Keystone Mercy Health Plan
AmeriHealth Mercy Health Plan

Year 2009
Quality Improvement Program Evaluation

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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 to enroll in one of the HealthChoices contracted HMOs. As one of the contracted HMOs, KMHP currently provides medical care to more than 300, 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 2,112 independent primary care practitioners in 1,022 sites and approximately 7,894 specialists in 6,260 sites*. Family practitioners, general practitioners, pediatricians, and Internists serve as primary care physicians. The major provider contracts include 65 hospitals, 174 ancillary providers, 140 skilled nursing facilities, and 9 laboratory providers. Behavioral health care is provided through a state contracted Behavioral Health Managed Health Organization

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

B. AmeriHealth Mercy Health Plan

AmeriHealth Mercy Health Plan 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 provides medical care to over 100,000 members.

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.

AmeriHealth Mercy's physicians are independent practitioners that include approximately 1239 primary care practitioners at 429 sites and 7172 specialists at 4045 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 89 hospitals, 122 ancillary providers, 107 skilled nursing facilities, and 9 laboratory providers. Behavioral health care is provided through a state contracted MBHO.

*Note: Dental and Vision subcontractors are not included in Specialist totals; all practitioner data is unduplicated by Common Practitioner Identification number. Hospitalists are included in 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 2008 program evaluation.

A. NCQA Accreditation
Keystone Mercy and AmeriHealth Mercy maintained an Excellent Accreditation status during 2009. Refer to Section V. for a summary of results.

B. URAC Accreditation
Both plans achieved URAC Disease Management Accreditation for Chronic Obstructive Pulmonary Disease. This is the fourth disease condition that is accredited in addition to Asthma, Diabetes and Heart Failure.

C. Expand Childhood Obesity Offerings

KMHP Discussion
KMHP expanded the Childhood Obesity Offerings with two after school programs.

Youth Challenge
In 2009, 3 separate 12-week Youth Challenge sessions were offered exclusively for Keystone Mercy adolescent members. The first session began in May, the second was an overlapping session that began in June and the third session began in October. In total 28 participants successfully started (defined as attending the kickoff orientation and receiving both the fitness and nutrition pre-assessments) the Youth Challenge Program. Of those 28 that successfully started the program, a total of 9 participants continued the program through the final assessments.

Every participant who completed the program, all of whom had a BMI was greater than the 85th Percentile for the CDC growth charts for teens, realized a reduction or stabilization in BMI. Of the 9 who completed the program, 6 actually were able to reduce their body fat by as much as 3 percentage points.
With the physical performance assessments, the data also shows a trend in overall improvement in strength and cardiovascular endurance with 2/3 or greater showing progress in each test.

La Fortaleza
In 2009, there were 3 cycles of the 9 week childhood obesity program offered at La Fortaleza. Approximately 46 children were enrolled in the program with 28 completing it. The participants' BMI showed little or no change when compared pre/post. At first glanced, this was viewed by the parents as failure, however once put in perspective, the outcomes were a success. No increase in BMI (between pre/post) is actually identified as a positive achievement, since the participants are going through growth, development, and musculoskeletal maturation. All but two of the 28 participants experienced stabilization of their BMI.

Overall, the La Fortaleza and Youth Challenge obesity initiatives proved to be a multifaceted success. Parents, who primarily control the in-home nutritional consumption, gained a great deal of tools and knowledge to help foster healthy eating habits, food type combinations, serving sizes/portion control. Parents also learned basic information regarding metabolism of different foods and bodily processes.
Both Parents and children gained valuable knowledge of the importance of "**energy in vs. energy out"** which is the impact that a sedentary lifestyle (TV watching, video games, etc...) have on weight gain and obesity.

Both programs have intentions of implementing new cycles for 2010.

Kids 4 Fitness Program
The program serviced no Keystone Mercy members in 2009 due to difficulty engaging participants. Funding for marketing activities to promote the program was not available.

AMHP Discussion
AMHP participated in several programs in 2009. 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.

A summary of initiatives appears below:

- American Lung Association: Asthma Olympics – Presented Healthy You…Healthy Me! to participants
- Healthy Kids Day: Wilkes-Barre YMCA – activities throughout the day focused on proper nutrition and exercise
- Children's Wellness Day – Healthy You…Healthy Me! and Healthy Heart Program
- Reading PAL, Feed a Friend – Presented Healthy you…Healthy Me Program
- Partnered with Shiloh Baptist Church with summer children's camp to gather pre/post BMI on elementary school aged children. Healthy You! Healthy Me Program presented at the camp
- Mercy Learning Center – Provided teacher in-service to staff outlining health education and wellness programs for elementary aged youth. Children attending this school are all special needs students, wellness programs adapted to fit their needs.

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 an 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:
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. Specific efforts are detailed below:

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.

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.

Other initiatives in process:
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.

  This two-year effort is designed to test innovative care delivery models for consumers with serious mental illness and physical co-morbidities that could be replicated statewide. Keystone Mercy Health Plan is a project partner, as are Magellan Behavioral Health and the Behavioral Health leadership of Montgomery, Bucks, and Delaware Counties. The project went live on July 1, 2009 with approximately 3,600 identified candidates. The candidates were stratified based on their physical health and behavioral health risks. Accomplishments included:
  - Designing and obtaining valid member consents (42% of consents received)

- Creating member educational materials
- Engaging providers (both PH and BH)
- Compiling and distributing member profiles
- Initiating care management (both PH and BH)
- Implementing the hospital notification for both PH and BH
- Incorporating pharmacy data specific to atypical antipsychotic utilization.

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
  - The AmeriHealth Mercy Behavioral Health MCO P&T Committee
  - The HealthChoices Lehigh/Capital BH P&T Best Practices Advisory Committee.

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 out reach 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 out patient behavioral health appointment.

Other initiatives:

- Continued participation in the Brain Injury Task Force meetings with a focus on improved physical and behavioral health coordination
- Participation in Pennsylvania Systems of Care grants work group administered by the PA Department of Health, PA Law project
- Cultural and Linguistic Appropriate Services (CLAS), on-going meetings to discuss health disparities
- ER Discharge form now available for providers on the AMHP web site
- Behavioral health directories are now available on the AMHP web site
- 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
- York County Focus Group. The purpose of this focus group is to assess knowledge, perception, and barriers of minorities seeking behavioral health services in York County
- ER Super User Pilot Program discussion with AMHP Medical Director and Reading Hospital for targeted BH-PH-Community Coordination for ER frequent flyers. Current stage is Reading Hospital is conducting interviews for FTE to lead the program
- AMHP Special Needs Unit attended the Bayada nurses / capabilities Expo event located in Lancaster to maximize capabilities for pediatric special needs
- AMHP Special Needs Unit coordinated meeting with the Medical Assistance Transportation Program state wide directors to coordinate and stream line the process in collaboration with AMHP government affairs
- Attended Child and Adolescent Service System Program meetings to assist in greater coordination and collaboration with members with behavioral health needs
- Attended Individuals with Disabilities Education Act and section 504 training at United Cerebral Palsy of central Pennsylvania
- Attended a group discussion for systems of care grant for high fidelity wrap around services, coordinated by Office of Mental Health and Substance Abuse Services and Youth and Family Training Institute to help shape the direction of the initiative.

F. Expand the Pay-for-Performance Practitioner Programs

Both AMHP and KMHP expanded their Pay for Performance Practitioner Programs, adding three new components:

- 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.

G. Maximize the CAQH Process and Credentialing Software Functionality

Practitioner utilization of The Council for Affordable Quality Healthcare (CAQH) universal credentialing database repository increased from 42% in 2008 to 68% in 2009.

The following three functionalities were implemented within the credentialing software:

- Auto submission of National Practitioner Database verifications

- Launched the Credentialing/Verification screen to assist with capturing the credentialing history
- Storing saved Approval Letters and Hospital Affiliation requests.

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

Several enhancements were made to the HEDIS data collection process during 2009, including the following:

- Enhanced MRR chase logic based on 2008 season experience and recommendations
- Captured, mapped and formatted Care Gap data for the HEDIS repository
- Developed and implemented QA protocols for loading data to Catalyst
- Re-mapped member benefits to identify potential exclusions for members with limited benefits
- Initiated the process to transition HEDIS data collection to the in-house Catalyst system
- Initiated a process with the three Southeast HealthChoices Health Plans to customize the initial OB assessment form to maximize data collection
- Identified the maternity bundle code as a barrier to receiving postpartum visit data and implemented a revised maternity code schedule
- Initiated a process to update in-coming OB forms in the clinical authorization system
- Initiated a process to obtain lab result data from additional hospitals
- Reduced the volume of data in the HEDIS repository to 4 years from12 years to improve efficiency.

AMHP improved the following ten measures to the next national Medicaid Percentile:

Measure	2008 Percentile	2009 Percentile
Breast Cancer Screening	50th	75th
HA1C	25th	50th
Diabetes LDL-Cholesterol<100	50th	75th
Diabetes Eye exams	50th	75th
Diabetes Monitoring for Nephropathy	50th	75th
Cardio Management LDL Cholesterol <100	50th	75th
Asthma: Appropriate Use of Medications 10-17 yrs	50th	75th
Childrens' Access to PCP • 12-24 months • 25-6 yrs • 7-11 yrs	 <10 <10 10th	 25th 10th 25th

KMHP improved the following eight measures to the next national Medicaid Percentile:

Measure	2008 Percentile	2009 Percentile
Breast Cancer Screening	25th	50th
Controlling High Blood Pressure	75th	90th
Diabetes LDL- Cholesterol <100	50th	75th
Diabetes Monitoring for Nephropathy	25th	50th

Cardiac LDL Cholesterol <100	25th	50th
Prenatal Care in the 1st Trimester	10th	25th
Chlamydia Screening 21-26 yrs	25th	50th
Adolescent Well Care	50th	90th

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

Several interventions specific to select HEDIS measure were implemented during 2009. Details can be found in Section VI, Clinical Performance. Access to Care Gap alerts was expanded to Member Services for inbound member calls and linked to the Provider Portal for Practitioners.

J. Rank within the Top 20 Medicaid Plans

AMHP maintained 25th place for the Best National Medicaid Plan as reported by US News and World Report.

KMHP improved from 34th to 26th place for the Best National Medicaid Plan as reported by US News and World Report.

US News and World Report Ranking is based on performance relative to other plans in member satisfaction, prevention and treatment, and accreditation by the National Committee for Quality Assurance. Medicaid plans are evaluated on 41 measures. The highest score for the Best National Medicaid Plan is 100. The number 1 Medicaid Plan as reported by US News and World Report achieved a score of 89.4 points.

US News and World Report Ranking Scores

	AMHP	KMHP
2008	83.9 (#25)	82.9 (#34)
2009	83.3 (#25)	83.1 (#26)

AMHP achieved a score of 83.3 while KMHP scored 83.1 points. The goal to rank within the Top 20 Medicaid Plans remains for 2010.

IV. 2009 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

The Quality Improvement Committee met eleven times during 2009. Voting committee member attendance for 2009 is as follows:

Meeting Date†	Jan	Feb	Mar	Apr	May	Jun	Jul	Sep	Oct	Nov	Dec	Total
Marge Angello, RN*	X	X	X	X	X	X	X	X	X	X	X	11
Eric Berman, D.O. (Chair)	A	X	X	X	X	X	X	X	X	X	X	10
Carol Bilardo	X	X	X	X	X	A	X	A	X	X	A	8
John Burroughs*	A	A	X	X	X	A	X	X	X	A	A	6
Joanne Dugan *	X	X	A	X	X	X	X	X	X	X	A	9
Jay Feldstein, D.O. (Chair)	X	X	A	A	A	A	A	A	A	A	A	2
Scott Fox *	X	A	X	X	X	X	X	X	A	X	X	9
Lawrence Kay, M.D.*	X	X	X	X	X	X	X	X	A	X	X	10
Catherine Killian*	A	A	X	X	A	X	X	X	X	X	A	7
Anthony Mato, MD*	A	A	X	X	A	X	A	A	A	A	A	3
Scott McNeal, D.O.*	A	A	A	A	A	A	A	A	A	A	A	0
Lori McNew, R.N.	A	X	X	X	X	X	X	X	X	X	X	10
Karen Michael, R.N.*	A	X	X	X	A	X	X	A	A	A	A	5
Tina Morton, R.N.*	X	X	X	X	X	X	X	X	X	X	X	11
James Nicholson, M.D.*	A	X	X	X	X	A	A	A	A	A	A	4
Raemma Paredes-Luck, M.D. *	A	X	A	A	A	X	X	A	X	A	X	5
Benetta Rapier*	A	A	X	X	X	X	X	X	A	X	A	7
David Solis, D.O. *	X	X	X	X	X	X	X	X	X	A	X	10
Dominick Sparandeo, R.N.	A	X	A	X	X	X	X	A	A	X	A	6
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 2009, the Chair was transferred from Jay Feldstein DO to Eric Berman DO, the new Chief Medical Officer. Three new members were added:

- Associate Vice President, Provider Network Operations, KMHP

- Director, Provider Contracting, AMHP
- Associate Vice President Operation, AMHP & KMHP.

B. Practitioner Participation

Participating network practitioners actively participated in clinical quality improvement activities and regularly attended committee meetings in 2009. Practitioners included both Primary Care Physicians (PCPs) and specialists. Additionally, the Regional Clinical Practice Committees provided input to the Quality Programs.

C. Quality Resources

Quality Improvement resources for 2009 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
Quality Management	*7.0*	*11.0*	*13.0*	*16.0*	*16.0*
Credentialing	*15.0*	*12.0*	*10.0*	*10.0*	*13.0*
Medical Informatics	*11.0*	*12.0*	*12.0*	*12.0*	*12.0*
Medical Management	*3.0*	*3.0*	*3.0*	*3.0*	*3.0*
Pharmacy Services	*7.0*	*12.0*	*12.0*	*12.0*	*12.0*
Operations	*1.5*	*14.50*	*14.50*	*14.50*	*14.50*

In 2009, due to a business need the Credentialing Department received two positions transferred from the Performance Management team within Quality Management and one position from AMHP's Provider Contracting department. All three positions were credentialing coordinator positions.

V. ACCREDITATION

NCQA:

KMHP and AMHP retained their Excellent Accreditation status in 2009.The results are summarized on the next page:

Results	KMHP	AMHP
2007 survey results (max 65.0)	*64.1465*	*64.1465*
2009 HEDIS and CAHPS (max 43.00)	*31.2210*	*31.5592*
Total Score (max 100)	*95.3675*	*95.7057*
Accreditation Status	Excellent	Excellent

The next NCQA Accreditation Survey is scheduled for July 2010.

URAC

Both AMHP and KMHP received full URAC re- accreditation for Case Management and Disease Management accreditation for Chronic Obstructive Pulmonary Disease.

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 2009, for each goal on the Pennsylvania Performance metrics required by the PA Department of Public Welfare:

Keystone Mercy

Element	2009 Goal	KMHP 2009 Results	KMHP Achieve Goal?
Breast Cancer Screening	50th National Medicaid Percentile	50th National Medicaid Percentile	Yes
Cervical Cancer Screening	75th National Medicaid Percentile	50th National Medicaid Percentile	No
Controlling High Blood Pressure	50th National Medicaid Percentile	90th National Medicaid Percentile	Yes
Diabetes- HbA1c Control ***Lower is better***	75th National Medicaid Percentile	50th National Medicaid Percentile	No
Diabetes-LDL-C Control <100	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Chol Mgmt-Received LDL-C Screening	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Cholesterol Management-LDL-C Control <100	50th National Medicaid Percentile	50th National Medicaid Percentile	Yes
Frequency of Ongoing Prenatal Care <= 81% of visits	75th National Medicaid Percentile	50th National Medicaid Percentile	No
Prenatal Care in the 1st Trimester	25th National Medicaid Percentile	25th National Medicaid Percentile	Yes
Adolescent Well Care	75th National Medicaid Percentile	90th National Medicaid Percentile	Exceeded
Emergency Room Utilization Rate	50th National Medicaid Percentile	75th National Medicaid Percentile	No

AmeriHealth Mercy

Element	2009 Goal	AMHP 2009 Results	AMHP Achieve Goal?
Breast Cancer Screening	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes

Element	2009 Goal	AMHP 2009 Results	AMHP Achieve Goal?
Cervical Cancer Screening	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Controlling High Blood Pressure	50th National Medicaid Percentile	75th National Medicaid Percentile	Exceeded
Diabetes- HbA1c Control ***Lower is better***	50th National Medicaid Percentile	50th National Medicaid Percentile	Yes
Diabetes-LDL-C Control <100	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Chol Mgmt-Received LDL-C Screening	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Cholesterol Management-LDL-C Control <100	50th National Medicaid Percentile	50th National Medicaid Percentile	Yes
Frequency of Ongoing Prenatal Care <= 81% of visits	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Prenatal Care in the 1st Trimester	50th National Medicaid Percentile	50th National Medicaid Percentile	Yes
Adolescent Well Care	75th National Medicaid Percentile	75th National Medicaid Percentile	Yes
Emergency Room Utilization Rate	90th National Medicaid Percentile	75th National Medicaid Percentile	No

A. Reporting Year 2009 HEDIS Rates

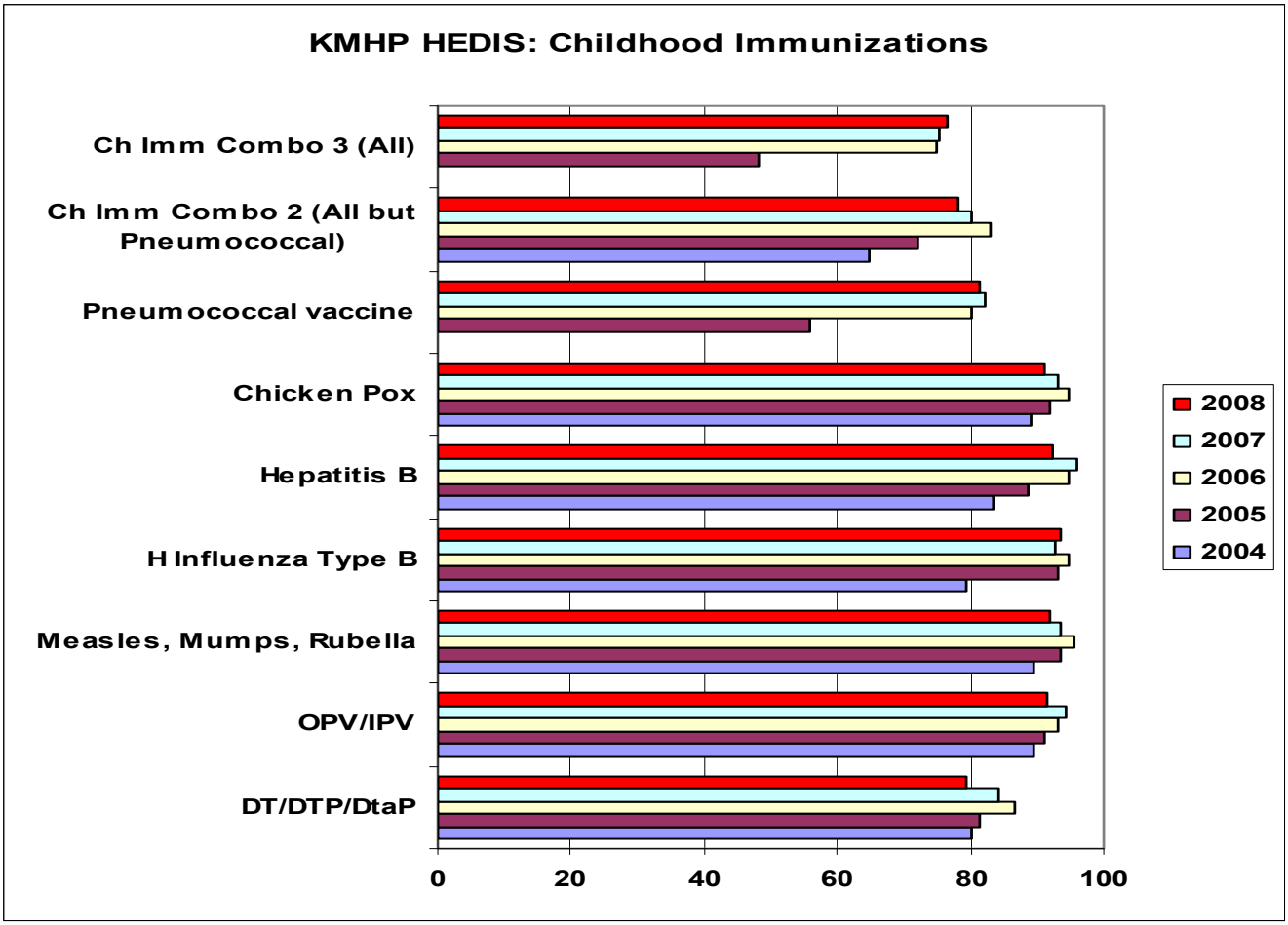
In 2009, KMHP/AMHP completed its 2008 HEDIS data collection and submitted the audited findings to NCQA. The HEDIS Effectiveness of Care tables in Appendix A outline the rates of clinical indicators for measurement years 2005, 2006, 2007, 2008, and 2009 and reflect the 2009 national Medicaid percentile achieved**.**

Performance rates were presented and reviewed by the Quality Improvement Committee (QIC) in July 2009.

Discussion – KMHP

KMHP HEDIS: Childhood and Adolescent Immunizations

All immunization rates decreased slightly with the exception of H Influenza B which increased slightly. Interventions that continued in 2009 included continuing 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.



KMHP HEDIS: Women's Health

All five Women's Health screening rates improved significantly. Breast Cancer screening rates exceeded the goal.

