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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 2012

Submitted by
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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
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
UM	Utilization Management
WVSIIS	West Virginia Statewide Immunization Information System

Annual Technical Report Executive Summary MY 2012

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) 2012, there were approximately 170,000 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) 2012 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. 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. CoventryCares, The Health Plan, and UniCare achieved compliance rates of 100%, 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 schedule of planned activities (work plan). All QAPI plans note that the ultimate authority of the QAPI Program rests with the MCO's governing body. All MCOs carry out their QAPI functions using committees (e.g. credentialing, pharmacy and therapeutics, quality improvement). Committee descriptions include:

- Responsibilities,
- Membership/composition,
- Their relationship to other committees, departments, and the MCO,
- Reporting mechanisms, and
- Meeting frequency.

The MY 2012 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).
- Documentation, including committee meeting minutes, to demonstrate coordination of activities among other performance monitoring activities such as Utilization Management (UM), risk management, and complaint, grievance and appeal management.
- Demonstrated that appropriate staff and committees are involved in the decision making process for UM and QI activities.
- Clinical practice guidelines in place, update them at least every two years. When applicable, the MCOs use them to make utilization management (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 conducted by the MCOs.
- Case and 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.
- 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).

The credentialing and recredentialing standards require the MCOs to query the List of Excluded Individuals or Entities (LEIE) and Excluded Parties List System (EPLS) databases. This review revealed that that one MCO was querying both required databases and two queried only the LEIE database. To ensure that CoventryCares and UniCare met the federal requirements, BMS required both MCOs to query both databases to ensure that they did not pay any excluded providers during the review period. Both MCOs completed the required searches and provided attestations that they did not pay any excluded providers.

Recredentialing requirements include an on-site visit to the provider's office. The on-site review revealed that one MCO conducted these visits, while two did not. Both have addressed this deficiency in their policies and procedures.

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 MHT MCOs used the PIP quality improvement process to include:

- Identifying problems relevant to their population,
- Setting appropriate goals,
- Calculating baseline and repeat measurements,
- Developing and implementing interventions aimed at improving performance, and
- Assessing effectiveness of interventions.

There are three MCO PIP topics related to quality. They are The Health Plan's Childhood Obesity PIP, UniCare's Childhood Immunization Status PIP, and the mandatory Diabetes Collaborative PIP in which all three MCOs must participate.

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 final PIP topic related to quality is the mandated Diabetes Collaborative 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.

According to the Behavioral Risk Factor Surveillance System, the national median prevalence of diagnosed diabetes doubled between 1996 and 2012. During that same time period, the prevalence rate nearly tripled for West Virginia (Centers for Disease Control and Prevention: National Diabetes Surveillance System. http://www.cdc.gov/diabetes/statistics).

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 by HEDIS 2016 (MY 2015). All MCOs have selected at least one additional HEDIS indicator for their projects to include Retinal Eye Exam, HgBA1c Testing, and LDL-C Level <100mg/dL. Best practices identified among the project proposals include:

- 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. (Coventry Cares and UniCare)
- 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. (The Health Plan)
- Member Incentive Program - The MCO will provide a $25 incentive for completing recommended diabetic screenings and a dilated eye exam.(UniCare)

Twelve HEDIS indicators were used to assess quality in the MHT program in the areas of immunizations, screening, and diabetes measures.

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Controlling High Blood Pressure
- Lead Screening for Children 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 12 quality measures, the MHT Weighted Average for five indicators improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012). They are:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Lead Screening for Children
- Comprehensive Diabetes Care – LDL-C Control (LDL-C<100)

Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) consumer satisfaction survey provide helpful insights that can be used to identify areas for improvement in member care. MCOs are required to collect and submit the results of the CAHPS Health Plan Adult and Child General Population surveys whose questions are relevant to the population served by the MHT MCOs. The following measures from the Adult and Child General Population CAHPS were used to assess the MCOs for quality:

- Customer Service Composite
- Shared Decision Making Composite
- 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 exceeded the Medicaid National Average and the National Medicaid 90th Percentile for *Customer Service* and compared favorably to the Medicaid National Average two additional measures:

- How Well Doctors Communicate
- Rating of All Health Care

For quality measures from the CAHPS Child General Population Survey, the MHT Average for *Customer Service* exceeded the National Medicaid Average and the National Medicaid 90th Percentile. The MHT Averages compared favorably to the National Medicaid Average for the remaining five Child CAHPS measures below.

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

Access

The SPR standards evaluate enrollee access to informational materials and services. The MCOs performed well for standards and elements related to access. All MCOs provided comprehensive member materials at or below the 6th grade reading level as required by the BMS/MCO contract. Telephone numbers to access Member/Customer service lines, hours of operation, and the MCO address are provided in member handbooks. Member handbooks describe the covered services, how to access those services, and any other special requirements (e.g. referrals and preauthorizations). Member materials also include a statement of enrollee rights, instructions on how to file complaints, grievances, and appeals and describe how to access a State Fair Hearing.

The MCOs are required to assess compliance with appointment access standards in the 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 to 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 did not assess the Initial Prenatal Care access standard. UniCare fell just short of the 90% threshold for routine care appointment within 21 days with a rate of 89% compliance and did not meet the 90% threshold for 24/7 access. The major issues identified for the 24/7 access standard were that answering services not connecting to a health care professional and no answer at the number on file.

The Emergency Department (ED) Utilization-related PIPs fall under the category of access due to accessibility barriers identified in the process. Access barriers identified include limited access to same day appointments with primary care practitioners and after hours appointments are very limited. All ED related PIPs were closed this review period. CoventryCares and The Health Plan's PIPs were closed as they achieved sustained improvement for at least one indicator. UniCare's ED PIP was closed following Delmarva's recommendation to close the PIP because the validation process determined that the interventions were passive and the project was not focused. All three MCOs will be participating in the mandatory Pediatric Asthma ED PIP that will be developed in MY 2013.

CoventryCares's PIP, which focused on ED utilization for all of its members, was able to improve performance (decrease in ED use) in the 20-44 year member age range. The MCO maintained improvement in the indicator that measured the ED utilization of PIHN Medicaid Members between the ages of 20 and 44 years. PIHN coordinates the scheduling of preventive care and PCP appointments for members who are overdue for screenings or who over-utilize the ED. This PIP is now closed as sustained improvement was achieved.

The Health Plan's ED PIP focused on children with respiratory diagnoses and adults with back pain. Sustained improvement, a reduction in ED visits from the baseline measurement period to the third remeasurement period, was achieved for both indicators. Targeted interventions such as outreach calls and case management for enrollees with ≥3 ED visits with the prior six months, are likely the source of the reduced inappropriate utilization. This PIP is now closed as it has achieved sustained improvement.

UniCare's ED PIP targeted two primary care practices in an effort to reduce utilization. Remeasurement results noted an improvement; however, their interventions were passive in nature, and the improved outcomes cannot be attributed to these interventions. The MCO has closed this PIP per Delmarva's request.

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 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)

In the area of access, the MHT Weighted Average for eight of nine access indicators compared favorably with the National Medicaid Average. *Adults' Access to Preventive/Ambulatory Health Services (24-64 Years)* was only five tenths of one percent below the National Medicaid Average. One indicator, *Prenatal and Postpartum Care - Timeliness of Prenatal Care,* exceeded the National Medicaid 90th Percentile.

For the CAHPS survey results, the MHT Average for the Adult Getting Needed Care Composite exceeded the National Medicaid Average and the MHT Average for the Child Getting Needed Care Composite exceeded the National Medicaid 90th Percentile.

Favorable performance on the access measures continues to be a strength for the MHT program. The MHT Weighted Averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2011 through HEDIS 2013.All four indicators for *Children 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.

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.

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For MY 2012, 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 providers were recredentialed within the three-year time requirement as required in the BMS/MCO contract. 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 delegated credentialing and recredentialing activities.

Complaint, grievance, and appeal logs 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 Utilization Management (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 general, the MCOs meet the timeliness standard. The few authorizations that did not meet the timeliness standard were due to needing additional information from the providers.

In addition, the MCOs must provide an expedited authorization 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 2012.

For MY 2012, CoventryCares's Adolescent Well-Care Visits PIP assesses timeliness. The indicator measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well care visit with a PCP or Obstetrics/Gynecology practitioner during the measurement year. The MCO achieved an increase in the indicator rate from the MY 2011 baseline rate to the first remeasurement rate in MY 2012.

Best practices identified in the review of the Adolescent Well-Care Visits project are listed below.

- Disease and case managers conduct targeted calls to members identified as non-compliant to educate members 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.

- 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 the National Medicaid Average. The three year trend from HEDIS 2011 to HEDIS 2013 indicated improving performance for all four timeliness measures.

For the CAHPS survey, the MHT Average for the Adults Getting Needed Care Quickly Composite exceeded the National Medicaid Average and the MHT Average for the Childs Getting Needed Care Quickly Composite exceeded the National Medicaid 90th Percentile.

MHT Program Strengths and Recommendations

Strengths

Systems Performance Review

- 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 has mandated that the MCOs become NCQA accredited by January 2014. All MCOs are on track to complete the survey process.
- BMS now requires all MCOs to conduct the most recent version of the HEDIS CAHPS Adult and Child Medicaid Surveys. This will provide BMS with comparable customer satisfaction data which will be able to be compared among the MCOs and to the MHT Average and National Benchmarks. Although the CAHPS survey is conducted under the purview of the PMV process, the SPR process uses the results to compare quality of services.

Performance Improvement Projects

- In general, MCOs continue to demonstrate improvement in basic project methodology by providing comprehensive project rationales, identifying fitting study questions and indicators, and conducting appropriate data collection procedures.
- Two MCOs successfully completed projects aimed at reducing ED utilization by demonstrating sustained improvement.

- With the closing of all ED-related projects, each MCO will begin two new collaborative PIP projects in MY 2013. One project focuses on increasing the percentage of MHT members 18-75 years of age with diabetes (Type 1 or Type 2) who had an HbA1c test result of <8.0% during the measurement year. The second collaborative PIP focuses on reducing ED utilization for pediatric enrollees diagnosed with asthma.
- In the new project proposals for diabetes and pediatric ED use, the MCOs are implementing more robust interventions to include face-to-face contact with providers, offering incentive programs, and preparing and distributing Gaps in Care Reports and Provider Profiles.

Performance Measure Validation

- All MCOs have experienced staff, established data systems, and well-defined processes to calculate and report HEDIS performance measures.

All three MCOs successfully implemented the new NCQA process for Medical Record Review Validation (MRRV) for HEDIS 2013 (MY 2012). The new process categorizes hybrid measures into like-measure groups for validation, reviews exclusions, applies a more stringent statistical test to the process, and defines MRR milestones more clearly to ensure consistency among plans. The new process uses a zero-based sampling plan and no acceptance of errors.

- BMS now requires all MCOs to conduct the most recent version of the HEDIS CAHPS Adult and Child Medicaid Surveys. This provides BMS with comparable data among the MCOs which is also able to be compared to national benchmarks.
- All MCOs are on-target to obtain NCQA accreditation by January 2014.
- All MCOs successfully integrated pharmacy data to report respiratory measures including Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with Upper Respiratory Tract Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Appropriate Medications for People with Asthma and Medication Management for People with Asthma. All MCOs successfully reported these measures to BMS as required.
- All three MCOs used targeted outreach programs in their efforts to increase member compliance for recommended services which favorable impacted several measures.
- Eight of nine access indicators compared favorably with the National Medicaid Average.
- In regards to measures of quality, the MHT rates for five indicators improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012). They are: Childhood Immunization Status (Combination 2 and Combination 3), Lead Screening for Children, and Comprehensive Diabetes Care-LDL-C Control (LDL-C<100).

- All four indicators for Children and Adolescents' Access to PCP (ages 12-24 months, 25 months-6 years, 7-11 years, and 12-19 years) 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 three year trend from HEDIS 2011 (MY 2010) to HEDIS 2013 (MY 2012) indicated improving performance for all four timeliness measures - Adolescent Well Care Visits, Frequency of Ongoing Prenatal Care (≥81%), Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, and 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 the National Medicaid Average.
- The Adult and Child CAHPS Customer Service Composite exceeded the National Medicaid Average and the National Medicaid 90th percentile.
- Six Adult and Child CAHPS measures were used to assess quality. The MHT Average for all six Child CAHPS quality measures and three Adult CAHPS quality measure exceeded the National Medicaid Average.
- One Adult and Child CAHPS survey measure was used to assess access. The MHT Average for the Adult CAHPS Getting Needed Care Composite measure exceeded the National Medicaid Average and the MHT Average for the Child CAHPS Getting Needed Care Composite exceeded the National Medicaid 90th Percentile.
- For the Adult and Child CAHPS measure for timeliness, the MHT Average for the Adult CAHPS Getting Needed Care Quickly Composite exceeded the National Medicaid Average and the MHT Average for the Child CAHPS Getting Needed Care Quickly Composite exceeded the National Medicaid 90th Percentile.

Recommendations

Systems Performance Review

BMS should require the MCOs to achieve 100% for each standard (ER, GS, QA, and FA). BMS currently requires the MCOs to achieve a compliance rate of 90% or greater for each standard. For each element or component that is not fully met (partially met or unmet), the MCO should be required to provide an improvement plan, detailing its plans to achieve full compliance.

Performance Improvement Projects

Continue with quarterly reporting of PIP progress. The MCOs have completed a full year of reporting their progress on a quarterly basis. This helps facilitate timely project analysis and earlier identification of

setbacks or opportunities. More frequent updates allowed the EQRO to provide more timely monitoring and feedback to the MCOs and BMS regarding PIP progress.

Continue to enhance project analyses- There is still opportunity for the MCOs to enhance their project analyses. Understanding barriers and causes for performance are critical components of the analysis that assist in effectively planning the next steps of PIP implementation. Interventions should be tied to barriers in the analyses. In addition, MCOs must ensure that they are completing statistical analyses to determine if improvement is significant.

Performance Measure Validation

Data Quality - All three MCOs are encouraged to continue exploring different avenues to improve their data quality and data capture.

Use of Pharmacy Data - The audit team recommended that the MCOs be prepared to fully report HEDIS measures that require pharmacy data for HEDIS 2014 (MY 2013). The MCOs will become responsible for the pharmacy benefit in April 2013.

Immunization Registry Data - BMS should continue its diligent efforts in working with the State agencies to ensure that the MCOs have adequate access to information from the West Virginia Statewide Immunization Information System (WVSIIS). The additional information may contribute to data completeness and improved HEDIS rates.

Mountain Health Trust Annual Technical Report MY 2012

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) 2012, there were approximately 170,000 members enrolled in 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 with data and information gained 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 activity on an annual basis.

The MY 2012 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 Strategy 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 2012. 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 and recommendations 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 HEDIS 2013 MCO Rates, MHT weighted averages, and National Benchmarks; Appendix 3 contains Trending Data: MCO Rates and MHT weighted averages for HEDIS 2011-2013; and Appendix 4 contains Numerators, Denominators, and Eligible Populations for HEDIS 2013 Measures. Appendix 5 provides the MHT Weighted Averages for HEDIS Respiratory Conditions and Smoking Cessation Measures calculated using pharmacy data provided by the fiscal agent and MCO survey data respectively. Appendix 6 contains all measures collected for HEDIS 2011 through 2013 and reported to the National Committee for Quality (NCQA). Appendix 7 contains a summary of the Status of Recommendations from the MY 2011 Review. Finally, Appendix 8 contains a description of the Consumer Assessment of Health Providers and Systems (CAHPS) survey and the MY 2012 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 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).*

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. For the MY 2012 SPR, BMS set the compliance threshold at 90 percent for each standard. MCOs not achieving 90 percent were required to develop and implement internal corrective action plans.

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.

PIP Validation Steps
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 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 2013 measure set includes 80 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 2 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

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

Validated measures support and promote accountability in managed care. Measures must be calculated according to specifications outlined in NCQA's *HEDIS 2013, 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 is a carved out service, 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 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

The MY 2012 SPR compliance rates for all three MHT MCOs are presented in Table 1.

Table 1. MCO SPR Compliance Rates for MY 2012

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

Program-wide the MHT program has performed well in meeting the EQR regulatory and contract requirements for the operational assessment. Compliance rates for all MCOs exceeded the 90% threshold established by BMS. All MCOs achieved a 100% compliance rating for the **Enrollee Rights Standard**, compliance rates of 98% to 100% for the **Grievance System Standard**, and 99% to 100% for **the Quality Assessment and Performance Improvement** Standard in MY 2012. Both CoventryCares and UniCare also performed well with the **Fraud and Abuse Standard** with compliance ratings of 98% and 100% respectively. The Health Plan Fraud and Abuse Program saw staffing and programmatic changes in MY 2012 which resulted in a compliance rate of 93%. These high performance rates demonstrate the MCOs' and BMS' commitment to meeting the structural and operational standards that are demonstrative of a high-quality program for the MHT enrollees. Individual MCO trending results and analysis follow in Tables 2-4.

CoventryCares, Inc.

CoventryCares's SPR results for MY 20010-MY 2012 are presented in Table 2.

Table 2. CoventryCares SPR Results MY 2010 – MY 2012

Standard	CoventryCares Compliance Rate		
	MY 2010	MY 2011	MY 2012
Enrollee Rights	100%	100%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	99%	94%	100%
Fraud and Abuse	100%	98%	98%

CoventryCares performed well for the MY 2012 review, achieving compliance rates ranging from 98% to 100%. Trending of results shows that the:

- ER Standard maintained a 100% compliance rate for the last three review years.
- GS Standard achieved a 100% compliance rate over the past three years.
- QA Standard compliance rate declined from MY 2010 to MY 2011 due to the lack of Quality Improvement (QI) Program documentation of activities and governing body oversight of the QI Program. CoventryCares was required to develop and implement an internal Corrective Action Plan (CAP) which resulted in achieving a 100% compliance rating in MY 2012.
- FA standard maintained consistently high compliance rates of 98% or greater across the three trend years.

In MY 2012 CoventryCares achieved SPR compliance ratings of 98% or greater, exceeding the 90% threshold. Both the **Enrollee Rights** and **Grievance Systems** standards achieved a 100% compliance rate.

For **Quality Assessment and Performance Improvement (QA)** several opportunities for improvement were identified during the MY 2011 review of CoventryCares's Quality Improvement Program (QIP) documents including the Quality Improvement (QI) Program Description, QI Work Plan, and committee meeting minutes. Oversight of the QIP was not sufficient. Although the QA standard exceeded the 90% threshold, quality is a key component to a successful program. Therefore, Delmarva required CoventryCares to develop and implement an internal corrective action plan (CAP) to address all of the QI Program deficiencies identified in the MY 2011 review. After the CAP was submitted by CoventryCares and approved by Delmarva, the MCO was required to provide quarterly progress reports on its efforts to correct the deficiencies. CoventryCares provided a comprehensive CAP which addressed all required elements, reported on progress quarterly, and met all of the QA standards for MY 2012. The CAP was closed after the MY 2012 review as it resulted in CoventryCares' achieving a 100% compliance rate for the measurement period.

