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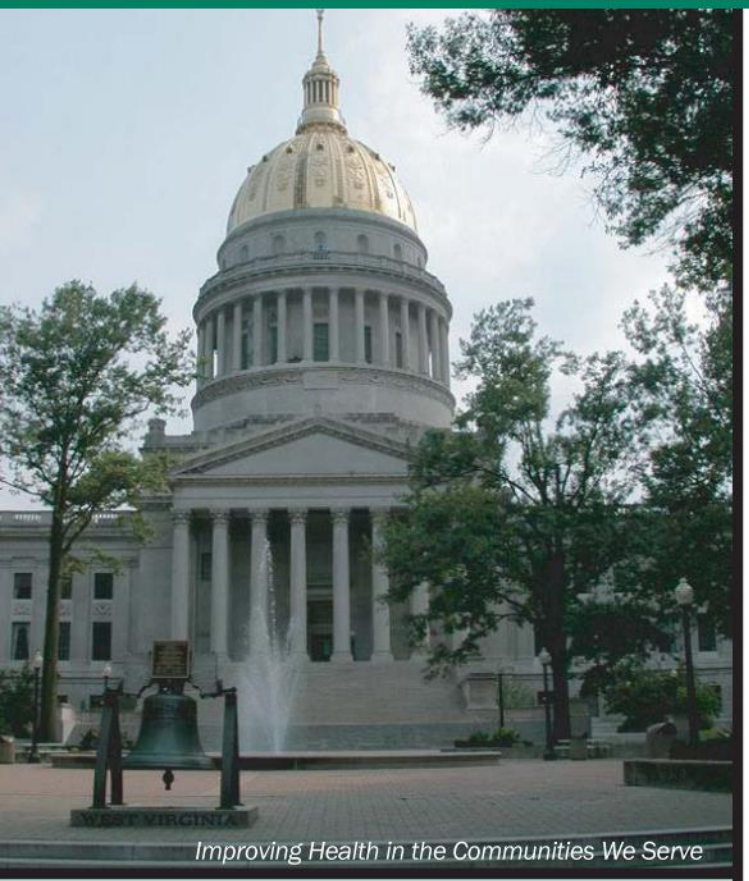

EXTERNAL QUALITY REVIEW ORGANIZATION

West Virginia Department of Health and Human Resources Bureau for Medical Services

Annual Technical Report

Final Report

Measurement Year 2013

Submitted by
Delmarva Foundation
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Commonly Used Acronyms in EQRO Reporting

Acronyms	
BBA	Balanced Budget Act of 1997
BMS	Bureau for Medical Services
CAHPS® Survey	Consumer Assessment of Healthcare Providers and Systems Survey
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
EQR	External Quality Review
EQRO	External Quality Review Organization
ED	Emergency Department
ER Standard	Enrollee Rights Standard
FA Standard	Fraud and Abuse Standard
FFS	Fee-for-Service
GS Standard	Grievance System Standard
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Healthcare Insurance Portability and Accountability Act of 1996
IDSS	Interactive Data Submission System
IRR	Inter-rater Reliability
ISCA	Information Systems Capabilities Assessment
MCO	Managed Care Organization
MHT	Mountain Health Trust
MHT-A	Mountain Health Trust Average
MHT-WA	Mountain Health Trust Weighted Average
MRRV	Medical Record Review Validation
MY	Measurement Year
NCQA	National Committee for Quality Assurance
PCP	Primary Care Provider
PIP	Performance Improvement Project
PMV	Performance Measure Validation
QA Standard	Quality Assurance and Performance Improvement Standard
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
ROADMAP	HEDIS Record of Administration Data Management and Processes
SFY	State Fiscal Year
UM	Utilization Management
WVSIIS	West Virginia Statewide Immunization Information System

Annual Technical Report Executive Summary MY 2013

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). For measurement year (MY) 2013, there were approximately 186,400 members enrolled in the three MHT Managed Care Organizations (MCOs). The three MCOs contracted with BMS to provide care to these enrollees are CoventryCares, Inc. (CoventryCares), The Health Plan of the Upper Ohio Valley (The Health Plan), and UniCare Health Plan of West Virginia, Inc. (UniCare).

BMS evaluates and monitors the care provided by the MCOs to the MHT enrollees. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, BMS contracts with Delmarva Foundation for Medical Care, Inc. (Delmarva) to perform external quality review (EQR) services. On an annual basis, Delmarva assesses each MHT MCO's performance with data and information gained through the three mandatory activities that follow:

- Systems Performance Review (SPR)
- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)

The SPR process is designed to assess MCO compliance with structural and operational standards in the areas Enrollee Rights, Grievance Systems, Quality Assessment and Performance Improvement, and Fraud and Abuse. Standards are derived from the Code of Federal Regulations (CFR) and the MHT MCO contractual requirements. To determine MCO compliance, Delmarva obtains information from document reviews, interviews with MCO staff, observation of processes, and chart reviews. Combined, these methods of data collection provide an accurate depiction of an organization's compliance with regulatory provisions.

PIPs are designed to provide a systematic approach to quality improvement and can assist MCOs in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or administrative processes. The validation process consists of determining whether or not PIPs were conducted correctly by assessing key components of the process. Areas validated include selection of study topic, development of the study question, selection of indicators, sampling methodology, data collection procedures, improvement strategies, findings, and whether or not improvement was achieved. Beginning fiscal year (FY) 2013, MCO are required to have three PIPs in place at all times.

Results of performance measures offer a snapshot of MCO quality, timeliness, and accessibility of care provided during a given time period. PMV assures that MCOs produce reliable and accurate measures in accordance with required specifications. The validation process includes an assessment of the MCO's information systems, procedures, and algorithms used to calculate the performance measures.

These assessments are conducted using the required EQR Protocols (Centers for Medicare and Medicaid Services, EQR Protocols). MCO specific SPR, PIP and PMV reports are prepared by Delmarva and submitted to BMS for each activity on an annual basis.

In accordance with 42 C.F.R. §438.364, the EQRO must provide a detailed technical report that describes the manner in which the data from all activities conducted were aggregated and analyzed and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished by MCOs contracting with the State. This Executive Summary describes the SPR, PIP, and PMV activities that were conducted for measurement year (MY) 2013 according to the dimensions of quality, access, and timeliness to meet this federal reporting requirement.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA 2013 Health Plan Standards and Guidelines*).

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Quality

In regards to the Systems Performance Review, all three MCOs performed well for the Quality Assessment and Performance Improvement (QA) standard for MY 2013. This standard is important because it assesses each MCO's internal Quality Improvement (QI) structure and its ability to improve the quality of care and services for its enrollees. CoventryCares, The Health Plan, and UniCare achieved compliance rates of 97%, 99%, and 99% respectively on the QA standard.

The MCOs have well documented Quality Assessment and Performance Improvement (QAPI) program plans that describe the organizational structure and include goals, objectives, and a detailed work plan. All QAPI plans note that the ultimate authority of the QAPI Program rests with the MCO's governing body, the Board of Directors (BOD). All MCOs carry out their QAPI functions using committees (e.g. credentialing, quality improvement, utilization management). Committee descriptions in the QAPI documents include all of the required components including committee responsibilities, a designated chairperson and responsibilities for each committee. The QAPI documents include organizational charts, describe the relationship between the committees, and how information is communicated among the committees and up to the BOD level.

The MY 2013 SPR demonstrated the following MCO accomplishments related to quality. All three MCOs have:

- Well documented Quality Improvement Program (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- Detailed committee meeting minutes that describe actions taken, problem identification and resolution, as well as coordination and communication among committees.
- Demonstrated that appropriate staff and committees are involved in the decision making process for Utilization Management (UM) and QI activities.
- Clinical practice guidelines(CPGs) in place, and update them at least every two years. All MCOs specifically reviewed their Diabetes and Asthma CPGs in 2013 to ensure they were current for use in the mandatory PIPs.
- CPG and other industry acceptable criteria (e.g. InterQual and Milliman and Robertson) are used them to make UM decisions (e.g. pre-authorization of procedures).
- Procedures in place to monitor delegated credentialing entities. Delegates are held to same standards as MCOs as demonstrated by the delegated credentialing audits and monitoring conducted by the MCOs.
- Disease management programs in place for enrollees with special health care needs.
- Health education programs in place that are based on enrollee characteristics and needs.
- Utilization management procedures in place that include using appropriate guidelines and clinical criteria to make authorization decisions.
- Methods in place to detect under- and over-utilization of services.

- The appropriate policies and procedures in place to cover and pay for emergency and post-stabilization care services.
- Processes in place to collect the required performance data (HEDIS measures) which is validated by the EQRO and provided to BMS as required. Data is analyzed and used for program planning (e.g. selection of areas for focused studies and PIPs).

During the credentialing and recredentialing process, all three MCOs query the required databases (e.g. National Practitioner Data Bank (NPDB) and Master Death File). Recredentialing requirements include an on-site visit to the provider's office. In the review for 2012 activities, it was noted that one MCO (CoventryCares) conducted these visits, while two did not (UniCare and The Health Plan). Both have addressed this deficiency in their policies and procedures and are scheduling the site visits that need to be completed.

MCOs have the appropriate structures and processes in place to monitor, evaluate, and improve the quality of services to the MHT enrollees using PIPs. In general, the have used data to identify problems relevant to their populations, set appropriate goals, select appropriate benchmarks, calculate baseline and repeat measurements, sample appropriately, develop and implement relevant interventions that effective and self-sustaining.

The MCO PIP topics related to quality include The Health Plan's Childhood Obesity PIP, UniCare's Childhood Immunization Status PIP, and the mandatory Diabetes Collaborative PIP.

The Childhood Obesity PIP focuses on three quality measures: evidence of BMI documentation, nutritional counseling, and counseling for physical activity for children 2-17 years of age. When compared to the baseline rate, two of the three indicators improved the Percentage of Members with Evidence BMI Documentation and the Percentage of Members with Evidence of Nutritional Counseling. The most notable intervention is face-to-face discussion/education with primary care providers (PCPs) regarding the documentation requirements. Provider education was provided to over 200 provider practices during the reporting period.

The Childhood Immunizations Combination 3 PIP is a project proposal submitted by UniCare. The MCO aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. Best practices for interventions include provider Gaps in Care Reports which are submitted to providers notifying them of members with missing services, including immunizations. In addition, the MCO is implementing a Well-Baby Care Visit Incentive Program which provides a $50 incentive for parents/caregivers when a child completes 6 of 8 well visits by 15 months of age.

The third quality-related PIP is the mandatory Diabetes Collaborative PIP in which all three MCOs are required to participate. Collaborative PIPs are beneficial in that the collaborative intervention targets *all* MHT enrollees with the selected disease or condition whether they remain in one MCO or move from MCO to MCO. Collaborative interventions are decided upon and implemented by all three MCOs. In addition to the collaborative intervention, the MCOs have also proposed additional MCO-specific interventions targeting - diabetic members to implement at the MCO level.

The mandatory indictor for the collaborative project is Hemoglobin A1c (HbA1c) Control (<8%) with the goal to meet or exceed the HEDIS 2014 National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). All MCOs have selected at least one additional HEDIS indicator for their projects to include Retinal Eye Exam (UniCare), HbA1c Testing (The Health Plan and UniCare), and LDL-C Level <100mg/dL (CoventryCares).

Best practices identified among the project proposals include:

- All MCOs - Provider Gaps in Care Reports: Providers receive list of their members with missing services (screenings, tests, visits etc.) to encourage providers to follow-up with non-compliant members. Delmarva recommended that all three MCOs put a mechanism in place to ensure that providers follow-up with enrollees to schedule them for missing services.
- All MCOs- the MCOs are developing a letter to mail to providers to notify them that the MHT MCOs are conducting this PIP. The letter contains information on diabetes care and resources (telephone numbers, websites) providers can contact for more information on diabetes care (e.g. clinical practice guidelines). The letter is targeted to be mailed in the first quarter of 2014.
- The Health Plan -Wellness and Health Promotion Call Center: The Call Center provides one-on-one personalized contact with diabetic members who are missing important services and/or testing. Claims histories are used to identify gaps in care that trigger members being placed in an outbound call queue. Following the phone call from the nurse, a letter is sent to the member with a checklist of all missing services that were discussed on the call. A similar letter is sent to the member's PCP urging the PCP to assist the member in obtaining any services the member chooses to pursue.
- UniCare- Member Incentive Program - The MCO provided a $25 incentive for completing recommended diabetic screenings and a dilated eye exam.

The following 21 HEDIS indicators were used to assess quality in the MHT program in the areas of prevention, immunizations, screenings, and the chronic conditions of asthma and diabetes:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Controlling High Blood Pressure
- Lead Screening for Children
- Adult BMI Assessment
- Medication Management for People With Asthma 75% Compliance
  - 5-11 Years
  - 12-18 Years
  - Total
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI Percentile
  - Counseling for Nutrition
- Medical Assistance with Smoking and Tobacco Use Cessation
  - Advising Smokers To Quit
  - Cessation Strategies Discussion
  - Cessation Medication Discussion
- Comprehensive Diabetes Care
  - Blood Pressure Control
  - Eye Exam
  - HbA1c Control (<8%)
  - HbA1c Testing
  - LDL-C Control (LDL-C <100 mg/dl)
  - LDL-C Screening
  - Medical Attention for Nephropathy

Of these quality measures, the MHT weighted average improved for five between HEDIS 2012 (MY 2011) and HEDIS 2014 (MY 2013). They are:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents -BMI Percentile

The following measures from the Adult and Child General Population CAHPS were used to assess the MCOs for quality:

- Customer Service Composite
- How Well Doctors Communicate
- Share Decision Making
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

For Adult Quality CAHPS measures, the MHT Average for *Customer Service* exceeded the National Medicaid 90th Percentile. Adult's *Shared Decision Making Composite* exceeded the 75th Percentile. Five out of seven Child Quality CAHPS measures performed very well compared to National Medicaid Percentiles. The MHT Average for *Customer Service* and *Rating of Health Care* exceeded the National Medicaid 75th Percentile.

The MHT Average for the following four measures exceeded the 50th Percentile:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Opportunities for improvement exist with the following five Adult CAHPS measures that were below the National Medicaid 50th Percentile:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of all Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Overall, in the area of quality, the MCOs had compliance rates of 97% to 99% in the SPR. In regards to PIPs, the Obesity PIP achieved improvement for two of three indicators. The Adolescent Well Care Visit PIP also realized an increase in the *Well-Child Visits* rate indictor. All three MCOs implemented the mandatory Diabetes Collaborative PIP and Asthma Collaborative PIP. For performance measure validation, the MHT Weighted Average improved for five indicators between HEDIS 2012 and HEDIS 2014. For CAHPS, the MHT Averages compared favorably to national benchmarks for two Adult and six Child CAHPS quality measures. The MHT Weighted Average for *Immunization Status for Adolescents- Combination 1* and *Medication Management for People With Asthma, 75% Compliance: Ages 5-11 Years* each exceeded the National Medicaid 75th Percentile. The *Medication Management for People With Asthma, 75% Compliance (Ages 12-19 Years and Total)* exceeded the National Medicaid 50th Percentile.

Access

All MCOs ensure that enrollees have access to the required member materials. Telephone numbers to access Member/Customer service lines are provided in member handbooks. Member handbooks describe the covered services, how to access those services, and any other special requirements such as whether or not referrals are required for specialist services.

The MCOs are required to assess compliance with appointment access standards in the BMS/MCO contract. Current BMS standards state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within 48 hours;
- Routine cases other than clinical preventive services must be seen within 21 days (exceptions are permitted at specific times when PCP capacity is temporarily limited);

- An initial prenatal care visit must be scheduled within 14 days of the date on which the woman is found to be pregnant.
- Qualified medical personnel must be accessible 24 hours each day, seven days a week (24/7), to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on call, licensed practical nurses, and registered nurses.

CoventryCares met all of the access standards. All MCOs met the Emergency and Urgent Care standards. The Health Plan's survey of 24/7 access yielded an 85% compliance rate. The MCO implemented interventions following the review to address the providers who were non-compliant. These interventions were included in the MCO's internal CAP. UniCare's 2013 access and availability assessment yielded a compliance rate of 62% for the Non-Urgent Sick Care appointment standard, 70% for Prenatal Visit within 14 Days, 85% for Routine PCP Visit, and 61% for the After Hours 24/7 Access standard. The Health Plan and UniCare must improve the compliance rates for these access standards to a minimum of 90% to meet the requirements specified in the contract.

Over the last three trend years, MY 2011-MY 2013, CoventryCares did not achieve the 24/7 access threshold in 2011, The Health Plan did not achieve the threshold in MY 2011 and MY 2013. Finally, UniCare did not achieve the threshold in all three measurement years. This access standard should become a focus of improvement efforts across the MHT program.

All three MHT MCOs submitted project proposals for the mandatory Asthma Emergency Department Collaborative PIP. This project was in the early implementation phase in 2013. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)*. MY 2013 is the baseline data year for this project. The goal for this indicator will be determined in MY 2014 by the Asthma ED Collaborative participants when baseline data are available. There are currently no benchmarks available for this indicator.

Nine HEDIS indicators were selected to measure MCO performance for Access to Care:

- Adults' Access to Preventive/Ambulatory Health Services (20-44 Years, 45-64 Years, Total)
- Children's and Adolescents' Access To PCP (12-24 months, 25 months - 6 Years, 7-11 Years, 12-19 Years)
- Prenatal Postpartum Care (Timeliness of Prenatal Care, Postpartum Care)

The MHT Weighted Average for seven of the nine access indicators compared favorably with national benchmarks. Four indicators showed improvement between HEDIS 2012 and HEDIS 2014.

The MHT Average for the CAHPS Adult *Getting Needed Care Composite* exceeded the National Medicaid 50th Percentile and the National Medicaid 75th Percentile for CAHPS Child *Getting Needed Care Composite*.

In summary, one MCO, CoventryCares, met all of the appointment access standards and all MCOs met the Emergency and Urgent Care access standards. The Health Plan met all access standards except for the 24/7 standard where it scored an 85%, falling short of the 90% threshold. UniCare did not meet the 90% threshold for the Non-Urgent (62%), Routine (85%), Initial Prenatal Care (70%) and 24/7 (61%) access standards. A review of the last three trend years, MY 2011- MY 2013, reveals that the MCOs should focus on meeting the 24/7 access standard consistently. CoventryCares met the standard in two of three years, The Health Plan met the standard one of three years, and UniCare did not achieve the threshold in all three measurement years. In regards to PIPs, all MCOs have implemented the mandatory Asthma ED project with baseline data to be collected for MY 2013 and reported in MY 2014.

In regards to PIPs, all three MHT MCOs implemented the mandatory Asthma Collaborative PIP. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)*. The goal for this indicator will be determined by the Asthma ED Collaborative participants as there are no benchmarks available for this indicator. Robust interventions that were being implemented in MY 2013 include Gaps in Care Reports (Coventry and UniCare), Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare), and Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare). A Wellness and Health Promotion (WH&P) Call Center (The Health Plan). The WH&P Call Center allows for one-on-one personalized contact with members who are Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program. The effectiveness of these interventions will be able to be assessed after they have been in place for at least a year (MY 2014)

Favorable performance on the HEDIS access measures continues to be a strength for the MHT program. The MHT Weighted Averages for seven of nine performance measures remained high compared to national benchmarks. All four indicators for *Children's and Adolescents' Access to PCP* improved all three years. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population. Finally, the MHT Average for the CAHPS Adult Getting Needed Care Composite exceeded the National Medicaid 50th Percentile.

Timeliness

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely in order not to disrupt or delay the provision of care or services to their members. There are SPR standards in place to evaluate timeliness as it relates to both the provision of services and timely access to customer services.

Access to necessary health care and related services alone is insufficient in advancing the health status of MHT recipients. Equally important is the timely delivery of those services, and systems of care that serve MHT recipients. The findings for the MHT MCOs related to timeliness are described below.

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely in order not to disrupt or delay the provision of care or services to their members. The SPR standards in place evaluate timeliness as it relates to both the provision of services and timely access to customer services.

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For MY 2013, Delmarva reviewed cases, files, and logs to assess timeliness of:

- Credentialing and recredentialing of providers,
- Resolution of complaints, grievances and appeals, and
- Authorization, pre-authorization and continuing authorization activities.

All provider recredentialing files in the sample were recredentialed within the three-year time requirement. All delegated credentialing providers are held to the same timeliness standards. All three MCOs complete annual audits of the delegates and no issues were identified with timely completion of credentialing and recredentialing activities.

Delmarva reviewed a sample of complaint, grievance and appeal logs and selected a sample appeals cases from each MCO for review. The BMS/MCO contract requires MCOs to process and provide notice to affected parties regarding enrollee grievances in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. All cases sampled were resolved and affected parties notified in less than 45 days. None of the cases included a request for an extension.

Each MCO has a UM program in place which includes policies and procedures to monitor the timeliness of utilization management decisions. According to the BMS/MCO contract, the MCOs must make authorization decisions and provide notice as expeditiously as required by the enrollee's health condition and within 14 measurement days of receiving the request for service for the purposes of standard authorization decisions. All MCOs monitor the time to completion for authorizations against this timeliness standard. Results are compiled at least monthly by all MCOs and reported through the QAPI channels at least quarterly.

In addition, the MCOs must provide an expedited authorization decision for services when the provider indicates that the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must make the expedited authorization decision and

provide notice to the enrollee as expeditiously as the enrollee's health condition requires, and no later than 3 working days after receipt of the request for service. This 3 working day period may be extended up to 14 additional days upon request of the enrollee or provider, or if the MCO justifies to BMS the need for additional information and how the enrollee might benefit from the extension.

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported through the QAPI channels by the UM department. There were no cases on file for expedited authorizations in MY 2013.

For MY 2013, there was one PIP that addressed timeliness. CoventryCares Adolescent Well-Care Visits project measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well care visit with a PCP or Obstetrician/Gynecologist during the measurement year. CoventryCares achieved an increase in the indicator rate from a baseline rate of 42.13% in MY 2011 to the first remeasurement rate of 46.58% in MY 2012 and the second remeasurement rate of 47.20% in MY 2013. Interventions such as face-to-face education of providers about medical record documentation, outreach calls to non-compliant members, provider report cards, and EPSDT reminder systems, target identified barriers.

Interventions identified as best practices in the review of CoventryCares Adolescent Well-Care Visits are listed below:

- Disease and case managers conduct targeted calls to members identified as non-compliant to educate them about the need for routine well-visits and assist with appointment scheduling if needed.
- Provider report cards are mailed monthly which contain all members that are non-compliant with the required services. The MCO encourages providers to follow-up with the non-compliant members. Delmarva recommended that the MCO put a mechanism in place to ensure that providers follow-up with members and attempt to get them up to date with the required services.
- Provider/office staff education, including appropriate medical documentation, was offered when HEDIS medical record reviews were being conducted on-site by the MCO.

Four HEDIS indicators were selected to represent MCO performance in the area of timeliness:

- Adolescent Well-Care Visits
- Frequency of On-going Prenatal Care (≥81%)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life (6 or more visits)

The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to national benchmarks. The three year trend from HEDIS 2012 to HEDIS 2014 indicated improving performance for *Adolescent Well-Care Visits* and *Well-Child Visits In The 3rd, 4th, 5th, and 6th Years of Life.*

The MHT Average for the Adults *Getting Needed Care Quickly Composite* exceeded the National Medicaid 50th Percentile and the MHT Average for the Child *Getting Needed Care Quickly Composite* exceeded the National Medicaid 90th Percentile.

Overall, the MCOs performed well in the area of timeliness. Credentialing and recredentialing of providers, resolution of complaints grievances and appeals as well as authorizations were completed in a timely manner according to the standards. CoventryCares's Adolescent Well-Care Visits PIP achieved improvement from the baseline measurement in MY 2011 to MY 2013. The three year trend from HEDIS 2012 to HEDIS 2014 showed improving performance for two HEDIS measures related to timeliness for the MHT program. The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to the national benchmarks. Both CAHPS timeliness measures performed well. The MHT Average for the Adults *Getting Care Quickly Composite* exceeded the National Medicaid 50th Percentile and the MHT Average for the Child CAHPS *Getting Care Quickly Composite* exceeded the National Medicaid 90th Percentile.

MHT MCO Strengths, Requirements, and Recommendations

Strengths, requirements and recommendations are provided by activity below. **Strengths** are provided to encourage MHT to foster efforts that are effective. R**ecommendations** are made where Delmarva has suggestions to improve current processes and practices that already meet requirements. Recommendations are not required to be implemented, although it is encouraged to strengthen the program. Finally, **Requirements** are provided to address elements and components to ensure that the participating MCOs are compliant with the BMS/MCO contract and federal regulations.

MHT Program Strengths, Requirements, and Recommendations

MHT Program Strengths, Requirements and Recommendations for MY 2013	
Systems Performance Review	**Strengths** • The MCOs have performed well for all standards from MY 2010 - MY 2012 achieving above the 90% threshold established by BMS for all four standards (ER, GS, QA, and FA). • BMS mandated that the MCOs become NCQA accredited by January 14, 2014. All MCOs are on track to complete the survey process. • Beginning MY 2012, all MCOs had CAHPS data available since BMS has mandated MCOs to use the most recent version of the CAHPS survey. This allows comparison of member satisfaction results among all three MCOs and program-wide against national benchmarks.