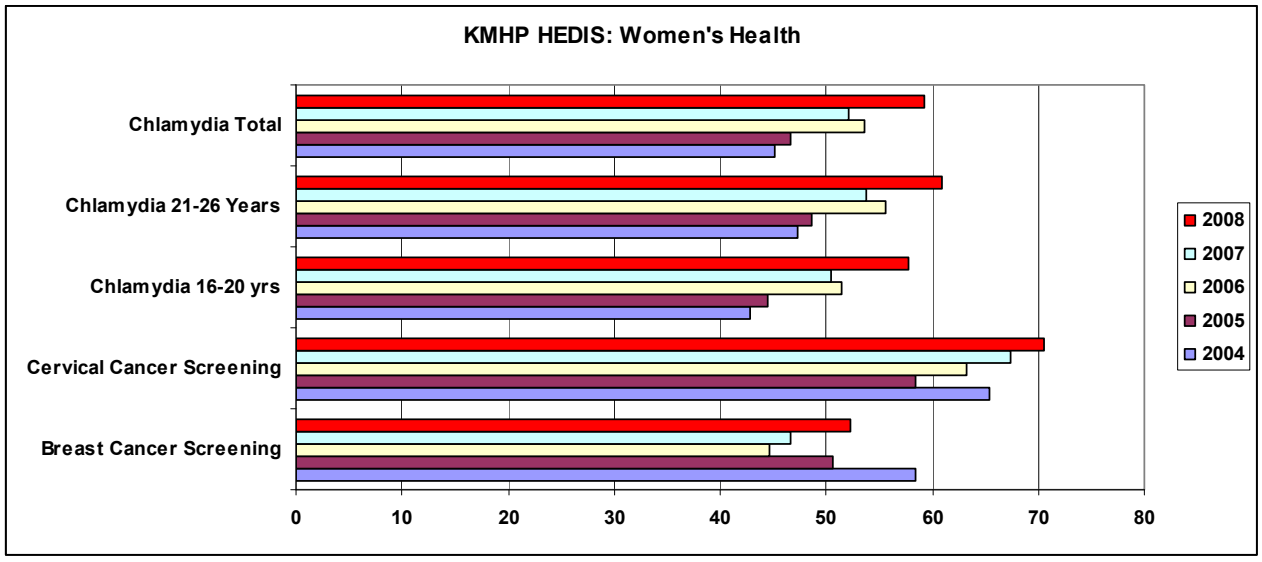
Interventions that carried over from 2008 through 2009 included the following:

- 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 made 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
- 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

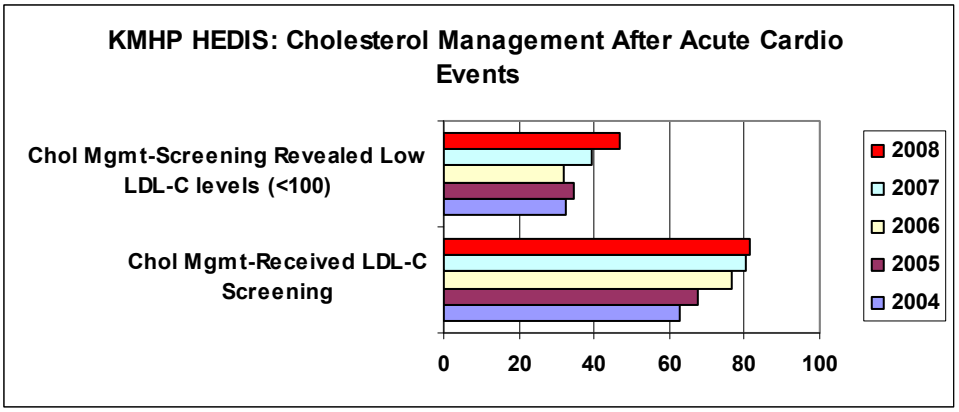
- The Quality of Care Compensation Program, a pay-for-performance program was implemented for primary care practitioners and included BCS and CCS measures
- Bill Above Re-imbursement to PCPs for performing cervical cancer screenings
- Select PCP practices were provided with member incentive gift cards for distribution at point-of-service (POS) specific to cervical cancer screenings
- Outreach calls were placed to members for scheduling of CCS and BCS. Transportation was arranged, if needed
- A partnership was started with Mercy Hospital of Philadelphia 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
- An arrangement was made with the Lackawanna mobile van to schedule on-site mammograms at high volume practices
- A program was started with 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.

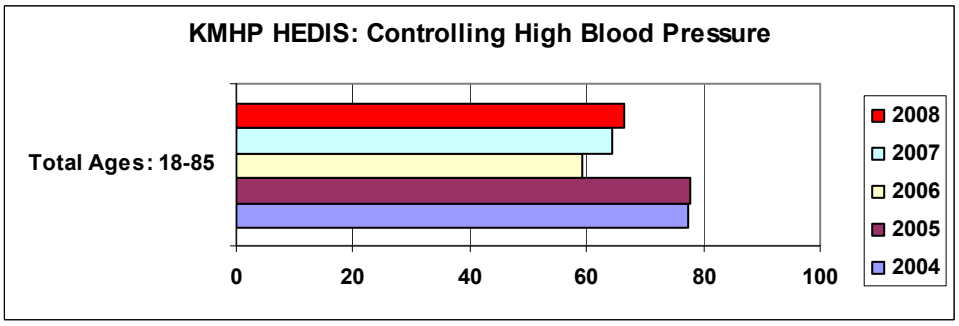
New interventions specific to 2009:

- Care Gap data, identifying members who were missing breast and/or cervical cancer screening tests was expanded to include Member Services for inbound member calls.
- Care Gap alerts were linked to the PCP provider portal.



KMHP HEDIS: Cardio-Vascular Health
Cholesterol management improved significantly while Controlling High Blood Pressure and Cholesterol Screening improved slightly.





Activities that have carried over from 2008 through 2009 include the following:

- Member Service on-hold messages addressing "Know 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
- A Care Gap database, including information on members missing recommended LDL-testing was made available to Care Management staff
- Case Management Heart Failure assessment tool
- 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.

Interventions in 2009 included the following:

- Care Gap alerts were linked to the PCP provider portal.
- Care Gap data, identifying members who were missing cholesterol screening tests was provided to Member Services for inbound member calls

- Performance on the screening measure LDL-C <100 mg/dl was added to the PCP Quality Care Compensation Program
- 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.

KMHP HEDIS: Comprehensive Diabetes Care

Improvements were seen in five measures: poor HbA1c control (lower is better), monitoring for nephropathy rates, blood pressure rates <130/80 and <140/90, LDL-C cholesterol <100mg/dl. Rates for three measures decreased slightly: HbA1c testing, eye exams, and LDL-C screenings.

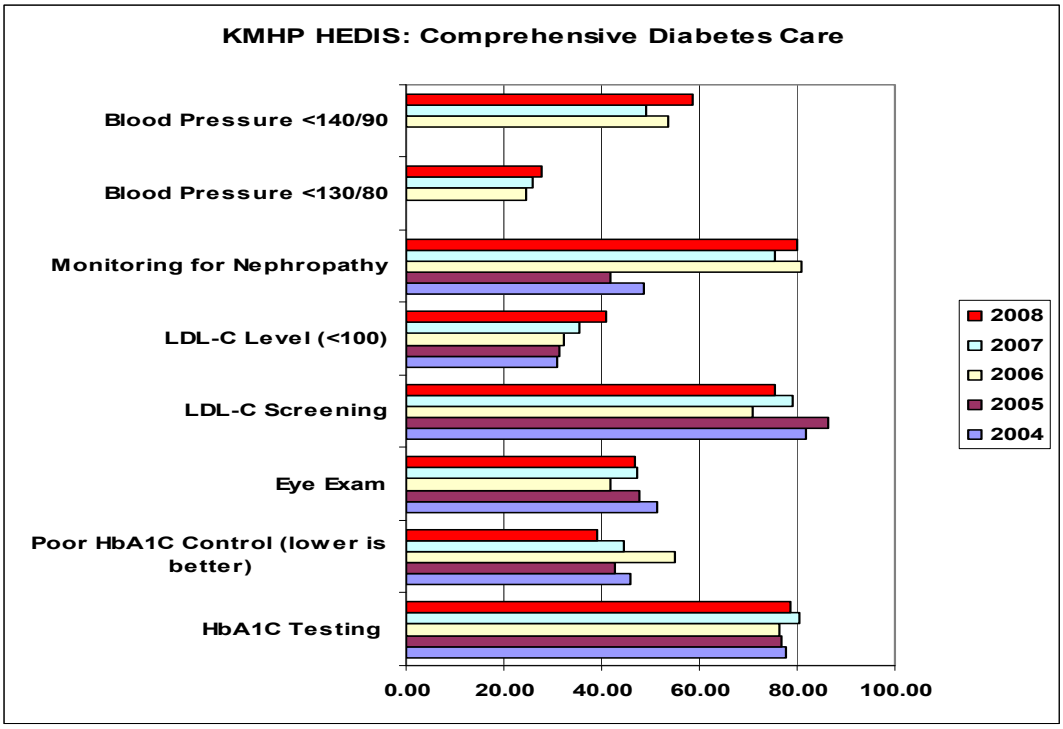
Activities that continued from 2008 through 2009 included the following:

- 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, including information on members missing recommended HgbA1c and LDL-C testing was made available to Care Management staff
- The Diabetes Health Risk Assessment tool addresses LDL-C cholesterol
- 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 and includes HgbA1c and LDL-C cholesterol screening rates
- 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 for practices with 75 or more members
- Automated telephonic member outreach educational calls regarding the importance of blood testing

New interventions for 2009 included:

- Lose to Win: A pilot initiative for adults with five Philadelphia YMCAs. Over 170 diabetic members participated over a twelve week period. Program consisted of monitoring of A1C, LDL, BMI as well as exercise, nutritional education
- Care Gap alerts were linked to the PCP provider portal
- Care Gap data identifying members who were missing HbA1C screening tests was provided to Member Services for inbound member calls
- A Certified Diabetic Educator was added to the KMHP Case Management Staff for assessments and education of members

- Performance on the screening measures HbA1c poor Control >9% and LDL-C <100 mg/dl for diabetics were added to the PCP Quality Care Compensation Program.



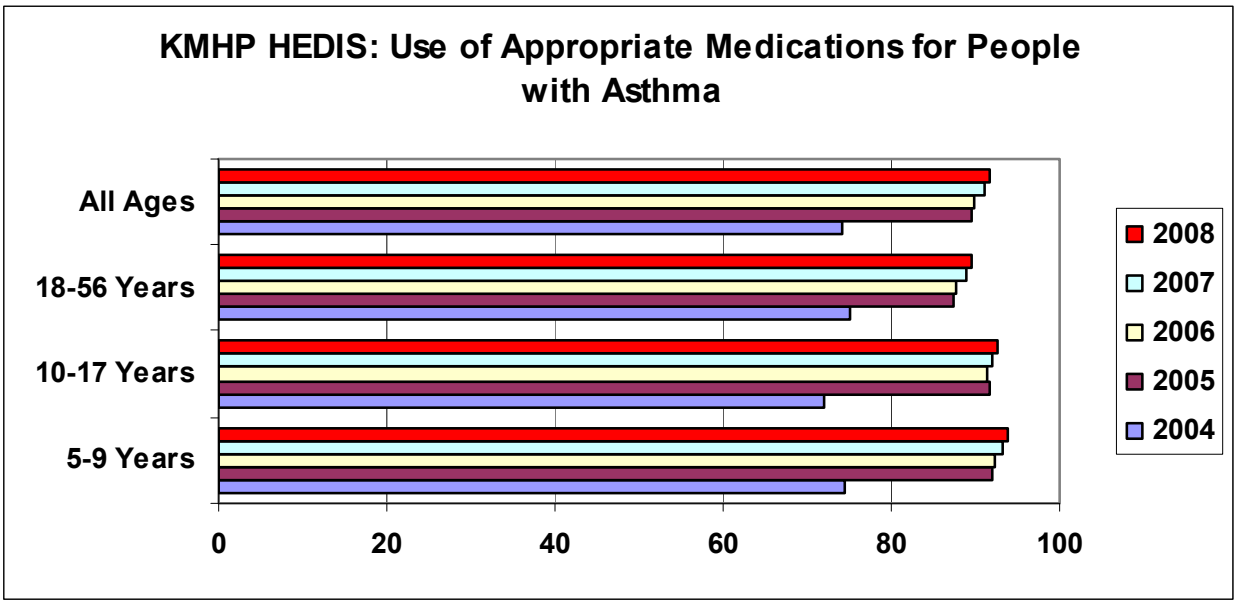
KMHP HEDIS: Use of Appropriate Medications for Asthma

Rates for all four age ranges increased slightly. Activities that continued from 2008 through 2009 included the following:

- Enrollment of members with Asthma in Care Coordination and Disease Management
- Late refill mailings to members and providers for members taking asthma controller medications
- Healthy Hoops program, attended by 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 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
- Peak Flow Meter Adherence Pilot with Southern Chester County Pharmacy
- 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 participant and his/her caregivers
- Participation in CHOP ED Study on Inhaled Corticosteroid Use and Continued PCP prescription
- The Asthma Centers of Excellence (ACE).

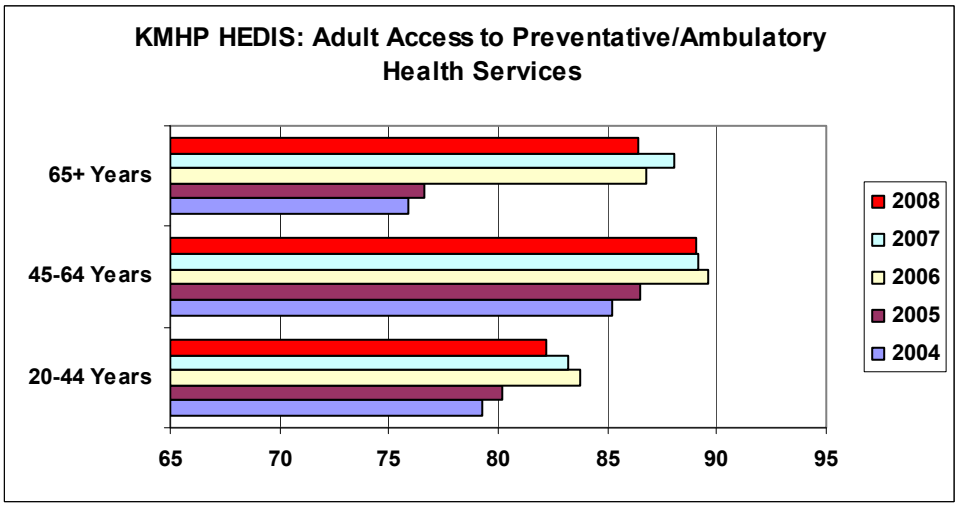
New interventions for 2009:

- 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.



KMHP HEDIS: Adult Access to Preventative and Ambulatory Health Care

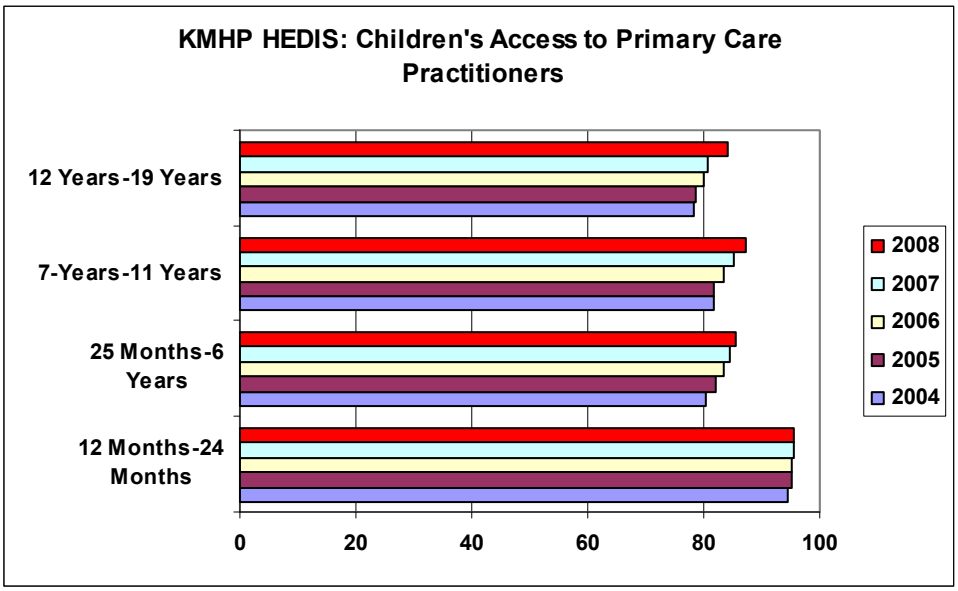
All measures for Adult Access to Preventative Services decreased slightly, however there were no statistically significant changes.



KMHP HEDIS: Children's Access to PCP
The rate for one of the four age ranges showed a significant increase: 25 months -6 years. Rates for the other three age ranges improved slightly.

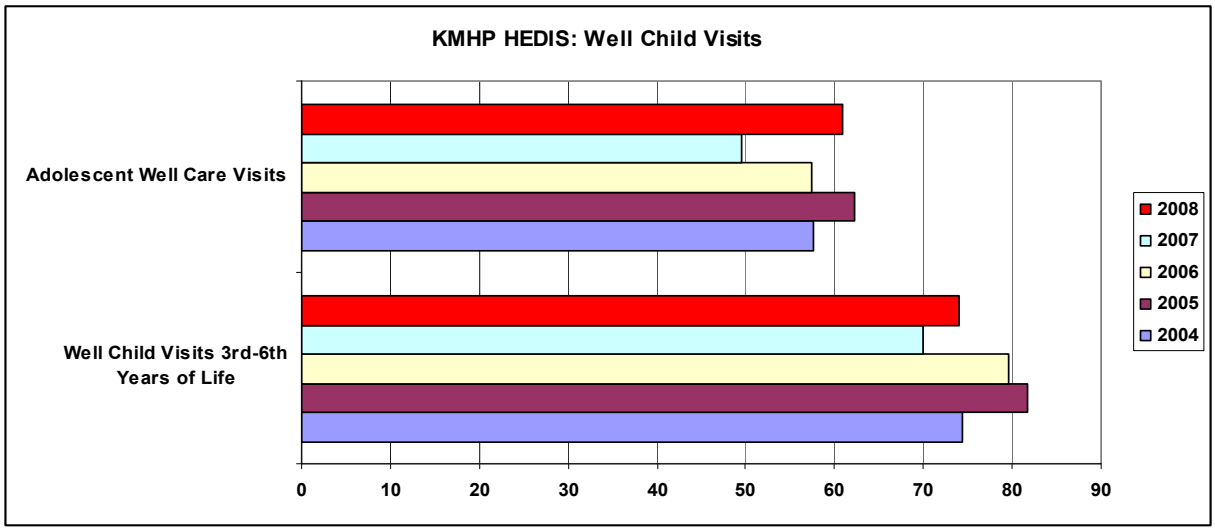
Activities that continued from 2008 through 2009 included the following:

- 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
Both the Adolescent and the Well Child (3 to 6 years) visit measures showed a significant increase.
Activities that continued from 2008 through 2009 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
- A pilot program for select practices to distribute member incentives (movie passes) to adolescents for having well visits
- Automated member outreach calls for members due or overdue for wellness check
- Care Gap data, including information on members missing an annual adolescent well visit, was made available to Care Management staff
- The Quality of Care Compensation Program, a pay-for-performance program for PCPs, included Adolescent well visit rates.

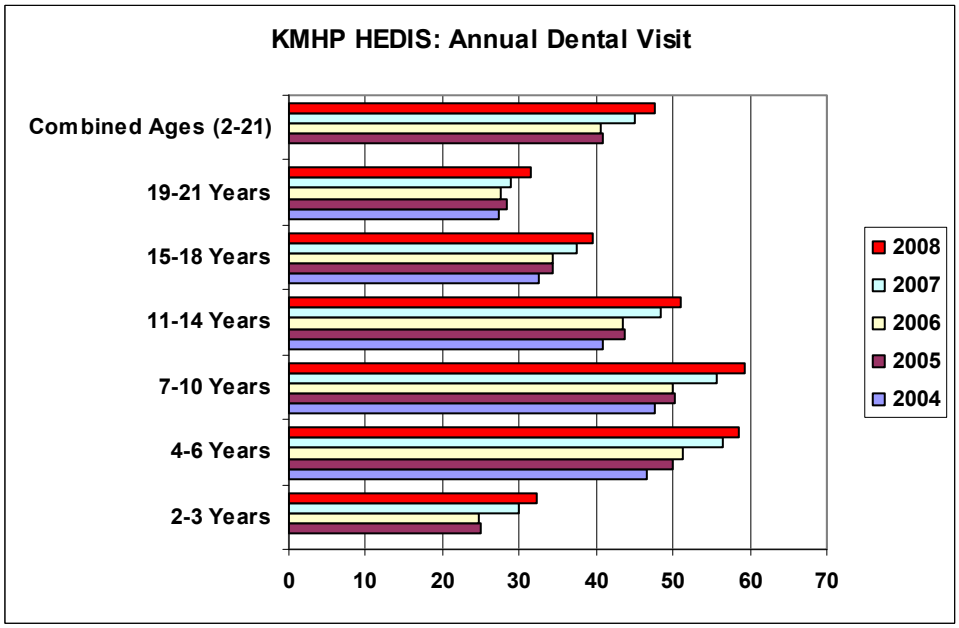


KMHP HEDIS: Annual Dental Visit

Results for all eight measures improved significantly.

Activities from 2008 continued in 2009 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
- 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, was implemented
- .Zoo-mobility a community event for Special Needs Children.

