Keystone Mercy Health Plan
AmeriHealth Mercy Health Plan

Year 2010
Quality Improvement Program Evaluation

Table of Contents

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I. BACKGROUND & HISTORY

A. Keystone Mercy Health Plan

Keystone Mercy Health Plan (KMHP) was established in April 1996 as a partnership joining two formerly separate Medical Assistance plans: Keystone First and Mercy Health Plan (MHP).

Keystone First, established in 1994, was operated by Keystone Health Plan East (KHPE), a HMO jointly owned by Independence Blue Cross (the Blue Cross licensee for Southeastern Pennsylvania) and Pennsylvania Blue Shield. MHP was established in 1983 and was originally operated by Mercy Health System in Philadelphia.

At the time of the partnership agreement in April 1996, MHP served 114,000 Members in the five-county Philadelphia area. In addition, MHP also served 24,000 Members in Berks, Lehigh and Lancaster counties. By comparison, Keystone First had 42,000 Members in the Philadelphia area. By June 1996, all Members served by Keystone First and MHP who resided in the five-county Philadelphia area were transitioned to the newly formed KMHP, which operated under a license owned by KHPE.

In February 1997, the Commonwealth of Pennsylvania mandated the HealthChoices program, which requires Medicaid recipients in the five-county Philadelphia area to enroll in one of the HealthChoices contracted HMOs. As one of the contracted HMOs, KMHP currently administers physical health and pharmacy benefits for more than 300,000 of these Members. Behavioral health care is provided through a carve-out Managed Care Behavioral Health Organization, contracted by the state.

On 7/1/04, KMHP moved from the KHPE license to the Vista Health Plan, Inc license, d/b/a Keystone First. Independence Blue Cross controls the Vista Health Plan, Inc. license. Nothing changed with respect to ownership or profit-status for KMHP.

The plan‘s network includes approximately 2,230 independent primary care practitioners in 1,025 sites and approximately 9,168 specialists in 7,305 sites.* Family practitioners, general practitioners, pediatricians, and Internists serve as primary care physicians. The major provider contracts include 45 hospitals, 364 ancillary providers, 131 skilled nursing facilities, and 5 laboratory providers.

*Note: Dental and Vision subcontractors are not included in the specialist totals; all practitioner data is unduplicated by Common Practitioner Identification number. Hospitalists are included in the specialist totals.

B. AmeriHealth Mercy Health Plan

AmeriHealth Mercy Health Plan (AMHP) was established in April 1997 as a partnership between Mercy Health Plan and Independence Blue Cross. AmeriHealth Mercy operated under a license held by AmeriHealth HMO, Inc., a subsidiary of Independence Blue Cross.

Prior to the partnership agreement, AmeriHealth Mercy Health Plan operated for eight years as Mercy Health Plan. At the time of the partnership agreement, AmeriHealth Mercy served over 20,000 Members in its service area of Berks, Lancaster Lehigh, and Northampton Counties.

In 2001, the Commonwealth of Pennsylvania began the transition from voluntary to mandated Medicaid managed care in counties in the Lehigh Capital zone that expanded the area and membership for AMHP. At that time AMHP added membership in Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry and York counties. In addition to the counties representing the Lehigh Capital zone, AmeriHealth Mercy also serves Members in four other counties that remain voluntary Medicaid managed care. Those counties are Carbon, Pike, Lackawanna and Luzerne. AMHP currently administers physical health and pharmacy benefits for over 100,000 Members. Behavioral health care is provided through a carve-out Managed Care Behavioral Health Organization, contracted by the state.

On 7/1/04, AMHP moved from the AmeriHealth HMO, Inc. license to the Vista Health Plan, Inc license, d/b/a AmeriHealth First. Independence Blue Cross controls the Vista Health Plan, Inc. license. Nothing changed with respect to ownership or profit-status for AMHP.

AMHP's physicians are independent practitioners that include approximately 1,216 primary care practitioners at 437 sites and 7,779 specialists at 4,045 sites.* Primary care practitioners are defined as physicians in the specialties of Family Practice, General Practice, Pediatrics, and Internal Medicine. The major provider contracts include 70 hospitals, 665 ancillary providers, 101 skilled nursing facilities, and 160 laboratory providers.

*Note: Dental and Vision subcontractors are not included in the specialist totals; all practitioner data is unduplicated by Common Practitioner Identification number. Hospitalists are included in the specialist totals.

II. PURPOSE

On an annual basis, KMHP/AMHP conducts a written evaluation of the effectiveness of its quality improvement activities to assess how well they meet the goals and objectives of the QI program and work plan. The evaluation assesses the program structure, practitioner participation, quality resources, completed and on-going activities, and barriers to improvement. The evaluation includes input from multiple departments and QI committees. Data from this analysis is subsequently used to develop recommendations for improvement and to propose goals and objectives for the following year's QI program.

This evaluation assesses the following elements:

- Effectiveness of the QI structure
- Completed and ongoing QI activities
- Performance measure trends

- Analysis of activity results and barriers to improvement
- Overall effectiveness of the QI program

III. PROGRESS AGAINST PRIOR YEAR OPPORTUNITIES

KMHP/AMHP made progress on several opportunities identified in the 2009 program evaluation.

A. NCQA Accreditation

Keystone Mercy and AmeriHealth Mercy maintained an Excellent Accreditation status during 2010. Refer to Section V. for a summary of results.

B. URAC Accreditation

Both plans maintained URAC Disease Management Accreditation for four disease states: Asthma, Chronic Obstructive Pulmonary Disease, Diabetes and Heart Failure.

C. Expand Childhood Obesity Offerings

In 2010, KMHP and AMHP established a multi departmental workgroup to focus on pediatric and adult obesity. The workgroup reviewed diagnosis and CPT codes for data analysis and stratification for designing new initiatives. Also, a Health and Wellness Guide was created as a resource for both AMHP and KMHP. The guide is a compilation of health and wellness resources for Members, providers and case managers to access. The guide is divided into several categories which includes obesity programs, resource information sites, healthy lifestyle sites such as the Boys and Girls club, local YMCA‘s and community centers. In 2011, The Health and Wellness Guide will be finalized and placed on both the Member and Provider portal.

KMHP Discussion

Three programs were discontinued in 2010 primarily based on the difficulty of the programs‘ ability to retain participants and to demonstrate measurable outcomes: La Forteleza, Vigorworks and Kids 4 Fitness.

Although La Forteleza fared better than Vigorworks and Kids 4 Fitness in retaining participants, there was little or no measurable success or attainment of objectives. In addition to the inability to retain participants, Vigorworks and Kids 4 fitness also struggled with recruitment. Vigorworks had some promising outcomes for its Members but the numbers were very few. After reviewing the post program data, a business decision was made to discontinue the programs and redesign the offerings for Pediatric Obesity.

Lose to Win

The Lose to Win program that was developed for adults in cooperation with the YMCA‘s Activate America Program and was launched in the fall of 2009 continued through January 2010. The focus of the initiative was Type II Diabetes and Obesity Education. The program was designed to educate high risk urban families by combining health screening, nutrition & weight management, preventive diabetes/obesity disease management and monitored exercise.

The program enrolled 137 Members and assigned them to a YMCA site based on their geographic location. Program activities included nutritionist guided supermarket tours, cooking demonstrations, nutrition workshops and dance classes.

A total of 115 participants completed the twelve week program and the average weight loss was 10-15 pounds. Several Members lost over 50 pounds and many reduced their need for diabetes and cardiovascular medications. On average, participants improved their BMI by 3.8 % and the average improvement in HDL was 5.5%.

The program culminated with a celebration for the 115 participants who completed the program. Each Member received a one year membership to the YMCA and other prizes were awarded to the participants demonstrating the most improvement in measured parameters.

New Programs in 2010:

Media Smart Youth Program

In the summer of 2010, Keystone Mercy provided the Media A Smart Facilitators Program to 15 youth in the Blue Print Leadership program from the City of Chester. Media Smart is an interactive after school program that helps young people ages 11-13 to understand the complex media world and its nutritional or physical impact on their health. Media Smart is a component of the national *We Can*® Obesity Prevention Program. The program began with 15 Blue Print Leadership participants who were also Keystone Mercy Members and ended with 11 of the teens completing the program. The objective is for the Leadership teens to implement the curriculum in several middle school classes in their community.

City Year Partnership

Keystone Mercy Health Plan partnered with City Year on a program developed to educate and motivate Philadelphia school students to become more active and to introduce healthier foods into their diet. The Young Philly Fit Program's "Wellness Ambassadors" training program was launched in October 2010. Eight schools have been selected to have "Wellness Ambassadors" engage kids through the use of pedometers and ongoing education around nutrition and the importance of a healthy lifestyle. Launching the programs to the eight schools is anticipated to occur in the first quarter 2011.

West Philadelphia YMCA Tours - June 7 – June 11, 2010

All seventh grade students in Philadelphia are eligible for a free year membership to the YMCA. Tours were provided to 7th grade students with their City Year Corp Members from West/Southwest Philadelphia Schools: Mastery Charter School, Rhoads Middle School, Lea Middle School, and Shaw Middle School. The YMCA staff guided the students around the facility emphasizing the benefits of utilizing the gym area, aquatics, swim lessons, arts and dance programs.

AMHP Discussion

AmeriHealth Mercy has developed several health education programs to stress the importance of early detection, preventive care, healthy behaviors, and overall personal health awareness. It is our hope that the health education programs will serve to not only improve the health of our Members and the communities we serve, but also empower people to take control of their health.

AMHP partners with community organizations to promote and educate children on proper nutrition and physical activity through our programs. We target children 3-13. The goals and objectives of the program are to increase physical activity, encourage healthy eating habits in the hopes of

maintaining a healthy weight or reducing BMI. In 2010, there were 53 programs targeting obesity which approximately 1500 children attended over the year.

Current Initiatives

- Collaborative obesity workgroup with K/A initiated earlier this year
- Staywell Member Portal – article on healthy weight
- Healthy You…Healthy Me Program.
    - Distribute materials –Finding Help for Your Overweight Child"
    - Food Pyramid
    - Jump ropes, pedometers, water bottles
- Summer camp programs before/after school utilizing portions of the –Catch Kids Klub" curriculum and equipment (bean bags, hula hoops, jump ropes, balls, Frisbees, etc)
- BMI collection at community events
- –Childhood Obesity Resource" listing of available programs within the 15 county Leigh/Capital Region

Community Outreach Initiatives

AMHP participated in several programs in 2010. The Healthy You…Healthy Me! Program is a combination PowerPoint presentation and curriculum utilizing the Coordinated Approach to Child Health (CATCH) Kids for children ages 7 – 13. The presentation includes physical activities and a nutritional snack. An additional program offered is the Healthy Heart Program which focuses on the functions of the heart and its importance. It also includes physical activity and healthy snack.

Examples of programs –

Childhood obesity programs held at Shiloh Baptist Church (50 kids), Pocono YMCA (50 kids) and Healthy Hoops (65 kids)-program focuses on nutrition and exercise as well as BMI data collection. A total of three 12-week after school sessions were held.

Additionally, two programs were held at the Head Start Program in East Stroudsburg and one with the Pocono YMCA focusing on activities such as balance, musical chairs, exercises, walking and teaching healthy eating. The Healthy Heart program was also presented.

Healthy Hoops, an annual event that helps children with asthma manage their condition, weight and prevent cardio-vascular disease was held during 2010. This program focuses on fun fitness activities and at the same time provides important information on asthma, nutrition, healthy cooking and cardiovascular activity. A key component of this program is the total family, parent and sibling's involvement and commitment. Outcome collection is in progress.

Provider Initiatives

- Quarterly packets – Information is shared in the provider quarterly packets on BMIs, related DPW Bulletins, billing codes for nutrition and weight management services. This information is also available on the plan website.
- Gaps in Care – Reminders of missing Adolescent Well Care visits (visit should include BMI measurement and counseling) are sent through care gap alerts during online eligibility checks (see below).

D. Begin integration of Care Gap data into systems for Plan, provider and Member use
During 2009, work was completed to link the Clinical Alert Service to the provider portal. This places care Gap information in the provider‘s office in the form of an alert that is returned when eligibility is checked as well on-demand through the report generation feature. Care Gaps are recommended clinical services and screenings for which there is no claim evidence of completion.

Care Gap information is available for Asthma, Diabetes, Coronary Artery Disease, Heart Failure, and Preventive Health Services. In August 2009, Care Gap data was also made available to the Member Services Call Center. When a Member name or ID number is entered in the system, a tab appears containing any missing or overdue services. The call center representatives review the needed services with the Member and work with the Member to arrange for the recommended services.

The Care Gap functionality was initially made available to the medical management staff in late 2008. The staff reviews the needed services with the Member and/or provider and work to arrange the recommended care.

E. Behavioral Health Managed Care Organizations (BH-MCO) and Physical Health Managed Care Organizations (PH-MCO) Collaboration
Keystone Mercy and AmeriHealth Mercy continue to improve collaborative efforts with the Behavioral Health Managed Care Organizations in their respective service areas.

KMHP Discussion:
HEALTHCHOICES/HealthConnections

The Center for Health Care Strategies (CHCS), through its *Rethinking Care Program,* focused on improving quality and reducing expenditures for Medicaid beneficiaries with complex medical and behavioral needs, and the Pennsylvania Department of Public Welfare (DPW) are joint sponsors of the HEALTHCHOICES/HealthConnections program.

This two-year effort was implemented in July 1, 2009 and continued in 2010. The initiative was designed to test innovative care delivery models for consumers with serious mental illness and physical co-morbidities that could be replicated statewide. The mental/behavioral health conditions targeted for this program are: Schizophrenia-ICD 295.xx; Mood Disorders-ICD 296.xx; and Borderline Personality Disorder-ICD 301.83.

Keystone Mercy Health Plan continued as a project partner with Magellan Behavioral Health and the Behavioral Health leadership of Montgomery, Bucks, and Delaware Counties.

The program is built around the following key focal points:

- Provider engagement: both physical and behavioral health
- Consumer engagement
- Promoting improved access to and utilization of appropriate physical and behavioral health services
- Promoting improved coordination of care: between physical and behavioral health managed care organizations, as well as physical and behavioral health providers
- Data management and information exchange: plan-to-plan; plan-to-provider

- Promoting appropriate Emergency Department use and timely/effective post-discharge follow-up
- Improved coordination of hospital discharge and timely/effective post-discharge follow-up
- Pharmacy Management: focus on promoting improved medication adherence for specific medications
- Improved alcohol and substance abuse treatment/care coordination.

Year one's (7/1/09-6/30/10) goal of creating 1,000 Member Health Profiles was met.

- Approximately 700 from HCHC Consented Members
- Approximately 300 from HCHC Members targeted for engagement by the Project Partners.

The Member Health Profile is a report that combines Physical Health and Behavioral Health utilization information over a rolling 12-month period. The Member Health Profile includes:

- Physical Health Gaps in Care
- Identification of selected Physical Health Disease states
- Pharmacy Utilization for targeted drug categories
- Physical Health and Mental Health Inpatient Admissions; Outpatient Services; and PCP/Specialist visits.

In addition to the utilization; and BH-PH information listed above, the Member Health Profile also includes:

- Behavioral Health Navigator and contact information
- Keystone Mercy Health Plan (KMHP) Case Manager and contact information, where applicable
- Primary Care Physician name and telephone number.

As Members signed the HCHC Consent, Member Health Profiles were created on a monthly basis and shared with Magellan; Behavioral Health Navigators; KMHP Case Managers. Throughout Year One there have been collaborative discussions between Keystone Mercy Health Plan and Magellan and joint case rounds of about 40 Members. For Program Year Two, (7/1/10-6/30/11) the focus is on targeted outcomes, specifically ER Visit and Inpatient Hospital rates.

Depression Screening

Depression screening is a component of Keystone Mercy's Care Management comprehensive assessment process for Members with chronic illnesses as well as those who are pregnant. Members identified as potentially having depression are given the BH-MCO contact numbers and may be referred directly, with their consent to the appropriate BH MCO. If a Member is found to be seriously mentally ill or depressed during a conversation with a Care Manager, the Care Manager inquires as to the Member's sense of safety from other's or self, conferences into the Crisis Line of the respective Behavioral Health Managed Care Plan and stays on the line with the Member until services are confirmed or an emergency responder arrives at the Member's location.

Community Care Behavioral Health

Community Care Behavioral Health, which is the Behavioral Health Managed Care Organization for Chester County, started a pilot program with Keystone Mercy Health Plan in July. The pilot program is designed to identify and refer Members who have had one inpatient psychiatric admission with known physical health co-morbidities. For 2010, ten Members were referred and integrated rounds instituted.

Keystone Mercy Health Plan remains an active participant on several regional behavioral health workgroups, including:

- The Physical Health MCO / Behavioral Health MCO Pharmacy & Therapeutics Subcommittee
- The Southeast Region Physical Health MCO /Behavioral Health MCO Steering Committee and Workgroup (since 2004)
- The Southeast Region initiative led by Philadelphia Coordinated Health Care for Deinstitutionalized Members, and those in Intermediate Care Facilities / Other Related Conditions (ICF/ORC)
- The Philadelphia Children's Team: The Physical Health MCO, Behavioral Health MCO, the Department Human Service (DHS) Philadelphia County and the Department of Public Welfare

Keystone Mercy worked with the BH- MCOs on several data sharing initiatives including: medication profiles, second-generation antipsychotic trends and coordination of discharge planning from inpatient psychiatric / drug and alcohol facilities.

Case Specific Coordination
Keystone Mercy‘s Care managers help coordinate specialized care for Members with behavioral health conditions. Many Members have health care needs that are exacerbated by their behavioral health conditions and vice versa. Examples include depression, pain management, and substance abuse.

AmeriHealth Mercy discussion:
AMHP continues to improve collaborative efforts with the Behavioral Health Managed Care Organizations in its service area. AmeriHealth Mercy remains an active participant on several regional behavioral health workgroups, including:

- Lehigh Capital Behavioral Health and Physical Health MCO coordination meeting
- Northeast CCBH Behavioral Health and Physical Health MCO coordination meeting.

AmeriHealth Mercy Health Plan worked with the BH- MCOs on several data sharing initiatives including: medication profiles, second-generation antipsychotic trends and coordination of discharge planning from inpatient psychiatric / drug and alcohol facilities. Specific efforts are detailed below:

Co-Morbid Patient Study: The Special Needs Unit of AmeriHealth Mercy continues to work with the behavioral health MCO staff at Magellan Behavioral Health to develop criteria for referring Members for case management. Magellan has an existing ―IMPACT" program where any adult Member that has more than one psychiatric admission within a 60-day time frame or any child with any psychiatric admission is contacted by Magellan to be engaged in active care management from Magellan specific to behavioral needs. The project examines Members in Magellan‘s high risk IMPACT program for co-morbid medical illnesses or high utilization. The goals of the project are to

develop care management coordination with the AmeriHealth Mercy care management team to improve non-hospital care, increase treatment compliance, and decrease hospital use. More recent discussions are in place to institute this program with all behavioral health organizations that provide services for AmeriHealth Mercy Members.

Suboxone Initiative: AmeriHealth Mercy continued with the 2007 Initiative related to the use and management of Suboxone and Subutex. Suboxone's prior authorization criteria were revised in 2009. The Special Needs Unit makes outreach calls to any Member who receives a denial or temporary supply of Suboxone. Prescribers receive an auto-populated prior authorization form two weeks prior to the expiration of the previous authorization. This prompts the provider to request continued authorization and reduces the risk of breaks in therapy.

Perinatal Depression Screening – In collaboration with CBHNP, CCBH, and Magellan (Behavioral Health MCOs serving AmeriHealth Mercy Members), AmeriHealth Mercy evaluates depression in pregnant woman who reside in the Lehigh Capital region with the Edinburgh depression screening tool. A positive screen triggers a three way call to the BH MCO who assists the Member in scheduling an outpatient behavioral health appointment.

Other initiatives:

- Continued participation in the Brain Injury Task Force meetings with a focus on improved physical and behavioral health coordination
- Cultural and Linguistic Appropriate Services (CLAS), on-going meetings to discuss health disparities
- AMHP internal shift care work group to address behavioral health care needs of Members requesting or receiving shift care services
- AMHP provided CCBH with data to address lipid and glucose testing in Members taking antipsychotics. CCBH to provide a summary of the analysis
- Special Needs Unit specific phone number SNU #1-800-684-5503
- ER Super User Pilot Program discussion with AMHP Medical Director and Reading Hospital for targeted BH-PH-Community Coordination for ER frequent flyers. Currently Reading Hospital is conducting interviews for FTE to lead the program.

F. Maximize the CAQH Process and Credentialing Software Functionality

Practitioner utilization of The Council for Affordable Quality Healthcare (CAQH) universal Credentialing database repository increased as indicated below:

Year	CAQH Participation Rate AMHP and KMHP Network Combined
2008	42%
2009	68%
2010	72%

A new functionality was implemented within the credentialing software:

- Scanner and Importer module- attaches the CAQH application to each practitioner's individual profile.

G. Further Enhance and Refine the HEDIS Data Collection and Analysis Process

Several enhancements were made to the HEDIS data collection process during 2010, including the following:

- Enhanced medical record review chase logic based on 2009 season experience and recommendations
- Designed and implemented GAP in Care data entry process with vendor to provide timely revisions to the care gap data set with provider updates.
- Implemented QA workflow and processes for all files loaded into the HEDIS repository
- Successfully finalized the HEDIS data processing in-source project which moved the compilation of HEDIS data and report generation in-house
- Established and stabilized live production environment
- Implemented a process for monthly interim HEDIS rate generation to identify issues\barriers and address them during the measurement year
- Implemented process for monthly Gap in Care data processing to allow providers the ability to follow up with the Members during measurement year
- Developed and implemented methodology to identify and exclude denied claims from use of services measures (ER, IP, Etc…)
- Supplemented the HEDIS data repository with additional hospital based lab data
- Hired and trained 3 additional data analysis for QM informatics.

H. Formulize interventions specific to select HEDIS measures to improve HEDIS rates

Several interventions specific to select HEDIS measure were implemented during 2010. Details can be found in Section VI, Clinical Performance.

I. Rank within the Top 20 Medicaid Plans

Neither AMHP nor KMHP were successful in achieving the goal of being ranked in the top 20 Medicaid plans nationally.

AMHP improved from 25th to 23rd place for the Best National Medicaid Plan as reported by The National Committee for Quality Assurance (NCQA). KMHP dropped from 26th to 27th place for the Best National Medicaid Plan as reported by NCQA.

The NCQA Ranking is based on performance relative to other plans in Member satisfaction, prevention and treatment, and accreditation. Medicaid plans are evaluated on 41 measures. The highest possible score for the Best National Medicaid Plan is 100. The number one Medicaid Plan achieved a score of 90.7 points. Although the score for both plans improved over the 2009 score, the rank relative to the other plans did not for KMHP.

NCQA Ranking Scores

	AMHP	KMHP
2008	83.9 (#25)	82.9 (#34)
2009	83.3 (#25)	83.1 (#26)
2010	85.2 (#23)	84.8 (#27)

The goal to rank within the top 20 Medicaid Plans remains for 2011.

IV. 2010 QI COMMITTEE STRUCTURE, PRACTITIONER PARTICIPATION & RESOURCES

A. Quality Improvement Committee (QIC) Structure

KMHP/AMHP committee structure addresses the Plan's quality management needs and includes committees, practicing practitioners, staff Members, and work groups that are designated the responsible party for specific quality aspects of care and service. The Quality Improvement Committee (QIC) is the coordinating body for the Plan's efforts to measure, manages, and improve the quality of care and services delivered to Members. The Committee evaluates the effectiveness of the Quality Improvement Program. The following committees report into the QIC: Medical Management Committee, Quality Service Committee and Credentialing Committee. The Regional Clinical Practice Committees (RCPCs) consists of practicing physicians from the Philadelphia and Lehigh Capital regions. The RCPC provides input into clinical programs and initiatives, with a dotted-line reporting relationship to the QIC. The Quality Improvement Committee reports to the Partnership Board, which serves as the governing body for the Plan and retains the ultimate responsibility for the QI Program.

The Quality Improvement Committee met eleven times during 2010. Voting committee Member attendance for 2010 was as follows:

2010 Meetings	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Total
Marge Angello, RN*	A	X	X	X	X	X	X	X	X	A	A	8
Eric Berman, D.O. (Chair)	X	X	A	X	X	A	X	X	X	X	X	9
John Burroughs*	X	A	A	A	A	A	A	A	A	A	A	2
Sandy Duffy *	NA	NA	X	X	X	X	A	A	X	A	A	5
Joanne Dugan *	X	X	A	X	X	X	A	A	X	X	X	8
Scott Fox *	A	X	X	X	X	X	X	X	X	X	X	10
Adele Jones *	NA	NA	A	X	A	A	X	X	A	X	X	5
Bindu Kansupada, MD *	NA	NA	NA	NA	X	X	A	A	X	A	A	3
Lawrence Kay, M.D.*	X	X	X	X	A	A	A	A	A	A	A	4
Catherine Killian*	A	X	X	A	X	X	X	X	A	X	X	8
Anthony Mato, MD*	A	A	X	X	A	X	A	A	A	A	A	3
Lori McNew, R.N. *	X	X	X	X	X	X	X	X	X	X	X	11
Karen Michael, R.N.*	X	X	X	A	A	X	A	A	A	A	A	4
Tina Morton, R.N.*	X	X	X	X	X	X	X	X	X	X	X	11
Benetta Rapier*	A	A	X	X	X	X	X	X	X	X	X	9
David Solis, D.O. *	X	X	X	A	X	X	X	X	X	X	X	10
Clinton Turner, M.D.*	X	X	A	A	X	X	X	X	X	A	X	8
Mika Valazquez, M.D*.	A	A	X	A	A	A	A	A	A	A	A	1
Robert Watterson, M.D. *	A	A	X	A	X	A	X	A	A	A	X	4
Tal Zarom *	A	A	X	A	A	X	X	X	X	A	A	5

X = Present, A = Absent, *= Voting Member † No meeting held in August

The chair contacts committee Members attending less than 50% of meetings, during the time for which they are active Members, regarding membership expectations.

In an effort to better utilize resources, a more focused, visible strategy of utilizing provider focus groups and expanding the contact between our Medical Directors and the practitioner network will be evolving in 2011. The following committee changes are planned for 2011: Both AMHP and KMHP's Regional Clinical Practice Committees and the Medical Management Committee (MMC) will be dissolved. The Quality Improvement Committee will be renamed the Quality Medical Management Committee and the Quality of Service Committee will remain. Both committees will absorb select responsibilities from MMC.

Practitioner Participation
Participating network practitioners actively participated in clinical quality improvement activities and regularly attended committee meetings in 2010. Practitioners included both Primary Care Physicians (PCPs) and specialists. Additionally, the Regional Clinical Practice Committees (RCPC) provided input to the Quality Programs. In 2011, the RCPCs will be dissolved and the practitioner feedback process will be redesigned utilizing quarterly symposiums and focus groups.

C. Quality Resources
Quality Improvement resources for 2010 include the four (4) main components of the Quality Structure (Quality Management, Appeals, Credentialing & Medical Informatics) as well as resources in the Medical Management, Pharmacy and Operations areas of the company.

	2005	2006	2007	2008	2009	2010
Quality Management	***7.0***	***11.0***	***13.0***	***16.0***	***16.0***	***17.0***
Credentialing	***15.0***	***12.0***	***10.0***	***10.0***	***13.0***	***12.0***
Medical Informatics	***11.0***	***12.0***	***12.0***	***12.0***	***12.0***	***10.0***
Medical Management	***3.0***	***3.0***	***3.0***	***3.0***	***3.0***	***3.0***
Pharmacy Services	***7.0***	***12.0***	***12.0***	***12.0***	***12.0***	***12.0***
Operations	***1.5***	***14.50***	***14.50***	***14.50***	***14.50***	***23.0***

The Quality Management Department added one new data analyst and the credentialing staff reduced their staffing by one coordinator. Due to restructuring the Medical Informatics staffing was decreased by two associates. The Operations staffing increased by 7.5 associates, forming a new team for quality auditing.

V. ACCREDITATION

NCQA:
KMHP and AMHP were re-surveyed by NCQA in July 2010 on the 2009 NCQA Standards using the 2010 HEDIS and CAHPS results. Both Plans retained their Excellent Accreditation status. The results are summarized on the following page:

Results	KMHP	AMHP
2010 survey results (max 57.00)	**57.00**	**57.00**
2010 HEDIS and CAHPS (max 43.00)	**37.5066**	**36.8477**
Total Score (max 100)	**94.5066**	**93.8477**
Accreditation Status	**Excellent**	**Excellent**

The next NCQA Accreditation Survey is scheduled for July 2013.

