exams only at the downtown Minneapolis Clinical Specialty Center which requires members to come to the downtown clinic location for the eye exam. This is often inconvenient for the members who receive their diabetic care through a community clinic location.

Effective 4<sup>th</sup> Quarter 2019 and ongoing, Hennepin Health has initiated a health care reward for members who complete a diabetic eye exam during the year. Members are eligible to receive a gift card annually when completing a diabetic eye exam. Postcards will be mailed to members with a

diagnosis of diabetes who have not completed an eye exam in 2019 informing them of the gift card incentive. The incentive information will be posted on the Hennepin Health website as of January 1, 2020.

F&C – MA Comprehensive Diabetes Care – HbA1c Testing: Hennepin Health has placed specific focus on diabetes care in recent year. In addition, Hennepin Health works with members to establish health care homes as stated above. Hennepin Health continues to work with HHS and NorthPoint providers aimed at improving health for those living with diabetes. Provider education regarding the importance of members who have diabetes to be seen annually by their PCP for diabetic care via the Hennepin Health Provider website has been conducted.

Effective 4<sup>th</sup> Quarter 2019 and ongoing, Hennepin Health has initiated a health care reward for members who have their HbA1c test during the year. Members are eligible to receive a gift card annually when a HbA1c test has been completed. Postcards will be mailed to members with a diagnosis of diabetes who have not had HbA1c testing in 2019 informing them of the gift card incentive. The incentive information will be posted on the Hennepin Health website as of January 1, 2020.

- **2017 Recommendation: CAHPS (Member Satisfaction)** – Hennepin health should conduct thorough root cause analyses for the measures listed above and implement target interventions to address identified barriers. Hennepin Health should also utilize complaints and grievances to identify and address trends that may impact the member-health plan experience.

**MCO Response:** Hennepin Health’s members’ experience is of critical importance to Hennepin Health. Hennepin Health monitors and uses the CAHPS results and grievance data to identify areas where Hennepin Health is doing well and areas in which Hennepin Health could improve. Strategies implemented take into consideration the member perception in receiving and obtaining health care and services. Hennepin Health also takes into consideration the member perception and experiences when dealing with the Hennepin Health plan. These experiences significantly impact member satisfaction.

Rating of Health Plan: Beginning in 2016, Hennepin Health conducted a root cause analysis of CAHPS and grievance data. In 2015, Hennepin Health moved to new software claims system, resulting in claims payment delays which increased both provider and member dissatisfaction. Hennepin Health implemented several corrective action plans to improve timeliness and accuracy of claims payment.

The Hennepin Health Customer Service Department underwent structural changes in 2016. The Customer Service Department was divided into two areas – Member Services and Provider Services. Training in these new roles and responsibilities was conducted for staff. New Customer and Provider Service staff were added in 2017 due to the influx of new members when Medica exited from the F&C

– MA market. With the influx of new members, Member Services call volumes significantly increased which decreased member satisfaction with Hennepin Health as members were experiencing long wait times. In 2018, a post-call satisfaction survey process was initiated for members who complete a call to the Hennepin Health Member Services. Initial data reveals that members are satisfied with the Hennepin Health Member Service experience.

The Hennepin Health F&C – MA provider network was limited when compared to other health plans offering the F&C – MA product. Members could only receive health care services at Hennepin Healthcare (formerly Hennepin County Medical Center), NorthPoint Health and Wellness Center and North Memorial. Members who were auto enrolled into the Hennepin Health F&C – MA product were often dissatisfied with the limited provider network as identified through the Hennepin Health grievance data. In addition, the members would contact the Department of Human Services Ombudsman Office to express their dissatisfaction with the limited provider network. Fairview Health System was added to the Hennepin Health F&C – MA provider network, effective January 1, 2019. The impact of the addition of the Fairview Health System to the F&C – MA network is currently under evaluation. Hennepin Health has seen fewer grievances related to the provider network in 2019.

Rating of All Health Care: As stated above, the Hennepin Health F&C – MA provider network was limited in comparison to other health plans offering F&C – MA product. Members could only receive health care services at Hennepin Healthcare (formerly Hennepin County Medical Center), NorthPoint Health and Wellness Center and North Memorial. This also limited the specialists available to the Hennepin Health F&C – MA product. Members who were auto enrolled into the Hennepin Health F&C – MA product were often dissatisfied with the limited provider network and specialty network as identified through the Hennepin Health grievance data. In addition, the members would contact the Department of Human Services Ombudsman Office to express their dissatisfaction with the limited provider network. Fairview Health System was added to the Hennepin Health F&C – MA provider network, effective January 1, 2019. The impact of the addition of the Fairview Health System to the F&C – MA network is currently under evaluation. Hennepin Health has seen fewer grievances related to the provider and specialty provider network in 2019.

Getting Care Quickly: Hennepin Health analyzed data from various sources such as grievance data and Hennepin Healthcare patient experience data relating to getting care quickly. As stated above, the Hennepin Health F&C – MA provider network was limited in comparison to other health plans offering F&C – MA product. Members could only receive health care services at Hennepin Healthcare (formerly Hennepin County Medical Center), NorthPoint Health and Wellness Center and North Memorial. This also limited the specialists available to the Hennepin Health F&C – MA product.

Grievance data analysis revealed that members were dissatisfied if they did not receive an appointment to see a specialist as quickly as they wanted it. Generally, the appointments to the specialist were available within the accepted timeframes outlined in the Department of Human

Services F&C – MA contract. In those instances, Hennepin Health would work with the Primary Care Clinic that initiated the specialty referral to obtain a referral to another specialty clinic that could see the member sooner.

Hennepin Health conducts an annual appointment access and availability survey to assess the availability of the network and to ensure providers are following standard guidelines for network adequacy. To determine gaps and the need for additional providers, Hennepin Health continues to analyze the provider network for access across primary care, specialty and behavioral health. Fairview Health System was added to the Hennepin Health F&C – MA provider network, effective January 1, 2019. The impact of the addition of the Fairview Health System to the F&C – MA network is currently being evaluated. Hennepin Health has seen fewer grievances related to appointment availability in 2019.

Shared Decision-Making: Analysis revealed that discussing why or why not to take a medication with a doctor or other health care provider was a critical factor in this measure. In collaboration with HHS, a pharmacy project was initiated in 2019. For this project, pharmacy residents at HHS meet with Hennepin Health members when hospitalized or at the clinic to review and discuss medications which identifies the right combination of medication to help members feel better. This activity has resulted in fewer readmissions due to medication issues and increased member satisfaction.

In July 2019, Hennepin Health added to its member website a vendor based link to Healthwise.com which is a community standard and leader in providing detailed, easy to understand information about health conditions and preventive screenings in both English and Spanish. Information about shared decision-making when deciding on treatment options is available through the Healthwise.com link.

---

## ITASCA MEDICAL CARE (IMCARE)

---

- **2017 Recommendation: Financial Withhold** – IMCare’s response to the previous year’s recommendations includes descriptions for a range of activities that aim to increase annual dental visits. IMCare should continue with this strategy for dental care and monitor the effectiveness of each initiative. IMCare should ensure that the reduction of hospital admissions is an organizational priority and that current initiatives aimed at reducing admissions continue.

**MCO Response:** What has the MCO done/planned to do to address each recommendation? IMCare’s dental rates, while not meeting the withhold threshold, continue to be well above the state average; in addition, Annual Dental Visits were at the 50<sup>th</sup> percentile nationally. IMCare will continue to implement several dental measures to promote dental access and utilization including, but not limited to the following:

- In partnership with Itasca County Public Health, IMCare Network Dentists and other community partners, IMCare formed the Itasca County Dental Access Subcommittee, to identify barriers to dental care for residents of Itasca County and work towards solutions.
- IMCare Dental Committee met on several occasions to identify outreach opportunities within their practice.
- IMCare provided each network dentist with a list of enrollees who had previously received a dental visit in 2015, 2016 or 2017, but had not yet received a visit in 2018. The dental offices did outreach to those enrollees to try and get visits scheduled.
- IMCare sent individual mailings to all enrollees who had not received a dental visit in 2018, educating them about the importance of oral health, provided them with transportation information and a list a network dental providers.
- IMCare developed a list of currently enrolled individuals who have not had any dental care in the last three years and made reminder calls, to offer information about scheduling a dental visit.
- IMCare attended the Community Connect event in October 2018 and provide information about annual dental visits and other preventative care services.
- IMCare developed a Dental Integrated Care System Partnership (ICSP), which is a pay-for-performance quality project that may further incentivize network dentists to assist in increasing our dental utilization rates and in-turn earn our 2018 withhold.
- Senior Care Coordinators addressed Dental status with enrollees at annual Health Risk Assessment visit, and followed up at six months with reminder.