MHT Program Strengths, Requirements and Recommendations for MY 2013	
	Recommendations • ***The MCOs must focus efforts on consistently meeting the 24/7 access standard.*** In the last three measurement years, CoventryCares met the threshold two years, The Health Plan met the standard in one year, and UniCare did not meet the standard in any of the three years. BMS should consider an MHT-wide approach to addressing this issue, such as a statewide provider educational initiative. • ***Continue to require the MCOs to achieve a 100% for each of the four standards (ER, GS, QA, FA).*** This is the first full review where BMS required the MCOs to achieve 100% compliance for each standard. The MCOs were required to submit an internal improvement plan for each standard, element, and/or component that was not fully met. The value of improvement plans will only be able to be assessed at the time of the next annual audit. It is expected that SPR results will improve based on the MCOs targeting areas for improvement.
Performance Improvement Projects	**Strengths** • All three MCOs successfully implemented two collaborative PIPs: Diabetes and Asthma ED. • The MCOs worked together to develop collaborative interventions for the two collaborative PIPs. • A collaboratively written letter was developed and will be sent to providers state-wide advising them that the MCO's have chosen to focus on reducing emergency department usage for members with asthma. • A second collaboratively written letter will be sent to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for diabetic members. Both letters provide information for providers to get resources and help for these specific populations. • The MCO have other interventions including face-to-face contact with providers, incentive programs, outreach calls, and preparing and distributing Gaps in Care Reports and Provider Profiles.
	Recommendation • The PIP Collaborative Team must meet to determine the collaborative indicator goal for the Emergency Department Collaborative.
Performance Measure Validation	**Strengths** • All three MCOs have experienced staff, established data systems, and well-defined processes to calculate and report HEDIS performance measures. • All three MCOs completed conversion from the State's proprietary enrollment file format to the HIPAA 834 compliant format in 2013 and continued to capture race, ethnicity, and language using the new enrollment format. • All MCOs achieved NCQA accreditation by the January 2014 deadline. • The MCOs all successfully integrated pharmacy data provided by the fiscal agent to report measures that use pharmacy data. • Beginning April 2013, all three MCOs successfully implemented the carve-in of pharmacy benefits into their programs. All the MCOs successfully reported all required measures to BMS for HEDIS 2014. • In regards to measures of quality, the MHT rates for four HEDIS indicators compared favorably with national benchmarks by exceeding the National Medicaid 50th Percentile. • The MHT Weighted Averages for seven of nine access indicators compared favorably with national benchmarks by exceeding the National Medicaid 50th Percentile. • The three year trend from HEDIS 2012 to HEDIS 2014 indicated improving performance for the MHT Weighted Averages for two timeliness measures- *Adolescent Well Care Visits* and *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life.* • For Adult and Child CAHPS measures, two Adult and five Child Quality measures

MHT Program Strengths, Requirements and Recommendations for MY 2013	
	compared favorably to national benchmarks by exceeding the National Medicaid 50th Percentile. • One Adult and Child CAHPS survey measure was used to assess access. The MHT Average for the Adult CAHPS Getting Needed Care Composite measure compared favorably to national benchmarks. • For the Adult and Child CAHPS measure for timeliness, the MHT Averages for the Adult and Child CAHPS Getting Needed Care Quickly Composite compared favorably to national benchmarks.
	Requirements • The MCOs must be prepared to fully report HEDIS measures that require pharmacy data to NCQA for HEDIS 2015 (MY 2014). • The MCOs must be prepared to report non-HEDIS performance measures to BMS from the CMS Child and Adult Quality Core Measure Sets for MY 2014. **Recommendations** • ***CMS Adult and Child Quality Core Measures*** - the MCOs must be fully prepared to report all BMS required measures form the CMS Adult and Child Core Sets. • ***Use of Pharmacy Data*** - The MCOs must be fully prepared to report HEDIS measures that require pharmacy data for HEDIS 2015 (MY 2014) to NCQA. • ***Data Quality*** - BMS and the MCOs are encouraged to share new ideas and innovations to gather data or improve the quality of data used to calculate required performance measures. With the new requirement to report Adult and Child Core Measures, the sharing of information will assist the MCOs to produce valid and reliable results that are comparable among the MCOs. The Task Force meeting can act as forum the MCOs to share "best practices" for successful data capture and reporting. • ***Data Quality*** – The MCOs and BMS are encouraged to collaborate with State work groups and State agencies to provide the MCOs access to data from state information systems required for reporting performance measures. For example, the MCOs provided technical assistance to the Adult Quality Measures Grant team to identify Vital Statistics data required to calculate for some of the measures. (As a result, a signed Memo of Understanding (MOU) with the Bureau of Public Health will provide the MCOs access to Vital Statistics required to report the Adult measures in 2014).

Mountain Health Trust Annual Technical Report MY 2013

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). Initiated in 1996, conceptually the program was based on each Medicaid beneficiary having a medical home—a primary care provider (PCP) knowing an enrollee's medical history and managing appropriate treatment and preventive services. BMS is responsible for assuring that all MHT beneficiaries receive comprehensive, high quality healthcare services. For measurement year (MY) 2013, there were approximately 186,400 members enrolled in the three MHT Managed Care Organizations (MCOs).

To ensure care and services provided to MHT MCO enrollees meet acceptable standards for quality, timeliness, and accessibility, BMS contracts with Delmarva Foundation for Medical Care, Inc. (Delmarva) to perform external quality review (EQR) services. Specifically, Delmarva evaluates the quality assurance program activities for each of the MHT MCOs: CoventryCares, Inc. (CoventryCares), The Health Plan of the Upper Ohio Valley (The Health Plan), and UniCare Health Plan of West Virginia, Inc. (UniCare).

In collaboration with the MCOs and the EQRO, BMS aims to improve beneficiary care by:

- ensuring access to primary care
- promoting preventive care
- encouraging appropriate postpartum care
- ensuring comprehensive chronic care

(*West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality*)

On an annual basis, Delmarva assesses each MHT MCO's performance using data and information collected through the following activities:

- Systems Performance Review (SPR)
- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)

MCO specific SPR, PIP, and PMV reports are prepared by Delmarva and submitted to BMS for each of these activities on an annual basis.

The MY 2013 annual technical report findings provide an assessment of the MHT program based on MCO performance, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Where applicable, the findings are compared to the goals and objectives found in the *WV Mountain Health Trust Program (Full-Risk MCO) State Quality Strategy (QS) for Assessing and Improving Managed Care*

Quality. The annual technical report provides an accurate and objective portrait of the MCOs' capabilities which can be used to promote accountability, improve important aspects of organizational achievement, and positively impact the quality of services provided to MHT beneficiaries.

This report will provide the results of the EQR annual assessment of the SPR, PIP, and PMV activities for MY 2013. Following the EQR methodology, the individual MCO findings for the Systems Performance Reviews, Performance Improvement Projects, and Performance Measurement Validation activities are presented. The findings from these activities are then summarized according to quality, access and timeliness as required by the EQR regulations. Conclusions, recommendations, and requirements are then provided for both the individual MCOs and the MHT program.

The appendices provide detailed information to support the Annual Technical Report findings. Appendix 1 provides the PIP indicator results for all projects. Appendices 2 through 4 provide information for measures used to assess quality, access, and timeliness in this report. Specifically, Appendix 2 includes the HEDIS 2014 measures contained within the State's Quality Strategy and the Performance Incentive Program along with the individual MCO rates, MHT weighted averages, and National Benchmarks. Appendix 3 contains the HEDIS 2014 MCO Rates, and MHT National Medicaid Percentiles. Appendix 4 contains trending data for the MCO Rates and MHT Weighted Averages for HEDIS 2012-2014. Appendix 5 provides the MHT Weighted Averages for the State Required HEDIS Respiratory Measures and Other Pharmacy Measures calculated using pharmacy data. Appendix 6 contains *all* measures collected for HEDIS 2012 through 2014 and reported to the National Committee for Quality Assurance (NCQA). Appendix 7 contains a summary of the Status of Recommendations from the MY 2012 Review. Finally, Appendix 8 contains a description of the Consumer Assessment of Health Providers and Systems (CAHPS) Survey and the MY 2013 MHT results.

EQR Methodology

Delmarva performs EQR activities in accordance with the requirements of the Balanced Budget Act (BBA) of 1997 and federal EQR regulations as outlined in Title 42 of the Code of Federal Regulations (CFR) part 438 et seq. The SPR, PIP, and PMV assessments are conducted using the required EQR Protocols (Centers for Medicare and Medicaid Services, EQR Protocols) which are referenced in this section for each activity.

Congruent with the regulations, Delmarva conducts a comprehensive review of the three MHT MCOs and assesses their performance relative to quality of care, timeliness of obtaining needed care and services, and accessibility to those services. For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health

services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA 2013 Standards and Guidelines for the Accreditation of Health Plans*).

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Health Plans*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Systems Performance Review

Key Delmarva SPR Activities

- Review policies and procedures
- Interview key staff
- Observe processes
- Assess credentialing and recredentialing activities
- Examine committee meeting minutes
- Evaluate performance improvement projects and activities
- Review enrollee manuals
- Assess appeal files
- Review denial letters

SPRs are designed to assess MCO compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Delmarva conducts these reviews in accordance with the CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs).* To determine MCO compliance, Delmarva obtains information from document reviews, interviews with MCO staff, observation of processes, and chart reviews (appeals, credentialing etc.). Information is collected pre-site, during the two-day on-site review, and post-site in response to the preliminary findings. Combined, these methods of data collection provide an accurate depiction of an organization's compliance with regulatory provisions.

SPR standards are derived from the BBA and the MHT MCO contractual requirements. Delmarva evaluates and assesses MCO performance and compliance with the following standards:

- Enrollee Rights (ER)
- Grievance Systems (GS)
- Quality Assessment and Performance Improvement (QA)
- Fraud and Abuse (FA)

Standards are comprised of components and elements, all of which are individually reviewed and scored. MCOs are expected to demonstrate full compliance with *all* standards and view the findings and recommendations as opportunities to improve quality and operational processes.

Delmarva uses a three-point scale for scoring: *Met—100%*, *Partially Met—50%*, and *Unmet—0%*. Components for each element are scored. The component scoring is rolled up to the element level, and finally the standard level. Aggregated results are reported by standard. BMS sets the minimum MCO compliance rating. Beginning MY 2013, MCOs are required to achieve 100% compliance for each standard. MCOs not achieving 100% on any of the four standards were required to develop and implement internal corrective action plans to address all deficiencies identified.

BMS requires a comprehensive review of all four Systems Performance Review Standards on an annual basis. This comprehensive review is a three phase process that includes pre-site document review, a two day on-site review, and post-site document review.

Performance Improvement Project Validation

PIPs are designed to provide a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or administrative processes. These improvements can enhance the quality of, access to, or timeliness of services provided to Medicaid beneficiaries, leading to improved health outcomes. Beginning fiscal year (FY) 2013, MCO are required to have three PIPs in place at all times.

Delmarva uses the CMS protocol, *Validating Performance Improvement Projects—A Protocol for use in Conducting Medicaid External Quality Review Activities*, as a guideline in PIP review activities. Delmarva reviewed each MCO's PIPs, assessed compliance with contractual requirements, and validated the activity for interventions as well as evidence of improvement. The following table summarizes the PIP validation activities.

PIP Validation Steps
Step 1. The **study topic** selected should be appropriate and relevant to the MCO's population.
Step 2. The **study question(s)** should be clear, simple, and answerable.
Step 3. The **study indicator(s)** should be meaningful, clearly defined, and measurable.
Step 4. The **study population** should reflect all individuals to whom the study questions and indicators are relevant.
Step 5. The **sampling method** should be valid and protect against bias.
Step 6. The **data collection procedures** should use a systematic method of collecting valid and reliable data that represents the entire study population.
Step 7. The **improvement strategies**, or interventions, should be reasonable and address barriers on a system-level.
Step 8. The **study findings**, or results, should be accurately and clearly stated. A comprehensive

PIP Validation Steps
quantitative and qualitative analysis should be provided.
Step 9. Project results should be assessed as **real improvement**.
Step 10. Sustained improvement should be demonstrated through repeated measurements.

Performance Measure Validation

Results of performance measures offer a snapshot of MCO quality, timeliness, and accessibility of care provided during a given time period. PMV assures that MCOs produce reliable and accurate measures in accordance with required specifications. The validation process includes an assessment of the MCO's information systems, procedures, and algorithms used to calculate the performance measures. Delmarva conducts all PMV activities in accordance with the CMS protocol, *Validating Performance Measures*.

In an effort to uniformly measure MCO quality of care, BMS requires MCOs to report nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS®) measures.[1] Since its introduction in the early 1990's, HEDIS has become the gold standard in managed care performance measurement and is used by the majority of MCOs nationally. The NCQA maintains and directs the HEDIS program.

The HEDIS 2014 measure set includes 81 performance measures across five domains of care. The domains include: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information. BMS requires the submission of all Medicaid HEDIS measures with the exception of measures that are based on carve out services such as behavioral health, pharmacy, and dental.

In accordance with 42 C.F.R. §438.364, the Annual Technical Report must describe the manner in which the data from all activities conducted were aggregated and analyzed and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished by MCOs. Therefore, this report focuses only on those measures that are representative of quality, access, and timeliness. The entire set of measures reported by the MCOs can be found in Appendix 3 of this report. Delmarva's role is to validate MCO performance measures and this is accomplished by:

- Evaluating the accuracy of the performance measures reported by (or on behalf of) an MCO.
- Determining the extent to which the performance measures followed the specifications for the measures.

Validated measures support and promote accountability in managed care. Measures must be calculated according to specifications outlined in NCQA's *HEDIS 2014, Volume 2: Technical Specifications.* Supporting information for all measures reported by the MCOs (e.g. numerators, denominators, trending information, and benchmarks) is found in Appendices 2-4. Although pharmacy was a carved out benefit

[1] The term *HEDIS* is a registered trademark of the NCQA.

through April 1, 2014, the MCOs have successfully utilized the data from the fiscal agent to calculate the HEDIS respiratory measures which are included in Appendix 5 along with the Smoking Cessation measures collected from CAHPS Survey data. All the HEDIS measures collected by the MCOs and reported to NCQA are found in Appendix 6.

The consumer experience with health care is an important part of quality of care and can affect the outcome of care. Survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) provide helpful insights that can be used to identify areas for improvement in member care. As part of the BMS requirement to obtain NCQA accreditation, MCOs are required to collect and submit the CAHPS consumer satisfaction survey results from the most recent version of the CAHPS Health Plan Adult and Child General Population surveys whose questions are relevant to the population served by the MHT MCOs.

The MCO must first contract with a Certified HEDIS CAHPS Vendor to conduct the actual surveys using the NCQA technical specifications and standardized protocols for conducting and reporting results. The MCOs survey samples are validated as part of their certified HEDIS audit required for NCQA accreditation. The MCOs then report the survey findings to Delmarva for analysis.

The summary results reported reflect consumer perceptions through rating and composite scores as well as the HEDIS Medical Assistance With Smoking and Tobacco Use Cessation measures. The **rating scores**, in accordance with the CAHPS protocol, show the results of survey questions that ask respondents to rate four health care concepts: all health care received, their personal doctor, their health plan, and the specialist they see most often. Answers are scored on a scale of 0-10, where 0 is the worst possible and 10 the best possible. The scores presented in Table A8-1 are the sum of positive responses that were scored 8, 9, and 10.

In addition, CAHPS results are reported for five composite categories: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making. The **composite scores** are obtained from responses to several survey questions that ask respondents how often they (or their child) received care under certain conditions. Each composite looks at a specific situation and has two or more underlying questions. All questions for each composite have the same potential response categories: Never, Sometimes, Usually, or Always. The composite scores in Table A8-1 are summary rates based on the sum of proportional averages for questions in each composite where the response was Usually or Always. Appendix 8 of this report provides further information on the CAHPS surveys and the HEDIS 2013 CAHPS results.

MHT MCO Findings

Systems Performance Review

Beginning MY 2013, BMS requires the MCOs to achieve full compliance for all four standards. MCOs not achieving 100% on any of the four standards were required to develop and implement internal corrective action plans (CAPs) to address all deficiencies identified.

The MY 2013 SPR compliance rates for all three MHT MCOs are presented in Table 1.

Table 1. MCO SPR Compliance Rates for MY 2013

SPR Standard	MY 2013 Compliance Rate		
	CoventryCares	The Health Plan	UniCare
Enrollee Rights (ER)	98%	100%	99%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	97%	99%	99%
Fraud and Abuse (FA)	100%	100%	98%

Program-wide the MHT program has performed well in meeting the EQR regulatory and contract requirements for the operational assessment. All MCOs achieved a 100% compliance rating for the **Grievance Systems Standard**, compliance rates of 97% to 99% for the **Quality Assessment and Performance Improvement Standard**, and 98% to 100% for **Enrollee Rights** and **Fraud and Abuse** Standards in MY 2013. The Health Plan performed the best with three standards achieving full compliance and the **QA Standard** achieving a 99% compliance rate. All MCOs submitted the required internal corrective action plans to address all non-compliant standards. CAPs are monitored by Delmarva on a quarterly basis. They are closed when Delmarva determines that the deficiencies have been addressed and are fully compliant with the requirements.

These high performance rates demonstrate the MCOs' and BMS' commitment to meeting the structural and operational standards that reflect the implementation of a high-quality program for MHT enrollees. Individual MCO trending results and analysis follow in Tables 2-4.

CoventryCares, Inc.

CoventryCares's SPR results for MY 2011-MY 2013 are presented in Table 2.

Table 2. CoventryCares SPR Results MY 2011 – MY 2013

Standard	CoventryCares Compliance Rate		
	MY 2011	MY 2012	MY 2013
Enrollee Rights (ER)	100%	100%	98%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	94%	100%	97%
Fraud and Abuse (FA)	98%	98%	100%

In MY 2013, CoventryCares achieved SPR compliance ratings of 100% for **Grievance Systems (GS)** and **Fraud and Abuse (FA)**. Both the **Enrollee Rights(ER)** and **Quality Assessment and Performance Improvement (QA)** standards achieved respectable compliance rates of 98% and 97% respectively. CoventryCares submitted an internal Corrective Action Plan (CAP) to address all elements within the ER and QA standards that were not fully met. The MCO submitted quarterly progress reports to Delmarva on all internal CAPs. These CAPs were closed during the MY 2014 on-site SPR review as CoventryCares fully met all of the outstanding requirements for the ER and QA standards.

In regards to the **ER** standards, two issues were identified. The Member Handbook section entitled Emergency Services implies, but does not specifically state, that preauthorization of services is not required. Secondly, there is no mechanism in place to notify enrollees how to request a copy of the MCO's Annual Report.

CoventryCares achieved a 97% in the **QA** standard. In 2013, CoventryCares retired its Case Management (CM) policies and procedures and did not replace them. This action resulted in a lack of formal policies to:

- Assign enrollees into case management according to established criteria.
- Specify the follow-up and outreach activities that must be initiated for missed appointments and failure to follow the treatment plan.
- Describe the required coordination of care with other appropriate agencies and/or institutions (e.g. school health clinics).
- Specify the required contents of individual CM records to include all results of referrals, consultations, inpatient records, and outpatient records.
- Require treatment plans to specify an adequate number of direct access visits to specialists to ensure implementation of the treatment plan for enrollees with special needs.

Trending of results shows that the:

- ER Standard decreased from 100% over the last two years to 98% in MY 2013.
- QA Standard compliance rate dropped from 100% compliance rate in MY 2012 to 97% in MY 2013.
- FA Standard maintained consistently high compliance rates of 98% or greater across the three trend years and achieved a 100% compliance rate for MY 2013.

The Health Plan of the Upper Ohio Valley

The Health Plan of the Upper Ohio Valley's SPR results for MY 2011-MY 2013 are presented in Table 3.

Table 3. The Health Plan of the Upper Ohio Valley SPR Results (MY 2011 – MY 2013)

Standard	The Health Plan Compliance Rate		
	MY 2011	MY 2012	MY 2013
Enrollee Rights (ER)	100%	100%	100%
Grievance Systems (GS)	99%	98%	100%
Quality Assessment and Performance Improvement (QA)	99%	99%	99%
Fraud and Abuse (FA)	90%	93%	100%

The Health Plan met the BMS performance requirement of 100% compliance for the **Enrollee Rights, Grievance Systems,** and **Fraud and Abuse** standards. The Health Plan was required to complete an internal CAP to address deficiencies identified in the **Quality Assessment and Performance Improvement** standard which achieved a commendable 99%, falling just one percentage point short of the 100% required compliance rating. The MCO submitted its internal CAP to Delmarva and is required to report on CAP progress quarterly. This CAP will be closed when the MCO fully meets all requirements of the QA standard.

The two deficiencies identified in the QA standard were in the areas of access and credentialing. As in MY 2012, there was an opportunity to improve after-hours accessibility for providers. The MCO's survey of after-hours accessibility yielded an 85% compliance rate. The MCO implemented interventions following the review to address the providers who were non-compliant. These interventions were included in the MCO's internal CAP. The Health Plan's CAP included educating and re-surveying those providers who were non-compliant in MY 2013. Fifty percent of the providers who were non-compliant in MY 2013 were compliant in MY 2014. However, the 24/7 compliance rate for MY 2014 did not meet the 90% threshold and therefore the MCO's CAP was not closed. (Based on the results of the MY 2014 review, the MCO must revise and resubmit this CAP for approval by Delmarva.)

For PCPs, obstetricians/gynecologists and other high-volume specialists, recredentialing requires a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards. In MY 2012, this requirement was not included in the MCO's policies and procedures. The policies and procedures were updated in 2013 to require an on-site visit for recredentialing for the specific provider types. During the on-site review, staff reported that PCPs that were recredentialed in MY 2012 who did not receive an on-site review were being brought up to compliance. The MCO provided an internal CAP which included a timetable to complete the on-site reviews for providers who should have received an on-site visit, but did not. The timetable included all the providers who were recredentialed in 2012 that were due for

a recredentialing on-site review, the date of the on-site review for providers who were brought up-to-date, and the anticipated on-site date for those that remain outstanding. The CAP addressing recredentialing was closed during the MY 2014 on-site SPR review as the MCO completed all of the outstanding on-site reviews.

Trending of the compliance rates for the four standards shows that:

- The Enrollee Rights standard has achieved a compliance rate of 100% for all trending years.
- The Grievance System Standard has improved to 100% compliance in MY 2013 after achieving 99% in MY 2011 and 98% in MY 2012.
- The Quality Assessment and Performance Improvement standard remained constant at 99% for all trending years.
- The Health Plan has continually improved its Fraud and Abuse program over the trending years and achieved 100% compliance in MY 2013. Improvements include the use of the STARS Sentinel software package to identify potential abuse, the implementation of policies and procedures, staff training and dedicating more staff to the fraud and abuse detection efforts.

UniCare Health Plan, Inc.

UniCare's results for MY 2011-MY 2013 are presented in Table 4.

Table 4. UniCare SPR Results (MY 2011 – MY 2013)

Standard	UniCare Compliance Rate		
	MY 2011	MY 2012	MY 2013
Enrollee Rights (ER)	100%	100%	99%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	98%	99%	99%
Fraud and Abuse (FA)	100%	100%	98%

For the 2013 review, UniCare achieved a compliance rating of 100% for **Grievance Systems**. The MCO achieved respectable compliance rates for **Enrollee Rights**, **Quality Assessment and Performance Improvement** and **Fraud and Abuse** standards at 99%, 99%, and 98% respectively.

One element within **Enrollee Rights** was not fully met. MCOs are required to submit an Annual Report to BMS by April 1 of each year, make copies of the annual report available at the local Department of Health and Human Resources (DHHR) offices in which it operates, and notify its members that they can receive a copy of the report upon request. UniCare submitted the Annual Report timely and provided copies at the local DHHR offices. However, the MCO did not notify enrollees that they could request a copy of the report and how to do so. The MCO developed an insert for the Member Handbook notifying enrollees that the report is available and how to request a copy. UniCare's member website was updated with this same information in 2014. These actions should result in full compliance for this element in the next annual review.

Appointment access and recredentialing issues were identified for the **Quality Assessment and Performance Improvement Standard**. MCOs are held to the access and availability standards in the BMS/MCO contract. UniCare's 2013 access and availability assessment yielded a compliance rate of 62% for the Non-Urgent Sick Care appointment standard, 70% for Prenatal Visit within 14 Days, 85% for Routine PCP Visit, and 61% for the After Hours 24/7 Access standard. The MCO must improve the compliance rates for these access standards to a minimum of 90% to meet the requirements specified in the contract.

UniCare's internal CAP for the 2013 findings includes the following actions:

- Conducting on-site office visits to reassess/confirm compliance in July. If provider is still non-compliant, he/she will be placed on a CAP which could include suspension of members,
- Phone calls to providers to explain importance of completing the MCO's annual provider access survey,
- Calls to providers to advise them of access and availability standards and explain importance of compliance, and/or
- Conducting access and availability training with providers via webinar or face-to-face sessions.

This internal CAP is still open. All of the above appointment access standards that did not meet the 90% threshold in MY 2013 did not meet the standards again in MY 2014.

In regards to recredentialing of PCPs, obstetricians/gynecologists and other high-volume specialists, the BMS/MCO contract requires a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards. In 2012, the MCO was using an on-site visit conducted by The Joint Commission (TJC) as a proxy for the recredentialing on-site visit. This is not compliant with the BMS/MCO contract requirements.

In 2013, the MCO began the process to complete on-site reviews for those providers that did not receive a recredentialing on-site assessment in 2012. The MCO began scheduling on-site reviews for providers who should have received them as part of the recredentialing process. The WV UniCare Site Visits Policy was updated in late 2013, but did not adequately address the need for site visits for the recredentialing process. A subsequent revision to the policy in 2014 addressed the requirement to complete an on-site review as part of the recredentialing process. This CAP remains open and will need to be revised as the MCO did not complete all outstanding on-site reviews in 2014.

UniCare received a 98% for the **Fraud and Abuse** standard as a result of not providing evidence of verifying that services reimbursed were actually furnished to members. Although the MCO had a policy and procedure in place to survey members, the survey letters were not distributed in 2013. UniCare's internal CAP notes that the MCO implemented the survey process in July 2014. This CAP is now closed as the MY 2014 on-site SPR verified that the survey process is in place and functioning.

Trending of results from 2011 through 2013 shows that the:

- Enrollee Rights Standard compliance decreased from 100% in MY 2011 and MY 2012 to 99% in MY 2013. The MCO did not notify members that they have the right to request the MCO's Annual Report and the process for making this request.
- Grievance Systems Standard has maintained its 100% compliance rate for the last three review periods.
- Quality Assessment and Performance Improvement Standard compliance rate has remained consistently high across all trend years with compliance rates of 98% through 99%. In MY 2012 the MCO had not completed all of the required on-site visits for recredentialing. The UniCare Site Visits Policy was updated to address the on-site requirement for recredentialing and all on-site reviews were brought up to date in 2014 as reported in UniCare's CAP.
- Timeliness of scheduling appointments and PCP accessibility 24/7 have been issues for UniCare for all three trend years. UniCare's rates for Non-Urgent Sick appointments and After hours 24/7 access are below the 90% requirement specified in the BMS/MCO contract.

Performance Improvement Projects

The BMS/MCO contract requires the MCOs to "conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction." For MY 2013 the MCOs are required to have three PIPs in place. All MCOs are required to participate in the mandatory Asthma Emergency Department (ED) Collaborative PIP and the mandatory Diabetes Collaborative PIP. All MCOs have the required three PIPs in place as summarized in the table below.