VI. CLINICAL PERFORMANCE

Clinical performance is monitored through a variety of standard measures, including HEDIS and Pennsylvania-specific Performance Measures. Each plan also incorporates population-specific measures in a primary care practitioner pay-for-performance program. Below are the results reported in 2010, for each goal on the Pennsylvania Performance metrics required by the PA Department of Public Welfare:

Keystone Mercy

HEDIS Measure	2009 Rate	2010 Rate	2010 Goal*	Goal Met?
Breast Cancer Screening	52.28	*57.87*	54.67	Yes
Cervical Cancer Screening	70.49	70.98	71.97	No
Controlling High Blood Pressure	66.58	66.58	68.25	No
Diabetes- HbA1c Poor Control**	38.93	36.29	36.98	Yes
Diabetes-LDL-C Control <100	40.88	41.45	43.38	No
Chol Mgmt-Received LDL-C Screening	75.67	80.00	76.89	Yes
Cholesterol Management-LDL-C Control <100	46.96	46.23	49.46	No
Frequency of Ongoing Prenatal Care >= 81% Expected Visits	65.94	67.08	67.64	No
Prenatal Care in the 1st Trimester	79.81	81.08	80.82	Yes
Adolescent Well Care	60.83	57.47	62.79	No
Emergency Room Utilization Rate***	65.55	69.21	63.05	No

*** 5% of the gap between the current rate and 100**
**** Lower is better**
*****Per 1000**

AmeriHealth Mercy

HEDIS Measure	2009 Rate	2010 Rate	2010 Goal*	Goal Met?
Breast Cancer Screening	59.17	61.49	61.21	Yes
Cervical Cancer Screening	73.48	70.43	74.81	No
Controlling High Blood Pressure	63.92	64.84	65.72	No
Diabetes- HbA1c Poor Control**	39.66	35.40	37.68	Yes

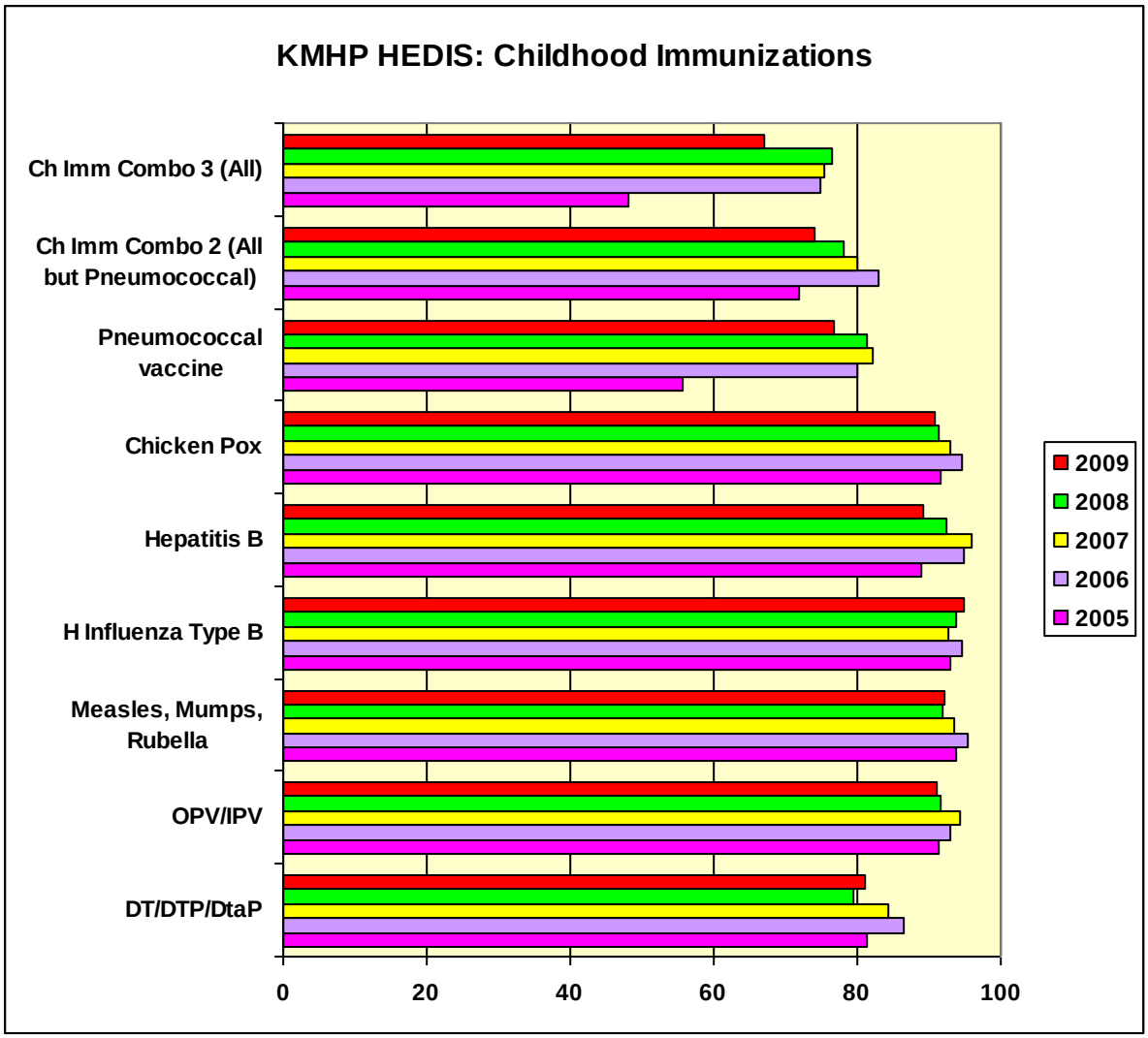
HEDIS Measure	2009 Rate	2010 Rate	2010 Goal*	Goal Met?
Diabetes-LDL-C Control <100	42.58	40.15	45.08	No
Chol Mgmt-Received LDL-C Screening	86.25	88.34	86.94	Yes
Cholesterol Management-LDL-C Control <100	49.57	53.35	52.07	Yes
Frequency of Ongoing Prenatal Care > = 81% Expected Visits	78.10	78.96	79.20	No
Prenatal Care in the 1st Trimester	89.29	89.89	89.83	Yes
Adolescent Well Care	56.27	57.78	58.46	No
Emergency Room Utilization Rate***	80.44	86.68	77.94	No

*** 5% of the gap between the current rate and 100**
**** Lower is better**
*****Per 1000**

A. Reporting Year 2010 HEDIS Rates
In 2010, KMHP/AMHP completed its 2010 HEDIS data collection and submitted the audited findings to NCQA. The HEDIS Effectiveness of Care tables in Appendix A outline the rates of clinical indicators for measurement years 2006, 2007, 2008, 2009, and 2010 and reflect the 2010 national Medicaid percentile achieved**.**

Performance rates were presented and reviewed by the Quality Improvement Committee (QIC) in July 2010.

Discussion – KMHP
KMHP HEDIS: Childhood and Adolescent Immunizations
No significant changes were identified in any of the individual immunization rates. A significant decrease was identified for the combination-3 rate. Interventions that continued in 2010 included the aggressive phone outreach program for children under two to contact the guardian with reminders of immunizations and anticipatory guidance; mailing of birthday cards with the immunization schedule for children ages 1 through 21; posting the current immunization clinical guidelines for providers on the Web; publishing provider and Member newsletter articles; and provision of immunization reminders to the pediatric case management population. In addition, information on missed immunizations appeared as a care gap for providers through the Provider Portal functionality described earlier. In 2010, an additional Member monthly outreach telephonic campaign for a total of 16,559 unique households was initiated specific to Members 8 to 17 months who were missing one or more in the series of the Prevar (pneumococcal conjugate vaccine) immunization.

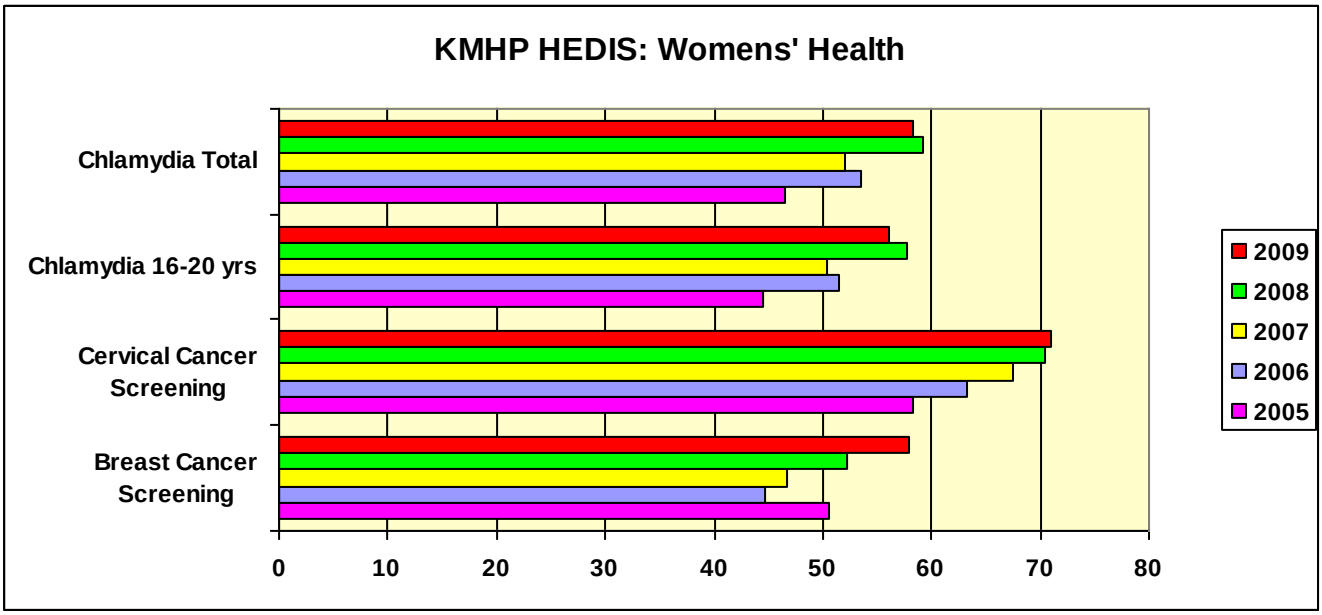


KMHP HEDIS: Women's Health

All five Women's Health screening rates had incremental improvement. Breast Cancer Screening (BCS) and Chlamydia (ages 16 -20) had significant improvement with BCS results meeting goal. Cervical Cancer Screening (CCS) rates did not meet goal. Interventions that carried over from 2009 through 2010 included the following:

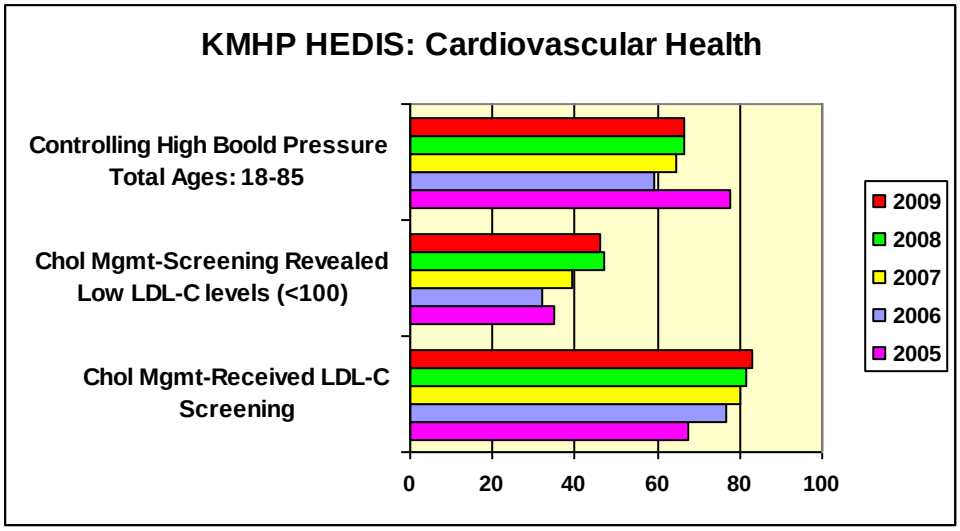
- Member Service on-hold messages related to breast and cervical cancer screening
- Member and provider newsletters articles
- Automated Member outreach reminder calls
- Wellness fairs
- Women's Health Ministry program targeting women's health issues
- Availability of Preventive Health Guidelines on the Plan web site
- Health Risk Assessment questions specific to mammography and PAP testing
- Care Gap data, identifying Members who were missing breast and/or cervical cancer screening tests, was available to care managers for Member outreach

- Care Gap reports identifying Members due or overdue for BCS and/or CCS were mailed to PCPs quarterly and provided via the provider portal at the time of eligibility check and through on-demand reports.
- A media campaign was launched on Radio One using ads that included testimonials and Member education for both breast and cervical cancer screenings
- Educational flyers were placed in high volume practice offices and in community settings
- The Quality of Care Compensation Program, a pay-for-performance program for primary care physicians included the BCS and CCS measures
- Bill-Above capitation was provided as additional re-imbursement to PCPs for performing cervical cancer screenings
- Select PCP practices (6) were provided with Member incentive gift cards for distribution at point-of-service specific to cervical cancer screenings
- Outreach calls were placed to Members for scheduling of CCS and BCS; transportation was arranged, if needed
- Partnerships continued with three hospitals (Mercy Hospital of Philadelphia, Jefferson Methodist and Einstein Women's Center) for block appointment scheduling for BCS and distribution of Member incentive gift card at the time the testing was completed – additional network facilities were added at the end of the year
- Arrangements continued with Lackawanna and Fox Chase mobile vans to schedule on-site mammograms at high volume practices
- The program was continued with the Shop Rite to have a Mobile mammography van on site with Member incentive gift cards distributed at the time testing was completed
- The Retention Team continued to assist with Member outreach for mammography and cervical cancer screenings



KMHP HEDIS: Cardio-Vascular Health

Cholesterol Management screening rates improved and met goal. While both Controlling High Blood Pressure and Cholesterol Management LDL-control < 100 mg/dl rates did not meet goals.

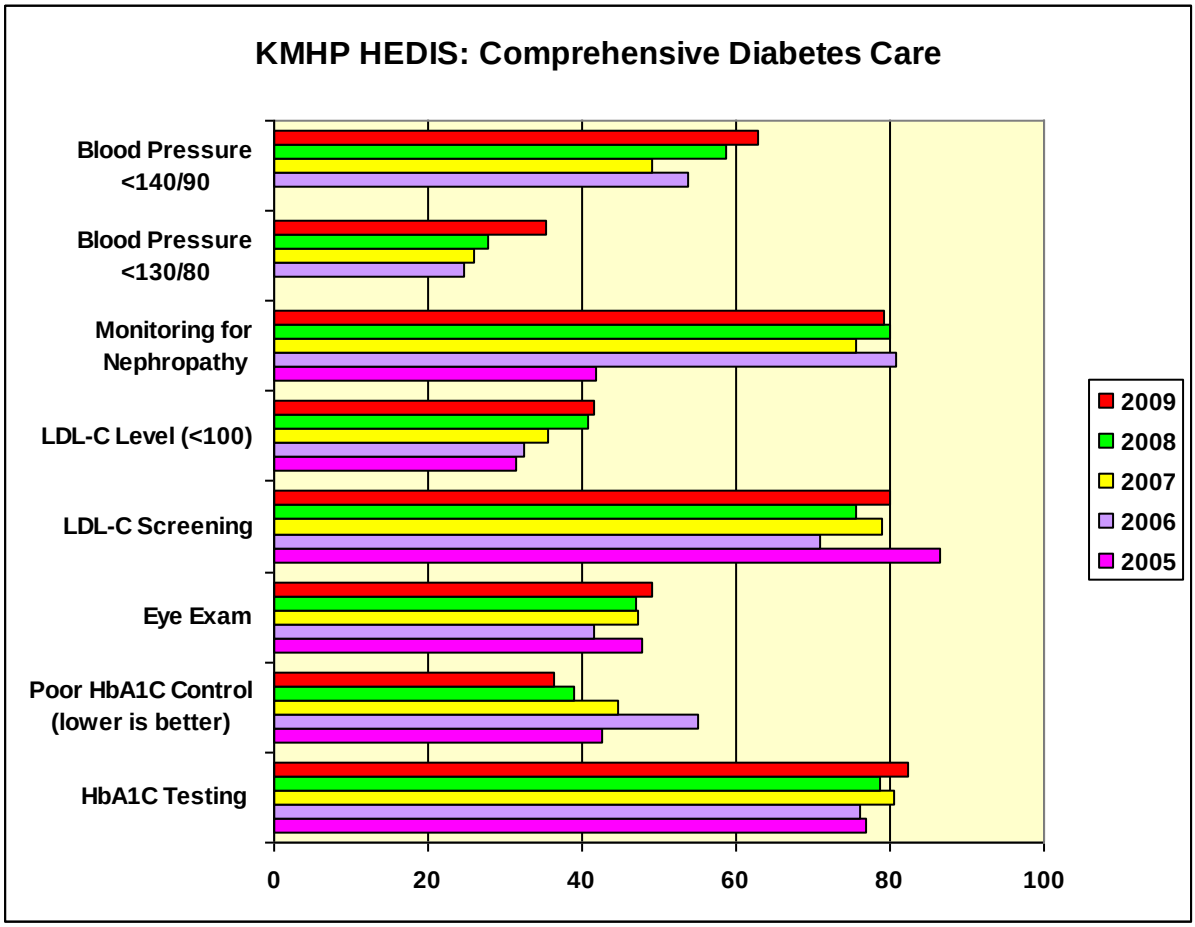


Activities that have carried over from 2009 through 2010 include the following:

- Member Service on-hold messages addressing ~~–K~~now your Numbers" for cholesterol
- Member educational mailings, Member newsletter articles
- Member outreach phone calls
- Clinical Guidelines posted on web
- Community wellness initiatives that included blood pressure screening, blood cholesterol screening, cardiovascular nutritional and physical activity, with distribution of educational materials during events about cardiovascular health
- Enrollment of Members with Heart Failure to Care Coordination and Disease Management
- Care Gap alerts were linked to the PCP provider portal on eligibility check and through on-demand reports
- PCP Quality Care Compensation program continued to include the screening measure LDL-C <100 mg/dl was added to the PCP Quality Care Compensation Program
- Care Gap data, including information on Members missing recommended LDL-testing, was available to Care Management staff and Member Service Staff
- Health Failure disease management Member assessment and education tool utilized by case managers
- Monthly adherence letters were sent to Members and providers when Members were late refilling cardiac medications: Beta-Adrenergic Blocking Agents, ACE Inhibitors, ARBS, Anticoagulants, Diuretics and Vasodilators
- A Heart Failure program continued with Mercy Fitzgerald and Mercy Home Health to provide coordinated follow-up, medication reconciliation and education for Members discharged after an inpatient admission related to Heart Failure

KMHP HEDIS: Comprehensive Diabetes Care

Incremental improvement was noted on all sub-measures with the exception of nephropathy and eye exam. Hemoglobin A1c poor control and screening rates met goal while Cholesterol LDL-C Control <100 mg/dl did not meet goal. Significant improvement was seen in controlling blood pressure <130/80.



Activities that continued from 2009 through 2010 included the following:

- Member Service on-hold messages
- Member newsletter articles, Member educational mailings
- Enrollment of Members with Diabetes in Care Coordination and Disease Management
- Risk stratification and targeted education for case managed Members that have diabetes
- Screening and education at Wellness Fairs
- Availability of clinical guidelines on the Plan website
- A Care Gap database, containing information on Members missing recommended HgbA1c and LDL-C testing is available to Care Management staff
- The Diabetes Health Risk Assessment tool screens for LDL-C cholesterol testing and levels
- Telephonic Member outreach to Members identified with A1C >8.5 conducted by the care management team

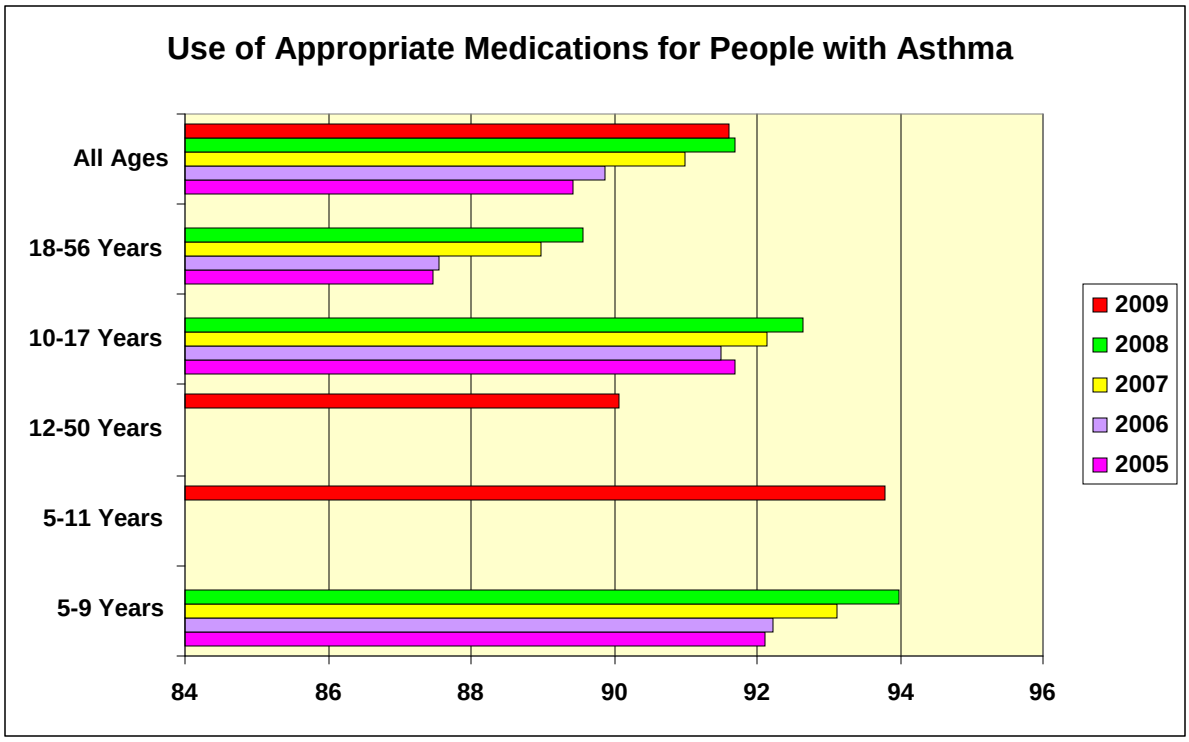
- The Quality of Care Compensation Program, a pay-for-performance program for primary care practitioners includes HgbA1c screening and poor control and LDL-C cholesterol screening and control <100
- Care Gap alerts were linked to the PCP provider portal
- Pilot with a Case Manager on-site at a provider office to address care gaps in coordination with the physician practice
- Late refill mailings were sent to Members and providers for Members taking oral hypoglycemic medications
- The technology pilot for high risk Members that allowed them to upload their blood sugar monitoring results to a secure application monitored by Plan care managers was concluded
- Provider Network Account Executives conducted in-services on HEDIS measures for practices with 75 or more Members
- Automated telephonic Member outreach educational calls regarding the importance of blood testing
- Lose to Win: A pilot initiative for adults with five Philadelphia YMCAs; over 125 Diabetic Members participated over a twelve week period. Program consisted of monitoring of A1C, LDL, BMI as well as exercise, nutritional education
- Care Gap data identifying Members who were missing HbA1C screening tests was provided to Member Services for inbound Member calls
- A Certified Diabetic Educator continued in the role of a Case Manager

New interventions for 2010 included:

- Drug Therapy Management in collaboration with our Pharmacy Benefit Manager was initiated in the fall of 2010
- Member outreach calls were conducted regarding formulary change (Lentus to Levimir)

KMHP HEDIS: Use of Appropriate Medications for Asthma

No significant changes were seen for all ages. Two new age groups were added this year:
Age 5 to 11 and 12 to 50 yrs old.



Activities that continued from 2009 through 2010 included the following:

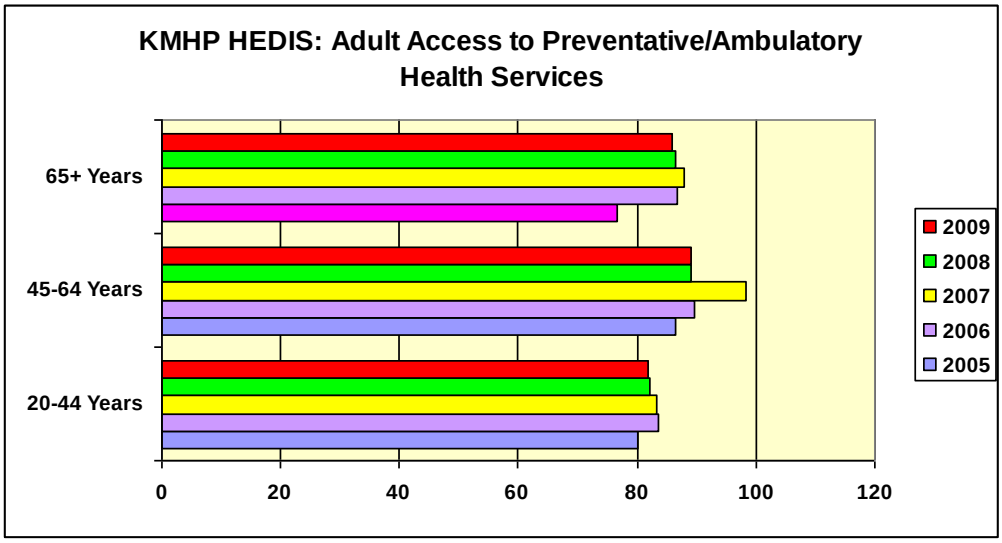
- Enrollment of Members with Asthma in Care Coordination
- Late refill mailings to Members and providers for Members taking asthma controller medications
- One Healthy Hoops Event was held in Philadelphia, attended by approximately 500 children ages 8 to 14 and their families; the program provides education on asthma and the importance of exercise in controlling asthma
- Availability of clinical guidelines on the Plan website
- Member and Provider educational newsletters articles
- Pharmacy reports identifying Members on asthma medications which include detailed Member and prescriber information and Member letters regarding controller meds and overuse of albuterol
- Asthma Safe Kids: A pilot program with the National Nursing Centers Consortium to promote better asthma management that included three home visits and two telephone calls with Member‘s parent/caregiver. Approximately 169 children ages 1-18 yrs old participated.
- Care Gap data, identifying Members who were missing appropriate asthma medication was provided to Member Services for inbound Member calls
- Care Gap data, including information on Members with asthma who may be candidates for controller medication, was made available to Care Management staff
- Care Gap alerts were linked to the PCP provider portal and provided during eligibility check and on-demand reports

New interventions for 2010:

- The Healthy Hoops Asthma Drug Therapy Management Program was initiated
- Chester Home Asthma Prevention Program, a home environmental assessment outreach program is in the developmental phase. The goal is to refer approximately 75 Members who have been

identified having Asthma and to work collaboratively with Member and their PCP for improved management

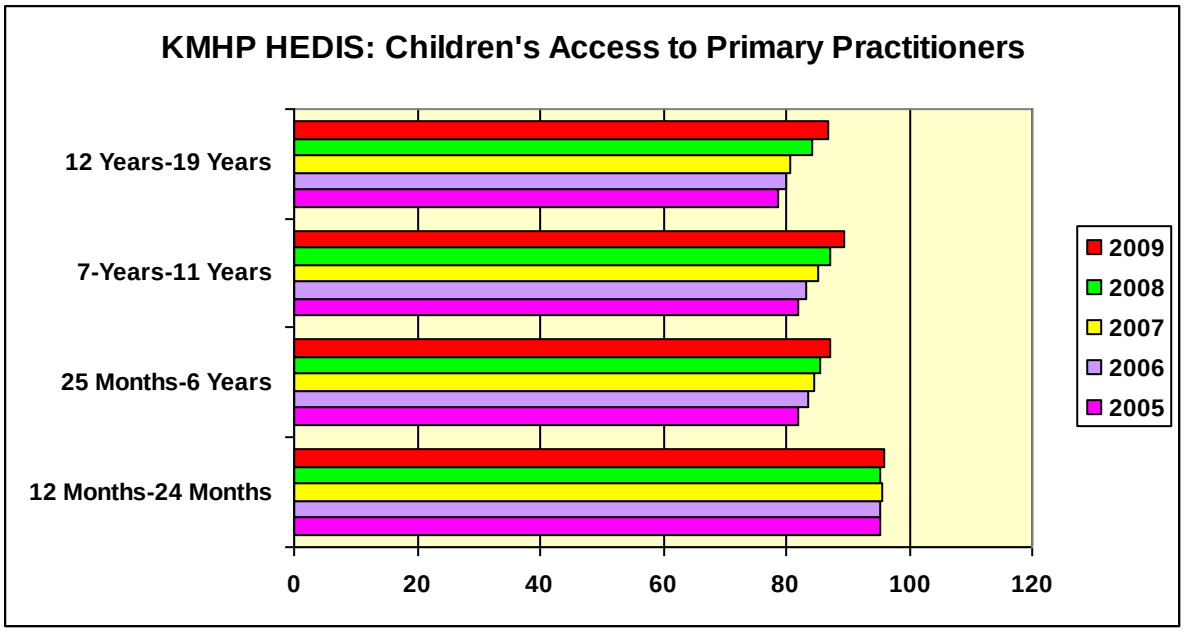
KMHP HEDIS: Adult Access to Preventative and Ambulatory Health Care
Adult Access to Preventative services decreased significantly for the 20-44 age group. All other age groups decrease slightly.



Interventions for 2010:

- Flu outreach telephonic campaign
- Telephonic outreach campaign for Members 65 years and older who did not have a claim or encounter for a physician visit by mid year

KMHP HEDIS: Children's Access to PCP
The rates for three of the four age ranges showed a statistically significant increase. The 12 to 24-month age group showed a slight improvement.

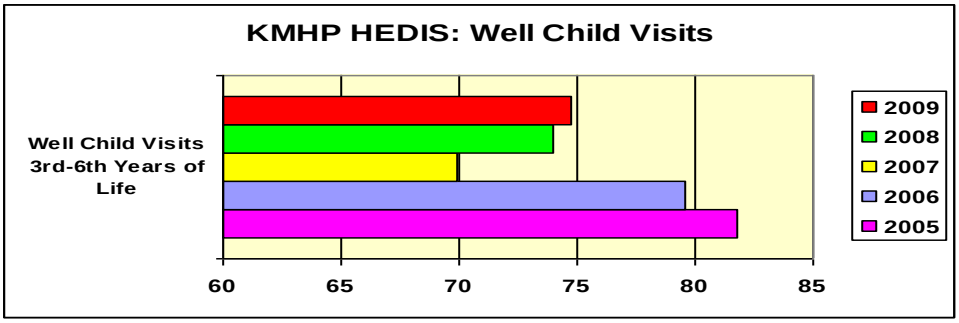


Activities that continued from 2009 through 2010 included the following:

- Birthday card reminders
- Member outreach reminder calls
- Member and provider newsletter articles,
- Availability of Preventative Health Guidelines on the Plan website
- Community Health Fairs

KMHP HEDIS: Well Child Visits

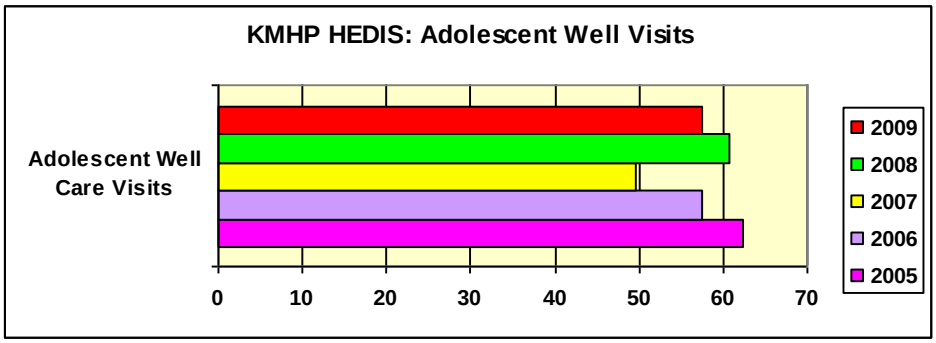
Well Child rates for children 3-6 years showed an incremental improvement.



