delmarva foundation

EXTERNAL QUALITY REVIEW ORGANIZATION

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

Annual Technical Report for Calendar Year 2010

Calendar Year 2010

Submitted by
Delmarva Foundation
February 2012

Table of Contents

Mountain Health Trust Annual Technical Report CY 2010

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 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 calendar year (CY) 2010, there were approximately 162,000 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: Carelink Health Plan, Inc. (Carelink), The Health Plan of the Upper Ohio Valley (The Health Plan), and UniCare Health Plan of West Virginia, Inc. (UHP).

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*, revised April 14, 2010)

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)

The CY 2010 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 CY 2010. 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 protocols. Conclusions and recommendations are then provided for both the individual MCOs and the MHT program.

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. 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 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" *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).

- **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." (*2006 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

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 and interviews with MCO staff. Combined, these methods of data collection provide an accurate depiction of an organization's compliance with regulatory provisions.

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

SPR criteria, known as 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 (components and elements) 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 CY 2010 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.

The CY 2010 SPR was a comprehensive review, as it included a review of *all* compliance standards including the Fraud and Abuse standards. Although this was the second year for review of the Fraud and Abuse standards, it was the first year the standards were rated.

The individual MCO SPR results will be presented in the SPR section of this report with a compliance rating for each standard (ER, GS, QA, and FA). In addition to overall results, MCO performance on components related to quality, access, or timeliness are discussed in the SPR section where deficiencies have been identified. Components of the standards that relate to quality, access, or timeliness will be discussed in the Summary of Quality, Access and Timeliness section of this report.

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. According to BMS requirements, MCOs must achieve meaningful improvement in two focus areas during the PIP remeasurement phase.

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

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

Delmarva's role is to validate MCO performance measures and is accomplished by:

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

Validated measures support and promote accountability in managed care. BMS requires the submission of all Medicaid HEDIS measures with the exclusion of measures that are based on carve out services such as behavioral health, pharmacy, and dental. Measures must be calculated according to specifications outlined in NCQA's *HEDIS 2011, Volume 2: Technical Specifications*. The results of the HEDIS 2011 performance measure activities are highlighted in this report for those that address quality, access, or timeliness of care. The rates for all HEDIS 2011 measures collected by the MCOs are found in Appendix 1.

MHT MCO Findings

Systems Performance Review

The CY 2010 SPR compliance rates for all three MHT MCOs are presented in Table 1.

Table 1. MCO SPR Compliance Rates for CY 2010

SPR Standard	CY 2010 Compliance Rate		
	Carelink	The Health Plan	UniCare
Enrollee Rights (ER)	100%	100%	100%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	99%	99%	98%
Fraud and Abuse (FA)	100%	96%	100%

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

This is the first year that a compliance rating is reported for the Fraud and Abuse standard. A baseline review of the FA standard was completed in CY 2009. Following this review, Delmarva provided each MCO with a baseline compliance rate and recommendations for improvement if any deficiencies were noted.
For CY 2010, all MCOs met the BMS established threshold of 90% compliance for the four standards. Therefore, no internal corrective action plans were requested by Delmarva as a part of the Systems Performance Review. Individual MCO SPR compliance rates for CY 2008-2010 are provided in Tables 2, 3 and 4 for trending purposes. Compliance rates for the MCOs are summarized below.

Carelink Health Plan, Inc.

Carelink's SPR results for CY 2008-CY 2010 are presented in Table 2.

Table 2. Carelink SPR Results (CY 2008 – CY 2010)

Standard	Carelink Compliance Rate		
	CY 2008	CY 2009	CY 2010
Enrollee Rights	86%	99%	100%
Grievance Systems	99%	100%	100%
Quality Assessment and Performance Improvement	97%	98%	99%
Fraud and Abuse	N/A	N/A	100%

Carelink's SPR results improved for the Enrollee Rights, Grievance Systems, and Quality Assessment and Performance Improvement standards from CY 2008 to CY 2010. Carelink performed well for the CY 2010 review, achieving compliance rates ranging from 99% to 100%. Trending of results shows that the:

- Enrollee Rights Standard compliance rate improved significantly from CY 2008. In 2008, a compliance rate of 86% was achieved, followed by 99%, and finally 100% in the CY 2010 review.
- Grievance Systems Standard compliance rate improved from its CY 2008 rate of 98%. In CY 2009, Carelink achieved 100% and this compliance rate was maintained for the CY 2010 review.
- Quality Assessment and Performance Improvement Standard compliance rate steadily improved since the CY 2008 review, achieving 97%, 98%, and 99%, consecutively.
- Fraud and Abuse Standard received a baseline assessment in the CY 2009 review; however, the results were not publicly reported. Carelink implemented Delmarva's recommendations from the baseline assessment and achieved a commendable 100% for the first reportable review in CY 2010.