CoventryCares	**Improving Adolescent Well Care Rates** - This is the second year for CoventryCares's Adolescent Well-Care visits (AWC) PIP which aims to improve the Adolescent Well-Care Visit rate. The MCO's goal is to increase the indicator rate by 5 percentage points over the prior year's rate. **Emergency Department Collaborative (Mandatory)** – The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* CoventryCares also selected and additional indicator for this project, *Use of Appropriate Medications for People With Asthma, ages 5-11 and 12-18.* **Diabetes Collaborative Project (Mandatory)** - The mandatory indicator is *Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Control (<8%)*. CoventryCares also selected an additional indicator for this project, *Comprehensive Diabetes Care-LDL-C Level Control (LDL-C<100 mg/dl),* with the same goal.
The Health Plan	**Childhood Obesity** - The project aims to increase by 5% annually, the percent of members with evidence of Body Mass Index (BMI) documentation and counseling for nutrition and physical activity for children 2-17 years of age. **Emergency Department Collaborative (Mandatory)** – The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* The MCO also selected an additional indicator for this project, the HEDIS *Asthma Medication Ratio*. **Diabetes Collaborative Project (Mandatory)** - The mandatory indicator is *Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Control (<8%).* The Health Plan also selected an additional measure, *Comprehensive Diabetes Care – HbA1c Testing,* for this project.

UniCare	**Childhood Immunizations Combination 3** – UniCare aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the *Childhood Immunization Status (CIS) - Combination 3* indicator. This indicator is the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influence type B (HiB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. **Emergency Department Collaborative (Mandatory)** – The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* The MCO also selected the HEDIS *Use of Appropriate Medications for People with Asthma* (MMA) indicators for use in this project. **Diabetes Collaborative Project (Mandatory)** - The mandatory indicator is *Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control <8.* UniCare also selected two additional indicators for this project: *HbA1c Testing* and *Eye (Retinal) Exam Performed*.

CoventryCares, Inc.

Adolescent Well-Care Visits (AWC)

This is the second year for CoventryCares's Adolescent Well-Care Visits (AWC) PIP which aims to improve the Adolescent Well-Care Visit rate. The MCO's goal is to increase the indicator rate by 5 percentage points over the prior year's rate. CoventryCares achieved an increase in the indicator rate from 46.58% in MY 2012 to 47.20% in MY 2013, falling short of its goal. Planned interventions appear to be well thought out and target identified barriers.

PIP Summary: Improving Adolescent Well-Care Visits Rates	
Rationale	• The *Adolescent Well-Care Visits (AWC)* measure is the percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. Approximately 25% of CoventryCares's membership is made up of adolescents 12-21 years of age. The HEDIS 2012 (MY 2011) rate of 42.13% was below the NCQA Quality Compass 50th Percentile of 49.71% for this measure presenting an opportunity for improvement.
Indicator and Goal	• The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year. The MCO's immediate goal is to increase the indicator rate 5 percentage points over the prior year's measurement.
Strengths	• The MCO selected a short term and long term goal. The short term goal is to achieve a 5 percentage point increase in the prior year's measurement rate. The long term goal is to achieve the NCQA Quality Compass 90th Percentile. • The indicator rate has improved over the first two remeasurement periods. The baseline rate (MY 2011) was 42.15%, the first remeasurement rate (MY 2012) was 46.58%, and the second remeasurement rate (MY 2013) was 47.20%. CoventryCares fell slightly below the benchmark of 48.18%. The rate was also below the goal of 51.58% (5 percentage point increase over prior year's rate).
Barriers	• Some adolescents may not feel comfortable being seen in an office where there are predominately younger or older clients. • Privacy and confidentiality are concerns for this population. • Many adolescents are seen for sick visits and not well-care visits. • Adolescents are receiving sports and school physicals vs. comprehensive well-care visits. • Some provider offices lack developmental screening and anticipatory guidance tracking tools.

PIP Summary: Improving Adolescent Well-Care Visits Rates	
Interventions	• Disease Managers and Case Managers call members identified as non-compliant to educate and assist with appointments if needed. • EPSDT reminder system identifies members in need of services, including the annual well-visit. • Site visits are conducted to high volume offices to review medical records throughout the year to collect supplemental data, and to provide education to office staff about the AWC measure.

PIP Results			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
MY 2011	Baseline	Not Applicable	42.13%
MY 2012	Remeasurement 1	5 percentage point increase over prior year's rate.	46.58%
MY 2013	Remeasurement 2	5 percentage point increase over prior year's rate.	47.20%

Findings. The indicator rate has improved over the first two remeasurement periods. The baseline rate (MY 2011) was 42.13%, the first remeasurement rate (MY 2012) was 46.58%, and the second remeasurement rate (MY 2013) was 47.20%. The rate was below CoventryCares goal of 51.58% (5 percentage point increase over prior year's rate).

Recommendations. CoventryCares should Continue PIP at least one more year to attempt to achieve significant improvement.

Asthma Collaborative

The MHT MCOs collaboratively aim to reduce emergency department utilization through interventions targeting members with asthma. The mandatory indicator is the *Annual Percentage of Asthma Patients with one or More Asthma-Related ED Visits (ages 2-20).* The MCO also selected an additional HEDIS measure, *Use of Appropriate Medications for People With Asthma* for use in this PIP.

PIP Summary: Asthma Collaborative	
Rationale	• This is a mandatory PIP. Asthma is a chronic disease in the WV MHT population which provides opportunity for improvement. According to the Centers for Disease Control and Prevention, in 2008 asthma prevalence among children was 11.5% in West Virginia, compared to 9% nationwide. Asthma was the third most costly diagnosis for CoventryCares members in 2013 when considering all treatment settings, and the second most costly for treatment specific to the Emergency Department (ED) setting.
Indicators and Goals	• The mandatory indicator is the *Annual Percentage of Asthma Patients with one or More Asthma-Related ED Visits (ages 2-20).* The MCO has selected the HEDIS *Use of Appropriate Medications for People With Asthma* indicator for use in this PIP. The goal will be selected after the baseline rate has been submitted (June 2014)

PIP Summary: Asthma Collaborative	
Strengths	• Clearly defined study question. • Clearly defined study population and indicators. • Clearly defined study design and data analysis plan. • Targeted member and provider interventions.
Barriers	• Members choose to seek care in ED for asthma "flare up" instead of ongoing care with primary care physician. • Lack of transportation. • Lack of an established relationship with a PCP or "medical home". • Member may not want to wait for available appointment with PCP and feel that it is quicker and more convenient to seek care in the ED.
Interventions	• Provider-Centric Asthma Condition Management Program - Provider volunteers are expected to reach out to members with asthma an encourage them to schedule office visits to complete a physical exam. Following the exam, the provider is expected to schedule a series of four educational visits designed to enhance the member's understanding of the disease. • Asthma Condition Management Member Incentive Program – Offers members a $25 gift card for regular health care visits with their Primary Care Provider (PCP) to manage their asthma and for compliance with maintenance medications. • Gaps in Care Lists - Lists of non-compliant members are sent to providers with hopes that the providers will follow-up to bring members in for missing services. • MCO Collaborative Letter - A collaboratively written letter was being developed by the MCOs in 2013 with plans to distribute to providers state-wide advising them that the MCO's have chosen to focus on reducing emergency department usage for members with asthma. (The letter was distributed in early 2014.)

PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined with the PIP Collaborative Team*	8.86%
Indicator 2: Use of Appropriate Medications for People with Asthma (ages 5-11 and 12-18)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	Goal Age 5-11: 94.92%, Goal Ages 12-18: 92.16%	Rate Ages 5-11: 92.62%, Rate Ages 12-18: 86.92%

***PIP Annual Reports were due July 2014. It is anticipated that the goal will be determined by the last quarter of 2014 and be reported in the 4th quarter report due February 2015.**

Findings. This PIP meets the requirements. CoventryCares should continue with this project, with MY 2014 as the first year of remeasurement data.

Recommendations. The MCO should add one-to-one provider education or face-to-face contact with providers in its interventions. The MCO sends providers lists of non-compliant members (Gaps in Care Lists) in hopes that they provide follow-up to get members into care. The MCO should put a mechanism in place to monitor or require follow-up by providers as part of the intervention.

The MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.

Diabetes Collaborative

The MHT weighted average and the MCO's rate for the mandatory indicator, *Comprehensive Diabetes Care (CDC) - HbA1c control (<8%)* are below the National Medicaid Average. CoventryCares selected an additional indicator, *LDL-C Level Control (LDL-C<100 mg/dL),* for use in this project. Each MCO will implement its own MCO-specific interventions in addition to the collaborative intervention(s) agreed upon by the MCOs.

PIP Summary: Diabetes Collaborative	
Rationale	• This is a mandated PIP. The Prevalence of diabetes in WV has nearly tripled since 1996. Diabetes is contributing to long-term complications, including blindness, kidney failure, amputation and heart disease.
Indicators and Goals	• The goal for both indicators is to meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015).
Strengths	• Comprehensive project rationale. • Both performance measures are HEDIS indicators.
Barriers	• Member lack of understanding of how to manage their diabetes and the importance of tests, exams, and screenings. • Member non-compliance with their management plan. • Providers may be unaware of resources available to them such as certified diabetes educators and patient education materials/resources.
Interventions	• Outreach Calls- Disease Management and Case Management make targeted calls to members with diabetes to educate and encourage members to get the recommended services and to enroll them in the appropriate Disease or Case Management program. • Customer Service Clinical Notifications – If a non-compliant member calls in to Customer Services, a notification comes up on the screen and the Customer Service Representative speaks with the member about missing services and helps to get them in for care. • Diabetes Passports – The MCOs mail diabetes passports to members for them to keep track of services needed and received. • Gaps in Care Lists- Lists of non-compliant members are sent to providers with hopes that the providers will follow-up to bring members in for missing services. • A collaboratively written letter was developed with the plan to distribute to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for members with diabetes. (The letter was distributed in early 2014.)

PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1C Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (2015)	41.32%

Indicator 2: Comprehensive Diabetes Care – LDL-C level Control (LDL-C<100mg/dl)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (2015)	22.00%

Findings. This PIP meets the requirements. CoventryCares should continue with this project, with MY 2014 as the first year of remeasurement data.

Recommendations. The MCO should investigate an intervention that includes one-to-one provider education or add face-to-face contact with providers as part of an existing intervention. Additionally, the MCO sends providers lists of non-compliant members (Gaps in Care Lists) in hopes that the providers provide follow-up with identified members. It is recommended that the MCO put a mechanism in place to monitor or require follow-up as part of the intervention.

The Health Plan

Childhood Obesity

The project aims to increase by 5% annually, the percent of members with evidence of Body Mass Index (BMI) documentation, counseling for nutrition, and counseling for physical activity for children 2-17 years of age.

PIP Summary: Childhood Obesity	
Rationale	• Identification of, and early interventions with obese members aged 2-17, can ultimately impact their health, decrease their morbidity of the disease, and enhance their quality of life. This can be accomplished with the identification of obesity through documentation of *BMI Percentile, Counseling for Nutrition* and *Counseling for Physical Activity,* the three project indicators.
Indicators and goals	• Members with evidence of BMI documentation (2-17 years of age). Goal: 5% annual increase. • Members with evidence of nutritional counseling (2-17 years of age). Goal: 5% annual increase. • Members with evidence of physical activity counseling (2-17 years of age). Goal: 5% annual increase.
Strengths	• Comprehensive project rationale. • The MCO's data analysis plan is comprehensive, addressing both the qualitative and quantitative findings.
Barriers	• Despite repeated attempts at educating providers, most practices are still not coding for their weight management activities; • Member knowledge deficits regarding the purpose and importance of BMI value and how weight impacts health; • Providers lack of knowledge of the importance of measuring a BMI and providing counseling; and • Provider knowledge deficit regarding obesity-related educational materials and assistance available through the MCO.
Interventions	• Provider education seminars were conducted during which the importance of coding for weight and nutritional counseling activities was stressed to providers.

PIP Results*			
Indicator 1: Members with evidence of BMI documentation (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	N/A	15.09%
MY 2009	Remeasurement 1	5% annual increase	1.45%
MY 2010	Remeasurement 2	5% annual increase	1.12%
MY 2011	Remeasurement 3	5% annual increase	1.36%
MY 2012	Remeasurement 4	5% annual increase	35.28%
MY 2013	Remeasurement 5	5% annual increase	38.93%
Indicator 2: Members with evidence of nutritional counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline		35.52%
MY 2009	Remeasurement 1	5% annual increase	0.94%
MY 2010	Remeasurement 2	5% annual increase	0.54%
MY 2011	Remeasurement 3	5% annual increase	1.22%
MY 2012	Remeasurement 4	5% annual increase	51.82%
MY 2013	Remeasurement 5	5% annual increase	47.69%
Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	N/A	32.12%
MY 2009	Remeasurement 1	5% annual increase	0.78%
MY 2010	Remeasurement 2	5% annual increase	0.45%
MY 2011	Remeasurement 3	5% annual increase	1.12%
MY 2012	Remeasurement 4	5% annual increase	20.92%
MY 2013	Remeasurement 5	5% annual increase	27.25%

***The hybrid data collection methodology was used in MY 2008, MY 2012, and MY 2013. The administrative rate was used for MY 2009- MY 2011.**

Findings. *BMI Percentile* improved from 15.09% in the baseline measurement to 38.93% in Remeasurement 5 and is considered "extremely statistically significant" using Fisher's Exact Test. *Nutritional Counseling* improved from 35.52% in the baseline measurement to 47.69% in Remeasurement 5 – an increase of 34%. Although Indicator 3, *Physical Activity Counseling*, did not increase from the baseline rate, it did improve from 20.92% in Remeasurement 4 (MY 2012) to 27.25% in Remeasurement 5 (MY 2013).

In November and December of 2013 provider education seminars were conducted during which the importance of coding for weight counseling activities was stressed to providers. Although it is highly unlikely

that this intervention greatly impacted the indicators for MY 2013, it is very likely that it will make an impact on the MY 2014 rates.

Recommendations. This PIP met requirements and is now closed as it achieved sustained improvement for two of the three indicators. Although the project will be closed, the MCO should continue its interventions that it determined to be effective.The MCO must develop a new PIP and provide the project proposal to Delmarva for review and approval.

Asthma Collaborative

The MHT MCOs collaboratively aim to reduce emergency department utilization through interventions targeting members with asthma. The mandatory indicator is the *Annual Percentage of Asthma Patients with One or More Asthma-Related ED Visits (ages 2-20).* The Health Plan also selected the indicator HEDIS *Asthma Medication Ratio* indicator for use in this PIP.

PIP Summary: Emergency Department Collaborative	
Rationale	• This is a mandatory PIP. Asthma is a chronic disease in the WV MHT population which provides opportunity for improvement. According to the Centers for Disease Control and Prevention, in 2008 asthma prevalence among children was 11.5% in West Virginia, compared to 9% nationwide. Asthma was the third most costly diagnosis for CoventryCares members in 2013 and the second most costly for treatment specific to the Emergency Department (ED) setting.
Indicators and Goals	• The MHT MCOs collaborative aims to reduce emergency department utilization through interventions targeting members with asthma. The mandatory indicator is the Annual Percentage of Asthma Patients with one or More Asthma-Related ED Visits (ages 2-20). The MCO selected the HEDIS Asthma Medication Ratio (AMR) as a secondary indicator for this project.
Strengths	• The MCO's proprietary HEART system allows for the identification of high utilizers of the ED, including those for respiratory conditions. Reports are generated for purposes of one-to-one outreach. • Interventions include one-to-one telephone contact with caregivers and high utilizers of the ED. • Notable improvement achieved for both indicators when comparing baseline to final remeasurement.
Barriers	• Engaging members with asthma is difficult. Members are difficult to contact and often stop taking their medication when they feel better. • Providers are often not maintaining their rosters and may not be aware of asthmatic patients.
Interventions	• Call Queue - The development and implementation of a call queue with a dedicated outreach representative will help to overcome the barrier of member engagement. • Gap Reports – Gap Reports are available to providers in "real time" via a secure web portal. This should help physicians to determine which members may not be following their action plans. These will also help member engagement by ensuring physicians know which members on their roster are asthmatic. • Collaborative Letter - A collaboratively written letter was developed with plans to send to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for members with asthma. (The letter was distributed in early 2014.)

PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined by the PIP Collaborative Team*	6.58%
Indicator 2: Asthma Medication Ratio			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	5% total increase	83.67%

***PIP Annual Reports were due July 2014. It is anticipated that the goal will be determined by the last quarter of 2014 and be reported in the 4th quarter report due February 2015.**

Findings. This PIP meets requirements. The Health Plan should continue with this collaborative PIP, with MY 2014 as the first year of remeasurement data.

Recommendations. MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a Collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.

Diabetes Collaborative

All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is *Comprehensive Diabetes Care-HbA1c Control (<8%)*. The Health Plan also selected an additional measure, *Comprehensive Diabetes Care- HbA1c Testing*, for this project.

PIP Summary: Diabetes Collaborative	
Rationale	• Prevalence of diabetes in WV has nearly tripled since 1996. Diabetes is contributing to long-term complications, including blindness, kidney failure, amputation and heart disease. The MHT weighted average and The Health Plan's rate for HbA1c Control (<8%) are below the National Medicaid Average.
Indicators and Goals	• All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is from the HEDIS measure set, Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%) with the goal to meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). The Health Plan also selected an additional measure, Comprehensive Diabetes Care - HbA1c Testing, for this project. The goal for this measure is to have 100% of the MCO's members with diabetes have their HbA1c tested at least annually.
Strengths	• Comprehensive project rationale. • The performance measures are HEDIS measures.
Barriers	• The total Medicaid diabetic population is quite small and widespread throughout the state which makes it difficult to stage focused interventions in areas that are convenient for members. • At the MCO level, there are limitations to the amount of automated lab results and medical records The Health Plan is able to obtain. When the lab results cannot be obtained, the member will always be noncompliant for the HbA1c Control <8% indicator.

PIP Summary: Diabetes Collaborative	
Interventions	• Wellness and Health Promotion Call Center - This provides one-on-one personalized contact with diabetic members who are missing important services and/or testing. Claims histories are used to identify the gaps in care that trigger members being placed in an outbound call queue. The queues are updated weekly. Following the phone call from the nurse, a letter is sent to the member with a checklist of all missing services that were discussed on the call. A similar letter is sent to the member's PCP urging the PCP to assist the member in obtaining any services the member desires. • Collaborative Letter - A collaboratively written letter was being developed with plans to be sent to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for members with diabetes. (The letter was sent in early 2014.)

PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (2015)	41.32%
Indicator 2: Comprehensive Diabetes Care – HbA1c Testing			
Time Period	Measurement	Goal	Rate or Results
1/1/2013 – 12/31/2013	Baseline	100%	73.91%

Findings. The MCO's baseline rates (MY 2013) for the indicators are 45.34% for *Comprehensive Diabetes Care- HbA1c Control <8%* and 73.91% for *Comprehensive Diabetes Care- HbA1c Testing*. The MY 2013 data will serve as the baseline measurement. HEDIS 2014 Quality Compass national benchmarks, once released, will be used to establish goals for the mandatory indicator. The Health Plan has chosen a goal of 100% for *Comprehensive Diabetes Care- HbA1c Testing*.

Recommendations. The Health Plan sends letters to providers containing members with missing services, hoping that providers will follow-up with non-compliant members. The MCO should implement a mechanism to ensure providers do some sort of follow-up.

UniCare Health Plan, Inc.

Childhood Immunizations Combination 3 Project

With the Childhood Immunizations Combination 3 PIP, UniCare aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H

influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. For HEDIS 2013, the National Medicaid Average was 72.08%.

Childhood Immunizations Combination 3	
Rationale	• UniCare selected the *Childhood Immunization Status, Combination 3* HEDIS indicator for this project. This indicator rate for HEDIS 2013 (MY 2012) was below the NCQA Quality Compass 25th percentile, indicating an opportunity for improvement. This PIP also shows a commitment to the US Department of Health and Human Services Healthy People 2020 goals to increase immunization rates and reduce preventable infectious diseases by supporting recommended vaccinations.
Indicators and Goals	• The goal of this project is to increase the *Childhood Immunization Status (CIS) – Combination 3* rate. This is the rate of children who turned two during the measurement year who received their age-appropriate immunizations based on the Centers for Disease Control and Prevention (CDC) Childhood Immunization Guidelines. The goal is to meet or exceed the previous year's NCQA Quality Compass Medicaid National Average. For HEDIS 2013, the National Medicaid Average was 72.08%.
Strengths	• The performance measure is a HEDIS measure. • Although not significant, the 1.9 percentage point increase from HEDIS 2013 to HEDIS 2014 appears to be the result of the combination of the interventions that are in place. • Interventions address many of the barriers identified, target and provide one-to-one contact with providers and enrollees. • Interventions are multifaceted using outreach phone calls, mailings, and provider gaps in care reports. Although the indicator did not improve significantly, it could be that interventions implemented in the 4th quarter (4th Quarter Push, data transfer from the WVSIIS) need additional time to impact the indicator.
Barriers	• Members are seen for urgent care/sick visits, but immunizations are not addressed. • Providers receive vaccines for free through the Vaccines for Children program, so the providers are only eligible to receive payment for the administration fee. Many providers do not bother to bill for the administration fee, so UniCare is missing administrative data on vaccine administration. • Many practices are no longer carrying vaccines and are referring members to the health department for immunizations.
Interventions	• Data Transfer - Initiation of a data transfer with the West Virginia State Immunization Information System (WVSIIS), the immunization registry, in December 2013. Beginning 2014, the MCO will conduct monthly data transfers of immunization data. • Incentive Program - Well-Baby Care Visit Incentive Program which provides a $50 incentive for parents/caregivers when a child completes 6 of 8 well visits by 15 months of age. • Last Quarter Push Effort - UniCare initiated a "4th Quarter Push" to get members in for their immunizations. They were able to reach 230 members with this effort. • Gaps in Care Reports.

PIP Results			
Indicator 1: The percentage of children 2 years of age who had received the Childhood Immunizations Combination 3 by their second birthday.			
Time Period	Measurement	Goal	Rate or Results
1/1/2012 – 12/31/2012	Baseline	71.93%	62.04%
1/1/2013 – 12/31/2013	Remeasurement 1	72.08%	63.43%

Findings. UniCare has a clear project rationale and indicators in its project. The project included baseline and one remeasurement year of data for it's MY 2013 submission. UniCare's Remeasurement 1 rate of

63.43% shows a 1.39 percentage point improvement over the baseline rate of 62.04%, but did not meet its goal or benchmark and remains below the 2013 NCQA Quality Compass 25th percentile (66.08%). The year's performance indicates an improving trend, but the increase was not statistically significant. These positive increases appear to be the result of the combination of the interventions that are in place. Some interventions were implemented late in 2013 and likely have not had time to fully impact the indicator.

Recommendations. UniCare delivers Gaps in Care Reports to providers with hopes that the providers will follow-up and help bring the members into compliance. UniCare should implement a mechanism to ensure that providers follow-up with non-compliant members.

Continue interventions that were implemented in late 2013. This will likely result in improvement as the interventions may not have had enough time to impact the indicator for this reporting cycle.

Asthma Collaborative

The MHT MCOs collaboratively aim to reduce emergency department utilization through interventions targeting members with asthma. The mandatory indicator is the *Annual Percentage of Asthma Patients with one or More Asthma-Related ED Visits (ages 2-20).* UniCare has selected the HEDIS *Use of Appropriate Medications for People with Asthma (ASM)* and *Medication Management for People with Asthma (MMA)* indicators for use in this PIP.

PIP Summary: Emergency Department Collaborative	
Rationale	• This is a mandatory PIP. Asthma is a chronic disease in the WV MHT population which provides opportunity for improvement. According to the Centers for Disease Control and Prevention, in 2008 asthma prevalence among children was 11.5% in West Virginia, compared to 9% nationwide.
Indicators and Goals	• In this mandatory project, the WV MHT MCOs collaboratively aim to reduce emergency department utilization through interventions targeting members with asthma. Indicator 1, the mandatory indicator, is the *Annual Percentage of Asthma Patients with One or More Asthma-Related ED Visits (ages 2-20)*. UniCare selected two additional indicators, *Use of Appropriate Medications for People with Asthma* (*ASM*) and *Medication Management for People with Asthma* (*MMA*), both of which are HEDIS indicators.
Strengths	• Interventions directly target the members identified as asthmatic as well as providers who treat asthmatic patients. • Interventions target identified barriers and provide on-to-one contact to members and providers. • Interventions are multi-faceted using outreach, case management, disease management, provider profiling and reporting. • UniCare chose two additional indicators in addition to the mandatory indicator.
Barriers	• Engaging members with asthma is difficult. Members are difficult to contact and often stop taking their medication when they feel better. • Members have difficulty navigating the health care system.

PIP Summary: Emergency Department Collaborative	
Interventions	• Participation in the WV Asthma Coalition meetings to better understand existing programs in WV and solicit suggestions from patients and providers about potential interventions and methods to reach target groups. • Disease management (Care Compass). Disease managers contact members or their guardians who meet program eligibility criteria to offer supportive clinical management and education on self-management of asthma. • A collaboratively written letter was developed with plans to distribute to providers state-wide advising them that the MCO's have chosen to focus on reducing emergency department usage for members with asthma. The letter was distributed in early 2014.

PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Department Visits (ages 2-20).			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To be determined with the PIP Collaborative Team*	8.29
Indicator 2: Use of Appropriate Medications for People with Asthma (ASM).			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To be determined upon release of Quality Compass Results	76.61
Indicator 3: Medication Management for People with Asthma (MMA).			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013	Baseline	To be determined upon release of Quality Compass Results	42.39

***PIP Annual Reports were due July 2014. It is anticipated that the goal will be determined by the last quarter of 2014 and be reported in the 4th quarter report due February 2015.**

Findings. This PIP meets the requirements. UniCare should continue with this project, with MY 2014 as the first year of remeasurement data.

Recommendations. MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a Collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.

Diabetes Collaborative

All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is the HEDIS indicator *HbA1c Control (<8%)*. The MCO also selected two additional HEDIS indicators which are *HbA1c Testing* and *Eye (Retinal) Exam Performed*. The Diabetes Collaborative PIP goal is to meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015).

PIP Summary: Diabetes Collaborative	
Rationale	• Prevalence of diabetes in WV has nearly tripled since 1996. Diabetes is contributing to long-term complications, including blindness, kidney failure, amputation and heart disease. The MHT weighted average and UniCare's rate for *HbA1c Control (<8%)* are below the National Medicaid Average.
Indicators and Goals	• All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is from the HEDIS measure set, Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%) with the goal to meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). UniCare also selected additional measures, Comprehensive Diabetes Care - HbA1c Testing, and Retinal Eye Exams for this project.
Strengths	• The performance measures are HEDIS indicators. • In addition to the mandatory indicator (HbA1c Control <8%), UniCare chose two additional indicators, HbA1c Testing and Retinal Eye Exam.
Barriers	• There exists a lack of knowledge about member's own condition and the link between poor diabetic control and disease complications. • Insufficient local health plan staff to provide individual consultation with practices and providers to drive quality improvement.
Interventions	• Member Incentive Program - Provides a $25 incentive each for completing diabetic screenings and an annual eye exam. • Member Outreach (live calls) - Live outreach phone calls based on Gaps in Care to assist in identifying obstacles in the member's life preventing them from getting the needed service. • Collaborative Letter - A collaboratively written letter was being developed to distribute to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for members with diabetes.(The letter was distributed in early 2014.)

PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	28.73%
Indicator 2: Comprehensive Diabetes Care – HbA1c testing			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	80.18%
Indicator 3: Comprehensive Diabetes Care – Eye (Retinal) Exam Performed			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	25.84%

Findings. This PIP meets the requirements. UniCare should continue with this project, using MY 2014 as the first year of remeasurement data.

Recommendations. UniCare should include study questions for the additional two indicators it has selected for this project (*HbA1c Testing* and *Eye (Retinal) Eye Exam Performed*).

Performance Measure Validation

HEDIS measures are categorized and reported in five domains that gage specific areas of care and service. The measures reported by the MHT MCOs related to quality, access, and timeliness for this report are found in the following three HEDIS domains:

- Effectiveness of Care
- Access/Availability of Care, and
- Utilization and Relative Resources Use

Measures in the Experience of Care and Health Plan Descriptive Information domains are not used in this report as they do not directly relate to the quality, access, and timeliness of care dimensions evaluated in this report.

For this section of the report the MHT Weighted Averages (MHT-WA) for selected measures are compared to the National Medicaid Percentiles (NMPs) for benchmarking purposes. MCO HEDIS measures and indicators rates, including trended rates are found in the Appendices.

MHT Quality Strategy (QS) and Performance Incentive Program

The *West Virginia Mountain Health Trust Program State Quality Strategy for Assessing and Improving Managed Care Quality* (Quality Strategy) was updated in 2013. It contains five priorities. They are:

1. Make care safer by promoting the delivery of evidence-based care.
2. Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider.
3. Promote effective communication and coordination of care.
4. Promote effective prevention and treatment of diseases that burden MHT enrollees.
5. Enhance oversight of MCO administration.

The Quality Strategy includes performance measures and improvement goals that align to two priorities. The two priorities and measures that align with them are as follows.

- Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider (*Children's and Adolescents' Access to PCP* and *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*).

- Promote effective prevention and treatment of diseases that burden MHT enrollees (*Adult BMI Assessment, Childhood Immunization Status Combination 3, Comprehensive Diabetes Care- HbA1c Control (<8%), Prenatal and Postpartum Care, Postpartum Care,* and *Weight Assessment and Counseling for Nutrition, Physical Activity, for Children/Adolescents – BMI Percentile*).

BMS implemented a Performance Incentive Program to reward MCOs for improved performance for three of the Quality Strategy (QS) measures (*Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, Childhood Immunization Status Combination 3,* and *Prenatal and Postpartum Care, Postpartum Care*). MCOs will receive up to a 1.5 percent increase their total capitation and delivery payments, if they improve their scores for these three measures compared with performance during the previous calendar year. Performance on each measure is worth 0.5 percent of the total capitation and delivery amount paid. Each quality measure has a Quality Strategy (QS) Goal based on Measurement Year (MY) 2012 performance. The QS Goal, MHT Weighted Averages (MHT-WA) for HEDIS 2012-HEDIS 2014, National Medicaid Average (NMA), and National Medicaid 90th Percentile for the QS measures are provided in Table 5.

Table 5. WV MHT Quality Strategy Measures

Measure	QS Goal	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	NMA HEDIS 2014 %	National Medicaid 90th Percentile HEDIS 2014 %
Priority: Engage individuals and families as partners in their care by strengthening the relationship between patients and their primary care provider						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	Achieve rates equal to or above the MY 2012 (HEDIS 2013) NMA (71.9%) by MY 2014 (HEDIS 2015)	67.3	67.5	70.0	71.5	82.7
Children's and Adolescents' Access To PCP (12-24 Months)	Achieve rates equal to or above the MY 2012 (HEDIS 2013) 75th Percentile (96.0%) by MY 2014	97.4	97.6	97.5	96.1	98.5
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	Achieve rates equal to or above the MY 2012 (HEDIS 2013) 75th Percentile (88.3%) by MY 2014	91.0	91.1	91.3	88.2	93.6

Measure	QS Goal	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	NMA HEDIS 2014 %	National Medicaid 90th Percentile HEDIS 2014 %
Children and Adolescents' Access To PCP (7-11 Yrs.)	Achieve rates equal to or above the MY 2012 (HEDIS 2013) 75th Percentile (89.8%) by MY 2014	92.9	93.5	93.8	90.0	95.2
Children and Adolescents' Access To PCP (12-19 Yrs)	Achieve rates equal to or above the MY 2012 (HEDIS 2013) 75th Percentile (88.3%) by MY 2014	90.4	92.0	92.7	88.5	94.4
Priority: Promote effective prevention and treatment of diseases that burden MHT enrollees						
Adult BMI Assessment	Achieve rates equal to or above the MY 2012 (HEDIS 2013) NMA (67.6%) by MY 2014 (HEDIS 2015)	48.4	64.5	66.9	75.9	90.8
Childhood Immunization Status – Combination 3*	Achieve rates equal to or above the MY 2012 HEDIS NMA (72.1%) by MY 2014 (HEDIS 2015)	62.4	63.3	66.3	70.9	80.9
Comprehensive Diabetes Care - HbA1c Control (<8%)	Achieve rates equal to or above the MY 2012 HEDIS NMA (46.6%) by MY 2014 (HEDIS 2015)	41.3	38.6	36.1	45.4	59.4
Prenatal and Postpartum Care - Postpartum Care*	Achieve rates equal to or above the MY 2012 HEDIS 75th percentile (63.1% by MY 2014 (HEDIS 2015)	63.7	63.9	62.7	61.3	74.0

Measure	QS Goal	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	NMA HEDIS 2014 %	National Medicaid 90th Percentile HEDIS 2014 %
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	Increase rate by 8% by MY 2014 (HEDIS 2015)	18.1	37.3	45.4	56.9	82.5

***Performance Incentive Program Measures**

The MHT-WA for the following QS measures met or exceeded their QS Goal:

- Children's and Adolescents' Access to PCP
  - Ages 12-24 months
  - Ages 24 months - 6 years
  - Ages 7-11 Years
  - Ages 12-19 Years
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- BMI Percentile

The MHT-WA for two QS measures were within one percent of meeting their QS Goal:

- Adult BMI Assessment
- Prenatal and Postpartum Care - Postpartum Care

The MHT-WA for five QS measures compared favorably to the National Medicaid Average. They are:

- Prenatal and Postpartum Care - Postpartum Care
- Children's and Adolescents' Access to PCP
  - Ages 12-24 months
  - Ages 24 months - 6 years
  - Ages 7-11 Years
  - Ages 12-19 Years

The MHT-WA improved for each year for all the QS measures except for *Comprehensive Diabetes Care - HbA1c Control (<8%)* and *Prenatal and Postpartum Care-Postpartum Care.*

For the QS measures, all but one performed favorably by achieving or exceeding QS Goals, meeting or exceeding NMA, or improving for each year between HEDIS 2012 and 2014. *Comprehensive Diabetes Care-HbA1c Control (<8%)* is the only measure not to show any improvement of performance. This measure is the focus of the mandatory Diabetes Collaborative PIP in which all MCOs are required to participate.

In 2014, BMS replaced the Performance Incentive Program with the Performance Withhold Program (PWP) and selected five measures to gage MCO performance. They are:

- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well-Care Visits
- Immunizations for Adolescents-Combination 1
- Medication Management for People with Asthma – 75% Compliance
- Prenatal and Postpartum Care - Postpartum Care

Beginning July 1, 2014, the Department will place each MCO at risk for five percent (5%) of the capitation payment by withholding that amount from the monthly capitation paid to the MCO by BMS. The Department's objective for the MCOs achieve performance standards that enable them to earn back the 5% withhold. Each MCO will receive a portion of the withheld capitation payment if it meets or exceeds the targeted benchmark on the selected performance measures or targets. Each of the five measures is worth up to 1.0 percent (1%) of the capitation payment based on the MCO's performance, using the following system:

Percentage of Capitation Payment Earned Back per Measure	Target/Goal
0.00%	Under the targeted benchmark
0.50%	Equal to the targeted benchmark
0.60%	Greater than or equal to 1 percentage point above the targeted benchmark
0.70%	Greater than or equal to 2 percentage points above the targeted benchmark
0.80%	Greater than or equal to 3 percentage points above the targeted benchmark
0.90%	Greater than or equal to 4 percentage points above the targeted benchmark
1.00%	Greater than or equal to 5 percentage points above the targeted benchmark

For additional information regarding HEDIS measures in the Quality Strategy and Performance Withhold Program, please refer to Appendix 2. The HEDIS 2014 MCO rates, MHT-WV, NMA, and National Medicaid 90th Percentile are provided for each measure.

Performance Measures

HEDIS measures collected, including those in Table 5, are presented in the Quality, Access, and Timeliness sections that follow. Through the discussion, a star rating system is used to compare the MHT Weighted Averages (MHT-WA) to the National Medicaid Percentiles (NMPs).

Table 6. Star Ratings for Performance Measure Tables

National Medicaid Percentile Ranges	Star Rating
Exceeds the 90th Percentile	★★★★★
Exceeds the 75th Percentile to 90th Percentile	★★★★
Exceeds the 50th Percentile to the 75th Percentile	★★★
Exceeds the 25th Percentile to the 50th Percentile	★★
25th Percentile or less	★

Quality Performance Measures

Twenty-one indicators that gauge prevention, immunizations, screenings, asthma, and diabetes care were selected from the HEDIS Effectiveness of Care Domain to assess the quality of care provided by the MHT MCOs. For the ease of reading, the 14 prevention, immunization, screening, and asthma measures are displayed in a separate table from the seven diabetes measures. The HEDIS 2012 through HEDIS 2014 MHT Weighted Averages (MHT-WA) for the immunization and screening measures are provided in the table below with the National Medicaid Percentile (NMP) comparisons.

Table 7. Quality Performance Measures – Prevention, Immunizations, Screenings, and Asthma

Measure Name and Goal	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Childhood Immunization Status - Combination 2	68.3	68.3	70.4	★
Childhood Immunization Status – Combination 3	62.4	63.3	66.3	★
Immunizations for Adolescents - Combination 1	45.0	65.5	80.7	★★★★
Lead Screening in Children	55.1	57.1	56.6	★
Controlling High Blood Pressure	64.7	54.9	49.5	★★
Adult BMI Assessment	48.4	64.5	66.9	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	18.1	37.3	45.4	★★

Measure Name and Goal	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	30.5	46.4	43.9	★
Medication Management for People With Asthma - Ages 5-11 Years, Compliance 75%+	39.3	38.0	36.8	★★★★
Medication Management for People With Asthma - Ages 12-18 Years, Compliance 75%+	32.8	35.1	27.6	★★★
Medication Management for People With Asthma – Total, Compliance 75%+	36.9	36.9	33.9	★★★
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	75.3	73.0	74.4	★★
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	45.8	38.9	42.1	★★
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	39.1	38.1	40.9	★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. One star represents a rate equal to or less than the 25th Percentile. Five stars represent the highest rating, a rate that is greater than the 90th Percentile. Refer to Table 6 for details.**

Eight of the 14 indicators improved between HEDIS 2012(MY 2011) and HEDIS 2014(MY 2013) including:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents - Combination 1
- Lead Screening in Children
- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI Percentile
  - Counseling for Nutrition
- Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies

The trending data for all three immunization measures shows continuous improvement for each year between HEDIS 2012 (MY 2011) through HEDIS 2014 (MY 2013). Rates also improved each year for *Adult BMI Assessment* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI*

Percentile. The *Immunizations for Adolescents-Combination 1* measure achieved the greatest improvement over the three year period with an increase of 35.7 percentage points.

The MHT Weighted Average for two measures received ratings of four stars, indicating they exceeded the National Medicaid 75th Percentile:

- Immunizations for Adolescents-Combination 1
- Medication Management for People With Asthma, 75% Compliance: Ages 5-11 Years

Medication Management for People With Asthma, 75% Compliance (Ages 12-19 Years and *Total)* received a rating of three stars and exceeded the National Medicaid 50th Percentile.

The MCO's continue to improve their outreach efforts for members to bring their immunizations up-to-date. In addition, all three MCOs continue to access data from the WV Statewide Immunization Information System (WVSIIS) and focus their attempts at securing immunization information from medical records during the HEDIS medical record abstraction process.

The table below presents seven selected indicators for *Comprehensive Diabetes Care (CDC)* and the comparative national benchmarks.

Table 8. Quality Performance Measures- Comprehensive Diabetes Care (CDC)*

Measure Name	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	68.8	61.6	60.4	★★
Comprehensive Diabetes Care - Eye Exams	32.8	29.9	29.4	★
Comprehensive Diabetes Care - HbA1c Control (<8%)	41.3	38.6	36.1	★
Comprehensive Diabetes Care - HbA1c Testing	76.8	73.6	76.4	★
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	27.7	27.9	22.6	★
Comprehensive Diabetes Care - LDL-C Screening	64.2	62.4	64.3	★

Measure Name	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Comprehensive Diabetes Care - Medical Attention for Nephropathy	63.1	57.3	59.7	★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. Refer to Table 6 for details.**
+ The eligible population for the CDC indictors is small with an eligible population of 1,075 of approximately 186, 400 enrollees.

The rate for *LDL-C Screening* improved from HEDIS 2012 to HEDIS 2014. The following three rates improved between HEDIS 2013 and HEDIS 2014:

- HbA1c Testing
- Medical Attention for Nephropathy
- Blood Pressure Control (<140/90)

For Diabetes indicators, the *Blood Pressure Control (<140/90)* rate received a two star rating and exceeded the National Medicaid 25th Percentile.

The following six measures from the Adult and Child General Population CAHPS were used to assess the MCOs for quality:

- Customer Service Composite
- How Well Doctors Communicate
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

The following table provides the MHT Average (MHT-A) for HEDIS 2013 and HEDIS 2014 and comparisons to National Medicaid Percentiles (NMPs).

Table 9. Quality Measures-CAHPS Composites and Ratings

Measure	MHT-A HEDIS 2013 %	MHT-A HEDIS 2014 %	MHT-A Compared to NMP HEDIS 2014*
Adult Measures			
Customer Service Composite	90.6	90.7	★★★★★
How Well Doctors Communicate Composite	90.4	89.5	★★
Shared Decision Making Composite+	73.8	55.4	★★★★
Rating of Health Plan	72.7	71.4	★
Rating of All Health Care	72.9	68.5	★
Rating of Personal Doctor	77.9	78.0	★
Rating of Specialist Seen Most Often	76.7	76.5	★
Child General Population Measures			
Child Survey - General Population: Customer Service Composite	92.7	91.0	★★★★
Child Survey - General Population: How Well Doctors Communicate Composite	93.8	94.5	★★★
Child Survey - General Population: Shared Decision Making Composite+	67.3	54.8	★★
Child Survey - General Population: Rating of Health Plan	86.6	86.5	★★★
Child Survey - General Population: Rating of All Health Care	84.0	86.9	★★★★
Child Survey - General Population: Rating of Personal Doctor	87.3	88.2	★★★
Child Survey - General Population: Rating of Specialist Seen Most Often	84.7	85.6	★★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. Refer to Table 6 for details.**
+ Measure specifications changed significantly between HEDIS 2013 and 2014 for Shared Decision Making Composite in both the Adult and Child Surveys. Therefore, results cannot be compared between years.

For the Adult Quality CAHPS measures, *Customer Service Composite* and *Rating of Personal Doctor* improved between HEDIS 2013 and 2014. The following four Child Quality CAHPS measures also improved between HEDIS 2013 and 2014:

- How Well Doctors Communicate Composite
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

For Adult Quality CAHPS measures, the *Customer Service Composite* exceeded the National Medicaid 90th Percentile and received the highest rating of five stars. The *Shared Decision Composite* exceeded the National Medicaid 75th Percentile and received the second highest rating of four stars. Four Child Quality CAHPS measures exceeded the National Medicaid 50th Percentile and received five stars. The four measures are:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Two other Child Quality CAHPS measures compared favorably to national benchmarks. The *Customer Service Composite* and *Rating of Health Care* exceeded the 75th Percentile as indicated by the rating of four stars.

Opportunities for improvement exist with the following five Adult Quality CAHPS measures that received two stars or less:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

For Child quality measures, there is one opportunity for improvement with the *Shared Decision Making Composite* with a rating of two stars.

Overall, in the area of quality for PMV, five indicators improved between HEDIS 2012 and HEDIS 2014. The *Immunizations for Adolescents-Combination 1* measure achieved the greatest improvement with an increase of 35.7 percentage points between HEDIS 2012 and HEDIS 2014. This improvement is most likely the result of the MCOs' continuing outreach efforts to have members bring their immunizations up-to-date, obtaining data from the WV Statewide Immunization Information System (WVSIIS), and more focused attempts at securing immunization information from medical records. For CAHPS, two Adult and six Child Quality CAHPS measures compared favorably to national benchmarks.

Access Performance Measures

Nine indicators from the HEDIS Access Domain represent MHT performance for accessibility of health care services.

Table 10. Access Performance Measures

Measure Name	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Adults' Access to Preventive/Ambulatory Health Services (20-44)	86.9	84.9	85.3	★★★
Adults' Access to Preventive/Ambulatory Health Services (45-64)	87.0	86.0	85.5	★
Adults' Access to Preventive/Ambulatory Health Services (Total)	86.9	85.0	85.3	★★★
Children's and Adolescents' Access To PCP (12-19 Yrs.)	90.4	92.0	92.7	★★★★
Children's and Adolescents' Access To PCP (12-24 Months)	97.4	97.6	97.5	★★★
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	91.0	91.1	91.3	★★★
Children's and Adolescents' Access To PCP (7-11 Yrs.)	92.9	93.5	93.8	★★★★
Prenatal and Postpartum Care - Postpartum Care	63.7	63.9	62.7	★★
Prenatal and Postpartum Care - Timeliness of Prenatal Care	93.4	94.1	92.7	★★★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. One star represents a rate equal to or less than the 25th Percentile. Five stars represent the highest rating, a rate that is greater than the 90th Percentile.**

The following indicators showed improvement between HEDIS 2012 and HEDIS 2014:

- Children's and Adolescents' Access To PCP
  - 12-24 Months
  - 25 Months- 6 Years
  - 7-11 Years
  - 12-19 Years

The MHT program continues to perform well in providing access to care for its members with seven out of nine measures comparing favorably with national benchmarks; three measures exceeded the National Medicaid 75th Percentile and four measures exceeded the National Medicaid 50th Percentile.

The following measures were rated four stars for exceeding the National Medicaid 75th Percentile:

- Children's and Adolescents' Access To PCP
  - 7-11 Years
  - 12-19 Years
- Prenatal and Postpartum Care-Timeliness of Prenatal Care

The following three measures received three stars for exceeding the National Medicaid 50th Percentile:

- Adults' Access to Preventive/Ambulatory Health Services
  - 20-44 Years
  - Total
- Children and Adolescents' Access To PCP
  - 12-24 Months
  - 25 Months-6 Years

The Getting Care Needed Composite from both the Adult and Child General Population CAHPS surveys was selected to represent access. The results are found in the following table.

Table 11. Getting Needed Care Composite Rates- Adult and Child CAHPS

Measure	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Adult Survey-Getting Needed Care Composite	82.2	83.3	★★★
Child Survey-General Population: Getting Needed Care Composite	91.8	88.7	★★★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. One star represents a rate equal to or less than the 25th Percentile. Five stars represent the highest rating, a rate that is greater than the 90th Percentile.**

The MHT Average for the Adults *Getting Needed Care Composite* exceeded the National Medicaid 50th Percentile and received a rating of three stars. The MHT Average for the Child Getting Needed Care Composite exceeded the National Medicaid 75th Percentile and received 4 stars.

The MHT Weighted Averages for seven out of nine access performance measures have remained high compared to national benchmarks. Over the past three years, four measures improved between HEDIS 2012

through HEDIS 2014. Both the Adult and Child CAHPS scores for *Getting Needed Care Composite* compared favorably to national benchmarks.

Timeliness Performance Measures

The table below contains the four performance measures for the HEDIS Utilization and Relative Resources Use domain that were selected to represent MHT performance for timeliness of care.

Table 12. HEDIS Performance Measures for Timeliness

Measure Name	MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Adolescent Well-Care Visits	38.7	45.6	43.6	★★
Frequency of Ongoing Prenatal Care (≥81%)	77.1	77.7	74.4	★★★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.3	67.5	70.0	★★
Well-Child Visits in the First 15 Months of Life (6 or more visits)	68.6	69.4	67.1	★★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. One star represents a rate equal to or less than the 25th Percentile. Five stars represent the highest rating, a rate that is greater than the 90th Percentile. Refer to Table 6 for details.**

The three year trend from HEDIS 2012 to HEDIS 2014 indicated improving performance for two measures:

- Adolescent Well-Care Visits
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

The MHT-WA for *Frequency of Ongoing Prenatal Care (≥ 81%)* received a rating of four stars and exceeded the National Medicaid 75th Percentile. The MHT-WA for *Well-Child Visits in the First 15 Months of Life (6 or more visits)* received a rating of three stars and exceeded the National Medicaid 50th Percentile.

The Getting Needed Care Quickly Composite from both the Adult and Child General Population CAHPS was selected to represent timeliness of care.

Table 13. Getting Needed Care Quickly Composite- Adult and Child CAHPS

Measure	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014*
Adult Survey - Getting Care Quickly Composite	83.7	83.3	★★★
Child Survey - General Population: Getting Care Quickly Composite	95.3	94.5	★★★★★

***Star ratings are based on the HEDIS 2014 (MY 2013) Quality Compass. One star represents a rate equal to or less than the 25th Percentile. Five stars represent the highest rating, a rate that is greater than the 90th Percentile.**

The rate for the Adult *Getting Care Quickly Composite* received a rating of three stars and exceeded the National Medicaid 50th Percentile. The rate for the Child *Getting Care Quickly Composite* exceeded the National Medicaid 90th Percentile and received the highest rating of five stars.

For timeliness, two HEDIS measures and both CAHPS measures compared favorably to national benchmarks. Two HEDIS measures showed improvement between HEDIS 2012 and HEDIS 2014.

Summary of Quality, Access, and Timeliness

The External Quality Review Results section of 42 CFR §438.364 requires the external quality review organization (EQRO) to provide a detailed technical report that describes the manner in which the data from all activities conducted were aggregated, analyzed, and conclusions were drawn as to the quality, access and timeliness of the care furnished by the MCO. This section summarizes the Systems Performance Review, Performance Improvement Project, and Performance Measure Validation activities according to the quality, access, and timeliness of care provided to the MHT enrollees.

Quality

Quality, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

The evaluation of quality includes an assessment of each MCO's structural and operational characteristics as well as the provision of health services to Medicaid recipients. Improving quality in any of these areas increases the likelihood of the desired health outcomes of its recipients.

All three MCOs performed well for the QA standard. CoventryCares, The Health Plan, and UniCare achieved compliance rates of 97%, 99%, and 99% respectively.

This standard is important because it assesses each MCO's internal Quality Improvement (QI) structure and its ability to improve the quality of care and services for its enrollees. Key components of the QI program such as goals and objectives, governing board oversight, quality improvement committee activity, provider participation in QI activities, clinical practice guidelines, and quality of care studies and measures are assessed as part of this standard.

The MCOs have well documented Quality Assessment and Performance Improvement (QAPI) program plans that describe the organizational structure and include goals, objectives, and a detailed work plan. All QAPI plans note that the ultimate authority of the QAPI Program rests with the MCO's governing body, the Board of Directors (BOD). All MCOs carry out their QAPI functions using committees (e.g. credentialing, quality improvement, utilization management). Committee descriptions in the QAPI documents include all of the required components including committee responsibilities, a designated chairperson and responsibilities for each committee. The QAPI documents include organizational charts, describe the relationship between the committees, and how information is communicated among the committees and up to the BOD.

The MY 2013 SPR demonstrated the following MCO accomplishments related to quality. All three MCOs have:

- Well documented Quality Improvement Program (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- Detailed committee meeting minutes that describe actions taken, problem identification and resolution, as well as coordination and communication among committees.
- Demonstrated that appropriate staff and committees are involved in the decision making process for Utilization Management (UM) and QI activities.
- Utilization management procedures in place for making authorization decisions.
- Clinical practice guidelines(CPGs) in place, and update them at least every two years. All MCOs specifically reviewed their Diabetes and Asthma CPGs in 2013 to ensure they were current for use in the mandatory PIPs.
- CPGs and other industry acceptable criteria (e.g. InterQual and Milliman and Robertson) are used them to make UM decisions (e.g. pre-authorization of procedures).
- Procedures in place to monitor delegated credentialing entities. Delegates are held to same standards as MCOs as demonstrated by the delegated credentialing audits and monitoring conducted by the MCOs.
- Disease management programs in place for enrollees with special health care needs.
- Health education programs in place that are based on enrollee characteristics and needs.

- Methods in place to detect under- and over-utilization of services.
- The appropriate policies and procedures in place to cover and pay for emergency and post-stabilization care services.
- Processes in place to collect the required performance data (HEDIS measures) which is validated by the EQRO and provided to BMS as required.
- Analyzed data collected in the QI and UM programs and use it for problem identification and resolution (e.g. interventions), and program planning (e.g. selection of areas for focused studies and PIPs).

Delmarva conducted a review of 10 initial credentialing and 10 recredentialing files at each MCO. Recredentialing requirements include an on-site visit to the provider's office. In 2012, CoventryCares conducted these visits, while The Health Plan and UniCare did not. Following the 2013 on-site review, both UniCare and The Health Plan began scheduling and completing the required on-site reviews for re-credentialing. The MCO's also began planning revising their recredentialing policies and procedures to incorporate this requirement as well.

MCOs have the appropriate structures and processes in place to monitor, evaluate, and improve the quality of services to the MHT enrollees using PIPs. The MCOs are required to have three PIPs in place at all times. All three MCOs have the required PIPs in place, including two mandatory Collaborative PIPs: Diabetes Collaborative PIP and Reducing Emergency Department (ED)Visits for Members with Asthma Collaborative PIP. The MCOs submitted their project proposals and indicators for the two mandatory PIPs. All were approved by Delmarva and implemented in MY 2013. Baseline data will be reported in June of 2014 for MY 2013.

There were three MCO PIP topics related to quality in MY 2013. They are Childhood Obesity (The Health Plan), Childhood Immunization Status (UniCare), and Diabetes (all three MCOs). The Health Plan's Childhood Obesity PIP focuses on evidence of BMI documentation, nutritional counseling, and counseling for physical activity for children 2-17 years of age. Over the project period (MY 2008 through MY 2013), the MCO was able to improve two of the three indicators. *BMI Percentile* improved from 15.09% to 38.93%, and *Counseling for Nutrition* improved from 35.52% to 47.69%. The *Counseling for Physical Activity* indicator decreased from 32.1% to 20.9%.