When and how will this be accomplished? The above interventions have already been implemented and IMCare will determine whether to repeat or continue such interventions when the final Dental withhold measures are released.

What are the expected outcomes or goals of the actions to be taken? Increased annual dental visit rate for both HEDIS ADV and the DHS dental rate.

What is the MCO's process for monitoring the action to determine its effectiveness? As noted above IMCare will evaluate the outcome measures to determine if they were effective.

- **2017 Recommendation: HEDIS (Quality of Care)** – IMCare demonstrates an overall opportunity for improvement in regard to women's health. IMCare should determine if there are access issues and/or quality of care issues negatively impacting preventive screenings for women. At a minimum, IMCare should routinely educate its female membership on the importance of preventive screenings and remind primary care providers and OB/GYNs of the recommended screenings and the frequency of such screenings.

**MCO Response:**

What has the MCO done/planned to do to address each recommendation?

- Enrollee newsletters were sent out in the Spring and Fall 2017. Article topics included information about preventive wellness visits and recommended screenings for females, vaccines, chronic medical conditions.

When and how will this be accomplished?

- Preventative health information will be added to the IMCare website and will consider breaking down information by age group.
- Added a section to newsletters on women's health, to include recommended screenings.
- Providing age-appropriate screening education with MSHO/MSC+ members at Health Risk Assessment visit.

What are the expected outcomes or goals of the actions to be taken?

- Increase of percentages of women completing recommended screening exams to include Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening in the F&C-MA population
- Increase in percentage of women completing Breast Cancer Screening in MSHO/MSC+ population

What is the MCO's process for monitoring the action to determine its effectiveness? Evaluating 2018 HEDIS data.

---

## MEDICA

---

- **2017 Recommendation: Financial Withhold** – Medica should monitor the impact of the SNBC Dental Access and Improvement Project and identify initiatives that are transferrable to the MSHO and MSC+ populations. Medica should identify solutions for the capturing of member insurance information at partnering free dental clinics.

**MCO Response:** Medica has identified dental access as a priority for our members. Medica has taken the lead on the SNBC Dental Access and Improvement project for the past three years, working closely with the other Managed Care Organizations to implement initiatives designed to improve the rate of members accessing dental services. Interventions implemented by the collaborative include: provider surveys and interviews with dental experts working with the disabled population to gather input on barriers to care; education and outreach with the dental provider community and care coordinators; and continued work and partnership with the DHS Dental Care and Treatment Clinics.

Medica has incorporated the learnings and intervention with Care Coordinators and extended it across all products. We have implemented internal initiatives aimed at providing member education and support for locating a dentist within their area and securing appointments. Medica provides care coordinators quarterly gap in care lists that identify MSHO, MSC+ and SNBC members who had a gap in an annual dental visit. Care Coordinators are equipped to educate members about the importance of regular preventive dental care, and addresses any barriers the member may be experiencing. Care Coordinators are trained to utilize Medica’s Dental Benefits Manager (Delta Dental) to assist members to find a provider and to secure an appointment if that level of help is needed.

In addition to Care Coordinator outreach, Medica has leveraged the expertise and resources of Delta Dental to provide telephonic outreach to MSHO members who had a gap in care for dental services. A dedicated team at Delta Dental then assists members to find a dental home and schedule a dental exam.

Capturing member information at free dental clinics is something that will require partnership with the groups who organize the clinics. Medica will explore a partnership with one of these clinics, and work with the organizers to identify barriers to collecting the information needed. Medica will discuss options with the collaborative group of Managed Care Organizations currently working with the SNBC Dental Access and Improvement Project, as a collaborative approach to this intervention may work best for the clinic organizers.

- **2017 Recommendation: HEDIS (Quality of Care)** – Medica demonstrates an overall opportunity for improvement in regard to women’s health. Medica should include cervical cancer screening in all of the improvement activities described in its response to the previous year’s recommendation. Medica

should also leverage its relationship with the American Cancer Society to identify best practices of health plans with similar memberships.

**MCO Response:** Medica staff continued efforts to improve women’s health, including Breast and Cervical Cancer Screening rates. Actions implemented in 2017 and 2018 designed to help improve cancer screening rates include: gaps in care mailings that provide members with individualized information about gaps in preventive care and work with the American Cancer Society to implement cancer screening initiatives in clinics. The gaps in care mailing includes education on the importance of screening and resources to help the member schedule an appointment.

Medica continues to collaborate 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.

Other interventions continued including: total cost of care clinic quality measures in provider contracts; provider newsletter articles and member newsletter articles twice per year highlighting the importance of preventive care. These interventions have led to an increase in Medica’s Cervical Cancer Screening rate for SNBC members, which shows an increase from 41.4% in 2017 to 57.91% in 2019.

Medica’s Quality Improvement (QI) program supports our mission to meet our customers’ needs for health plan products and services. The QI program’s purpose is to identify and implement activities that will: Improve member care, service, access and/or safety; Improve service to providers, employers, brokers and other customers and partners; and/or Improve Medica’s internal operations. Our QI program encompasses a wide range of clinical and service quality initiatives affecting our members, providers, employer and brokers, as well as internal stakeholders throughout Medica. The Quality Improvement department at Medica compiles the QI Work Plan with input from business units and stakeholders throughout Medica. The QI Work Plan is intended to highlight significant activities with potential to influence clinical quality, service quality, provider quality and safety for our members, including members in Medica’s current Medicaid products: MSHO, MSC+ and SNBC.

- **2017 Recommendation: CAHPS (Member Satisfaction)** – As SNBC member satisfaction with customer service has steadily declined, Medica should consider ways of obtaining member feedback shortly after the member’s interaction with health plan staff to ensure member issues are addressed in an expedited fashion. Member feedback should be captured and reviewed to identify specific elements of the customer experience that can be modified.

**MCO Response:** Medica offers surveys to our Medicaid members immediately following their interaction with a Medica customer service representative. This has traditionally been conducted with our customer service lines, and beginning in June, 2019 includes both customer services as well as our

provide-a-ride transportation lines. The survey results are reviewed by customer service leadership, who look for trends and opportunities for staff education and training. In addition, Medica has implemented other improvements that have focused on the member experience, such as:

- 100% call recording of all member interactions for quality and training purposes
- Use of member survey feedback at the individual Customer Service staff level to provide coaching and individualized training
- Increased overall headcount of Medicaid-trained staff to improve wait times and minimize seasonal spikes
- Additional auditing and monitoring oversight by Medica Quality Assurance and Gov't Programs Leadership Teams
- Including Medica Customer Services staff in Bi-Annual Member Advisory Meetings so that Members are able to provide feedback on their experience.

Medica's mission is to be the trusted health plan of choice for customers, members, partners and our employees. We are committed to using each phone call we receive in our Customer Service Call Center as an opportunity to educate the member about how to use his or her health benefits most effectively. We also use this as an opportunity to give the member a sense of confidence about using their benefits.

We have a separate committee reviewing results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS), including the Medicaid CAHPS results from DHS. This committee covers all business areas that conduct CAHPS reporting that trends member satisfaction across segments. Member satisfaction with care coordination is conducted annually with members. Survey results are compiled and analyzed by Medica and reported to clinical and segment leadership for intervention. Our multifaceted approach to measuring member satisfaction provides a strong foundation to identify what is working and what may need improvement. It is through our ongoing monitoring and evaluation activities coupled with a rigorous culture of structured performance improvement and accountability that we are able to make sustainable improvement.

---

## PRIMEWEST HEALTH

---

- **2017 Recommendation: Financial Withhold** – In regard to dental care, PrimeWest should continue with the robust quality improvement strategy described in its response to the previous year’s recommendation. Initiatives should be routinely monitored for effectiveness. PrimeWest should ensure that reducing hospital admissions and the increasing well-child visits are maintained as organizational priorities and that successful interventions continue.