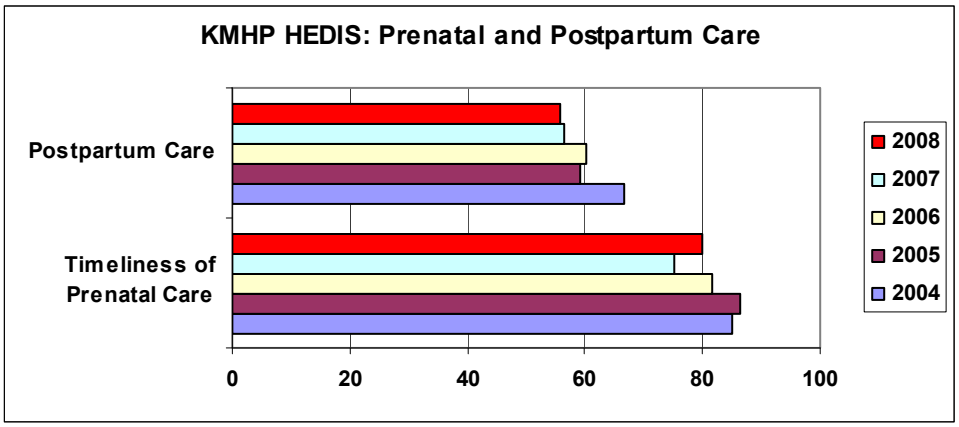


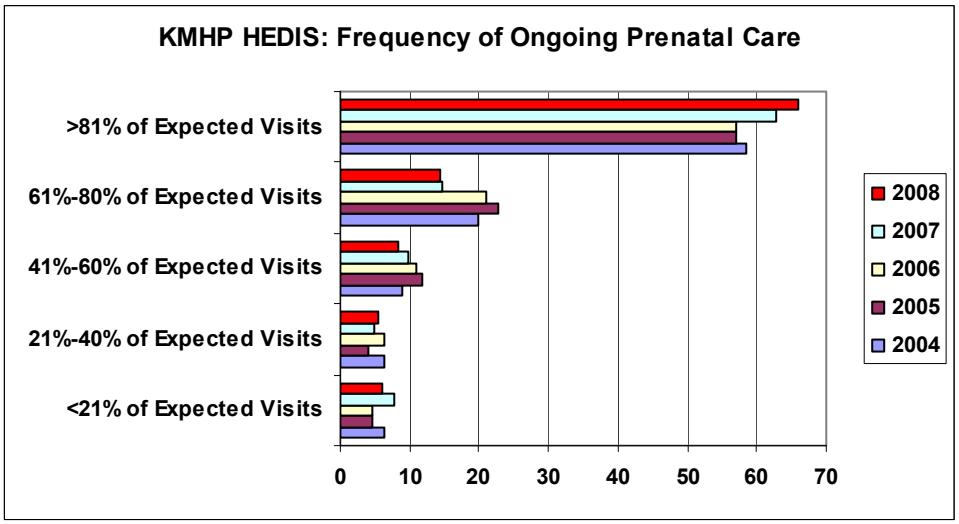
New interventions for 2009:

- Coordinated on-site dental screenings for pregnant members.
- Launched Doral Dental's real-time online directory
- Contracted with Special Touch Dentistry, SurgiCenter.

KMHP HEDIS: Prenatal and Postpartum Care

The rates for Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care (>81%) increase significantly. The Postpartum Care rate decreased slightly.





Activities from 2008 continued through 2009 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, Pettiway Foundation and Congresso) to assist with locating and educating members
- Member education on prenatal care at community health fairs
- Member 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
- A media campaign was conducted to educate members on the importance of early prenatal care.

New interventions for 2009:

- Co-hosted two community Baby Showers
- Revised OB practitioner assessment forms to include Depression and Smoking Cessation and Domestic abuse.

KMHP HEDIS Disparity Analysis

Both KMHP and AMHP recognized that the member race/ethnicity data is flawed. Both Plans rely on the Pennsylvania Department of Public Welfare (DPW) for race/ethnicity data of its 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, an initiative is underway for a HealthCare Equities project focused on improving the integrity of race and ethnicity data used for program planning and disparity analysis

An analysis of HEDIS results for Reporting Year 2009 by race and ethnicity 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.

KMHP HEDIS Disparity Analysis

Race analysis identified 9 statistically significant differences in 20 "Effectiveness of care" and "Access & Availability" measures. Main differences where identified in the diabetes, childhood immunization and well child measures.

Measure	2009 Finding
Well Visits in the first 15 months (6 visits)	➢ African American members were significantly less likely to receive child well visits in the first 15 month than White members. ➢ No significance was identified between Hispanics to non
Frequency of Prenatal care 981 - 100%)	➢ African American members were significantly less likely to receive prenatal care visits than White members. ➢ No significance was identified between Hispanics to non

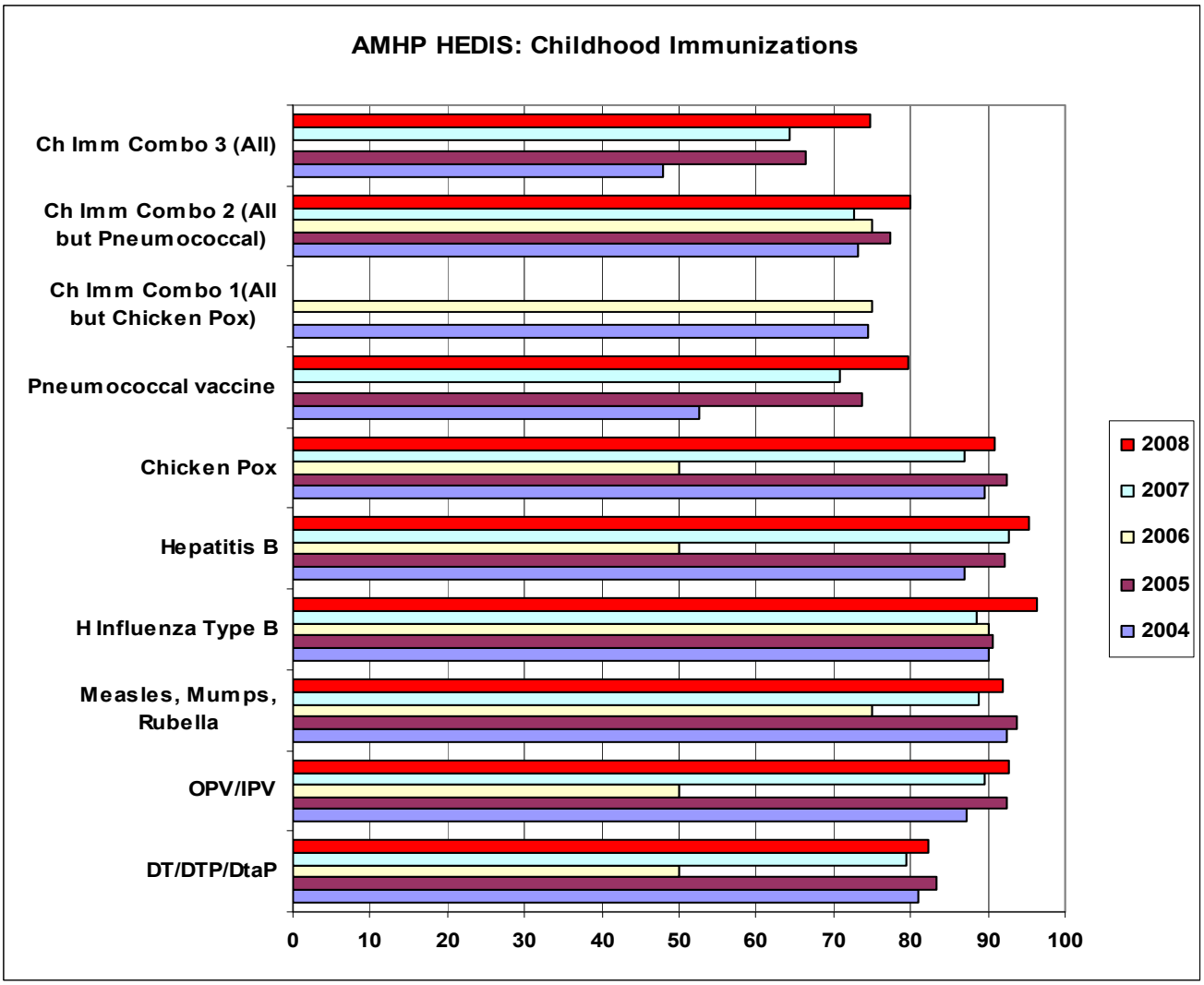
Measure	2009 Finding
Adolescent Well Child	➢ African American members were significantly higher likely to receive prenatal care visits than White members. ➢ No significance was identified between Hispanics to non
Diabetic BP (140/90)	➢ African American members were significantly less likely to control their hypertension than White members. ➢ No significance was identified between Hispanics to non
Controlling High Blood Pressure	➢ African American members were significantly less likely to control their hypertension than White members. ➢ No significance was identified between Hispanics to non
Childhood Immunization (Comb 4)	➢ African American members were significantly higher likely to receive their child immunizations than White members. ➢ Hispanic members were significantly higher likely to receive their child immunizations than Non Hispanics
Cardio LDL < 100	➢ African American members were significantly less likely to control their cholesterol level than White members. ➢ No significance was identified between Hispanics to non
Lead Screening	➢ African American members were significantly higher likely to receive lead screening than White members. ➢ Hispanic members were significantly higher likely to receive lead screening than Non Hispanics
Prenatal	➢ African American members were significantly less likely to receive prenatal care visits than White members. ➢ No significance was identified between Hispanics to non

Although it appears that there are significant gaps in some of the measures on the ethnicity chart, the low sample size for the non-Hispanic population included in the analysis did not allow statistical significance testing.

Discussion – AMHP

AMHP HEDIS: Childhood and Adolescent Immunizations

In 2009, all of the nine measures increased as compared to 2008. Interventions in 2008 that continued into 2009 included continuing 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 of provider and member newsletter articles and provision of immunization.



AMHP HEDIS: Women's Health

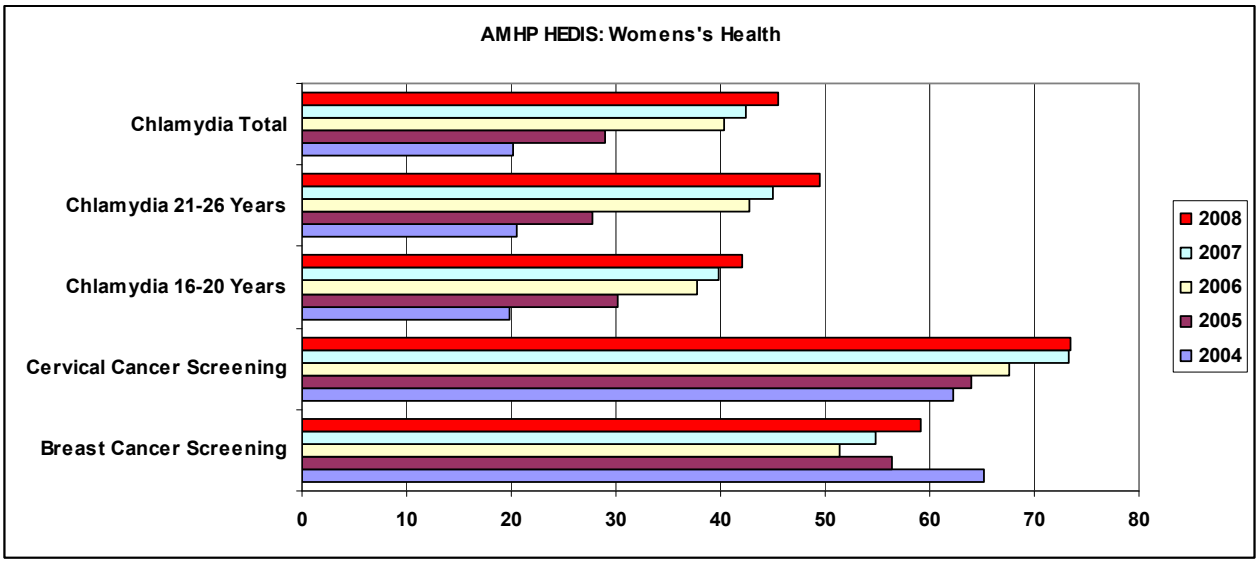
Cervical Cancer Screening, Breast Cancer Screening and Chlamydia Screening rates all increased. Activities in 2008 that continued through 2009 included:

- Member Service on-hold messages related to breast and cervical cancer screening
- 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
- Questions on a member's last mammography and PAP smear where added to the new member Health Risk Assessment
- The 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 calls
- Care Gap reports identifying members due or overdue for Mammography and/or Pap testing were mailed to PCPs quarterly

- Screening events were organized in the community using the Lackawanna Mobile mammography van.

New activities for 2009

- Care Gap data, identifying members who were missing breast and/or cervical cancer screening tests was expanded to include Member Services for inbound member calls
- Care Gap reports identifying members due or overdue for Mammography and/or Pap testing were mailed to PCPs quarterly.

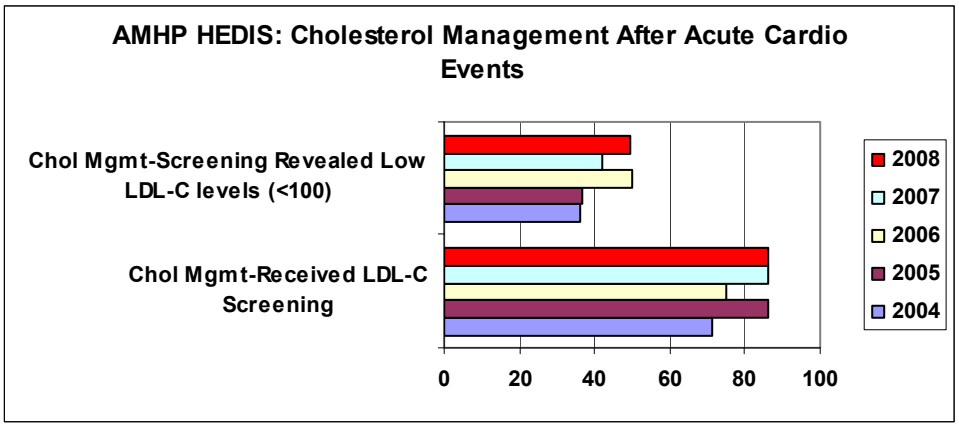


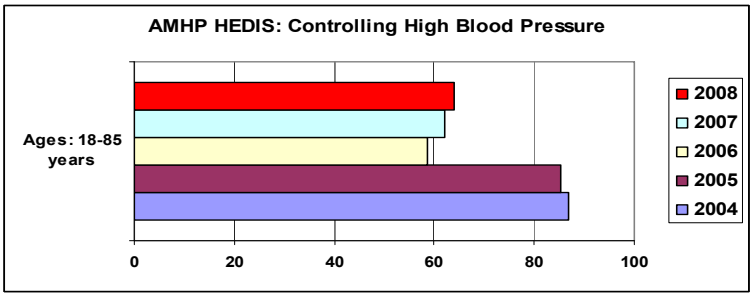
AMHP HEDIS: Cardiovascular Health

The rates for Controlling High Blood Pressure and LDL-C cholesterol management <100 mg/dl increased, with the LDL-C < 100 mg/dl exceeding the 2009 goal. There was no significant change in the cholesterol LDL-C screening rate.

Activities from 2008 continued and included the following: Member Service on-hold messages addressing "Know your Numbers" for cholesterol, member educational mailings, care gap data available to staff, 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. 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.

In 2009, Care Gap alerts for breast cancer screening and cervical cancer screening were linked to the PCP provider portal. Care Gap data was also provided to Member Service Representatives for inbound member calls.

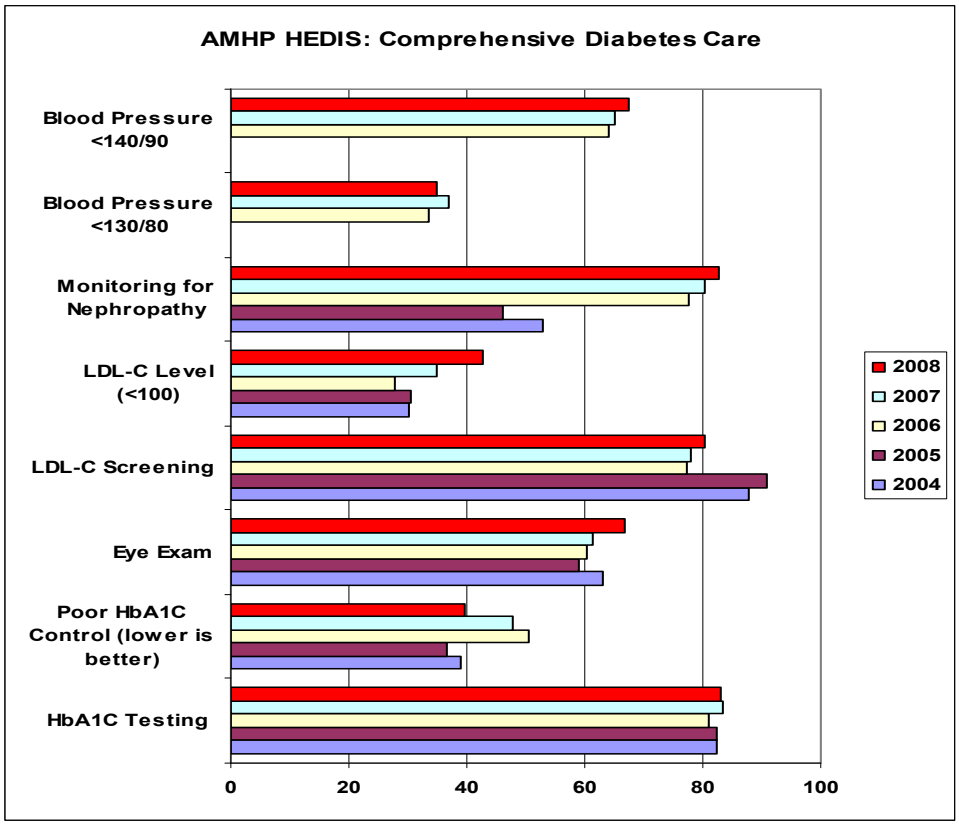




AMHP HEDIS: Comprehensive Diabetes Care
All of the Comprehensive Diabetes Care results improved. The 2009 goals for HbA1c poor control and LDL-C cholesterol management were exceeded.

Activities from 2008 that continued in 2009 included:

- Wellness educational workshops at faith-based and community centered organizations
- Member newsletter articles
- Educational posters for PCP offices
- 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.



New activities for 2009 include:

- The Diabetes Health Risk Assessment tool was enhanced to include a question on LDL-C cholesterol
- Care Gap reports identifying members due or overdue for LDL-C cholesterol screenings were mailed to PCPs quarterly
- The Care Gap report was augmented to include information on statin usage within the past 102 days.
- Measures related to HgbA1c and LDL-C screening rates were added to the Primary Care Provider Incentive Program, a pay-for-performance for primary care practitioners.
- A performance improvement project (PIP) was implemented targeting diabetes care for Latino members.

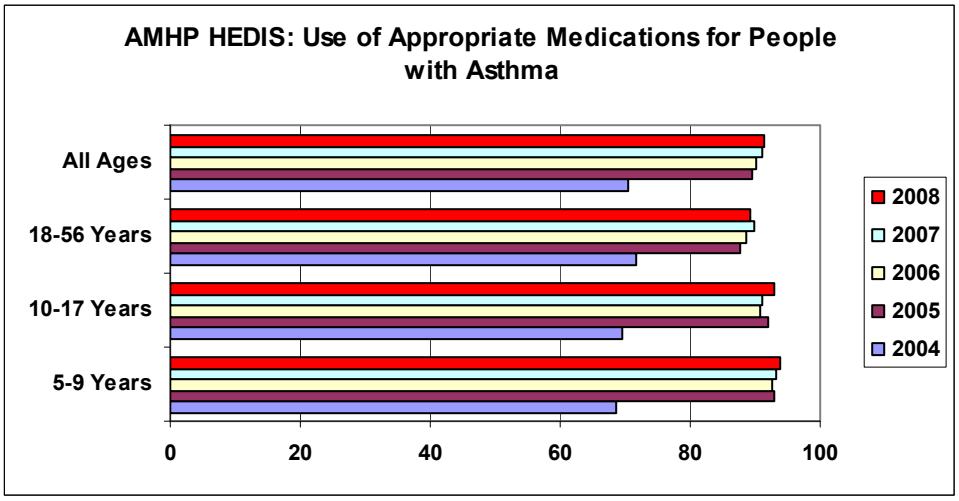
AMHP HEDIS: Use of Appropriate Medication for People with Asthma

In 2009, there was no statistically significant change in the rates as compared to 2008.
Activities from 2008 that 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.
- Overuse of rescue medications: Members overusing rescue medications based upon national guideline recommendations were identified. Education was 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
- A desktop application was implemented giving care managers access to real time pharmacy data.

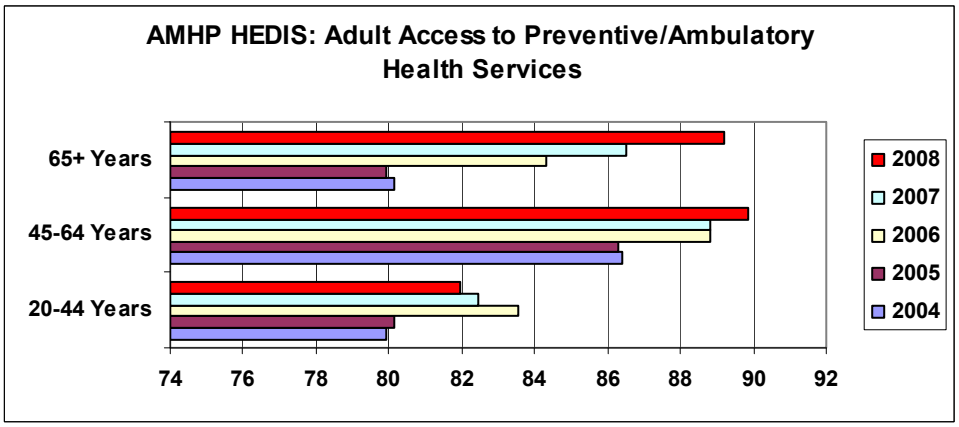


New activities for 2009

- Flag added to Pharmacy desktop application to alert care managers linking the application to the pharmacy data to identify members' overuse of rescue medications.