A best practice was identified for the Childhood Obesity PIP Project in MY 2012 and continued in 2013. Face-to-face education with providers and their office staff regarding a Provider Information Packet and documentation requirements was conducted. The packet included a Body Mass Index (BMI) chart, BMI percentile graph sheets, and childhood obesity program information. These educational sessions were conducted when data abstractors are in the provider offices conducting medical record data abstraction for HEDIS and other QI activities.

In UniCare's Childhood Immunizations Combination 3 PIP, the MCO aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. For HEDIS 2012 (MY 2011), the National Medicaid Average was 70.64%. The MCO's performance improved from the MY 2012 baseline rate of 62.04% to 63.43% for Remeasurement 1 (MY 2013).

Best practices for UniCare's interventions include Provider Gaps in Care Reports which are submitted to providers notifying them of members with missing services, including immunizations. The MCO hopes that providers will attempt to get members in for needed services. Delmarva recommended that the MCO put a mechanism in place to ensure that providers follow-up and attempt to get members in for missing services. In addition, the MCO implemented a Well-Baby Care Visit Incentive Program which provides a $50 incentive for parents/caregivers when a child completes six of eight well-visits by 15 months of age.

The final PIP topic related to quality is the mandated Diabetes Collaborative in which all three MCOs are required to participate. The mandatory indictor for the collaborative project is *Comprehensive Diabetes Care (CDC)-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). All MCOs have selected at least one additional HEDIS indicator for their projects to include *Retinal Eye Exam Performed* (UniCare), *HbA1c Testing* (The Health Plan and UniCare), and *LDL-C Level <100mg/dL* (CoventryCares) as recommended by Delmarva. For HEDIS 2012 (MY 2011), the Mountain Health Trust (MHT) Weighted Average (MHT-WA) for the *CDC - HbA1c Control (<8%)* measure was 41.3% compared to the National Medicaid Average (NMA) of 48.0%, resulting in a 6.7 percentage point difference and providing opportunity for improvement.

The mandatory Diabetes Collaborative PIP was in development in MY 2012 and was implemented by all three MCOs in MY 2013. Best practices for interventions for the Diabetes Collaborative have been identified in the MCO project proposals and are summarized below.

CoventryCares produces a Practitioner Report annually to high-volume practices including data about diabetes and other diseases. In addition, Practitioner Gaps in Care lists were produced and distributed monthly to encourage providers to contact members and get them in for needed services and tests. The gaps in care lists provide member-level detail of missing screenings, tests, and services. The MCO encourages providers to follow-up with enrollees who appear on these lists. Delmarva recommended that the MCO put a mechanism in place to ensure that the providers follow-up to get members with missing services in for an appointment.

The Health Plan's Wellness and Health Promotion Call Center provides one-on-one personalized contact with diabetic members who are missing important services and/or testing. Claims histories are used to identify gaps in care that trigger members being placed in an outbound call queue that is updated weekly. Following the phone call from the nurse, a letter is sent to the member with a checklist of all missing services that were discussed on the call. A similar letter is sent to the member's PCP urging the PCP to assist the member in obtaining any services the member chooses to pursue. This intervention is not just for diabetes, but is in place for multiple conditions.

UniCare also generates Provider Gaps in Care Reports that include member-level detail of gaps in care and distributes to providers in hopes that they will follow-up with enrollees on the lists. As with the other MCOs that produce these types of reports, Delmarva recommended that the MCO put a mechanism in place to ensure that the providers follow-up to get members with missing services in for an appointment. In addition, the MCO also has a Member Incentive Program which provides a $25 incentive for completing recommended diabetic screenings and a dilated eye exam.

The following HEDIS indicators were used to assess quality in the MHT program in the areas of immunizations, screenings, and chronic conditions of asthma and diabetes:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Controlling High Blood Pressure
- Lead Screening for Children
- Adult BMI Assessment
- Medication Management for People With Asthma 75% Compliance
  - 5-11 Years
  - 12-18 Years
  - Total
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI Percentile
  - Counseling for Nutrition
- Medical Assistance with Smoking and Tobacco Use Cessation
  - Advising Smokers To Quit
  - Cessation Strategies Discussion
  - Cessation Medication Discussion
- Comprehensive Diabetes Care
  - Blood Pressure Control
  - Eye Exam
  - HbA1c Control (<8%)
  - HbA1c Testing
  - LDL-C Control (LDL-C <100 mg/dl)
  - LDL-C Screening
  - Medical Attention for Nephropathy

Of these quality measures, the MHT weighted average improved for five between HEDIS 2012 (MY 2011) and HEDIS 2014 (MY 2013). They are:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents -BMI Percentile

The following measures from the Adult and Child General Population CAHPS were used to assess the MCOs for quality:

- Customer Service Composite
- How Well Doctors Communicate
- Share Decision Making
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

For Adult Quality CAHPS measures, the MHT Average for *Customer Service* received a rating of five stars and exceeded the National Medicaid 90th Percentile. Adult's *Shared Decision Making Composite* received four stars and exceeded the 75th Percentile.

Six out of seven Child Quality CAHPS measures performed well compared to National Medicaid Percentiles. The MHT Average for *Customer Service* and *Rating of All Health Care* were rated four stars and exceeded the National Medicaid 75th Percentile. The MHT Average for the following four measures received a rating of three stars and exceeded the 50th Percentile:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Opportunities for improvement exist with the following five Adult CAHPS measures that were below the National Medicaid 50th Percentile:

- How Well Doctors Communicate
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Overall, in the area of quality, the MCOs had compliance rates of 97% to 99% in the SPR. In regards to PIPs, the Obesity PIP achieved improvement for two of three indicators, and was retired. The Adolescent Well Care Visit PIP also realized an increase in the visit rate indictor. All three MCOs implemented the two mandatory PIPs focusing on diabetes and reducing ED visits for members with asthma. For performance

measure validation, the MHT Weighted Average improved for five quality-related measures between HEDIS 2012 and HEDIS 2014. The MHT Weighted Average for *Immunization Status for Adolescents- Combination 1* and *Medication Management for People With Asthma, 75% Compliance: Ages 5-11 Years* received ratings of four stars, indicating each rate exceeded the National Medicaid 75th Percentile. The *Medication Management for People With Asthma, 75% Compliance (Ages 12-19 Years* and *Total)* received a rating of three stars and exceeded the National Medicaid 50th Percentile.

For CAHPS, the MHT Averages compared favorably to national benchmarks for two Adult and six Child CAHPS quality measures.

Access

Access (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA 2013 Standards and Guidelines for the Accreditation of Health Plans*).

Access to care and services has historically been a challenge for Medicaid enrollees in rural areas. Access is an essential component of a quality-driven system of care. The findings with regard to access are discussed in the following sections.

All MCOs provided comprehensive member materials. Telephone numbers to access Member/Customer service lines are provided in member handbooks. Member handbooks describe the covered services, how to access those services, and any other special requirements such as whether or not referrals are required for specialist services.

The MCOs are required to assess compliance with appointment access standards in the BMS/MCO contract. Current BMS standards state that:

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within 48 hours;
- Routine cases other than clinical preventive services must be seen within 21 days (exceptions are permitted at specific times when PCP capacity is temporarily limited);
- An initial prenatal care visit must be scheduled within 14 days of the date on which the woman is found to be pregnant;
- Qualified medical personnel must be accessible 24 hours each day, seven days a week (24/7), to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on call, licensed practical nurses, and registered nurses.

CoventryCares met all of the access standards. All MCOs met the Emergency and Urgent Care standards. The Health Plan's survey of 24/7 access yielded an 85% compliance rate. The MCO implemented interventions following the review to address the providers who were non-compliant. These interventions were included in the MCO's internal CAP. UniCare's 2013 access and availability assessment yielded a compliance rate of 62% for the Non-Urgent Sick Care appointment standard, 70% for Prenatal Visit within 14 Days, 85% for Routine PCP Visit, and 61% for the After Hours 24/7 Access standard. The Health Plan and UniCare must improve the compliance rates for these access standards to a minimum of 90% to meet the requirements specified in the contract.

Over the last three trend years, MY 2011-MY 2013, CoventryCares did not achieve the 24/7 access threshold in 2011, The Health Plan did not achieve the threshold in MY 2011 and MY 2013. Finally, UniCare did not achieve the threshold in all three measurement years. This access standard should become a focus of improvement efforts across the MHT program.

In regards to PIPs, all three MHT MCOs implemented the mandatory Asthma Collaborative PIP. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)*. The goal for this indicator will be determined by the Asthma ED Collaborative participants as there are no benchmarks available for this indicator. The robust interventions that were implemented by the end of MY 2013 include Gaps in Care Reports (Coventry and UniCare), Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare), and Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare). A Wellness and Health Promotion Call Center (WH&P) allows for one-on-one personalized contact with members who are Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program.

Nine HEDIS indicators were selected to measure MCO performance for Access to Care:

- Adults' Access to Preventive/Ambulatory Health Services (20-44 Years, 45-64 Years, Total)
- Children's and Adolescents' Access To PCP (12-24 months, 25 months - 6 Years, 7-11 Years, 12-19 Years)
- Prenatal Postpartum Care (Timeliness of Prenatal Care, Postpartum Care)

The MHT Weighted Average for seven of the nine access indicators compared favorably with national benchmarks. Four indicators showed improvement between HEDIS 2012 and HEDIS 2014.

The MHT Averages for both the Adult and Child CAHPS, the *Getting Care Composite* compared favorably to national benchmarks.

In summary, one MCO, CoventryCares, met all of the appointment access standards and all MCOs met the Emergency and Urgent Care access standards. The Health Plan met all access standards except for the 24/7 standard where it scored an 85%, falling short of the 90% threshold. UniCare did not meet the 90% threshold for the Non-Urgent (62%), Routine (85%), Initial Prenatal Care (70%) and 24/7 (61%) access standards. A review of the last three trend years, MY 2011- MY 2013, reveals that the MCOs should focus on meeting the 24/7 access standard consistently. CoventryCares met the standard in two of three years, The Health Plan met the standard one of three years, and UniCare did not achieve the threshold in all three measurement years. In regards to PIPs, all MCOs have implemented the mandatory Asthma Collaborative PIP with baseline data to be collected for MY 2013 and reported in MY 2014. In 2013 the MCOs were working on developing a collaborative letter to distribute to providers to inform them of the collaborative effort and provide resources for them to access for help in treating members with asthma.

Favorable performance of the HEDIS access measures continues to be a strength for the MHT program. The MHT Weighted Averages for seven of nine performance measures remained high compared to national benchmarks. All four indicators for *Children's and Adolescents' Access to PCP* improved all three years. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population. The MHT Averages for both Adult and Child CAHPS *Getting Needed Care Composite* compared favorably to national benchmarks.

Timeliness

Timeliness, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Health Plans*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Access to necessary health care and related services alone is insufficient in advancing the health status of MHT recipients. Equally important is the timely delivery of those services, and systems of care that serve MHT recipients. The findings for the MHT MCOs related to timeliness are described below.

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely in order not to disrupt or delay the provision of care or services to their members. The SPR standards in place evaluate timeliness as it relates to both the provision of services and timely access to customer services.

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For MY 2013, Delmarva reviewed cases, files, and logs to assess timeliness of:

- Credentialing and recredentialing of providers,
- Resolution of complaints, grievances and appeals, and
- Authorization, pre-authorization and continuing authorization activities.

Delmarva sampled 10 credentialing and 10 recredentialing files for each MCO. All initial credentialing applications in the sample were processed according to the MCOs policies and procedures. All provider recredentialing files in the sample were recredentialed within the three-year time requirement. All delegated credentialing providers are held to the same timeliness standards. All three MCOs complete annual audits of the delegates and no issues were identified with timely completion of credentialing and recredentialing activities.

Delmarva reviewed complaint, grievance and appeal logs and selected a sample of 10 formal appeals cases from each MCO for review. In cases where an MCO did not have 10 appeals for MY 2013, all cases were reviewed. The BMS/MCO contract requires MCOs to process and provide notice to affected parties regarding enrollee grievances in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. All cases sampled were resolved and affected parties notified in less than 45 days. None of the cases included a request for an extension.

Each MCO has a UM program in place which includes policies and procedures to monitor the timeliness of utilization management decisions. According to the BMS/MCO contract, the MCOs must make authorization decisions and provide notice as expeditiously as required by the enrollee's health condition and within 14 measurement days of receiving the request for service for the purposes of standard authorization decisions. All MCOs monitor the time to completion for authorizations against this timeliness standard. Results are compiled at least monthly by all MCOs and reported through the QAPI channels at least quarterly.

In addition, the MCOs must provide an expedited authorization decision for services when the provider indicates that the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, and no later than 3 working days after receipt of the request for service. This 3 working day period may be extended up to 14 additional days upon request of the enrollee or provider, or if the MCO justifies to BMS the need for additional information and how the enrollee might benefit from the extension.

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported through the QAPI channels by the UM department. There were no cases on file for expedited authorizations in MY 2013.

For MY 2013, there was one PIP that addressed timeliness. CoventryCares Adolescent Well-Care Visits project measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well care visit with a PCP or Obstetrician/Gynecologist during the measurement year. CoventryCares achieved an increase in the indicator rate from a baseline rate of 42.13% in MY 2011 to the first remeasurement rate of 46.58% in MY 2012 and the second remeasurement rate of 47.20% in MY 2013. Interventions such as face-to-face education of providers about medical record documentation, outreach calls to non-compliant members, provider report cards, and EPSDT reminder systems, target identified barriers.

Interventions identified as best practices in the review of CoventryCares Adolescent Well-Care Visits are listed below:

- Disease and case managers conduct targeted calls to members identified as non-compliant to educate them about the need for routine well-visits and assist with appointment scheduling if needed.
- Provider report cards are mailed monthly which contain all members that are non-compliant with the required services. The MCO encourages providers to follow-up with the non-compliant members. Delmarva recommended that the MCO put a mechanism in place to ensure that providers follow-up with members and attempt to get them up to date with the required services.
- Provider/office staff education, including appropriate medical documentation, was offered when HEDIS medical record reviews were being conducted on-site by the MCO.

Four HEDIS indicators were selected to represent MCO performance in the area of timeliness:

- Adolescent Well-Care Visits
- Frequency of On-going Prenatal Care (≥81%)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life (6 or more visits)

The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to national benchmarks. The three year trend from HEDIS 2012 to HEDIS 2014 indicated improving performance for *Adolescent Well-Care Visits* and *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life.*

The MHT Average for the Adults *Getting Needed Care Quickly Composite* exceeded the National Medicaid 50th Percentile and the MHT Average for the Child *Getting Needed Care Quickly Composite* exceeded the National Medicaid 90th Percentile.

Overall, the MCOs performed well in the area of timeliness. Credentialing and recredentialing of providers, resolution of complaints grievances and appeals as well as authorizations were completed in a timely manner according to the standards. CoventryCares's Adolescent Well-Care Visits PIP achieved improvement from the baseline measurement in MY 2011 to MY 2013. The three year trend from HEDIS 2012 to HEDIS 2014 showed improving performance for two HEDIS measures related to timeliness. The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to the national benchmarks. Both CAHPS timeliness measures performed well. The MHT Average for the Adults *Getting Care Quickly Composite* exceeded the National Medicaid 50th Percentile and the MHT Average for the Child CAHPS *Getting Care Quickly Composite* exceeded the National Medicaid 90th Percentile.

MHT MCO Strengths, Requirements, and Recommendations

Strengths, requirements and recommendations for each standard are provided in the following tables for each MCO. **Strengths** are provided to encourage MCOs to continue efforts that are effective. R**ecommendations** are made where Delmarva has suggestions to improve current MCO processes and practices that already meet requirements. MCOs are not required to implement recommendations although it is encouraged. Finally, **Requirements** are provided to address elements and components that were not fully compliant (partially met or unmet) or that will need to be revised to maintain a current review determination of *Met*. All Requirements must be addressed by the MCO in order to be fully compliant at the time of the next annual review.

CoventryCares Strengths and Recommendations

Systems Performance Review

CoventryCares: 2013 SPR Strengths, Requirements and Recommendations	
Enrollee Rights	**Strengths** • Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. • Member materials are available in alternate formats such as large print, Braille and on audiotape for members. • The MCO provides oral interpretation for any language to enrollees free-of-charge as required. • Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. • The Member Handbook and other enrollee materials are available on the CoventryCares website for members to access 24/7. • The Provider Manual is available on CoventryCares website for providers to access 24/7. • Member materials are assessed to ensure a reading level of 6th grade or below using the Flesch-Kincaid metric. • All required enrollee rights and responsibilities are provided in the Member Handbook.

CoventryCares: 2013 SPR Strengths, Requirements and Recommendations	
	• The Member Handbook provides all of the required information to ensure enrollees have access to information on how to access services to which they are entitled. • The Member Handbook details how members can file grievances, appeals, and access the State Fair Hearing process.
	Requirements • The Emergency Services section of the Member Handbook must clearly state that emergency services do not require preauthorization. This is stated in the "Your Rights and Responsibilities" section of the Member Handbook but should be included in the Emergency Services section for easy access by members. • CoventryCares must provide evidence of informing members that they may request a copy of the MCO's Annual Report which is available at the local DHHR offices. This can be included in the Bear Facts Newsletter or posted on the MCO's Website.
Grievance Systems	**Strengths** • CoventryCares has a well-documented grievance system which meets requirements. • All complaint, grievance, and appeal resolutions reviewed on-site adhered to established policies and procedures were documented and easy to follow from registration through completion/resolution. • All of the appeals-related policies (pre- and post-service, pre-service transplant and urgent transplant) were updated and combined into one policy, the Medicaid Appeal Policy. • The Notice of Action (NOA) letter sent to enrollees includes all required elements. • All NOAs sent to enrollees include an attachment which notifies enrollees of their right to and process for filing a grievance, appeal, and State Fair Hearing. • All grievance and appeals files reviewed on-site contained the appropriate documentation, including an acknowledgment letter. All files reviewed were resolved within the appropriate time frame.
	Recommendation • Delmarva provided suggestions for the MCO to simplify its Medicaid Appeal policy. Delmarva recommended that the MCO state the similar pieces of each process once in the policy, rather than repeating it for each appeal type. Some examples are that no punitive actions can be taken against a provider who requests an expedited appeal or supports an enrollee's appeal, the MCO or enrollee can request an extension up to 14 days for all appeals types, and the MCO must pay for services continued during an appeal or State Fair Hearing if the ruling is in favor of the enrollee.
Quality Assessment and Performance Improvement	**Strengths** • The MCO achieved accreditation from the National Committee for Quality Assurance (NCQA) in October of 2013. • For Utilization Management decisions, CoventryCares exceeded the goal of an inter-rater reliability score (degree of agreement) of 85% for application of clinical screening criteria by its Preauthorization Nurses, Concurrent Review Nurses, Case Managers and Physicians. • Credentialing and recredentialing policies and procedures are comprehensive. All 20 files reviewed on-site were complete and timely. • Delegation oversight policies and procedures are in place and followed. The MCO provided the annual audit results for all delegated entities. No Corrective Action Plans (CAPs) were recommended based on the audit results. • Utilization Management monitors over and under-utilization of services to ensure enrollees have appropriate access to services. • The MCO is participating in the mandatory Pediatric Asthma Emergency Department and Diabetes Collaboratives. The MCO has individual interventions and is working with the

CoventryCares: 2013 SPR Strengths, Requirements and Recommendations	
	other two MCOs to develop collaborative interventions for each project. • The MCO reviews and updates (as needed) clinical practice guidelines (CPGs) every year. CPGs reviewed and approved in 2013 include Adult Immunizations, Childhood Immunizations, Diabetes, Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Coronary Artery Disease, Asthma, Child Preventive Care Guidelines, and Adult Preventive Care Guidelines. • Based on opportunities for improvement identified in Consumer Assessment Healthcare Providers and Systems (CAHPS) survey results, the MCO develops action items and implements interventions to address deficiencies. CoventryCares partners with West Virginia University (WVU) and their mobile mammography unit, Bonnie's Bus, to increase breast cancer screening rates.
	Requirements • **Coordination of Care** – CoventryCares retired its Case Management (CM) policies. The MCO has a Complex Case Management Program Description and uses an electronic system, NavCare, for recording its CM activities. However, CoventryCares must reinstate its CM policies and procedures or develop new ones to address the CM requirements. • **Coordination of Care** – The CM policies the MCO adopts must describe the procedures for the program to ensure the coordination and management of care. • **Coordination of Care** – The policies must describe the process to identify and refer individuals for CM services, must require treatment plans to specify an adequate number of direct access visits to specialists, and must include procedures to ensure the CM record is complete and includes the required components. • **Coordination of Care** – CoventryCares must develop and implement a policy and procedure which ensures the completeness of the case management record to include the results of referrals, consultations, inpatient records, and outpatient records. • **Utilization Management** – The Utilization Management Decision-Making & Time Frame Standards Policy (UM-014) was in place for part of 2013, but was replaced by the Timeliness of Utilization Management Decisions Policy later in the year. Delmarva reviewed the new policy and provided written feedback and to CoventryCares to improve the policy to ensure that it meets all of the requirements for the next annual review.
Fraud and Abuse	**Strengths** • CoventryCares's Program Integrity Plan specifically focuses on Medicaid. • The Medicaid Program Manager attends both the quarterly internal CoventryCares and monthly Corporate Compliance Meetings. This provides a link between the local MCO and the Corporate entity. • Committee meeting minutes for 2013 document appropriate activities at both the local and corporate levels. • Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse. • Coventry Health Care, CoventryCares parent company, uses the STARSSentinel software package to detect fraud, waste, and abuse both prospectively and retrospectively. • Coventry Health Care (Corporate) provides a comprehensive employee training program on compliance and ethics. Employee attendance and completion of mandatory training is recorded and tracked to ensure employee compliance with training requirements.
	Recommendations • The MCO achieved a 100% compliance rate; there are no recommendations.

Performance Improvement Projects

CoventryCares: MY 2013 PIP Strengths and Recommendations	
Adolescent Well-Care Visits	**Strengths** • The MCO selected a short term and long term goal. The short term goal is to achieve a 5 percentage point increase in the prior year's measurement rate. The long term goal is to achieve the NCQA Quality Compass 90th Percentile. • The indicator rate has improved over the first two remeasurement periods. The baseline rate (MY 2011) was 42.15%, the first remeasurement rate (MY 2012) was 46.58%, and the second remeasurement rate (MY 2013) was 47.20%. CoventryCares fell slightly below the benchmark of 48.18%. The rate was also below the goal of 51.58% (5 percentage point increase over prior year's rate).
	Recommendation • Continue PIP at least one more year to see if significant improvement can be achieved.
Emergency Department Collaborative	**Strengths** • Clearly defined study question. • Clearly defined study population and indicators. • Clearly defined study design and data analysis plan. • Targeted member and provider interventions.
	Recommendations • The MCO should add one-to-one provider education or add face-to-face contact with providers in its interventions. The MCO sends providers lists of non-compliant members (Gaps in Care Lists) in hopes that they provide follow-up to get members into care. The MCO should put a mechanism in place to monitor or require follow-up as part of the intervention. • MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a Collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.
Diabetes Collaborative	**Strengths** • Comprehensive project rationale. • Both performance measures are HEDIS indicators.
	Recommendation • The MCO should investigate an intervention that includes one-to-one provider education or add face-to-face contact with providers as part of an existing intervention. Additionally, the MCO sends providers lists of non-compliant members (Gaps in Care Lists) in hopes that the providers provide follow-up with identified members. It is recommended that the MCO put a mechanism in place to monitor or require follow-up as part of the intervention.

Performance Measure Validation

CoventryCares: MY 2013 PMV Strengths, Requirements and Recommendations

Strengths

- The pharmacy benefit was carved-out through the first quarter of 2013. CoventryCares successfully transitioned from the State's pharmacy benefit manager (PBM) to its contracted PBM, Express Scripts Incorporated (ESI), for the remainder of 2013. As a result, the MCO was able to report pharmacy measures required by the State for HEDIS 2014 (MY 2013) using both the State's PBM and ESI data. The MCO will be able to report all pharmacy-related measures to NCQA starting in 2015.
- The MCO completed conversion from the State's proprietary enrollment file format to the HIPAA 834 compliant format in 2013 and continued to capture race, ethnicity, and language using the new enrollment format.
- CoventryCares implemented provider incentive programs that provide payments on CPT Category II and ICD-9 V codes in MY 2012. The MCO also revised business rules on claims payment in West Virginia to provide an additional payment on a separate post-partum visit, even if the provider was already paid on a maternity global bill. The MCO anticipated that the impact would be recognized in HEDIS 2014 administrative rates. CoventryCares realized an increase of 3.0 percentage points in its current year administrative rate before exclusions for Prenatal Postpartum Care- Postpartum Care (PPC) between HEDIS 2013 (50.4%) and HEDIS 2014 (53.4%). The reported rate for PPC Postpartum Care increased .9 of a percentage point in the postpartum care visit rate in the same period.
- CoventryCares performed well with the measures from the Access and Availability of Care Domain where seven out of ten rates compared favorably to the national benchmarks and five out of ten rates improved between HEDIS 2012 (MY 2011) and HEDIS 2014 (MY 2013).
- CoventryCares performed well in the Utilization and Relative Resource Use Domain where three of four measures compared favorably to national benchmarks.
- For the Health Plan Descriptive Information Domain, CoventryCares compared favorably to national benchmarks for two provider categories - geriatricians and other physician specialists.
- For State Reported Respiratory Measures, one rate exceeded the MHT Weighted Average and two compared favorably to national benchmarks. For the Additional State Reported Measures (non-respiratory), two rates exceeded the MHT Weighed Average and two compared favorably to national benchmarks.
- CoventryCares performed well for both the Adult and Child CAHPS surveys. Four Adult and ten Child CAHPS measures compared favorably to national benchmarks.

Requirement

- CoventryCares must be prepared to report all HEDIS measures that require pharmacy data to NCQA for HEDIS 2015 (MY 2014).

Recommendations

- All MCOs are encouraged to continue to work closely with BMS to resolve barriers in obtaining data from various State agencies that may be need to report performance measures such as WVSIIS for immunization data and Vital Statistics data for use in collecting data for the Child Core Measures.
- CoventryCares is encouraged to continue exploring different avenues to improve their data quality and data capture. Their recent efforts have shown improvement in the Effectiveness of Care measures over the past year.