**MCO Response:** IPRO recommends that PrimeWest Health continue our robust quality improvement strategy focusing on dental care with routine monitoring of our initiatives. PrimeWest Health monitors the effectiveness of our initiatives through the following means:

- **Inclusion of annual dental visit in ARCH efforts:** PrimeWest Health continues to collaborate with our Accountable Rural Community Health (ARCH) providers to demonstrate internal person-centered care management that effectively facilitates coordination and integration to improve health outcomes, including dental care. PrimeWest Health uses these arrangements to reach out to members who use the emergency room (ER) for dental symptoms. PrimeWest Health provides our ARCH providers with quarterly risk lists that identify members who could benefit from assistance with coordinating their medical, behavioral, and dental care.
- **Deployment of mobile dental outreach clinic services:** PrimeWest Health currently contracts with three dental clinics that provide outreach dental services to PrimeWest Health members via mobile dental clinics. PrimeWest Health will increase our outreach calls to members (across all age groups) who have not accessed dental care and are residing in or near a community where a mobile dental outreach clinic will be held. Our increased mobile dental outreach clinics in identified areas of need help decrease the need for transportation to dental appointments and reduce members’ time away from work.
- **Provision of oral health education and support at the member, provider, and county levels:** PrimeWest Health collaborates with two dental providers to provide educational outreach in communities. These providers donate educational information and materials for teachers and Public Health to use with children, including oral health demonstration models, displays, toothbrushes, and lesson plans, all to support oral health education for continued and improved overall health. This outreach brings the oral health message full circle and further supports the idea that oral health is integral to overall health. PrimeWest Health provides periodic oral health education information to members through newsletters and mailings. We also offer additional preventive dental care, including coverage of a second dental cleaning per calendar year and a third and fourth dental cleaning when medically necessary.
- **Development of a Dental Care Management Program to facilitate timely and convenient access to comprehensive dental care, to help members establish dental homes and to promote good oral health:** Beginning in 2017, PrimeWest Health transitioned the process of identifying members seeking dental care in the ER each month and offering help finding a

- dental home to Care Management care coordinators to further integrate oral health with overall health. PrimeWest Health makes outreach calls to member who are in the area of upcoming mobile dental outreach clinics, including those members who have recently used the ER and those who have not had a dental visit in the preceding nine months. PrimeWest Health has a Dental Services Coordinator who coordinates dental care for members directly with dental providers. Further refinement to the oral health component of the Care Management program included providing members timely access to a care navigator or the Dental Services Coordinator for one-on-one assistance with their dental needs and concerns.
- **Participation in the Minnesota Department of Human Services (DHS) Special Needs BasicCare (SNBC) Dental Access Improvement and Evaluation Project:** PrimeWest Health participated in this program with other health plans and DHS to learn more about the dental habits of our SNBC members, mitigate barriers to service, and offer support leveraging the relationship and trust between case managers and members. While each health plan's case management model varies slightly, they all have two common components: the expertise at the health plan; and trained and knowledgeable case managers. Through this project, PrimeWest Health and the other health plans collaborated with DHS to conduct statewide trainings for the case managers and care coordinators. Beginning in 2018, SNBC members who have not had a dental visit in the last 12 months receive additional outreach and education as part of the participation in the DHS SNBC Dental Access project.
  - **Utilization of new member survey:** PrimeWest Health Dental Services Coordinator continues to place outreach phone calls to Families and Children and MinnesotaCare members who indicate on the new member survey that they have not had a dental visit in the last 12 months. During the call, the Dental Services Coordinator offers to help make an appointment and provides education about the importance of an annual dental visit.
  - **Provision of an educational program for nursing home staff:** PrimeWest Health continues to provide education for staff at nursing homes where our members reside, promoting mobile dental clinics and offering materials that support the importance of oral health.
  - **Collaboration with Head Start:** PrimeWest Health continues to collaborate with all Head Start programs operating in our 13 counties. These relationships allow us to offer educational resources about the importance of oral health for Head start staff and Head Start children and families. PrimeWest Health sees this as an important relationship that allows us to coordinate routine on-site dental services for Head Start children, as well as coordinating necessary treatment and follow-up care.
  - **Collaboration with other external partners:** PrimeWest Health continues to participate with the Minnesota Oral Health Coalition and local oral health promotion activities, including the Early Childhood Dental Network (ECDN), Early Childhood Dental Network Southwest (EDCN-SW), and the Head Start Advisory Council. These external relationships are necessary to keep statewide oral health concerns in the forefront of each community.

PrimeWest Health set a goal to improve members' oral health and access to care by decreasing the number of members using the ER for oral health symptoms to 1.3 per 1,000 member months (MM) each quarter. PrimeWest Health not only met our goal, we continued to increase utilization of dental services by our members. We directly attribute our success in reducing ER use for oral health symptoms to the continued increase in dental access and utilization of preventive, diagnostic, and restorative dental services with the above-stated initiatives. Additionally, for the Annual Dental Visits (ADV) Healthcare Effectiveness Data and Information Set (HEDIS®) measure, rates have improved for the following age groups from HEDIS 2018 to HEDIS 2019:

- 2 – 3 years increased from 34.86 percent to 36.95 percent
- 4 – 6 years increased from 58.77 percent to 60.04 percent

PrimeWest Health continues to work with county case managers to help maintain progress in reducing hospital admissions and increasing well-child visits. These remain priorities in our strategic plan and interventions continue.

- **2017 Recommendation: HEDIS (Quality of Care)** – In regard to women's health and child health, PrimeWest should continue with its "five-year strategic plan" for organization-wide improvement. PrimeWest should ensure that diabetes care is included in its strategic plan as well.

**MCO Response:** IPRO recommends that PrimeWest Health continue to focus on women's health and children's health in our five-year strategic plan.

- **Childhood Immunization Status (CIS):** PrimeWest Health currently sends personalized immunization schedules to families, letting them know when their babies are due for their next vaccines. We hope this personalized information will be more effective than generic education. We continue with educational materials for members and providers. Also, in 2019, PrimeWest Health notified providers about a free app that provides comprehensive vaccine information they can use when working with patients. The PrimeWest Health CIS Combo 10 measure increased from 28.22 percent in HEDIS 2017 to 34.31 percent in HEDIS 2018 and to 35.04 percent in HEDIS 2019.
- **Chlamydia Screening in Women (CHL):** PrimeWest Health works hard to educate our providers and members about the importance of chlamydia screening. We worked with the Minnesota Department of Health (MDH) to coordinate provider trainings at several of our clinics in 2018. We also started two pilot projects in 2019. One involves working with a third-party lab to send at-home testing kits to our members, and the other involves allowing direct access for chlamydia screening at one of our network hospital labs. The effectiveness of these interventions will be evaluated at the end of 2019. The PrimeWest Health CHL rate increased from 37.83 percent in HEDIS 2017 to 39.98 percent in HEDIS 2018 and 41.60 percent in HEDIS 2019.

- **Adolescent Well-Care Visits (AWC):** PrimeWest Health has an incentive program for well-child visits for members ages 12 – 21 in which members can earn a \$25 gift card for completing the service. PrimeWest Health also has seen an increase in our well-child visit rates due to clinic electronic medical record (EMR) systems that ask screening questions related to mental development and anticipatory guidance at all visits. These count towards the HEDIS measure in medical record review. The PrimeWest Health rate for HEDIS 2017 was 44.77 percent; the HEDIS 2018 rate was 59.61 percent. Unfortunately, in HEDIS 2019 our rate decreased to 52.07 percent. In 2019, we increased the incentive amount offered for this service from \$25 to \$50. We will continue to monitor this measure.
- **Breast Cancer Screening (BCS):** PrimeWest Health includes breast cancer screening in our incentive program and in our ARCH program. Members ages 50 – 74 can earn a \$100 gift card for receiving a mammogram. Additionally, ARCH providers can earn shared savings for reaching their goal in this area. PrimeWest Health has seen an increase in BCS rates over the years: HEDIS 2017 was 65.23 percent, HEDIS 2018 was 68.35 percent, and HEDIS 2019 was 67.65 percent. PrimeWest Health is also working with the American Cancer Society to have a provider panel discussion at our Fall Provider and Partner Conference in 2019.

PrimeWest Health’s strategic plan contains interventions related to diabetes care as that remains a priority as well.

---

## SOUTH COUNTRY HEALTH ALLIANCE (SCHA)

---

▪ **2017 Recommendation: Financial Withhold –**

- As dental care continues to be an area of concern across all programs, SCHA should routinely evaluate the effectiveness of the improvement strategy described in its response to the previous year’s recommendation and modify the approach as needed. SCHA should continue to address access and also consider non-traditional ways of increasing access. For remote areas of the state, SCHA should consider the use of mobile dental services, or hosting local dental fairs where members can receive care, or contracting with bordering out-of-state dental providers.
- As well-child visits in the first 15 months trends upward, SCHA should continue with the improvement strategy described in its response to the previous year’s recommendation. SCHA should enhance this strategy by including member education on the importance of well-care visits and the components of the well-care visit for each age.
- SCHA should investigate the increase in hospital admissions and consider implementing a robust strategy that includes member education, member support for scheduling primary care appointments, member transportation to primary care appointments, urgent care resources, etc.

**MCO Response:**

Dental Care: Dental access remains a challenge for all Minnesota Government Programs. South Country Health Alliance (South Country) has strived to improve dental access through innovative solutions including increased reimbursement rates to providers, increased non-pregnant adults’ preventive dental benefits and community-based reinvestment grants.

A SNBC Dental Access Improvement Project was implemented in 2017 to address dental access issues among SNBC enrollees. Interventions developed as part of that project are also applicable to other populations served by South Country, particularly seniors. In addition, South Country piloted an incentive program in 2018 whereby seniors and SNBC members who complete an annual dental visit have the opportunity to earn a gift card reward.