AMHP HEDIS: Adult Access to Preventive and Ambulatory Health Care

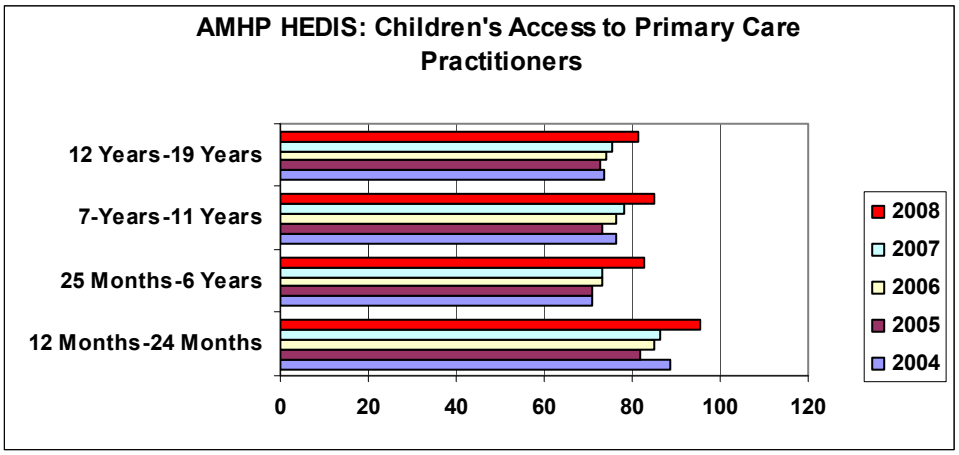
All three Adult Access measures remained stable.



AMHP HEDIS: Children's Access to PCP

All four Children's access measures improved. The 7-11 year and 12-1 9 year age groups showed a significant increase. Activities from 2008 continued in 2009 and 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.



AMHP HEDIS: Well Child Visits

The well child measure improved. Activities from 2008 continued in 2009 and 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
- A pilot program for select practices to distribute member incentives (movie passes) to adolescents for having well visits
- 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, was available to Care Management staff
- The Primary Care Provider Incentive Program, a pay-for-performance program, included measures based on Adolescent well visit rates.

New activities for 2009:

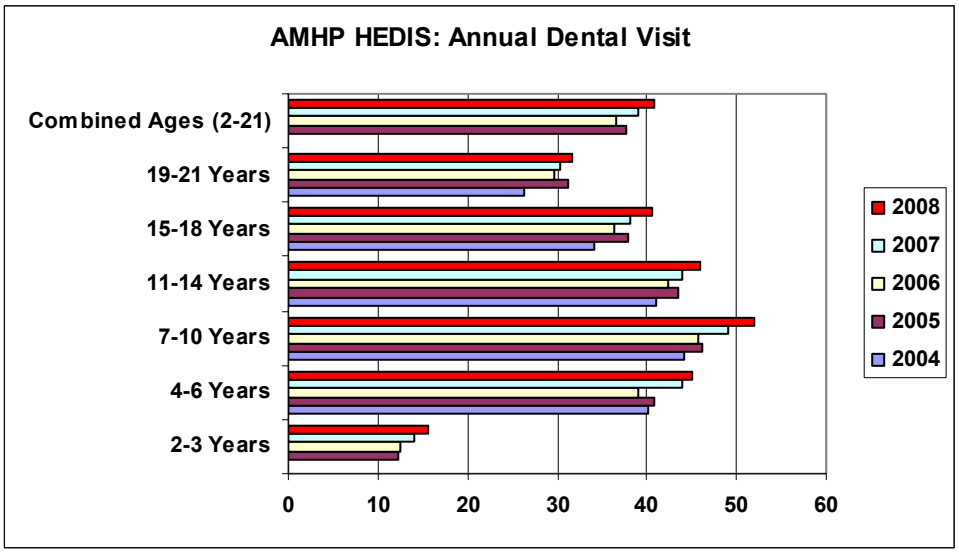
- Hired four EPSDT Outreach representatives to make reminder outreach calls.

AMHP HEDIS: Dental Visit

Results for all eight measures improved. Activities from 2008 continued in 2009 and included:

- 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.



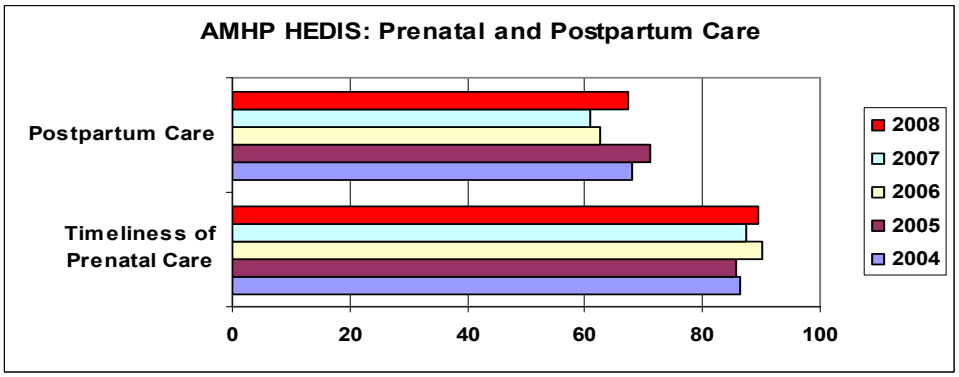
New activities for 2009:

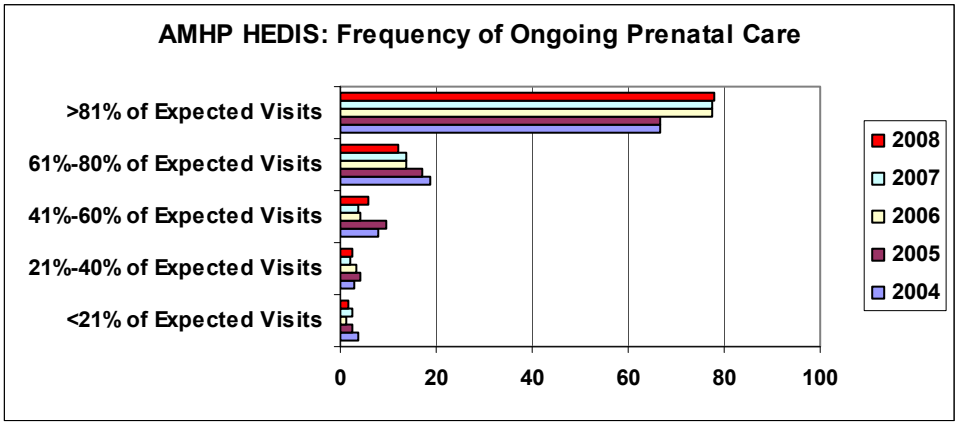
- Launched Doral Dental's real-time online directory.

AMHP HEDIS: Prenatal and Postpartum Care

The Frequency of Ongoing Prenatal Care rate > 81% visits and Postpartum Care measures increased and met the 2009 goal. Prenatal Care in the first trimester increased but remained in the 50th percentile. Activities from 2008 that continued in 2009 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 the 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.





New Activities for 2009:

- 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 initiated
- Restructured Obstetrical Needs Assessment Form (ONAF) to capture depression and preterm labor.

AMHP HEDIS Disparity Analysis:

An analysis of HEDIS results for Reporting Year 2009 by race and ethnicity 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.

The Race Analysis identified 6 statistically significant differences in 20 "Effectiveness of care" and "Access & Availability" measures. Main differences where identified in the diabetes, immunization and well child measures.

Measure	2009 Finding
Diabetic A1c Test	➢ African American members were significantly less likely to screen their glucose level than White members.
Diabetic A1c > 9	➢ African American members were significantly less likely to control their glucose level than White members.
Diabetic Eye Exam	➢ Hispanic members were significantly higher likely to receive diabetic eye exam than White members.
Lead Screening	➢ Hispanic members were significantly higher likely to receive lead screening than White members.
Cardio LDL Screening	➢ African American members were significantly less likely to screen their LDL level than White members.
Well child (W34)	➢ African American members were significantly less likely to receive adolescent well visit than White members.

B. Physician Performance

KMHP Discussion:
The Quality of Care Compensation Program (QCCP) initiated in 2008 continued in 2009. The program is open to PCPs with a panel size of 75 or more members. Approximately 595 PCPs 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 use of 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.

KMHP 2009 Quality Care Compensation Program
Quality Performance- KMHP provides incentives for eight HEDIS measures (Adolescent Well-Care Visit, Breast Cancer Screening; Cervical Cancer Screening; Comprehensive Diabetes Care (Hba1C test) appropriately prescribed medications for asthmatics**,** 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.

- 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.
- Encounter Submissions- KMHP provides an incentive to practices for submitting capitated encounters.

KMHP 2009 Quality Care Compensation Program Outcomes

QCCP MEASURE	CYCLE 1	CYCLE 2	% POINTS CHANGE C1 vs C2	CYCLE 3	% POINT CHANGE C2 vs C3
ADOLESCENT WELL CARE VISIT RATE	38%	44%	6%	47%	3%
BREAST CANCER SCREEN RATE	45%	49%	4%	51%	2%
CERVICAL CANCER SCREEN RATE	53%	53%	0%	54%	1%
DIABETES TESTING (HbA1c) RATE	62%	61%	-1%	63%	2%
APPROPRIATE ASTHMA MEDS RATE	85%	93%	8%	89%	-4%

AMHP Discussion:
The Primary Care Provider Incentive Program (PCPIP) continued in 2009. Approximately 200 PCPs are eligible for this program and receive quarterly reports 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 our Member Care Gaps reporting to our provider community:

- Quality Metrics- *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 PCP Incentive program (planned for incentive payment beginning December, 2010 - 6th cycle).

AMHP PCP Incentive program

- Quality Performance- AMHP provides incentives for six HEDIS measures (Adolescent Well-Care Visit, Breast Cancer Screening; Cervical Cancer Screening; Comprehensive Diabetes Care (Hba1C tests) twice a year, appropriately prescribed medications for asthmatics, and well child care visits.
- Severity of Illness- AMHP provides an incentive to PCPs who are treating sicker KMHP members.
- Emergency Utilization - PCPs are eligible for additional compensation based on their panels overall ER utilization and non emergent ER usage.

AMHP 2009 Quality Care Compensation Program Outcomes

AMHP	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Quality Aggregate: Peer Percentile Bracket Increases*	n/a	2 of 9	6 of 9	5 of 9
ER Utilization: Peer Percentile Bracket Decreases*	n/a	2 of 9	4 of 9	3 of 9
Non-Emergent ER Utilization: Peer Percentile Bracket Decreases*	n/a	4 of 9	7 of 9	3 of 9
Severity of Illness: Peer Percentile Bracket Increases*	n/a	6 of 9	8 of 9	4 of 9
Asthma Controller Med Use Score	87%	91%	89%	88%
Breast Cancer Screening Score	55%	57%	60%	61.50%
PCP Access 0-1 yo	94%	95%	96%	96%
PCP Access 2-6 yo	80%	83%	85%	87%
Well Adolescent Care	47%	48%	50%	52.80%
Number of Eligible Practices who filed an appeal of their results	4	n/a	1	n/a

C. GEO Access:
In 2009, 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 highest 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 will be working 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 availability to 2Pediatric 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 (13%) of Spanish speaking members, a GEO access report was generated for access to Spanish speaking PCPs. Nine of the ten urban/suburban counties met had two Spanish-speaking PCPs within 30 minutes. Only Lackawanna County did not have this level of access for Spanish-speaking PCPs, which may impact 40 members. All three rural counties had two Spanish-speaking PCPs available within 60 minutes.

AmeriHealth Mercy continues to track and analyze the geographic distribution of its practitioners and providers to identify opportunities for improvement.

D. Clinical Quality Improvement Initiatives

The following clinical quality initiatives were ongoing in 2009:

- 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 Percent of Members Diagnosed with Asthma or Diabetes or HIV Receiving a Flu Shot. (AMHP and KMHP)
- Improving the Management of Diabetes(AMHP and KMHP)
- Increasing member awareness of the dangers of lead poisoning and increasing screenings (AMHP)

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.

	KMHP					AMHP			
Measurement Years	**Baseline 2004**	**2006**	**2007**	**2008**		**Baseline 2004**	**2006**	**2007**	**2008**
Pregnant Members who receive prenatal care in the first trimester (HEDIS)	85.12%	81.51% (↓4.86%)	75.18% (↓6.33%)	79.81% (↑4.63%)		86.42%	90.21% (↑4.57%)	87.35% (↓2.86%)	90.36% (↑3.01%)
Pregnant members who attend 81% or more of their expected prenatal visits (HEDIS)	58.60%	56.93% (No change)	62.88% (↑5.05%)	65.94% (↑3.06%)		66.15%	77.39% (↑ 10.72%)	77.62% (↑0.23%)	80.29% (↑2.67%)
Low birth weight infants (1500 – 2500 grams)	9.25%	9.0% (↑1%)	7.66% (↓1.34%)	8.61% (↑.95%)		7.0%	7% (↓0.20%	7.19% (↑.19%)	5.73% (↓1.46%)
Very low birth weight infants (1000 – 1499 grams)	1.02%	2.0% (No change)	2.50% (↑.50%)	2.14% ↓.35%)		1,30%	2% (↓0.20%	1.90% (↓0.10%	1.22% (↓.68%)

2009 Interventions:

- **Centering Prenatal Care:** Keystone Mercy's ongoing collaboration with a local provider for a Centering Prenatal Program in 2009 in SW Philadelphia and expanded to a site in NE Philadelphia with approximately 20 participants. Centering Prenatal Care has proven to provide better outcomes (fewer preterm, low weight births), better compliance with prenatal visits, and better satisfaction with prenatal care.
- **Member Incentives:** The following two Member Incentives continued in 2009 for both KMHP and AMHP members: a onesie outfit for their newborn and a gift card upon completion of the post partum visit.
- **Dental Care:** AMHP continued and KMHP adopted the Smiling Storks Program provided by Doral Dental. Smiling Storks is designed to educate women about the importance of being screened for periodontal disease during pregnancy and the value of establishing good oral health habits for babies. Within a few weeks of identifying a pregnant member, Doral Dental mails detailed information encouraging the member to get dental screening and cleaning services during her pregnancy. Through this program, written educational materials were provided to enlists and OB/GYNs on the importance of good oral health during pregnancy. KMHP implemented activities to increase the percentage of pregnant women receiving a dental screening. The initiative is described in greater detail on page X.
- **17 P Alpha Hydroxyprogesterone.** In 2009, both AMHP and KMHP continued to develop processes for early identification of actual & potential candidates for 17 P and other enhanced services such as Doula support. Outreach and discussions with participating OB practitioners and early identification of members who may be candidates for the treatment, due to a prior preterm delivery also continued.
- **Community Baby Shower:** Keystone Mercy hosted two community Baby Showers.
- **Behavioral Health Collaboration:** AMHP implemented a pilot program with CBHNP, the Behavioral Health MCO for several of the counties in the AMHP service area. The pilot, which is described in more detail on page XX improves identification of prenatal depression through proactive screening and uses three-way call capabilities to connect the member to behavioral health care.
  In the last quarter of 2008, KMHP and Magellan collaborated to increase access to behavioral health care for pregnant women. Claim data from 10/1/2007 through 11/30/2008 was analyzed to identify members receiving both prenatal vitamins and a psychotropic medication who would benefit from collaborative care coordination efforts. Pregnant members are also identified for the program through their responses to the Edinburg survey. Additionally, KMHP began partnering with The Philadelphia Department of Health Perinatal Depression Project in November 2009 to identify and coordinate treatment for depression during pregnancy and the post partum period.
- Both AMHP and KMHP Implemented a Prenatal Vitamin Call-out Program. The program identifies women, through pharmacy claims data, that had a prescription filled for prenatal vitamins. Outreach is conducted to enroll women into the WeeCare case management program. This program also helps identify members who may benefit from 17P.

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.

Measurement year 2004 serves as the baseline year.

KMHP	Baseline 2004	2006	2007	2008
HA1c test (HEDIS)	77.8%	76.16% (↓0.73)	80.6% (↑4.44%)	78.59% (↓2.01%)
Poorly-controlled HgbA1c (HEDIS)	46.06%	54.99% (↑12.41%)	44.57% (↓10.42%)	38.93% (↓5.64%)
Micro-albumin test (HEDIS)	48.45%	80.78% (↑38.93%)	75.52% (↓5.26%)	80.05% (↑4.53%)
Diabetic retinal exam (DRE) (HEDIS)	51.31%	41.61% (↓6.08%)	47.34% (↑5.73%)	46.96% (↓0.38%)
Serum LDL-C <100 mg/dl (HEDIS)	31.03%	32.36% (↓14.11%)	35.57% (↑3.21%)	40.88% (↑5.31%)

AMHP	Baseline 2004	2006	2007	2008
HA1c test (HEDIS)	82.52%	80.97% (↓1.61%)	83.45% (↑2.48%)	83.21% (↓0.24%)
Poorly-controlled HgbA1c (HEDIS)	38.93%	50.66% (↑14.16%)	47.93% (↓2.73%)	39.66% (↓8.27%)
Micro-albumin test (HEDIS)	52.91%	77.65% (↑31.42%)	83.29% (↑5.64%)	82.73% (↓0.56%)
Diabetic retinal exam (DRE) (HEDIS)	62.94%	60.18% (↓1.30%)	61.31% (↑1.13%)	66.67% (↑5.37%)
Serum LDL-C <100 mg/dl (HEDIS)	30.07%	27.65% (↓2.76%)	35.04% (↑7.35%)	42.58% (↑7.54%)

For both Plans, the HA1c screening rates decreased slightly and the LDL-cholesterol <100 increased. The HA1c poor control decreased (lower is better). For KMHP the DRE measure remained the same and for AMHP the rate increased. The micro-albumin testing increased for KMHP and remained the same for AMHP.

2009 Interventions:

- Lose to Win: KMHP pilot initiative for adults with five Philadelphia YMCAs. Over 170 diabetic members participated over a twelve week period. Program consisted of monitoring of A1C, LDL, BMI as well as exercise, nutritional education
- Care Gap alerts were linked to the PCP provider portal
- Care Gap data identifying members who were missing HbA1C screening tests was provided to Member Services for inbound member calls
- A Certified Diabetic Educator was added to the KMHP Case Management Staff for assessments and education of members
- Performance on the screening measures HbA1c poor Control >9% and LDL-C <100 mg/dl for diabetics were added to the PCP Quality Care Compensation Program
- A performance improvement project (PIP) was implemented targeting diabetes care for AMHP's Latino members.

Reducing Emergency Room Utilization (AMHP and KMHP)

Trending of ER visit rates from 2000 through 2008 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.

	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)	65.77/K	80.44/K

In 2009, KMHP's ER rate increased 0.02/K members and AMHP's increased 1.27/K members. 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. Preliminary results indicate that over–reporting may be occurring.

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

Interventions performed in 2009:

KMHP:

- Continued the stratification of the ER outreach initiatives to include:
  - A mailing to Members with 3 visits in 90 days
  - An automated Member outreach for Members with 4 to 6 visits in 90 days
  - Case manager intervention for Members with 4 or more visits in 30 days
- Continued monthly medication adherence letters for Asthma, Diabetes & Heart Failure
- Initiated an automated Discharge outreach survey to promote ER follow-up post discharge
- Implemented targeted mailing for ER utilizers, based on common non-emergent diagnoses, i.e. otitis media or frequent usage
- Increased the visibility of Urgent care centers and Offices open after routine business hours to members
- Implemented the Asthma Safe Kids Pilot with National Nursing Care Consortium focusing on members with high ER utilization related to asthma
- Identified PCP'S with the highest and lowest ER utilization for Medical Director outreach
- Implemented an Acute Care Transition pilot at a large community hospital focused on intensive management of the discharge plan for members from the inpatient or emergency room setting
- Continued inclusion of 24/7 Nurse Line magnets in the new member Welcome Packet
- Continued follow up of calls to the 24/7 Nurse Line by Care Coordination staff
- Continued Member Newsletter Articles addressing appropriate utilization of ER.

AMHP:

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 2009 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
- Member Newsletter Articles addressing appropriate utilization of ER
- Postcard mailing to members with ER diagnosis of Otitis Media, general ER claims and dental issues
- 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 2009 goal of 18.96% was exceeded.

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 to seek preventive dental care.

The following interventions were implemented in 2009:

- Providing Member Incentive gift card to 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 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

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

This QIA was initiated in 2008 and continued in 2009. 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 were implemented 2009:

- Telephonic outreach to members identified as not having screenings
- Targeted mailing to members identified as not having screenings
- Promotora Program 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	AIC Screening	LDL- Cholesterol Screening
January 1 through June 30 2008	**75%**	**64%**
January 1 through June 30 2009	**78% (Goal – 78%)**	**77% (Goal 67%)**

For the 2009 measurement period, a goal of 78% was established for the A1c screening and a goal of 67% was established for the LDL screening. Improvement was seen in both the A1c and LDL-C screening rates. The goal for A1C screening was met and the goal for LDL screening was exceeded.

Common barriers identified through focus groups, ADA and CDC include:

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

The 2010 goal is to provide members with a better understanding of diabetes and its complications and to statistically improve the LDL and HgA1c screening rates in this population.

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

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.

AmeriHealth Mercy Health Plan 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.

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. 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 following metrics were measured:

- Of the pregnant members enrolled in WeeCare – percentage screened for perinatal depression utilizing the Edinburgh Tool: 357 of 357 members
- Percentage of pregnant women enrolled in WeeCare with a positive screening for perinatal depression and referred by warm transfer to BH :11 of 357 members
- Percentage of referred members enrolled in WeeCare with first BH appointment documented by WeeCare case manager: 11 of 11 members
- Percentage of referred members enrolled in WeeCare who attended the first BH appointment: 2 of 11 members.

Outcomes for the measurement period January 1, 2009 through June 30, 2009:

- Of the pregnant members enrolled in WeeCare – percentage screened for perinatal depression utilizing the Edinburgh Tool: **357 of 357 members**
- Percentage of pregnant women enrolled in WeeCare with a positive screening for perinatal depression and referred by warm transfer to BH :**11 of 357 members**

- Percentage of referred members enrolled in WeeCare with first BH appointment documented by WeeCare case manager: **11 of 11 members**
- Percentage of referred members enrolled in WeeCare who attended the first BH appointment: **2 of 11 members.**

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

The project was implemented in order to increase our collaboration with the BH MCOs and to capture data to establish rates/baselines. Currently, there is no structure in place to capture data. At that time, our CCNX system (case management documentation tool) was enhanced to include screening and documentation for purposes of data collection.

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.

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

This QIA was initiated in 2009. 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.

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 6/30/09.