The Health Plan Strengths and Recommendations

Systems Performance Review

The Health Plan: 2013 SPR Strengths, Requirements, and Recommendations	
Enrollee Rights	**Strengths** • Member materials are at or below the required 6th reading level as assessed using the Flesch-Kincaid metric. • The MCO has a strong outreach program. • Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. • Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. • The Member Handbook, an online Provider Directory, and other important enrollee materials and tools are available on The Health Plan's website for members to access 24/7.
	Requirements • The Member Handbook states that benefits ***will*** continue if the enrollee files an appeal or requests an appeal or State Fair Hearing. However, it is not clear that the enrollee ***must request*** that benefits be continued. In order to receive a finding of ***Met*** in the next annual review, The Member Handbook must clearly state that the enrollee ***has the right to have benefits continue, but must request that they be continued*** when an appeal is filed or a State Fair Hearing is requested. • The Appeals and Grievances section of the Member Handbook notes that an appeal may be "started by the Member or their **Doctor** with Member's signed consent." It also states that "you, your representative or the legal representative of a deceased enrollee's estate, or your **doctor** (with your written consent) may file an appeal with The Health Plan's Customer Service Department by phone or in writing". Any provider type is able to file an appeal on behalf of a member. In order to receive a finding of ***Met*** in the next annual review, The Health Plan must change **"*doctor*"** to **"*provider*"** in its grievance and appeals description in the Member Handbook and in any other documents that refer to appeals and grievances. **Recommendation** • The Health Plan provides its annual report to the local health departments. The MCO should inform members that they may request this report so members have access to this information. (The Health Plan stated that they will inform members how to access this report in one of its 2014 Enrollee Newsletters.)
Grievance Systems	**Strengths** • Complaint, grievance and appeals procedures are well established and interviews with staff confirm they are followed. • The Practitioner Procedural Manual provides information for providers to file grievances and appeals. • The Member Handbook provides an overview of procedures enrollees should use to file grievances, appeals, and to access a State Fair Hearing. • Complaints, grievances, and appeals are monitored for timeliness of completion. • All 2013 grievance and appeal case files reviewed on-site were completed in a timely manner. • Thorough documentation is maintained in appeal files in the MCO's electronic proprietary HEART system to support all decisions.

The Health Plan: 2013 SPR Strengths, Requirements, and Recommendations	
	Requirement • Any provider type is able to file an appeal on behalf of a member. In order to maintain a finding of ***Met*** in the next annual review, The Health Plan must change "***doctor***" to "***provider***" in its grievance and appeals description in all relevant policies, procedures, and the Member Handbook. **Recommendation** • Delmarva worked with the Grievance and Appeals staff during the on-site review. Various recommendations were made to improve the flow of the written Appeals Process policy and procedure (Policy CS/MHT-3) that is targeted to be revised and reformatted in 2014. The MCO is reminded that all grievance systems policies and procedures must meet federal requirements, West Virginia Statutes 33-25A-12, and must be approved in writing by the Department (BMS/MCO Contract, Article III, Section 3.8 Grievances and Appeals).
Quality Assessment and Performance Improvement	**Strengths** • The Quality Management (QM) and Utilization Management (UM) program documents are comprehensive and describe the major activities, goals, and objectives. • Disease and case management programs are in place. An electronic review of cases on-site demonstrated appropriate interventions and outreach efforts are in place. • The Health Plan successfully manages, tracks, and monitors its EPSDT-eligible enrollees via HEART, an electronic proprietary program. • The MCO Performance Improvement Project (PIP) topics and indicators are relevant and appropriate. • One PIP was closed (Emergency Department) due to achieving sustained improvement. • The MCO actively participated in the development and implementation of the MHT Collaborative PIP, Pediatric Asthma Emergency Department Visits for Pediatric Enrollees with Asthma. • Lines of authority and communication among the QM and UM committees are well documented. Meeting minutes document the information flow among these committees and up to the Executive Management Team (EMT). • There is documentation in QM and UM committee meeting minutes to demonstrate EMT involvement (feedback and recommendations etc.) in the various QM and UM activities. • Medical Director involvement is evident in all quality-related activities and documented in meeting minutes. • Provider participation is apparent throughout quality programs and initiatives as documented in committee meeting minutes. • All credentialing and recredentialing records sampled for the review period were completed timely. • The MCO appropriately reviews and updates clinical practice guidelines (CPGs) at least every two years, and more frequently if warranted. • The CPGs for Asthma and Diabetes guidelines were a focus of review efforts as they relate to the two MHT MCO Collaborative PIPs that were being developed and/or implemented in 2013. • The Health Plan has a comprehensive health education plan and targets its members and community needs.

The Health Plan: 2013 SPR Strengths, Requirements, and Recommendations	
	Requirements • **Access and Availability** – The compliance rate for the 24/7 access standard was 85%. Internal corrective action plans are in place to improve this rate. The MCO must improve this rate to 90% to receive a review determination of ***Met*** in the next annual review. • **Credentialing and Recredentialing** – The MCO must provide the number of practitioners that were due for a recredentialing on-site review in 2012, the number that have been completed, and the number that remained outstanding at the time of the 2013 on-site review. For those that are not up-to-date, the MCO must provide the anticipated date of completion. In order to receive a finding of ***Met*** in the next annual review, The Health Plan must provide evidence that all recredentialing site reviews are up to date. • **Coordination of Care** - In order to receive a finding of ***Met*** in the next annual review, the MCO must revise the Case Monitoring Policy to include more explicit language that describes specific monitoring processes including quality measures. • **Utilization Management** - The Health Plan must include in its Timeliness of Utilization Management and Behavioral Health Decisions policy that the MCO must justify to the state that the extension is in the enrollee's best interest when the MCO extends the decision time frame. • **Quality Assessment** - The Quality Management Program Description contains all the required components. However, it is not in the most logical format. Each committee description should be reviewed and revised to contain the same information in the same order that the reader can easily follow. Specifically, each committee description should state the chairperson of the committee (by title, not by name), describe the membership (Medical Director, President/CEO, Vice President of Operations etc.), role, function, and the reporting structure.
Fraud and Abuse	**Strengths** • Use of the STARSSentinel software has improved the MCOs ability to identify potential areas of fraud and abuse. It is being utilized to systematically identify potential fraud and abuse for further investigation. • Required staff education on compliance, fraud, waste, and abuse was conducted in 2013. • Staff educational materials include all required information. • The Compliance and Fraud and Abuse program documents were reviewed and updated in 2013 to include all required components. • Specific steps have been identified that are used to investigate potential fraud and abuse offenses, as well as follow-up steps when an offense has been confirmed. • The Compliance Committee is now meeting regularly. Meeting minutes document its activities.
	Requirement • It is recommended that the MCO include in its Fraud, Waste, and Abuse Policy Statement that if it refers cases of suspected fraud, waste, and abuse to an entity other than BMS regarding its Medicaid product, the MCO will notify BMS of the suspected fraud and abuse case. The current statement implies this is done, but it should be explicitly stated.

Performance Improvement Projects

The Health Plan: MY 2013 PIP Strengths, and Recommendations	
Childhood Obesity	**Strengths** • Comprehensive project rationale. • The MCO's data analysis plan is comprehensive, addressing both the qualitative and quantitative findings.
	Recommendation • This PIP is closed. The MCO should continue the interventions it has determined to be effective. The MCO must develop and submit a project proposal to Delmarva and BMS for approval to replace this PIP.
Emergency Department Collaborative	**Strengths** • The MCO's proprietary HEART system allows for the identification of high utilizers of the ED, including those for respiratory conditions. Reports are generated for purposes of one-to-one outreach. • Interventions include one-to-one telephone contact with caregivers and high utilizers of the ER. • Notable improvement achieved for both indicators when comparing baseline to final remeasurement.
	Recommendation • MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a Collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.
Diabetes Collaborative	**Strengths** • Comprehensive project rationale. • The performance measures are HEDIS measures.
	Recommendation • The MCO sends letters to providers containing members with missing services, hoping that providers will follow-up with non-compliant members. The MCO should consider implementing a mechanism to ensure providers do some sort of follow-up.

Performance Measure Validation

The Health Plan: MY 2012 PMV Strengths, Requirements and Recommendations
Strengths • The pharmacy benefit was carved-out through the first quarter of 2013. The Health Plan successfully transitioned from the State's pharmacy benefit manager (PBM) to its contracted PBM, Express Scripts Incorporated (ESI), for the remainder of 2013. As a result, The Health Plan was able to report pharmacy measures required by the State for HEDIS 2014 (MY 2013) using both the State's PBM and ESI data. The MCO will be able to report all pharmacy-related measures to NCQA starting in 2015. • The MCO completed conversion from the State's proprietary enrollment file format to the HIPAA 834 compliant format in 2013 and continued to capture race, ethnicity, and language using the new enrollment format. • The MCO's proprietary credentialing and transaction system maintained a system-generated provider data change log. All adds, deletes, and changes were automatically logged into a report, which tracks user, date and time, old data, and new data. • The MCO followed NCQA credentialing standards for credentialing and re-credentialing of providers, and underwent several NCQA accreditation surveys with no significant deficiencies identified. The Health Plan maintained appropriate oversight of delegated entities and conducted appropriate maintenance of non-delegated board certification and contracting data through scheduled audits and reconciliations. • The Health Plan effectively maintained supplemental laboratory data from a number of participating network hospitals to supplement its administrative data for HEDIS reporting.

The Health Plan: MY 2012 PMV Strengths, Requirements and Recommendations
• The Health Plan used appropriate naming conventions for data sets, including data type, such as supplemental, claims, or medical record. Also, data file identifications were used to uniquely identify data sets, such as West Virginia University Hospital (WVUH) or LabCorp, which facilitated analytics on measure impact by each data source within the data types. For example, it was possible to note the impact of Quest laboratory results versus the impact of LabCorp laboratory results on the Comprehensive Diabetes care measure even though both are from the same laboratory results data file. • In the Effectiveness Care Domain, seven indicators compared favorably to national benchmarks and eleven indicators showed improvement in rates between HEDIS 2012 (MY 2011) and HEDIS 2014 (MY 2013). • All ten measures for the Access/Availability of Services Measures compared favorably to national benchmarks. • In the Utilization and Relative Resource Use Domain, two of the four measures compared favorably to national benchmarks. One measure in this domain exceeded the National Medicaid 90th Percentile. Two out of four measures improved each year of the three-year period between HEDIS 2012 (MY 2011) and HEDIS 2014 (MY 2013). • In the Health Plan Descriptive Information Domain, The Health Plan exceeded the MHT Weighted Average for Board Certification for three provider categories. • For the pharmacy measures, six of seven respiratory indicators compared favorably to the MHT weighted average, three met or exceeded national benchmarks, and one exceeded the National Medicaid 90th Percentile. For the additional non-respiratory pharmacy measures six of seven rates met or exceeded the MHT weighted average and four compared favorably to national benchmarks. • The Health Plan performed well on the Adult and Child CAHPS survey. Eight of the Adult CAHPS survey measures compared favorably to national benchmarks and two met or exceeded the National Medicaid 90th Percentile. Eight Child CAHPS survey measures met or exceeded national benchmarks and two compared favorably to the National Medicaid 90th Percentile.
Requirement • The Health Plan must be fully prepared to report HEDIS measures that require pharmacy data to NCQA for HEDIS 2015 (MY 2014). **Recommendations** • All MCOs are encouraged to continue to work closely with BMS to resolve barriers in obtaining data from various State agencies that may be need to report performance measures such as WVSIIS for immunization data and Vital Statistics data for use in collecting data for the Child Core Measures. • The audit team recommended that the MCO continues to pursue opportunities to obtain BMI and BP results from participating hospitals and provider groups to supplement additional measures and indicators and reduce medical record review burden.

UniCare Strengths, Requirements and Recommendations

Systems Performance Review

UniCare: MY 2013 SPR Strengths, Requirements and Recommendations	
Enrollee Rights	**Strengths** • Member materials are comprehensive and provide enrollees with information on their benefits and how to access them. • Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. • The Member Handbook is available on UniCare's website for members to access 24/7. • The Provider Directory is available on UniCare's website for members to access 24/7. • The MCO provides oral interpretation for any language to enrollees free-of-charge as required. • Member materials are assessed to ensure a reading level of 6th grade or below using the Flesch-Kincaid metric.

UniCare: MY 2013 SPR Strengths, Requirements and Recommendations	
	• All required enrollee rights and responsibilities are provided in the Member Handbook. • The Member Handbook provides all of the required information to ensure enrollees have access to information on how to access services to which they are entitled. • The Member Handbook details how members can file grievances, appeals, and access the State Fair Hearing process.
	Recommendation • The MCO must provide evidence that it notifies enrollees of their right to receive the MCO's Annual Report and the process for requesting a copy of the report.
Grievance Systems	**Strengths** • UniCare has well-developed grievance policies and procedures that meet all requirements. • Appeals and grievance files contain all the required components. • The Notices of Action (NOA) letters are comprehensive and include all of the required elements. • NOAs inform enrollees how to file an appeal, outline the appeal process, and explain enrollee rights during the appeal process. • Appeals are resolved in an expeditious manner. All case files reviewed were resolved within the 30 day timeframe requirement.
	Recommendation • This standard received a 100% compliance rating. There are no recommendations for improvement.
Quality Assessment and Performance Improvement	**Strengths** • The MCO achieved Commendable Accreditation Status from NCQA which is effective through August 2015. • The MCO appropriately coordinates services for enrollees with special health care needs. • UniCare consistently applies review criteria for authorization decisions. • A credentialing and recredentialing file review demonstrates that UniCare meets timeliness requirements. No deficiencies were noted in the files that were audited on-site. • The delegated credentialing policies and procedures are comprehensive. All delegated entities received an annual audit and no CAPs were required as a result of the 2013 audits. • Clinical practice guidelines are in place and appropriately used to make authorization decisions. • UniCare maintains a quality and health information system that collects, analyzes, integrates, and reports data. All required HEDIS® measures were reported to NCQA and BMS. • UniCare has a comprehensive Health Education Plan and appropriately reaches out to members in an effort to engage them in health education related programs. • The MCO participates in the mandatory Diabetes and Pediatric Asthma Emergency Department Collaborative PIPs. • Collaboration between quality-related committees and sub-committees is clear and documented in meeting minutes/reports.

UniCare: MY 2013 SPR Strengths, Requirements and Recommendations	
	Requirements • **Access and Availability** - UniCare must achieve at least a 90% compliance rating for each type of appointment to ensure that members have timely access to care and services. The MCO's provider access survey found that providers were not meeting the 90% threshold for Non-Urgent Sick Appointment (62%), After Hours 24/7 Access to Primary Care Providers (61%), Prenatal Appointment within 14 Days (70%), and Routine Appointment (85%). • **Credentialing and Recredentialing** – UniCare's Site Visits Policy did not require an on-site visit for recredentialing. Additionally, not all providers had been brought up to date in 2013 for the on-site visits not completed in 2012. As reported in its CAP, the MCO revised its Site Visit Policy to require the on-site visit for recredentialing and completed all outstanding on-site visits in 2014.
Fraud and Abuse	**Strengths** • UniCare has a comprehensive set of policies and procedures that address fraud, waste and abuse. • The Standards for Ethical Business Conduct provides employees with the company's expectations for ethical behavior as well as their responsibilities for reporting suspected fraud, waste and abuse. • Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse. • UniCare provides a comprehensive employee training program on compliance/ethics. In this training, employees are educated on how to identify and report any suspicious activity. • Documentation of successful completion of mandatory training is maintained for each employee. • UniCare uses its experience in WV and nationally to detect fraud, waste and abuse. Any schemes identified in one region of the country are investigated in all their markets.
	Requirement • UniCare did not implement a process to verify that services reimbursed were actually furnished. The MCO had a policy and procedure in place to address this, but did not send out the survey. The CAP provided by UniCare states that the survey process was implemented in July 2014.

Performance Improvement Projects

UniCare: MY 2013 PIP Strengths and Recommendations	
Childhood Immunization Status Combination 3	**Strengths** • The performance measure is a HEDIS measure. • Although not significant, the 1.9 percentage point increase from HEDIS 2013 to HEDIS 2014 appears to be the result of the combination of the interventions that are in place. • Interventions address many of the barriers identified, target and provide one-to-one contact with providers and enrollees. • Interventions are multifaceted using outreach phone calls, mailings, and provider gaps in care reports. Although the indicator did not improve significantly, it could be that interventions implemented in the 4th quarter (4th Quarter Push, data transfer from the WVSIIS) need additional time to impact the indicator.
	Recommendations • The MCO delivers Gaps in Care Reports to providers with hopes that the providers will follow-up and help bring the members into compliance. UniCare should implement a mechanism to ensure that providers follow-up with non-compliant members.

UniCare: MY 2013 PIP Strengths and Recommendations	
	• Continue interventions that were implemented in late 2013. This will likely result in improvement as the interventions may not have had enough time to impact the indicator for this reporting cycle.
Emergency Department Collaborative	**Strengths** • Interventions directly target the members identified as asthmatic as well as providers who treat asthmatic patients. • Interventions target identified barriers and provide on-to-one contact to members and providers. • Interventions are multi-faceted using outreach, case management, disease management, provider profiling and reporting. • UniCare chose two additional indicators in addition to the mandatory indicator.
	Recommendation • MCO must participate with the PIP Collaborative Team to determine the collaborative indicator goal as there are no benchmarks for the Pediatric Asthma ED Visit measure. After the MCOs have their Pediatric Asthma ED indicator rate for 2013, the group will meet to review the results and determine if a Collaborative goal can be selected (if the indicator rate is similar for all 3 MCOs) or if the MCOs should select an MCO specific goal.
Diabetes Collaborative	**Strengths** • The performance measures are HEDIS indicators. • In addition to the mandatory indicator (HbA1c Control <8%), UniCare chose two additional indicators, HbA1c Testing and Retinal Eye Exam.
	Recommendation • UniCare should include study questions for the additional two indicators it has selected for this project (*HbA1c Testing* and *Eye (Retinal) Exam Performed*).

Performance Measure Validation

UniCare: MY 2013 PMV Strengths, Requirements and Recommendations
Strengths • The pharmacy benefit was carved-out through the first quarter of 2013. The MCO successfully transitioned from the State's pharmacy benefit manager (PBM) to its contracted PBM, Express Scripts Incorporated (ESI), for the remainder of 2013. As a result, UniCare was able to report pharmacy measures required by the State for HEDIS 2014 (MY 2013) using both the State's PBM and ESI data. The MCO will be able to report all pharmacy-related measures to NCQA starting in 2015. • UniCare completed conversion from State's proprietary enrollment file format to the Health Insurance Portability and Accountability Act (HIPAA) 834 compliant format in 2013 and it continued to capture race, ethnicity, and language on the new enrollment format. • The MCO followed NCQA credentialing standards for credentialing and re-credentialing of providers and underwent NCQA accreditation surveys with no significant deficiencies identified. UniCare maintained appropriate oversight of delegated entities and conducted appropriate maintenance of non-delegated board certification and contracting data through scheduled audits and reconciliations. • UniCare experienced a significant improvement in its Call Answer Timeliness (CAT) rate for MY 2013. The rate increased from 64.9% in MY 2012 to 93.6% in MY 2013. Starting in the fourth quarter of MY 2012, the MCO hired and trained additional staff in anticipation of increases in call volumes in MY 2013 related to the introduction of the Affordable Care Act (ACA). Increases in call volumes were also noted in April 2013, with the transition of the pharmacy benefit from the State to the MCO. • For the Effectiveness of Care Domain, four indicators met or exceeded the MHT Weighted Average and one indicator comapred favorably to national benchmarks. • For Access/Availability of Services Domain, nine of ten indicators compared favorably to national benchmarks.

UniCare: MY 2013 PMV Strengths, Requirements and Recommendations
• In the Utilization and Relative Resource Use Domain, two of four measures compared favorably to national benchmarks. • For the State reported respiratory measures, two out of six indicators compared favorably to national benchmarks. • All seven of the State-reported non-respiratory pharmacy measures compared favorably to national benchmarks and two exceeded the National Medicaid 90th Percentile. • For UniCare Adult and Child CAHPS survey results, five Adult and seven Child survey measures exceeded the national benchmarks. One Adult and two Child CAHPS survey measures exceeded the National Medicaid 90th Percentile.
Requirement • UniCare must be prepared to fully report HEDIS measures that require pharmacy data to NCQA for HEDIS 2015 (MY 2014). **Recommendations** • All MCOs are encouraged to continue to work closely with BMS to resolve barriers in obtaining data from various State agencies that may be need to report performance measures such as WVSIIS for immunization data and Vital Statistics data for use in collecting data for the Child Core Measures. • The MCO uses several sources of supplemental data and all with varying naming conventions. The audit team recommends the MCO collaborate with a certified vendor to generate a unique alpha numeric identifier, which could be assigned to each data source. The identifier would help to analyze how each data source impacts a specific measure. For example, UniCare could use this unique identifier number to assess the impact of Quest Lab results versus the impact of LabCorp lab.

MHT Program Strengths, Requirements, and Recommendations

MHT Program Strengths, Requirements and Recommendations for MY 2013	
Systems Performance Review	**Strengths** • The MCOs have performed well for all standards from MY 2010 - MY 2012 achieving above the 90% threshold established by BMS for all four standards (ER, GS, QA, and FA). • BMS mandated that the MCOs become NCQA accredited by January 14, 2014. All MCOs are on track to complete the survey process. • Beginning MY 2012, all MCOs had CAHPS data available since BMS has mandated MCOs to use the most recent version of the CAHPS survey. This allows comparison of member satisfaction results among all three MCOs and program-wide against national benchmarks.
	Recommendations • ***The MCOs must focus efforts on consistently meeting the 24/7 access standard.*** In the last three measurement years, CoventryCares met the threshold two years, The Health Plan met the standard in one year, and UniCare did not meet the standard in any of the three years. BMS should consider an MHT-wide approach to addressing this issue, such as a statewide provider educational initiative. • ***Continue to require the MCOs to achieve a 100% for each of the four standards (ER, GS, QA, FA).*** This is the first full review where BMS required the MCOs to achieve 100% compliance for each standard. The MCOs were required to submit an internal improvement plan for each standard, element, and/or component that was not fully met. The value of improvement plans will only be able to be assessed at the time of the next annual audit. It is expected that SPR results will improve based on the MCOs targeting areas for improvement.

MHT Program Strengths, Requirements and Recommendations for MY 2013	
Performance Improvement Projects	**Strengths** • All three MCOs successfully implemented two collaborative PIPs: Diabetes and Asthma ED. • The MCOs worked together to develop collaborative interventions for the two collaborative PIPs. • A collaboratively written letter was developed and will be sent to providers state-wide advising them that the MCO's have chosen to focus on reducing emergency department usage for members with asthma. • A second collaboratively written letter will be sent to providers state-wide advising them that the MCO's have chosen to focus on proper care and testing for diabetic members. Both letters provide information for providers to get resources and help for these specific populations. • The MCO have other interventions including face-to-face contact with providers, incentive programs, outreach calls, and preparing and distributing Gaps in Care Reports and Provider Profiles.
	Recommendation • The PIP Collaborative Team must meet to determine the collaborative indicator goal for the Emergency Department Collaborative.
Performance Measure Validation	**Strengths** • All three MCOs have experienced staff, established data systems, and well-defined processes to calculate and report HEDIS performance measures. • All three MCOs completed conversion from the State's proprietary enrollment file format to the HIPAA 834 compliant format in 2013 and continued to capture race, ethnicity, and language using the new enrollment format. • All MCOs achieved NCQA accreditation by the January 2014 deadline. • The MCOs all successfully integrated pharmacy data provided by the fiscal agent to report measures that use pharmacy data. • Beginning April 2013, all three MCOs successfully implemented the carve-in of pharmacy benefits into their programs. All the MCOs successfully reported all required measures to BMS for HEDIS 2014. • In regards to measures of quality, the MHT rates for four HEDIS indicators compared favorably with national benchmarks by exceeding the National Medicaid 50th Percentile. • The MHT Weighted Averages for seven of nine access indicators compared favorably with national benchmarks by exceeding the National Medicaid 50th Percentile. • The three year trend from HEDIS 2012 to HEDIS 2014 indicated improving performance for the MHT Weighted Averages for two timeliness measures- *Adolescent Well Care Visits* and *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life.* • For Adult and Child CAHPS measures, two Adult and five Child Quality measures compared favorably to national benchmarks by exceeding the National Medicaid 50th Percentile. • One Adult and Child CAHPS survey measure was used to assess access. The MHT Average for the Adult CAHPS Getting Needed Care Composite measure compared favorably to national benchmarks. • For the Adult and Child CAHPS measure for timeliness, the MHT Averages for the Adult and Child CAHPS Getting Needed Care Quickly Composite compared favorably to national benchmarks.

MHT Program Strengths, Requirements and Recommendations for MY 2013	
	Requirements • The MCOs must be prepared to fully report HEDIS measures that require pharmacy data to NCQA for HEDIS 2015 (MY 2014). • The MCOs must be prepared to report non-HEDIS performance measures to BMS from the CMS Child and Adult Quality Core Measure Sets for MY 2014. **Recommendations** • ***CMS Adult and Child Quality Core Measures*** - the MCOs must be fully prepared to report all BMS required measures form the CMS Adult and Child Core Sets. • ***Use of Pharmacy Data*** - The MCOs must be fully prepared to report HEDIS measures that require pharmacy data for HEDIS 2015 (MY 2014) to NCQA. • ***Data Quality*** - BMS and the MCOs are encouraged to share new ideas and innovations to gather data or improve the quality of data used to calculate required performance measures. With the new requirement to report Adult and Child Core Measures, the sharing of information will assist the MCOs to produce valid and reliable results that are comparable among the MCOs. The Task Force meeting can act as forum the MCOs to share "best practices" for successful data capture and reporting. • ***Data Quality*** – The MCOs and BMS are encouraged to collaborate with State work groups and State agencies to provide the MCOs access to data from state information systems required for reporting performance measures. For example, the MCOs provided technical assistance to the Adult Quality Measures Grant team to identify Vital Statistics data required to calculate for some of the measures. (As a result, a signed Memo of Understanding (MOU) with the Bureau of Public Health will provide the MCOs access to Vital Statistics required to report the Adult measures in 2014).

References

Bureau for Medical Services, *West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality, 2012*

Centers for Medicare and Medicaid Services (CMS). (2002, June). Final Rule: Medicaid Managed Care; 42 C.F.R. Part 400 et seq. Subpart D. Quality Assessment and Performance Improvement. Retrieved December 4, 2004, from CMS website: http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms2104f.pdf

Centers for Medicare and Medicaid Services (CMS). (2003, January). Final Rule: External Quality Review of Managed Care Organizations and Prepaid Inpatient Health Plans, 42 C.F.R. Part 438.300 et seq. Retrieved November 1, 2004, from CMS website: http://www.cms.gov/Regulations-and-Guidance/Regulations-and-policies/QuarterlyProviderUpdates/downloads/cms2015f.pdf

Centers for Medicare and Medicaid Services (CMS). (2012, September). External Quality Review Protocols. Retrieved February 14, 2013, from CMS website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html

Institute of Medicine (IOM), Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. (2001). *Envisioning the National Health Care Quality Report.* Retrieved February 24, 2005, from the National Academies Press website: http://www.nap.edu/html/envisioning/ch2.htm

National Committee for Quality Assurance (NCQA). (2012). *2013 Health Plan Standards and Guidelines*.