Early in 2017, South Country developed an internal workgroup to analyze our dental network. During the workgroup South Country’s staff reviewed each county separately by evaluating the locations where members were going to receive their dental care. This information was used to assess the effectiveness of our dental provider network and to identify gaps in geographical access to care. Identified areas received targeted outreach by our dental program manager. (This information was also very useful in our decision, later in the year, to partner with Delta Dental.)

In 2017, South Country’s Dental Program Manager targeted dental providers by completing onsite visits in the following cities: Long Prairie, Wadena, Menasha, Staples, Pillager, Deerwood, Little Falls, Rush City, New Ulm, Springfield, Sleepy Eye, Winthrop, Gaylord, Arlington, Mankato, Faribault, Blooming Prairie, Byron, Rochester, Kenyon, Cannon Falls, LeCenter, Albert Lea, Kasson, Goodhue,

Red Wing, Lake City, and Wabasha. The purpose of the visits was to retain and recruit dental providers. Information was supplied and questions regarding the MCO and TPA were answered. Topics included: benefit sets, reimbursement, prior authorization requirements, claims submission, county-based purchasing and general information regarding South Country.

During the summer of 2017, South Country's Dental Program Manager attended the following meetings: Brown County Early Childhood Dental Network Meeting and the Minnesota Oral Health Coalition's Oral Health Summit. She also presented at the Odyssey Conference regarding the SNBC dental project.

In December of 2016, the prior authorization (PA) requirement of proving medical necessity for 3rd and 4th dental cleanings was removed for SNBC members. In September 2017, South Country added MSHO members to this PA exemption to assist members that would be transitioning from SNBC to MSHO. This was done to ease administrative burden for dental providers and to improve access to preventive care for our members.

In the fall of 2017, South Country began the process of changing dental benefits administrators. We were informed by DentaQuest that they were not renewing our contract for 2018. An internal workgroup was formed to determine the best course of action for South Country. After reviewing several different options, a decision was made to contract with Delta Dental of MN (DDMN) as part of their CivicSmiles network. The advantage of choosing DDMN was that approximately 80% of our key dental providers were already contracted with this network. Therefore, providers would not have to go through the contracting and credentialing process. We held many meetings with DDMN to determine the best strategy for recruiting dental providers that were not contracted. South Country's Dental Program Manager visited dental offices with representatives from DDMN to recruit and assist providers with the transition. As a result, we had several dental clinics join the CivicSmiles network to continue to serve South Country members. We also gained a larger network by adding those providers that were not contracted by DentaQuest. Great efforts were made to make the transition as seamless as possible for providers, including keeping their reimbursement as consistent as possible, with our change in dental benefits administrator.

South Country continues to improve dental contract opportunities; South Country currently contracts with approximately 45 dental providers in the surrounding states.

South Country provided articles in several of our Provider Network News. In the winter 2017 Provider Network News, an article regarding Free Continuing Education for Dental Providers by DentaQuest was published.

DentaQuest launched an online learning resource focused on prevention and disease management, dental practice improvement, and technical assistance. The Dental Learning Center allows dental

professionals to earn continuing education units for completing learning modules on prevention, disease management, and the effective management of safety-net dental programs. The site includes an eight-module, self-paced curriculum on prevention and disease management of caries, from birth to maturity. Seven practice management modules will be released this summer. Dental providers can sign-up for free access to all learning resources. Go to [www.dentaquestinstitute.org/learn](http://www.dentaquestinstitute.org/learn).

In the summer 2017, Provider Network News, South Country published information on the Collaborative Special Needs BasicCare (SNBC) Dental Access Improvement Project providing information to providers on how South Country is partnering with Minnesota Managed Care Organizations to improve dental visit rates.

South Country Health Alliance is partnering with Medica, HealthPartners, Hennepin Health, UCare, Prime West, and the MN Department of Human Services on a collaborative project aimed at improving dental access for Special Needs BasicCare (SNBC) members. SNBC members consist of adults 18-64 years of age who are enrolled in Medicaid and live with a certified disability. Less than half (46%) of the Managed Care Organizations (MCOs) collective membership are accessing annual dental care. The goal of this 3-5 year project is to improve the dental visit rate by creating a dental home for our members and reducing their ER use for non-traumatic dental concerns.

Targeted surveys were used to gather insight and to determine action. A survey was sent to dental providers by the group of MCOs to find out current statuses, barriers to providing care, receptiveness to the projects, and any ideas or comments.

Member survey results are being collected and analyzed at this time. This included both a user survey for members accessing dental care within the last 12 months and a non-user survey for those members who have not seen a dentist in over a year.

#### SNBC Project Interventions:

- **Case Management:** South Country's SNBC members have local Care Coordinators who will work with them to achieve their dental needs. The Case Management intervention will strengthen and enhance this existing partnership.
- **Teledentistry:** This pilot project explores telehealth as an option to increase dental access. A dental support team from a MN DCT (Direct Care and Treatment) Dental Clinic would travel to a location in the members' community to provide preventive services and gather diagnostic records that will be securely and electronically transmitted to a dentist at the DCT clinic. The dentist will then be able to do an exam remotely, and a treatment plan can be formulated.
- **Provider Mentoring:** As proven in the provider survey, there are dental providers who would welcome opportunities for education on treating special needs patients. With the guidance of an Expert Panel, consisting of dental professionals with extensive experience and a passion

for special needs dentistry, tools and curriculum will be developed to increase providers' knowledge and comfort level in delivering care to the SNBC population.

In fall 2017, Member Connection, an article was published on the, "Top Questions About the Dentist".

- Whether you are 80 or 8, your oral health is important. Regular dental exams and good oral hygiene can prevent dental disease.
  - *Why do regular dental visits matter?* Regular dental visits are important at any age because they can help spot oral health and other health problems early on when treatment is likely to be simpler and more affordable. They also help prevent many problems from developing in the first place.
  - *Are regular dental exams covered by my health plan?* Dental checkups are a covered benefit for South Country Health Alliance members. Adult members, children, teens, pregnant women, and Medicare Advantage members are eligible for two oral exams, cleanings, and fluoride treatments each year. Look in your Member Handbook or Evidence of Coverage to see what dental services are covered.
  - *When should my child start visiting the dentist?* The Minnesota Department of Health (MDH) recommends that children see a dentist within six months after their first tooth appears, around 6 to 12 months of age. Don't wait for an emergency.
  - *Do I still need regular dental visits if I wear dentures?* Seeing a dentist at least once a year is still important even if you have no remaining natural teeth. During a routine dental visit, the dentist can check for gum health, screen for oral cancer, and refit dentures as needed.
  - *How do I find a dentist?* South Country's Member Services will help you find a dental provider in your area, including general dentists, oral surgeons, and orthodontists. Member Services can also help you schedule your appointment and arrange transportation for eligible members. Call Member Services at 1-866-567-7242 (TTY/TDD 1-800- 627-3529 or 711).
  - You can also check the 2017 Dental Provider Directory to look for dental providers available to members. The directory is on our website at [www. mnscha.org](http://www.mnscha.org) ("Find a Provider"). Member Services can also send you a printed directory in the mail. Source: American Dental Association, 2017

In 2017, South Country staff met with 32 local Food Shelves in our 11 counties. The goal was to educate the Food Shelves about South Country programs, and to provided them with child toothbrushes, brushing charts, and other member materials. South Country also provided toothbrushes and brushing charts to our counties that participate in the Dental Hygienist Program.

#### Well-Child Visits in the First 15 Months of Life

For many years, South Country has implemented a comprehensive strategy to promote and improve compliance with recommended infant well-child visits. This includes a reward program that offers

parents a gift card if their child completes 6 well-child visits before 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 was in place from 2014-2017 to improve compliance with well-child visits. Through this program, key clinic systems were 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 allowed clinics and South Country to better coordinate member care and document utilization for future data collection and reporting purposes. These activities supported South Country's success with the Well-Child Visit Withhold measure, but rates appeared to have plateaued in 2016; this measure has also been eliminated by DHS effective in 2018.

South Country's Pay for Performance (P4P) programs were in place through 2017 with six health care delivery systems that collectively serve over 80% of our membership. The program provides financial incentives to provider groups for aligning efforts with South County to improve quality of care measures and health outcomes of members. A top priority for the P4P is HEDIS Infant Well-Care visits measure (6 visits by 15 months of age) requiring intense collaboration between South Country and the clinics to understand identified barriers, share data and align intervention strategies.

South Country's reward program 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 summer 2017, Provider Network News, an article PIP Infant Well-child visits was published.

South Country's "Be Rewarded!" member incentive programs encourage active parental engagement in preventive care services for young children. Eligible members can earn a gift card reward for completing at least six well-child visits before 15 months of age.