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 1,136 pregnant KMHP members identified as residing in Delaware County between 1/1/09 and 6/30/09, 158 (13.91%) were contacted and screened for depression using the Edinburgh Depression Screening Tool. A total of 29 members were identified as needing further intervention by scoring 10 or more on the Edinburgh Depression screen tool. Four members (13.79%) agreed to a referral to the BH-MCO. Of note, an additional 4 members were already receiving Behavioral Health Services and had planned appointments. Of the 4 members that agreed to the referral for further assessment and appointment scheduling, one (1) member kept her appointment. Therefore, 25% of the total of 4 members referred to Magellan kept the appointment.

	Goal	Results	Comment
2009	6%	13.91%	Goal exceeded
2010	* 13.91%		

* 2010 Goal is to demonstrate sustainable improvement

Improving the Percent of Members Diagnosed with Asthma or Diabetes or HIV Receiving a Flu Immunization (KMHP)

This QIA was created in 2008. The Center for Disease Control and Prevention (CDC) recommends that people who are at risk of serious flu complications should receive a flu shot annually. The CDC identifies high risk population as adults and children 6months or older with the following chronic conditions:

- Chronic lung conditions, such as asthma
- Weakened immune system or infection with human immunodeficiency (HIV/AIDS)
- Metabolic diseases like diabetes.

Year	Benchmark/Goal	Results	Comments
Percent of adults with diagnosis of Asthma receiving flu shot during measurement year			
2007/8	Baseline	33.24%	
2008/9	36.24%	35.08%	Goal was not met
Percent of members with diagnosis of HIV receiving flu shot during measurement year			
2007/8	Baseline	21.86%	
2008/9	24.86%	26.63%	Goal was met
Percent of adult membership with diagnosis of Diabetes receiving flu shot during measurement year			
2007/8	Baseline	26.40%	
2008/9	29.40%	25.88%	Goal was not met

The measurement period for this activity crosses calendar year to be consistent with the flu season. Members with Asthma, Diabetes and HIV are targeted for outreach and education with the goal of improving the percent of those high risk members who receive a flu vaccination.

Common barriers included:

- Member's knowledge deficit re importance of vaccine and the risk of getting the flu in you have a chronic illness
- Fear of needles and of getting the flu
- Availability of flu shots
- Transportation

The following interventions occurred in 2009:

- Home Bound Flu Vaccine Outreach
- Member newsletter article
- Automated member outreach reminder calls

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 mammogram screening rates for women ages 52-69 exceeded goal while the measure for women ages 42-51 did not meet goal and remained flat with 2007 results. Rates for cervical cancer screenings increased and met goal. The rates for Chlamydia screenings increased for all three age groups (16-20, 21-25 and Total). The goal was not met for members receiving the HPV vaccine.

Common barriers included:

- Member's knowledge of the importance of preventive care
- Fear of pain/discomfort or test
- Cultural taboos

New interventions that occurred in 2009 include the following:

- Identified additional data sources (Family Planning, Hospital Labs) for data collection
- Launched Care Gap alerts to Member Services for inbound member calls and linked the alerts to the provider portal.

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 was not met
2008	54.12%	56.57%	Goal was met
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

Year	Benchmark/Goal	Results	Comments
2008	Goal: 50.44%	47.84%	Goal was not met
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 was 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 was 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
2008	Goal: 52.90%	60.93%	Goal was met
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 was met
Percent of members receiving human papillomavirus (HPV) vaccine (Ages 11-18)			
2007	Baseline	12.58%	
2008	Goal: 15.58%	12.30%	Goal was not met

AMHP Discussion:

For 2008 the age stratifications were removed for the Mammography screenings measure. The measurement includes all women between the ages of 42-69 who had a mammogram during the measurement year. Pap Smears and Chlamydia screening rates increased in 2008; however, the goals were not met for both categories. For percent of members receiving the HPV vaccine, the goal was not met for 2008, with 10% receiving the vaccine between ages 11 to 18.

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

Year	Benchmark/Goal	Results	Comments
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
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
2007	Baseline	14%	
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
2008	Goal: 50.52%	49.55% (Increase 4.53%)	Goal not met
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
Percent of members receiving human papillomavirus (HPV) vaccine (Ages 11-18)			
2007	Baseline	14%	
2008		10%	Goal not met

2009 Interventions 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 newsletter "Feeling Great in 2008 Checklist"
- Provider Newsletter articles
- Continue Women's Wellness empowerment fairs
- Utilize Lackawanna Mobile Mammogram Van at events
- Restructure "on hold" messaging.

Increasing member awareness of the dangers of lead poisoning and increasing screenings (AMHP)

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.

	Goal	Results	Comments
2007	Baseline	65.94%	NA
2008	69.23%	71.54%	Goal exceeded

Intervention that continued in 2009:

- Place Lead product recalls on member website – Product Recalls
- Developed member educational materials in Spanish
- Enclosed Provider educational materials in quarterly packet
- Contracted with Vendor (Medtox) to give providers the ability to draw finger-sticks at time of office visit
- Case Management provided for any member identified with lead level >10 to ensure appropriate follow with parent and PCP.

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 audit based on the criteria and standards listed above, which consisted of a file review and policies and procedures.

The audit summary findings are listed below:

Year	Audit Score
2009	Policies and Procedures:100% Initial Credentialing: 99.8% Recredentialing: 100% Data Validity: 100%

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

KMHP	NCQA Timeliness Standard: Within 180 days				
	2009	**2008**	**2007**	**2006**	**2005**
PCP and Specialist Initialing Credentialing	100%	99.9%	99%	100%	99.5%
PCP and Specialist Recredentialing	100%	100%	*92%	100%	99.8%

AMHP	NCQA Timeliness Standard: Within 180 days				
	2009	**2008**	**2007**	**2006**	**2005**
PCP and Specialist Initialing Credentialing	100%	100%	100%	100%	99.8%
PCP and Specialist Recredentialing	100%	100%	100%	100%	99.8%

* 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 2009 by plan, with a comparison of total activity from 2004 through 2009.

Category	KMHP	AMHP	Total 2009		Total 2008	Total 2007	Total 2006	Total 2005	Total 2004
Credentialing Approved Providers	**2294**	**1335**	**3629**		**2701**	**1464**	**1519**	**1515**	**2102**
Credentialing Approved Facilities	**41**	**44**	**85**		**51**	**113**	**47**	**36**	**44**
Cred Providers Denied	**4**	**1**	**5**		**4**	**2**	**3**	**2**	**1**
Recredentialing Approved Providers	**592**	**644**	**1236**		**2110**	**970**	**3356**	**3468**	**3942**
Recred Approved Facilities	**3**	**5**	**8**		**37**	**36**	**17**	**15**	**5**
Recred Providers Denied	**0**	**0**	**0**		**3**	**3**	**10**	**0**	**2**
Recred Facilities Denied	**0**	**0**	**0**		**0**	**0**	**0**	**2**	**0**
Reconsideration/Appeal	**2**	**2**	**4**		**3**	**7**	**0**	**2**	**15**
Delegates	**948**	**889**	**1837**		**4985**	**4264**	**2330**	**3756**	**3384**
Terminations	**887**	**442**	**1329**		**1061**	**280**	**527**	**649**	**1251**

The volume of terminations increased in 2009 due to providers not responding timely for the re-credentialing cycle due date. Should the provider express an interest to remain participating after the recredentialing deadline, the provider is placed in the initial credentialing process.

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 2009, the following process improvements were initiated:

- Implementation of the credentialing software to allow for auto submission of NPDB and a new user screen, Credentialing/Verification, to improve capturing the credentialing history
- System process improvements including saving Approval Letters and Hospital Affiliation requests within the credentialing system
- Addition of six reporting fields: board program name, sub specialty, board certification expiration date, hospital accreditation status, accreditation body and recredentialing to the credentialing event.

One new coordinator was added to the team. Also, during the last half of 2009, the Department was challenged to meet an internal file processing goal of 90 days. This goal was met in January 2010.

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 number of medical records reviewed in 2009 was 453 records per Plan.

The Medical Record audit score for passing remained at 90% for 2009.The number of practice sites that failed the audit is as follows:

KMHP: 20
AMHP: 10

Re-audits of the practices that scored below the 90% threshold occurred in the fourth quarter and continued into 2010.

The top two documentation deficiencies for each Plan were preventive care and the three requirements for an adolescent well visit [A health and developmental history (physical and mental), a physical exam, health education/anticipatory guidance].

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 2009 with the purpose of addressing intervention specific to any question scoring less than 70th percentile. Membership included A/KMHP representation from the following areas:

- Operations
- Provider Network Management
- Pharmacy
- Public Affairs
- Quality Management.

New team members were added from Utilization Management and Care Coordination. Additionally, two sub teams were formed to address: Plan Services Satisfaction and the Practitioner/Provider Satisfaction.

The Plan Services 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
- Health Promotion and Education
- Medical Assistance with Smiling Cessation.

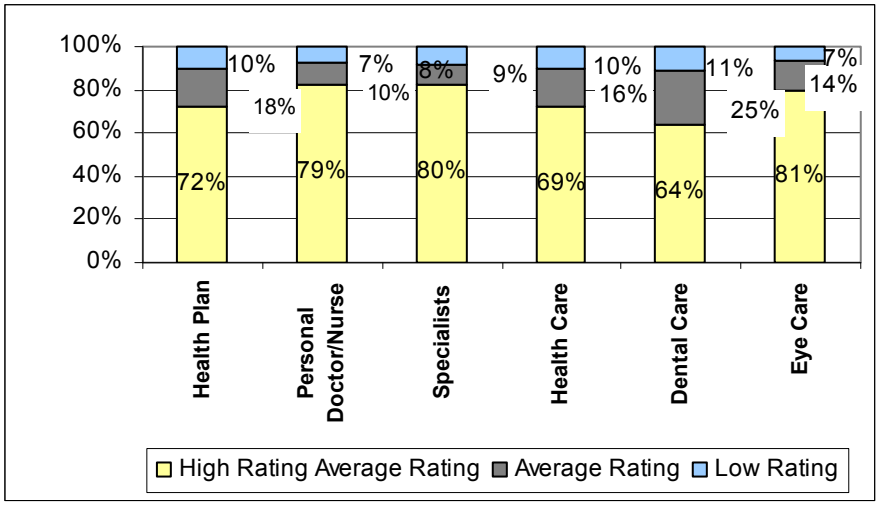
KMHP/AMHP utilized NCQA's HEDIS Consumer Assessment of Health Plans Study (CAHPS 4.0.H) Questionnaire for Medicaid Adults and Children to conduct the Member Satisfaction Survey. During 2008, the CAHPS 3.0.H Questionnaire for Children (Medicaid) was administered. An external NCQA certified vender, ***MORPACE,*** 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 2008. Using the HEDIS prescribed methodology; the Plan obtained a 31% response rate for adult CAHPS (478 completed surveys).

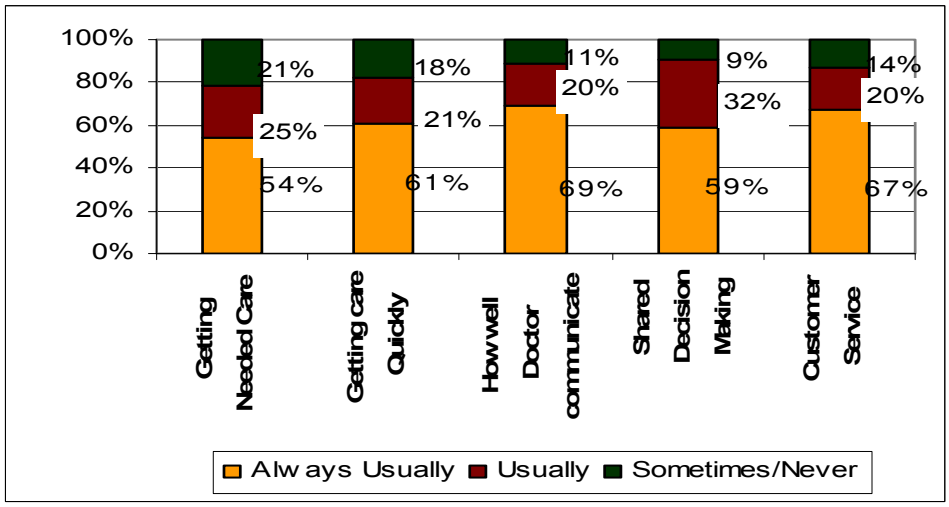
In addition to the standard CAHPS survey questions, KMHP added four questions to enable the Plan to further investigate particular areas of interest. These questions covered the areas of access to specialists, website use, and customer service.

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.)



In comparison to 2007 survey results, there were no statistically significant differences in 2008. No clear trends exist in the last three years of survey results.

KMHP 2008 Composite Scores



None of the composites changed significantly.

On an annual basis the National Committee on Quality Assurance (NCQA) releases information on national CAHPS findings that is used for accreditation. 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).

Variables	Percentile Rank		
	2008	2007	2006
Getting Care Quickly	90 ↑	75	90
Getting Needed Care	75 ↔	75	50
Customer Service	90 ↔	90	50
Rating of Health Plan	75 ↔	75	75
How Well Doctors Communicate	75 ↔	75	90
Rating of All Health Care	75 ↔	75	90
Rating of Personal Doctor	90 ↑	75	90
Rating of Specialist Seen Most Often	90 ↑	50	90

Additional Measures

In 2006 Keystone Mercy added some questions to the survey concerning appointments with specialists, customer service, and the internet. In 2008 there were virtually no significant difference compared to the previous year results. In terms of the Plan's website, it was found that 46% of respondents thought it was Always/Usually easy to find information about the plan on its website. It is down from previous year with a very small sample size (n=25). The added questions pertaining to specialists and customer service and corresponding findings are listed below.

Were any of the following a reason it was not easy to get an appt with a specialist?	Yes-2008	Yes-2007	Yes-2006
The specialist you wanted did not belong to your network	41%	47%	45%
You could not get an appt at a time that was convenient	51%	47%	43%
Not enough specialists to choose from	27%	36%	40%
The specialist you had to choose from were too far away	31%	28%	35%
You weren't sure where to find a list of specialists in your plan or network	30%	27%	27%
Health plan approval or authorization was delayed	19%	21%	24%
Your Dr. did not think you needed a specialist	20%	11%	8%

Reasons did not get information/help from health plan's customer service?	Yes-2008	Yes-2007	Yes-2006
Received incorrect information	37%	42%	54%
You had to call several times before you could speak to someone	32%	40%	48%
Customer service did not have the info you needed	52%	50%	38%
You waited too long for someone to call you back	31%	35%	32%
No one called you back	33%	39%	29%

Conclusions

In general, 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. A T-Test was computed on the overall means, and confirmed that there were no significant difference between years 2008 and 2007.

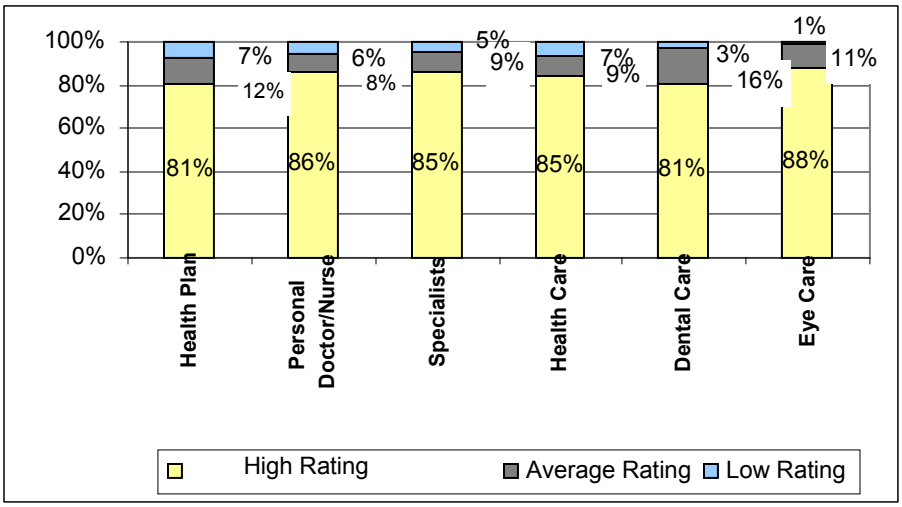
Fewer measures in the 2008 survey showed significant changes from the previous year. The dental visits are trending upward, evaluation of dental care in the past 6 months increased from the previous year. The personal doctor behavior toward members slightly improved. There was a slight increase in health care involving Specialists and access to care. Percentages related to health information through the internet available to members, service issues and paperwork stayed unchanged.

Opportunities for Improvement
The Plan looks at ratings, composite and other questions whose unadjusted score falls below the NCQA Quality Compass benchmark of 75th percentile. Based on that approach, the following areas appear to have opportunities for improvement:

Questions	Score	Percentile
Getting Care Quickly	82%	50th
Getting Needed Care	79%	50th
Shared Decision Making	59%	25th
How Well Doctors Communicate	89%	50th
Rating of Health Care	69%	50th
Rating of Health Plan	72%	50th
Health Promotion and Education	59%	50th
Coordination of Care	78%	50th
Medical Assistance with Smoking Cessation	69%	25th

B. KMHP Analysis of Child CAHPS Survey
The survey was sent to a random sample of 1,592 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, 2008 and who have been continuously enrolled for at least 5 out of the last 6 months of 2008. The Plan was successful in obtaining a 35% response rate for child CAHPS (551 completed surveys).

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.

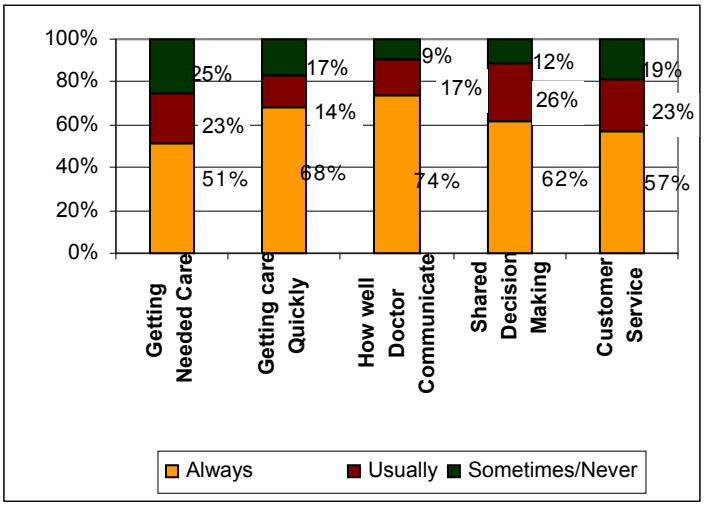


In comparison to 2007 results, there are several significant differences to note in 2008. The table below details the significant differences this year compared to last year's results.

Significant Changes in Member Satisfaction, 2008 vs. 2007

Ratings Areas	2008	2007	Difference
Made an appointment at doctor or clinic (yes)	82%	68%	↑
Have a personal doctor (yes)	93%	84%	↑
Child able to talk to doctor about care (yes)	61%	57%	↑
Tried to make an appointment to see a specialist (yes)	29%	40%	↓
Sought care, tests or treatment through health care (yes)	39%	54%	↓
Discussion about child feeling/growing/behaving	89%	81%	↑
Health care (8,9 &10)	85%	92%	↓

KMHP 2008 Composite Scores



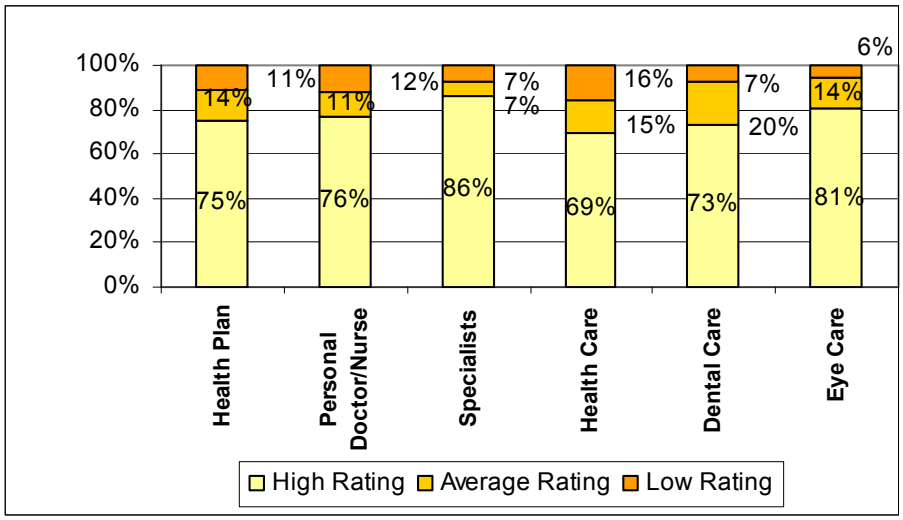
Opportunities for Improvement
Based on the analysis of the survey responses, the following areas appear to have opportunities for improvement. An opportunity is defined as any ratings, composite or other questions that has less than a 75% satisfaction rate, or a dissatisfaction rate of 25% or greater.

Opportunity for Improvement	2008
Shared Decision Making	62%
Getting Needed Care	74%
Health Promotion and Education	63%

Members continue to be generally satisfied with all aspects of their health care. Rating levels regarding the Plan and its providers continue to be leveled. Also, all of the significant differences from the previous measurement period are improvements. Encouragingly, there was a significant increase in the percentage of members reporting they received care from a dentist in the previous 6 months well as the proportion of members who gave their dental care high ratings. The significance is trending upward two years in a row.

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 1,589 adult enrollees from the universe members who have been continuously enrolled for at least 5 out of the last 6 months of 2008. Using the HEDIS prescribed methodology; the Plan obtained a 31% response rate for adult CAHPS (500 completed surveys).

AmeriHealth Mercy Health Plan members continue to provide strong ratings for their personal doctor/nurse and specialists. However, most of the percentages did not change significantly.