Carelink uses GeoAccess software to monitor provider access to its internal access standards. The MCO's Availability Analysis for 2010 indicated overall compliance rates of 99% - 100% for participating providers within 30 minutes of enrollees. Additional internal standards, where Carelink identified issues are:

- PCP/Pediatrician: Urban, 30 miles/45 minutes; rural, 45 miles/60 minutes
- OB/GYN, all other specialists and hospitals: Urban, 30 miles/45 minutes; rural, 60 miles/90 minutes.

Scores for high volume specialists ranged from 85.1% - 99.8%. Hematology/Oncology dropped from 93.5% in 2009 to 85.1% in 2010. Cardiology and Dermatology also present opportunities for improvement, scoring 86.3% and 88.5%, respectively. Although Carelink is in compliance with the West Virginia MCO program access requirements based on the BMS annual review, it is recommended that the MCO consider recruiting additional specialists to meet its internal standards.

The Health Plan of the Upper Ohio Valley

The Health Plan of the Upper Ohio Valley's SPR results for CY 2008-CY 2010 are presented in Table 3.

Table 3. The Health Plan of the Upper Ohio Valley SPR Results (CY 2008 – CY 2010)

Standard	The Health Plan Compliance Rate		
	CY 2008	CY 2009	CY 2010
Enrollee Rights	97%	99%	100%
Grievance Systems	99%	99%	100%
Quality Assessment and Performance Improvement	100%	100%	99%
Fraud and Abuse	N/A	N/A	96%

The Health Plan's SPR results improved for the Enrollee Rights and Grievance standards from CY 2008 to CY 2010. The QA standard remains relatively constant with remarkable rates of 99% to 100%. The MCO performed well for the CY 2010 review, achieving compliance rates ranging from 96% to 100%.

THP identified an access issue when monitoring the 24/7 access to PCP standard. THP conducted its Annual After-Hours Accessibility Survey in the fourth quarter of 2010. The 2010 After Hours PCP Accessibility Report included the results of 24 offices being called after hours. Only 16 offices (66.7%) returned the call within an hour. Only 3 (12.5%) of the provider offices not responding had appropriate recorded messages that informed enrollees how to obtain after-hours assistance. As part of the QI process, the following interventions were implemented:

- Individualized letters were written to eight (8) physician offices outlining the reasons for non-compliance with after-hours access.
- Corrective action was required for the non-compliant offices with follow-up in the first quarter of 2011.
- Follow-up after-hours calls were scheduled to be made to these offices in the 1st quarter 2011.
- Occurrences were to be entered into their respective provider files for use during recredentialing reviews.

After the Fraud and Abuse review in CY 2009, Delmarva provided The Health Plan with several recommendations to assist in achieving the 90% threshold for the CY 2010 review. The Health Plan used the recommendations and enhanced its fraud and abuse detection and compliance programs to meet many of the standards that were deficient in the first review. Specifically, the MCO developed comprehensive plans, workflows, and flowcharts. In addition, staff education programs were enhanced and activities were documented.

Trending of results shows that the:

- Enrollee Rights Standard compliance rate has steadily improved since the CY 2008 SPR, achieving 97%, 99%, and 100% for CY 2010.
- Grievance Systems Standard achieved a compliance rate of 100% after two consecutive years of 99% compliance.
- Quality Assessment and Performance Improvement Standard compliance dipped slightly from CY 2009 to CY 2010. The Health Plan's compliance rate fell from 100% to 99%.

UniCare Health Plan, Inc.

UniCare's results for CY 2008-CY 2010 are presented in Table 4.