The **Fraud and Abuse** compliance rate was 98%. The Member Handbook does not notify enrollees how to report suspected fraud, waste, and abuse. CoventryCares plans on including this information in the next revision of its Member Handbook.

The Health Plan of the Upper Ohio Valley

The Health Plan of the Upper Ohio Valley's SPR results for MY 2010-MY 2012 are presented in Table 3.

Table 3. The Health Plan of the Upper Ohio Valley SPR Results (MY 2010 – MY 2012)

Standard	The Health Plan Compliance Rate		
	MY 2010	MY 2011	MY 2012
Enrollee Rights	100%	100%	100%
Grievance Systems	100%	99%	98%
Quality Assessment and Performance Improvement	99%	99%	99%
Fraud and Abuse	96%	90%	93%

The Health Plan performed well for the MY 2012 review achieving rates from 93% to 100%. Trending of results shows that the:

- ER standard maintained a 100% compliance rate for the past three years.
- The GS Standard achieved consistently high compliance rates ranging from 98% to 100% across the trend years.
- The QA standard remained stable with a 99% compliance rate across all three trend years.
- The FA standard increased from MY 2011 to MY 2012.

In MY 2012 The Health Plan achieved SPR compliance ratings of 93% or greater, exceeding the 90% threshold. The Health Plan achieved a 100% compliance rate for the **Enrollee Rights** standard. A 98% compliance rate was achieved for the **Grievance Systems** standard with only one deficiency noted; the MCO did not notify enrollees that Customer Services is available to assist with the completion of forms during the grievance process. For **Quality Assessment and Performance Improvement**, The Health Plan achieved a commendable 99% compliance rate. As in MY 2011, there is an opportunity to improve its after-hours accessibility for providers. In addition, MCOs are required to query both the List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) databases during credentialing and recredentialing. The Health Plan queries the LEIE, but not the EPLS database. Lastly, The Health Plan achieved a 93% compliance rating for the **Fraud and Abuse** standard. The Health Plan overhauled its Fraud and Abuse program and structure in MY 2012. These changes included an increased attention to detection of fraudulent claims using the StarsSentinel software package as well as revising policies and procedures to meet requirements. The MCO must still ensure that it completes the educational requirements to include training and education of the employees about fraud, abuse, compliance, and false claims recoveries. The Health Plan must also produce evidence that it conducts regular reviews and audits to guard against fraud and abuse.

UniCare Health Plan, Inc.

UniCare's results for MY 2010-MY 2012 are presented in Table 4.

Table 4. UniCare SPR Results (MY 2010 – MY 2012)

Standard	UniCare Compliance Rates		
	MY 2010	MY 2011	MY 2012
Enrollee Rights	100%	100%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	98%	98%	99%
Fraud and Abuse	100%	100%	100%

In MY 2012 CoventryCares achieved SPR compliance ratings of 99% or greater, exceeding the 90% threshold established by BMS. UniCare was able to maintain a 100% compliance rating for ER, GS and FA from the MY 2010 through MY 2012. Trending of results shows that the:

- ER Standard compliance rate remained at 100% for the last three review periods.
- GS Standard has maintained its 100% compliance rate for the last three review periods.
- QA Standard compliance rate has remained consistently high across all trend years with compliance rates of 98% through 99%.
- The Fraud and Abuse Standard maintained its compliance rate of 100% for the last three review periods.

UniCare achieved compliance ratings of 99% and greater, exceeding the 90% threshold established by BMS. UniCare achieved a 100% compliance rating for the **Enrollee Rights**, **Grievance Systems** and **Fraud and Abuse** standards. A compliance rate of 99% for **Quality Assessment and Performance Improvement** was achieved. The areas of access and credentialing/recredentialing were identified for improvement efforts. The MCO's provider access survey found that providers were not meeting the 90% threshold for routine care appointment within 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%. Analysis shows that of the noncompliant PCPs, 79% were due to incorrect answering machines largely due to noncompliance with instructions for non-emergency care. For credentialing and recredentialing, the MCO was not searching the Excluded Parties List System (EPLS)/System for Awards Management (SAM) as required. Additionally, if a provider was accredited by The Joint Commission (TJC), UniCare was not completing an on-site visit as required in the BMS/MCO contract.

In response to the access and credentialing/recredentialing findings, UniCare provided mitigation responses. UniCare will contact all providers that were not compliant with the access standards, provide education on the standards, and re-survey them in the third quarter of 2013. Corrective action will be taken if necessary.

UniCare has implemented a process to validate the provider network against the EPLS/SAM database. The MCO will continue to conduct this validation monthly. Additionally, UniCare will no longer accept TJC accreditation as an alternative to site reviews. The MCO has identified 56 TJC accredited sites and will begin conducting site reviews. These actions should ensure compliance with the standards for the next review.

Performance Improvement Projects

CoventryCares, Inc.

Adolescent Well-Care Visits

This is the first remeasurement year for CoventryCares's Adolescent Well-Care Visit (AWC) PIP which aims to improve the Adolescent Well-Care Visits rate. The MCO's immediate goal is to increase the indicator rate 5 percentage points over the prior year's measurement. By the end of the project, CoventryCares would like to meet or exceed the performance target of the NCQA Quality Compass 90th Percentile, a true stretch goal. CoventryCares achieved an increase in the indicator rate from 42.13% in in MY 2011 (baseline measurement) to 46.58% in MY 2012, falling 0.55 of a percentage point below its goal of a 5 percentage point increase over the prior year's measurement.

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. Based on the AWC measure performance, the MCO felt that there was an opportunity for improvement. The baseline performance for MY 2011 was 42.13% which was below the NCQA Quality Compass Medicaid 50th Percentile and the National Medicaid Average for the same period. CoventryCares's goal is to prevent serious illnesses in this population, prevent epidemics, and save health care dollars. Interventions and improved compliance with well-care visits should lead to a healthier member population, during adolescence and later in life.
Indicators and Goals	• Adolescent Well-Care Visits — 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. • CoventryCares provided a comprehensive baseline and first remeasurement analysis. The analysis included a thorough assessment of noncompliant members. • The indicator increased 4.45 percentage points over the MY 2011 baseline rate.
Barriers	• Adolescent members often seek care for sick visits rather than preventive well-care visits. • Some adolescents have concerns related to privacy, which may prevent them from seeking well-care visits or limit the effectiveness of a well-care visit. • Not all providers document all required elements related to a well-care visit in the record. • Providers sometimes miss opportunities to capture well-care visit criteria during other

PIP Summary: Improving Adolescent Well-Care Visits Rates	
	appointments, such as sick visits.
Interventions	• EPSDT Reminder System identifies members in need of their annual well-visit and other EPSDT services. Outreach calls are made and letters are sent to non-compliant members/parents of non-compliant members. • Disease management/case managers conducted targeted calls to members identified as non-compliant to educate members about the need for routine well-visits and assist with appointments, if needed. • Provider education, including appropriate medical record documentation, was offered to providers and their office staff during the HEDIS Medical Records Review projects. • Provider Report Cards are mailed monthly which contain all non-compliant members. The MCO encourages providers to follow-up with these members.
Compliance with Previous Recommendations	• The MCO had more than one goal and it was recommended that it select only one goal or that it provide time frames for short and long term goals. The MCO provided short and long term goals. The short term goal is to improve the indicator rate 5 percentage points over the prior year's measurement. The long term goal-the goal the MCO hopes to achieve by the end of the project- is to meet or exceed the NCQA 90th Percentile.

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%

Findings. This is the first remeasurement for this PIP. CoventryCares demonstrated an improvement in the Adolescent Well-Care Visits indicator from the baseline rate of 42.13% in MY 2011 to 46.58% in MY 2012. The MY 2012 rate was 0.55 of a percentage point below the goal of a 5 percentage point increase. The MCO's interventions are well-thought out and target the identified barriers. Data and analysis are comprehensive.

Recommendations. CoventryCares should continue with implementing planned interventions and report remeasurement 2 results during the next annual submission.

Decreasing Emergency Department Utilization

CoventryCares's Emergency Department (ED) Utilization project aims to decrease ED Visits/1000 Member Months (MM) by 2.5 Visits/MM for three enrollee groups:

- Medicaid Members 20-44 years of age,
- Medicaid Members all ages, and
- Medicaid Members in the Partners in Health Network (PIHN) 20-44 years of age.

PIP Summary: Decreasing Emergency Department Utilization	
Rationale	• The emergency department utilization PIP topic is mandated. To support this project rationale, CoventryCares provided national and state-level statistics. WV ranks the 2nd highest in ED Visits with 652 per 1000 population. During 2008, members age 20-44 made up only 15.5% of the MCO's population, but this group utilized approximately 30.5% of the total visits. Therefore, this age group was targeted for reduction of ED use.
Indicators and Goals	• ED Visits/1000 Member Months (MM) for Medicaid Members (20-44 years of age), Goal: Reduce ED visits by 2.5 visits/1000 MM. • ED Visits/1000 MM for Medicaid Members (all ages), Goal: Reduce ED visits by 2.5 visits/1000 MM. • ED Visits/1000 MM for Partners In Health Network Medicaid Members (20-44 years of age), Goal: Reduce ED visits by 2.5 visits/1000 MM.
Strengths	• Strong interventions are in place promoting medical homes and continuity of care. • Monthly monitoring, reporting, and case management for members with ≥ 3 ED visits within the prior six months. • Promotion of NCQA Medical Home Certification for the PIHN. Increasing the number of PIHN Clinics with NCQA Medical Home Certification can provide consistent coordination of care and preventive care that should lead to a reduction in ED usage.
Barriers	• Lack of access to routine or immediate medical care. • Lack of an established relationship with a PCP or "medical home." • Lack of coordination with Primary Care Providers. • Lack of alternatives to the ED (urgent care centers, nurse lines, offices having extended/weekend hours). • Lack of education/knowledge of self-care alternatives. • Heavy marketing to the public of ED 24/7 availability and "Fast-Track" urgent care Visits.
Interventions	• Implemented incentive program to encourage PIHN Clinics to achieve NCQA Medical Home Certification. • Initiated provider incentives for decreasing ED utilization. • Collaborated with/educated PIHN to help define PIHN Clinic Specific Measures that will lead to a decrease in ED usage. • Completed monthly monitoring, reporting, and case management for members with ≥ 3 ED visits within the prior six months.
Compliance with Previous Recommendations	• It was recommended that the MCO improve its quantitative analysis and remove the newly developed indicator which was not meaningful. The MCO provide a more comprehensive analysis; comparisons were made to previous measurements and goals, statistical testing was completed, and interventions were assessed for effectiveness. The non-meaningful indicator was deleted from the project.

PIP Results			
Indicator 1: ED Visits (Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Not Applicable	146.45 Visits/1000 MM
MY 2009	Remeasurement 1	Reduce ED Visits by 2.5 Visits/1000 MM	151.37 Visits/1000 MM
MY 2010	Remeasurement 2	Reduce ED Visits by 2.5 Visits/1000 MM	147.10 Visits/1000 MM
MY 2011	Remeasurement 3	Reduce ED Visits by 2.5 Visits/1000 MM	146.00 Visits/1000 MM
MY 2012	Remeasurement 4	Reduce ED Visits by 2.3 Visits/1000 MM	144.41 Visits/1000 MM
Indicator 2: ED Visits (Medicaid Members, All Ages) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Not Applicable	74.66 Visits/1000 MM
MY 2009	Remeasurement 1	Reduce ED Visits by 2.5 Visits/1000 MM	81.70 Visits/1000 MM
MY 2010	Remeasurement 2	Reduce ED Visits by 2.5 Visits/1000 MM	74.65 Visits/1000 MM
MY 2011	Remeasurement 3	Reduce ED Visits by 2.5 Visits/1000 MM	78.18 Visits/1000 MM
MY 2012	Remeasurement 4	Reduce ED Visits by 2.3 Visits/1000 MM	75.56 Visits/ 1000 MM
Indicator 3: ED Visits (PIHN Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2010	Baseline	Not Applicable	136.56 Visits/1000 MM
MY 2011	Remeasurement 1	Reduce ED Visits by 2.5 Visits/1000 MM	131.36 Visits/1000 MM
MY 2012	Remeasurement 2	Reduce ED Visits by 2.3 Visits/1000 MM	133.54 Visits/1000 MM

Findings. Compared to the baseline rate, CoventryCares achieved sustained improvement for two of three indicators. Improvement (a decrease in ED visits) was realized for the 20-44 year old age group and also for the PIHN Medicaid Members in the 20-44 year old age group. An increase was noted in the ED visits for Medicaid members in the "all ages" group.

Recommendations. CoventryCares should close this project and participate in the MCO ED collaborative project which is currently under development. CoventryCares should continue with interventions and activities related to lowering ED visit rates for their members even though the current ED project is closing.

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.

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 supplemented with nutritional and physical activity counseling.
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	• Providers are not coding for BMI, nutritional and physical activity counseling activity, although they may be documenting it in the medical record (there is no financial incentive for them). • Provider and member knowledge deficits regarding the purpose and importance of obesity screenings. • Provider noncompliance with weight monitoring. • Provider knowledge deficit regarding obesity-related educational materials and assistance available through the MCO.
Interventions	• One-on-one discussions with physicians and/or their office staff regarding the Provider Information Packet. The packet includes a BMI chart, BMI percentile graph sheets, and the Childhood Obesity Program information. This intervention was implemented in 2010 and is conducted at least annually in over 200 provider offices. • Distribution of provider newsletters addressing the need to document and code annual BMIs. • A financial incentive for coding BMI and counseling for nutrition and physical activity is under consideration.
Compliance with Previous Recommendations	• It was recommended that the MCO enhance its quantitative analysis to include comparisons to previous measurements and goals. The MCO did not provide this comparison because of the change in data collection methodologies throughout the project. The MY 2012 rate can only be compared to the baseline rate (MY 2008) because both were calculated using the hybrid methodology. • The MCO continued its system-level interventions as recommended. • It was recommended that the MCO consider a hybrid review or conduct a sample of records to determine if providers are documenting BMI and counseling efforts. The MCO conducted a hybrid review to calculate the indicator rates for MY 2012. Administrative data rates were provided after the annual submission per Delmarva's request. The MCO must provide both administrative and hybrid rates for all measures for MY 2013 so that a full analysis can be conducted and sustained improvement assessed. • It was recommended that the MCO consider a financial incentive for coding BMI and counseling for nutrition and physical activity. The financial incentive is still under consideration.

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		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%
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%
Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline		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%

Findings. The MCO used the hybrid data collection methodology in MY 2008 and MY 2012, and the administrative data collection methodology in MY 2009 through MY 2011. Therefore, the MY 2012 rates can only be compared to the baseline rate as both used the same data collection methodology. The MCO must provide the hybrid data rate and administrative data rate for a complete analysis at the time of the next annual submission. Rates must be compared to prior year findings. Finally, the MCO must conduct statistical testing to determine whether improvement is statistically significant. Sustained improvement will be assessed after the next annual submission. System level interventions continued and appear to positively impact the indicators. The hybrid review resulted in improved rates for two of three indicator rates when compared to the baseline rate. The financial incentive is still under consideration.

Recommendations. The MCO's performance improved for two of three project indicators—BMI Percentile and Counseling for Nutrition. The MCO should continue implementation of system-level

interventions. 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. The MCO must conduct statistical testing to assess whether changes in indicator rates are significant, and should continue this project for at least one more year.

ER Utilization Diversion

With this PIP, The Health Plan aims to reduce by 5% annually:

- Emergency Department visits per 1000 member months (MM) for children ages 0-5 years with a respiratory diagnosis
- Emergency Department visits per 1000 MM (age 20 and older) with diagnosis of back pain

PIP Summary: Emergency Department Utilization Diversion	
Rationale	• BMS tasked each Medicaid MCO to implement its own ER utilization-related project. Analysis of emergency room utilization has consistently identified two key sub-populations in terms of over-utilization; members 0-5 years diagnosed with upper respiratory illness and members 20 and older with back pain. • Focusing on these two subpopulations, while continuing to address ER over-utilization in the general Health Plan population, should result in fewer ER visits and a healthier population in general.
Indicators and Goals	**Childhood Respiratory Conditions** • Emergency Department visits per 1000 member months (MM) ages 0-5 years with respiratory diagnosis. Goal: 5% annual reduction **Adult Back Pain** • Emergency Department visits per 1000 MM (age 20 and older) with diagnosis of back pain. Goal: 5% annual reduction
Strengths	• Enhanced reporting system. • Interventions include one-to-one contact with caregivers and high utilizers of the ER • Notable improvement achieved for both indicators when comparing baseline to final remeasurement.
Barriers	**Childhood Respiratory Conditions** • Caregivers unaware of obtaining services outside of an ER. • Providers unaware that accessibility is an issue for caregivers. **Adult Back Pain** • Members are unaware of alternative therapies for lower back pain.

PIP Summary: Emergency Department Utilization Diversion	
Interventions	**Childhood Respiratory Conditions** • An additional attempt at contacting the parent by making a second outreach call. • Identification of potential accessibility issues through the outreach calls. • Monthly monitoring, reporting, and case management of members with ≥ 3 ER visits within prior 6 months. **Adult Back Pain** • Enhancements made to the electronic data entry tool to allow notation of data discrepancies. • Enhancement made to include NSAIDS for complete pharmaceutical data. • Monthly monitoring, reporting, and case management of members with ≥ 3 ER visits within prior 6 months.
Compliance with Previous Recommendations	• It was recommended that the MCO improve its quantitative analysis by explicitly stating the indicator goals and make numeric comparisons to them. In response, the MCO included a comparison to the project goal for each indicator and statistical testing was conducted to assess whether or not improvement was real improvement. • Barriers were not clearly stated in the interventions table and were not included in the analysis in the MY 2011 submission. In the 2012 submission, The Health Plan did clarify barriers in the interventions table, but did not include them in the final analysis.

PIP Results			
Indicator 1: Emergency Room visits per 1000 member months (ages 0-5 years) with respiratory diagnosis			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		438.27 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	398.95 visits/1000 MM
4/1/2012—3/31/2013	Remeasurement 3	5% annual reduction	216.82 visits/1000 MM
Indicator 2: Emergency Room visits per 1000 member months (age 20 and older) with diagnosis of back pain			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		114.97 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	68.76 visits/1000 MM
4/1/2012 – 3/31/2013	Remeasurement 3	5% annual reduction	39.89 visits/1000 MM

Findings. The PIP met requirements with recommendations. Interventions are expected to improve indicator performance. Interventions directly target the members who are inappropriately or over-utilizing the ER. The one-on-one contact to provide education is likely to reduce inappropriate utilization.