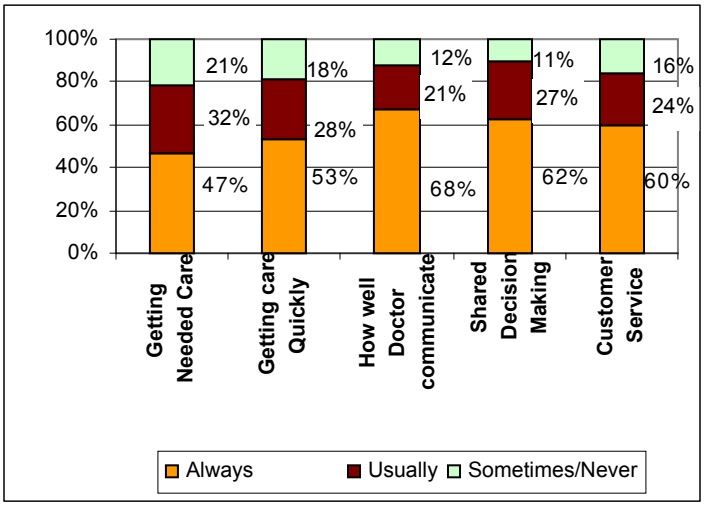


In comparison to 2007 survey results, there are a few key differences to note in 2008. The table below details the significant differences this year as compared to last year's results:

Significant Changes in Member Satisfaction, 2008 vs. 2007

Ratings Area	2008	2007	Difference
Specialist (8,9 & 10)	86%	76%	↑
Doctor or provider told you there was more than one choice (yes)	53%	40%	↑
Health plan gave you forms to fill Out (yes)	32%	25%	↑

AMHP 2008 Composite Scores



None of the composite scores changed significantly.

Variables	Percentile Rank		Direction
	2008	2007	
Getting Care Quickly	50	75	↓
Getting Needed Care	50	50	↔
Customer Service	90	90	↔
Rating of Health Plan	75	75	↔
How Well Doctors Communicate	75	75	↔
Rating of All Health Care	90	90	↔
Rating of Personal Doctor	75	90	↓
Rating of Specialist Seen Most Often	90	75	↑

Additional Measures

In 2006 AmeriHealth Mercy added some questions to the survey concerning appointments with specialists, customer service, and the internet. In 2008 there were virtually no significant difference compared to the previous year.

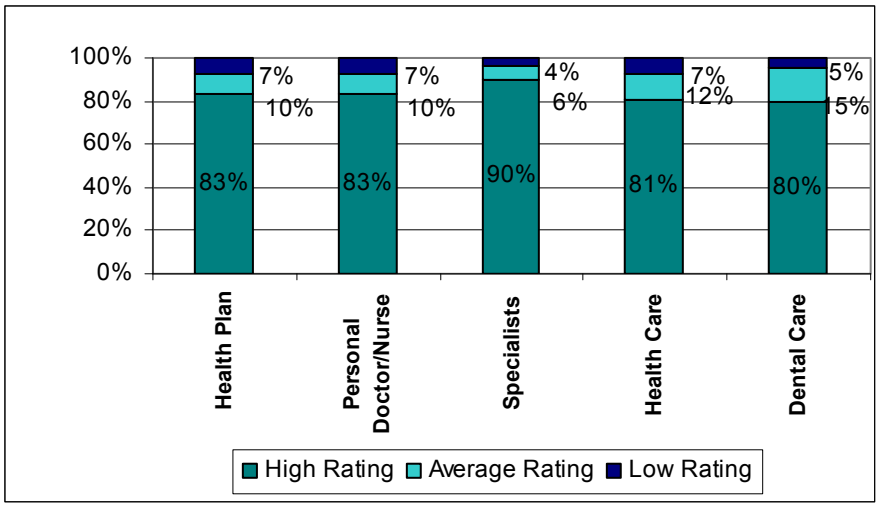
In terms of the Plan's website, it was found that 60% of respondents thought it was Always/Usually easy to find information about the plan on its website. Up from year 2006, but not significantly up.

The Plan looks at ratings, composite and other questions whose unadjusted score falls below the NCQA Quality Compass benchmark of 75th percentile. Based on that approach, the following areas appear to have opportunities for improvement:

Questions	Score	Percentile
Getting Care Quickly	82%	50th
Getting Needed Care	78%	50th
How Well Doctors Communicate	88%	50th
Rating of Health Care	69%	50th
Rating of Personal Doctor	76%	25th
Health Promotion and Education	55%	25th
Coordination of Care	76%	25th
Medical Assistance with Smoking Cessation	70%	50th

Conclusions
AmeriHealth Mercy adult members continue to provide strong ratings on their personal doctor/nurse, and specialists. However, the strong rating did not translate to significant increase. The two rating areas that did increase but not significantly, from the previous year involved rating of the health care they received and members reporting that doctors are not advising them to quit smoking as frequently as was done in the past. Improvement that is focused in these areas will likely increase AmeriHealth Mercy's overall satisfaction ratings and area composite scores

D. AMHP Analysis of Child CAHPS Survey
The 2008 survey was sent to a random sample of 1,638 child enrollees from the universe members continuously enrolled from 2007. Using the HEDIS prescribed methodology; the Plan obtained a 35% response rate for child CAHPS (570 completed surveys).



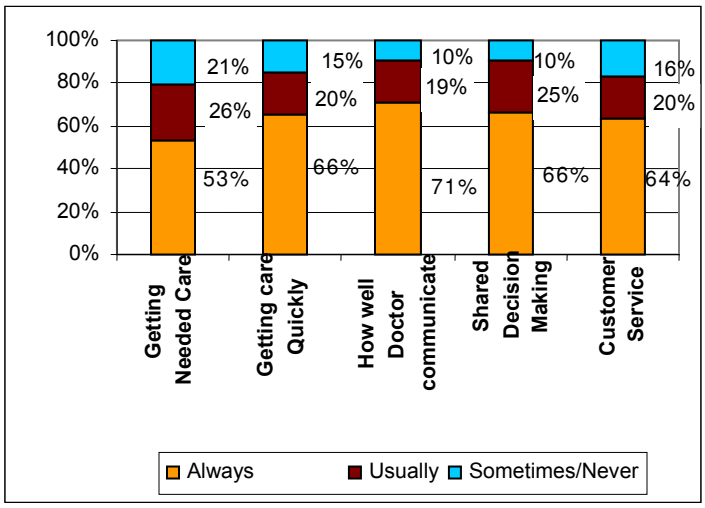
AmeriHealth Mercy Health Plan members continue to give positive ratings in all major areas for their health plan. Members are most satisfied with their specialist. Also, four of the overall ratings had significant improvement. The only area that remained constant is R*ating of Personal Doctor or Nurse.*

In comparison to 2007 results, there are several significant changes up in 2008 and a couple of significant changes down. The table below details areas of improvement or decreases from 2007 results.

Significant Changes in Member Satisfaction, 2008 vs. 2007

Ratings Areas	2008	2007	Change
Made an appointment at doctor or clinic (yes)	74%	68%	↑
Health Plan (8,9 &10)	83%	73%	↑
Tried to make an appointment to see a specialist (yes)	29%	40%	↓
Sought care, tests or treatment through health care (yes)	41%	62%	↓
Sought information/help from customer service (yes)	23%	31%	↑
Discussion about child growing/behaving (yes)	85%	71%	↑

There were no significant improvements among the five composites as shown below:



Conclusions

The survey results show that in general members' satisfaction has not changed much, with the exception of a significant improvement in their rating of the health plan

Opportunities for Improvement

Any composite, ratings or other question with a score of less than a 75% satisfaction rate or a dissatisfaction rate of greater than 25%, is considered as an opportunity for improvement. Based on the analysis of the survey responses, the following areas appear to be opportunities for improvement.

Opportunity for Improvement	Rate
Shared Decision Making	66%
Health Promotion and Education	56%

E. Actions to improve Member Satisfaction

Date Implemented	Keystone Mercy Health Plan/AmeriHealth Mercy Health Plan Member Initiatives 2007-2008
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	o Member Automated Outreach Telephone Message advising of the upcoming CAHPS survey and that their opinion is important to us. o Distribution of magnets and flyers to members during community event reminding them to schedule a well-check appointment with their PCP o An on-hold message was created to inform members of the importance of scheduling a well check appointment with their PCP o Created an employee awareness campaign with poster, message from CMO, CAHPS educational session**.**

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 2009 Annual Member Dissatisfaction Analysis examines the aggregate data from member dissatisfactions that were received from 1/1/2009 through 12/31/2009 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 2009 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 2007, 2008 and 2009.

KMHP Discussion:

- PCP, Dental and Administration represent 84.24% of all dissatisfactions in 2009.
- PCP dissatisfactions increased 105% from 2008.
  The top three reasons members filed dissatisfactions against PCPs:
  - Access represents 24%
  - Service from Providers Office represents 23%
  - Comprehensiveness of Care 7%
- Dental dissatisfactions decreased 19% from 2008.

Subject	2009 Total	Percent of Total	2009 per 1,000	2008 per 1,000	2007 per 1,000
PCP	1565	60.4%	4.82	2.51	1.74
Dental	384	14.8%	1.18	1.56	0.94
Pharmacy	29	1.12%	0.08	0.22	0.14
Admin.	232	8.96%	0.71	0.66	1.08
Spec.	151	5.83%	0.46	0.39	0.29
Vision	26	1.00%	0.08	0.05	0.10
DME	55	2.12%	0.16	0.15	0.06
Hos/Lab	97	3.74%	0.29	0.29	0.08
ER	27	1.04%	0.08	0.07	0.05
Pa.Ben.	8	0.30%	0.02	0.03	0.003
Therapy	14	0.54%	0.04	0.003	0.01
Behav Hlth	1	0.03%	0.003	0.003	0.01
Total	**2589**	**100%**	**7.92**	**5.93**	**4.5**

AMHP Discussion:

- PCP, Dental and Administrative dissatisfactions represent 81.2% of all dissatisfactions generated in 2009.
- Dental dissatisfactions decreased by 20%.
- Membership increased by 7.9%, however, dissatisfactions decreased by 12%.

Subject	2009 Total	Percent of Total	2009 per 1,000	2008 per 1,000	2007 per 1,000
Dental	79	26.9%	0.71	0.97	1.03
Admin.	45	15.3%	0.40	0.39	0.74
PCP	114	38.9%	1.03	1.27	1.17
Pharmacy	4	1.36%	0.03	0.09	0.01
Vision	11	3.75%	0.1	0.17	0.09
Specialist	24	8.19%	0.21	0.16	0.09
DME	3	1.02%	0.02	0.01	0.02
ER	1	0.34%	0.009	0.01	0
Hosp/Lab	7	2.38%	0.06	0.11	0.04
Therapy	0	0%	0	0.02	0
Pa. Benefits	4	1.36%	0.03	0	0
Behav. Hlth.	1	0.34%	0.009	0	0
Total	**293**	**100%**	**2.60**	**3.2**	**3.19**

Complaint and Grievance Analysis:
KMHP member complaint and grievance activity is listed in the following table:

Received	Annual '06		Annual '07		Annual '08		Annual '09	
	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000
Clinical Complaint Level-1	0	0	4	0.0144	7	0.0237	1	0.0033
Clinical Complaint Level-2	0	0	2	0.0072	0	0	0	0
Complaint Level-1	63	0.2307	59	0.2124	80	0.2704	81	0.2648
Complaint Level-2	20	0.0732	13	0.0468	16	0.0541	24	0.0785
Grievance Level-1	737	2.6987	594	2.1382	717	2.4232	872	2.8509
Grievance Level-2	262	0.9594	140	0.5039	158	0.534	174	0.5689
Grievance Rx Level-1	355	1.2999	396	1.4255	394	1.3316	263	0.8598
Grievance Rx Level-2	43	0.1575	62	0.2232	61	0.2062	29	0.0948
Total	1480	5.42	1270	4.57	1433	4.84	1444	4.72

In 2009, the Appeals and Grievances department received 11 additional appeals when compared to the 2008 annual. A comparison of the appeal rate based on membership for KMHP shows a decrease from 2008 to 2009 from 4.84 to 4.72 appeals/1000 members.

Complaints
Additional analysis of fist level complaints indicated that the Dental, DME, and Pharmacy categories were the most frequent categories for appeals. The dental appeal category showed a 2-percentage point decrease from 51% to 49% in level 1 complaints. DME is the second most frequent category for KMHP in 2009 with 18% of appeals in this category. Analysis of DME appeals revealed that most of the appeals are related to members who requested the deluxe or special models of equipment, which are not covered. The pharmacy appeal category showed a decrease from 25% in 2008 to 17% in 2009.

Grievances
A review of the level one grievances indicated that appeals for the Dental category remained the most frequent category. Dental grievances remained relatively the same from 2008 to 2009l.Home Health occupied the second most frequent category for level-1 grievances. Home health accounted for 23% of the level-1 grievances in 2009. Close review of service requests for skilled nursing care impacted the number of denials for service episodes and the number of service hours approved, resulting in grievance activity. DME appeals were the third most frequent category for level-1 grievances at 19% for 2009. This is a 6 percentage point increase over 2008. Pharmacy level 1 & 2 cases decreased 36%, overall. Additional medications were added to the drug formulary, which resulted in a decrease in the number of prescription denials

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

Received	Annual '06		Annual '07		Annual '08		Annual '09	
	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000	Received	rate per 1000
Clinical Complaint Level-1	0	0	0	0	1	0.0102	0	0
Clinical Complaint Level-2	0	0	1	0.0109	0	0	0	0
Complaint Level-1	12	0.1442	24	0.261	19	0.1942	40	0.3828
Complaint Level-2	0	0	5	0.0544	1	0.0102	10	0.0957
Grievance Level-1	161	1.9348	193	2.099	216	2.2079	353	3.3782
Grievance Level-2	35	0.4206	34	0.3698	30	0.3067	68	0.6508
Grievance Rx Level-1	117	1.406	139	1.5117	105	1.0733	75	0.7177
Grievance Rx Level-2	10	0.1202	12	0.1305	16	0.1636	11	0.1053
Total	335	4.02	408	4.44	388	3.97	557	5.33

In 2009 AmeriHealth Mercy's appeal rate per 1000 increased from 3.97 in 2008 to 5.33. The overall volume increased 44%. First level complaints were up 110%. First level grievances were up 63%. Second level grievances more than doubled in volume. During this period, AmeriHealth Mercy experienced a 6% increase in membership.

Complaints

A review of the level one complaints revealed that the most frequent category for complaints is Home Health at 28%. An in depth analysis was completed to the drivers behind the increase in requests, denials and subsequent complaints. The results of the analysis found that the increases were related to the use of skilled services for safety due to behavioral health issues. Skilled services are not covered for behavioral health issues.

Grievances

The dental category represented the most frequent type of AMHP level-1 grievances during 2009, accounting for 33% of the volume. Home Health and DME followed with 25% and 16%, respectively. In addition to the issue identified above, Close review of service requests for skilled nursing care impacted the number of denials for service episodes and the number of service hours approved, resulting in grievance activity. Analysis of DME appeals revealed that most of the appeals are related to members who requested the deluxe or special models of equipment, which are not covered.

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

KMHP Appointment Access

Every year, Keystone Mercy Health Plan 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 2008, utilizing self-administered questionnaires with 562 sites completing the survey.

Analysis

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.

Of the 562 PCP sites that completed the Appointment Access Survey, 97.0 % met KMHP's appointment access standards for all types of care. This rate is higher than that for previous years. With an alpha level of .05, this finding does not, however, differ significantly (P<.05) with that of 2007. The area with the lowest compliance rate (97%) is preventive care.

KMHP Appointment Access Survey Results

	2008				2007	2006	2005
Standard	Met Standard	Percent Met	Did Not Meet Standard	Percent Not Met	Percent Met	Percent Met	Percent Met
All types of care	562	97.0%	17	3.0%	96%	91%	95%
Preventive	545	97.0%	17	3.0%	96%	92%	96%
Routine	562	100.0%	0	0.0%	100%	100%	100%
Urgent	562	100.0%	0	0.0%	99%	99%	99%
Emergent	562	100.0%	0	0.0%	100%	100%	100%

The table below summarizes responses to the CAHPS member satisfaction questions that pertain to appointment availability. Although rates in all areas increased, there were no significant changes from the previous year.

MEASURE : Responses for Adult Members	2008	2007	2006
Able to get appt for regular or routine care as soon as wanted	80%	79%	79%
Able to get care for illness or injury as soon as wanted	85%	78%	75%*

* statistically significant difference from previous year. p<.05

AMHP Appointment Access

Every year, AmeriHealth Mercy Health Plan 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 2008, utilizing self-administered questionnaires. A total of 386 sites completed the survey.

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.

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

	2008				2007	2006	2005
Standard	Met Standard	Percent Met	Did Not Meet Standard	Percent Not Met	Percent Met	Percent Met	Percent Met
All types of care	375	97%	11	3%	88%	94%	78%
Preventive	375	97%	11	3%	89%	94%	84%
Routine	386	100%	0	0%	99%	100%	98%
Urgent	385	99.7%	1	0.3%	99%	100%	95%
Emergent	386	100%	0	0%	99%	100%	98%

Total PCP sites surveyed in 2008: 386

The table, below, summarizes responses to the CAHPS member satisfaction questions that pertain to appointment availability.

MEASURE: Response for Adult Members	2008	2007	2006
Able to get appointment for regular or routine care as soon as wanted	79%	80%	73%
Able to get care for illness or injury as soon as wanted	84%	80%	81%

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.

KMHP After-Hours Study

The purpose of the After-Hours Access Survey is to assess physician compliance with KMHP 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**.**

A total of 702 randomly selected PCP sites were surveyed for after-hours compliance utilizing the telephone survey methodology. The After-Hours survey was conducted between the months of October and December 2008 by TRC, an outside vendor.

It was determined that 94% of PCP sites had compliant after-hours coverage. This finding is an increase from 2007 when 88% were compliant. With an alpha level of .05 there was a significant difference in terms of the proportion of sites that were compliant with the after hours requirements. The reasons given for non-compliant PCP sites and their corresponding proportions are indicated in the table below. As in the previous three years the most cited reason for noncompliance is that no emergency instructions were provided on the answering machine.

Reasons Why PCP Sites Did Not Meet After-Hours Standards 2008, 2007 & 2006

	2008		2007		2006	
Reason	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant	#Non-Compliant	% Non-Compliant
Total	44	100%	84	100%	94	100%
= 10 Rings	13	30%	17	20%	21	22%
Answering Machine instructions to ER only	5	11%	18	21%	25	26%
No emergency instructions on answering machine	21	48%	46	55%	43	48%
Answering Service does not pick-up	5	11%	3	4%	5	5%

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 After-Hours Study

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 326 PCP sites that were successfully surveyed for after-hours compliance utilizing the telephone survey methodology.

It was determined that 97% of PCP sites had compliant after-hours coverage. This finding is a statistically significant increase from the results from 2007 (90% compliant). The reasons given for non-compliant PCP sites and their corresponding proportions are indicated in the table below.

The most sited reason for noncompliance is that no emergency instructions were provided on the answering machine.

Reasons Why PCP Sites Did Not Meet After-Hours Standards 2006, 2007 & 2008

Reason	2008		2007		2006	
	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant	# Non-Compliant	% Non-Compliant
Total	11	100%	27	100%	27	100%
> 10 Rings	1	9%	3	11%	2	7%
Answering Machine instructions to ER only	1	9%	2	7%	5	19%
No emergency instructions on answering machine	10	91%	16	59%	18	67%
Answering Service does not pick-up	1	9%	6	22%	2	7%

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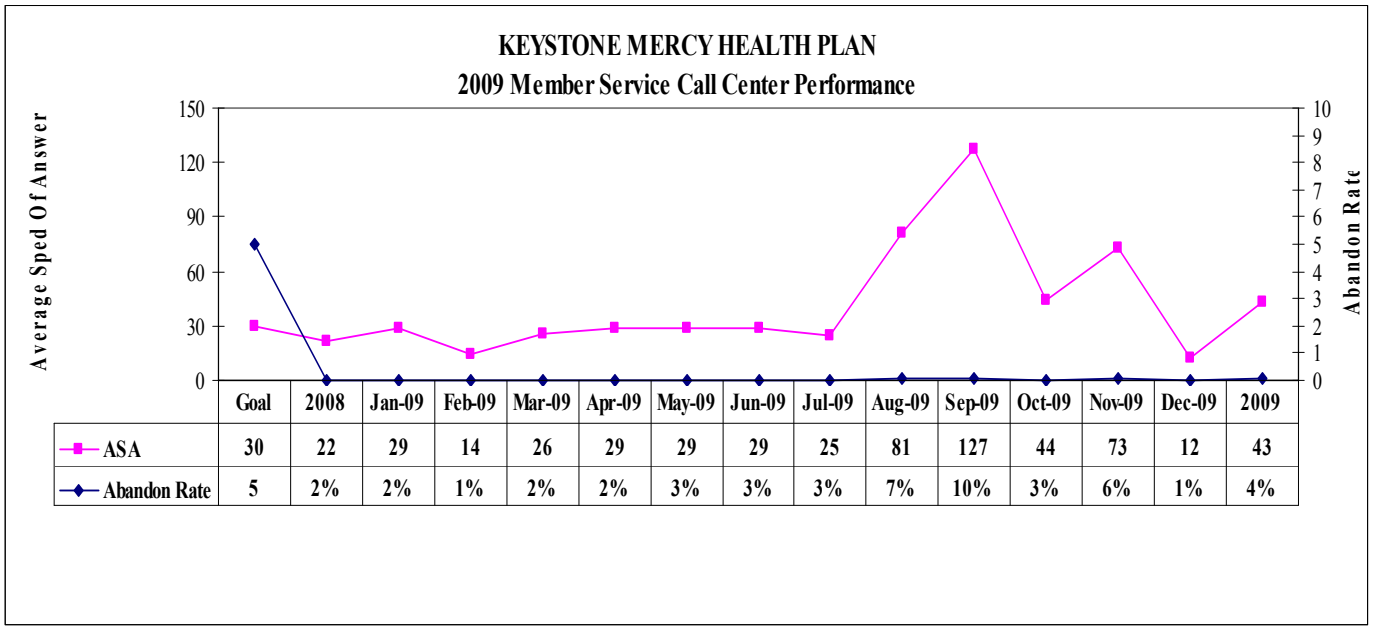
A list of the non-compliant PCP practice sites was forwarded to Provider Contracting for follow-up. These sites are also automatically added to the list to be surveyed the following year for further monitoring.