Table 4. UniCare SPR Results (CY 2008 – CY 2010)

Standard	UniCare Compliance Rate		
	CY 2008	CY 2009	CY 2010
Enrollee Rights	97%	88%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	98%	97%	98%
Fraud and Abuse	N/A	N/A	100%

UniCare performed well for the CY 2010 review, achieving compliance rates ranging from 98% to 100%. UniCare's SPR results remained constant for the Grievance System standard at a remarkable 100%. It is notable that UniCare received a 100% compliance rate for the Fraud and Abuse standard in the first year of public reporting.

Trending of results shows that the:

- The Enrollee Rights Standard compliance rate improved significantly from the CY 2009 SPR. The CY 2010 review demonstrates full compliance for this standard.
- The Grievance Systems Standard has maintained its 100% compliance rate for the last three review periods.

- The Quality Assessment and Performance Improvement Standard compliance rate has remained relatively consistent, demonstrating a slight improvement from 97% for CY 2009 to 98% for CY 2010.

In the CY 2009 review, UniCare's Enrollee Rights standard compliance rate of 88% fell below the 90% threshold established by BMS. Delmarva required the MCO to complete an internal corrective action plan (CAP) to address all elements that were not fully met in the ER standard. UniCare developed and implemented a CAP and addressed the deficiencies prior to the release of the CY 2009 final SPR report by developing and implementing a new member notification policy. As a result of the CAP, UniCare achieved a compliance rate of 100% for the Enrollee Rights standard in CY 2010.

Through monitoring its access standards, UniCare identified an access issue in CY 2010. The MCO's GeoAccess Report indicated that only 40% of counties met the threshold for high volume specialist availability. An inadequate number of Allergy/Immunology specialists was noted for over half of the counties in UniCare's service area. UniCare met the program's network access standards during the BMS annual review. As a result, it is noted that UniCare is in compliance with West Virginia's requirements, but it is recommended that the MCO should recruit additional specialists to meet its internal standards.

UniCare did not achieve its goal (95%) for meeting appointment scheduling timeliness standards in CY 2010. Overall, appointment wait time achieved an 81% score, the same score achieved in 2009. Results by appointment type were; urgent care appointment within 48 hours was 96%, non-urgent/sick appointment within 72 hours was 63%, and routine physical within 90 days was 99%. All remained the same or showed improvement when compared to 2009 results. Prenatal appointment within 7 days showed a dramatic drop (67%) when compared to 90% in 2009. It is noted that UniCare's internal standard for prenatal appointment is 7 days whereas the contractual standard is within 14 days.

Performance Improvement Project Validation

In addition to the BMS mandated Emergency Department (ED) PIP, the MHT MCOs have been working on a variety of PIP topics including childhood immunizations, childhood obesity, and asthma. PIP validation summaries, findings and recommendations are provided below.

Carelink Health Plan, Inc.

PIP Summary: Improving Compliance with Childhood Immunizations	
Rationale	• Carelink's population is predominately children, with almost 83% of members under 19 years of age. The federal government has established a goal that requires 90% of all children 19 to 35 months of age be fully immunized. State-level data for West Virginia indicates that the immunization gap for children ages 19 to 35 months without all immunizations is 31% as compared to 23% nationally, ranking the state with the 5th

PIP Summary: Improving Compliance with Childhood Immunizations	
	largest gap. Carelink HEDIS Childhood Immunization rates remain below the national Medicaid HEDIS averages.
Indicators and Goals	• Childhood Immunization Status—Combination 3 (the percentage of children 2 years of age who had 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hep B, 1 Chickenpox (VZV) and 4 Pneumococcal Conjugate (PCV) vaccines by their second birthday), Goal: National HEDIS Medicaid Average
Strengths	• Demonstrated sustained improvement and statistically significant improvement over baseline • Enhanced qualitative analysis
Barriers	• Member knowledge deficit (understanding the importance/impact of vaccinations) • Transportation • Continued access problems with the WV Immunization Registry (delays and technical feed issues) • Many children have been vaccinated, but the vaccine dates were outside of the HEDIS technical specifications (several days past their second birthday).
Interventions	• Utilization of a WV immunization module to track children not current with immunizations (developed by Cabin Creek Health Systems), this has been an ongoing intervention • Outreach by the Carelink Medicaid Outreach Team—45 visits were made during CY 2010 to community events, schools, and health fairs to provide education on immunizations • Added HEDIS component to the Navigator tracking system allowing customer service, case management, outreach, and quality improvement departments to identify non-compliant members and to add supplemental data information obtained from the providers when a wellness visit has happened.