Recommendations. This is the final submission for this PIP. CoventryCares will participate in the mandated Pediatric Asthma Emergency Department Collaborative.

UniCare Health Plan, Inc.

Childhood Immunizations Combination 3 Project Proposal

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 2012, the National Medicaid Average was 70.64%.

Childhood Immunizations Combination 3	
Rationale	• UniCare Health Plan of WV proposed Childhood Immunization Status (CIS) Combination 3 as a PIP topic. Within the BMS/UniCare contract, CIS is considered a preventive care focus area, as well as a priority area for the performance incentive program. UniCare selected the CIS Combination 3 HEDIS indicator for this project. This indicator rate for HEDIS 2012, MY 2011, 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 Health People 2020 goal to increase immunization rates and reduce preventable infectious diseases by supporting recommended vaccinations.
Indicators and Goals	• 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 2012, the National Medicaid Average was 70.64%.
Strengths	• Comprehensive project rationale. • The performance measure is a HEDIS indicator.
Barriers	• Parents requesting to spread out vaccines so a child does not receive all of them at one visit. This may impact timeliness of administration impacting compliance with the indicator specifications.
Interventions	• Provider "Gaps in Care Reports" are submitted to providers notifying them of members with missing services in hopes that providers will attempt to get members in for needed services including immunizations. • 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.
Compliance with Previous Recommendations	• There were no previous recommendations as this is a proposal submission.

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	Not Available	Available June 2014

Findings. UniCare has a clear project rationale and indicators in its project proposal. The proposal included a baseline data submission for MY 2012. Interventions will be assessed after the next annual submission in July 2014. A quantitative and qualitative analysis was performed for this project proposal.

Recommendations. This project proposal has been approved and UniCare should proceed with full implementation of this project.

Reducing Inappropriate ER Utilization

This project strives to reduce the rate of ER visits per 1000 Medicaid Members (MM) from two participating primary care practices that are referenced as Practice 1 and Practice 2. Practice 1's ER rate declined from 398 to 360 per 1000 MM and Practice 2's rate declined from 397 to 373 per 1000 MM with goals of 359 and 357 visits per 1000 MM, respectively.

PIP Summary: Reducing Inappropriate Emergency Department Utilization	
Rationale	• The emergency Room utilization project is mandated. UniCare noted that 30% percent of emergency room visits are avoidable and West Virginia experiences 30% more utilization than the national average. In an effort to reduce ER utilization, the MCO states, "The study aims to cement the medical home relationship between patients and families and their primary care providers." • UniCare is targeting the Princeton/Bluefield Community for this PIP and is working with two primary care practices identified as Practice 1 and Practice 2. With interventions targeting members of these practices, UniCare aimed to reduce their ER utilization.
Indicators and Goals	• The rate of ED visits per 1000 Medicaid members from a participating primary care practice in Princeton/Bluefield community, using total ED visits over total unique member count, Goal: Achieve a 10% reduction in ED Visits. • The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice in Princeton/Bluefield community, using total ED visits over total unique member count, Goal: Achieve a 10% reduction in ED Visits.

PIP Summary: Reducing Inappropriate Emergency Department Utilization	
Strengths	• UniCare is considering implementing a "gatekeeper" model that aims to strengthen the PCP/member relationship by requiring a PCP's referral to an in network specialist. The PCP's NPI number must be included on the specialist provider's claim to verify the referral. UniCare hopes that members will use the ED more appropriately if there is an established PCP/member relationship. • The MCO interacted with the practice sites on a one-to-one basis. Follow-up phone calls and on-site visits were made to participating practices to answer any questions and check the status of the pilot.
Barriers	• Member knowledge deficit regarding proper use of emergency room and lack of continuity of care with a PCP.
Interventions	• Participating practices were re-visited to answer any questions regarding the program, and provide and replace any brochures and posters as needed. • Follow-up phone calls made to participating practices were made to answer any questions and check on the status of the pilot.
Compliance with Previous Recommendations	• Indicator goals were not defined in the previous submission. Goals are now clearly defined and allow for comparing indicator rates to the selected goals. • The MCO developed a new brochure to educate members about proper use of the ER but had not distributed it yet. UniCare distributed the brochures in MY 2012 as recommended. The MCO maintained telephone and face-to-face contact with providers and sites to ensure they had an adequate amount of materials. • Delmarva recommended that the MCO develop and implement new, robust interventions or refocus the project as interventions were assessed as being too passive. Despite the weak interventions, the ER visit rates for both practices decreased (indicating improvement), but cannot be attributed to the project efforts. UniCare has closed this project and will participate in the mandated Pediatric Asthma Emergency Department Collaborative.

PIP Results			
Indicator 1: The rate of emergency room visits per 1000 Medicaid members from Practice 1 in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	88% or 876 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	788 visits per 1000 members	40% or 398 visits per 1000 members
10/1/2011 – 9/30/2012	Remeasurement 2	358 visits per 1000 members	36% or 360 visits per 1000
Indicator 2: The rate of emergency room visits per 1000 Medicaid members from Practice 2 in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	96% or 965 visits per 1000 members

Indicator 2: The rate of emergency room visits per 1000 Medicaid members from Practice 2 in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2010 – 9/30/2011	Remeasurement 1	868 visits per 1000 members	40% or 397 visits per 1000 members
10/1/2011 – 9/30/2012	Remeasurement 2	652 visits per 1000 members	37% or 373 visits per 1000 members

Findings. Interventions are not expected in improve outcomes. They are passive in nature and do not directly target members. They focus on posters/brochures and making contact with the participating practices to answer questions. UniCare did not take Delmarva's recommendation to develop and implement new and robust interventions or refocus its ER Utilization project. Delmarva required this PIP to be closed during the last quarterly reporting cycle. The MCO concurred and closed this project.

Recommendations. Confronting inappropriate ER utilization, as a whole, can be overwhelming. UniCare should continue their efforts to decrease the number of member ER visits after the close out of this PIP. The MCO will participate in the Pediatric Asthma ER Utilization PIP mandated by BMS. This PIP is currently under development and will replace this project.

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 for selected measures are compared to the National Medicaid Averages and 90th percentiles for benchmarking purposes. MCO HEDIS measures and indicators rates, including trended rates are found in the Appendices.

WV Mountain Health Trust Program State Strategy Objectives and Targets

The *West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality* (WV MHT State Strategy) includes objectives and targets for selected measures. The objectives, targets, and trended results are found in Table 5.

Table 5. WV MHT State Strategy Objectives, Targets, and Results

Objective	Target (over the next two years)	Baseline◘ (MY 2008)	MY◘ 2009	MY◘ 2010	MY◘ 2011	MY◘ 2012
Promote Child Preventive Health	Demonstrate improvement of five percentage points in the number of members two years of age compliant with an immunization 4:3:1:2:3:1:1* (HEDIS Childhood Immunization Status (CIS)-Combination 2 measure)	70.4%	62.2%	63.5%	68.3%	68.3%
Promote Child Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (80.3%) for the percent of members, age three to six years, who received one or more well-child visits with a primary care practitioner. (HEDIS Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life)	75.7%	72.4%	65.5%	67.3%	67.5%
Ensure Child Access to Primary Care Practitioners	Strive to meet the 2008 HEDIS 75th percentile (91.6%) for the number of children ages seven to 11 years who had a visit with a primary care practitioner. (HEDIS Child and Adolescents' Access to Primary Care Practitioners (PCP) age 7-11 Years)	86.2%	92.6%	92.6%	92.9%	93.5%
Promote Adult Access to Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (88.4%) for the percentage of adults, age 20-44 years, who had an ambulatory or preventive visit. (HEDIS Adults Access to Preventive/Ambulatory Health Services measure)	84.0%	88.4%	87.4%	86.9%	84.9%
Encourage Appropriate Postpartum Care	Strive to meet the 2008 HEDIS 75th percentile (68.5%) for the percentage of women who had a postpartum visit on or between 21 and 56 days of delivery. (HEDIS Prenatal and Post-Partum Care measure)	65.3%	67.8%	63.4%	63.7%	63.9%
Ensure Comprehensive Chronic Care	Strive to meet the 2008 HEDIS 75th percentile (63.3%) for the number of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90). (HEDIS Controlling High Blood Pressure measure)	58.2%	63.0%	61.0%	68.8%	54.9%

* Four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza Type B (HiB); three hepatitis B (HepB), and one chicken pox (VZV).

◘ The rates displayed are WV MHT Weighted Averages for the three MCOs.

The Quality Strategy target was achieved for Ensuring Child Access to Primary Care Practitioners (HEDIS Children and Adolescents' Access to Primary Care Practitioners for Children Age 7-11 Years measure).

Three of the selected measures increased from MY 2011 to MY 2012.

HEDIS measures collected, including those in Table 5, are presented in the Quality, Access, and Timeliness sections that follow.

Quality Performance Measures

Twelve measures that gauge immunizations, screenings, 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 five immunizations and screening measures are displayed in separate tables from the seven diabetes measures. The HEDIS 2011 through HEDIS 2013 MHT Weighted Averages for the immunization and screening measures are provided in Table 6 below with the National benchmarks.

Table 6. Quality Performance Measures - Immunizations and Screenings

Measure Name	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Childhood Immunization Status - Combination 2	63.5	68.3	68.3	75.8	85.4
Childhood Immunization Status – Combination 3	57.1	62.4	63.3	72.1	83.1
Immunizations for Adolescents - Combination 1	39.5	45.0	65.5	67.2	85.6
Lead Screening in Children	54.8	55.1	57.1	67.4	87.0
Controlling High Blood Pressure	61.0	64.7	54.9	56.1	69.4

Four out five indicators improved between HEDIS 2011(MY 2010) and HEDIS 2013(MY2012).
The three year trend for all three immunization measures shows continuous improvement for each year between HEDIS 2011 (MY 2010) through HEDIS 2013 (MY 2012). The *Immunizations for Adolescents-Combination 1* measure achieved the greatest improvement over the three year period with an increase of 26.0 percentage points. This indicator also achieved the greatest improvement with a 20.5 percentage point increase from HEDIS 2012(MY 2011) to HEDIS 2013 (MY2012). *Childhood Immunization Status-Combination 3* and *Lead Screening in Children* also improved year over year between HEDIS 2011 and HEDIS 2013.

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.

Table 7 presents seven selected indicators for Comprehensive Diabetes Care (CDC) and the comparative national benchmarks.

Table 7. Quality Performance Measures- Comprehensive Diabetes Care *

Measure Name	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	63.5	68.8	61.6	58.8	74.6
Comprehensive Diabetes Care - Eye Exams	30.6	32.8	29.9	53.2	67.6
Comprehensive Diabetes Care - HbA1c Control (<8%)	40.1	41.3	38.6	46.5	58.4
Comprehensive Diabetes Care - HbA1c Testing	76.9	76.8	73.6	82.9	91.0
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	24.7	27.7	27.9	33.9	43.8
Comprehensive Diabetes Care - LDL-C Screening	64.0	64.2	62.4	75.4	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	66.0	63.1	57.3	78.4	85.9

* It should be noted that the total eligible population for the Comprehensive Diabetes Care indicators is small with an eligible population of 951 out of approximately 170,000 enrollees.

For Diabetes indicators, the *Blood Pressure Control (<140/90)* rate exceeded the National Medicaid Average. The rate for *LDL-C Control (LDL-C<100 mg/dL)* improved from HEDIS 2011 to HEDIS 2013.

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 Adult and Child CAHPS Shared Decision Making Composites were also collected, but do not have benchmarks and therefore performance comparisons cannot be made. Results provided for this measure are for information only. The following table provides the MHT Average and national benchmarks for HEDIS 2013.

Table 8. Quality Measures-CAHPS Composites and Ratings HEDIS 2013 (MY 2012)

Measure	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Adult Measures			
Customer Service Composite	90.6	86.2	89.5
How Well Doctors Communicate Composite	90.4	89.3	92.6
Shared Decision Making Composite	73.8	NA	NA
Rating of Health Plan	72.7	73.5	81.3
Rating of All Health Care	72.9	70.8	76.3
Rating of Personal Doctor	77.9	78.4	82.9
Rating of Specialist Seen Most Often	76.7	79.4	84.4
Child General Population Measures			
Child Survey - General Population: Customer Service Composite	92.7	87.6	91.2
Child Survey - General Population: How Well Doctors Communicate Composite	93.8	92.6	95.4
Child Survey - General Population: Shared Decision Making	67.3	NA	NA
Child Survey - General Population: Rating of Health Plan	86.6	82.9	88.9

Measure	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Child Survey - General Population: Rating of All Health Care	84.0	83.1	87.0
Child Survey - General Population: Rating of Personal Doctor	87.3	87.1	90.2
Child Survey - General Population: Rating of Specialist Seen Most Often	84.7	84.5	89.5

For Adult Quality CAHPS measures, the MHT Average exceeded the National Medicaid 90th Percentile for *Customer Service* and compared favorably to the Medicaid National Average for the two following measures:

- How Well Doctors Communicate
- Rating of All Health Care

For quality measures from the CAHPS Child General Population Survey, the MHT Average for *Customer Service* exceeded the National Medicaid 90th Percentile. The MHT Averages compared favorably to the National Medicaid Average for the remaining five child measures:

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

For CAHPS, the MHT Averages compared favorably to national benchmarks for three Adult and all six Child quality measures. Opportunities for improvement exist with the following three Adult CAHPS measures that failed to meet the National Medicaid Average:

- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Overall, in the area of quality, for performance measure validation, the MHT Weighted Average improved for 5 out of the 12 immunization, screening and comprehensive diabetes care indicators between HEDIS 2011 and HEDIS 2013. The *Immunizations for Adolescents-Combination 1* measure achieved the greatest improvement with an increase of 26.0 percentage points between HEDIS 2011 and HEDIS 2013. 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, the MHT Averages compared favorably to national benchmarks for three Adult and six Child quality measures.

Access Performance Measures

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

Table 9. Access Performance Measures

Measure Name	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	87.4	86.9	84.9	80.2	88.3
Adults' Access to Preventive/Ambulatory Health Services (45-64)	85.9	87.0	86.0	86.5	91.2
Adults' Access to Preventive/Ambulatory Health Services (Total)	87.2	86.9	85.0	82.5	89.0
Children and Adolescents' Access To PCP (12-19 Yrs.)	89.8	90.4	92.0	88.3	93.7
Children and Adolescents' Access To PCP (12-24 Months)	97.4	97.4	97.6	96.0	98.5
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	89.2	91.0	91.1	88.3	93.6
Children and Adolescents' Access To PCP (7-11 Yrs.)	92.6	92.9	93.5	89.8	95.2
Prenatal and Postpartum Care - Postpartum Care	63.4	63.7	63.9	63.1	73.8
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.5	93.4	94.1	82.9	92.8

MHT continues to perform well in providing access to care for its members with all measures comparing favorably with national benchmarks. Eight out of nine measures exceeded the National Medicaid Average. *Adults' Access to Preventive/Ambulatory Health Services (45-64)* was within five tenths of a percentage point in meeting the National Medicaid Average.

The *Prenatal and Postpartum Care - Timeliness of Prenatal Care* measure performed best exceeding both the National Medicaid Average and the National Medicaid 90th Percentile.

The following indicators showed improvement between HEDIS 2011 and HEDIS 2013:

- Adults' Access to Preventive/Ambulatory Health Services (45-64)
- Prenatal and Postpartum Care - Postpartum Care
- Children and Adolescents' Access To PCP
  - 12-24 months
  - 25 months- 6 years
  - 7-11 years
  - 12-19 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 10. Getting Needed Care Composite Rates- Adult and Child CAHPS

Measure	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Adult Survey-Getting Needed Care Composite	82.2	80.6	85.4
Child Survey-General Population: Getting Needed Care Composite	91.8	84.4	90.4

The MHT Average for the Adults Getting Needed Care Composite exceeded the National Medicaid Average and the MHT Average for the Childs Getting Needed Care Composite exceeded the National Medicaid 90th Percentile.

Continuous favorable performance on the access measures is a strength for the MHT program. The MHT Weighted Averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2011 through HEDIS 2013. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population.

Timeliness Performance Measures

Table 11 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 11. Timeliness Performance Measures

Measure Name	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Adolescent Well-Care Visits	41.6	38.7	45.6	49.6	65.5
Frequency of Ongoing Prenatal Care (≥81%)	73.9	77.1	77.7	60.5	80.1
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	65.5	67.3	67.5	71.9	82.1
Well-Child Visits in the First 15 Months of Life (6 or more visits)	65.2	68.6	69.4	63.6	77.4

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 Medicaid Average. The three year trend from HEDIS 2011 to HEDIS 2013 also indicated improving performance for all four measures:

- Adolescent Well-Care Visits
- Frequency of Ongoing 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 Getting Needed Care Quickly Composite from both the Adult and Child General Population CAHPS was selected to represent timeliness of care.

Table 12. Getting Needed Care Quickly Composite- Adult and Child CAHPS

Measure	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Adult Survey-Getting Care Quickly Composite	83.7	81.2	85.4
Child Survey - General Population: Getting Care Quickly Composite	95.3	89.2	94.2

The MHT Average for the Adult Getting Care Quickly Composite compared favorably to the National Medicaid Average. The MHT Average for the Child Getting Care Quickly Composite compared favorably to the National Medicaid 90th Percentile.

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 100%, 99%, and 99% respectively.

The MCOs have well documented Quality Assessment and Performance Improvement (QAPI) program plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan) and. All QAPI plans note that the ultimate authority of the QI Program rests with the MCO's governing body. All MCOs carry out their QI functions using committees (e.g. credentialing, pharmacy and therapeutics, quality improvement). Committee descriptions include:

- responsibilities,
- membership/composition,
- their relationship to other committees, departments and the MCO
- reporting mechanisms, and
- meeting frequency.

The MY 2012 SPR demonstrated the following MCO accomplishments related to quality. All three MCOs have:

- Well documented Quality Improvement Programs (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- Documentation, including committee meeting minutes, to demonstrate coordination of activities among other performance monitoring activities such as Utilization Management (UM), risk management, and complaint, grievance and appeal management.
- Demonstrated that appropriate staff and committees are involved in the decision making process for UM and QI activities.
- Clinical practice guidelines in place, update them at least every two years. When applicable, the MCOs use them to make utilization management (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 conducted by the MCOs.
- Case and 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.
- 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).

Delmarva conducted a review of 10 initial credentialing and 10 recredentialing files per MCO. This review revealed that that one MCO, CoventryCares, was querying the List of Excluded Individuals or Entities (LEIE) and Excluded Parties List System (EPLS) databases as required by the Centers for Medicare and Medicaid Services (CMS). The Health Plan and UniCare were querying the LEIE database, but not the EPLS/SAM database. BMS required these two MCOs to query both databases to ensure that they did not pay any excluded providers during the review period. Both MCOs completed the required searches and provided attestations that they did not pay any excluded providers.