Activities that continued from 2009 through 2010 included the following:

- Member and provider newsletter articles
- Birthday cards with reminders for a well visit check up
- Member reminder outreach calls
- Education on Well Child Care at community health fairs

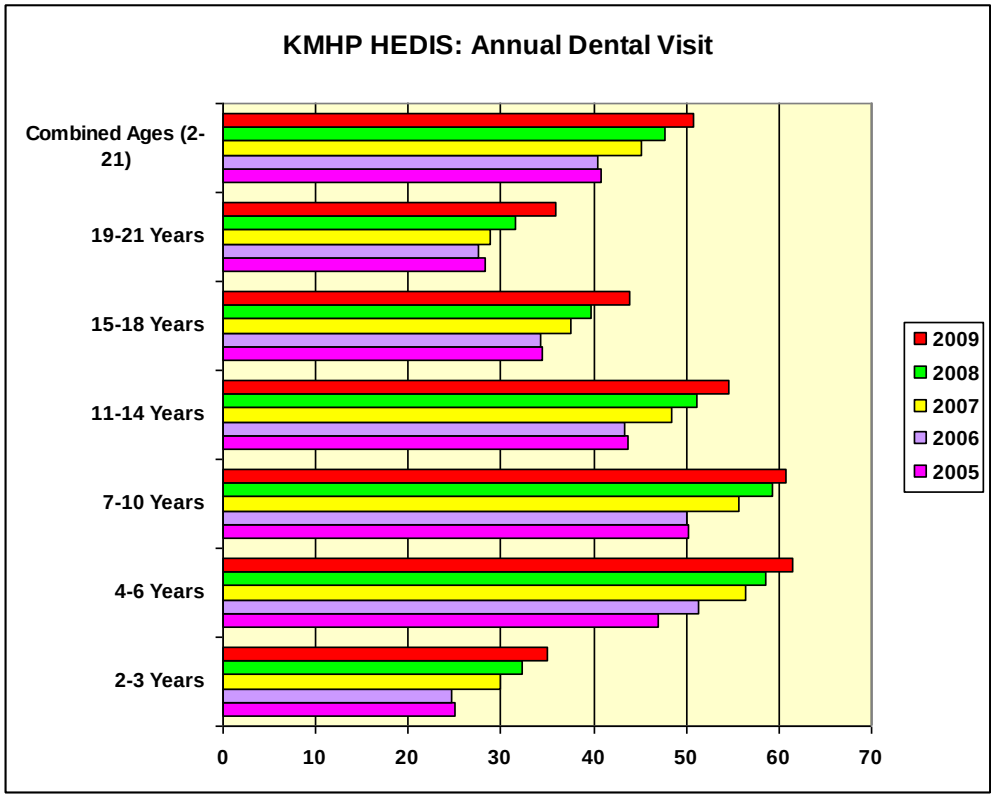
KMHP HEDIS: Adolescent Well Visit
The Adolescent Well Visit rate decreased slightly and the goal was not met.



Interventions that continued from 2009 into 2010:

- Care Gap data, including information on Members missing an annual adolescent well visit available to Care Management Staff and Member Service Staff
- The Quality of Care Compensation Program, a pay-for-performance program for PCPs, included Adolescent well visit rates
- A pilot program for select practices to distribute Member incentives (movie passes) to adolescents for having well visits continued into the first quarter only
- Automated Member outreach calls for Members due or overdue for wellness check

KMHP HEDIS: Annual Dental Visit
Results for all eight measures improved significantly.



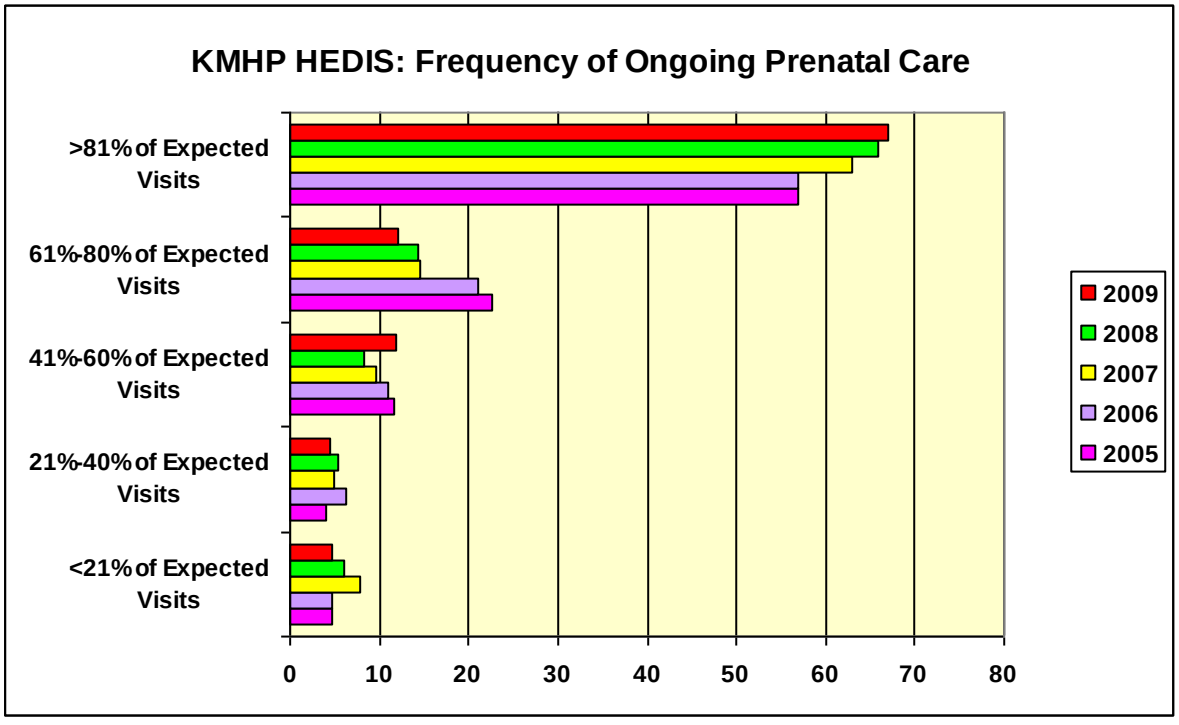
Activities from 2009 continued in 2010 and included the following:

- Provider and Member newsletter articles
- Birthday cards with dental care reminders
- Specific dental visit questions were added to the care management health risk assessment tool
- Online dental directory
- Wellness fairs with Member educational materials
- The Smiling Stork program, a dental educational program for pregnant Members regarding the importance of good dental health for both mom and baby

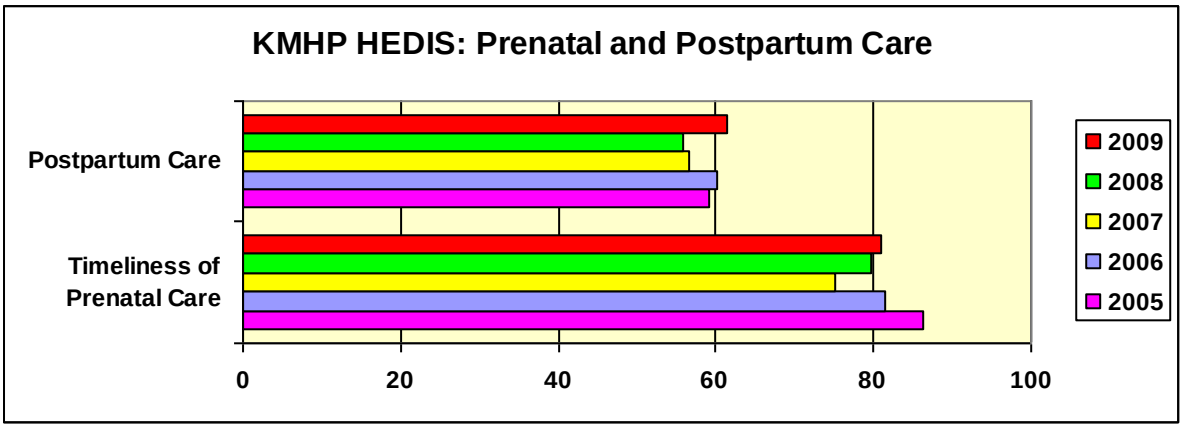
New interventions for 2010:

- Coordinated three on-site dental screening events for pregnant Members.
- Expanded care gaps to include an annual dental visit

KMHP HEDIS: Frequency of Ongoing Prenatal Care:
The rate for Frequency of Ongoing Prenatal Care >81% of Expected Visits was maintained and did not meet goal.



KMHP HEDIS: Prenatal and Postpartum Care
Both measures showed incremental improvement with Timeliness of Prenatal Care meeting goal.



Activities from 2009 continued through 2010 and included the following:

- Member incentive (newborn outfit) sent following delivery
- Availability of Doula services
- Partnerships with three community-based agencies (Intercultural Family, Maternity Care Coalition, and Congresso) to assist with locating and educating Members
- Member education on prenatal care at community health fairs
- Member educational newsletter articles
- Member Service on-hold message reinforcing the importance of early prenatal care
- Mailings to low risk Members on the importance of ongoing prenatal care
- Telephonic outreach by a maternity care manager for high risk Members
- Use of prenatal visit tracking tool within the Care Management system
- Members identified as pregnant in the enrollment file received priority outreach and engagement in the WeeCare program
- Continuation of the Centering Program
- Free pregnancy tests were distributed at wellness health fairs
- Member outreach was started to Members having a prescription for prenatal vitamins filled
- A Member incentive ($25 gift card) for completing post- partum visit
- Additional re-imbursement (above capitation) for PCPs completing the initial prenatal visit
- Practitioners using newly developed (2009) OB assessment form to capture Depression, Smoking Cessation and Domestic abuse
- A media campaign was conducted to educate Members on the importance of early prenatal care

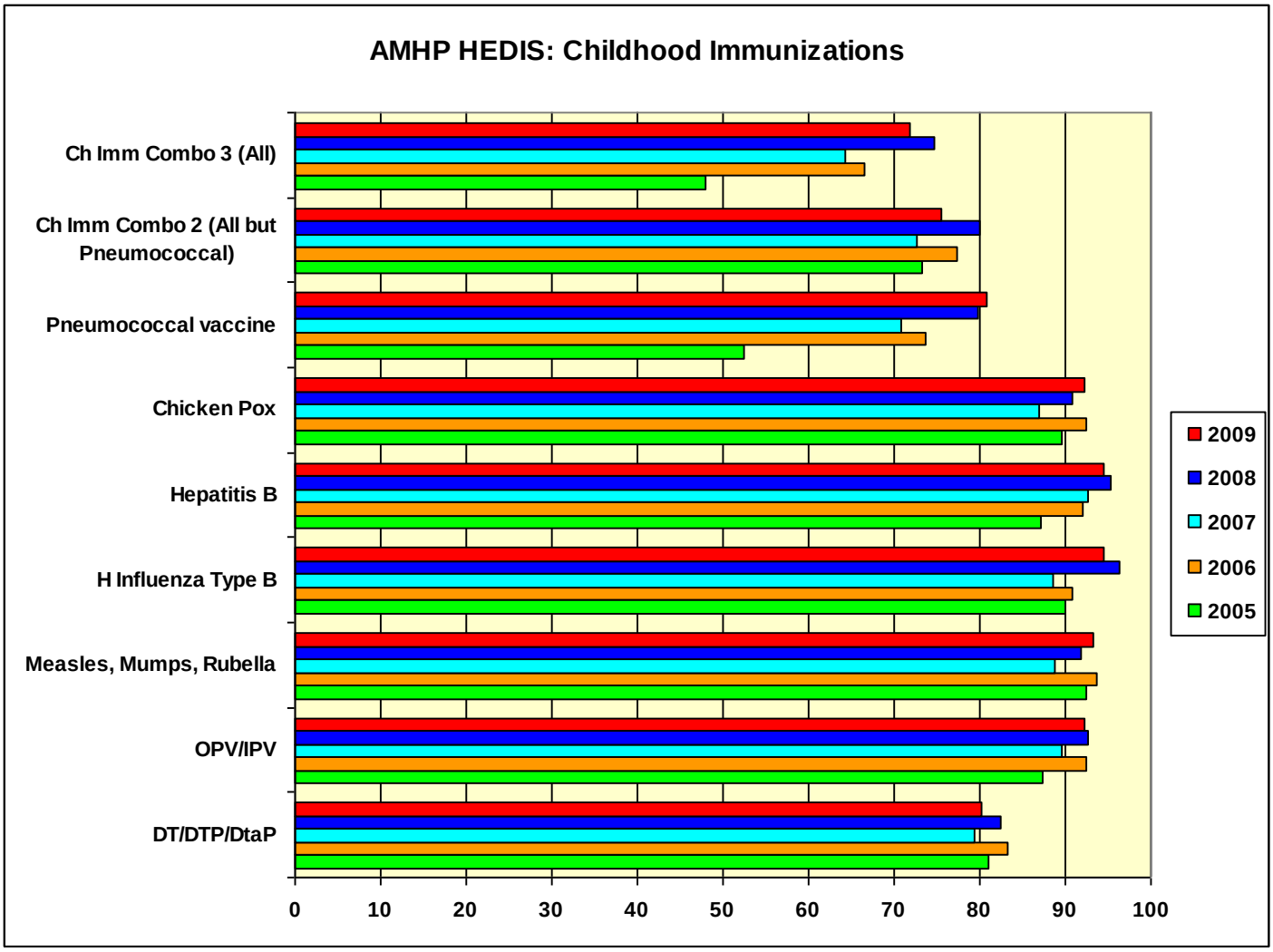
New interventions for 2010:

- Co-hosted three community baby showers.

Discussion – AMHP

AMHP HEDIS: Childhood and Adolescent Immunizations

In 2009, all immunization rates decreased slightly with the exception of the Pneumococcal vaccine, Chicken Pox and the MMR which increased slightly.

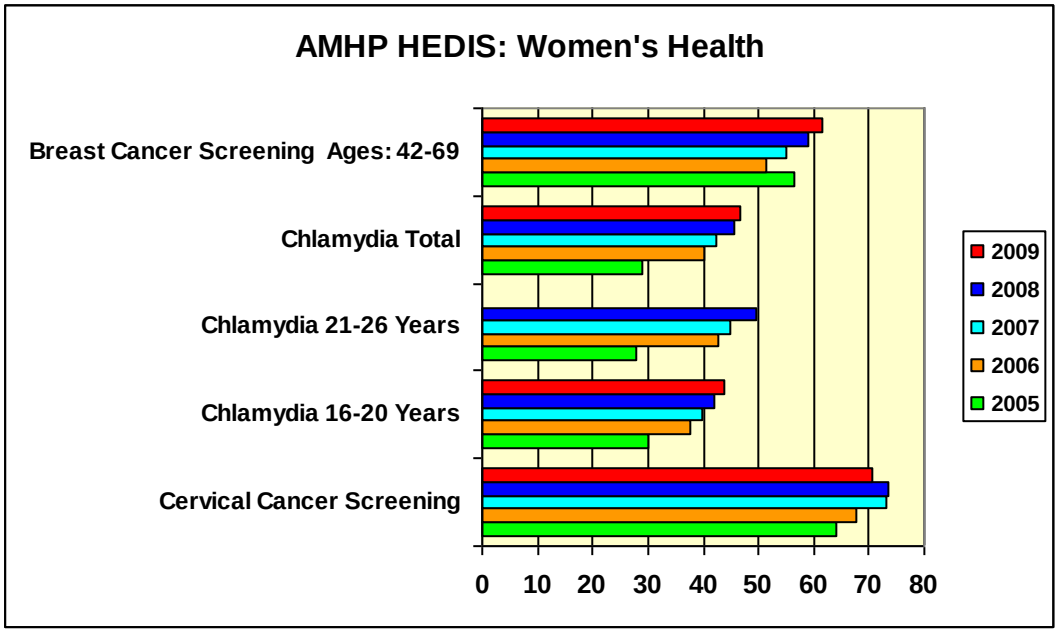


Interventions that continued from 2009 included:

- Aggressive phone outreach program for children under two to contact the guardian with reminders of immunizations and anticipatory guidance
- Birthday card mailings with the immunization schedule for children ages 1 through 21
- Immunization clinical guidelines posted for providers on the Web
- Provider and Member educational newsletter articles
- Immunization reminders to the pediatric case management population
- Care gap (missed immunizations) available to case managers, Member Services staff and Providers (via provider portal)

AMHP HEDIS: Women's Health

Breast Cancer Screening (BCS) and Chlamydia Screening rates increased with BCS meeting goal. There was a decrease in the Cervical Cancer Screening (CCS) rate.

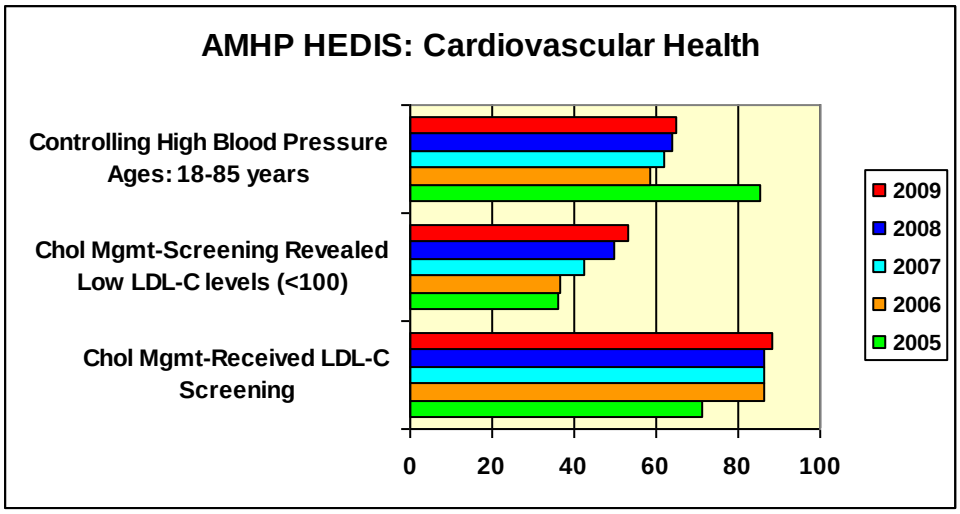


Activities continued from 2009 included:

- Member Service on-hold messages related to the importance of breast and cervical cancer screenings
- Member and provider newsletters articles
- Wellness workshops and health fairs given at faith-based organizations on women's health,
- Availability of Preventive Health Guidelines on the Plan web site
- New Member Health Risk Assessment questions specific to Member's last mammography and PAP smear
- Primary Care Provider Incentive Program, a pay-for-performance program for primary care practitioners includes measures based on breast cancer and cervical cancer screening rates,
- Member Service Representatives initiated Member educational closings on all inbound call
- Care Gap reports identifying Members due or overdue for Mammography and/or Pap testing were mailed to PCPs quarterly, as well as being accessible via the provider portal

AMHP HEDIS: Cardiovascular Health

The rates for Controlling High Blood Pressure and LDL-C cholesterol management <100 mg/dl increased with Cholesterol Management Screening and Control meeting goal.

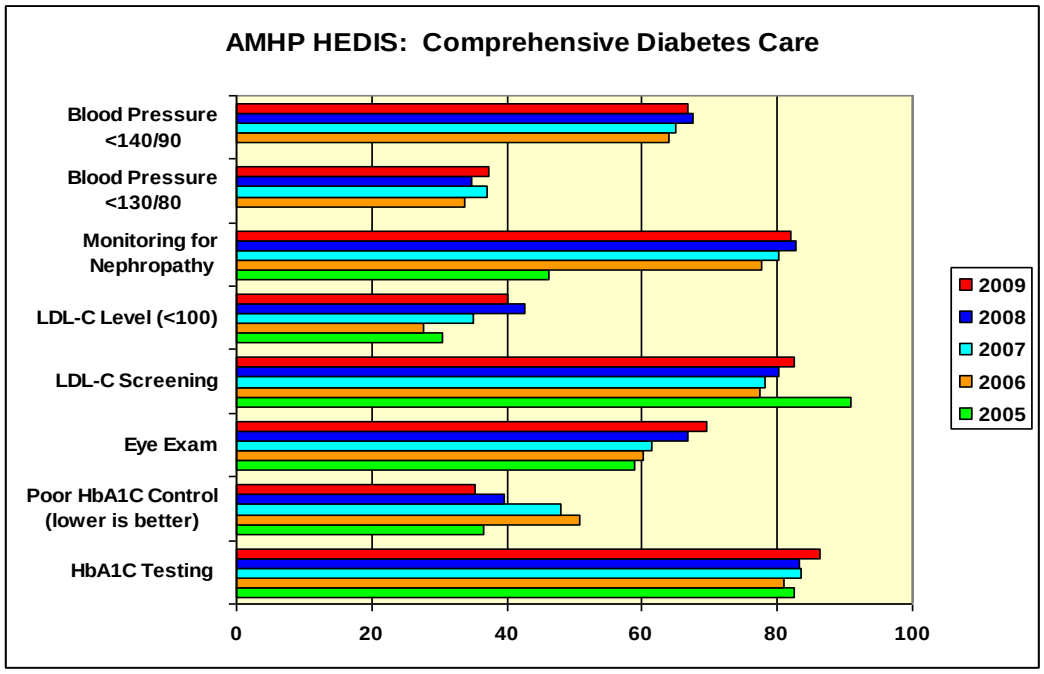


Activities that continued included the following:

- Member Service on-hold messages addressing –Know your Numbers" for cholesterol
- Member educational mailings, newsletters articles and outreach calls
- Care gap data available to case managers and Member Services staff
- Clinical Guidelines posted on web
- Community wellness initiatives that included blood pressure screening, blood cholesterol screening, cardiovascular nutritional and physical activity, with distribution of educational materials during events about cardiovascular health
- Health education programs were also offered to Members to help them understand the primary function of the heart and its importance
- In addition, monthly wellness workshops were conducted on topics that included healthy weight, healthy heart, heart healthy foods and stress management

AMHP HEDIS: Comprehensive Diabetes Care

Rates improved for Blood Pressure control 130/80, LDL Screening, eye exam, A1c Control and screening. Hemoglobin A1C Poor Control results met goal.

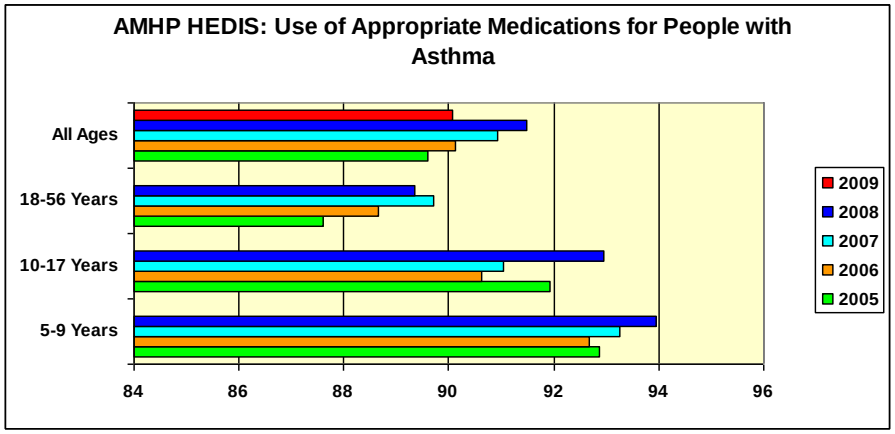


Activities that continued in 2010 from 2009 included:

- Wellness educational workshops at faith-based and community centered organizations
- Member educational newsletter articles
- Educational posters for PCP offices
- Educational Member service on-hold messages
- Quarterly educational mailings for Members identified as diabetic to encourage diabetic screening and provide information on diabetes and management of the condition
- Enrollment of Members identified with Diabetes in the Care Coordination Program,
- Care Gap data, including information on Members missing recommended HgbA1c and LDL-testing, available to Care Management staff and providers

AMHP HEDIS: Use of Appropriate Medication for People with Asthma

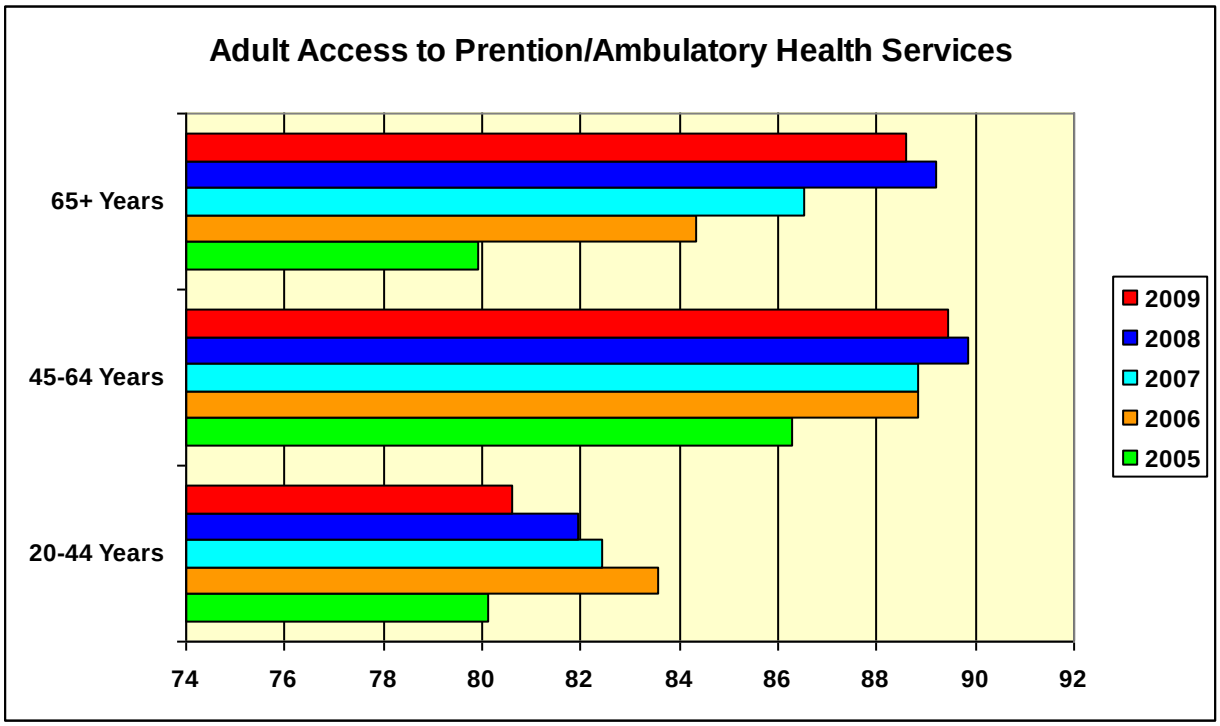
There was no statistically significant change in the rates for Use of Appropriate Medication for People with Asthma.



Activities continued in 2009 included:

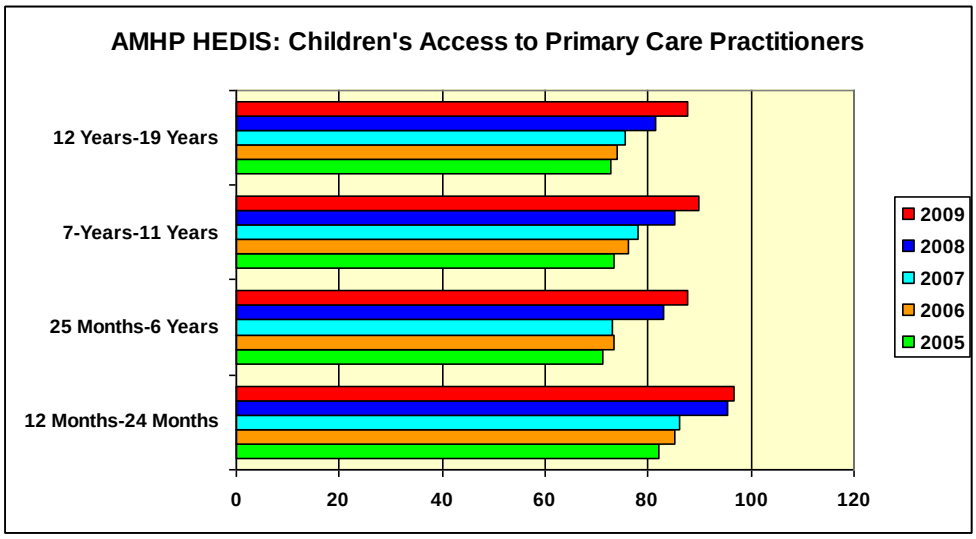
- Community Outreach Staff interaction with Members at various community events
- Member and Provider newsletters articles
- Enrollment of Members diagnosed with Asthma in the Care Coordination Program
- Missed refill Member and provider mailings sent to Members who are more than 6 days late in filling one of their controller medications; the letter encourages Members to take their medications regularly to best control their symptoms
- Identifying overuse of rescue medications: Members overusing rescue medications based upon national guideline recommendations were identified; educational materials were sent to both the provider and the Member encouraging the use of a controller medication to improve daily asthma symptoms; the Member letter informed the Member that they might be able to decrease their daily asthma symptoms with a controller medication that they use on a regular basis; the provider letter reminded providers of the formulary controller, medications, and provided the treatment algorithm pages from the NHLBI 2009 guidelines
- Care Gap data, including information on Members with asthma who may be candidates for controller medication, was available to Care Management staff
- Access to a pharmacy application giving care managers access to real time pharmacy data and to identify Members‘ overuse of rescue medications

AMHP HEDIS: Adult Access to Preventive and Ambulatory Health Care
All measures for Adult Access to Preventive decreased with only the 22 to 44-year age group having a statistically significant decrease from the previous year.



AMHP HEDIS: Children's Access to PCP

All four Children's Access to PCP measures had as statistically significant improvement.