The program is based on Minnesota Department of Health (MDH) and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) practice guidelines. Our performance on this topic as a health plan is measured by state and federal regulators through the National Committee for Quality Assurance (NCQA) HEDIS (Healthcare Effectiveness Data and Information Set) Infant Well-Child measure performance standards.

Following HEDIS technical specifications, South Country determines member compliance with well-child visits through a combination of medical claims data and medical record review. The following five components must be identified in order to deem a well-child exam complete:

- Health history

- Physical exam
- Mental health history
- Physical developmental history
- Health education/anticipatory guidance

These elements can be completed during the same office visit or over multiple sick or preventive care visits, as long as they comprise six completed well-child exams prior to the child turning 15 months of age. Services that are specific to an acute or chronic condition or provided during a visit to an emergency department or inpatient hospitalization do not count towards compliancy with this performance measure.

Every spring, we complete a comprehensive medical record review process to collect data for this and other HEDIS performance measures. Our most recent review of medical records in health systems across our network yielded the following themes:

- It was noted that many of the children do receive the recommended number of well-child visits during infancy. However the sixth visit commonly falls outside the parameters of the practice guidelines – usually between the 15 month to the 18th month of life.
- 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. The lack of documentation of discussion/education makes the chart non-compliant according to 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.

Well-child visits remain an area of focus for South Country’s quality improvement program. Through collaborative arrangements with our primary care providers, we have the opportunity to learn and share best practices and gain a better understanding of the challenges providers experience in delivering well-child services to patients – including our members. We will continue to work with our network providers on efforts to improve performance outcomes for infant well-child visits, through the sharing of data and aligning performance improvement strategies.

South County staff also attend local and regional Child & Teen Checkup meetings with clinic groups and county staff to discuss strategies in assisting with and promoting Well-Child visits.

At the May 2017, South Country's Family Health Committee, which includes representation from all South County counties, the topic of W15 Well-Child Visit rates was discussed.

The importance of 6 well care visits before the age of 15 months was stressed as it is both a HEDIS measure and a withhold specification. When staff were completing medical record reviews for HEDIS, they found several clinic sites scheduling the well infant checkups and noticed that if the appointment timing got off by a couple of weeks it continued to be off. For example, if the provider noted that the infant should come back in 3 months, it could be scheduled in 2 ½ months to get back on track. However, clinics may be scheduling the appointments out further due to unavailable appointment times. Other problems with the issue of getting 6 of the 7 well infant visits before 15 months include the 9 month checkup is often skipped, as there are no immunizations due at that age, parents who do a 2 week visit may not go back until the infant is 4 months old, thus, missing the 2 month checkup, parents who do not believe in giving immunizations and do not schedule well-child visits, and children who are ill/chronically ill.

MDH gave a presentation on motivating clinics to provide CTC exams (20-minute exams) and working with RHD/FQHC. Rural Health Clinics and Federally Qualified Health Centers have indicated they may only schedule well-child visits vs. the Child & Teen Checkups as these providers receive an enhanced rate for providing the well-child visit and may get the same rate as if they had done a Child & Teen Checkup. Also, providers are pressured to keep on a timely appointment schedule and Child & Teen Checkups take longer than well-child visits to complete. South Country's Provider Relations Representative, are willing to go with public health staff when they do their annual visits with providers to provide education and assistance on this subject.

In the October 2017, South Country Member Connection, an article on the Infant Well-Care Visit Reward was published.

South Country Health Alliance rewards families for completing important infant well-care visits before 15 months of age. Well-care visits, also known as Child & Teen Checkups (C&TC exams), are important for infants because they help keep your child healthy right from the very start. These visits help track your child's growth and development, offer preventative care, and establish strong relationships with your doctor.

As part of South Country Health Alliance's Be Rewarded™ program, families can get a gift card reward when their child completes at least six well-care visits before 15 months of age. See the schedule below to stay on track.

Checklist: Infant Well-care Visits: Child to complete at least 6 out of the 7 recommended well-care visits BEFORE 15 months of age. Visits can be completed with different doctors.

- 1st visit completed between 0 - 1 month of age
- 2nd visit completed by the age of 2 months
- 3rd visit completed by the age of 4 months
- 4th visit completed by the age of 6 months
- 5th visit completed by the age of 9 months
- 6th visit completed by the age of 12 months
- 7th visit completed before the age of 15 months

In addition to the reward program, parents of eligible children were mailed information about the importance of the well-child visits alongside the reward program voucher.

#### Increase in Hospital Admissions

In summary, upon review of hospitalization data in 2017; one product, MSC + shows members overall hospitalization rate increased. Hospitalizations rose 1st Quarter, dropped to average level for 2nd quarter and rose again by the 4th quarter. South Country also reviewed the following year, 2018 hospitalization rates for MSC + members, and determined hospitalization rates were lower than average 3 full quarters of 2018.

South Country analysis revealed the primary reason for the MSC + population data showing an increase in hospitalization rates in 2017 was:

Significant increase in membership resulting in an increase of members experiencing hospitalization – there was a spike in enrollment from December 2016 to January 2017. By January 2018 membership returned to 2016 levels.

Albeit a spike in membership, the primary causation to spike in hospitalizations, South Country has launched and continues to strategize ways to ensure members receive the right service at the right place, at the right time. Some of those strategies include:

- In 2016, South Country brought Case Management Services in house from a third-party vendor; in turn has fine-tuned our process and interventions to support members.
- In 2017, South Country developed a more robust process to identify, via enhanced reporting mechanisms, member hospitalizations, length of stays, and readmissions. Subsequently South Country identified the best practice to follow up with every member post discharge. This process involves County Care Coordination, Community Care Connector, Complex Case Management, and Behavioral Health Case Management. The shared software application to communicate and document tasks was in place but enhancement in the software occurs regularly. South Country has a formal Special Health Care needs Identification Process using data and criteria to isolate member events that will prompt a personal follow up.
- In addition, in 2018, Health Information Exchange (HIE) has been a pivotal project South Country has piloted with Allina Health System in two of our counties - Brown and Kanabec.

This system offers South Country real time data alerts for member admission and discharge. This moves the follow-up contact with the member nearly 2-4 weeks sooner after discharge. On a similar note, South country southern counties (Steele and Waseca) receive real time notices within the Mayo Health System.

- In 2019, Utilization Management Prior Authorizations requirements were amended and relaxed to allow members seeking Substance Use Disorder treatment to do so without requiring a South Country medical necessity review. South Country 2020 Population Health goals address the overarching strategies to support our members access and ease to achieve outpatient treatment to offset their need to access ER.
- **2017 Recommendation: HEDIS (Quality of Care)** – Overall, SCHA should continue with the initiatives described in its response to the previous year’s recommendation. In addition, SCHA should investigate the notable decline in diabetic eye exams in the MSHO program and consider ways to expand the chlamydia screening improvement strategy.

**MCO Response:**

MSHO Diabetic Eye Exams

South Country provides Disease Management (DM) services for members with selected chronic conditions. The programs are designed to meet NCQA requirements according to the “Standards and Guidelines for the Accreditation of Health Plans”. The Disease Management programs are known as the Step Up! For Better Health program, in order to engage more members, and provide a positive platform for members to become involved.

The “opt-in” Step Up! For Better Health program at South Country is member-driven, and utilizes curricula that prompt members to practice self-management. The program emphasizes intense work for a short time with members who are at risk for hospitalization and emergency department (ED) usage. Step Up! For Better Health has three sub-programs including Diabetes, Heart Failure, Asthma (Adult and Child). Registered Nurses licensed in the State of Minnesota conduct all programs and are highly knowledgeable in the selected content areas.

DM Coordinators are focused on providing a holistic approach for all participants, following evidence-based practice guidelines, while considering the unique needs of South Country members. The curricula for the programs encourage participants to actively participate in their care and are designed to go through the “steps” of the disease (diabetes) from understanding the disease processes, to taking preventative measures to avoid complications.

South Country’s Diabetes Disease Management program provides information to diabetic members regarding the importance of diabetic eye exams. During outreach calls, members are asked if they had had an eye exam within the past two years. A reminder letter is mailed to members who did not have an eye appointment as a reminder of the importance of an eye exam.

To be eligible for the diabetes program a member must be 18 years of age or older; members younger than 18 are considered on an individual basis. Diabetes participants cannot have end stage renal failure, be on dialysis, have steroid-induced or gestational diabetes, or polycystic ovary syndrome.

In 2017, South Country continued the approach of offering the program to eligible members approximately two times a year, and we did see an increase of opt-in enrollment this year.