Recredentialing requirements include an on-site visit to the provider's office. During the review period, CoventryCares conducted these visits, while The Health Plan and UniCare did not. UniCare allowed a successful on-site review conducted by The Joint Commission (TJC), a healthcare quality accreditation and certification organization, as meeting the on-site visit requirement for recredentialing. This does not meet the requirements. The MCO has begun conducting on-site audits for provider sites where TJC's on-site review

was used for recredentialing, and has revised its recredentialing policies to accurately reflect that the MCO must conduct this review. The other MCO began planning to revise its recredentialing policies and procedures to reflect this requirement as well.

In MY 2011 CoventryCares's QAPI program did not meet several key requirements. The BOD did not provide adequate oversight (the BOD did not meet in MY 2011), committee meetings were not held at least quarterly, and meeting minutes did not demonstrate communication among the various committees. Although CoventryCares exceeded the 94% threshold for the QA standard, Delmarva required the MCO to complete an internal corrective action plan to address all of the QI Program deficiencies identified in the MY 2011 review. After the CAP was submitted by CoventryCares and approved by Delmarva, the MCO was required to provide quarterly progress reports on its efforts to correct the deficiencies. CoventryCares provided a comprehensive CAP which addressed all required elements, reported on progress quarterly, and met all of the QA standards for MY 2012. The CAP was closed after the MY 2012 review as it resulted in CoventryCares' achieving a 100% compliance rate for the measurement period.

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 MHT MCOs used the PIP quality improvement process to include:

- Identifying problems relevant to their population,
- Setting appropriate goals,
- Calculating baseline and repeat measurements,
- Developing and implementing interventions aimed at improving performance, and
- Assessing effectiveness of interventions.

There are three MCO PIP topics related to quality which are Childhood Obesity, Childhood Immunization Status, and Diabetes. 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. Due to the changes in the data collection methodology during the project from the hybrid methodology in the baseline year (MY 2008), to the administrative data methodology (MY 2009-2011) and back to the hybrid methodology in MY 2012, this PIP could not compare improvement across the entire project period.

The MY 2012 analysis was completed comparing the MY 2008 baseline rate to the MY 2012 rate since both used the hybrid data collection methodology. The Percentage of Members with Evidence BMI Documentation improved from 15.09% to 35.28% while the Percentage of Members with Evidence of Nutritional Counseling improved from 35.52% to 51.82%. The percentage of Members with Evidence of Physical Activity Counseling indicator decreased from 32.12% to 20.92% in this same period. The most notable intervention is face-to-face discussions with primary care providers (PCPs) regarding the

documentation requirements. The MCO will provide the administrative and hybrid method rates for MY 2013 for all indicators and complete a full analysis across the entire project period.

A best practice was identified for the Childhood Obesity PIP Project. Face-to-face education with providers and their office staff regarding a Provider Information Packet and documentation requirements was conducted. The packet includes a BMI chart, BMI percentile graph sheets, and childhood obesity program information. These educational sessions are conducted when data abstractors are in the provider offices conducting medical record data abstraction. Over 200 provider practices were provided education during the reporting period.

In UniCare's Childhood Immunizations Combination 3 PIP Project Proposal, 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, the National Medicaid Average was 70.64%. Because this was a project proposal, only baseline data were submitted. The first remeasurement data (HEDIS 2013) will be available in June 2014. Best practices for 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. 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 final PIP topic related to quality is the mandated Diabetes Collaborative in which all three MCOs are required to participate. According to the Behavioral Risk Factor Surveillance System, the national median prevalence of diagnosed diabetes doubled between 1996 and 2012. During that same time period, the prevalence rate nearly tripled for West Virginia (Centers for Disease Control and Prevention: National Diabetes Surveillance System. http://www.cdc.gov/diabetes/statistics).

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 by HEDIS 2016 (MY 2015). For HEDIS 2012 (MY 2011), the Mountain Health Trust (MHT) weighted average for the Comprehensive Diabetes Care—HbA1c Control (<8%) measure was 41.3% compared to the National Medicaid Average of 48.0%, resulting in a 6.7 percentage point difference and providing opportunity for improvement. All MCOs have selected at least one additional HEDIS indicator for their projects to include Retinal Eye Exam, HgBA1c Testing, and LDL-C Level <100mg/dL.

This collaborative project was in the early development stage in MY 2012 and implementation is planned for MY 2013. Best practices for interventions for the Diabetes Collaborative have been identified in the MCO project proposals. They are summarized by MCO below.

CoventryCares will produce a Practitioner Report annually to high-volume practices. Data about diabetes and other disease entities will also be included. Practitioner "gaps in care" lists will be 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. In addition, Disease Management and Case Management staff will seek to identify high-risk members (based on established criteria) to discuss disease, wellness activities, and diabetes care.

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. 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 chooses to pursue. This intervention is not just for diabetes, but is in place for multiple conditions.

UniCare will generate gaps in care reports that include member-level detail of gaps in care and distribute to providers in hopes that providers will follow-up with enrollees on the lists. 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.

Twelve HEDIS indicators were used to assess quality in the MHT program in the areas of immunizations, screening, and diabetes measures.

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Controlling High Blood Pressure
- Lead Screening for Children 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 12 quality measures, the MHT Weighted Average for five indicators improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012). They are:

- Childhood Immunization Status
  - Combination 2
  - Combination 3
- Immunizations for Adolescents-Combination 1
- Lead Screening for Children
- Comprehensive Diabetes Care – LDL-C Control (LDL-C<100)

Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) consumer satisfaction survey provide helpful insights that can be used to identify areas for improvement in member care. MCOs are required to collect and submit the results of the CAHPS Health Plan Adult and Child General Population surveys whose questions are relevant to the population served by the MHT MCOs. The following measures from the Adult and Child General Population CAHPS were used to assess the MCOs for quality:

- Customer Service Composite
- Shared Decision Making Composite
- 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 exceeded the National Medicaid 90th Percentile for *Customer Service* and compared favorably to the Medicaid National Average for the two following measures:

- How Well Doctors Communicate
- Rating of All Health Care

For quality measures from the CAHPS Child General Population Survey, the MHT Average for *Customer Service* exceeded the National Medicaid 90th Percentile. The MHT Averages compared favorably to the National Medicaid Average for the remaining five child measures:

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

For CAHPS, the MHT Averages compared favorably to national benchmarks for three Adult and six Child quality measures. Opportunities for improvement exist with the following three Adult CAHPS measures that did not meet the National Medicaid Average:

- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Overall, in the area of quality, the MCOs had compliance rates of 99% to 100% 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 visit rate indictor. All three MCOs provided project proposals for the mandatory Diabetes Collaborative PIP. This PIP is scheduled to be implemented in MY 2013. For performance measure validation, the MHT Weighted Average improved for 5 out of the 12 immunization, screening and comprehensive diabetes care indicators between HEDIS 2011 and HEDIS 2013. For CAHPS, the MHT Averages compared favorably to national benchmarks for three Adult and all six Child 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 Health Plan Standards and Guidelines*).

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.

The MCOs performed well for standards and elements related to access. 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 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 to 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 did not assess the Initial Prenatal Care access standard. UniCare fell just short of the 90% threshold for routine care appointment within 21 days with a rate of 89% compliance and did not meet the 90% threshold for 24/7 access. The major issues identified for the 24/7 access standard were that answering services not connecting to a health care professional and no answer at the number on file.

The Emergency Department Utilization-related PIPs fall under the category of access due to accessibility barriers identified in the process. Access barriers identified include limited access to same day appointments with primary care practitioners and after hours appointments are very limited. All ED related PIPs were closed this review period. CoventryCares and The Health Plan's PIPs were closed as they achieved sustained improvement for at least one indicator. UniCare's PIP was closed due to Delmarva's recommendation to close because the PIP validation process determined that the interventions were passive and the need to refocus the project. All three MCOs will be participating in the mandatory Pediatric Asthma ED PIP that will be developed in MY 2013.

CoventryCares's ED PIP, which focuses on ED utilization for all of its members, was able to improve performance (decrease in ED use) in the 20-44 year member age range. CoventryCares maintained improvement in the indicator that measured the PIHN Medicaid Members' ED utilization. PIHN coordinates the scheduling of preventive care and PCP appointments for members who are overdue for screenings or who over-utilize the ED. This PIP is now closed.

The Health Plan's ED PIP focuses on children with respiratory diagnoses and adults with back pain. Sustained improvement, a reduction in ED visits from the baseline measurement period to the third remeasurement period, was achieved for both indicators. Targeted interventions such as outreach calls and case management for enrollees with ≥3 ED visits with the prior six months, are likely the source of the reduced inappropriate utilization. This PIP is now closed.

UniCare's ED PIP targets two primary care practices in an effort to reduce utilization. Remeasurement results noted an improvement; however, their interventions were passive in nature, and cannot be attributed to the improve outcomes. UniCare has closed this PIP per Delmarva's request.

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 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 eight of the nine access indicators compared favorably with the National Medicaid Average. *Adults' Access to Preventive/Ambulatory Health Services (24-64 Years)* was only five tenths of one percent below the National Medicaid Average. One indicator, *Prenatal and Postpartum Care - Timeliness of Prenatal Care,* exceeded the National Medicaid 90th Percentile.

The MHT Average for the Adults Getting Needed Care Composite exceeded the National Medicaid Average and the MHT Average for the Childs Getting Needed Care Composite exceeded the National Medicaid 90th Percentile.

In summary, one MCO met all six of the appointment access standards. All MCOs met the Emergency and Urgent Care access standards. One MCO did not meet the Routine Care within 21 Days standard and one MCO did not meet the 24/7 access standard. One MCO did not assess the Initial Prenatal Care standard. All three MCOs had ED-related PIPs in place. Coventry Cares was able to reduce the ED Visit Rate indicator in the 20-44 year old age range. The Health Plan's ED PIP focused on reducing ED visits for children with respiratory conditions and enrollees with low back pain. The MCO achieved a reduction in ED visits for in both indicators. UniCare achieved a reduction in the ED visit rates for two indicators, but the interventions were passive and cannot be attributed to improving outcomes. All three MCOs closed their ED projects – two because they achieved sustained improvement (CoventryCares and The Health Plan) and one (UniCare) based on Delmarva's recommendation. All MCOs will be participating in the mandatory ED Asthma project to be developed in MY 2013.

Favorable performance on the HEDIS access measures continues to be a strength for the MHT program. The MHT Weighted Averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2011 through HEDIS 2013. Eight of the nine access indicators compared favorably with the National Medicaid Average. All four indicators for *Children 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 Average for the CAHPS Adult Getting Needed Care Composite exceeded the National Medicaid Average and the MHT Average for the CAHPS Child Getting Needed Care Composite exceeded the National Medicaid 90th Percentile.

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 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).*

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 2012, 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.

Complaint, grievance and appeal logs were reviewed. Delmarva selected a sample of 10 formal appeals cases for each MCO. In cases where an MCO did not have 10 appeals for MY 2012, 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 Utilization Management (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 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 2012.

For MY 2012, there was one PIP that addressed timeliness. CoventryCares has an Adolescent Well-Care Visits project. The indicator measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well care visit with a PCP or Obstetrics/Gynecology practitioner 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. The indicator rate fell only .55 of a percentage point below its goal of a 5 percentage point increase over the prior year's measurement. Planned 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, appear to be well thought out and target identified barriers.

Best practices identified 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.
- 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 the National Medicaid Average. The three year trend from HEDIS 2011 to HEDIS 2013 indicated improving performance for all four timeliness measures.

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

Overall, the MCOs performed well on the dimension 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 2012. The three year trend from HEDIS 2011 to HEDIS 2013 showed improving performance for all four 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 Medicaid Average. Both CAHPS timeliness measures performed well. The MHT Average for the Adults Getting Needed Care Quickly Composite exceeded the National Medicaid Average and the MHT Average for the Child CAHPS Getting Needed Care Quickly Composite exceeded the National Medicaid 90th Percentile.

MHT MCO Strengths and Recommendations

CoventryCares Strengths and Recommendations

Systems Performance Review

CoventryCares: MY 2012 SPR Strengths and Recommendations	
Enrollee Rights	**Strengths** • 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 and Provider Directory are available on CoventryCares website for members 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. • 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 the State Fair Hearing process.
	Recommendations • 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 Member Handbook state how members will be informed of any changes in benefits. The same Member Handbook was used in MY 2011 and MY 2012 so this recommendation remains for MY 2012.
Grievance Systems	**Strengths** • CoventryCares has a well-documented grievance system which meets the requirements. • The policies and procedures in place and are followed; all complaint, grievance, and appeal resolutions were documented and easy to follow from registration through completion/resolution of the complaints, grievances, and appeals reviewed on-site. • The Notice of Action statement includes all required elements including enrollee rights during the grievance/appeals process. • All grievance/appeals files reviewed contained adequate documentation and were resolved well within the required timeframes.
	Recommendations • The Member Handbook notes CoventryCares'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). This recommendation was made in MY 2011. The policies were reviewed and approved in 2011, but this revision was not made. Therefore, this recommendation is made again for MY 2012.

CoventryCares: MY 2012 SPR Strengths and Recommendations	
Quality Assessment and Performance Improvement	**Strengths** • 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 were complete and timely. • Delegated oversight policies and procedures are in place and followed. The MCO provided the annual audit results for all delegated entities. No CAPs were recommended based on the audit results. • CoventryCares has well-established policies and procedures in place to identify persons in need of case management and/or disease management. • Utilization Management monitors over and under-utilization of services to ensure enrollees have appropriate access to services. • The MCO reviews/ updates clinical practice guidelines at least every two years. • Based on opportunities for improvement identified in CAHPS survey results, the MCO develops action items and implements interventions to address deficiencies. • Health education efforts included promoting their hand washing campaign nutrition/obesity educational outreach, baby showers in the community, perinatal health education including information on immunizations. • CoventryCares also partners with WVU and their mobile mammography unit, Bonnie's Bus, to increase breast cancer screening rates.
	Recommendations • **Enrollment and Disenrollment** - CoventryCares must develop formal written policies and procedures for disenrollment.
Fraud and Abuse	**Strengths** • Coventry'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 MY 2012 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 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 Member Handbook did not include information on how enrollees can report suspected fraud, waste, and abuse in the MY 2011 review. The same Member Handbook was used in MY 2012 so this recommendation remains for MY 2012.

Performance Improvement Projects

CoventryCares: MY 2012 PIP Strengths and Recommendations	
Adolescent Well-Care Visits	**Strengths** • Identification of a short term goal of achieving a 5 percentage point increase in the prior year's measurement rate, and a long term goal of achieving the NCQA Quality Compass 90th percentile. • CoventryCares provided a comprehensive baseline and first remeasurement analysis. The analysis included a thorough assessment of noncompliant members. • Rates demonstrated a 4.45 percentage point increase over the MY 2011 baseline rate.
	Recommendations • Continue PIP.
Decreasing Emergency Department Utilization	**Strengths** • Strong interventions in place promoting member medical home and continuity of care. • Monthly monitoring, reporting, and case management for members with ≥3 ED visits within the prior six months. • Promotion of NCQA Medical Home Certification for the PIHN. Increasing the number of PIHN Clinics with NCQA Medical Home Certification can provide consistent coordination of care and preventative care that should lead to a reduction in ED usage.
	Recommendations • Close this project and participate in the MCO ED Collaborative Project that is currently under development. • Continue attempts and activities surrounding lowering the rates of Emergency Department visits for their members even though the current ED project is closing.

Performance Measure Validation

CoventryCares: MY 2012 PMV Strengths and Recommendations
Strengths • CoventryCares reorganized and increased staffing in the Quality Improvement Department. The changes were implemented to increase operational efficiencies and to align quality improvement and accreditation responsibilities. CoventryCares is scheduled to have its first NCQA accreditation visit in the later part of 2013. • CoventryCares met the July 1, 2012 deadline for HIPAA 5010 compliance and continued its ICD-10 testing and translation projects. It is anticipated they will be fully ICD-10 compliant by October 1, 2014. • The organization maintains case management and HEDIS Navigator software applications for issue management and call documentation. CoventryCares has successfully used automated notifications for member services representatives so they may discuss the flagged HEDIS services that members need to complete. • CoventryCares continues to use a work group for master data management and metadata registry management. CoventryCares maintains formal data governance policies, including approved vendor lists and endorsed methodologies for software development. Another work group is responsible for maintaining and enhancing data integration, workflow, and processes associated with HEDIS measure calculation and reporting. • Production of the organization's HEDIS reports continues to be a well-coordinated and shared responsibility between Coventry corporate and CoventryCares local staff. Corporate staff maintained responsibility for transaction systems, data integration, and HEDIS report production, while local staff coordinated medical record retrieval, abstraction, and data entry. These arrangements enabled the organization to recognize efficiencies through centralization at the corporate level and through market familiarity at the local level. • CoventryCares performed well with the measures from the Access and Availability of Care Domain where seven out ten rates also compared favorably to the National Medicaid Average and five out ten rates improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012).

• CoventryCares also performed well in the Utilization and Relative Resource Use Domain where three measures exceeded the National Medicaid Average with one exceeding the National Medicaid 90th Percentile. All four measures from the Utilization and Relative Resource Use Domain improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012) with two measures showing improvement each year.
Recommendations • The audit team recommended that the organization be prepare to fully report HEDIS measures that require pharmacy data for HEDIS 2014 to BMS. The MCOs became responsible for the pharmacy benefit in April 2013. • 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.

The Health Plan Strengths and Recommendations

Systems Performance Review

The Health Plan: MY 2012 SPR Strengths 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 and a Provider Directory search are available on The Health Plan's website for members to access 24/7.
	Recommendations • This standard received a 100% compliance rating. There are no recommendations for improvement.
Grievance Systems	**Strengths** • Complaint, grievance and appeals policies are in place and are followed. • The Practitioner Procedural Manual provides information for providers to file grievances and appeals. • The Member Handbook outlines the procedures for enrollees to file grievances, appeals, and to access a State Fair Hearing. • Complaints, grievances, and appeals are monitored for timeliness of completion. • All MY 2012 grievance and appeal case files reviewed on-site were completed in a timely manner. • Thorough documentation is maintained in appeal files to support the MCO's decisions.
	Recommendations • The MCO must give enrollees any reasonable assistance in completing forms. This provision was inadvertently removed from the Member Handbook in the MY 2012 revision. The same Member Handbook was used in MY 2012 and therefore this recommendation is made again for MY 2012.
Quality Assessment and Performance Improvement	**Strengths** • The Quality Management and Utilization Management program documents are comprehensive and describe the major activities, goals, and objectives. • Disease and case management programs are in place. A 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 a homegrown program. • Performance improvement project topics and indicators are relevant and appropriate.