Appendix 1 - PIP Results

Table A1-1. CoventryCares Performance Improvement Project (PIP) Results.

PIP Results-Adolescent Well-Care Visits			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
MY 2011	Baseline	Not Applicable	42.13%
MY 2012	Remeasurement 1	5 percentage point increase over prior year's rate	46.58%
MY 2013	Remeasurement 2	5 percentage point increase over prior year's rate	47.20%
PIP Results-Emergency Department Collaborative			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined with the PIP Collaborative Team	8.86%
Indicator 2: Use of Appropriate medications for People With Asthma (ages 5-11 and 12-18)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	Goal Ages 5-11: 94.92%, Goal Ages 12-18: 92.16%	Rate Ages 5-11: 92.62%, Rate Ages 12-18: 86.92%
PIP Results-Diabetes Collaborative			
Indicator 1: Comprehensive Diabetes Care – HbA1C Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (2015)	41.32%
Indicator 2: Comprehensive Diabetes Care – LDL-C level Control (LDL-C<100mg/dl)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (2015)	22.00%

Table A1-2. The Health Plan of the Upper Ohio Valley Performance Improvement Project (PIP) Results.

PIP Results-Childhood Obesity			
Indicator 1: Members with evidence of BMI documentation (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Not Applicable	15.09%
MY 2009	Remeasurement 1	5% annual increase	1.45%
MY 2010	Remeasurement 2	5% annual increase	1.12%
MY 2011	Remeasurement 3	5% annual increase	1.36%
MY 2012	Remeasurement 4	5% annual increase	35.28%
MY 2013	Remeasurement 5	5% annual increase	38.93%
Indicator 2: Members with evidence of nutritional counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Not Applicable	35.52%
MY 2009	Remeasurement 1	5% annual increase	0.94%
MY 2010	Remeasurement 2	5% annual increase	0.54%
MY 2011	Remeasurement 3	5% annual increase	1.22%
MY 2012	Remeasurement 4	5% annual increase	51.82%
MY 2013	Remeasurement 5	5% annual increase	47.69%
Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Not Applicable	32.12%
MY 2009	Remeasurement 1	5% annual increase	0.78%
MY 2010	Remeasurement 2	5% annual increase	0.45%
MY 2011	Remeasurement 3	5% annual increase	1.12%
MY 2012	Remeasurement 4	5% annual increase	20.92%
MY 2013	Remeasurement 5	5% annual increase	27.25%
PIP Results-Emergency Department Collaborative			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined by the PIP Collaborative Team	6.58%
Indicator 2: Asthma Medication Ratio			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	5% increase	83.67%

PIP Results-Diabetes Collaborative			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
1/1/2013 – 12/31/2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	45.34%
Indicator 2: Comprehensive Diabetes Care – HbA1c testing			
Time Period	Measurement	Goal	Rate or Results
1/1/2013 – 12/31/2013	Baseline	100%	73.91%

Table A1-3. UniCare Health Plan Performance Improvement Project (PIP) Results.

PIP Results–Childhood Immunizations Combination 3			
Indicator 1: The percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday.			
Time Period	Measurement	Goal	Rate or Result
1/1/2012–12/31/2012	Baseline	71.93%	62.04%
1/1/2013-12/31/2013	Remeasurement 1	72.08%	63.43%
PIP Results-Emergency Department Collaborative			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20).			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined with the PIP Collaborative Team	8.29%
Indicator 2: Use of Appropriate Medications for People with Asthma (ASM).			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined upon release of NCQA's Quality Compass	76.61%
Indicator 3: Medication Management for People with Asthma (MMA).			
Time Period	Measurement	Goal	Rate or Results
1/1/2013-12/31/2013	Baseline	To be determined upon release of NCQA's Quality Compass	42.39%

PIP Results-Diabetes Collaborative			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	28.73%
Indicator 2: Comprehensive Diabetes Care – HbA1c testing			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	80.18%
Indicator 3: Comprehensive Diabetes Care – Eye (Retinal) Exam Performed			
Time Period	Measurement	Goal	Rate or Results
HEDIS 2014 (MY 2013)	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	25.84%

Appendix 2 – HEDIS 2014 (MY 2013) Quality Strategy and Performance Withhold Program Measures

The table below provides a comparison of the HEDIS 2014 (MY 2013) MCO Rates, MHT Weighted Average (MHT-WA), and National Medicaid Benchmarks for the Quality Strategy and Performance Withhold Program measures. Measures maybe in the Quality Strategy (QS), the Withhold Program (PWP) or both (B).

Measure	Measure Set (B, PWP QS)	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	National Medicaid Average HEDIS 2014 %	National Medicaid 90th Percentile HEDIS 2014 %
Prenatal and Postpartum Care - Postpartum Care	B	60.6	62.8	64.9	62.7	61.3	74.0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	B	73.7	71.3	66.9	70.0	71.5	82.7
Adolescent Well-Care Visits	PWP	47.2	43.1	41.2	43.6	50.0	65.6
Medication Management for People With Asthma – Total Compliance 75%	PWP	30.7	37.5	42.4	33.9	31.4	43.4
Immunizations for Adolescents - Combination 1	PWP	83.4	83.2	78.0	80.7	70.1	86.5
Childhood Immunization Status – Combination 3	QS	67.4	72.5	63.4	66.3	70.9	80.9
Adult BMI Assessment	QS	71.5	67.9	63.1	66.9	75.9	90.8
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	QS	53.8	38.9	41.3	45.4	56.9	82.5

Measure	Measure Set (B, PWP QS)	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	National Medicaid Average HEDIS 2014 %	National Medicaid 90th Percentile HEDIS 2014 %
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	QS	52.6	47.7	36.4	43.9	58.7	77.5
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	QS	75.0	74.6	73.6	74.4	75.8	81.4
Comprehensive Diabetes Care - HbA1c Control (<8%)	QS	41.3	45.3	28.7	36.1	45.4	59.4
Children's and Adolescents' Access To PCP (12-19 Yrs.)	QS	93.5	91.7	92.6	92.7	88.5	94.4
Children's and Adolescents' Access To PCP (12-24 Months)	QS	97.7	98.0	97.2	97.5	96.1	98.5
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	QS	92.5	89.9	90.7	91.3	88.2	93.6
Children's and Adolescents' Access To PCP (7-11 Yrs.)	QS	94.4	92.4	93.9	93.8	90.0	95.2

Appendix 3 – HEDIS 2014 (MY 2013) MCO Rates, MHT Weighted Average, and National Percentile Ranges

Tables A3-1 through A3-3 below provides a comparison of the MCO Rates, MHT Weighted Average (MHT-WA), and National Medicaid Percentile (NMP) for HEDIS 2014 (MY 2013).

Table A3 Star Ratings for Performance Measure Tables

National Medicaid Percentile Ranges	Star Rating
Exceeds the 90th Percentile	★★★★★
Exceeds the 75th Percentile to 90th Percentile	★★★★
Exceeds the 50th Percentile to the 75th Percentile	★★★
Exceeds the 25th Percentile to the 50th Percentile	★★
25th Percentile or less	★

Table A3-1 Quality Measures

Measure Name	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMPs HEDIS 2014 %
Childhood Immunization Status - Combo 2	72.0	75.7	67.4	70.4	★
Childhood Immunization Status - Combo 3	67.4	72.5	63.4	66.3	★
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	64.3	69.6	54.1	60.4	★★
Comprehensive Diabetes Care - Eye Exams	32.3	32.9	25.8	29.4	★
Comprehensive Diabetes Care - HbA1c Control (<8%)	41.3	45.3	28.7	36.1	★
Comprehensive Diabetes Care - HbA1c Testing	72.9	73.9	80.2	76.4	★
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	22.0	28.6	21.2	22.6	★

Measure Name	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMPs HEDIS 2014 %
Comprehensive Diabetes Care - LDL-C Screening	60.6	65.2	67.0	64.3	★
Comprehensive Diabetes Care - Medical Attention for Nephropathy	55.3	57.8	64.1	59.7	★
Controlling High Blood Pressure	56.0	67.0	40.1	49.5	★★
Immunizations for Adolescents - Combination 1	83.4	83.2	78.0	80.7	★★★★
Lead Screening in Children	59.4	51.6	56.0	56.6	★
Adult BMI Assessment	71.5	67.9	63.1	66.9	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	53.8	38.9	41.3	45.4	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	52.6	47.7	36.4	43.9	★
Medication Management for People With Asthma - Ages 5-11 Years, Compliance 75%+	34.6	39.3	41.9	36.8	★★★★
Medication Management for People With Asthma - Ages 12-18 Years, Compliance 75%+	23.8	30.3	44.4	27.6	★★★
Medication Management for People With Asthma – Total, Compliance 75%+	30.7	37.5	42.4	33.9	★★★
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	75.0	74.6	73.6	74.4	★

Measure Name	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMPs HEDIS 2014 %
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	39.8	49.7	36.7	42.1	★
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	42.5	46.4	33.7	40.9	★★

Table A3-2 Access Measures

Measure Name	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	84.2	86.8	85.7	85.3	★★★
Adults' Access to Preventive/Ambulatory Health Services (45-64)	83.6	89.4	85.8	85.5	★
Adults' Access to Preventive/Ambulatory Health Services (Total)	84.1	87.0	85.7	85.3	★★★
Children's and Adolescents' Access To PCP (12-19 Yrs.)	93.5	91.7	92.6	92.7	★★★★
Children's and Adolescents' Access To PCP (12-24 Months)	97.7	98.0	97.2	97.5	★★★
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	92.5	89.9	90.7	91.3	★★★
Children's and Adolescents' Access To PCP (7-11 Yrs.)	94.4	92.4	93.9	93.8	★★★★
Prenatal and Postpartum Care - Postpartum Care	60.6	62.8	64.9	62.7	★★
Prenatal and Postpartum Care - Timeliness of Prenatal Care	92.7	93.2	92.5	92.7	★★★★

Table A3-3 Timeliness Measures

Measure Name	Coventry Cares HEDIS 2013 %	The Health Plan HEDIS 2013 %	UniCare HEDIS 2013 %	MHT-WA HEDIS 2013 %	MHT-WA Compared to NMP HEDIS 2014 %
Adolescent Well-Care Visits	47.2	43.1	41.2	43.6	★★
Frequency of Ongoing Prenatal Care (≥ 81%)	76.1	90.5	65.3	74.4	★★★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	73.7	71.3	66.9	70.0	★★
Well-Child Visits in the first 15 Months of Life (6 or more visits)	65.2	69.1	68.0	67.1	★★★

Appendix 4 - Three-Year Trend Data for MCOs and MHT Weighted Average

Tables A4-1 through A4-3 provide the MCO Rates and MHT Weighted Averages for the three-year period from HEDIS 2012 through HEDIS 2014

Table A4-1 Quality Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %
Childhood Immunization Status - Combo 2	67.1	66.9	72.0	70.6	73.5	75.7	68.6	67.9	67.4	68.3	68.3	70.4
Childhood Immunization Status - Combo 3	62.5	63.6	67.4	63.8	66.2	72.5	62.0	62.0	63.4	62.4	63.3	66.3
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	61.8	58.6	64.3	74.5	68.2	69.6	71.2	61.6	54.1	68.8	61.6	60.4
Comprehensive Diabetes Care - Eye Exams	34.9	34.2	32.3	34.5	33.8	32.9	31.0	25.8	25.8	32.8	29.9	29.4
Comprehensive Diabetes Care - HbA1c Control (<8%)	36.5	37.9	41.3	47.6	45.3	45.3	42.1	37.0	28.7	41.3	38.6	36.1
Comprehensive Diabetes Care - HbA1c Testing	75.1	70.5	72.9	77.9	83.1	73.9	77.5	72.8	80.2	76.8	73.6	76.4
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	23.2	27.0	22.0	28.3	33.8	28.6	30.2	26.8	21.2	27.7	27.9	22.6
Comprehensive Diabetes Care - LDL-C Screening	61.8	59.9	60.6	67.6	71.0	65.2	64.6	61.6	67.0	64.2	62.4	64.3
Comprehensive Diabetes Care - Medical Attention for Nephropathy	67.6	59.9	55.3	66.2	68.9	57.8	59.3	52.1	64.1	63.1	57.3	59.7
Controlling High Blood Pressure	56.9	55.4	56.0	77.9	63.1	67.0	67.4	52.7	40.1	64.7	54.9	49.5
Immunizations for Adolescents - Combination 1	49.8	64.0	83.4	45.5	60.1	83.2	41.9	68.4	78.0	45.0	65.5	80.7
Lead Screening in Children	53.6	58.5	59.4	54.5	53.8	51.6	56.5	56.9	56.0	55.1	57.1	56.6

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %
Adult BMI Assessment	46.6	65.9	71.5	47.7	62.5	67.9	49.6	64.2	63.1	48.4	64.5	66.9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	22.7	44.4	53.8	1.1	35.3	38.9	21.4	33.8	41.3	18.1	37.3	45.4
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	45.4	47.2	52.6	1.2	51.8	47.7	32.4	44.3	36.4	30.5	46.4	43.9
Medication Management for People With Asthma - Ages 5-11 Years, Compliance 75%+	40.0	10.9	34.6	25.0	31.1	39.3	46.0	51.9	41.9	39.3	38.0	36.8
Medication Management for People With Asthma - Ages 12-18 Years, Compliance 75%+	33.0	8.9	23.8	26.0	38.1	30.3	36.0	45.7	44.4	32.8	35.1	27.6
Medication Management for People With Asthma – Total, Compliance 75%+	36.0	10.6	30.7	26.0	33.4	37.5	42.0	50.0	42.4	36.9	36.9	33.9
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	74.5	74.2	75.0	80.0	75.2	74.6	76.2	69.2	73.6	75.3	73.0	74.4
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	50.0	40.2	39.8	41.8	42.3	49.7	71.6	34.3	36.7	45.8	38.9	442.1
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	42.0	39.4	42.5	40.5	42.2	46.4	36.1	32.8	33.7	39.1	38.1	40.9

Table A4-2 Access Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2014 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	84.6	83.3	84.2	89.4	87.0	86.8	87.6	85.3	85.7	86.9	84.9	85.3
Adults' Access to Preventive/Ambulatory Health Services (45-64)	87.6	82.7	83.6	89.2	87.8	89.4	85.9	87.8	85.8	87.0	86.0	85.5
Adults' Access to Preventive/Ambulatory Health Services (Total)	84.9	83.3	84.1	89.4	87.1	87.0	87.5	85.6	85.7	86.9	85.0	85.3
Children's and Adolescents' Access To PCP (12-19 Yrs.)	87.5	90.1	93.5	91.6	92.1	91.7	91.7	93.2	92.6	90.4	92.0	92.7
Children's and Adolescents' Access To PCP (12-24 Months)	97.2	96.9	97.7	98.2	98.0	98.0	97.3	98.1	97.2	97.4	97.6	97.5
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	89.6	89.9	92.5	91.8	91.0	89.9	91.6	92.0	90.7	91.0	91.1	91.3
Children's and Adolescents' Access To PCP (7-11 Yrs.)	90.6	91.6	94.4	92.9	93.3	92.4	94.3	94.6	93.9	92.9	93.5	93.8
Prenatal and Postpartum Care - Postpartum Care	60.7	59.7	60.6	66.4	69.3	62.8	65.0	65.7	64.9	63.7	63.9	62.7
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.0	94.9	92.7	93.7	94.4	93.2	92.9	93.4	92.5	93.4	94.1	92.7

Table A4-3 Timeliness Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2013 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2013 %
Adolescent Well-Care Visits	42.1	46.6	47.2	41.4	44.9	43.1	35.5	45.3	41.2	38.7	45.6	43.6
Frequency of Ongoing Prenatal Care (≥ 81%)	83.1	82.9	76.1	83.2	84.7	90.5	70.9	71.1	65.3	77.1	77.7	74.4
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.6	72.5	73.7	63.9	67.5	71.3	68.2	64.2	66.9	67.3	67.5	70.0
Well-Child Visits in the first 15 Months of Life (6 or more visits)	71.1	71.9	65.2	64.9	68.6	69.1	67.6	67.8	68.0	68.6	69.4	67.1

Appendix 5 – State Requested Measures Using Pharmacy Data

For HEDIS 2014, MHT MCOs were required provide several additional HEDIS measures to BMS. They are:

- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Pharmacotherapy Management of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma
- Asthma Medication Ratio
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Antidepressant Medication Management
- Follow-Up for Children Prescribed ADHD Medication
- Annual Monitoring for Patients on Persistent Medications
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia

For HEDIS 2014 (MY 2013) these measures were collected and reported only to BMS and not to NCQA as the pharmacy benefit was provided by the State for the first three months of MY 2013. The MCOs became responsible for the pharmacy benefit in April 2013. BMS worked with the State's Pharmacy Third Party Administrator (TPA) to provide each MCO with complete pharmacy data from the first three months of MY 2013 needed for the MCOs to calculate the respiratory and pharmacy benefit measures. CoventryCares found the data complete enough to use and to calculate all measures according to the specifications.

Table A5-1 provides the MCO rates, MHT weighted average (MHT-WA), and a comparison of the MHT-WA to National Medicaid Percentiles (NMP) for the selected measures.

Table A5-1 State Requested Measures Using Pharmacy Data

Measure	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014
Appropriate Testing for Children With Pharyngitis	61.5	66.2	66.3	63.3	★★

Measure	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014
Appropriate Treatment for Children With Upper Respiratory Infection	61.5	77.5	70.9	68.4	★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.1	15.3	21.9	18.2	★
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	83.3	^	^	74.5	★★
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	79.2	^	^	83.0	★★
Use of Appropriate Medications for People With Asthma (5-11 Years)	92.6	90.6	79.8	90.3	★★
Use of Appropriate Medications for People With Asthma (12-18 Years)	86.9	85.0	72.5	84.9	★★
Use of Appropriate Medications for People With Asthma (19-50 Years)	71.4	67.6	60.0	69.7	★★
Use of Appropriate Medications for People With Asthma (51-64 Years)	60.0	^	^	^	^
Use of Appropriate Medications for People With Asthma (Total)	87.9	86.0	76.6	86.0	★★★
Medication Management for People With Asthma: Medication Compliance 50% (5-11 Years)	61.0	66.2	75.8	64.6	^
Medication Management for People With Asthma: Medication Compliance 75% (5-11 Years)	34.6	39.3	41.9	36.8	★★★★
Medication Management for People With Asthma: Medication Compliance 50% (12-18 Years)	51.9	51.2	66.7	52.8	^
Medication Management for People With Asthma: Medication Compliance 75% (12-18 Years)	23.8	30.3	44.4	27.6	★★★
Medication Management for People With Asthma: Medication Compliance 50% (19-50 Years)	68.0	78.3	^	72.4	^
Medication Management for People With Asthma: Medication Compliance 75% (19-50 Years)	34.0	60.9	^	42.1	★★★★
Medication Management for People With Asthma: Medication Compliance 50% (51-64 Years)	^	^	^	^	^
Medication Management for People With Asthma: Medication Compliance 75% (51-64 Years)	^	^	^	^	^
Medication Management for People With Asthma: Medication Compliance 50% (Total)	58.8	61.1	73.9	61.0	^
Medication Management for People With Asthma: Medication Compliance 75% (Total)	30.7	37.5	42.4	33.9	★★★

Measure	Coventry Cares HEDIS 2014 %	The Health Plan HEDIS 2014 %	UniCare HEDIS 2014 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014
Asthma Medication Ratio (5-11 Years)	82.1	92.0	75.7	83.5	★★★★
Asthma Medication Ratio (12-18 Years)	74.3	77.1	48.7	72.5	★★★★
Asthma Medication Ratio (19-50 Years)	53.6	72.7	60.0	58.3	★★★★
Asthma Medication Ratio (51-64 Years)	^	^	^	^	^
Asthma Medication Ratio (Total)	75.9	83.7	65.8	76.7	★★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack	^	^	^	^	^
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	^	^	^	^	^
Antidepressant Medication Management - Effective Acute Phase Treatment	48.0	56.7	74.7	54.6	★★★★
Antidepressant Medication Management - Effective Continuation Phase Treatment	32.3	38.3	59.0	38.3	★★★★
Follow-Up for Children Prescribed ADHD Medication-Initiation Phase	40.4	41.0	^	40.5	★★
Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	46.2	40.02	^	43.9	★★
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Members on Ace Inhibitors or ARBs	81.9	88.1	85.8	85.8	★★
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Members on Digoxin	^	^	^	^	^
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Members on Diuretics	84.6	86.6	86.6	86.6	★★
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Members on Anticonvulsants	45.3	^	67.4	56.9	★
Annual Monitoring for Patients on Persistent Medications - Total	80.1	85.6	87.3	84.0	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	83.3	^	83.6	82.1	★★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	^	^	^	^	^

^ Measure not collected, or benchmark is not available, or denominator is less than 30 and too small to calculate a reliable rate.

Appendix 6 –HEDIS Measures Collected and Reported to NCQA (HEDIS 2012-HEDIS 2014)

These tables provide information for all measures collected and reported for HEDIS 2012 through HEDIS 2014 (MY 2011-MY 2013) by HEDIS domains. Individual MCO rates for three years, the MHT Weighted Average (MHT-WA) for three years, and a comparison of MHT-WA (MY 2013) to the most current National Medicaid Percentiles (NMP) are provide for each measure.

Table A6-1 Effectiveness of Care Domain Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %				
Adult BMI Assessment	46.6	65.9	71.5	47.7	62.5	67.9	49.6	64.2	63.1	48.4	64.5	66.9	★
Breast Cancer Screening	40.4	36.4	50.0	44.1	43.0	^	40.0	36.6	46.7	40.9	37.6	48.1	★
Cervical Cancer Screening	63.9	60.9	55.2	62.3	63.3	57.3	70.4	56.9	61.5	66.9	59.3	58.5	★
Non-recommended Cervical Cancer Screening in Adolescent Females (A lower rate is better)	^	^	7.9	^	^	9.5	^	^	10.2	^	^	9.3	^
Childhood Immunization Status - Combo 2	67.1	66.9	72.0	70.6	73.5	75.7	68.6	67.9	67.4	68.3	68.3	70.4	★
Childhood Immunization Status - Combo 3	62.5	63.6	67.4	63.8	66.2	72.5	62.0	62.0	63.4	62.4	63.3	66.3	★
Chlamydia Screening in Women - Total	43.2	43.9	43.9	33.7	43.0	40.4	37.3	40.4	40.2	38.9	42.1	41.6	★
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	^	^	^	^	^	^	^	^	^	^	^	^	^
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	^	^	^	^	^	^	^	^	^	^	^	^	^
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	34.9	30.4	36.7	42.1	41.2	45.3	44.7	36.0	31.4	41.2	34.9	34.9	★★

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %				
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	61.8	58.6	64.3	74.5	68.2	69.6	71.2	61.6	54.1	68.8	61.6	60.4	★★
Comprehensive Diabetes Care - Eye Exams	34.9	34.2	32.3	34.5	33.8	32.9	31.0	25.8	25.8	32.8	29.9	29.4	★
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	26.9	27.4	29.8	^	^	^	^	^	^	26.9	27.4	29.8	★★
Comprehensive Diabetes Care - HbA1c Control (<8%)	36.5	37.9	41.3	47.6	45.3	45.3	42.1	37.0	28.7	41.3	38.6	36.1	★
Comprehensive Diabetes Care - HbA1c Testing	75.1	70.5	72.9	77.9	83.1	73.9	77.5	72.8	80.2	76.8	73.6	76.4	★
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	23.2	27.0	22.0	28.3	33.8	28.6	30.2	26.8	21.2	27.7	27.9	22.6	★
Comprehensive Diabetes Care - LDL-C Screening	61.8	59.9	60.6	67.6	71.0	65.2	64.6	61.6	67.0	64.2	62.4	64.3	★
Comprehensive Diabetes Care - Medical Attention for Nephropathy	67.6	59.9	55.3	66.2	68.9	57.8	59.3	52.1	64.1	63.1	57.3	59.7	★
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	54.8	51.4	48.7	40.0	43.9	46.6	47.6	53.8	64.1	48.5	51.4	55.5	★
Controlling High Blood Pressure	56.9	55.4	56.0	77.9	63.1	67.0	67.4	52.7	40.1	64.7	54.9	49.5	★★
Human Papillomavirus Vaccine for Female Adolescents	22.0	17.2	23.6	20.7	24.8	26.8	9.8	10.5	13.2	15.7	15.3	19.0	★★
Immunizations for Adolescents - Combination 1	49.8	64.0	83.4	45.5	60.1	83.2	41.9	68.4	78.0	45.0	65.5	80.7	★★★★
Lead Screening in Children	53.6	58.5	59.4	54.5	53.8	51.6	56.5	56.9	56.0	55.1	57.1	56.6	★
Use of Imaging Studies for Low Back Pain	67.1	68.8	65.5	69.2	76.5	71.7	69.7	69.7	65.5	68.8	70.4	66.4	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents - BMI percentile	22.7	44.4	53.8	1.4	35.3	38.9	21.4	33.8	41.3	18.1	37.3	45.4	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	45.4	47.2	52.6	1.2	51.8	47.7	32.4	44.3	36.4	30.5	46.4	43.9	★

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA HEDIS 2012 %	MHT-WA HEDIS 2013 %	MHT-WA HEDIS 2014 %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	39.8	33.6	35.8	1.1	20.9	27.3	16.3	21.7	27.0	20.4	25.2	30.1	★

(x)==> HEDIS percentiles are from NCQA Quality Compass 2014 (MY 2013)
(^)==> Measures not collected or benchmark not available, or denominator is less than 30 and too small to calculate reliable rate

Table A6-2 Access to Care Domain Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA (MY 2011) - %	MHT-WA (MY 2012) - %	MHT-WA (MY 2013) - %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 – %	HEDIS 2014 – %	HEDIS 2012 – %	HEDIS 2013 – %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 – %	HEDIS 2014 - %				
Adults' Access to Preventive/Ambulatory Health Services (20-44)	84.6	83.3	84.2	89.4	87.0	86.8	87.6	85.3	85.7	86.9	84.9	85.3	★★★
Adults' Access to Preventive/Ambulatory Health Services (45-64)	87.6	82.7	83.6	89.2	87.8	89.4	85.9	87.8	85.8	87.0	86.0	85.5	★
Adults' Access to Preventive/Ambulatory Health Services (Total)	84.9	83.3	84.1	89.4	87.1	87.0	87.5	85.6	85.7	86.9	85.0	85.3	★★★
Call Answer Timeliness	81.7	79.7	82.1	96.2	94.8	91.2	81.0	64.9	93.6	83.5	78.4	85.7	★★
Children's and Adolescents' Access To PCP (12-19 Yrs.)	87.5	90.1	93.5	91.6	92.1	91.7	91.7	93.2	92.6	90.4	92.0	92.7	★★★★
Children's and Adolescents' Access To PCP (12-24 Months)	97.2	96.9	97.7	98.2	98.0	98.0	97.3	98.1	97.2	97.4	97.6	97.5	★★★
Children's and Adolescents' Access To PCP (25 Months-6 Yrs.)	89.6	89.9	92.5	91.8	91.0	89.9	91.6	92.0	90.7	91.0	91.1	91.3	★★★
Children's and Adolescents' Access To PCP (7-11 Yrs.)	90.6	91.6	94.4	92.9	93.3	92.4	94.3	94.6	93.9	92.9	93.5	93.8	★★★★

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA (MY 2011) - %	MHT-WA (MY 2012) - %	MHT-WA (MY 2013) - %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 – %	HEDIS 2014 – %	HEDIS 2012 – %	HEDIS 2013 – %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 – %	HEDIS 2014 - %				
Prenatal and Postpartum Care - Postpartum Care	60.7	59.7	60.6	66.4	69.3	62.8	65.0	65.7	64.9	63.7	63.9	62.7	★★
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.0	94.9	92.7	93.7	94.4	93.2	92.9	93.4	92.5	93.4	94.1	92.7	★★★★

(x)==> HEDIS percentiles are from NCQA Quality Compass 2014 (MY 2013)
(^)==> Measures not collected or benchmark not available or denominator is less than 30 and too small to calculate reliable rate

Table A6-3 Utilization and Relative Resource Use Domain

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT-WA (MY 2011) - %	MHT-WA (MY 2012) - %	MHT-WA (MY 2013) - %	MHT-WA Compared to NMP HEDIS 2014 - %
	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2014 - %				
Adolescent Well-Care Visits	42.1	46.6	47.2	41.4	44.9	43.1	35.5	45.3	41.2	38.7	45.6	43.6	★★
Frequency of Ongoing Prenatal Care (≥ 81%)	83.1	82.9	76.1	83.2	84.7	90.5	70.9	71.1	65.3	77.1	77.7	74.4	★★★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.6	72.5	73.7	63.9	67.5	71.3	68.2	64.2	66.9	67.3	67.5	70.0	★★
Well-Child Visits in the first 15 Months of Life (6 or more visits)	71.1	71.9	65.2	64.9	68.6	69.1	67.6	67.8	68.0	68.6	69.4	67.1	★★★

(x)==> HEDIS percentiles are from NCQA Quality Compass 2014 (MY 2013)
(^)==> Measures not collected or benchmark not available or denominator is less than 30 and too small to calculate reliable rate

Appendix 7 - Status of Recommendations from Measurement Year 2012 Review

Delmarva provided recommendations to all three MCOs based on the results of the 2012 SPR, PIP, and PMV activities with the expectation that they would be addressed. The tables below provide the recommendations made and the actions, if any, that have been undertaken by each of the MCOs in 2013 to address these recommendations. Summaries are presented below by MCO and activity.