PIP Results			
Indicator 1: Childhood Immunizations (Combo 3) by 2 years of age			
Time Period	Measurement	Goal	Rate or Results
CY 2006	Baseline		45.03%
CY 2007	Remeasurement 1	65.40%	53.86%
CY 2008	Remeasurement 2	67.52%	60.19%
CY 2009	Remeasurement 3	69.29%	54.40%
CY 2010	Remeasurement 4	69.29%	60.93%

Findings. Steps 1-10 were all *met* for Carelink. Significant and sustained improvement was achieved in the Childhood Immunization—Combo 3 indicator. The last annual measurement of 60.93% (remeasurement 4) increased by almost 16 percentage points when compared to the baseline measurement. Carelink improved its

quantitative analysis as recommended in the previous review, and thus provided a comprehensive assessment. The analysis included comparisons to baseline and the project goal, which were previously not included.

Recommendations. Carelink should continue to implement efforts to improve immunization compliance. After four remeasurement periods, Delmarva recommends closing this project. Carelink should identify and report on a new PIP topic based on MCO data analysis and opportunity for improvement.

PIP Summary: Decreasing Emergency Department Utilization	
Rationale	• The emergency department utilization PIP topic is mandated by BMS. Carelink noted, "It has been observed that one-third or more of all ER visits are classified by the triage nurse as non-emergent. There is also evidence which supports the finding that Medicaid members utilize emergency services more than their privately insured counterparts." • Carelink has experienced a significant increase in growth: 29,568 (12/31/07) to 53,421 (12/31/09). With this membership growth, the plan has experienced an increase in ER utilization claims. Ten of the counties serviced are considered very rural. Within these rural areas, generally, there are few primary care providers (PCPs) and health clinics. Interestingly, it was determined that only 16% of Carelink's members are 20-44 years of age; however, this age group accounted for 31% of all ED visits. One of Carelink's project measures is specifically targeting this age group and tracking their ED utilization.
Indicators and Goals	• ED Visits/1,000 Member Months for Medicaid Members (20-44 years of age), Goal: 2.5% Annual Improvement • ED Visits/1,000 Member Months for Medicaid Members (all ages), Goal: Regional HEDIS Medicaid Average
Strengths	• Strong case management initiatives in place to reduce inappropriate ED utilization
Barriers	• Limited access to same day appointments/provider availability (including after hours) • Member knowledge deficit/accountability for treatment of minor injuries/illnesses • Invalid member contact information hinders educational mailings/telephone calls • Note: Carelink has seen a significant increase in its membership over the last couple of years due to expansion and the current economic conditions. With this expansion of covered members, the plan has noted an increase in ER utilization claims, particularly in rural areas where there are a limited number of primary care providers and clinics.
Interventions	• Extended clinic hours are offered to improve accessibility. • Collaboration with Partners in Health, one of Carelink's High Performance Networks, to engage members in appropriate care and to decrease inappropriate ED utilization. Partners in Health is an organization that provides case management support, member call strategies, and resources for consumer self-care. • Case management activities include educating members on assigned PCPs, changing

PIP Summary: Decreasing Emergency Department Utilization	
	PCPs if preferred, and helping to set up appointments. Educational materials are mailed to members including references to the availability of the 24 hour nurse line. If case managers determine a member may be drug seeking from emergency room to emergency room, the member is referred to pain management. • Direct Provider is a tool available for provider utilization that tracks non-compliant patients and assists with preventive care and disease management. • Monthly ED reports are run to identify members with at least three ER visits within the last six months. Member contact is then made for educational purposes and to assist members in finding providers, including dentists. The case manager works with the member to seek care in a preventive manner that avoids the ER.