The Health Plan: MY 2012 SPR Strengths and Recommendations	
	• Communication between quality-related committees and sub-committees is clear and documented in meeting minutes/reports. • Medical Director involvement is evident and documented in meeting minutes. • Provider participation is apparent throughout quality programs and initiatives. • All credentialing and recredentialing records sampled for the review period were completed timely. • The MCO appropriately reviews and updates clinical practice guidelines, as required. • The Health Plan has a comprehensive health education plan and targets its members and community needs. • The MCO met the 24/7 PCP accessibility requirement with a compliance rate of 90%.
	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. Findings must be 90% compliant or greater. • **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**- In order to receive a met in the next review, the MCO must require an on-site review during the recredentialing process. This must be included in the policies and procedures and documented in the provider recredentialing files. • **Credentialing and Recredentialing** – The Health Plan must include a query of the EPLS/SAM database when credentialing and recredentialing providers. Credentialing policies and procedures must include a querying of these databases. • **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. • **Case Management** - 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.
Fraud and Abuse	**Strengths** • Staffing changes in MY 2012 have resulted in increased attention to the fraud and abuse efforts. • The Compliance and Fraud and Abuse program documents were reviewed and updated in MY 2012. • 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. • The StarsSentinel Software package is being utilized to systematically identify potential fraud and abuse for further investigation.

The Health Plan: MY 2012 SPR Strengths and Recommendations	
	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.

Performance Improvement Projects

The Health Plan: MY 2012 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.
	Recommendations • Continue implementation of system-level interventions. • 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 conduct this project for at least one more year.
Emergency Room Utilization Diversion	**Strengths** • Enhanced reporting system. The MCO's proprietary HEART system allows for the identification of high utilizers of the ED, including those for childhood respiratory conditions and adults back pain regardless of diagnosis. 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.
	Recommendations • Close this PIP and participate in the mandatory Pediatric Asthma Emergency Department Collaborative that is currently under development. • Continue effective interventions to maintain or improve the indicators.

Performance Measure Validation

The Health Plan: MY 2012 PMV Strengths and Recommendations
Strengths • The Health Plan of the Upper Ohio Valley met the July 1, 2012 deadline for HIPAA 5010 compliance and continued its ICD10 testing and translation projects in anticipation of ICD10 compliance by October 1, 2014. • The Health Plan continues to use and maintain a birth file database that is populated by a nurse case manager who receives pregnancy notifications from claims or directly from providers. The hospital contacts the MCO regarding date of delivery, which is recorded in the database with data on gestational age and diagnoses. The MCO reconciles data with claims, but the database has higher priority than claims as it has been proven to be most accurate. Claims for which there were no case management records are verified against claims data or medical records before counting towards maternity measures. • The Health Plan effectively maintained supplemental lab data from a number of participating network hospitals to supplement its administrative data for HEDIS reporting. • The organization's proprietary credentialing and transaction system maintains a system-generated provider data change log. All transactions such as adds, deletes, and updated are automatically logged into a report which tracks user, date and time, old data and new data. • The Health Plan consistently maintains a Call Answer Timeliness rate of 95%, which benchmarks at the 95th percentile of the National Medicaid benchmark. • In the Effectiveness Care Domain, six indicators compared favorably to the National Medicaid Average and all but four indicators showed improvement in rates between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012). • All ten measures for the Access/Availability of Services Measures compared favorably to the National Medicaid Average and two measures exceeded the 90th Percentile. • In the Utilization and Relative Resource Use Domain, two of the four measures compared favorably to the National Medicaid Average. One measure exceeded the National Medicaid 90th Percentile. All four measures improved each year of the three-year period between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012).
Recommendations • The audit team urges the organization to continue to pursue opportunities to obtain BMI and blood pressure results from participating hospitals and provider groups to supplement additional measures and indicators, and reduce medical record review burdens. • The audit team recommended that the organization anticipate full reporting on pharmacy measures in the BMS HEDIS 2014 report. The members' pharmacy benefit was carved back into the organization starting in April 2013.

UniCare Strengths and Recommendations

Systems Performance Review

UniCare: MY 2012 SPR Strengths 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 the Member Handbook. • The Member Handbook and Provider Directory (search) are available on UniCare's website for members to access 24/7.
	Recommendations • This standard received a 100% compliance rating. There are no recommendations for improvement.

UniCare: MY 2012 SPR Strengths and Recommendations	
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. • 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 cases files reviewed were resolved within the 30 day timeframe requirement.
	Recommendations • This standard received a 100% compliance rating. There are no recommendations for improvement.
Quality Assessment and Performance Improvement	**Strengths** • 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. • The delegated credentialing policies and procedures are comprehensive. All delegated entities received an annual audit with no major deficiencies identified. • Clinical practice guidelines are in place and appropriately used to make authorization decisions. A variety of guidelines relevant to the enrollee population was reviewed and/or updated and approved in 2012. Some examples are Asthma, Maternity, Diabetes, and Hypertension. • 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. • The MCO informs providers of quality-related initiatives and requires provider participation in quality improvement activities. • UniCare has a comprehensive Health Education Plan and appropriately reaches out to members in an effort to engage them in health education related programs. • Performance improvement project topics and indicators are relevant and appropriate. • Collaboration between quality-related committees and sub-committees is clear and documented in meeting minutes/reports. • Four of the seven CAHPS® adult member satisfaction rating and composite scores improved in 2012 while three of the seven CAHPS® child member satisfaction rating and composite scores improved in 2012. Five of the seven child satisfaction scores achieved or exceeded the Quality Compass ® 75th percentile.

UniCare: MY 2012 SPR Strengths and Recommendations	
	Recommendations • **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 is going to 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.) • **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. • **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.) • **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. Treatment plans must specify an adequate number of direct access visits to specialists to accommodate implementation of the treatment plan. • **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.)
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 both locally (WV) and nationally to detect fraud, waste and abuse. Any "schemes" identified in one region of the country are investigated in all their markets.

UniCare: MY 2012 SPR Strengths and Recommendations	
	Recommendations • UniCare continues to achieve a 100% compliance rating for Fraud and Abuse. There are no recommendations for improvement.

Performance Improvement Projects

UniCare: MY 2012 PIP Strengths and Recommendations	
Childhood Immunization Status Combination 3	**Strengths** • Comprehensive project rationale. • The performance measure is a HEDIS indicator.
	Recommendations • PIP proposal met requirements and is approved. • Implement this project.
Reducing Inappropriate Emergency Room Utilization	**Strengths** • UniCare is considering implementing a "gatekeeper: model that aims to strengthen the PCP/member relationship by requiring a PCP's referral to an in network specialist. The PCP's NPI number must be included on the specialist provider's claim to verify the referral. UniCare hopes that members will use the ED more appropriately if there is an established PCP/member relationship.
	Recommendations • Interventions were not expected to improve outcomes. They are passive in nature and do not directly target members. They focus on posters/brochures and making contact with the participating practices to answer questions. • UniCare did not take Delmarva's recommendation from the last review to develop and implement new and robust interventions or refocus its ER Utilization project • UniCare must close this PIP and participate in the Pediatric Asthma ED Project that is currently under development.

Performance Measure Validation

UniCare: MY 2012 PMV Strengths and Recommendations
Strengths • UniCare met the July 1, 2012 deadline for HIPAA 5010 compliance and continued its ICD10 testing and translation projects in anticipation of ICD10 compliance by October 1, 2014. • UniCare successfully transitioned to MediConnect, a front-end medical record abstraction application acquired by Verisk and integrated with Verisk Quality Reporter application. There were no significant changes to the medical record abstraction workflow. MediConnect features include better pursuit data and a scheduler function. MediConnect allows for fax submission and receipt that can be linked directly to abstracted records by request ID and barcodes. • Production of the organization's HEDIS reports is a well-coordinated and shared responsibility between UniCare corporate and UniCare local staff members. Corporate staff maintained responsibility for transaction systems operations, data integration, and HEDIS report production, while local health organization staff coordinated medical record retrieval, abstraction, and data entry. These arrangements enabled the organization to recognize efficiencies through centralization at the corporate level and through market familiarity at the local level. • For Effectiveness of Care Domain, twenty-one indicators met or exceeded the MHT Weighted Average and two indicators met or exceeded the National Medicaid Average. Six measures improved each year between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012).

- For Access/Availability of Services Domain, nine out of ten indicators compared favorably to the National Medicaid Average and Prenatal and Postpartum Care- Timeliness of Prenatal Care exceeded the National Medicaid 90th Percentile. Seven out of ten indicators improved between HEDIS 2011(MY 2010) and HEDIS 2013 (MY 2012).
- In the Utilization and Relative Resource Use Domain, two measures compared favorably to the National Medicaid National Average and three measures showed improvement between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY2012).
- In State Reported measures, three respiratory measures exceeded the National Medicaid 90th Percentile.

Recommendations

- 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.
- It is recommended that UniCare anticipate full reporting of pharmacy measures in NCQA IDSS HEDIS 2014 report as the pharmacy benefit was carved back into the MCO starting in April 2013.
- The MCO 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.

MHT Program Strengths and Recommendations

MHT Program Strengths and Recommendations	
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 • BMS currently requires the MCOs to achieve a compliance rate of 90% or greater for each of the four standards (ER, GS, QA, FA). BMS should increase the compliance rate to 100% for all standards. For each element or component that is not fully met (partially met or unmet), the MCOs should be required to provide an improvement plan, detailing the plans to achieve full compliance. Quarterly monitoring should be conducted to ensure MCOs remain on track with plans to comply with the SPR requirements.
Performance Improvement Projects	**Strengths** • In general, MCOs continue to demonstrate improvement in basic project methodology by providing comprehensive project rationales, identifying fitting study questions and indicators, and conducting appropriate data collection procedures. • Two MCOs successfully completed projects aimed at reducing ED utilization by demonstrating sustained improvement. (All three MCOs have closed their ED PIPS for MY 2102.) • Beginning in MY 2013, each MCO will begin two new collaborative PIP projects to address two new conditions/diagnoses. One project focuses on increasing the percentage of MHT members 18-75 years of age with diabetes (Type 1 or Type 2) who had an HbA1c test result of <8.0% during the measurement year. The second collaborative PIP focuses on reducing ED utilization for the Mountain Health Trust (MHT) program pediatric

MHT Program Strengths and Recommendations	
	enrollees diagnosed with asthma. Because of the implementation of these collaborative PIPS, the MCOs are each closing out their current Emergency Room PIPs. • In the new project proposals for diabetes and pediatric asthma ED use, the MCOs have proposed more robust interventions to include face-to-face contact with providers, offering incentive programs, and preparing and distributing Gaps in Care Reports and Provider Profiles.
	Recommendations • Quarterly reporting on PIP progress began in MY 2012. This requirement has allowed Delmarva to ensure that the MCOs are keeping on task with their PIPs and to identify any issues earlier than was possible with annual reporting. • There is still opportunity for the MCOs to enhance their project analyses. Understanding barriers and causes for performance are critical components of the analysis that assist in effectively planning the next steps of PIP implementation. Interventions should be tied to barriers in the analyses.
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 successfully implemented the new NCQA process for Medical Record Review Validation for HEDIS 2013 (MY 2012). • All MCOs are on-target to obtain NCQA accreditation by January 2014. • BMS now requires all MCOs to conduct the most recent version of the HEDIS CAHPS Adult and Child Medicaid Surveys. This will now provide BMS with comparable customer satisfaction data which can be compared among the MCOs and to the MHT Average and National Benchmarks. • The MCOs all successfully integrated pharmacy data provided by the fiscal agent to report respiratory measures to the State including Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with Upper Respiratory Tract Infection (URI), Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM) and Medication Management for People With Asthma (MMA). All the MCOs successfully reported all required measures to BMS for HEDIS 2012. • All three MCOs used targeted outreach programs in efforts to increase member compliance for recommended services. • In regards to measures of quality, the MHT rates for five indicators improved between HEDIS 2011 (MY 2010) and HEDIS 2013 (MY 2012). They are: Childhood Immunization Status (Combination 2 and Combination 3), Lead Screening for Children, and Comprehensive Diabetes Care-LDL-C Control (LDL-C<100). • The MHT Weighted Averages for eight of nine access indicators compared favorably with the National Medicaid Average. • The MHT Weighted Averages for all four indicators for Children and Adolescents' Access to PCP (ages 12-24 months, 25 months-6 years, 7-11 years, and 12-19 years) 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 three year trend from HEDIS 2011 to HEDIS 2013 indicated improving performance for the MHT Weighted Averages for all four timeliness measures- Adolescent Well Care Visits, Frequency of Ongoing Prenatal Care (≥81%), Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, and 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 the National Medicaid Average.

MHT Program Strengths and Recommendations	
	• The Adult and Child CAHPS Customer Service Composite exceeded the National Medicaid Average and the National Medicaid 90th percentile. • Six Adult and Child CAHPS measures were used to assess quality. The MHT Average for all six Child CAHPS quality measures and three Adult CAHPS quality measure exceeded the National Medicaid Average. • One Adult and Child CAHPS survey measure was used to assess access. The MHT Average for the Adult CAHPS Getting Needed Care Composite measure exceeded the National Medicaid Average and the MHT Average for the Child CAHPS Getting Needed Care Composite exceeded the National Medicaid 90th Percentile. • For the Adult and Child CAHPS measure for timeliness, the MHT Average for the Adult CAHPS Getting Needed Care Quickly Composite exceeded the National Medicaid Average and the MHT Average for the Child CAHPS Getting Needed Care Quickly Composite exceeded the National Medicaid 90th Percentile.
	Recommendations • All three MCOs are encouraged to continue exploring different avenues to improve their data quality and capture to include the 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). • The Audit Team recommended that the MCOs be prepared to fully report HEDIS measures that require pharmacy data for HEDI 2014 (MY 2013) as the MCOs will become responsible for the pharmacy benefit in April 2013. • BMS should continue its diligent efforts in working with State agencies to ensure that the MCOs have adequate access to information from the WV Statewide Immunization Information System (WVSIIS). The additional information may contribute to data completeness and improved HEDIS rates.

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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%
PIP Results-Emergency Department Utilization			
Indicator 1: ED Visits (Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline		146.45 Visits/1000 MM
MY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	151.37 Visits/1000 MM
MY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	147.10 Visits/1000 MM
MY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	146.00 Visits/1000 MM
MY 2012	Remeasurement 4	Reduce ER Visits by 2.3 Visits/1000 MM	144.41 Visits/1000 MM
Indicator 2: ED Visits (Medicaid Members, All Ages) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2008	Baseline	Reduce ER Visits by 2.5 Visits/1000 MM	74.66 Visits/1000 MM
MY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	81.70 Visits/1000 MM
MY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	74.65 Visits/1000 MM
MY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	78.18 Visits/1000 MM
MY 2012	Remeasurement 4	Reduce ER Visits by 2.3 Visits/1000 MM	75.56 Visits/1000 MM
Indicator 3: ED Visits (PIHN Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
MY 2010	Baseline	Not Applicable	136.56 Visits/1000 MM
MY 2011	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	131.36 Visits/1000 MM
MY 2012	Remeasurement 2	Reduce ER Visits by 2.3 Visits/1000 MM	133.54 Visits/1000 MM

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%
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%
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%
PIP Results-Emergency Department Utilization			
Indicator 1: Emergency Room visits per 1000 member months (ages 0-5 years) with respiratory diagnosis			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline	Not Applicable	438.27 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	398.95 visits/1000 MM
4/1/2012 – 3/31/2013	Remeasurement 3	5% annual reduction	293.73 visits/1000 MM
Indicator 2: Emergency Room visits per 1000 member months (age 20 and older) with diagnosis of back pain			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline	Not Applicable	114.97 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	68.76 visits/1000 MM
4/1/2012 – 3/31/2013	Remeasurement 3	5% annual reduction	68.21 visits/1000 MM

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	Not Applicable	62.04%
1/1/2013-12/31/2013	Remeasurement 1	Meet or exceed the previous year's NCQA Quality Compass National Medicaid Average. (70.64%)	Available June 2014

PIP Results- Emergency Department Utilization			
Indicator 1: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Al Attar) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	88% or 876 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	788 visits per 1000 members	40% or 398 visits per 1000 members
10/1/2011 – 9/30/2012	Remeasurement 2	359 visits per 1000 members	36% or 360 visits per 1000 members
Indicator 2: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Peters) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	96% or 965 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	868 visits per 1000 members	40% or 397 visits per 1000 members
10/1/2011 – 9/30/2012	Remeasurement 2	357 visits per 1000 members	37% or 373 visits per 1000 members

Appendix 2 – HEDIS 2013 (MY 2012) MCO Rates, MHT Weighted Average, and National Benchmarks

Tables A2-1 through A2-3 below provide a comparison of the MCO Rates, MHT Weighted Average, and National Medicaid Benchmarks for HEDIS 2013 (MY 2012).