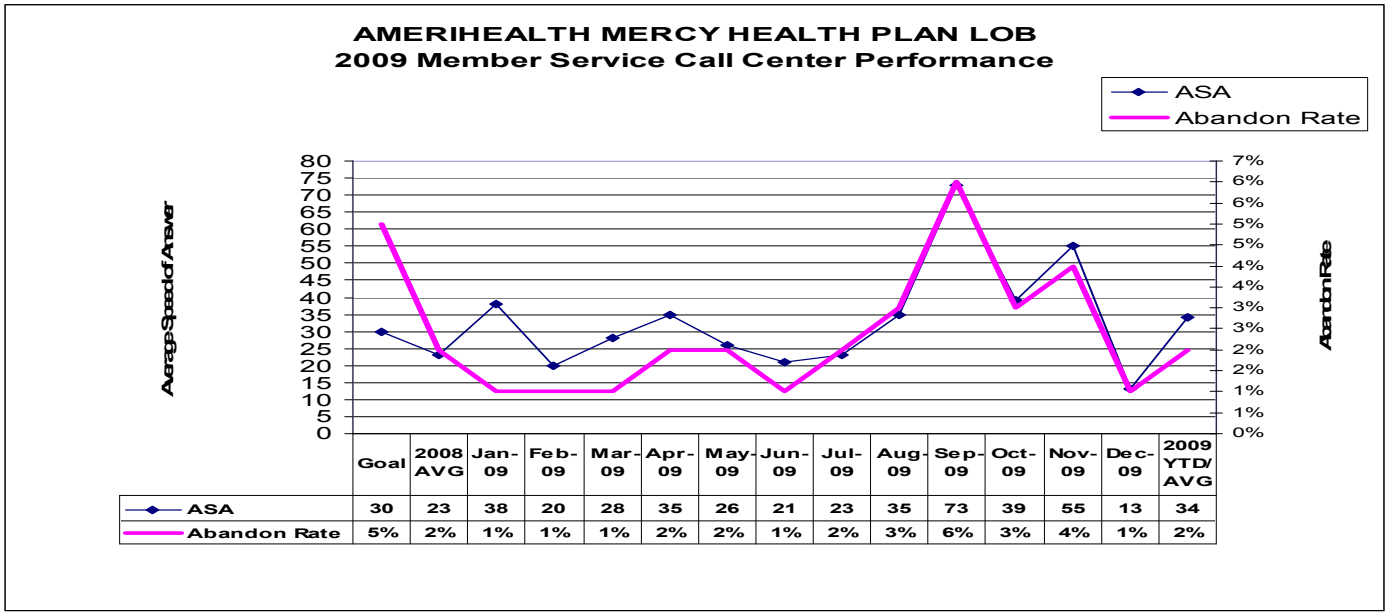
Member Service Phone Availability

The universe for the Member Service telephone accessibility measure consisted of all calls that came into AMHP or KMHP between January 1, 2009 and, December 31, 2009. No sampling was used.



	Goal	2008	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	2009
ASA	30	22	29	14	26	29	29	29	25	81	127	44	73	12	43
Abandon Rate	5	2%	2%	1%	2%	2%	3%	3%	3%	7%	10%	3%	6%	1%	4%

KMHP did not meet the ASA performance metric of 30 seconds for August, September, October and November. Influencing factors included the introduction of Care Gap workflows and a new call tracking system (EXP) as well as staffing. The abandonment rate met the performance goal of less than 5% for all months.



	Goal	2008 AVG	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	2009 YTD/ AVG
ASA	30	23	38	20	28	35	26	21	23	35	73	39	55	13	34
Abandon Rate	5%	2%	1%	1%	1%	2%	2%	1%	2%	3%	6%	3%	4%	1%	2%

AMHP did not meet the ASA performance metric of 30 seconds for 6 out of 12 months. Contributing factors included the introduction of Care Gap workflows and the new call tracking system (EXP), as well as staffing. The abandonment rate goal of less than 5% was met for all months.

The following actions were taken to improve performance:

- 26 hire-ahead associates are now supporting the Member Services lines.
- Vacant Member Services positions were backfilled.
- Buddy coaching sessions were implemented to increase the confidence level of new associates.
- The management team is working closely with the Member Services staff to resolve EXP system issues as they arise.
- Overtime was offered during peak hours to assist with telephone calls and EXP queues.
- Enhancements were made to the IVR Self Service System used to verify member eligibility, and order ID cards, member handbooks and provider directories.

H. Service Quality Improvement Initiatives

The following two service quality initiatives continued in 2009:

- Increasing Access to Dental Care
- Improving Access to Care (CAHPS)

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 center on member outreach. Interventions for 2009 include:

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 • Zoo-mobility event – dental screening for Special Needs children • 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	2008	2007	2006
CAHPS	**Received care from dentist**	**36%**	**36%**	**33%**
	Rating of dental care (High)	**61%**	**53.2%**	**68%**
HEDIS	**Annual Dental Visit (4-21)**	**47.6%**	**43.1%**	**43.2%**
Internal	**Dental Dissatisfactions/10,000 members**	**9.11**	**13.52**	**12.90**

KMHP saw a statistically significant increase in annual dental visits and high rating of dental care and a statistically significant decrease in dental dissatisfactions.

AMHP Results

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

AMHP saw a statistically significant increase in annual dental visits and high rating of dental care and a statistically significant decrease in dental dissatisfactions.

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:

- 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.

Improving Perception Around Access (KMHP)

Analysis of the 2008 member dissatisfaction data 2008 indicated that 17% of member dissatisfactions were related to PCP access. This is a 47% increase in volume from 2007.

The KMHP CAHPS survey conducted in 2009 resulted in CAHPS scores that fall on the 50th Percentile for members' experience with Getting Needed Care and Getting Care Quickly.

Member dissatisfaction with Access issues related to PCPs and specialists was identified as an opportunity for improvement.

KMHP	# Member Dissatisfactions related to PCP Access/10,000 members	Got Care right away for an illness/ injury (CAHPS Adult)	Got care right away for an illness / injury (CAHPS Child	Got appt. for routine care as soon as needed (CAHPS Adult)	Got appt. for routine care as soon as needed (CAHPS Child)	Rating of personal nurse/ doctor (CAHPS Adult)	Rating of personal nurse/ doctor (CAHPS Child
2007	NA	77.3% (75th Percentile)	90.3% (Baseline)	78.6% (75th Percentile)	86.2% (Baseline)	78.08% (75th Percentile)	88% (Baseline)
2008 Goal		81.16% 90th Percentile	94.1%	82.53% 90th Percentile	90.51%	83.03% 90th Percentile	92.4%
2008	10.37% (Baseline)	82.29% (50th Percentile)	84.5%	78.68% (50th Percentile)	73.7%	79.40% (75th Percentile)	85.9%
2008 Comment		Goal not met	Goal not met	Goal not met	Goal not met		Goal not met
2009	11.55%						

Improving Perception Around Access (AMHP)

Analysis of member dissatisfaction data from 2008 indicated that Access is ranked as the third highest dissatisfier and has increased 118% in volume since 2006. Access dissatisfactions generated against PCPs represent 77% of all Access dissatisfactions.

The KMHP CAHPS survey conducted in 2009 resulted in CAHPS scores that fall on the 50th Percentile for members' experience with Getting Needed Care and Getting Care Quickly.

Member dissatisfaction with Access issues related to PCPs and specialists was identified as an opportunity for improvement

AMHP	# Member Dissatisfactions related to PCP Access/10,000 members	Got Care right away for an illness/ injury (CAHPS Adult)	Got care right away for an illness/ injury (CAHPS Child	Got appt. for routine care as soon as needed (CAHPS Adult)	Got appt. for routine care as soon as needed (CAHPS Child)	Rating of personal nurse/ doctor (CAHPS Adult)	Rating of personal nurse/ doctor (CAHPS Child
2007	3.63%	79.8% (75th Percentile)	86.7%[h]	80.3% (50th Percentile)	86.2% (75th Percentile)	79.8% (75th Percentile)	84%
2008 Goal	3.44%	83.79%	91.03%	84.3%	90.51%	83.79%	88.2%
2008	4.27%	81.72% (50th Percentile)	86%	78.20% (50th Percentile)	73.7%	76.06% (25th Percentile)	83%
2008 Comment	Goal not met	Goal not met	Goal not met	Goal not met	Goal not met	Goal not met	
2009							

Interventions that occurred for both AMHP and KMHP in 2009:

- Conducted audits (Director of Quality Operations) on 20 dissatisfactions a month, gives feedback to Operations and Pharmacy Management so they deliver individual coaching and training sessions
- Scheduled biweekly meetings for Member Dissatisfaction Task Force to complete follow up mechanisms for providers with high rates of dissatisfactions
- Revised the biannual report that captures PCPs who had a dissatisfaction generated against them, the panel count and reason for dissatisfaction. A statistical analysis identifies outliers from the report and individual dissatisfactions. This process links dissatisfactions to recredentialing. Threshold was developed and implemented in 2005, but original methodology was not capturing enough outliers.
- Revised Training Module and deliver training to Member/Provider Services and Quality auditing
- Placed training module on Online Help for Representatives to access at any time
- Developed and deliver formal Dissatisfaction training annually, and ongoing training in staff meetings
- Enhanced reports to include members' county, language, special needs, ethnicity in order to identify recruitment needs, disparities

- Conducted further research on *Access dissatisfactions*. Conduct follow up member survey. Conduct gap analysis of provider directory
- Compared threshold and follow up mechanism for providers with high rates of member dissatisfactions to P4P Program.
- Linked PCP changes to dissatisfactions when appropriate and identify trends
- Conducted brainstorming sessions with Provider Network Management and Provider Contracting about how to make PCPs more receptive to communicating
- Developed strategies around outliers who generate high rates of member dissatisfactions related to access
- Identified PCPs with the highest rate of *Access* dissatisfactions generated against them. Provide detailed information to Provider Network Management and develop a strategy to address with PCPs.

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:

2009	Keystone Mercy	AmeriHealth Mercy	Total
Referrals	416	181	597
Accepted Cases	215	85	300
Declined Cases	201	96	297
Closed cases	223	74	297

Distribution of Outcomes of Sentinel Events and Member Concerns:

2009 Outcomes	Keystone Mercy	AmeriHealth Mercy
NQC – No Quality of Care Concern	**192**	**70**
PEO – Provider Education Opportunity	**31**	**4**
PRC – Peer Review Committee	**0**	**0**
F – Failure to reply to request for more information	**0**	**0**
Cases Pending Outcome	**129**	**38**

Additional 2009 Quality of Care activities consisted of focus studies and ad-hoc reviews, as described below:

	Review Type	Quality of Care Activity	Outcome
Keystone Mercy	**Focus Study**	**Review of Physician Practice issue. (identified through a QOC review)**	**Medical record Standards not met. Provided Medical Record Standards & Guideline Education.**
Keystone Mercy and AmeriHealth Mercy	**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.**
Keystone Mercy and AmeriHealth Mercy	**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.**
Keystone Mercy and AmeriHealth Mercy	**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 2009.

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.

Keystone Mercy 2009	EXTERNAL AUDIT RESULTS	QUALITY REVIEW TIMELINESS
	Audit Score	**Internal Monitoring**
1st qtr	100%	97%
2nd qtr	100%	87%
3rd qtr	100%	98%
4th qtr	100%	100%

AmeriHealth Mercy 2009	EXTERNAL AUDIT RESULTS	QUALITY REVIEW TIMELINESS
	Audit Score	**Internal Monitoring**
1st qtr	100%	96%
2nd qtr	100%	65%
3rd qtr	100%	90%
4th qtr	100%	100%

B. KMHP Practitioner and Provider Satisfaction

Out of the 1,249 physicians surveyed, 232 were completed and returned, yielding a response rate of 19% a decrease of 16% in 2008. The 2008 Physician Satisfaction Survey indicates that 87.5% of practitioners are satisfied with Keystone Mercy Health Plan. This is in line with the 2008 result of 89%.

The Provider Satisfaction Survey was sent to hospital and ancillary providers. A total of 484 surveys were sent. There were 68 surveys returned yielding a response rate of 16% unchanged from 2008. In the 2008 survey, 42 out of 60 (63%) service indicators achieved the threshold of 85% favorable response. This is a small increased from the previous year where 56% of the service indicators achieved the benchmark.

Keystone Mercy utilizes questions in the provider satisfaction survey to assess provider use and satisfaction with the KMHP website. The results of the survey indicate that 98% of our providers use the Internet a significant increased from 2007 only 72% of providers report using it.

Opportunities for improvement:

- Knowing their assigned Provider Account Executive (Field Representative).

C. AMHP Practitioner and Provider Satisfaction

Out of the 464 physicians surveyed, 74 were completed and returned, yielding a response rate of 16%. The response rate remained the same as in the previous two years (16%).

The Practitioner Satisfaction Survey indicates that almost all 86.6% of practices are satisfied with AmeriHealth Mercy Health Plan. There was no statistically significant difference from the previous year.

Out of the 367 providers surveyed, 34 were completed and returned, yielding a response rate of 9. The response rate decreased from the previous year (14%).

Opportunities for Improvement:

- Comprehensiveness of the drug formulary -- this indicator had the lowest score on the survey for two years in a row. Approximately 74% of respondents provided a favorable rating for this indicator slightly up from last year.
- Consistency of decisions made by AMHP medical directors to approve or deny authorizations.
- The survey should be more and more internet based.

In addition to an increased focus on visits to practitioners and routine dialogue with providers, several initiatives were implemented to increase satisfaction with KMHP and AMHP:

- Pay-for-performance programs were implemented for both plans. These programs allow practitioners to earn additional revenue dollars for meeting quality and effectiveness goals. The process is transparent, with the methodology and possible payouts disclosed to providers at the onset.
- A searchable formulary was added to the Provider web-site. This allows providers to have up-to-date information on the formulary status of a medication, instead of relying on periodic newsletter communication or printed formulary mailings.
- Plan access was implemented through Navinet, and internet application widely used by practitioners and providers in the state. By making KMHP and AMHP information available over Navinet, office staff can use one portal to access multiple health plans, decreasing their workload.
- KMHP and AMHP contracted with the Council for Affordable Quality Healthcare (CAQH) for access to credentialing information. Practitioners submit their information to CAQH one time, where it can be accessed by participating health plans, eliminating the need for the practitioner to submit the same information to multiple entities.
- A phone queue was implemented to triage incoming calls related to the credentialing process. This improved the ability of the caller to interact with a live person at the time of the call.

D. Clinical Practice Guidelines

During 2009 the following updated or additional clinical practice guidelines were approved for KMHP and AMHP:

Guideline Topic	Guideline Source
Diabetes	**American Diabetes Association - Clinical Practice Recommendations 2009**
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.**

Guideline Topic	Guideline Source
HIV	***Pennsylvania Medicaid*** **- Pennsylvania Medicaid Adult HIV Clinical Practice Guideline, Volume 5, Number 1, 2008-2009**
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.**

The following existing clinical practice guidelines were reviewed and approved for both KMHP and AMHP:

Guideline Topic	Guideline Source
Sickle Cell Disease	**National Heart, Lung, and Blood Institute: Division of Blood Diseases and Resources - The Management of Sickle Cell Disease**
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)**
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**
Heart Failure	**American College of Cardiologists and the American Heart Association - ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult, 2005**
Asthma	**Global Initiative for Asthma (GINA) - Global Strategy for Asthma Management and Prevention** **National Institute of Health (NIH) - Expert Panel Report 3 (EPR3): Guidelines for the Diagnosis and Management of Asthma**

E. Member Safety

Several initiatives were completed for the 2008 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	**Interventions were implemented as planned. Barriers to effectiveness include the reliance on paper-based communication. However, paper remains a relatively inexpensive**	• **Continue current paper-based interventions**

<table>
<tr><th>Activity</th><th>Analysis & Barriers</th><th>Next Steps</th></tr>
<tr><td>• Recall notifications
• DUR</td><td>mechanism to reach large numbers of people and document that notification occurred.</td><td></td></tr>
<tr><td>Credentialing of practitioners and providers against DPW, Plan and NCQA requirements
<table><tr><td>Cred & Recred</td><td>KMHP</td><td>AMHP</td></tr><tr><td>Practitioners</td><td>2,886</td><td>1,979</td></tr><tr><td>Facilities and Providers</td><td>44</td><td>49</td></tr></table></td><td>Credentialing and recredentialing remains an effective mechanism to periodically review provider and practitioner qualifications.</td><td>Continue current process</td></tr>
<tr><td>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</td><td>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.</td><td>• Continue current practice
• Expand measurement activities to include focused interventions based on results</td></tr>
<tr><td>Playground Build
Toby Farms</td><td>Safe play areas reduce the number of preventable injuries sustained by children.</td><td>Continue to partner with community agencies to build more playgrounds</td></tr>
</table>

F. Childhood Obesity

As discussed on page X, KMHP initiated two new programs with La Forteleza and VigorWorks. Additionally, KMHP continues to be represented on the leadership council of the Pennsylvania Advocates for Nutrition and Activity (PANA). PANA is a statewide organization supported by a coalition of more than 500 public, private, academic, professional and volunteer groups, working to promote policies and environments that support healthy eating and activity. PANA's efforts include outreach and education, advocacy, and evaluation in three priority areas: Community, School, and Healthcare Settings. A partnership with Mercy Circle of Care did not enroll any children in 2009.

A second partnership with Mercy Circle of Care continued through the Healthy Hoops Family Fit Program, for families who participate in Healthy Hoops- an annual Philadelphia event that helps children with asthma manage their condition, weight and prevent cardio-vascular disease. This

program focuses on fun fitness activities and at the same time provided important information on asthma, nutrition, healthy cooking and cardiovascular activity. Outcome collection is in progress but preliminary results indicate that the fitness extension of this program is successful.

Community events such as the Health Ministry Program incorporated nutritional education, exercise as well as blood pressure and body mass index measurement.

G. Reducing Disparities at the Practice Sites Initiative:
This Initiative began in the 4th quarter of 2008 and continued in 2009. KMHP joined the Reducing Disparities at the Practice Sites (RDPS) Initiative, along with the other two SEPA HealthChoice 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 "high-opportunity" primary care practices where the greatest impact can be made. The following criteria was used to identify these practices:

- Large volume of Medicaid patients;
- Racially and ethnically diverse patient panel;
- Large volume of patients with chronic conditions; and
- Opportunities to improve performance based on national quality indicators.

With technical support from CHCS and experts in the field, teams are assisting practice sites to implement interventions focused on:

- 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.

Although 14 practices were originally identified in 2008, only seven became active participants in 2009. A Practice Coach was hired in July by DPW to assist with practice transformation and member contact. A registry, *Reach My Doctor,* was introduced to the practices to track member outcomes. The Practice Coach and the Plan's Diabetes Case Manager conducted weekly calls to collaborate on members' barriers to care. In late 2009, the Second Annual Meeting was held where Best Practices were shared.

H. 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.

I. The QI Program Description
The 2009 QI Program Description was approved by the Quality Improvement Committee. The following components were updated:

- Member Demographic data
- Committee compositions and descriptions
- Staffing data.

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. One delegate's contract (Alere) was terminated in July1, 2009.

Organization	Delegated Functions	Score	Action Plan
University of Pennsylvania Health System (UPHS)	Credentialing Files	100%	No
	Re-credentialing Files	100%	
	Credentialing Documents	100%	
Doral Dental	Credentialing Documents	100%	No
	Utilization Management Documents	100%	
	Quality Management Documents	100%	
	Utilization Management Files	100%	
	Quality Management Files	100%	
	Credentialing Files	99.6%	
	Recredentialing Files	99,8%	
Nemours Group	Credentialing Files	99%	No
	Re-credentialing Files	99.8%	
	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%	
	Quality Files	100%	
Hershey Medical Center	Credentialing Files	99%	No
	Recredentialing Files	100%	
	Document Review	100%	
Prime Source	Credentialing Files	96%	No
	Recredentialing Files	99%	
	Document Review	100%	

Organization	Delegated Functions	Score	Action Plan
South Central Preferred (WellSpan)	Credentialing Files	100%	No
	Recredentialing Files	100%	
	Document Review	99%	
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	97%	
St. Lukes PHO	Credentialing Files	99%	No
	Recredentialing Files	99%	
	Document Review	100%	
ProgenyHealth, Inc.	UM File Review	96% URAC Accreditation for Health Utilization Management	No
	CM File Review	99%	

B. New Delegates
Four new delegates were approved in 2009. Their pre-delegation audit results follow:

1. Berkshire Health Partners pre-delegation audit for credentialing was conducted in December, 2008. The audit result exceeded the required passing score of 95%:

Category	Score
Document Review	**100%**
Credentialing Files	**96%**
Recredentialing Files	**100%**

2. Jefferson University Physicians pre-delegation audit for credentialing was conducted in October 2009. The audit results exceeded the required passing score of 95%:

Category	Score
Document Review	**100%**
Credentialing Files	**100%**
Recredentialing Files	**99.8%**

3. PerformRx's pre-delegation audit for pharmacy benefit management was conducted in December 2009. PerformRx is URAC accredited as a Pharmacy Benefit Manager (PBM) through 11/1/2010. The denial file audit results did not meet the passing score of 95% and a Corrective Action Plan was initiated.

Category	Score
Document Review	98%
Denial File Review	71.89%

A Corrective Action Plan was initiated based on the denial file review results not meeting the passing score of 95%.

4. Take Care Health's pre-delegation audit for credentialing was conducted in December 2009. The audit results exceeded the required passing score of 95%:

Category	Score
Document Review	**100%**
Credentialing Files	**98%**
Recredentialing Files	***NA**

*No recredentailing files were available to review as this is a new organization.

X. STRENGHTS, OPPORTUNITIES AND GOALS

Overall, the KMHP/AMHP Quality Improvement Program operated effectively and met its goals during 2009. 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 2010.