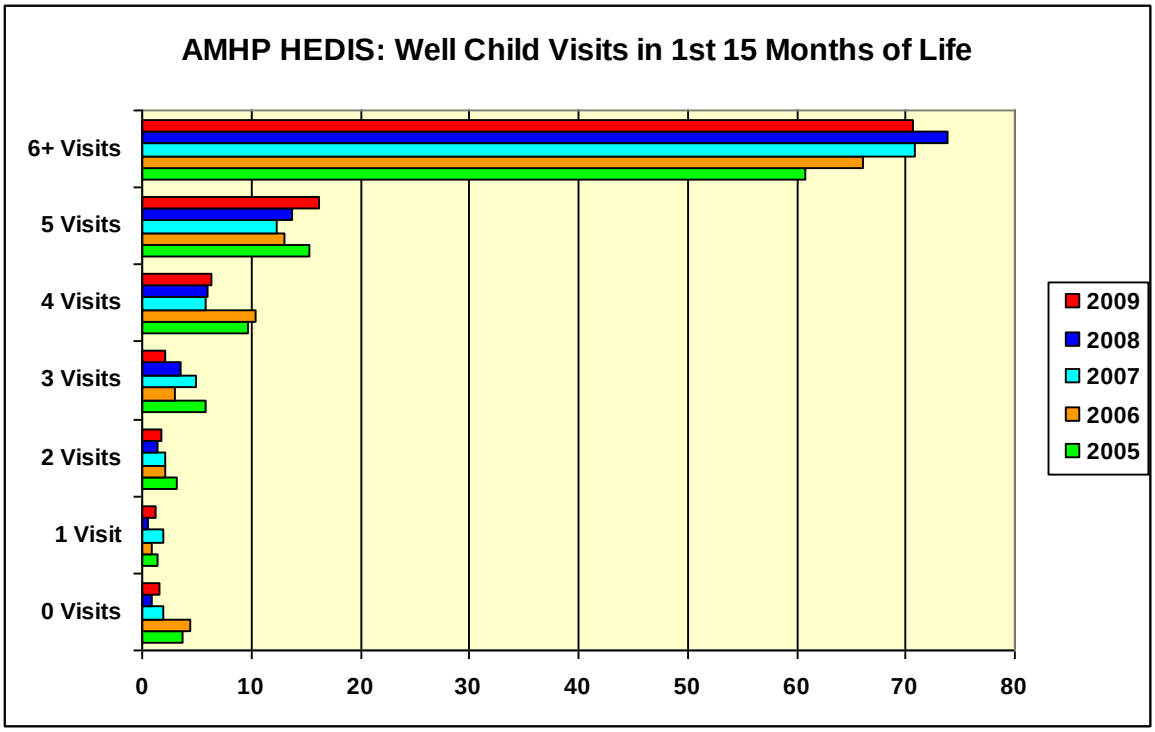


Activities continued and included:

- Birthday card reminders
- Member outreach reminder calls
- Member and provider newsletter articles
- Availability of Preventative Health Guidelines on the Plan's website
- Health Fairs

AMHP HEDIS: Well Child Visits

The Well Child Visit measure 3-6th Years of Life improved. The Well Child in the 1st 15 Months of Life showed a non-significant decrease.

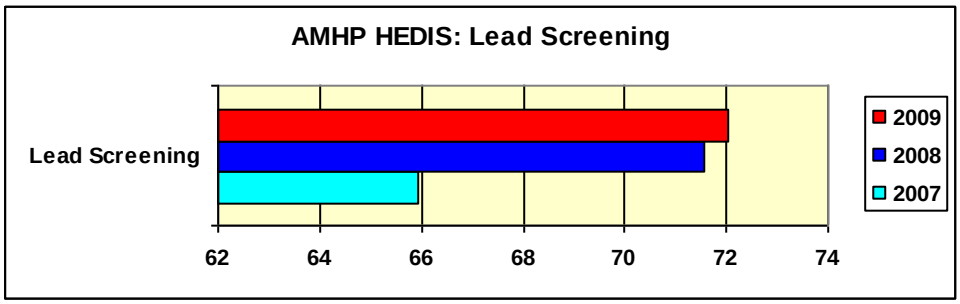


Activities that continued from the previous year included the following:

- Member and provider newsletter articles
- Birthday cards with reminders for a well visit check up
- Member reminder outreach calls by EPSDT staff
- Education on Well Child Care at community health fairs
- Automated Member outreach calls for Members due or overdue for a wellness check
- Care Gap data, including information on Members missing an annual adolescent well visit,
- The Primary Care Provider Incentive Program, a pay-for-performance program, included measures based on Adolescent well visit rate
- Reminder calls to Members to make appointments by the EPSDT Outreach

AMHP HEDIS: LEAD Screenings

In 2009, the lead screening rate increased over the 2008 rate from 71.58 to 72.02.



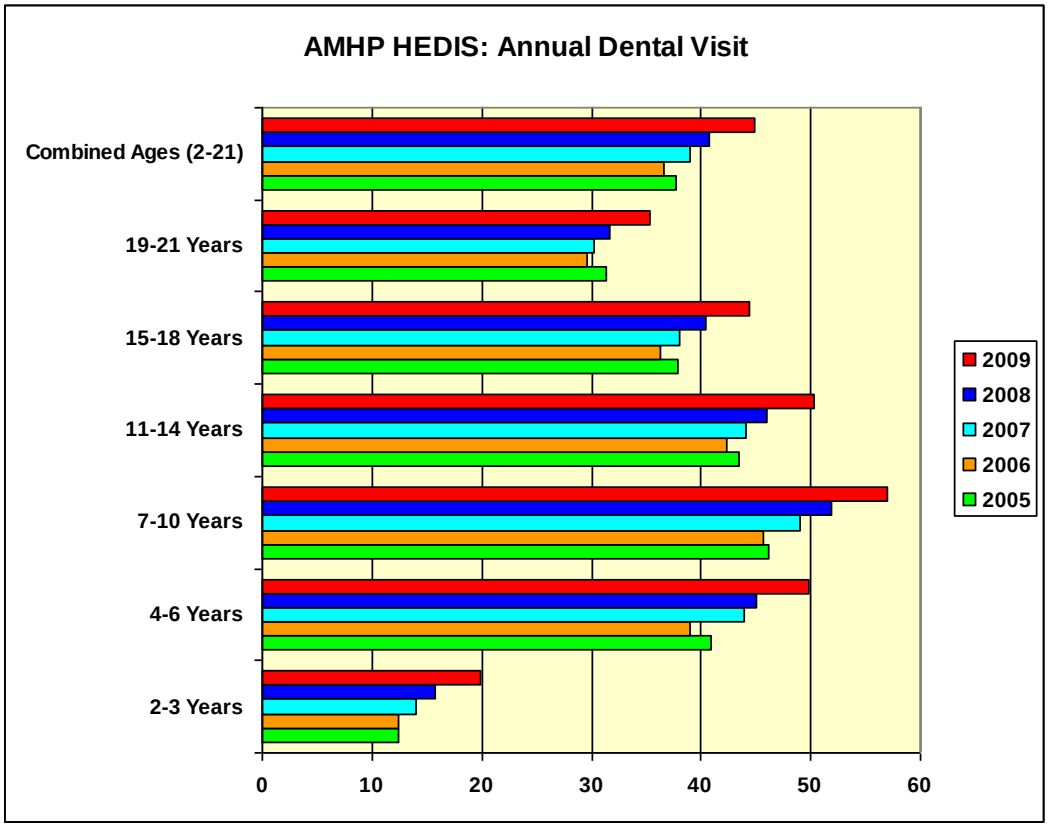
Interventions that continued:

- Care Gap functionality
- EPSDT Member telephonic outreach team for missed screenings

- Case management outreach to Members with higher than normal lead screenings
- Educational material (fact sheet) for Members during community events
- Provider education on the requirement that all Medicaid children be screened for elevated lead levels

AMHP HEDIS: Dental Visit

Results for all dental measures had a statistically significant improvement.

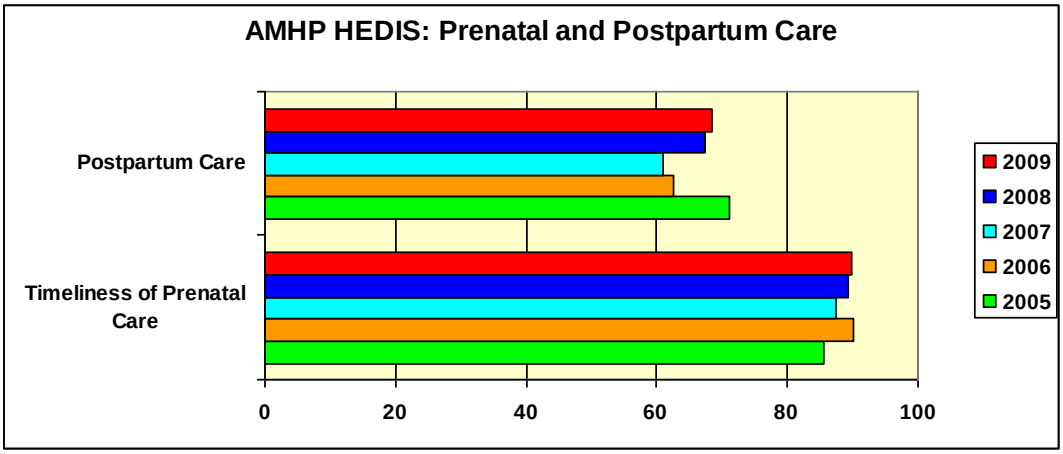


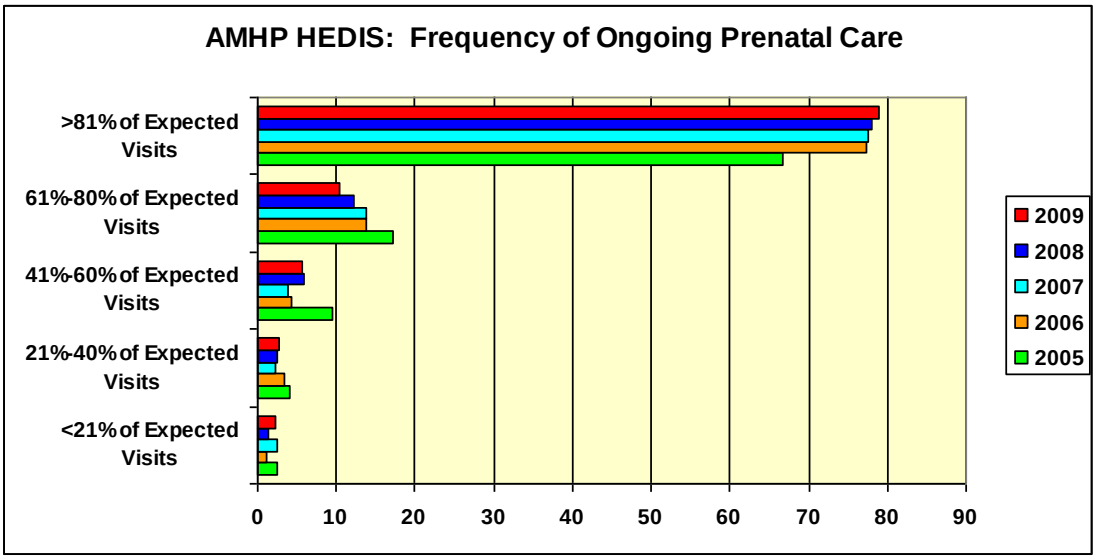
Activities that continued from the previous year:

- Provider and Member newsletter articles
- Birthday cards with dental care reminders
- Specific dental visit questions as part of the care management health risk assessment tool
- Wellness fairs with Member educational materials
- Smiling Stork Dental program
- On-Hold Messaging
- Prescription Appointment Reminder Cards provided to PCPs
- Doral Dental real-time online directory
- Case Management Technician outreach to Members that have been to the ER for dental issues; the Technician assists with alleviating barriers and scheduling dental appointments

AMHP HEDIS: Prenatal and Postpartum Care

The Frequency of Ongoing Prenatal Care rate > 81% visits and Postpartum Care rates increased.





Activities that continued form the previous year included:

- Member incentives to encourage Members to attend the follow up postpartum visit
- WeeCare maternity management program
- Member Service on-hold messages reinforcing the importance of early prenatal care
- Member Newsletter Articles
- Educational meetings with select maternity providers in the Lehigh Capital Zone to promote the WeeCare program and identify ways to seamlessly communicate with the practices to facilitate coordination of care
- Mailings to low risk Members on the importance of ongoing prenatal care
- Telephonic outreach by a maternity care manager for high risk Members
- The 17P Program to promote the use of this medication in Members at risk for pre-term birth
- Depression screening on all Members engaged in WeeCare
- Prenatal vitamin call-out program

HEDIS Disparity Analysis:
Both KMHP and AMHP recognized that the Member race/ethnicity/language data received from the Department of Public Welfare (DPW) is flawed. Both plans rely on the DPW for race/ethnicity/language data for their membership. DPW acknowledges that this data is somewhat inaccurate due to possible varying collection policies in the counties and Member non-compliance with self-identification on the initial application. As the result of our findings, the HealthCare Equities project was initiated in 2009 and continued in 2010 with a focus on improving the integrity of the race/ethnicity/language data used for program planning and disparity analysis. Additionally, both plans applied as an early adopter of NCQA's Multicultural Health Care (MHC) Distinction with the survey to be completed in 1st quarter 2011.

An analysis of the 2010 HEDIS results (measurement year 2009) by the available race, ethnicity and language was conducted using a two-tailed z test at the 95% confidence level. The analysis compared African American and Hispanic Members to White Members, and Hispanic Members to non-Hispanic Members using race and ethnicity data supplied by DPW in the enrollment file. The language analysis compared English to non-English speaking Members.

KMHP Discussion:
Most differences were identified in the diabetes, asthma management, maternity, lead screening and dental visits.

KMHP 2010 HEDIS Summary Analysis Based on Race	
Measure	**Significance Identified**
Frequency of Prenatal Care > 81-100% Expected Visits	African American compliance is significantly lower compared to total.
Diabetes A1c >9	African American and White rates are lower but not significantly Asian compliance is significantly higher
Diabetes Blood Pressure < 130/80	African American compliance is significantly lower compared to total.
Diabetes Blood Pressure < 140/80	
Lead Screening	White compliance is significantly lower.
Prenatal Visits	African American compliance is significantly lower compared to total.
Asthma	African American, Hispanic and Asian are lower but not significantly White compliance is significantly higher compared to total.
Breast Cancer Screening	White compliance is significantly lower.
Annual Dental Visit	African American compliance is significantly lower.
KMHP 2010 HEDIS Summary Analysis based on Ethnicity	
Measure	**Significance Identified**
Diabetes LDL- Screening	Non-Hispanic compliance is lower but not significantly Hispanic compliance is significantly higher compared to total
Asthma	Hispanic compliance is significantly lower compared to total.
Breast Cancer Screening	Non-Hispanic compliance is significantly lower.
Annual Dental Visit	Non-Hispanic compliance is significantly lower.

KMHP 2010 HEDIS Summary Analysis based on Language	
Measure	**Significance Identified**
Adult Access to PCP Age 20 - 44	Rate for English-speaking population is lower Asian/Pacific island is significantly higher than the total
Adult Access to PCP Age 45 - 64	Rate for English-speaking population is lower Spanish, Other Indo-Euro and Asian Pacific Islander are significantly higher than the total
Dental	Rate for English-speaking population is significantly lower in the 4-10 age group Spanish, Other Indo-Euro and Asian Pacific Islander are significantly higher than the total in most age groups
Breast Cancer Screening	Rate for English-speaking population is significantly lower Spanish and Asian Pacific Islander are significantly higher than the total.
Children Access to PCP	Rate for English-speaking population is lower Spanish and Asian Pacific Islander are significantly higher than the total in most age groups
Lead Screening	Rate for English-speaking population is lower Spanish are significantly higher than the total

The following activities were implemented in 2010 to address the above disparities:

- Asthma: Healthy Hoops (focusing on the African American community)
- Maternity: Focused community baby showers in West Philadelphia (African American and new immigrant communities)
- Dental Visits: Focused community events.

AMHP Discussion:
The analysis identified 7 statistically significant differences in 20 of the –Effectiveness of care" and –Access & Availability" measures. The main differences where identified in the diabetes, breast cancer screening, maternity and dental care.

AMHP 2010 HEDIS Summary Analysis Based on Race	
Measure	**Significance Identified**
Diabetes A1C Test	African American compliance is significantly lower in both A1C screenings and levels compared to total.
Diabetes A1c >9	
Cardiovascular LDL Screening	African American compliance is significantly lower compared to total.
Postpartum Visits	White compliance is significantly higher compared to total.
Prenatal Visits	African American compliance is significantly lower compared to total.
Breast Cancer Screening	African American and White compliance is significantly lower compared to total.
Annual Dental Visit	White compliance is significantly lower compared total.

AMHP 2010 HEDIS Summary Analysis Based on Ethnicity	
Measure	**Significance Identified**
Cervical Cancer Screening	Hispanic compliance is significantly higher compared to total.
Postpartum	Hispanic compliance is significantly lower compared to total.
Breast Cancer Screening	Non-Hispanic compliance is significantly lower than the total Hispanics compliance is significantly higher than the total.
Annual Dental Visit	Hispanic rate is significantly higher compared to total.
AMHP 2010 HEDIS Summary Analysis based on Language	
Measure	**Significance identified**
Diabetes A1c >9	Spanish speaking population is significantly lower(better) than total
Adult access to PCP	Spanish speaking population is significantly higher than total in all age groups. English speaking population is significantly lower in most age groups
Dental	Spanish speaking population is significantly higher than total in all age groups. English speaking population is significantly lower in most age groups
Breast Cancer Screening	Spanish speaking population is significantly higher than total. English are significantly lower
Children Access to PCP	Spanish speaking population is significantly higher than total in all age groups.

The following activities were implemented in 2010 to address the following disparities:

- Diabetes and Maternity: Promotora program – providing education in Spanish using culturally-adopted materials
- Dental and Breast Cancer Screening: Focused community educational events.

B. Physician Performance

KMHP Discussion:

The Quality of Care Compensation Program (QCCP) initiated in 2008 continued in 2010. The program is open to PCPs with a panel size of 75 or more Members. Approximately 595 primary care provider sites are eligible for this program. Profiles are distributed every six months. The program is a pay-for performance incentive based on high quality, cost-effective care, Member service and convenience, and health data submission. The following HEDIS measures are included in the program: adolescent well care visits, breast cancer screening, cervical cancer screening, HbA1c screening, use of appropriate medications for people with asthma and emergency room utilization. In 2009, three additional HEDIS measures were added: They are: HbA1C Poor Control >9% for diabetics; LDL-C Control <100 mg/dl for diabetics; and LDL-C Control <100 mg/dl for patients with cardiovascular conditions. Although these measures were introduced in 2009, PCPs were not officially ranked on these measures until 2010 (Cycle 6).

KMHP 2010 Quality Care Compensation Program

A Performance Incentive Payment is made for the following four program components:

- **Quality Performance**- KMHP provides incentives for eight HEDIS measures {Adolescent

Well-Care Visit; Breast Cancer Screening; Cervical Cancer Screening; Diabetes Care (HbA1C test); HbA1C Poor Control >9% for Diabetics; LDL-C Control <100 mg/dl for Diabetics; LDL-C Control <100 mg/dl for patients with cardiovascular conditions and Use of Appropriate Medications for People with Asthma}.

- **Severity of Illness**- KMHP provides an incentive to PCPs who are treating sicker KMHP Members.
- **Medical Cost Management**- KMHP provides an incentive for practices that use cost-effective services to maintain average or better than average medical costs
- **Emergency Room Utilization** - KMHP provides an incentive to practices who maintain average or better than average ER utilization compared to their peers. Practices are evaluated on overall ER utilization and non-emergent ER utilization.

In addition, Keystone Mercy provides an incentive to practices for submitting encounters for capitated services.

KMHP 2010 Quality Care Compensation Program Outcomes

QCCP MEASURE	CYCLE 5	CYCLE 6	% POINTS CHANGE C5 vs C6
ADOLESCENT WELL CARE VISIT RATE	50%	52%	2%
BREAST CANCER SCREEN RATE	58%	59%	1%
CERVICAL CANCER SCREEN RATE	57%	64%	7%
DIABETES TESTING (HbA1c) RATE	75%	77%	2%
DIABETES HbA1c POOR CONTROL > 9% RATE	N/A	47%	N/A
DIABETES LDL-C CONTROL <100 MG/DL RATE	N/A	29%	N/A
PATIENTS WITH CARDIOVASCULAR CONDITIONS LDL-C CONTROL <100 MG/DL RATE	N/A	35%	N/A
APPROPRIATE ASTHMA MEDS RATE	88%	91%	3%

AMHP Discussion:

The Primary Care Provider Incentive Program (PCPIP) continued in 2010. Approximately 200 PCPs are eligible for this program and receive quarterly Gap in Care updates. The following six HEDIS measures continued to be included in the this program: breast cancer screening, cervical cancer screening, HbA1c screening, use of appropriate medications for people with asthma, adolescent well care, children's well-care visits and emergency room utilization.

In 2009, AMHP also began including data for the following measures into the Member Care Gap reporting to the provider community; the scores for these measures were included in the December 2010 Performance Report, but were not paid as part of the Quality Performance incentive payment:

- *Comprehensive Diabetes Monitoring*
  - HbA1c Poor Control (>9.0%)
  - LDL-C Control (<100mg/dl)
- *Cholesterol Management for Patients with Cardiovascular Conditions*
  - LDL-C Control (<100 mg/dl)

The above measures are slated to be added to the AMHP PCPIP incentive payment beginning in June 2011 (7th cycle).

AMHP Quality Care Compensation Program Outcomes
2009 (cycles 3 and 4); 2010 (cycles 5 and 6)

	Cycle 3	Cycle 4	Cycle 5	Cycle 6
Quality Aggregate: Peer Percentile Bracket Increases*	**6 of *9**	**5 of *9**	**7 of *9**	3 of *9
ER Utilization: Peer Percentile Bracket Decreases*	**4 of *9**	**3 of *9**	**0 of *9**	0 of *9
Non-Emergent ER Utilization: Peer Percentile Bracket Decreases*	**7 of *9**	**3 of *9**	**7 of *9**	0 of *9
Severity of Illness: Peer Percentile Bracket Increases*	**8 of *9**	**4 of *9**	**0 of *9**	3 of *9
Asthma Controller Med Use Score	**89%**	**88%**	**87.6%**	92.7%
Breast Cancer Screening Score	**60%**	**61.50%**	**53.9%**	52.3%
Cervical Cancer Screening Score	**66.4%**	**66.1%**	**60.4%**	60.0%
Hemoglobin A1c Testing 2x/year	**45.6%**	**46.4%**	**47.3%**	42.6%
PCP Access 0-1 yr	**96%**	**96%**	**99.1%**	94.9%
PCP Access 2-6 yr	**85%**	**87%**	**92.7%**	84.5%
Well Adolescent Care	**50%**	**52.80%**	**54.9%**	45.6%
Number of Eligible Practices who filed an appeal	1	0	1	0

**** The 55th , 75th, and 95th percentile bracket thresholds for Pediatric, FP/GP and IM practices were compared from cycle to cycle totaling 3 sets of comparisons for each specialty type = 9 total bracket comparisons for this analysis.***

C. GEO Access:
In 2010, KMHP and AMHP performed a GeoAccess Analysis to assess membership access to participating practitioners (PCPs, high-volume Specialists) and hospitals for the delivery of necessary benefits and services in a timely manner and without the need to travel excessive distances. High-volume specialties are defined as the specialty types, when ranked in order, having the highest number of office visits within the analysis period. The top three high-volume specialty types for each plan were utilized for purposes of the analysis.

For KMHP, the high-volume specialists identified were Obstetrics/Gynecology/Certified Registered Nurse Midwives, Cardiologists and Orthopedic Surgery.

For AMHP, the high-volume specialists identified were Obstetrics/Gynecology/Certified Registered Nurse Midwives, Cardiologists and Physical Therapists.

KMHP GEO Access Summary:
Keystone Mercy is within the established standards for providing its Members with an acceptable number and distribution of PCPs, Pediatric PCPs, Cardiologists, Obstetrics/Gynecologists, Orthopedic Surgeons and hospitals in all of the geographic regions of the Southeastern section of Pennsylvania.

Keystone Mercy will continue to track and analyze the geographic distribution of its practitioners and providers to identify opportunities for improvement, and will begin steps to improve practitioner availability whenever necessary.

AMHP GEO Access summary:

AmeriHealth Mercy Health Plan exceeds the established standards for providing at least 98% of its Members with an acceptable number and distribution of PCPs, Pediatric PCPs, OB/GYNs, Cardiologists, Physical Therapists and Hospitals in all of the geographic regions it serves. While AmeriHealth Mercy is well within the established standards for OB/GYNs, cardiologists, physical therapists and hospitals for its Members, a very small percentage of its Members do not meet the accessibility standards for these specialties. AmeriHealth Mercy's Provider Contracting Representatives continue to work to enroll providers of these specialties in these areas.

There are very few Pediatric Members under eighteen years of age who live in Perry County that do not have the availability of two (2) Pediatric PCPs based on the 60-minute drive. There are no Pediatric PCPs in the County, except in New Bloomfield. Most of the Primary Care in Perry County is provided by Family Practitioners. AmeriHealth Mercy is well within the established standards for providing the appropriate number and distribution of PCPs, Pediatric PCPs, OB/GYNs, Physical Therapists and Hospitals within each geographic region.

AmeriHealth Mercy will continue to track and analyze the geographic distribution of its practitioners and providers to identify opportunities for improvement, and will begin steps to improve practitioner availability wherever necessary. AMHP will continue to recruit additional PCPs and Specialists in geographic areas in order to enhance the network.

Due to the high percentage (15%) of Spanish speaking Members, a GEO access report was generated for access to Spanish speaking PCPs. Gaps in access to care were identified per specialty for Urban /Suburban and Rural.

An action plan was created to improve access for the Spanish speaking membership:

- Continue to obtain incoming language data via our recent Provider Surveys to determine office site language capabilities; store and report on the data; and post the data via media and access points available to our Members and providers
- Continue assessing our provider network capabilities to meet the needs of our Spanish speaking and Latino Members on an annual basis
- Develop county-specific assessment of language and cultural capabilities for our counties with over 45% Hispanic population (Berks, Lancaster, Lehigh and Northampton counties)
- Offer our Provider communities access to our language translation vendor at a discounted rate, similar to our MCO contracted rates
- Continue to recruit Spanish speaking providers as they are identified, especially in our counties with over 45% Hispanic population (Berks, Lancaster, Lehigh and Northampton counties)
- Outreach to National Spanish Medical Professional Organizations, such as the National Hispanic Medical Association, for advice and partnership in our efforts to recruit Spanish speaking providers to our provider networks

- Continue outreach and partnership with our local agencies, such as the Puerto Rican Committee of Lancaster, the Spanish American Civic Assoc. (SACA), Latino American Alliance of Northeast PA (LAANEPA), churches and schools within the Latino Community

We will also look to build new partnerships in our efforts as opportunities present themselves.

D. Clinical Quality Improvement Initiatives

The following clinical quality initiatives were ongoing in 2010:

- Improving Birth Outcomes (AMHP and KMHP)
- Reducing Emergency Room Utilization (AMHP and KMHP)
- Improving Women's Health (AMHP and KMHP)
- Increasing the Percentage of Dental Visits during Pregnancy (KMHP)
- Improving the Management of Diabetes in the Latino Population through Screening Measures (AMHP)
- Early Recognition and Intervention of Perinatal Depression to Improve/Increase Screening and Behavioral Health Coordination (AMHP and KMHP)
- Improving the Management of Diabetes(AMHP and KMHP)
- Increasing Member awareness of the dangers of lead poisoning and increasing screenings (AMHP and KMHP)

Improving Birth Outcomes (KMHP and AMHP)

Over 50% of KMHP/AMHP Members are women. The absence of prenatal care is associated with low birth weight and higher detained baby rates. KMHP/AMHP has identified improving birth outcomes as a meaningful activity because it is an issue that affects a large number of the KMHP/AMHP Members.

Barriers**:**

- Lack of knowledge on the importance of early prenatal care
- Long time period between when the pregnant Member is identified in the OB office and when the Plan is notified
- Lack of correct phone numbers and addresses of the pregnant Members
- Many Members that are contacted either do not want care management services (opt-out) or agree to care management, but do not continue with services during the length of their pregnancy
- OB forms used to identify pregnant Members are not always timely so that the case managers can outreach and make an impact

KMHP Discussion:

Year (CY)	Benchmark/Goal	Results	Comments
% Pregnant Members who receive prenatal care in the first trimester (HEDIS)			
2006	Baseline	81.51%	
2007	83.36%	75.18%	Goal was not met
2008	77.66%	79.81%	Goal was met
2009	81.83%	81.08%	Goal was not met
2010	82.03%		
% Pregnant Members who attend 81% or more of their expected prenatal visits (HEDIS)			
2006	Baseline	56.93%	
2007	61.24%	62.88%	Goal was met
2008	66.59%	65.94%	Goal was not met
2009	69.35%	67.08%	Goal was not met
2010	68.73%		
% Newborns detained after mother discharged			
2006	Baseline	15.27%	
2007	13.27%	17.00%	Goal was not met
2008	15.00%	19.27%	Goal was not met
2009	17.27%	19.61%	Goal was not met
2010	18.63%		
% Low Birth Weight (>/= 1500 gm and < 2500 gm)			
2006	Baseline	8.64%	
2007	6.64%	7.66%	Goal was not met
2008	5.66%	8.61%	Goal was not met
2009	6.661%	8.86%	Goal was not met
2010	8.42%		
% Very Low Birth Weight (<1500 gm)			
2006	Baseline	1.63%	
2007	1.13%	2.50%	Goal was not met
2008	2.00%	2.14%	Goal was not met
2009	1.64%	2.79%	Goal was not met
2010	2.65%		

2010 Interventions:

- Hosted Three Community Baby Showers
  - 3/31/10 Please Touch Museum
  - 6/4/10 St Luke‘s Church Chester
  - 6/17/10 Intercultural Family Services
- Continued working with community partners for Member location and interventions
- Behavioral Health intervention for Members who are identified as depressed
- Data enhancements (LOINC codes and pharmacy data) to assist in early identification of high risk Members
- Stratification for high risk Member outreach (2010)
- Continued with ongoing radio spots on local radio stations that encourage women to seek frequent prenatal care
- Continued dental initiative continued with providing incentives to pregnant Members to ensure a dental screen during to decrease the result of a pre-term baby

- Continued with encouraging the use of 17P for Members who have a history of PTL/PTD
- In 2010 Pharmacy eliminated prior authorization requirement for 17P. Delays are now eliminated. Extra progesterone can help prevent preterm birth for some women
- Continued with the use of Doulas. Member advocates and help the mother emotionally, but also increase the chance of her having a healthier birth and newborn
- Case Management engagement, education and care plan in collaboration with the Member and the provider
- Partnered with text4baby, a free mobile information service designed to promote maternal and child health; text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB) that provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life
- Continued collaborative relationship with the Centering Prenatal Care

AMHP Discussion:
Four of the five measures saw improvement; however, the goals set were not met. Improvement was seen in the timeliness of care and the frequency of expected visits; however, the goals set were not met. There was a decrease in the rate of % of babies that are detained and % of Low Birth Weight Babies (>/= 1500 grams and < 2500 grams), but the goals set were not met. The % of Very Low Birth Weight Babies saw an increase in the rate from the previous measurement year. Barriers include lack of correct phone numbers and addresses of the pregnant Members and an increase in the amount of annual pregnant Members on the plan. Additional education about the importance of caring for mom and baby is needed.