Table A2-1. Quality Measures

Measure Name	Coventry Cares HEDIS 2013 %	The Health Plan HEDIS 2013 %	UniCare HEDIS 2013 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Childhood Immunization Status - Combo 2	66.9	73.5	67.9	68.3	75.8	85.4
Childhood Immunization Status - Combo 3	63.6	66.2	62.0	63.3	72.1	83.1
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	58.6	68.2	61.6	61.6	58.8	74.6
Comprehensive Diabetes Care - Eye Exams	34.2	33.8	25.8	29.9	53.2	67.6
Comprehensive Diabetes Care - HbA1c Control (<8%)	37.9	45.3	37.0	38.6	46.5	58.4
Comprehensive Diabetes Care - HbA1c Testing	70.5	83.1	72.8	73.6	82.9	91.0
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	27.0	33.8	26.8	27.9	33.9	43.8
Comprehensive Diabetes Care - LDL-C Screening	59.9	71.0	61.6	62.4	75.4	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	59.9	68.9	52.1	57.3	78.4	85.9
Controlling High Blood Pressure	55.4	63.1	52.7	54.9	56.1	69.4
Immunizations for Adolescents - Combination 1	64.0	60.1	68.4	65.5	67.2	85.6
Lead Screening in Children	58.5	53.8	56.9	57.1	67.4	87.0

Table A2-2 Access Measures

Measure Name	Coventry Cares HEDIS 2013 %	The Health Plan HEDIS 2013 %	UniCare HEDIS 2012 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	83.3	87.0	85.3	84.9	80.2	88.3
Adults' Access to Preventive/Ambulatory Health Services (45-64)	82.7	87.8	87.8	86.0	86.5	91.2
Adults' Access to Preventive/Ambulatory Health Services (Total)	83.3	87.1	85.6	85.0	82.5	89.0
Children and Adolescents' Access To PCP (12-19 Yrs.)	90.1	92.1	93.2	92.0	88.3	93.7
Children and Adolescents' Access To PCP (12-24 Months)	96.9	98.0	98.1	97.6	96.0	98.5
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	89.9	91.0	92.0	91.1	88.3	93.6
Children and Adolescents' Access To PCP (7-11 Yrs.)	91.6	93.3	94.6	93.5	89.8	95.2
Prenatal and Postpartum Care - Postpartum Care	59.7	69.3	65.7	63.9	63.1	73.8
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.9	94.4	93.4	94.1	82.9	92.8

Table A2-3. Timeliness Measures

Measure Name	Coventry Cares HEDIS 2013 %	The Health Plan HEDIS 2013 %	UniCare HEDIS 2013 %	MHT Weighted Average HEDIS 2013 %	National Medicaid Average HEDIS 2013 %	National Medicaid 90th Percentile HEDIS 2013 %
Adolescent Well-Care Visits	46.6	44.9	45.3	45.6	49.6	65.5
Frequency of Ongoing Prenatal Care (≥ 81%)	82.9	84.7	71.1	77.7	60.5	80.1
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	72.5	67.5	64.2	67.5	71.9	82.1
Well-Child Visits in the first 15 Months of Life (6 or more visits)	71.9	68.6	67.8	69.4	63.6	77.4

Appendix 3 - Three-Year Trend Data for MCOs and MHT Weighted Average

Tables A3-1 through A3-3 provide the MCO Rates and MHT Weighted Averages for the three-year period from HEDIS 2011 through HEDIS 2013

Table A3-1 Quality 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 %
Childhood Immunization Status - Combo 2	66.2	67.1	66.9	62.3	70.6	73.5	62.2	68.6	67.9	63.5	68.3	68.3
Childhood Immunization Status - Combo 3	60.9	62.5	63.6	56.0	63.8	66.2	55.1	62.0	62.0	57.1	62.4	63.3
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	51.0	61.8	58.6	67.6	74.5	68.2	68.3	71.2	61.6	63.5	68.8	61.6
Comprehensive Diabetes Care - Eye Exams	25.3	34.9	34.2	39.3	34.5	33.8	30.2	31.0	25.8	30.6	32.8	29.9
Comprehensive Diabetes Care - HbA1c Control (<8%)	29.7	36.5	37.9	44.8	47.6	45.3	43.5	42.1	37.0	40.1	41.3	38.6
Comprehensive Diabetes Care - HbA1c Testing	74.3	75.1	70.5	80.7	77.9	83.1	76.8	77.5	72.8	76.9	76.8	73.6
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	17.3	23.2	27.0	28.3	28.3	33.8	27.0	30.2	26.8	24.7	27.7	27.9
Comprehensive Diabetes Care - LDL-C Screening	58.4	61.8	59.9	70.3	67.6	71.0	64.4	64.6	61.6	64.0	64.2	62.4
Comprehensive Diabetes Care - Medical Attention for Nephropathy	67.3	67.6	59.9	72.4	66.2	68.9	63.2	59.3	52.1	66.0	63.1	57.3
Controlling High Blood Pressure	50.0	56.9	55.4	63.8	77.9	63.1	66.4	67.4	52.7	61.0	64.7	54.9
Immunizations for Adolescents - Combination 1	42.1	49.8	64.0	41.1	45.5	60.1	37.2	41.9	68.4	39.5	45.0	65.5
Lead Screening in Children	55.2	53.6	58.5	49.8	54.5	53.8	56.2	56.5	56.9	54.8	55.1	57.1

Table A3-2 Access 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 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	85.9	84.6	83.3	88.2	89.4	87.0	88.1	87.6	85.3	87.4	86.9	84.9
Adults' Access to Preventive/Ambulatory Health Services (45-64)	81.7	87.6	82.7	90.6	89.2	87.8	86.5	85.9	87.8	85.9	87.0	86.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	85.5	84.9	83.3	88.4	89.4	87.1	87.9	87.5	85.6	87.2	86.9	85.0
Children and Adolescents' Access To PCP (12-19 Yrs.)	86.0	87.5	90.1	92.0	91.6	92.1	90.7	91.7	93.2	89.8	90.4	92.0
Children and Adolescents' Access To PCP (12-24 Months)	97.3	97.2	96.9	97.8	98.2	98.0	97.3	97.3	98.1	97.4	97.4	97.6
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	88.1	89.6	89.9	91.2	91.8	91.0	89.1	91.6	92.0	89.2	91.0	91.1
Children and Adolescents' Access To PCP (7-11 Yrs.)	90.3	90.6	91.6	93.9	92.9	93.3	93.2	94.3	94.6	92.6	92.9	93.5
Prenatal and Postpartum Care - Postpartum Care	61.0	60.7	59.7	65.7	66.4	69.3	64.6	65.0	65.7	63.4	63.7	63.9
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.9	94.0	94.9	95.6	93.7	94.4	94.2	92.9	93.4	94.5	93.4	94.1

Table A3-3 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	44.0	42.1	46.6	38.4	41.4	44.9	41.4	35.5	45.3	41.6	38.7	45.6
Frequency of Ongoing Prenatal Care (≥ 81%)	79.4	83.1	82.9	79.6	83.2	84.7	67.6	70.9	71.1	73.9	77.1	77.7
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.1	67.6	72.5	60.9	63.9	67.5	66.1	68.2	64.2	65.5	67.3	67.5
Well-Child Visits in the first 15 Months of Life (6 or more visits)	69.0	71.1	71.9	60.4	64.9	68.6	64.2	67.6	67.8	65.2	68.6	69.4

Appendix 4-1 WV HEDIS 2013 Rates, Numerators, Denominators, and Eligible Populations

Tables A4-1a through A4-3c provides all the data collection method (administrative or hybrid), numerators, denominators, and eligible populations used to calculate the MCO Rates and MHT Weighted Averages for the three-year period from HEDIS 2011 through HEDIS 2013.

Table A4-1a Quality Measures HEDIS 2013 (Measurement Year 2012)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2012) %
	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP			
Childhood Immunization Status - Combo 2	H	303	453	66.9	2,893	H	302	411	73.5	1,058	H	279	411	67.9	3,298	7,249	4952	68.3
Childhood Immunization Status - Combo 3	H	288	453	63.6	2,893	H	272	411	66.2	1,058	H	255	411	62.0	3,298	7,249	4585	63.3
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H	187	319	58.6	323	H	101	148	68.2	148	H	253	411	61.6	480	951	586	61.6
Comprehensive Diabetes Care - Eye Exams	H	109	319	34.2	323	H	50	148	33.8	148	H	106	411	25.8	480	951	284	29.9
Comprehensive Diabetes Care - HbA1c Control (<8%)	H	121	319	37.9	323	H	67	148	45.3	148	H	152	411	37.0	480	951	367	38.6
Comprehensive Diabetes Care - HbA1c Testing	H	225	319	70.5	323	H	123	148	83.1	148	H	299	411	72.8	480	951	700	73.6
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	H	86	319	27.0	323	H	50	148	33.8	148	H	110	411	26.8	480	951	266	27.9
Comprehensive Diabetes Care - LDL-C Screening	H	191	319	59.9	323	H	105	148	71.0	148	H	253	411	61.6	480	951	594	62.4
Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	191	319	59.9	323	H	102	148	68.9	148	H	214	411	52.1	480	951	546	57.3
Controlling High Blood Pressure	H	243	439	55.4	499	H	113	179	63.1	181	H	193	366	52.7	765	1,445	794	54.9
Immunizations for Adolescents - Combination 1	H	290	453	64.0	1,448	H	247	411	60.1	824	H	281	411	68.4	2,263	4,535	2970	65.5
Lead Screening in Children	H	265	453	58.5	2,893	H	221	411	53.8	1,058	H	234	411	56.9	3,298	7,249	4138	57.1

Table A4-1b Access Measures HEDIS 2013 (Measurement Year 2012)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2012) %
	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	3,817	0	83.3	4,580	A	1651	0	87.0	1,897	A	5,026	0	85.3	5,890	12,367	10,490	84.9
Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	340	0	82.7	411	A	166	0	87.8	189	A	516	0	87.8	588	1,188	1,022	86.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	A	4,157	0	83.3	4,991	A	1,817	0	87.1	2,086	A	5,543	0	85.6	6,479	13,556	11lk520	85.0
Children and Adolescents' Access To PCP (12-19 Yrs.)	A	6,051	0	90.1	6,716	A	3,843	0	92.1	4,174	A	10,310	0	93.2	11,064	21,954	20,207	92.0
Children and Adolescents' Access To PCP (12-24 Months)	A	2,777	0	96.9	2,866	A	1,103	0	98.0	1,125	A	3,472	0	98.1	3,538	7,529	7,350	97.6
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	A	10,006	0	89.9	11,125	A	4,368	0	91.0	4,802	A	14,535	0	92.0	15,801	31,728	28,908	91.1
Children and Adolescents' Access To PCP (7-11 Yrs.)	A	5,354	0	91.6	5,847	A	3,458	0	93.3	3,706	A	9,416	0	94.6	9,949	19,502	18,225	93.5
Prenatal and Postpartum Care - Postpartum Care	H	258	432	59.7	3,494	H	285	411	69.3	1,298	H	247	376	65.7	4,111	8,903	5,686	63.9
Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	410	432	94.9	3,494	H	388	411	94.4	1,298	H	351	376	93.4	4,111	8,903	8,381	94.1

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

Table A4-1c Timeliness Measures HEDIS 2013 (Measurement Year 2012)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2012) %
	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP	CM	Num	Denom	HEDIS 2013 %	EP			
Adolescent Well-Care Visits	H	211	453	46.6	9,742	A	2350	0	44.9	5,239	H	186	411	45.3	14,959	29,940	13,669	45.6
Frequency of Ongoing Prenatal Care (≥ 81%)	H	358	432	82.9	3,494	H	348	411	84.7	1,298	A	2924	0	71.1	4,111	8,903	6,919	77.7
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	292	403	72.5	8,823	A	2686	0	67.5	3,982	H	231	360	64.2	13,129	25,934	17,513	67.5
Well-Child Visits in the first 15 Months of Life (6 or more visits)	H	271	377	71.9	2,118	A	632	0	68.6	922	H	248	366	67.8	2,793	5,833	4,049	69.4

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

***** HEDIS specifications dictate a required sample size of 411 with an oversample (5-20 percent) for hybrid measures.

Column Definitions:

Data Collection Method- defines how the MCO collected data for the measure either Administrative (A) or Hybrid (H).

Administrative Data Collection Method-The MCO uses only claims and other administrative data to report the measure. There is no sampling and the eligible population is used as the denominator for the measure calculation.

Hybrid Data Collection Method-The MCO uses a systematic sampling of medical records to calculate the measures. The final sample size is used as the denominator for the measure calculation.

Numerator-The number of positive events for a certain measure.

Denominator-The systematic drawn sample from the eligible population used to calculate measure using the hybrid data collection method. In some cases, the size of the eligible population for a measure may be smaller than the required sample size. The organization then must use its entire eligible population. A zero in this field indicates the MCO used the administrative data method.

HEDIS 2012 %-Is the measure rate reported by the MCO for measurement year (MY) 2011.

Eligible Population-Is used to calculate the measure when the administrative data collection method is used. The eligible population for any measure is all members who satisfy all specified criteria for age, continuous enrollment, benefit, event, or anchor date enrollment requirements.

MHT Total Eligible Population-The sum of the MCO eligible population per measure.

MHT Weighted Average Numerator-The numerator events in the MHT Weighted Average.

MHT Weighted Average- MHT Weighted Average Numerator divided by the MHT Total Eligible Population.

Appendix 4-2 WV HEDIS 2012 Rates, Numerators, Denominators, and Eligible Populations

Table A4-2a Quality Measures HEDIS 2012 (Measurement Year 2011)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2011) %
	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP			
Childhood Immunization Status - Combo 2	H	304	453	67.1	2,939	H	290	411	70.6	1,120	H	282	411	68.6	3,742	7,801	5,330	68.3
Childhood Immunization Status - Combo 3	H	283	453	62.5	2,939	H	262	411	63.8	1,120	H	255	411	62.0	3,742	7,801	4,871	62.4
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H	149	241	61.8	253	H	108	145	74.5	145	H	269	378	71.2	414	812	559	68.8
Comprehensive Diabetes Care - Eye Exams	H	84	241	34.9	253	H	50	145	34.5	145	H	117	378	31.0	414	812	267	32.8
Comprehensive Diabetes Care - HbA1c Control (<8%)	H	88	241	36.5	253	H	69	145	47.6	145	H	159	378	42.1	414	812	336	41.3
Comprehensive Diabetes Care - HbA1c Testing	H	181	241	75.1	253	H	113	145	77.9	145	H	293	378	77.5	414	812	624	76.8
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	H	56	241	23.2	253	H	41	145	28.3	145	H	114	378	30.2	414	812	225	27.7
Comprehensive Diabetes Care - LDL-C Screening	H	149	241	61.8	253	H	98	145	67.6	145	H	244	378	64.6	414	812	522	64.2
Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	163	241	67.6	253	H	96	145	66.2	145	H	224	378	59.3	414	812	513	63.1
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	H	132	241	54.8	253	H	58	145	40.0	145	H	180	378	47.6	414	812	394	48.5
Controlling High Blood Pressure	H	199	350	56.9	392	H	67	86	77.9	100	H	250	371	67.4	661	1,153	746	64.7
Immunizations for Adolescents - Combination 1	H	215	432	49.8	1,350	H	187	411	45.5	871	H	172	411	41.9	2,202	4,423	1,991	45.0
Lead Screening in Children	H	243	453	53.6	2,939	H	224	411	54.5	1,120	H	232	411	56.5	3,742	7,801	4,300	55.1

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

Table A4-2b Access Measures HEDIS 2012 (Measurement Year 2011)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2011) %
	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	2827	0	84.6	3,340	A	1456	0	89.4	1,628	A	4177	0	87.6	4,767	9,735	8,457	86.9
Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	276	0	87.6	315	A	173	0	89.2	194	A	464	0	85.9	540	1,049	913	87.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	A	3103	0	84.9	3,655	A	1629	0	89.4	1,822	A	4641	0	87.5	5,307	10,784	9,376	86.9
Children and Adolescents' Access To PCP (12-19 Yrs.)	A	5778	0	87.5	6,601	A	4017	0	91.6	4,385	A	10285	0	91.7	11,222	22,208	20,083	90.4
Children and Adolescents' Access To PCP (12-24 Months)	A	3070	0	97.2	3,157	A	1156	0	98.2	1,177	A	3566	0	97.3	3,666	8,000	7,791	97.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	A	9349	0	89.6	10,438	A	4816	0	91.8	5,248	A	15040	0	91.6	16,420	32,106	29,211	91.0
Children and Adolescents' Access To PCP (7-11 Yrs.)	A	5077	0	90.6	5,606	A	3666	0	92.9	3,945	A	9341	0	94.3	9,907	19,458	18,086	92.9
Prenatal and Postpartum Care - Postpartum Care	H	262	432	60.7	3,283	H	273	411	66.4	1,396	H	247	380	65.0	4,555	9,234	5,880	63.7
Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	406	432	94.0	3,283	H	385	411	93.7	1,396	H	353	380	92.9	4,555	9,234	8,626	93.4

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

Table A4-2c Timeliness Measures HEDIS 2012 (Measurement Year 2011)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2011) %
	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP	CM	Num	Denom	HEDIS 2012 %	EP			
Adolescent Well-Care Visits	H	182	432	42.1	9,533	A	2236	0	41.4	5,401	H	146	411	35.5	14,780	29,714	11,496	38.7
Frequency of Ongoing Prenatal Care (≥ 81%)	H	359	432	83.1	3,283	H	342	411	83.2	1,396	A	3229	0	70.9	4,555	9,234	7,119	77.1
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	292	432	67.6	8,096	A	2766	0	63.9	4,327	H	253	371	68.2	13,374	25,797	17,359	67.3
Well-Child Visits in the first 15 Months of Life (6 or more visits)	H	307	432	71.1	2,310	A	562	0	64.9	866	H	257	380	67.6	2,779	5,955	4,083	68.6

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

***** HEDIS specifications dictate a required sample size of 411 with an oversample (5-20 percent) for hybrid measures.

Column Definitions:

Data Collection Method- defines how the MCO collected data for the measure either Administrative (A) or Hybrid (H).

Administrative Data Collection Method-The MCO uses only claims and other administrative data to report the measure. There is no sampling and the eligible population is used as the denominator for the measure calculation.

Hybrid Data Collection Method-The MCO uses a systematic sampling of medical records to calculate the measures. The final sample size is used as the denominator for the measure calculation.

Numerator-The number of positive events for a certain measure.

Denominator-The systematic drawn sample from the eligible population used to calculate measure using the hybrid data collection method. In some cases, the size of the eligible population for a measure may be smaller than the required sample size. The organization then must use its entire eligible population. A zero in this field indicates the MCO used the administrative data method.

HEDIS 2012 %-Is the measure rate reported by the MCO for measurement year (MY) 2011.

Eligible Population-Is used to calculate the measure when the administrative data collection method is used. The eligible population for any measure is all members who satisfy all specified criteria for age, continuous enrollment, benefit, event, or anchor date enrollment requirements.

MHT Total Eligible Population-The sum of the MCO eligible population per measure.

MHT Weighted Average Numerator-The numerator events in the MHT Weighted Average.

MHT Weighted Average- MHT Weighted Average Numerator divided by the MHT Total Eligible Population.