The Centers for Medicare and Medicaid (CMS) uses Star Ratings to score and rank Medicare Advantage health plans according to the quality of services they offer Medicare beneficiaries. CMS rates health plans on a one to five star scale representing the highest quality. In 2017, South Country received a 4 STAR rating for our MSHO population in the area of Staying Healthy-Diabetes Care- Eye Exam. In 2018, South Country increased Staying Health- Diabetes Care- Eye Exam to a 5 STAR rating for our MSHO population.

#### Chlamydia Screening

Starting 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.

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.

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.

Identified strategies to improve member satisfaction for 2017 included 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.

In 2017, South Country's Young Adult Well-Visit voucher has been changed to include an additional \$25 bonus for the member having a Chlamydia screening at the time of their well visit. The importance of the Chlamydia screening was stressed as STD's are on the rise in rural counties for both males and females. A new educational flyer, Chlamydia screening, was developed at South Country and are being sent to members in their monthly target mailings of Young Adult Well-Visit vouchers. Family Health County Committee members indicated they get lots of information from MDH regarding HPV, however, do not receive much regarding Chlamydia and there was positive feedback noted from counties.

In 2018, South Country continued to provide the additional \$25 bonus for members having a Chlamydia screening.

---

## UCARE

---

▪ **2017 Recommendation: Financial Withhold –**

- UCare should continue with its strategy to improve dental care. UCare should consider collaborating with other MCOs to identify and address common barriers.
- As UCare has demonstrated improvement with hospital admissions, effective interventions should be leveraged to address readmissions.

**MCO Response:** UCare’s workgroup is dedicated to improving access to dental providers, and in 2018 and beyond, UCare conducted a number of different initiatives to try to improve this rate. Intervention strategies that were implemented to improve efforts for dental access included:

- A Member Engagement Specialist, who provided telephonic outreach to members who had a gap in care for dental visits. The specialist helped members to find a dentist and get transportation scheduled. Members who were not reached via phone received an educational letter about the importance of scheduling a dental exam.
- UCare’s delegate, Delta Dental, provided additional telephonic outreach to members who had a gap in care for dental services and assisted members to find a dental home and schedule a dental exam.
- Interactive Voice Response (IVR) call campaigns to educate members on scheduling preventive dental exams.
- An emergency room diversion letter is sent to members who had a non-traumatic dental visit within the year on how and where to find appropriate care. Members also received a phone call from an Outreach Specialist (a new position) to provide education on appropriate care and to schedule a follow-up dental exam.
- The mobile dental clinic, in conjunction with the University of Minnesota School of Dentistry, provided services in Greater Minnesota. Outbound and IVR calls were conducted to assist members with scheduling on the mobile dental clinic due to the limited number of providers accepting new patients and the associated Medicaid reimbursement.
- Care coordinator training to educate on the importance of scheduling annual dental exams for members. Care coordinators were trained on how to use Delta Dental to assist with finding dental homes for members.
- A dental postcard to hand out to members through care coordinators as well as conferences and events to educate members on their dental benefits.
- UCare provided a dental incentive to members to engage with them on getting in to see their dental provider.

Following is a description of a few key strategies UCare employed in 2018 to address and reduce admissions and readmissions:

- Minnesota Restricted Recipient Program (MRRP): UCare maintained a high rate of enrollment of members in this program throughout calendar year 2018, with an average monthly

enrollment of over 575. In 2018, we analyzed health care utilization of members who were enrolled in the MRRP within the reporting period of calendar year 2017. Overall, health care utilization was lower for members after the date of restriction. Emergency room visits decreased by 46%, inpatient hospitalization trended down by 53%, office visits dropped by 28% and prescriptions were 25% fewer.

- Special Health Care Needs Program: The intent of this program is to identify members with special health care needs, offer and provide case management services as appropriate, assist with access to care and monitor their treatment plans. All Minnesota Health Care Programs (MHCP) members are eligible for case management through this program. UCare identifies adults and children with special health care needs by regularly analyzing claims data for specific diagnoses and utilization patterns as well as through screenings, requests for services and other mechanisms or "triggers." Analysis in 2018 demonstrated that inpatient length of stay exceeding seven days decreased by 4% year over year, while hospital readmissions within 14 days for a similar diagnosis increased by 8% year over year based on members/1000. Type 1 diabetes, mental health and substance use disorder diagnoses were the number one reason for readmissions in 2018. In April 2018 UCare implemented an Integrated Case Management Program that identifies members with co-occurring mental health and medical conditions. With mental health and substance use disorder diagnoses leading the readmissions category, this program may help to address this need. Preliminary data demonstrated that per member per month (PMPM) was reduced by 26.2% due to the reduction in emergency department and inpatient hospitalizations.
- Transitions of Care: UCare care coordinators assist members with all care transitions, and UCare continues to work to improve transition of care (TOC) documents and processes that assist care coordinators in this work. To prevent readmissions, case managers provide education for members or responsible parties about transitions and how to prevent future transitions, to prevent re-admissions.

UCare conducts annual TOC reviews to monitor compliance with transitions of care processes and identify the need for potential process modifications. UCare's goal is that care coordinators strive to be 100% compliant with each element. UCare has maintained this review for the past several years. 2018 analysis of 2017 data findings showed varying degrees of compliance with the transition of care requirements. Many areas show a decrease in compliance, which in part may be attributed to missing information in logs. This is not noted in particular to one delegate, but across delegates. Compliance with required elements ranged from 76% to 100% as compared to 85% to 100% in the previous year. In 2019, UCare provided this information to care coordinators and care coordination delegates. Compliance improvement is discussed in newsletters and at meetings with care coordination partners led by the Clinical Care Systems Liaisons.

UCare also works in collaboration with the other MCOs to identify barriers and develop intervention strategies to improve dental access for all members. The following activities were undertaken for this collaborative work:

- Provided continuing education to case managers in regards to oral health. During the fall of 2018, UCare’s Member Engagement Specialist co-presented to case managers statewide on how to effectively engage with members and offered talking points and strategies on how to help members schedule an appointment, as well as how to work closely with MCOs’ Dental Benefit Managers.
- Created a Mentoring Program to identify experts in the field serving the Medicaid and populations with disabilities and have them come together to provide additional education regarding the care of patients with special needs, so that more Minnesota dental providers are willing to serve Medicaid members. To assist the MCOs in understanding dental provider concerns with serving Medicaid and populations with disabilities, a Mentoring Expert Panel was created to advise the project. The purpose of the panel was to advise DHS and the MCOs in the development and implementation of a mentoring program for special needs dental care in Minnesota for the SNBC Dental Project. There were 12 participants who were recruited in addition to MCO staff attending. Participants included representatives with a variety of specialties and various levels and background experience working with Medicaid and patients with disabilities such as those providing care to patients with disabilities, community dentists and those affiliated with academic institutions and active in policy-making.
- The MCOs collaborated with Direct Care & Treatment (DCT)—Dental Clinic staff to identify gaps in knowledge about MCOs, dental delegates and dental benefits for the patients the clinics serves. MCOs worked on the following initiatives with DCT Clinics:
  - Conducted presentations at dental conferences and other dental venues to educate dental staff and providers as applicable.
  - Developed a dental care MCO 101 grid on dental benefits and services, plus a FAQ to clarify dental benefits, coverage and best practices.
- MCOs collaborated with DHS to conduct two Annual Provider Access Surveys to better understand dental access. The Annual Provider Access Survey was an electronic survey sent out to dentists to gather information on community dental providers’ capacity to accommodate Medicaid and the special needs population and access to care.
  - Survey results drove intervention strategies around education on working with the Medicaid and special needs population groups.
  - Other survey results identified barriers to access of care and impacts on treatment options due to dentists not accepting new Medicaid patients, inadequate reimbursement and a limited benefits set.

UCare will continue to monitor trending rates quarterly, as well as annually. UCare will evaluate the effectiveness of intervention strategies on an annual basis to determine what strategies demonstrated an increase in dental access rates. Based on this analysis, UCare will continue to look to expand proven intervention strategies to reach additional members. UCare will also continue to implement new interventions, thus improving dental access rates.

UCare uses a multi-prong approach to address and reduce avoidable emergency room admissions, inpatient admissions and re-admissions. Our cross-organizational team reviews and analyzes data, designs, and implements and oversees these efforts. We review utilization data on a quarterly basis through 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 top diagnoses for admissions and readmissions.

▪ **2017 Recommendation: HEDIS (Quality of Care)**

- Although not identified as an opportunity for improvement, the below average access to primary care rate for the 12-19 years group suggests that adolescent well-care visits are low partially because members are not accessing the system. As such, UCare should determine why members are not accessing the system, or if they are attempting to access the system, what barriers are they facing.
- In regard to women’s health, UCare should conduct root cause analysis to determine the major factors negatively impacting certain screenings.
- UCare’s dedicated workgroup should enhance its controlling high blood pressure strategy to include additional member-focused interventions. Effort should be made to improve member blood pressure readings to the clinical standards.