2010 Interventions:

- Partnered with text4baby, a free mobile information service designed to promote maternal and child health; text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB) that provides pregnant women and new moms with information they need to take care of their health and give their babies the best possible start in life
- Case Management engagement, education and care plan in collaboration with the Member and the provider
- Behavioral Health intervention for Members who are identified as depressed
- Data enhancements (LOINC codes and pharmacy data) to assist in early identification of high risk Members
- Enhanced stratification algorithm for high risk Member outreach (2010).

Year (CY)	Benchmark/Goal	Results	Comments
% Pregnant Members who receive prenatal care in the first trimester (HEDIS)			
2006	Baseline	90.21%	
2007	91.19%	87.35%	Goal was not met
2008	88.62%	89.29%	Goal was met
2009	90.36%	89.89%↑	Goal not met
2010	90.36%		
% Pregnant Members who attend 81% or more of their expected prenatal visits (HEDIS)			
2006	Baseline	77.39%	
2007	79.65%	77.62%	Goal was not met
2008	79.86%	78.10%	Goal was not met
2009	80.29%	78.96%↑	Goal not met
2010	79.20%		
% Detained Babies after mother discharged			
2006	Baseline	9.51%	
2007	7.51%	12.38%	Goal was not met
2008	10.38%	14.92%	Goal was not met
2009	12.92%	13.20%↓	Goal not met
2010	12.92%		
% Low Birth Weight (>/= 1500 gm and < 2500 gm)			
2006	Baseline	7.12%	
2007	5.12%	7.19%	Goal was not met
2008	5.19%	7.73%	Goal was not met
2009	5.73%	7.66%↓	Goal not met
2010	5.73%		
% Very Low Birth Weight (<1500 gm)			
2006	Baseline	1.60%	
2007	1.10%	1.90%	Goal was not met
2008	1.40%	1.72%	Goal was not met
2009	1.22%	1.89%↑	Goal not met
2010	1.22%		

Improving the Management of Diabetes (AMHP and KMHP)

Review of claims data shows that approximately 6,000 KMHP Members and 1,460 AMHP Members had diabetes in 2004. This population has shown a steady increase for both Plans since 2004. In addition, numerous studies demonstrate that control of blood sugar and cholesterol levels, along with monitoring for complications can improve long-term health status and reduce the incidence of complications. This Quality Improvement Activity is relevant for both Plans.

KMHP	Baseline 2004	2006	2007	2008	2009	Comment
HgbA1c test (HEDIS)	**77.8%**	**76.16% (↓0.73)**	**80.6% (↑4.44%)**	**78.59% (↓2.01%)**	**82.26% (↑ 3.67%)**	**Goal Exceeded**
Micro-albumin test (HEDIS)	**48.45%**	**80.78% (↑38.93%)**	**75.52% (↓5.26%)**	**80.05% (↑4.53%)**	**79.35% (↓0.70%)**	**Goal Not Met**

KMHP	Baseline 2004	2006	2007	2008	2009	Comment
Diabetic retinal exam (HEDIS)	**51.31%**	**41.61% (↓6.08%)**	**47.34% (↑5.73%)**	**46.96% (↓0.38%)**	**49.03% (↑ 2.07%)**	**Goal Not Met**
Serum LDL-C <100 mg/dl (HEDIS)	**31.03%**	**32.36% (↓14.11%)**	**35.57% (↑3.21%)**	**40.88% (↑5.31%)**	**40.88% No change**	**Goal Not Met**

AMHP	Baseline 2004	2006	2007	2008	2009	Comment
HgbA1c test (HEDIS)	**82.52%**	**80.97% (↓1.61%)**	**83.45% (↑2.48%)**	**83.21% (↓0.24%)**	**86.31% (↑ 2.86%)**	**Goal Exceeded**
Poorly-controlled HgbA1c (HEDIS)	**38.93%**	**50.66% (↑14.16%)**	**47.93% (↓2.73%)**	**39.66% (↓8.27%)**	**35.40% (↓ 4.26%)**	**Goal Exceeded**
Micro-albumin test (HEDIS)	**52.91%**	**77.65% (↑31.42%)**	**83.29% (↑5.64%)**	**82.73% (↓0.56%)**	**81.93% (↓ 0.8%)**	**Goal not met**
Diabetic retinal exam (HEDIS)	**62.94%**	**60.18% (↓1.30%)**	**61.31% (↑1.13%)**	**66.67% (↑5.37%)**	**69.53% (↑ 2.86%)**	**Goal Exceeded**
Serum LDL-C <100 mg/dl (HEDIS)	**30.07%**	**27.65% (↓2.76%)**	**35.04% (↑7.35%)**	**42.58% (↑7.54%)**	**40.15% (↓2.43%)**	**Goal not met**

For both Plans, the HA1c screening rates, eye exams and micro-albumin rates increased while the poor control decreased.

2010 Interventions:

- PCP Performance Program inlcuded HgbA1c screening, HbA1c poor Control >9% and LDL-C <100 mg/dl
- KMHP: Lose to Win pilot initiative continued through first quarter 2010; the program was for adults with five Philadelphia YMCAs; over 170 diabetic Members participated over a twelve week period; the program consisted of monitoring of A1C, LDL, BMI as well as exercise, nutritional education
- AMHP: A performance improvement project (PIP) continued targeting diabetes care for AMHP's Latino Members

Reducing Emergency Room Utilization (AMHP and KMHP)

Trending of ER visit rates from 2000 through 2009 indicated a steady increase, with rates above the HEDIS Medicaid average for all of the years. Based on the increasing ER utilization, and the risk of fragmented care, duplicate testing and lack of continuity associated with ER use, reducing ER visits continues to be the focus of a quality improvement initiative for KMHP/AMHP.

During 2009, a discussion was held based on analysis of data regarding the report criteria selection for ER claims. This discussion initiated investigation to determine if the ER volume is over-reported due to reporting issues. As a result of this research throughout 2010, over–reporting may have been occurring.

For HEDIS 2010, both AMHP and KMHP saw a slightly decrease in the rates

	KMHP	AMHP
HEDIS 2006 (CY-2005)	**61.59/K**	**72.32/K**
HEDIS 2007 (CY- 2006)	**64.83/K**	**77.27/K**
HEDIS 2008 (CY- 2007)	**65.75/K**	**79.17/K**
HEDIS 2009 (CY- 2008)	**65.55/K**	**80.44/K**
HEDIS 2010 (CY- 2009)	**63.05/K**	**77.94/K**

Barriers include but are not limited to:

Incomplete discharge planning

Member inability to get to PCP office due to lack of open, scheduling, limited office hours

- Lack of transportation and knowledge of how to access the medical assistance transportation program
- Members' knowledge deficit of ER alternatives and access to the alternatives (local Urgent Care Centers).

KMHP Discussion:

The ER strategy workgroup continued and new interventions were implemented in 2010:

- Implemented Winter Seasonality messages
- Implemented "Seasonality" Member communication initiatives
- Implemented Walgreen's Flu Shot Campaign
- Included "How and Where to Get Care" document on Member Center (web site) and Member mailings
- Updated new Member HRA to pose the question: "Has any Member in your household been to the emergency room 4 or more times in the last 6 months?"
- Compiled a list of resources to provide to Members without pharmacy benefits to obtain necessary medications post discharge
- Expanded the Acute Care Transition Program (onsite clinical resources to assist Members to effectively navigate the healthcare delivery system following an emergency visits or inpatient admission) to a high volume ER in center city Philadelphia
- Added alert to the medical management system indicating that the Member does not have pharmacy benefits
- Posted Member Newsletter Articles addressing appropriate utilization of ER

AMHP Discussion:

To address the issue of increased emergency room utilization, AMHP continued an ER strategy Outreach program. Any Member with frequent ER use (defined as 2 or more visits in 30 days), new to the plan; or identified with high Chronic Illness and Disability Payment System (CDPS) scores were reviewed and referred to the case management department for outreach, education and engagement in the care coordination program. Primary Care Physicians (PCPs) and facilities with high ER utilization were also contacted.

The 2010 interventions focused on the following opportunities:

- PCP outreach
- Member outreach & education regarding use of the PCP's office and ER
- Special Needs identification and Member outreach by the Special Needs Unit to assist in coordinating behavioral health issues and dental issues

- Outreach and enrollment into Care Coordination
- 24/7 Nurse Line magnets included in new Member Welcome Packet
- 24/7 Nurse Line follow up by Care Coordination staff
- Postcard mailing to Members with ER diagnosis of Otitis Media, general ER claims and dental issues
- Member Newsletter Articles addressing appropriate utilization of ER
- Recipient Restriction Program to identify Members at risk with respect to their medication and medical service utilization patterns in order to more effectively manage the identified Members' total health care and reduce the incidence of mis-utilization and abuse
- Increased the visibility of Urgent Care Centers

Increasing Percentage of Dental Visits during Pregnancy (KMHP)

Over the past eight to ten years there has been increasingly compelling evidence relating the presence of periodontal (gum) disease in pregnant women to increased incidence of pre-term birth and low birth weight. This QIA was initiated in 2009 using the 2008 data as the baseline. The goal of this QIA is to make statistically significant improvement in dental services among pregnant women who deliver in August, September and October. The 2010 results of 25% exceeded the goal of 19.36%.

Barriers included:

- Members' knowledge deficit of the importance of good dental health during pregnancy
- Knowledge deficit of MA transportation process
- Appointment unavailability
- Practitioners' knowledge deficit of medical guidelines for pregnant Members and preventive dental care

The following interventions implemented in 2009 continued in 2010:

- Providing Member Incentive gift cards for Babies R Us for Members completing a dental visit
- Providing transportation and scheduling assistance
- Conducting on-site Dental Screenings at Community Events
- Providing education regarding dental care of pregnant women to the Doral Dental network
- Providing PCPS and OBs with education about the initiative
- Arranging block schedule time at select dental practitioners.

	Results	**Comments**
2008	12.96%	Baseline
2009	19.36% (Goal: 18.96%	Goal Met
2010	25% (Goal: 19.36%)	Goal exceeded

Improving the Management of Diabetes in the Latino Population through Screening Measures (AMHP)

This QIA was initiated in 2008 and continued in 2010. This initiative was designed to address the cultural barriers associated with the Latino population. The AMHP membership has seen a steady growth in Lehigh and Northampton Counties. These two counties comprise the highest population of Latino Members as compared to other counties. Hispanic Members with diabetes are less likely to self test and treat than the general population. Dietary preferences also contribute to increased risk of diabetes. Because of the growing diabetic population, particular interventions have been designed to address cultural barriers to fight the disease.

The following interventions implemented 2009 continued in 2010:

- Telephonic outreach to Members identified as not having screenings
- Targeted mailing to Members identified as not having screenings
- Promotora Program operationalized at 5 offices/clinics. The Promotora Program is a train-the-trainer program that utilizes ADA curriculum targeted at adults with type 2 diabetes; sessions are held on a monthly basis to educate diabetics on the disease process, monitoring, nutrition, prevention of complications and self-management of the disease
- Aggressive outreach to Members for enrollment in case management

Percentage of Latino diabetic Members in Lehigh and Northampton counties that had Screenings	**HgbA1C Screening**	**LDL- Cholesterol Screening**
January 1 through June 30 2008	**75%**	**64%**
January 1 through June 30 2009	**78% (Goal: 78%)**	**77% (Goal: 67%)**
January 1 through June 30 2010	**86% (Goal: 79%)**	**85% (Goal: 78%)**

For the 2010 measurement period, a goal of 79% was established for the HgbA1c screening and a goal of 78% was established for the LDL screening. Both results exceeded the respective goals.

Common barriers identified through focus groups and review of ADA and CDC literature include:

- Member knowledge deficit of the long term effects of diabetes
- Transportation
- Availability of healthy and culturally relevant diet options
- Fear of needle pain

Early Recognition and Intervention of Perinatal Depression to Improve/Increase Screening and Behavioral Health Coordination

AMHP Discussion:

It is estimated that depression during and after pregnancy affects as many as 1 in 7 pregnant women and new mothers and is the number one complication of childbirth in the United States today. A systematic review of the studies that produced these estimates found that new episodes of major depression alone may occur in 3.1 to 4.9 percent of women at various times during pregnancy. Either

major or minor depression may affect 8.5 to 11 percent of women during pregnancy. Many women continue to suffer from depressive episodes that began prior to pregnancy.

AMHP has approximately 4,000 births per year. Depression is a serious medical condition. It poses risks for the woman and her baby. Maternal prenatal stress and depression is associated with low birth weight and prematurity, anxiety, preeclampsia. Early recognition and intervention of depression can increase positive outcomes for both the baby and the mother. Early detection is uncommon even though it is known to improve maternal well-being and child outcomes. Providing psychosocial support and counseling to pregnant women at risk of depression may be effective in decreasing related symptoms. Improving the outcomes for the mother and the baby may decrease the risk of newborns being admitted into the Newborn Intensive Care Unit.

Common barriers to screening for and treatment of depression around pregnancy include:

- Information about perinatal depression is not readily available to the public
- Social stigma related to depression and fear of judgment
- Lack of coordination between physical health and behavioral health
- Lack of follow-through with mental health referrals

To address these barriers, in collaboration with CBHNP, a pilot project was developed to assess and address depression in pregnant women enrolled in the WeeCare Program who reside in Dauphin and Lancaster counties. CBHNP is the behavioral health provider for our Members in those counties. The current pilot started in the last quarter of 2008 with expansion of the project to the Lehigh/Capital region in the first quarter of 2009. The expansion was in collaboration with Magellan and continued into June 2010. Regular meetings are held with the BH MCOs to continue to implement and refine the pilot as it moves forward.

The Edinburgh Postnatal Depression Scale (EPDS) is given to Members enrolled in the WeeCare Program in the specified counties to identify pregnant Members with depression. Any Member that scores positive for depression is directly referred to the BH MCO for assessment and referral.

The project was implemented in order to increase our collaboration with the BH MCOs and to capture data to establish rates/baselines. The AMHP goal is to focus on educating Members to ensure they have a healthy pregnancy with a positive outcome by ensuring they receive adequate behavioral health referrals and care.

	Measurement: January 1 through June 30	**2009**	**2010**	**2010 Goal**
1.	Percent of Members screened for perinatal depression	357/357 (100%)	189/189 (100%)	100%
2.	Members with a positive screening for perinatal depression and referred by warm transfer to behavioral health	11/11 (100%)	6/6 – (100%)	100%
3.	Percentage of referred Members enrolled in WeeCare with first behavioral health appointment document by WeeCare case manager in the care coordination database	11/11 (100%)	6/6 (100%)	100%
4.	Percentage of referred Members enrolled in WeeCare who attended the first scheduled BH appointment	2/11 18%	5/6 – 83%	20%

KMHP Discussion:
This Quality Improvement Plan was initiated in 2009 and continued in 2010. Depression poses a risk for mother and baby. Early recognition and intervention of depression can increase positive outcomes for both baby and mother. Early detection is uncommon unless efforts are taken to understand how the mother is coping post-delivery.

Common barriers to screening for and treatment of depression around pregnancy as identified by discussions with BH MCOs include:

- Information about perinatal depression is not readily available to the public
- Social stigma related to depression and fear of judgment
- Lack of coordination between physical health and behavioral health
- Lack of follow-through with mental health referrals

In collaboration with Magellan Behavioral Health Plan in Delaware County, a project was developed to assess and address depression in pregnant women enrolled in the WeeCare Program who resided in Delaware County. All known pregnant Members that reside in Delaware County were provided an outreach call to offer enrollment in the Wee Care program. This program was conducted from 1/1/09 through 6/30/10.

Interventions included:

- Established call with Member
- Created warm transfer process with Member and Behavioral Health
- Created follow-up tracking tools
- Educated staff on the Edinburgh tool
- Opened discussion with Member for Behavioral Health MCO assistance

Of the 547 pregnant KMHP Members identified as residing in Delaware County between 1/1/10 and 6/30/10, 114 (20.84%) were contacted and screened for depression using the Edinburgh Depression Screening Tool. A total of 21 Members were identified as needing further intervention by scoring 10 or more on the Edinburgh Depression screen tool. Twelve Members (57.14%) agreed to a referral to the BH-MCO. Of note, an additional 2 Members were already receiving Behavioral Health Services and declined additional appointment scheduling.

Percent of Members Screened for Perinatal Depression	**Goal**	**Results**	**Comment**
2009	6%	13.91%	Goal exceeded
2010	* 13.91%	20.84%	Goal exceeded

* 2010 Goal is to demonstrate sustainable improvement

Improving Women's' Health (AMHP and KMHP)
Women's Health Issues are a major concern of health professionals specifically breast cancer, cervical cancer and sexually transmitted diseases such as Chlamydia. More than 50% of KMHP and AMHP Members are women. This QIA addresses breast and cervical cancer screenings, Chlamydia screenings and human papillomavirus (HPV) vaccine.

KMHP Discussion:
The screening for breast cancer has improved significantly. There is still room for improvement with cervical cancer and chlamydia screenings. In addition the administration of the papillomavirus (HPV) vaccine for children has improved. See attached interventions and initiatives below for strategies to address areas that do not meet goal.

Interventions that continued from the previous year included:

- Care Gaps are available to the provider via the provider portal
- Scheduling Members to "open days" in several Hospital in Philadelphia for PAP and Mammography screening
- Soundbite campaigns alerting Members to call for scheduling breast cancer screening and cervical cancer screening
- On-hold messages alerting "women over the age of 18 need a special test to check for cervical cancer…Talk to your doctor"
- Gaps in Care continue in 2009 addressing all Members who outreach to Member Services Members are assessed for breast cancer screening and cervical cancer screening and referred to the retention unit for scheduling
- Mobile Mammography screening events
- Member educational mailings.

Year	Benchmark/Goal	Results	Comments
Percent of Members having a Mammogram **(HEDIS – Ages 52-69)**			
2005	Baseline	50.57%	
2006	Goal: 55.51%	50.40% (Decrease of 1.17% from 2005 results)	Goal was not met
2007	Goal: 55.36%	51.70% (Increase of 1.3% from 2006 results)	Goal not met
2008	54.12%	56.57%	Goal was met
2009	Goal: 58.74%	61.43%	Goal exceeded
Percent of Members having a Mammogram **(HEDIS- Ages 42-51)**			
2006	Baseline	33.49%	
2007	Goal: 45.54%	47.83% (Increase 14.34% from 2006 results)	Goal exceeded
2008	Goal: 50.44%	47.84%	Goal not met
2009	Goal: 50.23%	54.02%	Goal exceeded
Percent of Members that have a Pap Smear **(HEDIS 18-64)**			
2005	Baseline	46.58%	
2006	Goal: 51.92%	63.26% (Increase of 17.68% from 2005 results)	Goal exceeded
2007	Goal: 66.93%	67.45% (Increase of 4.19% from 2006 results	Goal exceeded
2008	Goal: 69.08%	70.49%	Goal met
2009	Goal: 71.97%	70.98%	Goal not met
Year	**Benchmark/Goal**	**Results**	**Comments**
Percent of Members having Chlamydia screening **(HEDIS – Ages 16-20)**			
2005	Baseline	44.48%	
2006	Goal: 50.03%	51.41% (Increase of 6.93% from 2005 results)	Goal exceeded
2007	Goal: 56.275%	50.42% (Decrease of 0.99% from 2006 results)	Goal not met
2008	Goal: 52.90%	57.76%	Goal met
2009	Goal: 59.87%	56.14%	Goal not met
Percent of Members having Chlamydia screening **(HEDIS – Ages 21-25)**			
2005	Baseline	48.57	
2006	Goal: 53.71%	55.68% (Increase of 14.64% from 2005 results)	Goal exceeded
2007	Goal: 60.11%	53.70% (Decrease of 1.98% from 2006 results)	Goal not met

Year	Benchmark/Goal	Results	Comments
2008	Goal: 52.90%	60.93%	Goal met
2009	Retired		
Percent of Members having Chlamydia screening **(HEDIS – Ages 21-24)**			
2009	Baseline	61.18	
Percent of Members having Chlamydia screening **(HEDIS – Total Ages)**			
2005	Baseline	46.58%	
2006	Goal: 51.92%	53.57% (Increase of 6.99%from 2005 results)	Goal exceeded
2007	Goal: 58.21%	52.07% (Decrease of 1.5% from 2006 results	Goal not met
2008	Goal: 54.47%	59.18%	Goal met
2009	Goal: 61.22%	58.36%	Goal not met
Percent of Members receiving human papillomavirus (HPV) vaccine (Ages 11-18)			
2007	Baseline	12.58%	
2008	Goal: 15.58%	12.30%	Goal not met
2009	Goal: 37.53%	38.70%	Goal met

AMHP Discussion:

AMHP experienced a decrease in the PAP smear rate for measurement year (MY) 2009. This decrease may be attributed to the ongoing fear of having the screening and the misconception of not needing the screening or the lack of education on the importance of the screening. The Chlamydia rate increased for both the 16-20 age group and the total population; however, our goal was not met. It should be noted that the upper age limit for age group 21-26 (as previously measured) was decreased to 24 for MY 2009. The HPV measurement ages 11-18 significantly increased from the 2008 rate. This may be attributed to increased awareness due to public media campaigns and AMHP newsletter articles, as well as, better data collection.

Year	Benchmark/Goal	Results	Comments
Percent of Members having a Mammogram **(HEDIS – Ages 52-69)**			
2005	Baseline	56.34%	
2006	Goal: 60.71%	56.53% (Increase of 0.19% from 2005 result)	Goal not met
2007	Goal: 64.13%	60.14% (Increase of 3.61% from 2006 result)	Goal not met
2008	**Measure retired***		
Percent of Members having a Mammogram **(HEDIS- Ages 42-51)**			
2006	Baseline	46.81%	
2007	Goal: 52.13%	49.97% (Increase of 3.16% from 2006 result)	Goal not met
2008	**Measure retired***		
Percent of Members that have a Pap Smear **(HEDIS 18-64)**			
2005	Baseline	63.99%	
2006	Goal: 67.59%	67.52% (Increase of 3.53% from 2005 result)	Goal not met
2007	Goal: 70.77%	73.24% (Increase of 5.72% from 2006 result)	Goal exceeded
2008	Goal: 75.92%	73.48% (Increase .24%)	Goal not met
2009	Goal: 74.81	70.43 (decrease 3.05)	Goal not met
Percent of Members having Chlamydia screening **(HEDIS – Ages 16-20)**			
2005	Baseline	30.16%	
2006	Goal: 37.14%	37.68 % (Increase of 7.52% from 2005 result)	Goal met
2007	Goal: 43.91%	39.76% (Increase of 2.08% from 2006 result)	Goal not met
2008	Goal: 45.78	42.05% (Increase 2.29%)	Goal not met
2009	Goal: 44.95	43.75 (Increase 1.70)	Goal not met
Percent of Members having Chlamydia screening **(HEDIS – Ages 21-25)**			
2005	Baseline	27.27%	
2006	Goal: 34.54 %	42.79% (Increase of 15.52% from 2005 result)	Goal exceeded
2007	Goal: 48.51%	45.02% (Increase of 2.23% from 2006 result)	Goal not met

Year	Benchmark/Goal	Results	Comments
2008	Goal: 50.52%	49.55% (Increase 4.53%)	Goal not met
2009	Retired		
Percent of Members having Chlamydia screening **(HEDIS – Ages 21-24)**			
2009	Baseline	61.18	
Percent of Members having Chlamydia screening **(HEDIS – Total Ages)**			
2005	Baseline	28.89%	
2006	Goal: 36.0%	40.29% (Increase of 11.4% from 2005 result)	Goal exceeded
2007	Goal: 46.26%	42.44% (Increase of 2.15% from 2006 result)	Goal not met
2008	Goal: 48.20%	45.48% (Increase 3.04%)	Goal not met
2009	Goal: 48.21	46.58 (Increase 1.1)	Goal not met
Percent of Members receiving human papillomavirus (HPV) vaccine (Ages 11-18)			
2007	Baseline	14%	
2008	Goal: 22.60	28.39% (Increase 6.28)	Goal met
2009	Goal: 31.97	36.36% (Increase 7.97)	Goal met

Interventions that continued form the previous year included:

- Providing Care Gap alerts to Member Services for inbound Member calls and linking the Care Gaps to the provider portal for practitioners
- Including Breast and Cervical Screening components in the provider Pay –For-Performance program
- Member and Provider educational newsletters articles
- Provider Newsletter articles
- Women‘s Wellness empowerment fairs
- Utilize Lackawanna Mobile Mammogram Van at events

Improving the Lead Screening Rates (AMHP and KMHP)

Per the Center for Disease Control (CDC), approximately 250,000 U.S. children aged 1-5 years have blood lead levels greater than 10 micrograms of lead per deciliter of blood, the level at which the CDC recommends. Lead poisoning can affect nearly every system in the body and often occurs with no obvious symptoms. The CDC guidelines state that every Medicaid-eligible child should be screened at age l and again at age 2.

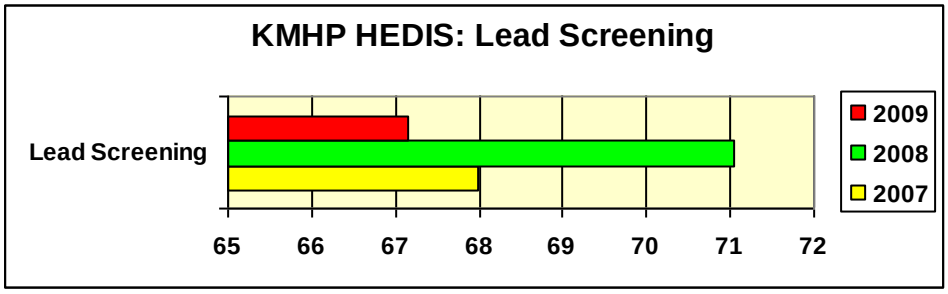
Lead is a common metal found in many place around the home. Lead poisoning is a serious disease. Even small amounts of lead can be very dangerous, especially to small children. Lead poisoning can cause difficulty in learning, delay in development, speech and hearing problems and muscle weakness. Larger amounts of lead can cause damage to the brain, nervous system, kidneys and bone marrow. Some of the effects of lead poisoning may be permanent. Children under six are the most at risk. Lead poisoning is preventable by reducing the family‘s exposure to lead. Because lead poisoning is preventable, it is important to educate our Members/consumers about the importance of screenings and prevention of lead poisoning.

Barriers identified:

- Parents unfamiliar with the cause/effects of lead poisoning
- Services not offered at time of office visit
- Transportation to another site for lab draw
- Anxiety of child—pain from needle stick
- Parental refusal

- Results not reported to Plan
- Provider unaware of CDC guidelines that require every eligible Medicaid child to be screened

KMHP discussion:
The Lead Screening rate for children before the age of two decreased from the previous year.



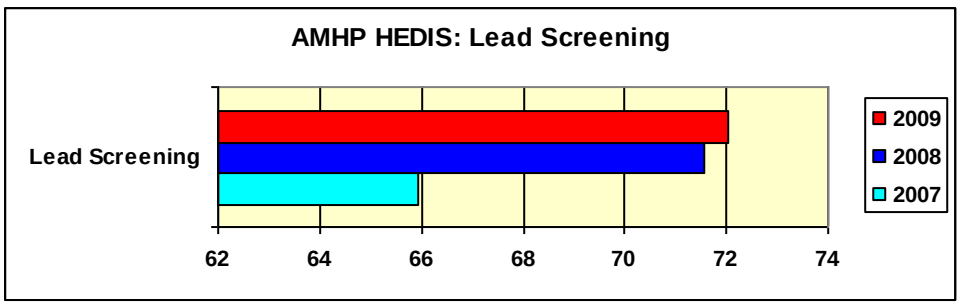
Interventions that continued form the previous year:

- Obtained additional and up-to-date lead materials from Department of Health
- Make every Member count – Gaps in Care available to Case Managers and Member Services
- Place Lead product recalls on Member website – Product Recalls
- Implemented Member Education Portal – various topics about Lead
- On Hold message for incoming calls from Members
- Contracted with Medtox (allowing practitioners are able to draw finger-stick lead levels during an office visit)
- Lead Poisoning article in Provider Newsletter-Messenger
- EPSDT Unit implemented to conduct Member outreach calls
- Birthday Cards to remind parents of child‘s immunization and screenings

New interventions for 2010:

- Held three lead screening community events
- Implemented two targeted telephonic Member outreach message campaigns
- Provider (PCP) fax blasts re: the CDC‘s recommendation
- Lead Screening added to the Care Gap data made available to case managers and Member Service Representatives as well as to the providers via the provider portal

AMHP Discussion:
The Lead Screening rate increase slightly.



Interventions that continued from the previous year:

- Place Lead product recalls on Member website – Product Recalls
- Developed Member educational materials in Spanish
- Enclosed Provider educational materials in quarterly packet
- Contracted with Medtox to give providers the ability to draw finger-stick lead levels during an office visit
- Case Management provided for any Member identified with lead level >10 to ensure appropriate follow with parent and PCP
- Educational fact sheet for Members

New 2010 intervention:

- Lead Screening added to the Care Gap data available to case managers and Member Service Representatives as well as to the providers via the provider portal.