Appendix 4-3-WV HEDIS 2011 Rates, Numerators, Denominators, and Eligible Populations

Table A4-3a Quality Measures HEDIS 2011 (Measurement Year 2010)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2010) %
	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP			
Childhood Immunization Status - Combo 2	H	300	453	66.2	2,394	H	256	411	62.3	1,239	H	244	392	62.2	3,787	7,420	4,712	63.5
Childhood Immunization Status - Combo 3	H	276	453	60.9	2,394	H	230	411	56.0	1,239	H	216	392	55.1	3,787	7,420	4,238	57.1
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H	103	202	51.0	204	H	98	145	67.6	145	H	215	315	68.3	420	769	489	63.5
Comprehensive Diabetes Care - Eye Exams	H	51	202	25.3	204	H	57	145	39.3	145	H	95	315	30.2	420	769	235	30.6
Comprehensive Diabetes Care - HbA1c Control (<8%)	H	60	202	29.7	204	H	65	145	44.8	145	H	137	315	43.5	420	769	308	40.1
Comprehensive Diabetes Care - HbA1c Testing	H	150	202	74.3	204	H	117	145	80.7	145	H	242	315	76.8	420	769	591	76.9
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	H	35	202	17.3	204	H	41	145	28.3	145	H	85	315	27.0	420	769	190	24.7
Comprehensive Diabetes Care - LDL-C Screening	H	118	202	58.4	204	H	102	145	70.3	145	H	203	315	64.4	420	769	492	64.0
Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	136	202	67.3	204	H	105	145	72.4	145	H	199	315	63.2	420	769	508	66.0
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	H	122	202	60.4	204	H	69	145	47.6	145	H	150	315	47.6	420	769	392	51.0
Controlling High Blood Pressure	H	165	330	50.0	372	H	63	127	63.8	149	H	239	360	66.4	692	1,213	741	61.0
Immunizations for Adolescents - Combination 1	H	182	432	42.1	1,225	H	169	411	41.1	842	H	153	411	37.2	2,104	4,171	1,644	39.5
Lead Screening in Children	H	250	453	55.2	2,394	A	617	0	49.8	1,239	H	231	411	56.2	3,787	7,420	4,067	54.8

CM=Collection Method(Hybrid or Administrative) Num=numerator Denom=denominator EP=Eligible population

Table A4-3b Access Measures HEDIS 2011 (Measurement Year 2010)

Measure Name	CoventryCares, Inc.					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2010) %
	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	2,798	0	85.9	3,258	A	1,601	0	88.2	1,815	A	4,279	0	88.1	4,858	9,931	8,679	87.4
Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	241	0	81.7	295	A	182	0	90.6	201	A	442	0	86.5	511	1,007	865	85.9
Adults' Access to Preventive/Ambulatory Health Services (Total)	A	3,039	0	85.5	3,553	A	1,783	0	88.4	2,016	A	4,721	0	87.9	5,369	10,938	9,539	87.2
Children and Adolescents' Access To PCP (12-19 Yrs.)	A	4,567	0	86.0	5,308	A	4,170	0	92.0	4,532	A	9,677	0	90.7	10,673	20,513	18,415	89.8
Children and Adolescents' Access To PCP (12-24 Months)	A	3,089	0	97.3	3,176	A	1,199	0	97.8	1,226	A	3,987	0	97.3	4,098	8,500	8,277	97.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	A	8,285	0	88.1	9,408	A	5,173	0	91.2	5,673	A	14,714	0	89.1	16,514	31,595	28,176	89.2
Children and Adolescents' Access To PCP (7-11 Yrs.)	A	3,992	0	90.3	4,420	A	3,793	0	93.9	4,040	A	8,612	0	93.2	9,242	17,702	16,398	92.6
Prenatal and Postpartum Care - Postpartum Care	H	263	431	61.0	3,552	H	270	411	65.7	1,347	H	221	342	64.6	4,372	9,271	5,876	63.4
Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	409	431	94.9	3,552	H	393	411	95.6	411	H	322	342	94.2	4,372	8,335	7,882	94.5

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

Table 4-3c Timeliness Measures HEDIS 2011 (Measurement Year 2010)

Measure Name	CoventryCares					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2010) %
	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP			
Adolescent Well-Care Visits	H	211	453	46.6	9,742	A	2,350	0	44.9	5,239	H	186	411	45.3	14,959	29,940	13,669	45.6
Frequency of Ongoing Prenatal Care (≥ 81%)	H	358	432	82.9	3,494	H	348	411	84.7	1,298	A	2924	0	71.1	4,111	8,903	6,919	77.7
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	292	403	72.5	8,823	A	2,686	0	67.5	3,982	H	231	360	64.2	13,129	25,934	17,513	67.5
Well-Child Visits in the first 15 Months of Life (6 or more visits)	H	271	377	71.9	2,118	A	632	0	68.6	922	H	248	366	67.8	2,793	5,833	4,049	69.4

CM=Collection Method (H/A) Num=Numerator Denom=Denominator EP=Eligible Population

* HEDIS specifications dictate a required sample size of 411 with an oversample (5-20 percent) for hybrid measures.

Column Definitions:

Data Collection Method- defines how the MCO collected data for the measure either Administrative (A) or Hybrid (H).

Administrative Data Collection Method-The MCO uses only claims and other administrative data to report the measure. There is no sampling and the eligible population is used as the denominator for the measure calculation.

Hybrid Data Collection Method-The MCO uses a systematic sampling of medical records to calculate the measures. In some cases, the size of the eligible population for a measure may be smaller than the required sample size. The organization then must use its entire eligible population. The final sample size is used as the denominator for the measure calculation.

Numerator-The number of positive events for a certain measure.

Denominator-The systematic drawn sample from the eligible population used to calculate measure using the hybrid data collection method. In some cases, the size of the eligible population for a measure may be smaller than the required sample size. The organization then must use its entire eligible population. A zero in this field indicates the MCO used the administrative data method.

HEDIS 2011 %-Is the measure rate reported by the MCO for measurement year (MY) 2010.

Eligible Population- **i**s used to calculate the measure when the administrative data collection method is used. The eligible population for any measure is all members who satisfy all specified criteria for age, continuous enrollment, benefit, event, or anchor date enrollment requirements.

MHT Total Eligible Population-The sum of the MCO eligible population per measure.

MHT Weighted Average Numerator-The numerator events in the MHT Weighted Average.

MHT Weighted Average- MHT Weighted Average Numerator divided by the MHT Total Eligible Population.

Appendix 5 – Special Measures Requested by BMS: Respiratory Conditions and Smoking Cessation

For HEDIS 2013, MHT MCOs were asked to calculate rates for several additional HEDIS measures. 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, Compliance 75%
- Asthma Medication Ratio (new for HEDIS 2013)
- Medical Assistance with Smoking and Tobacco Use Cessation

For HEDIS 2013 (MY 2012) these measures were collected and solely reported to BMS and not to NCQA as the pharmacy benefit was provided by the State and not the MCOs during MY 2012. Since the benefit was carved out from the MCOs, their access to pharmacy data was limited. BMS worked with the State's Pharmacy Third Party Administrator (TPA) and the three MCOs to provide each one with pharmacy data file of their beneficiaries. All three MCOs were able to calculate reportable rates according to measure specifications.

Beginning with HEDIS 2014 (MY 2013), the MCOs will be responsible for the pharmacy benefit and they will be reporting all measures that use pharmacy data in their HEDIS submissions to NCQA. Table A5-1 provides the MHT weighted average, and national benchmarks for the selected measures.

Table. A5-1 State Requested Measures Using Pharmacy Data

Measure	MHT Weighted Average (MY 2011)	MHT Weighted Average (MY2012)	National Medicaid Average HEDIS 2013 (MY 2012)	National Medicaid 90th Percentile HEDIS 2013 (MY 2012)
Appropriate Testing for Children With Pharyngitis	57.5%	59.7	68.0	85.1
Appropriate Treatment for Children With Upper Respiratory Infection	62.9%	69.3	85.1	93.0
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.2%	33.3	24.2	35.5
Pharmacotherapy Management of COPD Exacerbation- Systemic corticosteroid	62.2%	38.5	65.3	77.1

Measure	MHT Weighted Average (MY 2011)	MHT Weighted Average (MY2012)	National Medicaid Average HEDIS 2013 (MY 2012)	National Medicaid 90th Percentile HEDIS 2013 (MY 2012)
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	73.3	53.8	81.5	90.2
Use of Appropriate Medications for People With Asthma –Ages 5-11 Years	92.0	93.7	89.7	94.9
Use of Appropriate Medications for People With Asthma—Ages 12-18 Years	83.6	86.8	85.6	92.2
Use of Appropriate Medications for People With Asthma – Ages 19-50 Years	72.0	71.4	74.0	84.3
Use of Appropriate Medications for People With Asthma – Ages 51-64 Years	NA	NA	71.5	83.3
Use of Appropriate Medications for People With Asthma – Total	87.7	89.6	83.8	89.8
Medication Management for People With Asthma- Ages 5-11 Years, Compliance 75%	39.3	38.0	25.4	36.0
Medication Management for People With Asthma- Ages 12-18 Years, Compliance 75%	32.8	35.1	25.1	35.9
Medication Management for People With Asthma- Ages 19-50 Years, Compliance 75%	38.9	37.4	34.4	45.2
Medication Management for People With Asthma- Ages 51-64 Years, Compliance 75%	75.0	NA	50.3	62.5
Medication Management for People With Asthma – Total, Compliance 75%	36.9	36.9	29.0	39.4
Asthma Medication Ratio (AMR)- Ages 5-11 Years	^	81.4	^	^
Asthma Medication Ratio (AMR)- Ages 12-18 Years	^	71.7	^	^
Asthma Medication Ratio (AMR)- Ages 19-50 Years	^	62.0	^	^
Asthma Medication Ratio (AMR)- 51-64 Years	^	NA	^	^
Asthma Medication Ratio (AMR)- Total	^	76.6	^	^

NA- Denominator is too small (<30) to calculate a reliable rate
^ Measure not collected or benchmark not available

The MSC measure is collected from the CAHPS survey. All pertinent information was collected and provided to BMS. The following MHT average is based on the two MCOs that fielded a CAHPS survey.

Table A5-2 Medical Assistance with Smoking and Tobacco Use Cessation

Indicator	MHT Average (MY 2011)	MHT Average (MY2012)	National Medicaid Average HEDIS 2013 (MY 2012)	National Medicaid 90th Percentile HEDIS 2013 (MY 2012)
Advising Smokers and Tobacco Users to Quit	75.3	72.9	75.6	81.3
Discussing Cessation Medications	45.8	38.9	45.8	57.5
Discussing Cessation Strategies	39.1	38.1	41.1	50.7

Appendix 6 –HEDIS Measures Collected and Reported to NCQA (HEDIS 2011-HEDIS 2013)

Table Appendix 6-1 provides information for all measures collected and reported for HEDIS 2011 through HEDIS 2013 (MY 2010-MY 2012) by HEDIS domains. Individual MCO rates for three years, the MHT Weighted Average for three years, the most current National Medicaid Average, and the most current National Medicaid 90th Percentile are provide for each measure.

Table A6-1. Effectiveness of Care Domain Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	MHT Weighted Average (MY 2012) - %	National Medicaid Average HEDIS 2013 - %	National Medicaid 90th Percentile HEDIS 2013 - %
	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %					
Adult BMI Assessment	45.4	46.6	65.9	10.3	47.7	62.5	41.4	49.6	64.2	36.6	48.4	64.5	67.6	85.8
Breast Cancer Screening	31.2	40.4	36.4	51.1	44.1	43.0	45.9	40.0	36.6	43.6	40.9	37.6	51.7	62.9
Cervical Cancer Screening	58.8	63.9	60.9	64.7	62.3	63.3	70.4	70.4	56.9	65.7	66.9	59.3	64.1	76.6
Childhood Immunization Status - Combo 2	66.2	67.1	66.9	62.3	70.6	73.5	62.2	68.6	67.9	63.5	68.3	68.3	75.8	85.4
Childhood Immunization Status - Combo 3	60.9	62.5	63.6	56.0	63.8	66.2	55.1	62.0	62.0	57.1	62.4	63.3	72.1	83.1
Chlamydia Screening in Women - Total	40.7	43.2	43.9	43.2	33.7	43.0	36.6	37.3	40.4	39.1	38.9	42.1	56.9	68.8
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	50.0	^	^	14.3	^	^	42.9	^	^	39.2	^	^	41.2	54.1
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	100.0	^	^	^	^	^	57.1	^	^	^	^	^	81.5	88.8
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	30.2	34.9	30.4	44.1	42.1	41.2	42.9	44.7	36.0	39.7	41.2	34.9	37.8	50.6
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	51.0	61.8	58.6	67.6	74.5	68.2	68.3	71.2	61.6	63.5	68.8	61.6	58.8	74.6
Comprehensive Diabetes Care - Eye Exams	25.3	34.9	34.2	39.3	34.5	33.8	30.2	31.0	25.8	30.6	32.8	29.9	53.2	67.6
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	21.0	26.9	27.4	33.3	^	^	30.8	^	^	28.8	26.9	27.4	34.0	43.2

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	MHT Weighted Average (MY 2012) - %	National Medicaid Average HEDIS 2013 - %	National Medicaid 90th Percentile HEDIS 2013 - %
	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %					
Comprehensive Diabetes Care - HbA1c Control (<8%)	29.7	36.5	37.9	44.8	47.6	45.3	43.5	42.1	37.0	40.1	41.3	38.6	46.5	58.4
Comprehensive Diabetes Care - HbA1c Testing	74.3	75.1	70.5	80.7	77.9	83.1	76.8	77.5	72.8	76.9	76.8	73.6	82.9	91.0
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	17.3	23.2	27.0	28.3	28.3	33.8	27.0	30.2	26.8	24.7	27.7	27.9	33.9	43.8
Comprehensive Diabetes Care - LDL-C Screening	58.4	61.8	59.9	70.3	67.6	71.0	64.4	64.6	61.6	64.0	64.2	62.4	75.4	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	67.3	67.6	59.9	72.4	66.2	68.9	63.2	59.3	52.1	66.0	63.1	57.3	78.4	85.9
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	60.4	54.8	51.4	47.6	40.0	43.9	47.6	47.6	53.8	51.0	48.5	51.4	44.8	31.1
Controlling High Blood Pressure	50.0	56.9	55.4	63.8	77.9	63.1	66.4	67.4	52.7	61.0	64.7	54.9	56.1	69.4
Human Papillomavirus Vaccine for Female Adolescents	^	22.0	17.2	^	20.7	24.8	^	9.8	10.5	^	15.7	15.3	--	--
Immunizations for Adolescents - Combination 1	42.1	49.8	64.0	41.1	45.5	60.1	37.2	41.9	68.4	39.5	45.0	65.5	67.2	85.6
Lead Screening in Children	55.2	53.6	58.5	49.8	54.5	53.8	56.2	56.5	56.9	54.8	55.1	57.1	67.4	87.0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile Use of Imaging Studies for Low Back Pain	67.3	67.1	68.8	65.6	69.2	76.5	71.9	69.7	69.7	69.3	68.8	70.4	75.6	82.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents - BMI percentile	24.3	22.7	44.4	1.1	1.4	35.3	14.1	21.4	33.8	14.1	18.1	37.3	51.9	80.2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	44.4	45.4	47.2	0.5	1.2	51.8	34.6	32.4	44.3	30.0	30.5	46.4	55.1	75.2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	40.5	39.8	33.6	0.5	1.1	20.9	19.5	16.3	21.7	21.2	20.4	25.2	44.3	64.7

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2013 (MY 2012)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Table A6-2 Access to Care Domain Measures

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	MHT Weighted Average (MY 2012) - %	National Medicaid Average HEDIS 2013 - %	National Medicaid 90th Percentile HEDIS 2013 – %
	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %					
Adults' Access to Preventive/Ambulatory Health Services (20-44)	85.9	84.6	83.3	88.2	89.4	87.0	88.1	87.6	85.3	87.4	86.9	84.9	80.2	88.3
Adults' Access to Preventive/Ambulatory Health Services (45-64)	81.7	87.6	82.7	90.6	89.2	87.8	86.5	85.9	87.8	85.9	87.0	86.0	86.5	91.2
Adults' Access to Preventive/Ambulatory Health Services (Total)	85.5	84.9	83.3	88.4	89.4	87.1	87.9	87.5	85.6	87.2	86.9	85.0	82.5	89.0
Call Abandonment (lower rate is better)	1.7	1.9	^	1.9	1.9	^	4.4	5.3	^	2.2	2.5	^	--	--
Call Answer Timeliness	82.8	81.7	79.7	96.7	96.2	94.8	79.3	81.0	64.9	84.1	83.5	78.4	83.9	94.7
Children and Adolescents' Access To PCP (12-19 Yrs.)	86.0	87.5	90.1	92.0	91.6	92.1	90.7	91.7	93.2	89.8	90.4	92.0	88.3	93.7
Children and Adolescents' Access To PCP (12-24 Months)	97.3	97.2	96.9	97.8	98.2	98.0	97.3	97.3	98.1	97.4	97.4	97.6	96.0	98.5
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	88.1	89.6	89.9	91.2	91.8	91.0	89.1	91.6	92.0	89.2	91.0	91.1	88.3	93.6
Children and Adolescents' Access To PCP (7-11 Yrs.)	90.3	90.6	91.6	93.9	92.9	93.3	93.2	94.3	94.6	92.6	92.9	93.5	89.8	95.2
Prenatal and Postpartum Care - Postpartum Care	61.0	60.7	59.7	65.7	66.4	69.3	64.6	65.0	65.7	63.4	63.7	63.9	63.1	73.8
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.9	94.0	94.9	95.6	93.7	94.4	94.2	92.9	93.4	94.5	93.4	94.1	82.9	92.8

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2013 (MY 2012)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Table A6-3 Utilization and Relative Resource Use Domain

Measure	CoventryCares, Inc.			The Health Plan			UniCare			MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	MHT Weighted Average (MY 2012) - %	National Medicaid Average HEDIS 2013 – %	National Medicaid 90th Percentile HEDIS 2013 – %
	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2013 - %					
Adolescent Well-Care Visits	44.0	42.1	46.6	38.4	41.4	44.9	41.4	35.5	45.3	41.6	38.7	45.6	49.6	65.5
Frequency of Ongoing Prenatal Care (≥ 81%)	79.4	83.1	82.9	79.6	83.2	84.7	67.6	70.9	71.1	73.9	77.1	77.7	60.5	80.1
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.1	67.6	72.5	60.9	63.9	67.5	66.1	68.2	64.2	65.5	67.3	67.5	71.9	82.1
Well-Child Visits in the first 15 Months of Life (6 or more visits)	69.0	71.1	71.9	60.4	64.9	68.6	64.2	67.6	67.8	65.2	68.6	69.4	63.6	77.4

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2013 (MY 2012)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Appendix 7 - Status of Recommendations from the MY 2011 Review

Delmarva provided recommendations to all three MCOs in the 2011 review for the 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 MY 2012 to address recommendations. Summaries are presented below by MCO and activity.

CoventryCares SPR

CoventryCares: MY 2011 SPR Recommendations and MY 2012 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 Member Handbook state how members will be informed of any changes in benefits.
	Status • The MCO used the same Member Handbook in MY 2011 and MY 2012. Therefore, this recommendation was not addressed.
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 • This recommendation was made in MY 2011. Policies were reviewed and approved in 2011, but this revision was not made. Therefore, this recommendation is made again for MY 2012.
Quality Assessment and Performance Improvement	**Recommendations** • Ensure that the various quality committees are meeting at least as frequently as required in QI program documents. Minutes must document the quality related activities (findings, recommendations, actions taken), and information must be communicated through the appropriate channels/departments. Documentation must be in place to ensure that communication is timely and ultimately reaches the governing body. • Increase governing body meeting frequency to allow for an increase in guidance, and oversight of QI related activities. Minutes must demonstrate that the governing body routinely receives and reviews written reports from the QIP. • Complete the annual quality evaluation, work plans and QIP description in a timely manner. Ensure that these documents are also reviewed and approved by the governing body in a reasonable timeframe. • Identify specific, measurable goals/objectives in the Quality and Utilization Management Work Plans. • The 24/7 PCP access survey yielded a 72.2% compliance rate. CoventryCares should provide evidence of follow-up for non-compliant PCPs and documentation of any other efforts employed to improve the overall survey compliance rate to a minimum of 90%.