**MCO Response:**

Barrier Analysis

*Members:* There are many issues that create barriers to members getting care and scheduling their annual wellness exam, which include:

- Logistics of scheduling appointments if parent/guardian have work/other children.
- Limitation of appointment availability in evenings and weekends to accommodate the working parent/guardian.
- Limited health care and health insurance literacy resulting in visits for “illness” care, not preventive care.
- Confusion between an illness visit and a preventive/well child visit.
- Perception of need, particularly as a child gets older.
- Fear of immunizations.
- When members have chronic conditions (asthma, ADHD), they are in the office more frequently, and families don’t see value in returning for well-care visits.
- Some members are followed by multiple specialists, and it is not clear who is managing the preventive care.
- Parents feeling the burden of bringing children in for specialist visits and primary care visits.

*Providers:* Barriers continue to occur with providers appropriately assessed for all well-care (Child & Teen C check-up) components during a well-child exam. Barriers include:

- Lack of understanding of the criteria and evidence supporting components of C&TC.
- A low risk member means some primary care providers don't always reach out to the children after a kindergarten visit.
- Work flow for illness visits capturing well visit components isn't always included.
- The time it takes for one C&TC visit is often the same as two illness visits.
- When members have chronic conditions (asthma, ADHD), they are in the office more frequently and a provider's perception is it is a burden to bring family back in just for the C&TC.
- Some members with chronic conditions are followed by multiple specialists; therefore, primary care thinks another practitioner is providing the C&TC care for members.
- The Minnesota Department of Health periodicity schedule outlined that members should see their primary care provider every two years for a well child visit, whereas the Academy of Pediatrics periodicity schedule states annually. It was determined through telephonic outreach and engagement with providers that primary care was following the Minnesota Department of Health periodicity schedule and was coaching members and their guardians to come in every two years for an annual well care visit.

UCare's internal workgroup dedicated to improving access to primary care providers (PCPs) met in 2018, and in 2018 UCare continued to conduct a number of different initiatives to improve this rate and the care for our adolescent members. Intervention strategies we implemented to improve efforts for well care access to PCPs included:

- Development of a three-pronged approach to target members who have not seen their primary care provider. Strategies included an IVR call, followed by telephonic outreach, followed by an incentive mailing (additional details listed below).
- Interactive voice recording calls to prompt members to get their well child visit and flu vaccine.
- A Member Engagement Specialist made calls to members to provide education over the phone (specifically on the importance of a well-child visit), assist in scheduling well child visits and, as needed, with scheduling transportation and an interpreter.
- A \$25 incentive for completing an annual adolescent well care visit.
- Collaboration with Parents in Community Action (PICA) to provide education on well child, adolescent well care and postpartum care visits.
- Customer Services hold-time messages and articles for members and providers on the importance of scheduling C&TC visits.
- Collaboration with community groups for various C&TC initiatives and educational opportunities
- Articles in our provider newsletter, [health lines](#).

- Articles in our [member newsletter](#) *A Healthier U* and 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 well child visits and the periodicity schedule.
- Providing the [Parent's Guide](#) after delivery, which includes information on the importance of well child visits and the periodicity schedule.
- Provider education on the frequency of well care visits occurring every year versus every other year.

Barrier Analysis – Prenatal and Postpartum: UCare recognizes that members and providers experience barriers when it comes to prenatal/postpartum care:

*Members:* UCare recognizes and addresses the real and perceived barriers members may have receiving excellent pre- and post-partum care:

- Transportation to medical appointments.
- Financial support for coverage of prenatal vitamins.
- Access to culturally sensitive care; for example, concerns regarding the gender of the obstetrician.
- Gap in understanding how early and ongoing pregnancy care helps the member and her unborn child.
- Suboptimal member health literacy, which may cause difficulty with medication adherence, chronic condition management and member recognition of pregnancy risk factors.
- Lack of health insurance literacy, which may lead to gaps in health insurance coverage for the mother and her unborn child/infant.
- Feeling overwhelmed by pregnancy and implications.
- Social determinants of health related to nutrition, housing stability, transportation and social support.

*Providers:* UCare collaborates with providers to overcome real and perceived barriers to providers' ability to deliver high quality, evidence based, and culturally sensitive care. Barriers may include:

- Cultural barriers, for example the gender of the obstetrician.
- Challenges resulting from lack of resources to address the needs of members related to social determinants of health.
- Payment difference between primary care obstetric care and obstetrician providing the pre and post-natal care.
- Complex financial and financial professional relationships when a provider of prenatal and postnatal care is not affiliated with the providers (laborists) at the hospital who perform deliveries.
- Several health systems limitations about what provider type, located in which clinics, are allowed to care for pregnant women.

### Barrier Analysis – Breast and Cervical Cancer Screening

*Members:* Reaching members was identified as a barrier. When members enroll in a health plan, they are required to provide their email address or phone number, and many times members provide their email address and not their phone number; therefore, they do not receive IVR calls or calls from an outreach specialist about getting their mammogram or cervical cancer screening. Also, member information at times is outdated or incomplete, making contact with members difficult. Other barriers include member lack of knowledge of the importance of seeing their doctor annually for a wellness exam, as well as consulting with their primary care provider about getting screened for cervical cancer or frequency of getting a mammogram.

*Providers:* Additionally, barriers to members receiving cervical cancer screening are the provider and clinic system:

- Lack of flexible scheduling to accommodate a patient in the office who last minute wants to have a cervical cancer screening.
- Provider applying the clinical practice guidelines in their own manner (e.g. three negative PAPs before allowing a three-five year schedule).
- Providers not taking a detailed medical/surgical history that allows for a proper screening schedule to be established.
- Provider stigma about who should be screened, such as someone with a disability.
- Patient Health Maintenance Schedules in EMRs not updated or filled out correctly.
- Providers not ordering and labeling HPV co-testing correctly.
- Changing clinical guidelines and screening modalities like High Risk Primary HPV Screening (hrHPV) being used by providers that are not yet able to count in the cervical cancer screening measure.

UCare’s internal workgroup dedicated to improving access to primary care providers (PCPs) met in 2018, and in 2018 UCare continued to conduct a number of different initiatives to improve women’s health, ranging from prenatal and postpartum visits, cervical cancer screening and breast cancer screening. Intervention strategies we implemented to improve efforts for women’s health included:

### Prenatal and Postpartum Strategies

- A Member Engagement Specialist made calls to members to provide education over the phone on getting the right care for prenatal and postpartum, assistance in scheduling visits, scheduling transportation and an interpreter as needed.
- A \$75 incentive for completing a prenatal appointment within the first trimester.
- A \$75 incentive for completing a postpartum appointment within three to eight weeks post-delivery.
- A \$25 incentive for completing UCare’s tobacco cessation program for pregnant mothers.

- A partnership project with PCPs to submit timely notification of members when they are identified as pregnant. UCare’s Health Promotion team reviews low – high risk members and refers them to the appropriate level of care and support services at UCare.

#### Breast and Cervical Cancer Screenings

- Development of a three-pronged or two-pronged approach to target members who have not completed their cancer screenings: an IVR call, followed by telephonic outreach, followed by an incentive mailing (additional details listed below).
- Interactive voice recording calls to prompt members to get their breast cancer and/or cervical cancer screen.
- A Member Engagement Specialist made calls to members to provide education over the phone, assisted in scheduling appointments, transportation and an interpreter as needed.
- A \$50 incentive for completing a mammogram.

UCare’s internal workgroup worked to improve and control high blood pressure, and in 2018 (and future years) UCare’s interventions to improve this rate were and will be:

- As in past years, reviewing charts of members who are identified as having hypertension. Charts were reviewed to determine blood pressure readings, determine the appropriate level of care specific to members’ providers, number of follow-up visits conducted with their provider in the given year and an analysis to determine how members’ blood pressure readings were documented in charts. Results of the charts showed that members’ blood pressure was in control based on the feedback from their providers regardless of the established guidelines for HEDIS. Some members missed the control readings by a couple numbers, which meant they were not compliant.
- Providing education to providers about ongoing monitoring of members’ blood pressure and guidelines.
- Developed a member letter, education handout and tracking card for members to educate them and provide a better understanding of how to monitor their blood pressure.
- Hold-time messages on the Customer Service line providing education to members about controlling high blood pressure.
- Developed a blood pressure website to educate members on the new blood pressure guidelines, what it means to have hypertension and recommendations on managing blood pressure.

UCare will continue to monitor trending rates quarterly and annually. UCare will evaluate the effectiveness of intervention strategies on an annual basis to determine what strategies demonstrated an increase HEDIS Quality of Care measures. Based on this analysis, UCare will continue to look to expand proven intervention strategies to reach additional members. UCare will also continue to explore intervention strategies that include working more collaboratively with providers

on conducting outreach to members and identify cultural specific interventions to work more effectively with our membership.