E. Practitioner Credentialing and Recredentialing

AMHP and KMHP credentialed and recredentialed the Practitioner, Provider and Facility network in accordance with criteria and standards consistent with Pennsylvania (PA) Department of Health, Pennsylvania Department of Public Welfare (DPW) and the National Committee of Quality Assurance (NCQA) requirements. The recredentialing cycle is every three years. Independence Blue Cross conducted an annual delegation oversight audit based on the criteria and standards listed above, which consisted of a review of files, policies and procedures and data validity.
The audit summary findings are listed below:

Year	Audit Score
2010	**Policies and Procedures: 100%** **Initial Credentialing: 99.2%** **Recredentialing: 100%** **Data Validity: 100%**

In addition, KMHP and AMHP monitor the following performance metrics:

KMHP	NCQA Timeliness Standard: Within 180 days				
	2010	**2009**	**2008**	**2007**	**2006**
PCP and Specialist Initialing Credentialing	100%	100%	99.9%	99%	100%
PCP and Specialist Recredentialing	100%	100%	100%	*92%	100%

AMHP	NCQA Timeliness Standard: Within 180 days				
	2010	**2009**	**2008**	**2007**	**2006**
PCP and Specialist Initialing Credentialing	100%	100%	100%	100%	100%
PCP and Specialist Recredentialing	100%	100%	100%	100%	100%

* Threshold not met. Action Plan developed and implemented.

Both KMHP and AMHP's PCP and Specialist Credentialing activity met the timeliness threshold.

The table below represents KMHP and AMHP Credentialing and Recredentialing activity for 2010 by plan, with a comparison of total activity from 2004 through 2010.

Category	KMHP	AMHP	Total 2010		Total 2009	Total 2008	Total 2007	Total 2006	Total 2005	Total 2004
Credentialing Approved Providers	**1825**	**896**	**2721**		**3629**	**2701**	**1464**	**1519**	**1515**	**2102**
Credentialing Approved Facilities	**130**	**79**	**209**		**85**	**51**	**113**	**47**	**36**	**44**
Cred Providers Denied	**3**	**1**	**4**		**5**	**4**	**2**	**3**	**2**	**1**
Recredentialing Approved Providers	**969**	**701**	**1670**		**1236**	**2110**	**970**	**3356**	**3468**	**3942**
Recred Approved Facilities	**41**	**30**	**71**		**8**	**37**	**36**	**17**	**15**	**5**
Recred Providers Denied	**0**	**0**	**0**		**0**	**3**	**3**	**10**	**0**	**2**
Recred Facilities Denied	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**2**	**0**
Reconsideration/Appeal	**3**	**1**	**4**		**4**	**3**	**7**	**0**	**2**	**15**
Delegates	**985**	**974**	**1959**		**1837**	**4985**	**4264**	**2330**	**3756**	**3384**
Terminations	**340**	**147**	**487**		**1329**	**1061**	**280**	**527**	**649**	**1251**

KMHP and AMHP continued to participate with the Council for Affordable Healthcare (CAQH), a non-profit alliance of health plans and trade associations. CAQH offers a secure web-based universal provider data source for credentialing. CAQH streamlines provider data by using a standard electronic form that reduces the administrative burden on the provider office and improves provider satisfaction. In 2010, the following process improvements were initiated:

- Implemented the CAQH Importer and Scanning module in Visual Cactus (credentialing software program) which added the new functionality to bring in CAQH applications directly to Visual Cactus
- Developed a new process and format to report Medical Director files presented to the Credentialing Committee
- Installed the Adobe Writer application for Credentialing Coordinators which grants access to Right fax and allows the Coordinators to fax from their desk
- Implemented a fax process for practitioner recredentialing notifications through Right Fax
- Implemented a Credentialing On-Line Reference
- Launched a Credentialing Newsletter to inform stakeholders of process improvements
- Hosted the 1st Annual AMFC Credentialing Summit to discuss process improvements

At the beginning of 2010, the internal file processing time (from file arrival in the department to committee decision date) was 120 days. By June, the file processing time was down to 60 days. In September, the processing time decreased to 30 days.

The average internal quality audit scores for the credentialing coordinators exceeded the threshold of 95%.

Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10
97.99%	98.16%	97.95%	98%	96.07%	96.61%	97.61%	96.68%	99.30%	98.98%	98.39%	97.88%

F. Medical Record Review

Medical record reviews were conducted to assess compliance with KMHP/AMHP Medical Record Standards. The review process was incorporated into the HEDIS chart abstraction process and was specific to PCPs associated with the HEDIS adolescent well visit sample.

The Medical Record audit score for passing remained at 90% for 2010.The number of practice sites that failed the audit is as follows:

KMHP: 8 of 37
AMHP: 4 of 21

Re-audits of the practices that scored below the 90% threshold will be conducted in 2011.

The top two documentation deficiencies for each Plan were preventive care and healthcare education. In addition to an educational session provided upon the audit exit interview, an educational article was placed in the Provider Newsletter. A new office /medical record tool for adolescent well visits was developed and sent to provider offices to assist them in documenting all components of the well-care visit.

VII. SERVICE PERFORMANCE

Service performance is analyzed though a variety of mechanisms, including formal satisfaction surveys, dissatisfaction analysis, process timeliness measures and access/availability measures.

The CAHPS workgroup continued in 2010 with the purpose of addressing intervention specific to any question scoring less than 75th percentile. Membership included representation from the following areas:

- Operations
- Provider Network Management
- Pharmacy
- Public Affairs
- Quality Management.
- Utilization Management
- Care Coordination

Two sub-teams continued, focusing on Plan Service Satisfaction and the Practitioner/Provider Satisfaction.

The Plan Service Workgroup‘s goals are to improve satisfaction in the following areas:

- Rating of Health Plan
- Rating of Health Care
- Health Promotion and Education

The Practitioner/Provider Workgroup's goal are to improve satisfaction in the following areas:

- Getting Care Quickly
- How Well Doctor's Communicate
- Shared Decision Making
- Health Promotion and Education
- Medical Assistance with Smoking Cessation.

KMHP/AMHP utilized NCQA's HEDIS Consumer Assessment of Health Plans Study (CAHPS 4.0.H) Questionnaire for Medicaid Adults and Children to conduct the Member Satisfaction Survey. During 2010, the CAHPS 3.0.H Questionnaire for Children (Medicaid) was administered. An external NCQA certified vender, *MORPACE,* administered the survey using a randomly selected sample of Members.

A. KMHP Analysis of Adult CAHPS Survey

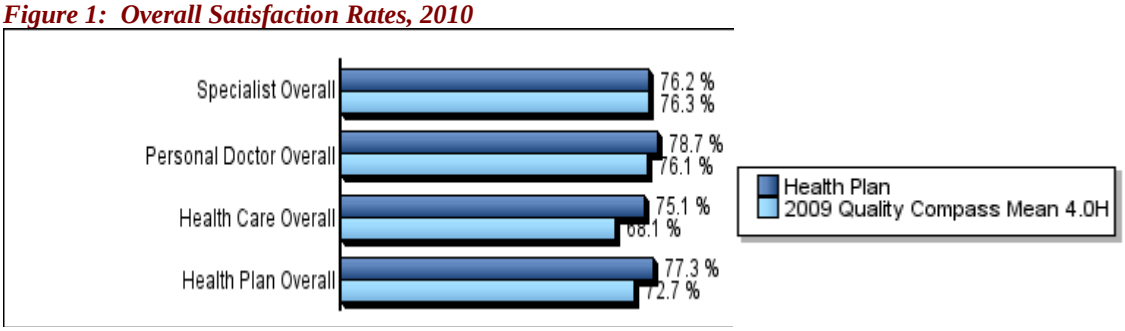
The survey was sent to a random sample of 1,620 adult enrollees from the universe of Members who have been continuously enrolled for at least 5 out of the last 6 months of 2009. Using the HEDIS prescribed methodology; the Plan obtained a 32% response rate for adult CAHPS (478 completed surveys).

In addition to the standard CAHPS survey questions, KMHP added four questions to enable the Plan to further investigate particular areas of interest. These questions covered the areas of access to specialists, website use, and customer service. In terms of the Plan's website, it was found that 63% of respondents thought it was Always/Usually easy to find information about the plan on its website. This is a non-statistically significant difference from the previous year result of 46%.

Overall rating of the health plan

Overall, Keystone Mercy Health Plan Members are satisfied with all aspects of their healthcare, giving high ratings for care received from a personal doctor, care received from specialists, and satisfaction with the health plan. (A rating of 8, 9 or 10 indicates a highly positive evaluation or perception.) Seven out of ten Members rate Keystone Mercy as the best health plan possible.

Figure 1: Overall Satisfaction Rates, 2010



On an annual basis the National Committee on Quality Assurance (NCQA) releases information on national CAHPS findings. This information allows the Plan to compare its results to a national benchmark (the 90th percentile of national results) and to national thresholds (the 75th, 50th and 25th percentiles). The percentile ranking is listed on the following page:

Variables	Percentile Rank 2008	2009	2010	2009 to 2010 Direction
Getting Care Quickly	75	90	75	↓
Getting Needed Care	75	75	50	↓
Customer Service	90	90	90	↔
Rating of Health Plan	75	75	50	↓
How Well Doctors Communicate	75	75	50	↓
Rating of All Health Care	75	75	90	↑
Rating of Personal Doctor	75	90	50	↓
Rating of Specialist Seen Most Often	50	90	25	↓
Shared Decision Making	10	50	90	↑

Overall, Keystone Mercy Health Plan Members continue to be satisfied with the service provided, evidenced by positive scores for satisfaction with care received from doctors and specialists, and satisfaction with the Plan itself. Rating of Overall Health has been trending upward since 2009.

No key measures in the 2010 survey showed statistically significant changes from the previous year.

B. KMHP Analysis of Child CAHPS Survey

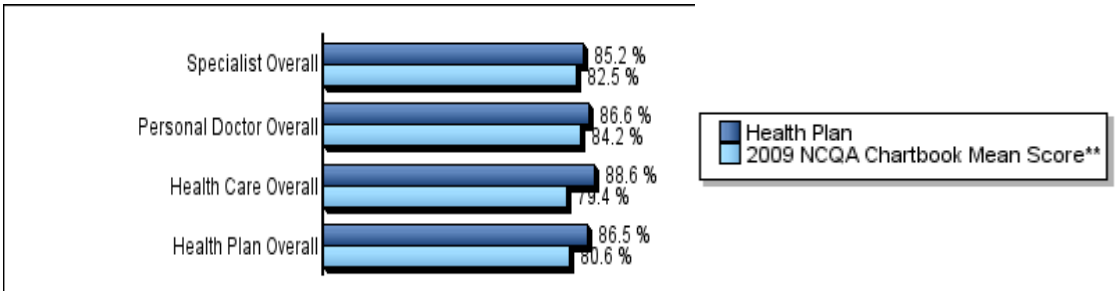
The survey was sent to a random sample of 1,650 child enrollees from the universe of all current Members enrolled at the time the survey was conducted, who were 7 years and younger as of December 31, 2009 and who have been continuously enrolled for at least 5 out of the last 6 months of 2009. The Plan was successful in obtaining a 36% response rate for child CAHPS (570 completed surveys).

Overall Rating of the Health Plan

Parents/Guardians of Keystone Mercy Health Plan child Members continue to give positive ratings in all overall satisfaction areas of their health plan. A rating of 8, 9 or 10 indicates a highly positive evaluation or perception. Nearly 9 out of 10 Members rate Keystone Mercy Health Plan as the best health plan possible (86.5%).

Parents/Guardians of Keystone Mercy Health Plan child Members continue to give positive ratings in all major areas of their health plan. All of these areas surpassed KMHP's goal of 75% satisfaction rate.

Figure 1: Overall Satisfaction Rates, 2010



In comparison to 2009 results, there is only one significant difference to note in 2010. The Overall Rating Measure of Health Plan, increased by 5 percentage points. The percentile ranking and change appear in the table below:

Variables	Percentile Rank 2008	2009	2010	2009 to 2010 Direction
Getting Care Quickly	NT	25	50	↑
Getting Needed Care	NT	25	25	↔
Customer Service	NT	50	50	↔
Rating of Health Plan	10	50	25	↓
How Well Doctors Communicate	25	25	25	↔
Rating of All Health Care	90	50	25	↓
Rating of Personal Doctor	25	25	25	↔
Rating of Specialist Seen Most Often	50	90	75	↓
Shared Decision Making	NA	25	10	↓

Opportunities for Improvement

Based on the analysis of the survey responses, the following areas appear to have opportunities for improvement. An opportunity is defined as any ratings, composite or other questions that has less than a 75% satisfaction rate, or a dissatisfaction rate of 25% or greater.

Ratings Areas	2008	2009	2010
Q3. Child had illness/injury/condition that needed care right away from clinic, ER, or doctor's office (YES)	42%	39%	40%
Q5. Made an appointment at doctor or clinic (YES)	68%	82%	82%
Q12a. Child get care from dentist‘s office/clinic in last 6 months (YES)	60%	55%	56%
Q12f. Child had a routine eye exam in last 6 months? (YES)	39%	34%	38%
Q18. Child able to talk to doctor about care (YES)	57%	61%	60%
Q25. Tried to make an appointment to see a specialist (YES)	40%	29%	29%
Q29. Sought care, tests or treatment thought child needed through his/her health care (YES)	54%	39%	37%

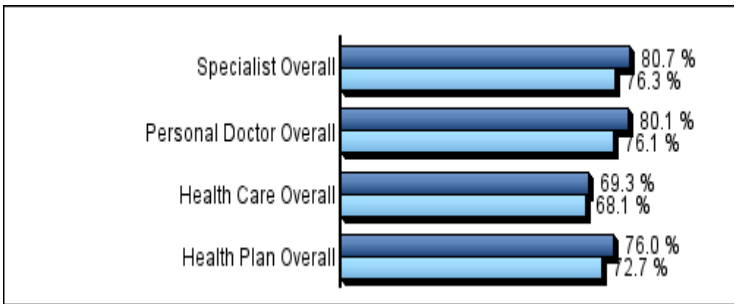
Overall, Keystone Mercy child caregivers continue to provide strong ratings on their personal doctor/nurse, and specialists. However, the strong ratings and percentage increases did not translate

to statistically significant changes as there was only one area that showed a statistically significant change (Overall Health Plan).

C. AMHP Analysis of Adult CAHPS Survey

AMHP contracted with MORPACE to administer the CAHPS 4.0H Adult Questionnaire (Medicaid). This year the survey was offered in both English and Spanish. The survey was sent to a random sample of 1,620 adult enrollees from the universe Members who have been continuously enrolled for at least 5 out of the last 6 months of 2009. Using the HEDIS prescribed methodology; the Plan obtained a 39% response rate for adult CAHPS (613 completed surveys).

AMHP Members continue to provide strong ratings for their personal doctor/nurse and specialists. However, none of the composite scores changed significantly.



The percentile ranking and change appear in the table below:

Variables	Percentile Rank 2008	2009	2010	2009 to 2010 Direction
Getting Care Quickly	25	50	50	↔
Getting Needed Care	25	50	25	↓
Courteous & Helpful Office Staff	NA	NA	NA	NA
Customer Service	75	50	50	↔
Rating of Health Plan	25	50	50	↔
How Well Doctors Communicate	50	50	75	↑
Rating of All Health Care	75	50	50	↔
Rating of Personal Doctor	75	50	75	↑
Rating of Specialist Seen Most Often	25	90	90	↔
Shared Decision Making	90	75	75	↔

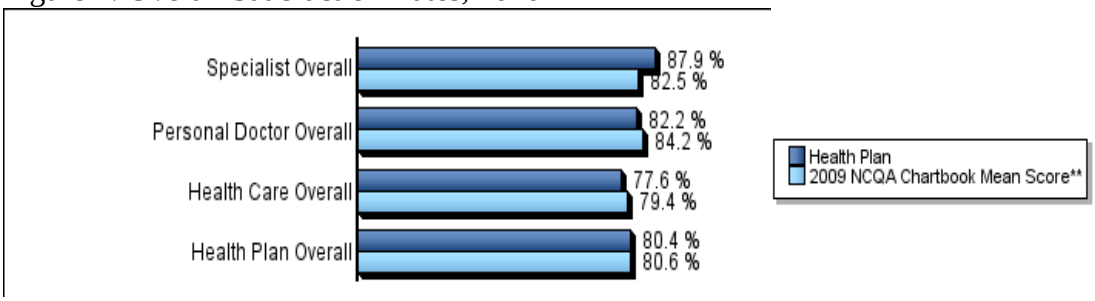
Overall, AmeriHealth Mercy adult Members continue to provide strong ratings on their personal doctor/nurse, and specialists. However, the strong ratings did not translate to significant increases.

D. AMHP Analysis of Child CAHPS Survey

The 2009 survey was sent to a random sample of 1,650 child enrollees from the universe Members continuously enrolled for at least 5 of the last 6 months of 2009. Using the HEDIS prescribed methodology; the Plan obtained a 33% response rate for child CAHPS (540 completed surveys).

AMHP Members continue to give positive ratings in all major areas for their health plan. Overall, Members are most satisfied with their specialist.

Figure 1: Overall Satisfaction Rates, 2010



Neither Overall Ratings nor Composite Measures had any statistically significant changes from the previous year. All Overall Rating Measures decreased from the previous year and all composite measures, except Getting Care Quickly, decreased from the previous year.

Based on the analysis of the survey responses, the following areas appear to have opportunities for improvement. An opportunity is defined as any indicator that has less than a 75% satisfaction rate, or a dissatisfaction rate of 25% or greater.

Ratings Areas	2008	2009	2010
Q5. Made an appointment for your child's health at doctor's office or clinic (YES)	68%	74%	75%
Q12a. Child get care from dentist's office/clinic in last 6 month (YES)	----	47%	52%
Q12f. Child had a routine eye exam in last 6 months? (yes)	----	35%	37%
Q21. Discussion about child feeling/growing/behaving (YES)	71%	85%	84%
Q25. Tried to make an appointment for child to see a specialist (YES)	40%	29%	29%
Q29. Sought care, tests or treatment for child through health plan (YES)	62%	41%	40%
Q31. Sought information/help from customer service at child's health plan (YES)	31%	23%	23%
Q36. Health Plan (% 8, 9 &10)	73%	83%	80%

Overall, AMHP child caregivers continue to provide strong ratings on their personal doctor/nurse, and specialists. However, the strong ratings did not translate to significant changes as there were zero areas that showed statistically significant changes from 2009 to 2010.

Barriers to Improvement

The following have been identified as possible barriers to improving Member concerns identified through the 2010 Child CAHPS survey:

- ***Lack of Doctor knowledgeable regarding the interpreter availability***. Even though AMHP has taken various measures to educate physicians regarding the availability of interpreters for their patients it is possible that some doctors may still be uninformed. AMHP will continue

to provide information on this issue through newsletters and other various dissemination tactics.

- ***Availability of dentists.*** Currently the nation as a whole is experiencing a dentist shortage. This is negatively impacting our Member's ability to receive recommended care.
- ***High volume patient times*.** Some times of the year ("flu season" and "back-to-school") it is difficult, if not impossible for doctors to maintain the standard of less than a 15 wait period for scheduled appointments.

E. Actions to Improve Member Satisfaction

Date Implemented	Keystone Mercy Health Plan/AmeriHealth Mercy Health Plan Member Initiatives 2007-2010
2007-2008	CAHPS Workgroup to target Smoking Cessation and try to improve CAHPS Survey scores.
2008	Member Focus studies were conducted to ascertain the barriers to preventative health compliance.
2008	Interactive Web Site launched containing health and wellness educational materials and calculator tools.
2009	• Member Automated Outreach Telephone Message advising of the upcoming CAHPS survey and that their opinion is important to us. • Distribution of magnets and flyers to Members during community event reminding them to schedule a well-check appointment with their PCP • An on-hold message was created to inform Members of the importance of scheduling a well check appointment with their PCP • Created an employee awareness campaign with poster, message from CMO, CAHPS educational session**.**
2010	• Continued CAHPS workgroups • CAHPS awareness phone message from Chief Medical Officer • Continued the Member Automated Outreach Telephone Message advising of the upcoming CAHPS survey and that their opinion is important to us.

F. Member Dissatisfactions and Complaints_

Member dissatisfactions are verbal expressions of dissatisfaction with the Plan, practitioners, providers, benefits or services. Dissatisfactions are documented and investigated with the result communicated to the Member. Members have the option of filing a formal complaint if they are not satisfied with the outcome of the investigation and subsequent efforts to remediate the area of dissatisfaction. KMHP and AMHP Member complaints continue to be processed by Independence Blue Cross under the Vista Health Plan license. Complaints are divided into two categories, Clinical Complaints (concerning medical necessity determinations) and Non-Clinical Complaints (concerning issues not related to medical necessity).

Dissatisfaction Analysis

The 2010 Annual Member Dissatisfaction Analysis examines the aggregate data from Member dissatisfactions that were received from 1/1/2010 through 12/31/2010 in order to track and trend reasons for dissatisfaction and to identify opportunities for improvement. No sampling was used.

Member Dissatisfaction data from the year 2010 was collected by type of dissatisfaction. Frequencies for each dissatisfaction category were calculated and rank-ordered. The table below shows Member dissatisfactions by type (subject), percentage of total and rate per 1000 Members, with a comparison of 2009.

KMHP Discussion:

Key findings:

- Member dissatisfactions decreased by 1,162 (39.1%).
- Dissatisfactions per 1,000 Members decreased to 5.96 down 3.19 (34.9%).
- PCP, Dental and Specialist make up KMHP's top 3 dissatisfaction topics consisting of 79.13% of all dissatisfactions in 2010. These three subjects decreased by 989 (40.9%).
    - PCP dissatisfactions decreased by 50.9%.
    - Dental dissatisfactions decreased by 15.3%.
    - Specialist dissatisfactions increased by 15.3%.

Subject	Variance in Totals		2010			2009		
			Total	% of Total	Per 1,000 Members	Total	% of Total	Per 1,000 Members
PCP	⇩	-50.89%	854	47.29%	2.82	1739	58.59%	5.36
Dental	⇩	-15.34%	414	22.92%	1.37	489	16.48%	1.51
Specialist	⇩	-15.26%	161	8.91%	0.53	190	6.40%	0.59
Admin.	⇩	-31.42%	155	8.58%	0.51	226	7.61%	0.70
Hosp/Lab	⇩	-28.81%	84	4.65%	0.28	118	3.98%	0.36
DME	⇩	-36.23%	44	2.44%	0.15	69	2.32%	0.21
Vision	⇧	12.90%	35	1.94%	0.12	31	1.04%	0.10
ER	⇩	-24.24%	25	1.38%	0.08	33	1.11%	0.10
Pharmacy	⇩	-70.21%	14	0.78%	0.05	47	1.58%	0.14
Therapy	⇩	-23.53%	13	0.72%	0.04	17	0.57%	0.05
PA Benefit	⇩	-14.29%	6	0.33%	0.02	7	0.24%	0.02
Bhv. Hlth	⇩	-50.00%	1	0.06%	0.00	2	0.07%	0.01
Totals			1806	100%	5.96	2968	100%	9.15

AMHP Discussion:

Key Findings:

- Member dissatisfactions increased by 6 (1.4%).
- Dissatisfactions per 1,000 Members increased to 3.94 down .15 (3.8%).
- PCP, Dental, and Administrative make up AMHP's top 3 dissatisfaction topics, consisting of 75.9% of all dissatisfactions in 2010. These three subjects decreased by 18 (5.3%).
    - PCP dissatisfactions decreased by 31.82%.
    - Dental dissatisfactions increased by 16.7%.
    - Administrative dissatisfactions increased by 31.5%.

Subject	Variance in Totals		2010			2009		
			Total	% of Total	Per 1,000 Members	Total	% of Total	Per 1,000 Members
PCP	⇩	-31.82%	120	28.37%	1.12	176	42.21%	1.60
Dental	⇧	16.67%	105	24.82%	0.98	90	21.58%	0.82
Admin.	⇧	31.51%	96	22.70%	0.89	73	17.51%	0.66
Specialist	⇧	30.56%	47	11.11%	0.44	36	8.63%	0.33

Subject	Variance in Totals	2010 Total	2010 % of Total	2010 Per 1,000 Members	2009 Total	2009 % of Total	2009 Per 1,000 Members
Vision	⇧ 42.86%	20	4.73%	0.19	14	3.36%	0.13
Pharmacy	⇩ -11.11%	8	1.89%	0.07	9	2.16%	0.08
ER	⇧ 700.00%	8	1.89%	0.07	1	0.24%	0.01
Hosp/Lab	⇩ -46.15%	7	1.65%	0.07	13	3.12%	0.12
DME	⇧ 600.00%	7	1.65%	0.07	1	0.24%	0.01
PA Benefit	⇧ 33.33%	4	0.95%	0.04	3	0.72%	0.03
Bhv. Hlth	0.00%	1	0.24%	0.01	1	0.24%	0.01
Totals		**423**	**100.00%**	**3.94**	**417**	**100.00%**	**3.79**

Complaint and Grievance Analysis:

KMHP Member complaint and grievance activity is presented in the following table:

	Annual '07		Annual '08		Annual '09		Annual '10	
	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000
***Clinical Complaint- Level 1**	4	0.0144	7	0.0237	1	0.0033	4	0.0129
***Clinical Complaint - Level-2**	2	0.0072	0	0	0	0	1	0.0032
Complaint Level-1	59	0.2124	80	0.2704	81	0.2648	102	0.3284
Complaint Level-2	13	0.0468	16	0.0541	24	0.0785	22	0.0708
Grievance Level-1	594	2.1382	717	2.4232	872	2.8509	1123	3.6159
Grievance Level-2	140	0.5039	158	0.534	174	0.5689	229	0.7373
Grievance Rx Level-1	396	1.4255	394	1.3316	263	0.8598	92	0.2962
Grievance Rx Level-2	62	0.2232	61	0.2062	29	0.0948	16	0.0515
Total	1270	4.57	1433	4.84	1444	4.72	1589	5.17

In 2010, the Appeal and Grievance Department received 10% increase in appeals when compared to the 2009 annual volume. A comparison of the membership for KMHP shows an increase from the 2009 annual period to the 2010 annual. KMHP showed an increase of 25,492 Members from last measurement period to the current measurement period. This translated into an increase from 4.72 to 5.17 in the rate per 1000 appeals and a 29% increase in level-1 and 31% increase in level 2 grievances received, during this measurement period.

Complaints: Most Frequent Categories

Additional analysis of first level complaints indicated that the Dental, DME, and Pharmacy categories were the most frequent categories for appeals.

- **Dental -** The dental category showed a 9-percentage point increase from 49% to 58% in level 1 complaints**.**
- **Durable Medical Equipment (DME) -** DME is the second most frequent category for KMHP in 2010 with 15% of complaints falling into this category. The analysis of DME complaints revealed that the determinations appealed related to requests for deluxe and special models of equipment, which are not covered.
- **Pharmacy -** Pharmacy is the third most frequent category for KMHP complaints for 2010 with 7% of appeals completed. An analysis of these complaints revealed that Members were appealing drugs that were not covered under their plan, therefore were benefit exclusions.

Grievances: Most Frequent Categories

- **Dental -** A review of the level one grievances indicated that appeals related to Dental services remained the most frequent category. Dental grievances increased from 42% I 2009 to 45% in 2010.
- **Home Health -** Home Health occupied the second most frequent category for level-1 grievances. Home health accounted for 20% of the level-1 grievances in 2010. Services for skilled nursing care were being reviewed more closely. This impacted the number of denials for both services and the number of service hours approved.
- **DME -** DME appeals were the third most frequent category for level-1 grievances at 10% for annual 2010. This is nine percentage point decrease over the 2009 rate.
- **Pharmacy -** Pharmacy level 1 & 2 cases show a decrease of 22% overall. Additional medications were added to the drug formulary, which resulted in a decrease in the number of prescription denials.

The AMHP Member complaint and grievance activity is listed in the following table:

	Annual '07		Annual '08		Annual '09		Annual '10	
	Received	Rate Per 1000	Received	Rate Per 1000	Received	Rate Per 1000	Received	Rate Per 1000
Clinical Complaint - Level-1	0	0	1	0.0102	0	0	1	0.0095
Clinical Complaint - Level-2	1	0.0109	0	0	0	0		
Complaint Level-1	24	0.261	19	0.1942	40	0.3828	29	0.2764
Complaint Level-2	5	0.0544	1	0.0102	10	0.0957	2	0.0191
Grievance Level-1	193	2.099	216	2.2079	353	3.3782	390	3.7177
Grievance Level-2	34	0.3698	30	0.3067	68	0.6508	67	0.6387
Grievance Rx Level-1	139	1.5117	105	1.0733	75	0.7177	45	0.429
Grievance Rx Level-2	12	0.1305	16	0.1636	11	0.1053	11	0.1049
Total	408	4.44	388	3.97	557	5.33	545	5.2

In 2010 AmeriHealth Mercy's appeals rate per 1000 decreased from 5.33 in 2009 to 5.20. The overall volume decreased 2%. Although the volume of appeals received only decreased 2%, first level complaints were down 27%. First level grievances were up 10%. Second level grievances remained relatively the same.

Grievances: Most Frequent Categories

In 2010, the dental category represented the most frequent type of AMHP appeals for level-1 grievances at 43%. Home Health and Drug followed with 14% and 11%, respectively**.** An in depth analysis was completed to research the reason for skilled care or what prompted the need for the skilled care. The results of the analysis found that this increase was related to the use of skilled services for safety due to behavioral health issues. Skilled services are not covered for behavioral health issues. In addition, services for skilled nursing care were being reviewed more closely. This impacted the number of denials for both services and the number of service hours approved.

G. Availability and Access

Availability and Access are monitored through appointment access surveys, after-hour calls to provider offices and accessibility of Plan staff via a toll-free phone number. After-hours compliance is measured by making calls to PCP sites during an after hour period and logging the response. After-Hours is defined as Monday through Friday before 8:00 AM and after 8:00 PM, Saturday after 3:00 PM and Sunday all day. The results are evaluated against the following standards:

Measure	Standard
Appointment Access	**Preventive Care – within three weeks** **Routine Care – within ten business days** **Urgent Care – within 24 hours** **Emergency Care - immediately**
After Hours Access	**Answer by 10th ring** **Any answering machine message must give instructions on contacting an answering service and/or the physician in case of emergency**
Phone Access to Plan	**Average Speed of Answer ≤ 30 seconds** **Calls Abandoned ≤ 5 percent**

Appointment Access

Every year, KMHP/AMHP monitors compliance with appointment availability standards to identify opportunities for improvement. The Plan uses two separate sources for the evaluation: 1) Appointment Access Survey and, 2) CAHPS (Member satisfaction survey)

The Appointment Access Survey was completed between January and December of 2009, utilizing self-administered questionnaires. Data collected through the survey was analyzed at an aggregate level for each type of care. The unit of analysis was practice site. Site-specific results were applied to all physicians at the particular practice site.