PIP Results			
Indicator 1: Medicaid Members (20-44 years of age) Who Have Received ER Services Reported Per 1000 Member Months			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline		146.45/1000 member months
CY 2009	Remeasurement 1	2.5% reduction*	151.37/1000 member months
CY 2010	Remeasurement 2	2.5% reduction*	147.10/1000 member months
Indicator 2: Medicaid Members (all ages) Who Have Received ER Services Reported Per 1000 Member Months			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline	(HEDIS regional averages)	74.66/1000 member months
CY 2009	Remeasurement 1	71.51/1000 member months	81.70/1000 member months
CY 2010	Remeasurement 2	75.16/1000 member months	74.64/1000 member months

*Goal setting based on previous annual performance

Findings. Steps 1-4 and 6-9 were *met*. Step 5, Sampling, was not applicable as the entire population was studied. Step 10, Sustained Improvement, was *unmet*. Even with an improved barrier analysis and strong case management initiatives in place, Carelink was unable to improve upon baseline rates for emergency department utilization. The MCO should consider further analyzing data and specific diagnoses. Perhaps there are a couple of diagnoses that provide opportunity for focused interventions.

Recommendations. The MCO should continue to implement focused interventions in an effort to improve emergency department utilization. Additionally, Carelink's project analysis would benefit from a strengthened quantitative assessment. The MCO should continue this project for at least one more year.

The Health Plan

PIP Summary: Asthma	
Rationale	• Each year, between 700 and 800 children are diagnosed with asthma within The Health Plan membership. Close to 25% of these children are identified through acute inpatient or emergency room visits. Numerous studies have demonstrated the negative effects of smoking/second hand smoke on children with respiratory issues.
Indicators and Goals	• Persistent asthmatics who were appropriately prescribed medication (0-17 years of age), Goal: 5% annual increase • Average number of asthma prescriptions (for asthmatics) (0-17 years of age), Goal: 5% annual increase • Persistent asthmatics who had physician management (0-17 years of age), Goal: 5% annual increase • Persistent asthmatics who had an inpatient visit (with respiratory specific diagnosis)—visits per 1000 (0-17 years of age), Goal: 5% annual increase • Persistent asthmatics who had an emergency room encounter (with respiratory specific diagnosis)—visits per 1000 (0-17 years of age), Goal: 5% annual increase
Strengths	• Comprehensive project rationale and study question • Sustained improvement achieved in indicator #1, persistent asthmatics (0-17 years of age) who were appropriately prescribed medication
Barriers	• Lack of member knowledge on disease process and management • Lack of member compliance in keeping physician appointments • Providers unaware of education/services/programs relating to asthma management offered by the MCO
Interventions	• One-to-one contact with physician and/or office staff to provide education, tools, contact information for asthma related materials and services offered by the MCO (over 200 offices were visited in 2010) • Distributed an asthma kit (peak flow meter, spacer, etc.) and a cinch pack • Targeted mailing to members identified through claims as having asthma. Mailing contained asthma-related educational materials and letter encouraging the member to make an appointment with his/her provider

PIP Results			
Indicator 1: Persistent asthmatics who were appropriately prescribed medication (0-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2007	Baseline		80.62%
CY 2008	Remeasurement 1	5% annual increase	85.87%
CY 2009	Remeasurement 2	5% annual increase	83.77%
CY 2010	Remeasurement 3	5% annual increase	86.41%
Indicator 2: Average number of asthma prescriptions (for asthmatics) (0-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		6.43 prescriptions/member
Indicator 3: Persistent asthmatics who had physician management (0-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		83.54%
CY 2010	Remeasurement 1	5% annual increase	83.01%
Indicator 4: Persistent asthmatics who had an inpatient visit (with respiratory specific diagnosis)—visits per 1000 (0-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		57.61 k/month
Indicator 5: Persistent asthmatics who had an emergency room encounter (with respiratory specific diagnosis)—visits per 1000 (0-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		11.69 k/month