CoventryCares SPR

CoventryCares: MY 2012 SPR Recommendations and MY 2013 Current Status	
Enrollee Rights	**Recommendation** • Changes to member benefits, policies etc. must be communicated to members within 30 days. The Member Handbook states that members will be notified, but does not state how they will be notified. It is recommended that the MCO clarify how members will be notified.
	Status • The MCO revised its Member Handbook in 2013. The "Your Rights and Responsibilities" section of the Member Handbook states that as a CoventryCares member you have the right "to be told at least 30 days before there are any program or site changes that affect you." The Medicaid Provider Status Change – Member Notification Policy states that members will be notified via letter.
Grievance Systems	**Recommendation** • The Member Handbook notes the MCO's liability when a denial of delivered services is reversed, but the appeal-related policies do not. It is recommended that CoventryCares include this language in its appeal-related policies (Medicaid Pre and Post Service Appeal and Medicaid Urgent Appeal policies).
	Status • CoventryCares combined all of its appeal-related policies into one policy, the Medicaid Appeal Policy. This policy addresses the MCO's liability when a denial of services is reversed.
Quality Assessment and Performance Improvement	**Recommendation** • CoventryCares must develop formal written policies and procedures for disenrollment.
	Status • The MCO developed disenrollment policies and procedures. The Eligibility and Enrollment section of the Member Handbook describes reasons why a member may no longer qualify and need to be disenrolled. This section also instructs enrollees how to disenroll and informs them that they can disenroll at any time for any reason.
Fraud and Abuse	**Recommendation** • As in 2011, the Member Handbook does not include information on how enrollees can report suspected fraud, waste, and abuse. CoventryCares must include this information in the Member Handbook.
	Status • The same Member Handbook was used in 2011 and 2012 and so this recommendation was not addressed. CoventryCares revised its Member Handbook

CoventryCares: MY 2012 SPR Recommendations and MY 2013 Current Status	
	in 2013 and included a section entitled "Reporting Fraudulent Activity" which informs members how to report suspected fraud or abuse.

CoventryCares – PIP

CoventryCares: MY 2012 PIP Recommendations and MY 2013 Current Status	
Adolescent Well-Care Visits	**Recommendation** • There were no recommendations for this PIP from the MY 2012 report except to continue the PIP
	Status • Not applicable.
Emergency Department Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.
Diabetes Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.

CoventryCares -PMV

CoventryCares: MY 2012 PMV Recommendations and MY 2013 Current Status
Recommendation • The audit team recommended that the MCO be prepared to report all HEDIS measures that require pharmacy data for HEDIS 2014. The MCOs became responsible for the pharmacy benefit in April 2013. The MCO should work with BMS to obtain pharmacy data for January-March 2013 from the TPA. **Status** • The MCO successfully reported all State required measures using its own pharmacy data and data provided by the Third Party Administrator for the first quarter of 2013.
Recommendation • CoventryCares is encouraged to continue exploring different avenues to improve their data quality and data capture with special emphasis on measures in the Effectiveness of Care Domain. **Status** • CoventryCares continues to explore new ways to improve performance measures of high interest such as diabetes. For example, the MCO has a provider incentive program to increase Comprehensive Diabetes Care indicators such as HbA1c Testing and LDL-C Screenings. Both indicators increased between HEDIS 2013 and 2014.

The Health Plan - SPR

The Health Plan: MY 2012 SPR Recommendations and MY 2013 Current Status	
Enrollee Rights	**Recommendation** • This standard received a 100% compliance rating. There were no recommendations for improvement.
	Status • Not applicable.
Grievance Systems	**Recommendation** • The MCO must give enrollees any reasonable assistance in completing forms. This provision was inadvertently removed from the Member Handbook in the 2011 revision. The same Member Handbook was used in 2012 and therefore the recommendation was made again for 2012.
	Status • The Member Handbook was updated for 2013 to include this information.
Quality Assessment and Performance Improvement	**Recommendations** • **Access and Availability** - The Health Plan must provide evidence of assessing compliance with the BMS prenatal care visit standard of 14 days from which the woman was found to be pregnant. • **Access and Availability** - The Health Plan must assess and report compliance using the access standards found in the BMS/MCO contract. The Accessibility of Practitioners Policy (and any other materials identifying timely access requirements) must reflect the BMS access standards found in the BMS contract. The MCO may choose to evaluate its own internal standards, but it must provide evidence of monitoring compliance with all access standards found in the BMS contract to meet the BMS requirements. • **Credentialing and Recredentialing** - The MCO has revised its Initial Credentialing and Recredentialing Process policy and its Site Survey policy to require on-site reviews for recredentialing of providers. Completed on-site reviews for recredentialed providers were in place for the 2013 sample provider files reviewed. • **Credentialing and Recredentialing** – The Initial Credentialing and Recredentialing policy was revised in 2013 to include the EPLS/SAM requirement. • **Utilization Management** – Enhance the authorization decision extension timeframe portion of the Timeliness of Utilization Management and Behavioral Health Decision Policy. Language should be added to include: If the MCO determines that an extension is necessary to gather additional information, the MCO must justify, upon request, to the State that this extension is in the enrollee's best interest. • **Coordination of Care** – Revise the Case Management policy and include more specific language to describe the specific monitoring processes and measures that are used; the current policy is vague and does not describe specific processes and measures.

The Health Plan: MY 2012 SPR Recommendations and MY 2013 Current Status	
	Status • **Access and Availability** - The Health Plan provided evidence of assessing compliance with the BMS prenatal care visit standard of 14 days from which the woman was found to be pregnant. The 2013 Obstetrician/Gynecologist (OB/GYN) Appointment Accessibility Standards Audit Report shows a compliance rate of 94.47% for prenatal appointments. • **Access and Availability** - The Health Plan assessed and reported compliance using the access standards found in the BMS/MCO contract. The Accessibility of Practitioners Policy was updated in 2013 and now includes these same standards. Compliance for all access standards was assessed and reported in its 2013 Appointment Accessibility Standards Audit. • **Credentialing and Recredentialing** - The MCO has revised its Initial Credentialing and Recredentialing Process policy and its Site Survey policy to require on-site reviews for recredentialing of providers. Completed on-site reviews for recredentialed providers were in place for the 2013 provider files reviewed. • **Credentialing and Recredentialing** – The Initial Credentialing and Recredentialing policy was revised to include the EPLS/SAM requirement in 2013. • **Utilization Management** - The MCO did not include the language in the decision extension timeframe portion of the Timeliness of Utilization Management and Behavioral Health Decision Policy. In order to receive a determination of Met in the next annual review, the MCO must add language stating that if the MCO determines that an extension is necessary to gather additional information, the MCO must justify, upon request, to the State that this extension is in the enrollee's best interest. • **Coordination of Care** - The MCO did not revise the policy to describe the specific monitoring processes and measures that are used; the current policy is vague and does not describe specific processes and measures.
Fraud and Abuse	**Recommendations** • The Health Plan must annually train their employees on fraud, waste, and abuse and have a mechanism in place to record and track annual employee compliance training requirements. • The MCO must provide the specific details of the internal monitoring and audit processes. The Health Plan must provide documentation of audits conducted as part of the Internal Auditor Work Plan and their outcomes/results. • The Health Plan must provide documentation that its employees receive the required education on false claims recoveries.
	Status • All annual employee compliance, fraud, waste, and abuse educational sessions are now recorded and tracked in an electronic system. The Compliance Department monitors the due date for the annual trainings and records completion dates for all components for each staff member. • Documentation of internal audits, such as claim compliance, was provided to demonstrate that the MCO is now conducting audits according to its policies and procedures. • The educational materials on false claims recoveries were provided for review. In addition, documentation of completion of education on false claims recoveries was provided during the on-site review. The newly implemented system records completion of the false claims recovery education in an electronic database.

The Health Plan – PIP

The Health Plan: MY 2012 PIP Recommendations and MY 2013 Current Status	
Childhood Obesity	**Recommendations** • The Health Plan should use the hybrid methodology again to evaluate MY 2013, so sustained improvement can be assessed. Administrative data rates should also be provided to fully assess the project indicators and effectiveness of the interventions for MY 2013. • The MCO should conduct statistical testing to assess whether changes in indicator rates are significant for all measurement years for the next quarterly reporting cycle. • The MCO should continue this project for at least one more year.
	Status • The MCO was able to conduct a complete analysis from baseline to the final measurement. • The MCO closed this PIP per Delmarva's request as it achieved sustained improvement in two indicators, BMI percentile and Counseling for Nutrition • This PIP is closed. The MCO should continue the interventions it has determined to be effective. The MCO must develop and submit a project proposal to Delmarva and BMS for approval to replace this PIP.
Emergency Room Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.
Diabetes Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.

The Health Plan – PMV

The Health Plan: MY 2012 PMV Recommendations and MY 2013 Current Status
Recommendation • The audit team recommended that the MCO pursue opportunities to obtain BMI and blood pressure results from participating hospitals and provider groups to supplement additional measures and indicators and reduce the medical record review burden. **Status** • The Health Plan continues to gage opportunities to obtain supplemental data such as approaching network hospitals and providers to obtain supplemental lab data which is used to lower the medical record burden.
Recommendation • The audit team recommended that the MCO be prepared to fully report HEDIS measures that require pharmacy data for HEDIS 2014. The MCOs became responsible for the pharmacy benefit in April 2013. The MCO should work with BMS to obtain pharmacy data for January-March 2013 from the TPA. **Status** • The MCO successfully reported all State required measures using its own pharmacy data and data provided by the Third Party Administrator for the first quarter of 2013.

UniCare – SPR

UniCare: MY 2012 SPR Recommendations and MY 2013 Current Status	
Enrollee Rights	**Recommendation** • This standard received a 100% compliance rating. There were no recommendations for improvement.
	Status • Not applicable.
Grievance Systems	**Recommendation** • This standard received a 100% compliance rating. There were no recommendations for improvement.
	Status • Not applicable.
Quality Assessment and Performance Improvement	**Recommendations** • **Access and Availability** - UniCare must assess and report compliance using the BMS standards, and not the internal UniCare standards (which are more stringent). The Access to Care Standards Policy (and any other materials identifying timely access requirements) must reflect the timely access requirements as they are identified in the BMS/MCO contract. • **Access and Availability** - UniCare must achieve at least a 90% compliance rating for each type of appointment to ensure that members have timely access to care and services. The MCO's provider access survey found that providers were not meeting the 90% threshold for routine care appointments within the BMS/MCO contract standard of 21 days. Additionally, compliance with 24/7 access to Primary Care Providers (PCPs) also fell short of the 90% threshold with a rate of 68%. (In response to these findings UniCare stated it would contact all providers that were not compliant, provide education on the standards, and re-survey them in the third quarter of 2013. Corrective action will be taken if necessary.) • **Credentialing and Recredentialing** - UniCare must revise its policies to not allow TJC accreditation to substitute for an on-site review during the credentialing and recredentialing process. The MCO must provide documentation of the actual on-site visits to be compliant with the BMS/MCO contract. (In response to the findings, UniCare identified 56 TJC accredited sites and has begun the process of completing the required site reviews.) • **Credentialing and Recredentialing** - For credentialing and recredentialing, the MCO was not searching the Excluded Parties List System (EPLS)/ System for Awards Management (SAM) as required. (In response to this finding, UniCare has implemented a process to validate the provider network against the EPLS/SAM database. The MCO will continue to conduct this validation monthly. • **Coordination of Care** - While specifying an adequate number of direct access visits to specialists in treatment plans is practiced; it is not formally included in a policy and procedure. This is a new component based on the MCO contract. In order to maintain a review determination of met in the next annual review UniCare must provide evidence of a case management policy that addresses this requirement (component CC.3.e). Treatment plans must specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan.
	Status • **Access and Availability** - UniCare provided access and availability rates for the access standards found in the BMS/MCO contract as required.

UniCare: MY 2012 SPR Recommendations and MY 2013 Current Status	
	• **Access and Availability** - In response to the 2012 findings, UniCare contacted all providers that were not compliant, provided education on the standards, and planned to re-survey them in the third quarter of 2013. The survey was conducted in August and September of 2013 with an overall decline in compliance rates despite UniCare's educational efforts. The Provider Access, Availability, and Satisfaction Comprehensive Analysis Report for 2013 recommends that "UniCare's Network Education Representatives should contact non-compliant PCPs directly, in person or by direct telephone contact with the physician or office manager" to provide education on the standards. UniCare also provided a CAP in response to the 2013 findings which includes (1) conducting on-site office visits to reassess/confirm compliance in July. If provider still non-compliant, he/she will be placed on a CAP including suspension of members, (2) phone call to provider to explain importance of answering service completing the survey (3) call to provider to advise of standards and explain importance of compliance, (4) conduct training via webinar or training session. • **Credentialing and Recredentialing** – UniCare revised its policies to include an on-site visit for recredentialing. UniCare put a schedule in place complete all outstanding recredentialing on-site visits. Visits were up to date by July 2014. • **Credentialing and Recredentialing** - UniCare's credentialing policies now include the requirement to validate the provider network against the EPLS/SAM database. The MCO conducts this validation monthly. • **Coordination of Care** - The Members and Children with Special Health Care Needs Policy was updated and now states, "UniCare will also work collaboratively with the enrollee's PCP and specialist(s), as appropriate, to ensure that the treatment plan specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan."
Fraud and Abuse	**Recommendation** • This standard received a 100% compliance rating. There were no recommendations for improvement.
	Status • Not applicable.

UniCare – PIP

UniCare: MY 2012 PIP Recommendations and MY 2013 Current Status	
Childhood Immunizations Combination 3	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.
Emergency Department Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.
	Status • Not applicable.
Diabetes Collaborative	**Recommendation** • There were no previous recommendations as this is the first submission for this project.

UniCare: MY 2012 PIP Recommendations and MY 2013 Current Status	
	Status • Not applicable.

UniCare - PMV

UniCare: MY 2012 PMV Recommendations and MY 2013 Current Status
Recommendation • The audit team recommended that the MCO be prepared to fully report HEDIS measures that require pharmacy data for HEDIS 2014. The MCOs became responsible for the pharmacy benefit in April 2013. The MCO should work with BMS to obtain pharmacy data for January-March 2013 from the TPA. **Status** • The MCO successfully reported all State required measures using its own pharmacy data and data provided by the Third Party Administrator for the first quarter of 2013.
Recommendation • The MCO is encouraged to continue researching ways to improve HEDIS initiatives that improve data collection and data completeness. UniCare should continue to research ways to improve initiatives so that changes in indicators from baseline can be assessed both clinically and statistically. **Status** • The MCO has on-going initiatives through the year such as sending annual preventive reminders to members and providing monthly outreach lists to providers for members needing EPSDT services.

MHT Recommendations

MHT: MY 2012 Recommendations and MY 2013 Current Status
Recommendation • The MCOs are committed to quality performance evidenced by their results on the Systems Performance Review with compliance rates greater than 90%. However, collecting certain EPSDT data, tracking of referrals and treatments that result from EPSDT screenings, continue to be problematic for some of the MCOs. In MY 2010, BMS established algorithms and reporting templates for reporting these indicators. These data are now collected and the MCOs are required to submit the data to BMS on a quarterly basis. It is recommended that the rates submitted be monitored for reasonability when there are at least a year's worth of data. **Status** • All MCOs have been reporting the EPSDT data to BMS on a quarterly basis during MY 2012. BMS now has adequate data to assess reasonability of the MCO submissions.
Recommendation • All three MCOs are encouraged to continue use of tools and methodologies such as modeling and regression to further hone their outreach programs to increase member compliance for services included in the HEDIS measures (e.g. immunizations and preventive visits). **Status** • Each MCO continues to improve their outreach efforts.

MHT: MY 2012 Recommendations and MY 2013 Current Status
Recommendation • All the MCOs are encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. **Status** • All the MCOs successfully implemented the new MRRV process for HEDIS 2013.
Recommendation • MCOs should work with BMS and corresponding State agencies to assure they have adequate access to information from the West Virginia Immunization Registry (WVIMS). The MCOs should also confer with the West Virginia Health Information Network (WVHIN) whose members are working to establish a statewide health information technology (HIT) system. These additional resources may contribute to data completeness and improved HEDIS rates MCOs reasonable access to the West Virginia Statewide Immunization Information System (WVSIIS) continues to be an issue for Performance Measure Validation. State law requires all providers to report all immunizations they administer to children under age 18 to the WVSIIS within two weeks. These data are important in collecting accurate rates for the Childhood Immunization Status and Immunizations for Adolescents measures. It is recommended that BMS lead the effort to bring the MCOs, the Division of Immunization Services, and the Vaccines for Children program together to share best practices, to explore joint outreach and to develop messaging opportunities. In addition, it is recommended this collaborative identify a consistent method for the MCOs to access this important data source. **Status** • BMS efforts are proving successful to provide the MCOs access to data from State agencies (i.e. Vital Statistics and Immunization Registry) needed to calculate and report the required performance measures.

Appendix 8– Consumer Assessment of Health Providers and Systems (CAHPS) Measures

The consumer experience with health care is an important part of quality of care and can affect the outcome of care. Survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) provide helpful insights that can be used to identify areas for improvement in member care.

BMS requires MCOs to obtain NCQA accreditation. As a part of that process, MCOs are required to collect and submit the CAHPS survey results from the Health Plan Adult and Child General Population version survey results, whose questions are relevant to the population served by the MHT MCOs. Submission of the CAHPS Adult and Child Medicaid survey results meets both the NCQA and MCO/BMS contractual requirements.

CAHPS surveys ask patients to report on their experiences with a range of health care services at multiple levels of the delivery system. Several surveys ask about experiences with ambulatory care providers such as health plans, physicians' offices, and mental health plans, while others ask about experiences with care delivered in facilities such as hospitals, dialysis centers, and nursing homes. The types of CAHPS surveys include Health Plan, Clinician and Group, Surgical Care, Dental Plans, Experience of Care and Health Outcomes (behavioral health care), American Indian, Home Health Care, Hospital, In-Center Hemodialysis, and Nursing Home.

Most CAHPS surveys include a core questionnaire, which supports standardization of survey content across users, as well as optional supplemental items that users may add to customize their questionnaire. For the CAHPs Health Plan Survey, optional supplemental questionnaire sets include the Children with Chronic Conditions Item Set and the People with Mobility Impairments Item Set.

NCQA provides technical specifications and standardized protocols for conducting and reporting results from the CAHPS surveys. Providing an additional layer of certainty, all West Virginia MCOs use NCQA Certified CAHPS Survey Vendors. The summary results reported reflect consumer perceptions through rating and composite scores as well as the *Medical Assistance With Smoking and Tobacco Use Cessation* measure. (The results for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure can be found in Appendices 1 and 2.) The purpose of Appendix 8 is to provide a general explanation of how the percentages in Table A8-1 for the ratings and composite measures, as well as the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, are derived.

The **rating scores**, in accordance with the CAHPS protocol, show the results of survey questions that ask respondents to rate four health care concepts on a scale of 0-10, where 0 is the worst possible and 10 the best possible. The scores presented in Table A8-1 are the sum of positive responses that were scored 8, 9, and 10. The four concepts for respondents to rate included all health care, their personal doctor, their health plan, and the specialist seen most often.

The **composite scores**, according to the CAHPS protocol, provide insight into main areas of concern or composite areas. Composite scores are obtained from responses to several survey questions that ask respondents how often they (or their child) received care under certain conditions. Each composite looks at a specific situation and has two or more underlying questions. All questions for each composite have the same potential response categories: Never, Sometimes, Usually, or Always. The composite scores in Table 5 are summary rates based on the sum of proportional averages for questions in each composite where the response was Usually or Always. The composite categories are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

The last measure for the Adult CAHPS results to discuss is the *Medical Assistance With Smoking and Tobacco Use Cessation* measure located in Appendix 1 and 2. This score utilizes a **two-year rolling average** and is based on the percentage of members who indicated that they Sometimes, Usually or Always received advice to quit smoking or stop using tobacco by a doctor or health care practitioner.

The MHT MCOs conducted the 2015 Consumer Assessment of the Health Providers and Systems (CAHPS) survey to meet NCQA accreditation standards and their contractual requirements with BMS. Different summary measures are used to report survey results including composites and ratings. Table A8-1 provides the summary results for the MHT MCOs, the MHT Average (MHT-A), and comparison of the MA to National Medicaid Percentiles (NMPs) for HEDIS 2014 (MY 2013). The following star ratings and scale are used in the comparison of each MA to the NMPs:

Table A8-0. Star Ratings for Adult and Child CAHPS Measures

National Medicaid Percentile Ranges	Star Rating
Exceeds the 90th Percentile	★★★★★
Exceeds the 75th Percentile to 90th Percentile	★★★★
Exceeds the 50th Percentile to the 75th Percentile	★★★
Exceeds the 25th Percentile to the 50th Percentile	★★
25th Percentile or less	★

Table A8-1. Adult and Child CAHPS Measure Results HEDIS 2014 (MY 2013)

Measure	CoventryCares HEDIS 2014 (MY 2013) %	The Health Plan HEDIS 2014 (MY 2013) %	UniCare HEDIS 2014 (MY 2013) %	MA HEDIS 2014 (MY 2013) %	MA Compared to NMPs HEDIS 2014 (MY 2013) %
Adult Measures					
Customer Service Composite	88.7	92.6	NA	90.7	★★★★★
Getting Needed Care Composite	80.5	85.7	83.7	83.3	★★★
Getting Care Quickly Composite	80.9	84.0	85.0	83.3	★★★
How Well Doctors Communicate Composite	88.0	90.6	90.0	89.5	★★
Shared Decision Making Composite*	55.2	55.2	55.8	55.4	★★★★
Rating of Health Plan	65.2	78.6	70.3	71.4	★
Rating of All Health Care	65.4	71.2	69.0	68.5	★
Rating of Personal Doctor	75.4	78.2	80.4%	78.0	★★
Rating of Specialist Seen Most Often	73.5	79.4	NA	76.5	★
Child Measures- General Population					
Child Survey - General Population: Customer Service Composite	93.8	91.0	88.2	91.0	★★★★
Child Survey - General Population: Getting Needed Care Composite	90.3	86.2	89.6	88.7	★★
Child Survey - General Population: Getting Care Quickly Composite	95.1	94.0	94.4	94.5	★★★★
Child Survey - General Population: How Well Doctors Communicate Composite	94.8	95.5	93.4	94.5	★★★
Child Survey - General Population: Shared Decision Making Composite*	58.7	55.0	50.9	54.8	★★
Child Survey - General Population: Rating of Health Plan	87.4	87.3	84.8	86.5	★★★
Child Survey - General Population: Rating of All Health Care	89.4	87.8	83.7	86.9	★★★★
Child Survey - General Population: Rating of Personal Doctor	91.4	88.4	84.7	88.2	★★★

Measure	CoventryCares HEDIS 2014 (MY 2013) %	The Health Plan HEDIS 2014 (MY 2013) %	UniCare HEDIS 2014 (MY 2013) %	MA HEDIS 2014 (MY 2013) %	MA Compared to NMPs HEDIS 2014 (MY 2013) %
Child Survey - General Population: Rating of Specialist Seen Most Often	86.8	78.2	91.7	85.6	★★★

❖ CAHPS percentiles are from NCQA Quality Compass 2014 (MY 2013)
NA indicates that denominator was too small to report a rate or that a comparative benchmark is not available
+ Measure specifications changed significantly between HEDIS 2013 and 2014 for Share Decision Making Composite in both the Adult and Child Surveys.