KMHP Discussion:

Of the 664 PCP sites that completed the Appointment Access Survey, 95.0 % met KMHP's appointment access standards for all types of care. This rate is lower than that of previous years. With an alpha level of .05, this finding does not, however, differ significantly (P<.05) with that of 2008. The area with the lowest compliance rate (95%) is preventive care.

KMHP Appointment Access Survey Results

	2007	2008				2009			
Standard	**% Met**	**Met Standard**	**% Met**	**Did Not Meet Standard**	**% Not Met**	**Met Standard**	**% Met**	**Did Not Meet Standard**	**% Not Met**
All types of care	96%	562	97%	17	3%	632	95%	32	5%
Preventive	96%	545	97%	17	3%	636	95%	28	6%
Routine	100%	562	100%	0	0%	662	99%	2	1%
Urgent	99%	562	100%	0	0%	663	99.9%	1	.01%
Emergent	100%	562	100%	0	0%	662	99%	2	1%

Overall, KMHP PCP sites are adhering to the appointment access standards. Of the 664 PCP sites that completed the Appointment Access Survey, 95.0 % met KMHP's appointment access standards for all types of care. This is a decrease from 2008 where 97% (n=545) meet the standards for all types of appointment access (Preventive, Routine, Urgent, Emergent). This is equivalent to the benchmark of 95% and higher than the compliance rate in 2007 (96%).

AMHP Appointment Access

Of the 386 PCP sites that completed the Appointment Access Survey, 97% met AMHP's appointment access standards for all types of care. With an alpha level of .05, this is a significant ($p<.05$) increase from the previous year (88%). Overall, AMHP PCP sites appear to be adhering to the appointment access standards. Out of all of the PCP practice sites returning surveys, 97% meet the standards for all types of appointment access (Preventive, Routine, Urgent, and Emergent). This rate is above the AMHP benchmark of 95% compliance

AMHP Appointment Access Survey Results

	2007	2008			2009		
Standard	**% Met**	**Met Standard**	**% Met**	**Did Not Meet Standard**	**Met Standard**	**% Met**	**Did Not Meet Standard**
All types of care	88%	375	97%	11	375	97%	11
Preventive	89%	375	97%	11	375	97%	11
Routine	99%	386	100%	0	386	100%	0
Urgent	99%	385	99.70%	1	386	100%	0
Emergent	99%	386	100%	0	386	100%	0

In 2009 AMHP analyzed all PCPs in the Plan. Overall, AMHP PCP sites appear to be adhering to the appointment access standards. Out of all of the PCP practice sites returning surveys, 97% meet the standards for all types of appointment access (Preventive, Routine, Urgent, and Emergent). This rate is above the AMHP benchmark of 95% compliance.

Although appointment availability for illness or injury improved, satisfaction remained consistent with last year's levels as neither of the differences were found to be statistically significant.

After-Hours Study

The purpose of the After-Hours Access Survey is to assess physician compliance with KMHP and AMHP availability standards. Furthermore, the survey results are used to identify opportunities for improvement with respect to after-hours availability and develop action plans to improve those areas. The After-Hours survey was conducted between the months of October and December 2009 by TRC, an outside vendor.

KMHP discussion

A total of 702 randomly selected PCP sites were surveyed for after-hours compliance utilizing the telephone survey methodology.

The 2009 PCP practice site compliance rate 94.5% with after-hours access standards is a decrease over the rate from 2008 (94.1%). The most cited reason for non-compliance was _no emergency instructions on answering machine'. With an alpha level of .05 there was not a significant difference in terms of the proportion of sites that were compliant with the after hours requirements from 2008 to 2009. Despite the lack of statistical significance, the results are still extremely important and

should not be deemed irrelevant. The barrier to compliance have been identified by KMHP as it has been found in previous years, that a few of the sites originally notified as being non-compliant with after-hours had the wrong phone number listed. The number in our database is sometimes an administrative number and not that of the clinical practice. KMHP is currently working to address this issue.

Reasons Why PCP Sites Did Not Meet After-Hours Standards 2009, 2008 & 2007

	2009		2008		2007	
Reason	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant	# Non-Compliant	# Non-Compliant
Total	**49**	**100%**	44	100%	84	84
= 10 Rings	10	20%	13	30%	17	17
Answering Machine instructions to ER only	10	20%	5	11%	18	18
No emergency instructions on answering machine	18	37%	21	48%	46	46
Answering Service does not pick-up	11	23%	5	11%	3	3

A list of the non-compliant PCP practice sites was forwarded to Provider Network Management for follow-up. These sites are also automatically added to the list to be surveyed the following year for further monitoring.

AMHP Discussion

The purpose of the After-Hours Access Survey is to assess physician compliance with AMHP availability standards. Furthermore, the survey is used to identify opportunities for improvement with respect to after-hours availability and to develop action plans to improve those areas. The study consisted of a random sampling of 365 PCP sites that were successfully surveyed for after-hours compliance utilizing the telephone survey methodology.

It was determined that 94% (n=365) of PCP sites had compliant after-hours coverage. This finding is a decrease from the 2008 after-hours compliance results (96% compliant). The reasons given for non-compliant PCP sites and their corresponding proportions are indicated in the table below. The most sited reason for non-compliance is ~~a~~nswering service does not pick up".

Reasons Why PCP Sites Did Not Meet After-Hours Standards 2009, 2008 & 2007

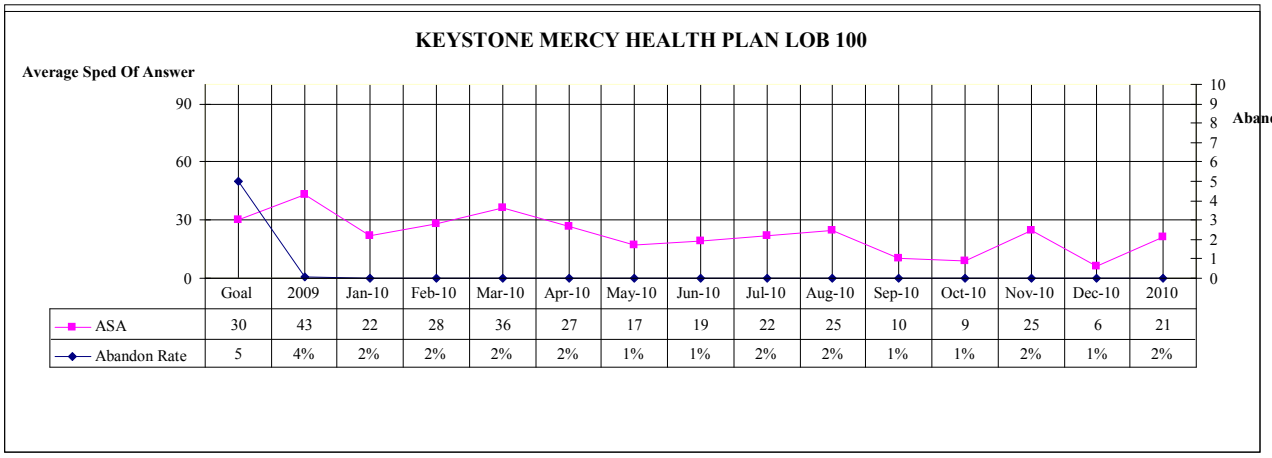
	2009		2008		2007	
Reason	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant
Total	23	6%	11	100%	27	100%
> 10 Rings	3	13%	1	9%	3	11%
Answering Machine instructions to ER only	5	22%	1	9%	2	7%
No emergency instructions on answering machine	2	8%	10	91%	16	59%
Answering Service does not pick-up	13	56%	1	9%	6	22%

It should be noted that the sites that had been non-compliant in 2008 were compliant for 2009.

The following barrier to compliance has been identified by AMHP:
It has been found in previous years, that a few of the sites originally notified as being non-compliant with after-hours had the wrong phone number listed. The number in our database is sometimes an administrative number and not the number provided for Members use. AMHP is currently working to address this issue.

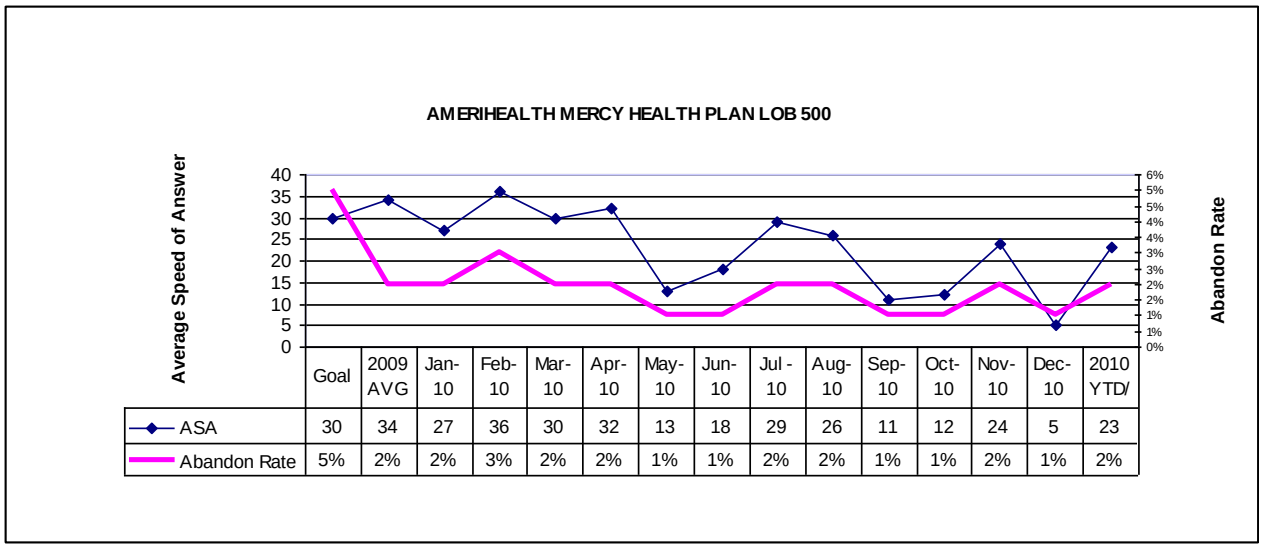
A list of the non-compliant PCP practice sites was forwarded to Provider Contracting for follow-up. These sites are also automatically added to the list to be surveyed the following year for further monitoring.

Member Service Phone Availability
The universe for the Member Service telephone accessibility measure consisted of all calls that came into AMHP or KMHP between January 1, 2010 and, December 31, 2010. No sampling was used.



	Goal	2009	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	2010
ASA	30	43	22	28	36	27	17	19	22	25	10	9	25	6	21
Abandon Rate	5	4%	2%	2%	2%	2%	1%	1%	2%	2%	1%	1%	2%	1%	2%

All goals were met with the exception of March, in which the call volume increased due to a potential hospital termination. Goals were met for the remaining months.



	Goal	2009 AVG	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	2010 YTD/
ASA	30	34	27	36	30	32	13	18	29	26	11	12	24	5	23
Abandon Rate	5%	2%	2%	3%	2%	2%	1%	1%	2%	2%	1%	1%	2%	1%	2%

AMHP Discussion

The Average Speed of Answer (ASA) was not met during the months of February 2010 and April 2010 due to staffing issues. Two full time employees were on intermittent Family Medical Leave and the team had one vacant Member Service Representative position. Overall, the ASA averaged 23 seconds for the year; this result is well within the required standard of 30 seconds. Member Services consistently exceeded the abandonment rate performance goal of 5% during 2010.

Service Quality Improvement Initiative

Increasing Access to Dental Care

Access to dental care is a continuing quality improvement focus for KMHP and AMHP. Efforts in prior years focused on improving provider attitudes by changing reimbursement policies, expanding access for Members with Special Needs and Member education. In addition to continued provider recruitment, current efforts centered on Member outreach. Interventions for 2010 included the following:

Keystone Mercy Health Plan	AmeriHealth Mercy Health Plan
Interventions • Recruitment of 90 new providers • Dental screenings provided at community events • Dental education and handout materials at community events • Smiling Stork— Aggressive outreach program for pregnant women to reduce the incidence of pre-term, low birth weight babies by stressing the importance of pre-natal dental care • Maternity/Dental Performance Improvement Plan	Interventions • Recruitment of 41 new providers • Dental screenings provided at community events • Dental education and handout materials at community events • Smiling Stork— Aggressive outreach program for pregnant women to reduce the incidence of pre-term, low birth weight babies by stressing the importance of pre-natal dental care. • Emergency Room/Dental Call out Program – Outbound call to Members who are identified in a report of dental-related ER visits

KMHP Results

	Rating Area	2009	2008	2007	2006
CAHPS	**Received care from dentist**	**38%**	**36%**	**36%**	**33%**
	Rating of dental care (High)	**71%**	**61%**	**53.2%**	**68%**
HEDIS	**Annual Dental Visit (4-21)**	**50.75%**	**47.6%**	**43.1%**	**43.2%**
Internal	**Dental Dissatisfactions/10,000 Members**	**10.37**	**9.11%**	**13.52%**	**12.90%**

AMHP Results

	Rating Area	2009	2008	2007	2006
CAHPS	**Received care from dentist**	**38%**	**38%**	**36%**	**34%**
	Rating of dental care (High)	**65%**	**67%**	**61%**	**64%**
HEDIS	**Annual Dental Visit (4-21)**	**44.96%**	**43%**	**40%**	**41%**
Internal	**Dental Dissatisfactions/10,000 Members**	**9.80**	**6.47**	**11.61**	**14.2**

Barriers identified include:

- Members‘ fear of dentists
- Members‘ knowledge deficit regarding the importance of dental health and preventive care
- Transportation
- Dental office-hours availability.

Plan for 2011:

- Insource a Dental Management Program for KMHP
- Continue with Member educational campaigns
- Continue with monitoring dental dissatisfactions
- Continue with community events that include provide dental screenings
- Continue to provide education regarding the Medical Assistance Transportation Program
- Continue to expand dental network.

KMHP's comprehensive dental management program will be phased in during 2011. The program will:

- ***Engage*** a closer relationship with dental providers by offering three different reimbursement methods.
- ***Encourage*** a closer relationship between Members and their dental providers by developing a Dental Home concept for all Members.
- ***Evaluate*** care patterns for consistently high quality and utilization of services.

VIII. ADDITIONAL QUALITY ACTIVITIES

A. Quality of Care Activity

Keystone Mercy/AmeriHealth Mercy has a review process for investigating and responding to events that may indicate potential quality issues in the inpatient or ambulatory setting. A Quality of Care review referral may include Member concerns, sentinel events, and investigations based on trended information and inquiries. The plan has a goal to resolve all potential quality of care concerns within 30 days from the receipt of all investigative information**.**

The Quality of Care case referral activity is as noted below:

2010	KMHP	AMHP	Total
Referrals	335	141	476
Accepted Cases	180	58	238
Declined Cases	155	83	238
Closed cases	305	126	431

Distribution of Outcomes of Sentinel Events and Member Concerns:

2010 Outcomes	KMHP	AMHP
NQC – No Quality of Care Concern	**144**	**54**
PEO – Provider Education Opportunity	**6**	**2**
PRC – Peer Review Committee	**3**	**1**
F – Failure to reply to request for more information	**0**	**0**
Cases Pending Outcome	**30**	**15**

Additional 2010 Quality of Care activities consisted of focus studies and ad-hoc reviews, as described below:

Health Plan	Review Type	Quality of Care Activity	Outcome
KMHP	Focus Study	Review of Physician Practice issue. (Identified through a QOC review)	Medical Record Standards not met. Provided Medical Record Standards & Guideline education provided.
KMHP AMHP	Ad Hoc Activity	Care Gap initiative	Care Gap information was obtained and entered into a database for use as HEDIS data and for other wellness activity.
KMHP AMHP	Ad Hoc Activity	HEDIS Data Collection: Identify Member compliance with HEDIS measures	A process was established and followed to identify Member compliance with HEDIS measures with improvement in HEDIS scores.
KMHP AMHP	Ad Hoc Activity	Continued work on processes to identify for nonpayment or reimbursement for ―Never Events"	Process established to integrate QM function within the process.

Serious Adverse Events
In January, 2008, The Department of Public Welfare issued a bulletin and payment policies regarding Serious Adverse Events that were determined to have been preventable. Preventable Adverse Events are defined as those that are harmful, are of inferior quality or medically unnecessary (e.g. medication errors associated with death or serious disability, pressure ulcers, etc.). Processes were developed to capture and address these events. This activity continued through 2010.

Process Oversight
External oversight audits of the Quality of Care review process are performed by Independence Blue Cross. In addition, quarterly internal monitoring is performed. The Quality of Care review timeliness performance measure benchmark is 30 days from receipt of all information required for the review. The threshold for meeting this benchmark is 95%. The timeliness threshold for the combination of Member-identified and other-identified concerns was impacted by dedication to the HEDIS project. All Member-identified concerns were closed within 30 day timeframe per the NCQA requirement.

External oversight audit results identified for improvement was with provider notification resolution which brought the total score for the 2nd and 3rd Quarters of 2010 to an average of 87.5% which is below the 95% benchmark for NCQA requirement. A Corrective Action Plan was initiated for the 4th Quarter and the area identified for improvement was the follow-up process relating to obtaining medical records in a timely manner. The total score for the CAP was 85% again below the 95% benchmark for NCQA requirements. Subsequently, new processes were initiated to include all health care providers receive notification of no quality of care issues as well as additional follow-up criteria for records not received within a specific timeframe

B. KMHP Practitioner and Provider Satisfaction
Practitioner Survey:

Out of the 1,655 physicians surveyed, 257 were completed and returned, yielding a response rate of 15.53% a decrease of 3.47% in 2008. The 2009 Physician Satisfaction Survey indicates that 82.72% of practitioners are satisfied with Keystone Mercy Health Plan.

The 2009 Practitioner Satisfaction Survey indicates that overall, 82.72% of practitioners are satisfied with Keystone Mercy Health Plan. This is slightly less than the previous year (87.38%).

Four areas did not meet the 85% threshold:

1) Provider Account Executive (Field Representative)
    a. Overall Satisfaction
        2008 = 78.44% 2009 = 80.32%
2) Provider Claims Services Telephone Line
    a. Responsiveness
        i. 2008 = 83.68% 2009 = 84.73%
3) Pharmacy Staff
    a. Comprehensiveness of drug formulary
        i. 2008 = 68.71% 2009 = 72.10%
4) Pharmacy Authorization Process
    a. Pharmacy Prior Authorization Process
        i. 2008 = 65.52% 2009 = 67.44%
    b. Accessibility of prior authorization staff
        i. 2008 = 68.21% 2009 = 73.22%
    c. Notification Process of Denials
        i. 2008 = 68.97% 2009 = 74.71%
    d. Notification Process of Approvals
        i. 2008 = 74.14% 2009 = 79.29%
    e. Consistency of Decisions made by Keystone Mercy clinical pharmacists to approve or deny authorizations
        i. 2008 = 69.41% 2009 = 71.88%
    f. Overall Satisfaction of Pharmacy Department
        i. 2008 = 69.36% 2009 = 72.61%

Provider Survey:

The Provider Satisfaction Survey was sent to hospital and ancillary providers. A total of 518 surveys were sent. There were 57 surveys returned yielding a response rate of 11%, a decreased response rate of 3%. In the 2009 survey, 39 out of 53 (73.53%) service indicators achieved the threshold of 85% favorable response. This is a (non-statistically significant at 95%) increase from the previous year where 42 (63%) of the service indicators achieved the benchmark. Despite the lack of statistical significance, this is an important and valuable increase.

The 2009 Provider Satisfaction Survey indicates that well over three-quarters (91.11%) of providers are satisfied with Keystone Mercy Health Plan. This is up from the previous year (89.83%).

Areas with that did not achieve the threshold of 85% are:

1. Overall Claims Process
    a. 2008 = 80.70% 2009 = 84%
2. Response Time to Problem Resolution (Provider Account Representative/Field Representative)
    a. 2008 = 68.42% 2009 = 77.42%
3. Overall Satisfaction (Provider Account Representative/Field Representative)
    g. 2008 = 68.42% 2009 = 80.65%

Keystone Mercy utilizes questions in the provider satisfaction survey to assess provider use and satisfaction with the KMHP website and the iEXCHANGE application. The results of the survey indicate that 94.44% of our providers use the Internet for office-related business (a decrease from 2008 when 98.39% of providers reported using it); however, only 47.06% use the KMHP's website. In addition, 88.89% of our providers use KMHP's provider portal services through NaviNet. It was found that the overwhelming majority (95.83%) of those who do use the website are satisfied. The respondents were provided space to list suggestions for the improving NaviNet. The most consistent suggestion surrounded being able to process and adjust claims online. The results of the survey also indicate that 20.41% of our providers are aware of iEXCHANGE authorization request portal, with 6.67% of providers reporting use.

C. AMHP Practitioner and Provider Satisfaction

The surveys were administered via either mail or electronically via the internet (specifically Survey Monkey – a free web based survey creation tool) by way of email contact. The decision was made not to just send to our top 5-10 high volume specialties as was done in years past, but rather, surveys were sent to all major specialties. A total of 219 practitioners received the survey via email and 1,260 via hard mail. No sample was taken. Included in the hard mailing, in addition to the survey, was a cover letter explaining the purpose of the study as well as a prepaid return envelope. The surveys administered via Survey Monkey yielded 18 e-survey responses.

Out of the 1,479 physicians surveyed, 126 (108 mail/18 electronic) were completed and returned, yielding a response rate of 8.5%.

The Practitioner Satisfaction Survey indicates that almost all 86.61% of practices are satisfied with AmeriHealth Mercy Health Plan. There was no significant difference from the previous year.

Provider Survey:

Out of the 375 providers surveyed, 52 (34 mail/18electronic) were completed and returned, yielding a response rate of 13.9%. While the response rate has increased from the previous year, the additional e-surveys may have impacted the increase.

The 2009 Provider Satisfaction Survey indicates that 81.82% of providers are satisfied overall with AmeriHealth Mercy Health Plan. This is a decrease from 2008 where 89.66% were satisfied overall. Areas of overall satisfaction > 85% are:

- Provider Claims Services Telephone Line:
  2008 = 93.94% 2009 = 86.21%
- Case Management Services:
  2008 = 100% 2009 = 100%
- Provider Contracting Representative(Field Rep):
  2008 = 84.00% 2009 = 88.00%
- Credentialing/Recredentialing:
  2008 = 100.00% 2009 = 88.00%
- AMHP Website:
  2008 = 94.74% 2009 = 92.86%
- Navinet:
  2008 = 86.36% 2009 = 95.24%

OPPORTUNITIES FOR IMPROVEMENT:
Based on the analysis of the survey responses, there were five areas where the favorable response rate was less than 85% and were identified as opportunities for improvement. These areas as listed below could be viewed as those areas driving down the overall satisfaction rating with AMHP (81.82%).

Area	2008	2009
Overall Satisfaction Prior Authorization Process	92.59%	74.29%
Overall Satisfaction Medical Directors	87.50%	82.61%
Overall Satisfaction Claims	90.32%	82.61%
Overall Satisfaction Home Care Services	100.00%	83.33%
Overall Satisfaction AMHP	89.66%	82.14%

D. Clinical Practice Guidelines
During 2010 the following eleven clinical practice guidelines were approved for KMHP and AMHP:

Guideline/Topic	Guideline Source
Asthma	Global Initiative for Asthma (GINA) 2009 http://www.ginasthma.com/Guidelineitem.asp??l1=2&l2=1&intId=60 National Institute of Health (NIH) 2009 http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm
Cholesterol	National Heart, Lung, and Blood Institute: National Cholesterol Education Program - Third Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), 2004
Chronic Obstructive Lung Disease	National Heart, Lung, and Blood Institute, World Health Organization and the American Thoracic Society/European Respiratory Society - Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2008.
Chlamydia	US Preventive Services Task Force, 2007. Chlamydia Screening
Diabetes	American Diabetes Association - Clinical Practice Recommendations 2010
HIV	*Pennsylvania Medicaid* - Pennsylvania Medicaid Adult HIV Clinical Practice Guideline, Volume 5, Number 1, 2008-2009
Hemophilia	Medical and Scientific Advisory Council (MASAC) of the National Hemophilia Foundation - MASAC Recommendations Concerning the Treatment of Hemophilia and Other Bleeding Disorders, 2003, (151)

Guideline/Topic	Guideline Source
Heart Failure	2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults http://circ.ahajournals.org/cgi/content/full/119/14e/e391 Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease http://ahajournals.org/cgi/content/full/115/21/2761
Hypertension	National Heart Lung and Blood Institute (NIH): The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
Maternity	Institute for Clinical Systems Improvement - Routine Prenatal Care, Thirteenth Edition, August 2009. The United States Preventative Services Taskforce guidelines on Primary Care Interventions to Promote Breastfeeding developed in 2008. Michigan Quality Improvement Consortium Routine prenatal and postnatal care July 2006. US Preventative Services Taskforce (USPST) Primary Care Interventions to Promote Breastfeeding, October 2008.
Sickle Cell Disease	National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources - The Management of Sickle Cell Disease

E. Member Safety

Several initiatives were completed for the 2010 KMHP/AMHP Member safety plan. Highlights of the activities, analysis of barriers and effectiveness and identification of next steps appears below:

Activity	Analysis & Barriers	Next Steps
Notification of Members and providers related to • Medication safety • Drug recalls • Drug utilization issues Methods • Newsletter articles • Recall notifications • DUR	**Interventions were implemented as planned. Barriers to effectiveness include the reliance on paper-based communication. However, paper remains a relatively inexpensive mechanism to reach large numbers of people and document that notification occurred.**	**Continue current paper-based interventions**

Activity	Analysis & Barriers	Next Steps
Credentialing of practitioners and providers against DPW, Plan and NCQA requirements	**Credentialing and recredentialing remains an effective mechanism to periodically review provider and practitioner qualifications.**	**Continue current process**
Disseminate evidence-based guidelines • Clinical guidelines were distributed via the provider internet site. Providers were notified via the newsletter and have the option of requesting a hard copy of the guidelines. • Reports on Members in need of services recommended by select guidelines were mailed to providers quarterly	**Use of nationally-accepted guidelines is an effective mechanism to promote consistency in management of chronic conditions since the guidelines have national credibility and are not plan specific. However, move needs to be done to effect change when the treatment rendered does not follow guidelines.**	**Continue current practice** **Expand measurement activities to include focused interventions based on results**
Two Playground Builds: • St Rose of Lima • Woodlands Academy	**Safe play areas reduce the number of preventable injuries sustained by children.**	**Continue to partner with community agencies to build more playgrounds**

F. Reducing Disparities at the Practice Sites Initiative:
This Initiative began in the 4th quarter of 2008 and continued in 2010. KMHP participates in the Reducing Disparities at the Practice Sites (RDPS) Initiative, along with two other Southeast Pennsylvania HealthChoices Plans and DPW. The Initiative was developed by the Center for Health Care Strategies (CHCS) to support quality improvement in small practices serving a high volume of racially and ethnically diverse Medicaid beneficiaries. This three-year project sponsored by the Robert Wood Johnson Foundation, assists Medicaid agencies and health plans to partner with small practices to reduce racial and ethnic disparities and improve overall outcomes.

The goal is to build the quality infrastructure and care management capacity of ~~–h~~high-opportunity" primary care practices where the greatest impact can be made. The focus of interventions continued in 2010:
- Tracking patients and outcomes using an electronic data management tool
- Adopting evidence-based guidelines for targeted chronic conditions
- Incorporating team-based care into ongoing practice operations

The challenges continue to be the inability to reach the Members due to disconnected phones, the Members who do not follow-up with their PCP despite multiple outreaching call and letters as well as the overburdened office staff and or office staff turnover.

Considering the practices‘ slow adoption to change, 2010 accomplishments include the following:
- Flow Sheets

  - Six practices were printing out the registry low sheets prior to each visit and update registry or are using EMR flow sheet
  - Two practices are utilizing the practice coach for data entry
  - Four practices are printing out the registry reports to do patient outreach with coach support
- Evidenced Based Guidelines
  - Eight of the 9 practices were following the EBG and flow chart
- Electronic Health Records
  - One practice using EMR
- Third party practice assessments were completed in two practices

The overall conclusions are that the practices are now very engaged in quality improvement despite their own infrastructure challenges and that the practices are actively working to redesign internal workflows.

G. Quality Improvement (QI) Work plan

The QI work plan activities were approved by the Quality Improvement Committee and were completed on schedule during the year with the exception of two items. The two items are listed below and were added to the 2011 QI /UM work plan.

- Maternity Dental PIP (KMHP) – the delay was due to data collection to allow for claims lag
- AMHP HEOAC's 3rd Qtr 2010 report – the delay was due to a transition in the committee chair

H. The QI Program Description

The 2010 QI Program Description was approved by the Quality Improvement Committee. The following components were updated:

- Member demographic data
- Committee compositions and descriptions
- Staffing data
- Enhanced program scope to include health disparities and linguistic and culturally competence
- Enhanced program goals to include the assessment and revision of data sources used to evaluate the memberships' race and ethnicity to address disparities
- Enhanced the program objectives to include facilitating the delivery of culturally competent healthcare
- Enhanced the program activities to include the Health Care Equity workgroup

IX. OVERSIGHT OF DELEGATED ACTIVITIES

A. Oversight of Existing Delegates

KMHP/AMHP delegated health plan functions to the organizations identified in the table below. KMHP/AMHP conducted oversight for each of the delegates, specific to the delegated functions. Action plans were developed and monitored, as needed, for oversight elements not meeting Plan standards.