CoventryCares: MY 2011 SPR Recommendations and MY 2012 Current Status	
	• Assess compliance with contractual appointment access standards. It is recommended that the MCO conduct a survey to determine compliance rather than attempting to use CAHPS survey results and complaint data which do not address the specific access standards for the different appointment types (prenatal, urgent care, routine etc.). • CoventryCares must provide evidence of corrective action for providers that are non-compliant with the 24/7 PCP access standard and appointment access standards. • CoventryCares must identify measureable goals and objectives for the activities identified in their work plans. It is difficult to measure success without such measures.
	Status • The MCO was required to develop and implement a CAP to address all of the outstanding QA concerns listed above. CoventryCares provided the requested CAP which was approved by Delmarva. CoventryCares provided quarterly updates which were reviewed by Delmarva to ensure that the MCO was taking the necessary steps to remedy the issues identified in the MY 2011 review. The MY 2012 on-site review conducted in March 2013 demonstrated that the MCO had taken Delmarva's recommendations and completed the CAP. The result is a 100% compliance rate for QA in MY 2012.
Fraud and Abuse	**Recommendation** • As in MY 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 MY 2011 and MY 2012. Therefore this recommendation is made again for MY 2012.

CoventryCares – PIP

CoventryCares: MY 2011 PIP Recommendations and MY 2012 Current Status	
Adolescent Well-Care Visits	**Recommendation** • The study question should be revised to identify only one numeric goal of study aim or provide time frames for short and long term goals.
	Status • The MCO clarified its goals. The short term goal is to improve the indicator rate 5 percentage points over the prior year's measurement. The long term goal – the goal the MCO hopes to achieve by the end of the project is to meet or exceed the NCQA 90th Percentile. This clarification aids in providing direction for the project aim.
Decreasing ED Utilization	**Recommendations** • CoventryCares provided an improved analysis, but could still further enhance its quantitative analysis by providing comparisons to goals and benchmarks and not just stating whether the goal was met or not. • Eliminate the new indicator which measures ED visits for PIHN members against all Medicaid members. The indicator that measures ED visits for PIHN members against all PIHN Medicaid members more appropriately assesses the effectiveness of the PIHN initiative.

CoventryCares: MY 2011 PIP Recommendations and MY 2012 Current Status	
	Status • The qualitative and quantitative analyses were more comprehensive. Comparisons were made to previous measurements, goals and benchmarks. • Statistical testing was completed. • Project success and intervention effectiveness were discussed. • CoventryCares chose to delete the indicator that measured PIHN ED visits using the entire population as a denominator as recommended. • The MCO has closed this project. It will be replaced with the ED Asthma Project mandated by BMS.

CoventryCares -PMV

CoventryCares: MY 2011 PMV Recommendations and MY 2012 Progress
Recommendations • Due to issues and challenges identified in obtaining data from the West Virginia Statewide Immunization Information System (WVSIIS), CoventryCares was unable to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011. It is recommended that the MCOs work with BMS and the WVSIIS to obtain reasonable access to the data. • While CoventryCares exhibited a well-coordinated HEDIS reporting process, efficiencies may be gained by equipping nurse reviewers with portable technology such as laptops for medical record abstraction. CoventryCares is encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. The new MRRV process categorizes hybrid measures into like-measure groups for validation, reviews exclusions, applies a more stringent statistical test to the process and defines MRR milestones more clearly to ensure consistency among plans. The new process uses a zero-based sampling plan and no acceptance of errors.
Status • All the MCOs continue to have limited access to the WVSIIS where they can only review individual records one at a time. Any other form of access has yet to be granted by the State to the WVSIIS. • Paper abstraction tools are preferred due to the remoteness of some rural and mountainous areas where internet access is limited or not available. The quality staff continues to assess the needs for medical abstractors from year to year. • CoventryCares successfully implemented the new NCQA Medical Record Review Validation process and met all timelines.

The Health Plan - SPR

The Health Plan: MY 2011 SPR Recommendations and MY 2012 Status	
Enrollee Rights	**Recommendations** • Clearly state in the Member Handbook that enrollees have the option to have benefits continue during the time the enrollee requests a State Fair Hearing. This information is provided in the notice of action to the enrollee, but it would be helpful to have this information in the Member Handbook. • The Health Plan informs enrollees regarding the time frames for filing a grievance/appeal via the Member Handbook. It is recommended that this information be included in the appeals/grievances information on the website.

The Health Plan: MY 2011 SPR Recommendations and MY 2012 Status	
	Status • The same Member Handbook was used in MY 2011 and MY 2012. Therefore the recommendation to include the option for enrollees to have benefits continues during the State Fair Hearing process is made again in MY 2012. • The MCO's website for members includes an Appeals Procedures link which takes members to the appeals process on the website.
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 MY 2012 revision.
	Status • The Member Handbook was not updated for MY 2012 to include this information. This recommendation is made again for MY 2012.
Quality Assessment and Performance Improvement	**Recommendations** • Continue efforts to improve compliance with the 24/7 PCP access standard. The compliance rate for returning calls within one hour decreased from MY 2011 to MY 2012. • As part of its credentialing and recredentialing procedures, the MCO must query the Excluded Provider List System (EPLS) database. • Ensure that the Quality Management program documents are approved by committees and the governing body in the correct sequence. In the past two review periods, the Board of Directors approved the program documents prior to approval of the Executive Management Team. • Include the minimum compliance requirement (90%) for physician inter-rater reliability (degree of agreement) in its Physician Inter-rater Review Policy. As written, the policy applies only to case managers and nurses. • 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. • 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.
	Status • The MCO met the 24/7 access standard with a compliance rate of 90% for MY 2012. • The MCO did not begin querying the EPLS/SAM data base as required. This recommendation is made again for MY 2012. • The Health Plan followed the appropriate sequence for document approval in MY 2012. • The Physician Interrater Review Policy was updated and now includes a required compliance rate of 90%. • The MCO did not revise the Timeliness of Utilization Management and Behavioral Health Decision Policy to include the statement 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. This recommendation is made again for the MY 2012 review. • There are several case management type policies that include measures and specific monitoring processes (e.g. Case Monitoring and Case Assessment policies).

The Health Plan: MY 2011 SPR Recommendations and MY 2012 Status	
Fraud and Abuse	**Recommendations** • Implement a process to record and track employee completion of annual compliance training requirements. Attendance logs are maintained for sessions, but not recorded for each individual employee upon successful completion. • Provide results/documentation of internal monitoring and auditing efforts as described in policies and procedures. • The Health Plan has developed a process to verify that services provided were actually received. The MCO should implement this process as planned.
	Status • The Fraud and Abuse program has been re-organized which includes new staff. A process was not developed to record and track employee completion of annual compliance training requirements. • There was no evidence provided of internal monitoring and auditing efforts. • The MCO implemented the process to verify that services provided were actually received. The Health Plan provided a "BMS No Visit Report" submitted by Customer Service. The report includes member name, service date on claim, claim type, claim number, provider number, and the date Customer Service conducted the survey with the enrollee to determine if the service on the claim was actually rendered.

The Health Plan – PIP

The Health Plan: MY 2011 PIP Recommendations and MY 2012 Progress	
Childhood Obesity	**Recommendations** • The MCO should enhance its quantitative analysis. Specific indicator performance should include comparisons to previous measurements and include a comparison to each respective goal. • Continue implementation of system level interventions. • Consider a hybrid review for the next annual assessment, or at least review a small sample of records to determine if providers are providing obesity-related services/counseling. This would provide additional insight on the magnitude of the coding issue with providers. The MCO can determine if services are being provided and just not being coded. • If feasible, consider implementing a financial incentive for providers who appropriately document BMI.
	Status • The MCO did not provide a comparison to all previous measurements. Due to a change in data collection methodologies (hybrid methodology used in 2008 and 2012, administrative methodology used 2009-2011), the MY 2012 rate can only be compared to the baseline rate as both used the hybrid data collection methodology. • The MCO continued the system-level interventions. • Hybrid review was conducted for MY 2012. • As of Spring 2012, there was renewed interest in potential reimbursement for providers documenting BMI and BMI percentile codes. If the MCO chooses to implement this incentive, it will only be implemented in 2013.
Emergency Room Utilization Diversion	**Recommendations** • There remains an opportunity to enhance the quantitative portion of the analysis. The Health Plan should explicitly state what the indicator goals are and make

The Health Plan: MY 2011 PIP Recommendations and MY 2012 Progress	
	numeric comparisons to them. • Clearly state barriers in the interventions table. Barriers should be identified in the analysis, as well as in the interventions table.
	Status • Quantitative analysis included a comparison to project goal (5% annual reduction). Statistical tests were included to assess whether or not improvement was real improvement. • Barriers were included in the interventions table, but were not included in the final analysis. • The MCO has closed this project. It will be replaced with the ED Asthma Project mandated by BMS.

The Health Plan – PMV

The Health Plan: MY 2011 PMV Recommendations and MY 2012 Progress
Recommendations: • The Health Plan was the only MCO successful in obtaining access to the WV Immunization Registry for HEDIS 2011, but it was not without challenges. Due to persistent issues and challenges identified in obtaining data from the WVSIIS over the last two years, it is recommended that the MCOs work with BMS and the WVIIS to obtain/maintain reasonable access to the data. • The Health Plan is encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. The new MRRV process categorizes hybrid measures into like-measure groups for validation, reviews exclusions, applies a more stringent statistical test to the process and defines MRR milestones more clearly to ensure consistency among plans. The new process uses a zero-based sampling plan and no acceptance of errors. • The audit team recommended that the organization pursue opportunities to obtain BMI and blood pressure results from participating hospitals and provider groups to supplement additional measures and indicators and reduce medical record review burden.
Status: • All the MCOs continue to have limited access to the WVSIIS where they can only review individual records one at a time. Any other form of access has yet to be granted by the State to the WVSIIS. • The Health Plan successfully implemented the new NCQA Medical Record Review Validation process and met all timelines. • The Health Plan gages 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 data collection burden.

UniCare – SPR

UniCare: MY 2011 Recommendations and MY 2012 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.

UniCare: MY 2011 Recommendations and MY 2012 Status	
	Status • Not Applicable
Quality Assessment and Performance Improvement	**Recommendations** • Increase the internal minimum compliance rating for medical record documentation standards from 80% to 90%. The current standard is too low. • The timeliness of scheduling appointments appears to be an ongoing issue, specifically with non-urgent /sick and prenatal appointments. UniCare's internal prenatal appointment standard of 7 days is much more stringent than the contractual standard of 14 days. It is recommended that the MCO assess its compliance rate with the contractual standard in addition to its internal standard. UniCare should also conduct a barrier analysis and develop methods to effectively address this issue. • Access to PCPs 24/7 also appears to be an ongoing issue. UniCare's 2012 survey of 918 PCPs yielded a 66% compliance rate- a 4% decrease in compliance from 2011. For the noncompliant PCPs the most common issue was non-compliance with instructions for non-emergency care on answering machine messages. UniCare notifies noncompliant providers via mail, telephone, or in person. Corrective actions are required in some cases. UniCare should increase its provider education efforts in this area to improve compliance with this contractual standard. • UniCare notifies enrollees that preventive health screenings (pap smears and mammograms) are available. However, the eligible ages are not clearly stated. UniCare should clearly document the age requirements for such screenings. This can be communicated in the Member Handbook and enrollee newsletter. • UniCare provides coverage of colorectal cancer screening, as referenced in its Well Woman Reminder Program Policy. However, it is not evident that this screening is addressed in the member handbook or the annual newsletter. UniCare must clearly communicate the availability of this screening to members. This can be communicated in the Member Handbook and enrollee newsletter.
	Status • UniCare chose not to take the recommendation to increase the internal minimum compliance rating for medical record documentation standards from 80% to 90%. • In response the appointment access findings UniCare conducted provider education. Remeasurement showed some improvement. In response to the MY 2012 findings, UniCare is making a more concerted effort to improve the access compliance rates that are deficient in MY 2012 (routine care within 21 days and 24/7 access by PCPs) by contacting individual providers and providing in-office education. The MCO will resurvey the non-compliant members in the third quarter of 2013. Corrective actions will be implemented where necessary. • UniCare has met the access standards for preventive health screenings. • Members are made aware of the availability of colorectal cancer screening as required by the standards.
Fraud and Abuse	**Recommendation** • This standard received a 100% compliance rating. There were no recommendations for improvement.
	Actions • Not applicable.

UniCare – PIP

UniCare: MY 2011PIP Recommendations and MY 2012 Status	
Reducing Inappropriate ER Utilization	**Recommendations** • Clearly state goals for indicators. • Distribute newly created brochures educating members on the proper use of the ER as soon as possible • Develop and implement new, robust interventions or refocus the project.
	Status • Goals for indicator rates were clarified. • New brochures were distributed. The MCO followed-up with providers to ensure sites had an adequate amount of copies throughout the project period. • No additional interventions were developed nor did the MCO change its focus. • The MCO closed this project per Delmarva's recommendation. This PIP is being replaced by the ED Asthma project mandated by BMS.

UniCare - PMV

UniCare: MY 2011 PMV Recommendations and MY 2012 Progress
Recommendations • Due to issues and challenges identified in obtaining data from the West Virginia Statewide Immunization Information System (WVSIIS), UniCare was unable to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011. It is recommended that the MCOs work with BMS and the WVSIIS to obtain reasonable access to the data. • For HEDIS 2011, the MCO created two separate hybrid samples for Childhood Immunization Status and Lead Screening in Children. The audit team informed the MCO that NQCA specifications allow the MCO to use the same sample for both of these measures. Also NCQA allows both sample sizes to be reduced if the reduction policy is applied. The MCO will consider using one sample for these two measures for HEDIS 2013 reporting to reduce the medical record collection burden on the MCO. • UniCare is encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. The new MRRV process categorizes hybrid measures into like-measure groups for validation, reviews exclusions, applies a more stringent statistical test to the process and defines MRR milestones more clearly to ensure consistency among plans. The new process uses a zero-based sampling plan and no acceptance of errors.
Status • All the MCOs continue to have limited access to the WVSIIS where they can only review individual records one at a time. Any other form of access has yet to be granted by the State to the WVSIIS. • The MCO's HEDIS Roadmap indicates this recommendation was successfully applied for HEDIS 2013. • UniCare successfully implemented the new NCQA Medical Record Review Validation process and met all timelines.

MHT Recommendations

MHT: MY 2011 Recommendations and MY 2012 Progress
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

MHT: MY 2011 Recommendations and MY 2012 Progress
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 • 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 continues its efforts to get MCOs reasonable access to the WVIIS. Although the MCOs continue to query the database one record at a time for their HEDIS data collection, the immunization rates for all measures collected continue to improve.

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 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 in Table A8-1 is the *Medical Assistance With Smoking and Tobacco Use Cessation* measure. 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. This measure along with the rating and composite scores in Table A8-1 provide a comprehensive picture of the consumer's experience with their health care and their provider.

The MHT MCOs conducted the 2013 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, ratings, and one HEDIS measure (*Medical Assistance With Smoking and Tobacco Use Cessation*). Table A8-1 provides the summary results for the MHT MCOs, the MHT Average, and national benchmarks for HEDIS 2013 (MY 2012).

Table A8-1. Adult and Child CAHPS Measure Results HEDIS 2013 (MY 2012)

Measure	CoventryCares HEDIS 2013 (MY 2012) %	The Health Plan HEDIS 2013 (MY 2012) %	UniCare HEDIS 2013 (MY 2012) %	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Adult Measures						
Customer Service Composite	92.7	88.6	NA	90.6	86.2	89.5
Getting Needed Care Composite	82.6	85.2	78.9	82.2	80.6	85.4
Getting Care Quickly Composite	83.9	85.1	82.0	83.7	81.2	85.4

Measure	CoventryCares HEDIS 2013 (MY 2012) %	The Health Plan HEDIS 2013 (MY 2012) %	UniCare HEDIS 2013 (MY 2012) %	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
How Well Doctors Communicate Composite	92.0	88.9	90.4	90.4	89.3	92.6
Shared Decision Making Composite	75.8	71.8	NA	73.8	NA	NA
Rating of Health Plan	66.0	78.1	73.9	72.7	73.5	81.3
Rating of All Health Care	75.3	72.9	70.6	72.9	70.8	76.3
Rating of Personal Doctor	79.7	76.8	77.3	77.9	78.4	82.9
Rating of Specialist Seen Most Often	73.9	79.6	NA	76.7	79.4	84.4
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)- Advising Smokers and Tobacco Users to Quit Advised to	74.5	75.2	69.2	72.9	75.6	81.3
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)- Discussing Cessation Medications	40.2	42.3	34.3	38.9	45.8	57.5
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)- Discussing Cessation Strategies	39.4	42.2	32.8	38.1	41.1	50.7
Child General Population Measures						
Child Survey - General Population: Customer Service Composite	93.5	93.9	90.6	92.7	87.6	91.2
Child Survey - General Population: Getting Needed Care Composite	94.1	93.2	88.3	91.8	84.4	90.4
Child Survey - General Population: Getting Care Quickly Composite	94.7	95.5	95.7	95.3	89.2	94.2
Child Survey - General Population: How Well Doctors Communicate Composite	93.3	94.8	93.4	93.8	92.6	95.4
Child Survey - General Population: Shared Decision Making	69.7	80.1	52.1	67.3	NA	NA
Child Survey - General Population: Rating of Health Plan	85.3	89.7	84.8	86.6	82.9	88.9

Measure	CoventryCares HEDIS 2013 (MY 2012) %	The Health Plan HEDIS 2013 (MY 2012) %	UniCare HEDIS 2013 (MY 2012) %	MHT Average HEDIS 2013 (MY 2012) %	National Medicaid Average HEDIS 2013 (MY 2012) %	National Medicaid 90th Percentile HEDIS 2013 (MY 2012) %
Child Survey - General Population: Rating of All Health Care	85.0	85.3	81.6	84.0	83.1	87.0
Child Survey - General Population: Rating of Personal Doctor	87.0	88.1	86.7	87.3	87.1	90.2
Child Survey - General Population: Rating of Specialist Seen Most Often	91.3	80.9	81.9	84.7	84.5	89.5

⌘ CAHPS percentiles and mean rates are from NCQA Quality Compass 2013 (MY 2012)
NA indicates that denominator was too small to report a rate or that a comparative benchmark is not available