▪ **2017 Recommendation: CAHPS (Member Satisfaction)**

- UCare should utilize the results of the secret shopper survey to improve provider network deficiencies. UCare should consider closing patient panels for providers who fail to meet contractual standards for wait times and appointment times. UCare should also consider conducting onsite audits of provider scheduling systems to determine compliance with contractual standards. UCare should educate members on standard appointment times to manage member expectations.
- UCare should utilize member grievances and complaints to identify providers or provider sites that could benefit from direct outreach.
- UCare should consider ways of obtaining member feedback shortly after the member's interaction with health plan staff to ensure member issues are addressed in an expedited fashion. Member feedback should be captured and reviewed to identify specific elements of the customer experience that can be modified.

**MCO Response:** UCare has published clear standards in our [Provider Manual](#) that ensure our members are able to receive care in a timely manner. Upon initial provider site surveys, we ask the provider about wait times and appointment times for urgent care, emergency care, sub-acute care and routine physicals. We also monitor our providers to ensure that they are meeting these standards. We call a statistically relevant random sample of our provider network (primary care, high impact/high volume specialty care and behavioral health providers) to find the soonest available appointment for potential members. We aggregate this data and follow up with providers who are outside of the prescribed timelines. Because only recently our Provider Manual was updated to reflect appointment time standards, patient panels have not yet been closed on any providers.

The appointment availability data is not only used in ensuring our providers are not causing any undue burden to our members but also to isolate any greater network trends. Potentially, if an ophthalmologist is not able to meet the appointment availability timeline it may be indicative a geographic provider shortage. This is important for us to understand because there may be more reasons than ineffective scheduling systems that cause our providers to not meet the standards.

We address some of these global provider network access issues in a monthly cross-departmental meeting called "Maximizing Provider Networks," hosted by our Provider Relations & Contracting (PRC) Department. In addition to appointment availability trends from secret shopping, the team monitors complaints data, non-participating provider utilization, out of network request data, single case agreement data and third-party geographic provider data. We also use anecdotal data from a wide array of internal and external stakeholders to figure out ways to make our provider networks stronger. The network meetings chronicle our discussions in minutes, and PRC tracks providers targeted for

potential contracting. UCare has also added disciplined processes such as establishing a closed network appeals process and a standard regular review of our open and closed networks. Combined, these strategies help us address not only providers who are not performing with regard to appointment timeliness but help providers who may be overwhelmed and unable to meet appointment timelines.

Going forward, we will also explore ways to make standard appointment time information available to members through current workgroups, such as Maximizing Provider Networks.

Quarterly, in the cross-departmental “Maximizing Provider Networks” meetings, UCare reviews our Appeals and Grievances Log for provider outreach and contracting opportunities. Our PRC Department takes meeting minutes, along with maintaining a Targeted Providers log to identify providers who would reduce our members’ barriers to care. Providers who are found to have chronic issues are contacted by PRC to understand the issues that are occurring and to respond appropriately. This response includes collaboration with providers, reminding them of their contract terms and terminating them if necessary.

Also, PRC and our Appeals and Grievances area are working closely in 2019 to ensure data is collected in a meaningful way so that we can isolate and effectively act on trends. Our appeals staff understands the work they are doing can impact our network as a whole and organizing issues in ways that allow us to act and improve our provider network.

Our PRC Department uses the identified trends to understand if this is an issue across providers or with an individual provider. If it is an issue across providers, we work with them to discover the root cause and resolve the underlying issue. However, if this is specific to an individual provider, PRC works with the provider, reminding them of their contract terms. If necessary, the provider is terminated.

UCare’s Customer Service Quality Assurance Team monitors post call surveys. 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 Supervisors provide feedback to representatives based on the call performance to improve member satisfaction.

Annually, UCare’s Quality Advocates and Customer Service Manager review each customer service representatives’ expectations to set realistic goals. Our internal quality goals are based on quality performance results, the current and future environment such as staffing, new processes, systems updates to better enhance the member (and employee) experience.

UCare's performance expectations for Customer Service representatives is to achieve a score of 86% during the review of their call. This realistic goal allows representatives to become familiar with new system changes, while continuing to better engage with members and answer their questions in one call attempt, which helps increase employee satisfaction and improve member experience.

UCare's Customer Service team focuses on continuing to provide education and training to representatives. Quarterly training is provided for representatives and covers information on benefits and authorizations that include new changes, updates and existing information. UCare's Quality Advocates and Customer Service Supervisor work directly with representatives who did not score a 100% on the quality assurance check. Results are shared with the representatives as well as suggestions for improvement.

---

## **CHAPTER 5: MCO FEEDBACK ON 2018 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 2018 ATR. MCO comment resulting in modification to the ATR is noted as “addressed”.

---

## BLUE PLUS

---

- Page 15: Change PIP topic timeframe to 2015-2017. **Addressed.**
- Page 15: Include statement about 2018 PIP. **Addressed.**
- Table 5: General edits to 2019 rates. **Not addressed. Data in table was verified.**

---

## HEALTHPARTNERS

---

- Page 31: Revisions to PIP summary. **Addressed.**
- General: Remove space between Health and Partners. **Addressed.**
- Table 11: Correction to a rate. **Addressed.**
- Comment: HealthPartners supports the use of the validated, audited HEDIS measures submitted to NCQA as the DHS methodology cannot be validated by the MCO. **Not Addressed. DHS administrative rates presented in this report were validated by MetaStar, a certified HEDIS vendor.**

---

## HENNEPIN HEALTH

---

- Performance Improvement Project, page 43. It is noted “The following PIP was in progress: ***The Reduction of Racial Disparities in the Management of Depression: Improving Antidepressant Medication Adherence (2015-2017)***”. “The following PIP was in progress:” is confusing; perhaps, it could be noted that the PIP ended on December 31, 2017 with the final report being submitted in September 2018. ***Addressed.***
- The MCO Clinical Practice Guidelines, page 46. The Clinical Practice Guidelines listed were adopted by Hennepin Health for 2019, not for 2018. The 2018 Clinical Practice Guidelines adopted were the same as 2017. ***Addressed.***
- The Hennepin Health MNCare CAHPS Survey was combined with SCHA, PrimeWest and IMCare as the Hennepin Health MNCare sample size was small. The areas identified as opportunities for improvement under the MNCare CAHPS are listed as strengths for SCHA, page 102. It states SCHA performed well in regard to the following areas of member satisfaction. ***Addressed.***

---

## ITASCA MEDICAL CARE (IMCARE)

---

No feedback.

---

## MEDICA

---

- Page 15: Change PIP topic timeframe to 2015-2017. **Addressed.**
- Page 15 and Page 67: Include statement about 2018 PIP. **Addressed.**
- Page 68: Update to Evaluation of 2018 Annual QAPI. **Addressed.**
- Figure 8: Revise 2016-2017 to 2017-2018. **Addressed.**
- Page 68: Revisions to summary of Evaluation of QAPI. **Addressed.**

---

## PRIMEWEST HEALTH

---

- Page 75 – there is an extra period in the second sentence. **Addressed.**
- Page 75 – we noticed it lists only the AMM PIP as being for the F&C population. This was for all populations with no mention of the other products, rates or information. **Not Addressed.**
- Page 77 – PrimeWest’s Quality Assurance work plan item is highlighted, unclear as to why. **Addressed.**
- We do not see any reference to our 2018 PIP. However, this may be due to it starting in 2018 and there were no outcomes yet. **Addressed.**
- We are unable to confirm/validate the DHS calculated HEDIS rate as this differs from our administrative rates as calculated through HEDIS. **Not Addressed.**

---

## SOUTH COUNTRY HEALTH ALLIANCE (SCHA)

---

- Page 15: Change PIP topic timeframe to 2015-2017. *Addressed.*

---

## UCARE

---

- Page 15: Change PIP topic timeframe to 2015-2017. **Addressed.**
- Table 40: Revised rates for 2016 and 2017. **Not Addressed. These rates were restated by the new CAHPS vendor.**
- Page 116: Added SNBC CHAPS opportunities for improvement.
- Chapter 4: General edits to UCare’s response. **Addressed.**

---

## CHAPTER 6: EQRO RECOMMENDATIONS TO DHS

---

### Recommendations

- Size and quality 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.
- DHS should consider including a summary of the DHS quality strategy for MHCP into the 2019 Annual Technical Report to provide interested parties a broader view of DHS's goals and priorities for health care.
- DHS should assess how the revised CMS EQR Protocols of 2020 will impact the validation of performance measures, the validation of performance improvement projects and the validation of network adequacy. DHS should also consider how these changes will impact the production of future ATRs.
- As dental care is a common opportunity among the MCOs, DHS should consider intervening with MHCP-wide actions that address network gaps.