Organization	Delegated Functions	Score	Action Plan
University of Pennsylvania Health	**Credentialing Files**	**94.18%**	**Yes**
	Re-credentialing Files	**95.65%**	

Organization	Delegated Functions	Score	Action Plan
System (UPHS)	Credentialing Documents	100%	
DentaQuest (formerly Doral Dental)	Credentialing Documents	100%	No
	Utilization Management Documents	100%	
	Quality Management Documents	100%	
	Utilization Management Files	99.99%	
	Quality Management Files	100%	
	Credentialing Files	99.45%	
	Recredentialing Files	99.83%	
Nemours Group	Credentialing Files	95.45%	Yes
	Re-credentialing Files	95.65%	
	Credentialing Documents	100%	
Davis Vision	Credentialing Documents	100%	No
	Quality Management Documents	100%	
	Utilization Management Documents	100%	
	Credentialing Files Recredentialing Files	100% 100%	
	Utilization Management Files	99.83%	
	Quality Files	100%	
Jefferson University Physicians	Credentialing Files	100%	No
	Re-credentialing Files	100%	
	Credentialing Documents	100%	
Take Care Health System	Credentialing Files	95.45%	Yes
	Re-credentialing files	N/A	
	Credentialing Documents	100%	
PerformRx	Document Review	98%	No
	Denial File Review	100%	
South Central Preferred (WellSpan)	Credentialing Files	99%	No
	Recredentialing Files	100%	
	Document Review	100%	

Organization	Delegated Functions	Score	Action Plan
Med Advantage	**Verification of education for non-board certified physicians (M.D. and D.O.)**	**NCQA CVO Accreditation**	**No**
National Imaging Associates	**Document Review**	**100%**	**Yes**
	Utilization Management Files	**98%**	
Berkshire Health Partners	**Credentialing Files**	**95%**	**No**
	Re-credentialing files	**95%**	
	Credentialing Documents	**95%**	
ProgenyHealth, Inc.	**UM File Review**	**96%** **URAC Accreditation for Health Utilization Management**	**No**
	CM File Review	**96%**	

X. STRENGHTS, OPPORTUNITIES AND GOALS

Overall, the KMHP/AMHP Quality Improvement Program operated effectively and met its goals during 2010 with the exception of increasing select HEDIS results to the next national Medicaid percentile. The methodology for determining the HEDIS goals was revised to 5% of the gap between the current rate and 100. The program accomplishments are outlined throughout this document, with highlights summarized below. Opportunities and challenges will be addressed through initiatives and undertakings in the year 2011.

A. Major Strengths and Accomplishments of the 2010 QI Program

The Plan demonstrated strengths and accomplishments through the 2010 QI Program as indicated below: including,

- Maintained NCQA Excellent Accreditation Status
- Achieved significant improvement in numerous HEDIS measures
- Continued the Health Care Equities project
- Applied as early adopter for NCQA‘s Multicultural Health Care Distinction Award
- Enhanced the HEDIS data collection
- Successfully in-sourced the HEDIS/Catalyst process
- Initiated additional programs for Childhood Obesity Programs
- Improved credentialing process from paper to paperless
- Reduced the credentialing file processing time from 120 days to 30 days
- Launched a credentialing Newsletter to all LOBs

- Created an on-line help job aide for credentialing coordinators
- Continued participation in the Reducing Disparities at the Practice Sites Initiative with DPW and the three SE Health Choices Plans and the Center for Health Care Strategies
- Continued participation in the DPW Initiative HealthChoices/HealthConnections
- Expanded Care Gaps to include annual dental visit and lead screening
- Implemented Drug Therapy Management for Diabetes in collaborative with our Pharmacy Benefit Manager
- Improved AMHP's national ranking 25th to 23rd (Best national Medicaid Plan)

B. Opportunities/challenges for the Year 2011

Several opportunities for improvement and challenges exist and will be addressed through initiatives and undertakings in the year 2011:

Challenges & Opportunities for 2011:

- Maintain Excellent NCQA Accreditation Status
- Achieve NCQA Multicultural Health Care Distinction Award
- Formalize a Cultural and Linguistically Appropriate Services (CLAS) Committee, Charter and Work Plan
- Identify and prioritize opportunities to reduce healthcare disparities (Race/Ethnicity/Language)
- Assess, re-design (if applicable) and or implement clinical programs to reduce healthcare disparities
- Maximize the credentialing application with 3 new functionalities
- Strengthen the childhood obesity programs/initiatives
- Initiate two new Clinical Initiatives
- Enhance HEDIS medical record review/data collection process
- Continue to improve HEDIS rates and PA External Quality Measures
- Achieve significant improvement in two Member Satisfaction (Consumer Assessments of Health Providers Systems) Composites that are below or at the 75 percentile
- Re-design the practitioner feedback process
- Conduct a minimum of two practitioner focus groups per Plan
- Continue collaborative efforts with Behavioral Health MCOs
- Continue participation in the Reducing Disparities at the Practice Sites Initiative with DPW and the three SE Health Choices Plans and the Center for Health Care Strategies
- Continue participation in the HealthChoices/HealthConnections
- Successfully in-source the Dental Program
- Rank within the Top 20 Medicaid Plans

C. 2011/2012 Clinical and Service Quality Goals

Using data from HEDIS, EQR and internal measures, clinical and service quality goals were set for 2011. Initiatives to reach these goals will be implemented during 2011, with measurement and reporting in 2011/2012.

<table>
<tr><th>Topic</th><th>Goal</th></tr>
<tr><td>Accreditation</td><td>a) Maintain Excellent NCQA Accreditation Status
b) Achieve NCQA Multicultural Health Care Distinction
c) Achieve NCQA Certification for Credentialing Verification Organization (KMHP)
d) Improve national ranking to within top 20 Medicaid Plans.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>IBC Annual Oversight Delegation Audit</td><td>a) Achieve passing threshold for annual Credentialing audit
b) Achieve passing threshold for annual QM audit</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Clinical Initiatives</td><td>a) Reduce Pediatric Obesity
• Increase BMI documentation rates from 2010
• Increase documentation for counseling for nutrition and physical activity from 2010
b) Reduce Potentially Preventable Readmissions
c) Reduce Re-admission for Members Diagnosed w Serious Mental Illness</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Cultural and Linguistically Appropriate Services</td><td>a) All Associates will participate in CLAS training
b) Host Member Focus Groups to gather Members‘ feedback and identify potential concerns on the scripting of REL data collection by end of
c) Integrate Members‘ REL data into the clinical management application by 4th Qtr
d) Develop a CLAS or Cultural Diversity web page for the Member Center
e) Formalize a CLAS work plan w task, timelines and responsible parties
f) Formalize the post translation/interpreter Member survey process to include timeframes and frequency
g) Conduct 2011 HEDIS and CAHPS Race/Ethnicity/Language (REL) disparity analysis
h) Design strategy to address identified disparities s based on HEDIS and CAHPS analysis
i) Enhanced the HEAC and HEOAC committees agendas‘ to increase cultural diversity 2nd Qtr
j) Distribute Spanish healthcare beliefs to PCP who serve the AMHP‘s Hispanic membership
k) Distribute Vietnamese health care beliefs to PCPs who serve the Vietnamese speaking membership</td></tr>
<tr><td></td><td></td></tr>
<tr><td>External Quality Review Measures (PA)</td><td>a) Improve all measures by 5% (of current gap to 100%)
<table>
<tr><th>KMHP (PA EQR Measures)</th><th>Sub Measure</th><th>HEDIS 2010</th><th>HEDIS 2011 Goals</th></tr>
<tr><td rowspan="3">Early and Periodic Screenings, Diagnosis and Treatment (EPSDT) Development Screenings</td><td># 1</td><td>5.53%</td><td>8.03%</td></tr>
<tr><td># 2</td><td>1.88%</td><td>4.38%</td></tr>
<tr><td># 3</td><td>21.23%</td><td>23.73%</td></tr>
</table></td></tr>
</table>

Topic	Goal			
		# 4	18.55%	21.05%
	Cervical Cancer Screening for Women who are HIV Positive		46.70%	49.20%
	Emergency Department Encounter Rate for Asthma in Children and Adolescents		24.32%	26.82%
	Periodic Dental Evaluations for Children, Adolescents and Adults and Dental Sealants for Children	# 1	48.21%	50.71%
		# 2	31.47%	33.97%
		# 3	52.73%	55.10%
	Annual Dental Visits for Members with Developmental Disabilities		43.54%	46.04%
	Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit	# 1	88.06%	88.65%
		# 2	7.22%	9.72%
		# 3	41.49%	43.99%
		# 4	11.11%	13.61%
		# 5	37.23%	39.73%
	Perinatal Depression Screening	# 1	66.94%	68.60%
		# 2	18.26%	20.76%
		# 3	43.18%	45.68%
		# 4	54.21%	56.50%
		# 5	11.49%	13.99%
		# 6	76.47%	77.65%

AMHP (PA EQR Measures)	Sub Measure	HEDIS 2010	HEDIS 2011 Goals
Early and Periodic Screenings, Diagnosis and Treatment (EPSDT) Development Screenings	# 1	17.16%	19.66%
	# 2	6.74%	9.24%
	# 3	25.58%	28.08%
	# 4	26.26%	28.76%
Cervical Cancer Screening for Women who are HIV Positive		49.49%	51.99%
Emergency Department Encounter Rate for Asthma in Children and Adolescents		21.53%	24.03%
Periodic Dental Evaluations for Children, Adolescents and Adults and Dental Sealants for Children	# 1	41.61%	44.11%
	# 2	30.06%	32.56%
	# 3	54.11%	56.41%
Annual Dental Visits for Members with Developmental Disabilities		37.24%	39.74%
Prenatal Screening for Smoking and Treatment Discussion during a Prenatal Visit	# 1	91.18%	91.62%
	# 2	23.42%	25.92%
	# 3	73.91%	75.21%
	# 4	19.44%	21.94%
	# 5	45.22%	47.72%
Perinatal Depression Screening	# 1	72.18%	73.57%
	# 2	29.77%	32.27%
	# 3	62.82%	64.68%
	# 4	70.70%	72.17%
	# 5	16.02%	18.52%
	# 6	89.66%	90.18%

HEDIS Measures

a) Improve all P4P Measures by 5% (of current gap to 100%)

KMHP	**2010 rate**	**2011 Goal**
Breast Cancer Screening	57.87	59.98
Cervical Cancer Screening	70.98	72.43
Controlling High Blood Pressure	66.58	68.25
Diabetes- HbA1c Poor Control*	36.29	34.48
Diabetes-LDL-C Control <100	41.45	43.95
Cholesterol Mgmt-Received LDL-C Screening	80.00	81.00
Cholesterol Mgmt-LDL-C Control < 100	46.23	48.73
Frequency of Ongoing Prenatal Care <= 81%	67.08	68.73
Prenatal Care in the 1st Trimester	81.08	82.03
Adolescent Well Care	57.47	59.60
Emergency Room Utilization Rate**	69.21	66.71
AMHP	**2010 rate**	**2011 Goal**
Breast Cancer Screening	61.49	63.42
Cervical Cancer Screening	70.43	71.91
Controlling High Blood Pressure	64.84	66.60
Diabetes- HbA1c Poor Control*	35.40	33.63
Diabetes-LDL-C Control <100	40.15	42.65
Cholesterol Mgmt-Received LDL-C Screening	88.34	88.92
Cholesterol Mgmt-LDL-C Control < 100	53.35	55.68
Frequency of Ongoing Prenatal Care <= 81%	78.96	80.01
Prenatal Care in the 1st Trimester	89.89	90.40
Adolescent Well Care	57.78	59.89
Emergency Room Utilization Rate**	86.68	84.18

b) Improve measures by 5% (of current gap to 100%)

KMHP	**2010 rate**	**2011 Goal**
Chlamydia	58.36	60.44
Childhood Immunization (Combo2)	73.97	75.27
Use of Appropriate Medication for Asthma	91.62	92.04
Postpartum Care	61.43	63.36

AMHP	**2010 rate**	**2011 Goal***
Chlamydia	46.58	49.08
Childhood Immunization (Combo2)	75.48	76.71
Use of Appropriate Medication for Asthma	90.08	90.58
Postpartum Care	68.58	70.15

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>6.</td><td>Service Performance</td><td>a) Improve CAHPS ratings :
KMHP: Improve in 2 of 7 areas:
<table>
<tr><th>KMHP
Opportunities for Improvement 2010/2011</th><th>2010 Score</th><th>2011 Goal</th></tr>
<tr><td>Getting Needed Care</td><td>78.7%</td><td>75th or 79.75%</td></tr>
<tr><td>Rating of Specialist</td><td>76.2%</td><td>50th or 79.24%</td></tr>
<tr><td>Rating of Personal Doctor</td><td>78.7%</td><td>90th or 80.93%</td></tr>
<tr><td>How Well Doctors Communicate</td><td>87.6%</td><td>75th or 89.19%</td></tr>
<tr><td>Rating of the Health Plan</td><td>77.3%</td><td>90th or 79.28%</td></tr>
<tr><td>Shared Decision Making</td><td>65.0%</td><td>90th or 65.22%</td></tr>
<tr><td>Medical Assistance with Smoking Cessation</td><td>74.5%</td><td>Increase 5%</td></tr>
</table>
AMHP: Improve in 2 of 10 areas
<table>
<tr><th>AMHP
Opportunities for Improvement 2010//2011</th><th>2010 Score</th><th>2011 Goals</th></tr>
<tr><td>Getting Care Quickly</td><td>82.8%</td><td>75th or 83.53%</td></tr>
<tr><td>Getting Needed Care</td><td>77.2%</td><td>75th or 79.75%</td></tr>
<tr><td>Customer Service</td><td>81.8%</td><td>75th or 84.12%</td></tr>
<tr><td>Rating of Specialist</td><td>76.2%</td><td>50th or 79.24%</td></tr>
<tr><td>Rating of Personal Doctor</td><td>78.7%</td><td>90th or 80.93%</td></tr>
<tr><td>How Well Doctors Communicate</td><td>89.6%</td><td>75th or 89.19%</td></tr>
<tr><td>Rating of the Health Plan</td><td>76.0%</td><td>90th or 79.28%</td></tr>
<tr><td>Shared Decision Making</td><td>63.1%</td><td>90th or 65.22%</td></tr>
<tr><td>Rating of Health Care</td><td>69.3%</td><td>75th or 69.95%</td></tr>
<tr><td>Medical Assistance with Smoking Cessation</td><td>74.7%</td><td>Increase by 5%</td></tr>
</table>
b) Member Service Phone Availability will meet monthly ASA (<=30 second) and Abandonment (<5%) goals.</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>7.</td><td>Credentialing</td><td>a) Maintain timeliness for 95% of files processed <= 14 calendar days
b) Maintain adherence to NCQA, DPW and DOH standards for credentialing
c) Implement the credentialing database management module (to auto populate from CAQH to the database) in 3rd Qtr
d) Establish processes and procedures to support successful in sourcing of Credentialing for Dental practitioners
e) Implement customized application to auto populate delegates‘ data to credentialing database in 3rd Qtr.</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>8.</td><td>Access and Availability of Care</td><td>a) Maintain compliance to access and availability standards
b) Design and implement interventions if benchmark is not met</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>9.</td><td>Delegation Monitoring</td><td>a) Annual audits will be conducted timely within NCQA guidelines (14) months
b) Opportunities for improvement will be identified and monitored
c) Monthly or Quarterly reports will be monitored timely</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>10.</td><td>Practitioner and Provider Satisfaction</td><td>a) Conduct annual assessment and achieve internal benchmark
b) Design and implement interventions if benchmark is not met</td></tr>
</table>

11.	Member Dissatisfactions	a) Achieve >95% quarterly IBC oversight audit results
12.	Quality of Care Reviews	a) Review process will meet established timeliness goal (within 30 days of receipt of all investigative information) b) Achieve >95% of quarterly IBC oversight audit results
13.	Provider Feedback (per LOB)	a) Conduct quarterly provider symposiums b) Host at least 2 provider focus sessions
14.	Collaboration with Behavioral Health MCOs	a) Participate in one collaborative initiative

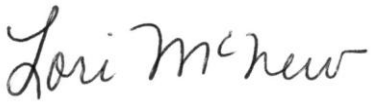
XI. Acknowledgement and Approval

This Quality Improvement Program Evaluation is submitted by:

3/24/11

Tina Morton, RN, BSN, CPHQ
Sr. Director, Quality Management, KMHP

Date



3/24/11

Lori McNew, RN, MSN, MBA
Director, Quality Management, AMHP

Date

Approvals:

3/24/11

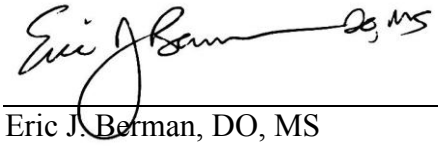
Marge Angello, RN
Executive Director, AMHP

Date

3/24/11

Karen E. Michael, RN, MSN, MBA
Vice President, Clinical Services

Date



3/24/11

Eric J. Berman, DO, MS
Regional Chief Medical Officer
Northern Division Managed Care

Date

Appendix A – HEDIS RESULTS: Measurement Year 2005- 2009[1]

KMHP HEDIS: Immunization Status

Childhood Immunization Status	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
DT/DTP/DtaP	81.27%	**86.62%**	84.22%	79.51%	81.02%	25th
OPV/IPV	91.24%	92.94%	94.43%	91.53%	91.00%	50th
Measles, Mumps, Rubella	**93.67%**	95.38%	93.50%	91.80%	92.21%	50th
H Influenza Type B	**92.94%**	94.65%	92.81%	93.72%	94.89%	25th
Hepatitis B	88.81%	**94.89%**	95.82%	92.35%	89.29%	25th
Chicken Pox	91.73%	94.65%	93.04%	91.26%	90.75%	25th
Pneumococcal vaccine	55.72%	**80.05%**	82.13%	81.42%	76.40%	25th
Combo 2 (All but Pneumococcal)	**72.02%**	**82.97%**	80.05%	78.14%	73.97%	25th
Combo 3 (All)	48.18%	**74.94%**	75.41%	76.50%	**66.91%**	25th

KMHP HEDIS: Respiratory Treatment

Respiratory Treatment	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Appropriate Treatment for Children w/ Upper Respiratory Infection	**84.49%**	84.80%	85.15%	85.84%	**86.70%**	50th
Appropriate Testing for Children with Pharyngitis	49.52%	47.50%	49.02%	**52.25%**	**56.75%**	25th

[1] **Bold – significant change from previous year**

AMHP HEDIS: Immunization Status

Childhood Immunization Status	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
DT/DTP/DtaP	81.02%	83.33%	79.32%	82.37%	80.29%	25th
OPV/IPV	87.35%	**92.36%**	89.54%	92.63%	92.21%	50th
Measles, Mumps, Rubella	**92.46%**	93.75%	**88.81%**	91.84%	93.19%	50th
H Influenza Type B	**90.02%**	90.74%	88.56%	**96.32%**	94.40%	25th
Hepatitis B	**87.10%**	**92.13%**	92.70%	95.26%	94.40%	50th
Chicken Pox	**89.54%**	92.36%	**86.86%**	90.79%	92.21%	50th
Pneumococcal vaccine	52.55A	**73.61%**	70.80%	**79.74%**	80.78%	50th
Combo 2 (All but Pneumococcal)	**73.24%**	77.31%	72.75%	**80.00%**	75.48%	25th
Combo 3 (All)	47.93%	**66.44%**	64.23%	**74.74%**	71.78%	50th

AMHP HEDIS: Respiratory Treatment

Respiratory Treatment	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Appropriate Treatment for Children w/ Upper Respiratory Infection	78.91%	78.94%	**82.54%**	81.67%	**84.72%**	25th
Appropriate Testing for Children with Pharyngitis	35.78%	**45.08%**	**41.34%**	**44.38%**	**53.09%**	10th

KMHP HEDIS: Women's Health

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Breast Cancer Screening	**50.57%**	**44.72%**	**46.72%**	52.28%	**57.87%**	50th
Cervical Cancer Screening	**58.39%**	**63.26%**	67.45%	70.49%	70.98%	50th
Chlamydia Screening						
16-20 Years	**44.48%**	**51.41%**	**50.42%**	57.76%	**56.14%**	50th
21-24 Years	NA	NA	NA	NA	61.18%	25th
21-26 Years	48.57%	**55.68%**	**53.70%**	60.93%	NA	NA
Total	**46.58%**	**53.57%**	**52.07%**	**59.18%**	58.36%	50th

AMHP HEDIS: Women's Health

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Breast Cancer Screening	**56.34%**	**51.32%**	**54.89%**	**59.17%**	**61.49%**	75th
Cervical Cancer Screening	63.99%	**67.521%**	73.24%	73.48%	70.43%	50th
Chlamydia Screening						
16-20 Years	**30.16%**	**37.68%**	39.76%	42.05%	43.75%	10th
21-24 Years	NA	NA	NA	NA	50.08%	10th
21-26 Years	**27.72%**	**42.79%**	45.02%	**49.55%**	NA	NA
Total	**28.89%**	**40.29%**	**42.44%**	**45.48%**	46.58%	10th

KMHP HEDIS: Cardiovascular Health

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Controlling High Blood Pressure	77.86%	**59.12%**	64.40%	66.58%	66.58%	75th
Received LDL-C Screening	67.64%	76.64%	80.14%	81.51%	82.97%	50th
Screening Revealed Low LCL-C Levels <100	34.79%	32.12%	**39.25%**	**46.96%**	46.23%	50th

AMHP HEDIS: Cardiovascular Health

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Controlling High Blood Pressure	***85.16%***	**58.76%**	62.04%	63.92%	64.84%	75th
Received LDL-C Screening	71.29%	86.31%	86.27%	86.25%	88.34%	75th
Screening Revealed Low LCL-C Levels < 100	36.25%	36.51%	42.25%	49.57%	53.35%	75th

KMHP HEDIS: Comprehensive Diabetes Care

** Lower numbers are better for this measure

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
HBA1C Testing	76.89%	76.16%	80.60%	78.59%	82.26%	50th
Poor HBA1C Control**	42.58%	**54.99%**	**44.57%**	38.93%	36.29%	50th
Eye Exam	47.69%	41.61%	47.34%	46.96%	49.03%	25th
LDL-C Screening	86.37%	**70.80%**	**78.98%**	75.67%	80.00%	50th
LDL-C Level <100	31.39%	32.36%	35.57%	40.88%	41.45%	75th
Monitoring for Nephropathy	41.85%	80.78%	75.52%	80.05%	79.35%	50th
Blood Pressure <130/80	NA	24.57%	25.87%	27.74%	**35.32%**	50th
Blood Pressure <140/90	NA	53.77%	49.19%	**58.64%**	62.74%	50th

AMHP HEDIS: Comprehensive Diabetes Care

** Lower numbers are better for this measure

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
HBA1C Testing	82.48%	80.97%	83.45%	83.21%	83.21%	50th
Poor HBA1C Control**	36.50%	**50.66%**	47.93%	**39.66%**	35.40%	50th
Eye Exam	58.88%	60.18%	61.31%	66.67%	69.53%	75th
LDL-C Screening	90.75%	**77.43%**	78.10%	80.29%	82.48%	75th
LDL-C Level <100	30.41%	27.65%	**35.04%**	**42.58%**	40.15%	50th
Monitoring for Nephropathy	46.23%	77.65%	80.29%	82.73%	81.93%	50th
Blood Pressure <130/80	NA	33.63%	36.98%	34.79%	37.41%	75th
Blood Pressure <140/90	NA	63.94%	64.96%	67.40%	66.79%	50th

KMHP HEDIS: Use of Appropriate Medications for Asthma

AGE RANGE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
5 – 9 Years	**92.12%**	92.22%	93.13%	93.98%	NA	NA
5 – 11 Years	NA	NA	NA	NA	93.80%	50th
12 – 50 Years	NA	NA	NA	NA	90.08%	75th
10 – 17 Years	**91.69%**	91.50%	92.13%	92.64%	NA	NA
18 – 56 Years	**87.46%**	87.56%	88.97%	89.58%	NA	NA
All Ages	**89.43%**	89.87%	**90.99%**	91.69%	91.62%	75th

AMHP HEDIS: Use of Appropriate Medications for Asthma

AGE RANGE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
5 – 9 Years	**92.86%**	92.67%	93.25%	93.95%	NA	NA
5 – 11 Years	NA	NA	NA	NA	94.18%	75th
12 – 50 Years	NA	NA	NA	NA	87.66%	50th
10 – 17 Years	**91.93%**	90.62%	91.03%	92.94%	NA	NA
18 – 56 Years	**87.61%**	88.65%	89.71%	89.35%	NA	NA
All Ages	**89.59%**	90.13%	90.94%	91.49%	90.08%	50th

KMHP HEDIS: Access to Care

Adult Access to Preventative & Ambulatory Health Services	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
20 – 44 Years	**80.19%**	**83.71%**	**83.19%**	**82.23%**	**81.74%**	25th
45 – 64 Years	**86.48%**	**89.57%**	89.17%	89.03%	88.93%	50th
65 + Years	76.60%	**86.78%**	88.04%	86.38%	85.93%	25th
Children's Access to PCP						
12 – 24 Months	**95.16%**	95.34%	95.45%	95.39%	95.82%	25th
25 – 6 Years	**81.92%**	**83.44%**	**84.44%**	**85.40%**	**87.15%**	25th
7 – 11 Years	81.89%	**83.41%**	**85.25%**	**87.16%**	**89.29%**	25th
12 – 19 Years	78.79 %	**79.93%**	**80.64%**	**84.09%**	**86.94%**	25th

AMHP HEDIS: Access to Care

Adult Access to Preventative & Ambulatory Health Services	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
20 – 44 Years	80.13%	**83.57%**	**82.43%**	81.96%	**80.61%**	25th
45 – 64 Years	86.28%	**88.83%**	88.83%	89.86%	89.45%	50th
65 + Years	79.90%	**84.32%**	86.51%	89.19%	88.68%	50th
Children's Access to PCP						
12 – 24 Months	**81.97%**	**85.09%**	86.24%	**95.54%**	**96.60%**	25th
25 – 6 Years	71.06%	**73.39%**	73.16%	**82.86%**	**87.74%**	25th
7 – 11 Years	**73.35%**	**76.18%**	**78.06%**	**85.14%**	**89.83%**	25th
12 – 19 Years	**72.86%**	**74.09%**	**75.49%**	**81.46%**	**87.67%**	25th

KMHP HEDIS: Prenatal and Postpartum Care

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Timeliness of Prenatal Care	86.37%	81.51%	**75.18%**	79.81%	81.08%	25th
Postpartum Care	**59.12%**	60.10%	56.50%	55.72%	61.43%	25th

AMHP HEDIS: Prenatal and Postpartum Care

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
Timeliness of Prenatal Care	85.64%	90.21%	**87.35%**	89.29%	89.89%	50th
Postpartum Care	71.05%	**62.70%**	**60.83%**	67.40%	68.58%	50th

KMHP HEDIS: Frequency of Ongoing Prenatal Care

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
< 21% of Expected Visits	***4.62%***	4.62%	7.8%	6.08%	4.67%	25th
21% - 40% of Expected Visits	4.14%	6.33%	4.96%	5.35%	4.42%	25th
41% - 60% of Expected Visits	11.68%	10.95%	9.69%	8.27%	11.79%	75th
61% - 80% of Expected Visits	22.63%	21.17%	**14.66%**	14.36%	12.04%	25th
≥81% of Expected Visits	56.93%	56.93%	62.88%	65.94%	67.08%	50th

AMHP HEDIS: Frequency of Ongoing Prenatal Care

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
< 21% of Expected Visits	2.43%	1.17%	2.43%	1.46%	2.19%	10th
21% - 40% of Expected Visits	4.14%	3.50%	2.19%	2.43%	2.73%	10th
41% - 60% of Expected Visits	9.49%	4.20%	3.89%	5.84%	5.74%	25th
61% - 80% of Expected Visits	17.27%	13.75%	13.87%	12.17%	10.38%	25th
≥81% of Expected Visits	66.67%	**77.39%**	77.62%	78.10%	78.96%	75th

KMHP HEDIS: Well Child Visits

Well Child Visits in 1st 15 Months	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
0 Visits	0.97%	1.95%	1.62%	2.00%	2.22%	50th
1 Visit	1.22%	0.49%	0.93%	2.49%	1.98%	50th
2 Visits	3.41%	2.68%	2.78%	2.74%	4.94%	75th
3 Visits	6.08%	6.08%	5.32%	6.23%	4.94%	25th
4 Visits	10.46%	11.44%	10.42%	9.23%	10.12%	25th
5 Visits	18.25%	16.79%	20.83%	21.20%	18.77%	50th
Well Child Visits 3-6 yrs	**81.75%**	79.56%	**69.91%**	74.01%	74.77%	50th
Adolescent Well Care Visits	62.29%	57.42%	**49.54%**	60.83%	57.47%	75th

AMHP HEDIS: Well Child Visits

Well Child Visits in 1st 15 Months	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
0 Visits	3.65%	4.4%	1.95%	0.86%	1.52%	50th
1 Visit	1.46%	0.93%	1.95%	0.57%	1.22%	25th
2 Visits	3.16%	2.09%	2.19%	1.44%	1.83%	10th
3 Visits	5.84%	3.02%	4.87%	3.45%	2.13%	10th
4 Visits	9.73%	10.44%	**5.84%**	6.03%	6.40%	10th
5 Visits	15.33%	12.99%	12.41%	13.79%	16.16%	25th
Well Child Visits 3-6 yrs	75.18%	78.65%	**62.53%**	**73.45%**	78.05%	75th
Adolescent Well Care Visits	58.88%	61.11%	55.23%	56.27%	57.78%	75th

KMHP HEDIS: Annual Dental Visit

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
2-3 Years	25.02%	24.72%	**29.84%**	**32.29%**	**34.97%**	50th
4-6 Years	**49.97%**	**51.24%**	**56.43%**	**58.59%**	**61.52%**	50th
7-10 Years	**50.19%**	**50.07%**	**55.75%**	**50.27%**	**60.84%**	50th
11-14 Years	**43.78%**	43.36%	**48.44%**	**51.05%**	**54.56%**	25th
15-18 Years	**34.37%**	34.28%	**37.59%**	**39.68%**	**43.88%**	25th
19-21 Years	28.26%	27.65%	28.81%	**31.57%**	**35.94%**	50th
Combined Ages 2-21	43.73%	40.53%	**45.08%**	**47.68%**	**50.75%**	50th

AMHP HEDIS: Annual Dental Visit

MEASURE	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	2009 (cy)	National Medicaid Percentile Achieved
2-3 Years	12.37%	12.38%	**13.95%**	**15.68%**	**19.86%**	25th
4-6 Years	40.89%	**39.02%**	**43.95%**	45.11%	**49.84%**	25th
7-10 Years	**46.15%**	45.70%	**49.08%**	**51.89%**	**57.00%**	25th
11-14 Years	**43.48%**	42.29%	**44.01%**	**45.93%**	**50.26%**	25th
15-18 Years	**37.82%**	36.33%	**38.09%**	**40.49%**	**44.38%**	25th
19-21 Years	**31.33%**	29.61%	30.29%	31.65%	**35.33%**	25th
Combined Ages 2-21	**37.76%**	36.54%	**39.01%**	**40.81%**	**44.96%**	25th