A. Major Strengths and Accomplishments of the 2009 QI Program

The Plan demonstrated strengths and accomplishments through the 2009 QI Program, including,

- Maintained NCQA Excellent Accreditation Status
- Achieved URAC Disease Management Accreditation for Chronic Obstructive Pulmonary Disease
- Achieved URAC Re-Accreditation for Case Management
- Achieved significant improvement in numerous HEDIS measures
- Revamped the medical record review process for efficiency and cost effectiveness
- Enhanced Credentialing software system to capture additional fields (Board program name, sub specialty, board certification expiration date, hospital accreditation status, accreditation body and recredentialing to credentialing event
- Verified all Board Certifications to meet revised NCQA requirements
- Participated in the Reducing Disparities at the Practice Sites (RDPS) Initiative with DPW and the three SE HealthChoices Plans and the Center for Health Care Strategies
- Participated in the HEALTHCHOICES/HealthConnections Initiative with DPW and the Center for Health Care Strategies
- Expanded the Care Gaps functionality and process to practitioners through the provider portal and the Member Services Call Center

- Achieved 100% on the Quality of Care External Audits conducted by Independence Blue Cross
- Improved KMHP national ranking from 34th to 26th in US News and World Reports ranking of national Medicaid Plan. AMHP maintained their 25th national Medicaid Plan ranking.
- Initiated planning for a Health Care Equities project focused on improving the integrity of race and ethnicity data used for program planning and disparity analysis.

B. Opportunities/challenges for the Year 2010

Several opportunities for improvement and challenges exist and will be addressed through initiatives and undertakings in the year 2010:

- Maintain Excellent NCQA Accreditation Status
- Conduct gap analysis for the 2010 NCQA standards
- Conduct gap analysis for the 2011 URAC Disease Management re- accreditation
- Evaluate the Pay for Performance Practitioner programs
- Maximize the CAQH process and credentialing software importer functionality
- Evaluate and explore expanding the Childhood Obesity Programs/Initiatives
- Continue collaborative effects with behavioral health organizations
- Continue participation with the RDPS and HEALTHCHOICES/HealthConnections Initiatives
- Increase the availability of member clinical information to providers at the point of service
- Disseminate the care gap information to providers and members at actual points of encounter
- Further enhance and refine the HEDIS data collection and analysis process, including completion of the in-sourcing process of the Catalyst transition
- Increase HEDIS results to the next national Medicaid Percentile (12 measures for KMHP and 16 measures for AMHP)
- Achieve significant improvement in two CAHPS Composites: Getting Needed Care and Getting Care Quickly.
- Improve the rank of AMHP and KMHP to within the Top 20 Medicaid Plans

C. 2009/2010 Clinical and Service Quality Goals

Using data from HEDIS, EQR and internal measures, clinical and service quality goals were set for 2009. Initiatives to reach these goals will be implemented during 2010, with measurement and reporting in 2011.

Keystone Mercy Health Plan
The following goals were set for Keystone Mercy Health Plan:

2009 HEDIS Results with 2010 Goals for KMHP

MEASURE	2009 (08 cy) Rate	National Medicaid Percentile Achieved (2009	2009 Goal	2010 Goal
Breast Cancer Screening	**52.28%**	**50th**	50th National Medicaid Percentile	75th National Medicaid Percentile
Cervical Cancer Screening	**70.49%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Chlamydia Screening in Women > Total	**59.18%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
HbA1C Screening	**78.59%**	**25th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Poor HBA1C Control**	**38.93%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Diabetes LDL C < 100	**40.88%**	**75th**	75th National Medicaid Percentile	90th National Medicaid Percentile
Timeliness of Prenatal Care	**79.81%**	**25th**	25th National Medicaid Percentile	50th National Medicaid Percentile
PostPartum Care	**55.72%**	**25th**	50th National Medicaid Percentile	50th National Medicaid Percentile
Frequency of Ongoing Prenatal Care: >81% of Expected Visits	**65.94%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Annual Dental Visits for > Combined Ages 2-21	**47.68%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Chol Mgmt-Received LDL-C Screening	**81.51%**	**50th**	75th National Medicaid Percentile	75th National Medicaid Percentile
Chol Mgmt-	**46.96%**	**50th**	50th	75th

MEASURE	2009 (08 cy) Rate	National Medicaid Percentile Achieved (2009	2009 Goal	2010 Goal
Screening Revealed Low LDL-C levels <100			National Medicaid Percentile	National Medicaid Percentile
Adolescent Well Visits	**60.83%**	**90th**	75th National Medicaid Percentile	90th National Medicaid Percentile
Controlling High Blood Pressure	**66.58%**	**90th**	50th National Medicaid Percentile	90th National Medicaid Percentile
Emergency Room Utilization Rate**	**65.77/K**	**50th**	62.46/K	50th National Medicaid Percentile

** Lower results are better for this measure.

AmeriHealth Mercy Health Plan

The following goals were set for AmeriHealth Mercy Health Plan:

2009 HEDIS Results with 2010 Goals for AMHP

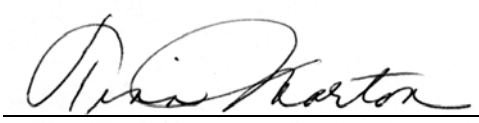
MEASURE	2009 (08 cy) Rate	National Medicaid Percentile Achieved (2009)	2009 Goal	2010 Goal
Breast Cancer Screening	**59.17%**	**75th**	**75th National Medicaid Percentile**	**Increase to 90th percentile**
Cervical Cancer Screening	**73.48%**	**75th**	**76.90%**	**Increase to 90th percentile**
Chlamydia Screening in Women > Total	**45.48%**	**10th**	**25th National Medicaid Percentile**	**Goal increase to 25th percentile**
HbA1C Screening	**83.21%**	**50th**	**75th National Medicaid Percentile**	**Goal increase to 75th percentile-~2%**
Poor HBA1C Control**	**39.66%**	**50th**	**50th National Medicaid Percentile**	**Increase to 75th percentile**
Diabetes-LDL Screening	**80.29%**	**50th**	**50th National Medicaid Percentile**	**Increase to 90th percentile~2%**

MEASURE	2009 (08 cy) Rate	National Medicaid Percentile Achieved (2009)	2009 Goal	2010 Goal
Diabetes- LDL-C < 100	42.58%	75th	75th National Medicaid Percentile	Goal increase to 90th percentile-~5%
Timeliness of Prenatal Care	89.29%	50th	75th National Medicaid Percentile	Goal increase to 75th percentile~.05%
Frequency of Ongoing Prenatal Care: >81% of Expected Visits	78.10%	75th	75th National Medicaid Percentile	Goal increase to 90th percentile
PostPartum Care	67.40%	50th	65.87%	Goal increase to 75th percentile – ~2%
Annual Dental Visits for > Combined Ages 2- 21 *	40.81%	25th	50th National Medicaid Percentile	Goal increase to 50th percentile
Chol Mgmt-Screening Revealed Low LDL-C levels <100	49.57%	75th	75th National Medicaid Percentile	Goal increase to 90th percentile
Chol Mgmt-Received LDL-C Screening	86.25%	75th	90.58%	Goal increase to 90th percentile - ~1%
Adolescent Well Visits	56.27%	75th	57.99%	Goal increase to 90th percentile
Controlling High Blood Pressure	63.92%	75th	65.14%	Goal increase to 90th percentile
Emergency Room Utilization Rate **	80.44/K	90th	75.21/K	Goal decrease by 10%

** Lower results are better for this measure

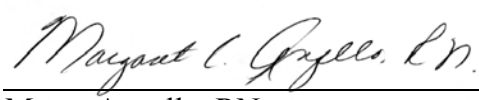
XI. Acknowledgement and Approval

This Quality Improvement Program Evaluation is submitted by:



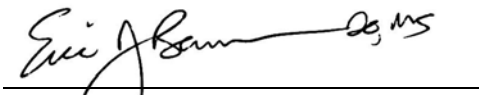
Tina Morton, RN, BSN, CPHQ — 4/8/2010
Sr. Director, Quality Management — Date

Approvals:



Marge Angello, RN — 4/8/2010
Executive Director — Date

Karen E. Michael, RN, MSN, MBA — 4/8/2010
Vice President, Clinical Services — Date



Eric Berman, DO — 4/8/2010
Chief Medical Officer — Date

Appendix A – HEDIS RESULTS: Measurement Year 2003- 2007[1]

KMHP HEDIS: Immunization Status

Childhood Immunization Status	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
DT/DTP/DtaP	80.00%	81.27%	**86.62%**	84.22%	79.51%	25th
OPV/IPV	89.53%	91.24%	92.94%	94.43%	91.53%	50th
Measles, Mumps, Rubella	89.53%	**93.67%**	95.38%	93.50%	91.80%	50th
H Influenza Type B	79.53%	**92.94%**	94.65%	92.81%	93.72%	25th
Hepatitis B	83.26%	88.81%	**94.89%**	95.82%	92.35%	50th
Chicken Pox	89.07%	91.73%	94.65%	93.04%	91.26%	25th
Pneumococcal vaccine	N/A	55.72%	**80.05%**	82.13%	81.42%	50th
Combo 2 (All but Pneumococcal)	64.88%	**72.02%**	**82.97%**	80.05%	78.14%	50th
Combo 3 (All)	N/A	48.18%	**74.94%**	75.41%	76.50%	75th

KMHP HEDIS: Respiratory Treatment

Respiratory Treatment	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Appropriate Treatment for Children w/ Upper Respiratory Infection	83.32%	**84.49%**	84.80%	85.15%	85.84%	50th
Appropriate Testing for Children with Pharyngitis	50.91%	49.52%	47.50%	49.02%	**52.25%**	10th

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

AMHP HEDIS: Immunization Status

Childhood Immunization Status	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
DT/DTP/DtaP	76.10%	81.02%	83.33%	79.32%	82.37%	50th
OPV/IPV	**85.15%**	87.35%	**92.36%**	89.54%	92.63%	50th
Measles, Mumps, Rubella	87.47%	**92.46%**	93.75%	**88.81%**	91.84%	25th
H Influenza Type B	**80.05%**	**90.02%**	90.74%	88.56%	**96.32%**	50th
Hepatitis B	78.89%	**87.10%**	**92.13%**	92.70%	95.26%	75th
Chicken Pox	83.29%	**89.54%**	92.36%	**86.86%**	90.79%	25th
Pneumococcal vaccine	NA	52.55A	**73.61%**	70.80%	**79.74%**	50th
Combo 2 (All but Pneumococcal)	**62.65%**	**73.24%**	77.31%	72.75%	**80.00%**	50th
Combo 3 (All)		47.93%	**66.44%**	64.23%	**74.74%**	50th

AMHP HEDIS: Respiratory Treatment

Respiratory Treatment	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Appropriate Treatment for Children w/ Upper Respiratory Infection	79.97%	78.91%	78.94%	**82.54%**	81.67%	25th
Appropriate Testing for Children with Pharyngitis	38.10%	35.78%	**45.08%**	**41.34%**	**44.38%**	10th

KMHP HEDIS: Women's Health

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Breast Cancer Screening	58.47%	**50.57%**	**44.72%**	**46.72%**	52.28%	50th
Cervical Cancer Screening	65.35%	**58.39%**	**63.26%**	67.45%	70.49%	50th
Chlamydia Screening						
16-20 Years	42.89%	**44.48%**	**51.41%**	**50.42%**	57.76%	50th
21-26 Years	**47.30%**	48.57%	**55.68%**	**53.70%**	60.93%	50th
Total	**45.15%**	**46.58%**	**53.57%**	**52.07%**	**59.18%**	50th

AMHP HEDIS: Women's Health

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Breast Cancer Screening	65.20%	**56.34%**	**51.32%**	**54.89%**	**59.17%**	75th
Cervical Cancer Screening	62.24%	63.99%	**67.521%**	73.24%	73.48%	75th
Chlamydia Screening						
16-20 Years	**19.76%**	**30.16%**	**37.68%**	39.76%	42.05%	10th
21-26 Years	**20.57%**	**27.72%**	**42.79%**	45.02%	**49.55%**	10th
Total	***20.19%***	***28.89%***	***40.29%***	***42.44%***	**45.48%**	10th

KMHP HEDIS: Cardiovascular Health

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Controlling High Blood Pressure	77.53%	77.86%	**59.12%**	64.40%	66.58%	90th
Received LDL-C Screening	62.94%	67.64%	76.64%	80.14%	81.51%	50th
Screening Revealed Low LCL-C Levels <100	32.63%	34.79%	32.12%	**39.25%**	**46.96%**	50th

AMHP HEDIS: Cardiovascular Health

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Controlling High Blood Pressure	**86.77%**	***85.16%***	**58.76%**	62.04%	63.92%	75th
Received LDL-C Screening	64.12%	71.29%	86.31%	86.27%	86.25%	75th
Screening Revealed Low LCL-C Levels < 100	28.24%	36.25%	36.51%	42.25%	49.57%	75th

KMHP HEDIS: Comprehensive Diabetes Care

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
HBA1C Testing	**77.80%**	76.89%	76.16%	80.6%	78.59%	25th
Poor HBA1C Control**	46.06%	42.58%	**54.99%**	**44.57%**	38..93%	50th
Eye Exam	51.31%	47.69%	41.61%	47.34%	46.96%	25th
LDL-C Screening	81.62%	86.37%	**70.80%**	**78.98%**	75.67%	25th
LDL-C Level <100	**31.03%**	31.39%	32.36%	35.57%	40.88%	75th
Monitoring for Nephropathy	**48.45%**	41.85%	80.78%	75.52%	80.05%	50th
Blood Pressure <130/80	NA	NA	24.57%	25.87%	27.74%	25th
Blood Pressure <140/90	NA	NA	53.77%	49.19%	**58.64%**	25th

** Lower numbers are better for this measure

AMHP HEDIS: Comprehensive Diabetes Care

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
HBA1C Testing	**82.52%**	82.48%	80.97%	83.45%	83.21%	50th
Poor HBA1C Control**	38.93%	36.50%	**50.66%**	47.93%	**39.66%**	50th
Eye Exam	62.94%	58.88%	60.18%	61.31%	66.67%	75th
LDL-C Screening	**87.65%**	90.75%	**77.43%**	78.10%	80.29%	75th
LDL-C Level <100	30.07%	30.41%	27.65%	**35.04%**	**42.58%**	75th
Monitoring for Nephropathy	**52.91%**	46.23%	77.65%	80.29%	82.73%	75th
Blood Pressure <130/80	NA	NA	33.63%	36.98%	34.79%	50th
Blood Pressure <140/90	NA	NA	63.94%	64.96%	67.40%	75th

** Lower numbers are better for this measure

KMHP HEDIS: Use of Appropriate Medications for Asthma

AGE RANGE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
5 – 9 Years	74.47%	**92.12%**	92.22%	93.13%	93.98%	50th
10 – 17 Years	72.04%	**91.69%**	91.50%	92.13%	92.64%	75th
18 – 56 Years	75.14%	**87.46%**	87.56%	88.97%	89.58%	75th
All Ages	74.17%	**89.43%**	89.87%	**90.99%**	91.69%	75th

AMHP HEDIS: Use of Appropriate Medications for Asthma

AGE RANGE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
5 – 9 Years	68.72%	**92.86%**	92.67%	93.25%	93.95%	50th
10 – 17 Years	69.49%	**91.93%**	90.62%	91.03%	92.94%	75th
18 – 56 Years	71.60%	**87.61%**	88.65%	89.71%	89.35%	75th
All Ages	70.49%	***89.59%***	90.13%	90.94%	91.49%	75th

KMHP HEDIS: Access to Care

Adult Access to Preventative & Ambulatory Health Services	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
20 – 44 Years	**79.29%**	**80.19%**	**83.71%**	**83.19%**	**82.23%**	50th
45 – 64 Years	**85.17%**	**86.48%**	**89.57%**	89.17%	89.03%	50th
65 + Years	**75.86%**	76.60%	**86.78%**	88.04%	86.38%	25th
Children's Access to PCP						
12 – 24 Months	94.52%	**95.16%**	95.34%	95.45%	95.39%	25th
25 – 6 Years	**80.47%**	**81.92%**	**83.44%**	**84.44%**	**85.40%**	10th
7 – 11 Years	**81.73%**	81.89%	**83.41%**	**85.25%**	**87.16%**	25th
12 – 19 Years	**78.22%**	78.79 %	**79.93%**	**80.64%**	**84.09%**	25th

AMHP HEDIS: Access to Care

Adult Access to Preventative & Ambulatory Health Services	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
20 – 44 Years	**79.93%**	80.13%	**83.57%**	**82.43%**	81.96%	50th
45 – 64 Years	**86.41%**	86.28%	**88.83%**	88.83%	89.86%	75th
65 + Years	80.17%	79.90%	**84.32%**	86.51%	89.19%	50th
Children's Access to PCP						
12 – 24 Months	**88.47%**	**81.97%**	**85.09%**	86.24%	**95.54%**	25th
25 – 6 Years	70.98%	71.06%	**73.39%**	73.16%	**82.86%**	10th
7 – 11 Years	**76.31%**	**73.35%**	**76.18%**	**78.06%**	**85.14%**	25th
12 – 19 Years	**73.47 %**	**72.86%**	**74.09%**	**75.49%**	**81.46%**	10th

KMHP HEDIS: Prenatal and Postpartum Care

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Timeliness of Prenatal Care	85.12%	86.37%	81.51%	**75.18%**	79.81%	25th
Postpartum Care	66.74%	**59.12%**	60.10%	56.50%	55.72%	10th

AMHP HEDIS: Prenatal and Postpartum Care

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
Timeliness of Prenatal Care	86.42%	85.64%	90.21%	**87.35%**	89.29%	50th
Postpartum Care	68.15%	71.05%	**62.70%**	**60.83%**	67.40%	50th

KMHP HEDIS: Frequency of Ongoing Prenatal Care

MEASURE	**2004 (cy)**	**2005 (cy)**	**2006 (cy)**	**2007 (cy)**	**2008 (cy)**	**National Medicaid Percentile Achieved**
< 21% of Expected Visits	6.28%	***4.62%***	4.62%	7.8%	6.08%	25th
21% - 40% of Expected Visits	6.28%	4.14%	6.33%	4.96%	5.35%	50th
41% - 60% of Expected Visits	9.07%	11.68%	10.95%	9.69%	8.27%	50th
61% - 80% of Expected Visits	19.77%	22.63%	21.17%	**14.66%**	14.36%	50th
>81% of Expected Visits	58.60%	56.93%	56.93%	62.88%	65.94%	50th

AMHP HEDIS: Frequency of Ongoing Prenatal Care

MEASURE	**2004 (cy)**	**2005 (cy)**	**2006 (cy)**	**2007 (cy)**	**2008 (cy)**	**National Medicaid Percentile Achieved**
< 21% of Expected Visits	3.75%	2.43%	1.17%	2.43%	1.46%	<10th
21% - 40% of Expected Visits	3.04%	4.14%	3.50%	2.19%	2.43%	10th
41% - 60% of Expected Visits	7.96%	9.49%	4.20%	3.89%	5.84%	25th
61% - 80% of Expected Visits	18.74%	17.27%	13.75%	13.87%	12.17%	25th
>81% of Expected Visits	66.51%	66.67%	**77.39%**	77.62%	78.10%	75th

KMHP HEDIS: Well Child Visits

Well Child Visits in 1st 15 months	**2004 (cy)**	**2005 (cy)**	**2006 (cy)**	**2007 (cy)**	**2008 (cy)**	**National Medicaid Percentile Achieved**
0 Visits	1.39%	0.97%	1.95%	1.62%	2.00%	50th
1 Visit	**2.55%**	1.22%	0.49%	0.93%	2.49%	50th
2 Visits	3.70%	3.41%	2.68%	2.78%	2.74%	25th
3 Visits	6.71%	6.08%	6.08%	5.32%	6.23%	50th
4 Visits	**6.71%**	10.46%	11.44%	10.42%	9.23%	25th
5 Visits	15.51%	18.25%	16.79%	20.83%	21.20%	75th
Well Child Visits 3 – 6 yrs	74.31%	**81.75%**	79.56%	**69.91%**	74.01%	50th
Adolescent Well Care Visits	57.64%	62.29%	57.42%	**49.54%**	60.83%	90th

AMHP HEDIS: Well Child Visits

Well Child Visits in 1st 15 months	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
0 Visits	2.08%	3.65%	4.4%	1.95%	0.86%	10th
1 Visit	0.93%	1.46%	0.93%	1.95%	0.57%	10th
2 Visits	**2.55%**	3.16%	2.09%	2.19%	1.44%	10th
3 Visits	5.32%	5.84%	3.02%	4.87%	3.45%	10th
4 Visits	11.57%	9.73%	10.44%	**5.84%**	6.03%	10th
5 Visits	15.28%	15.33%	12.99%	12.41%	13.79%	10th
Well Child Visits 3rd – 6th Years	71.76%	75.18%	78.65%	**62.53%**	**73.45%**	75th
Adolescent Well Care Visits	55.32%	58.88%	61.11%	55.23%	56.27%	75th

KMHP HEDIS: Annual Dental Visit

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
2-3 Years	N/A	25.02%	24.72%	**29.84%**	**32.29%**	50th
4-6 Years	**46.64%**	**49.97%**	**51.24%**	**56.43%**	**58.59%**	50th
7-10 Years	**47.57%**	**50.19%**	**50.07%**	**55.75%**	**50.27%**	25th
11-14 Years	**40.86%**	**43.78%**	43.36%	**48.44%**	**51.05%**	25th
15-18 Years	**32.58%**	**34.37%**	34.28%	**37.59%**	**39.68%**	25th
19-21 Years	**27.23%**	28.26%	27.65%	28.81%	**31.57%**	25th
Combined Ages 2-21	N/A	43.73%	40.53%	**45.08%**	**47.68%**	50th

AMHP HEDIS: Annual Dental Visit

MEASURE	2004 (cy)	2005 (cy)	2006 (cy)	2007 (cy)	2008 (cy)	National Medicaid Percentile Achieved
2-3 Years	N/A	12.37%	12.38%	**13.95%**	**15.68%**	10th
4-6 Years	**44.18%**	40.89%	**39.02%**	**43.95%**	45.11%	25th
7-10 Years	**44.22%**	**46.15%**	45.70%	**49.08%**	**51.89%**	25th
11-14 Years	**41.07%**	**43.48%**	42.29%	**44.01%**	**45.93%**	25th
15-18 Years	**34.20%**	**37.82%**	36.33%	**38.09%**	**40.49%**	25th
19-21 Years	**26.28%**	**31.33%**	29.61%	30.29%	31.65%	25th
Combined Ages 2-21	N/A	**37.76%**	36.54%	**39.01%**	**40.81%**	25th