Findings. Steps 1-4, 6-8, and 10 were *met* for The Health Plan. Step 5, Sampling, was not applicable as the MCO studied the entire population. Step 9, Assessment of Real Improvement, was *partially met* as project indicators have constantly evolved over time. The MCO is always looking for meaningful ways to report using more telling and accurate data. As an example, previously The Health Plan reported on members with persistent asthma who had an emergency room encounter. This indicator was modified to only include persistent asthmatics with an emergency room encounter *that included a respiratory diagnosis*. Multiple indicators have undergone specification changes to more accurately reflect data (including utilization and the impact of interventions); however, as indicator specifications change, it becomes more difficult to assess the success of the project. As specifications change, trending data becomes a futile task. To The Health Plan's benefit, there was one indicator that remained consistent over time. This indicator, which measured the rate of persistent asthmatics who where appropriately prescribed medication, was the backbone of the project and assisted the MCO in achieving sustained improvement for this PIP. Over time, it saw an improvement of almost 6 percentage points, achieving a final rate of 86.41%. Positively, The Health Plan responded to the previous year's recommendations and implemented interventions that specifically targeted barriers.

Recommendations. Ever changing indicators and their respective specifications negatively impact the ability to assess the project over time. The one indicator that remained constant did demonstrate sustained improvement for the PIP: persistent asthmatics who where appropriately prescribed medication. Sustained improvement may be attributed to The Health Plan developing and implementing interventions that targeted defined barriers, based on the previous review's recommendations. After four years, demonstration of sustained improvement in the consistent indicator and strong interventions in place, Delmarva recommends closing this project.

PIP Summary: Childhood Obesity	
Rationale	• West Virginia is currently ranked third in the nation for obesity. While childhood obesity is difficult to measure within The Health Plan (many physicians are not coding for obesity or documenting body mass index (BMI) within the medical record), it is impacting children of all ages, spanning from 1 year to 17 years of age. Discussions with plan physicians and school wellness teams reinforce the prevalence of childhood obesity and identify it as one of the top health issues.
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 • In addition to targeting providers with interventions, The Health Plan is also targeting members of the plan, community, and school systems
Barriers	• Provider and member knowledge deficit 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 discussion with physician/appropriate office staff regarding the provider education packet which includes BMI chart, BMI percentile graph worksheets, and Childhood Obesity Program information. Over 200 offices were visited during 2010 • Practitioner Procedural Manual was updated to include all information named above. Additionally, this information is on the provider website • Community-based health fairs included BMI screenings; counseling was provided and included encouragement to discuss results with PCPs

PIP Summary: Childhood Obesity	
	• School-based collaborative functions included BMI-related screenings; students were educated and asked to discuss results with parents and PCPs • MCO website was enhanced to include wellness information on nutrition, activity, and weight loss initiatives

PIP Results			
Indicator 1: Members with evidence of BMI documentation (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		1.45%
CY 2010	Remeasurement 1	5% annual increase	1.12%
Indicator 2: Members with evidence of nutritional counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.94%
CY 2010	Remeasurement 1	5% annual increase	0.54%
Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.78%
CY 2010	Remeasurement 1	5% annual increase	0.45%

Findings. Steps 1-4 and 6-8 were *met* for The Health Plan. Step 5, Sampling, was not applicable as the MCO studied the entire population. As recommended, The Health Plan continues to implement interventions that focus on identified barriers, member and provider knowledge deficits. Step 9, Assessment of Real Improvement, was *partially met* as there was no noted improvement in any of the project indicators. Step 10, Sustained Improvement, was not applicable as one more reporting period is required before this assessment can occur.

Recommendations. As previously recommended, the MCO should continue to assess barriers to improvement annually and develop very specific, directed interventions based on this analysis. The Health Plan targeted educational efforts for both the providers and members in response to this recommendation. The effectiveness of each intervention should also be assessed and adjustments made accordingly. Additionally, The Health Plan should strengthen its quantitative analysis to provide a more comprehensive project assessment. The MCO should continue this project for at least one more year.

PIP Summary: Emergency Department Utilization Diversion	
Rationale	• Emergency Department Utilization is a mandated project topic. The Health Plan claims analysis identified throat/respiratory complaints as a top emergency room diagnosis in the 0-5 age group. The MCO notes that children with upper respiratory illnesses are better handled by primary care providers (PCPs) and can often be treated at home with over-the-counter remedies. Providing caregivers with the knowledge of how to treat such conditions at home should result in fewer ER visits. • For back pain, The Health Plan states that there appears to be a progression from initial acute back pain to the development of drug seeking behavior in the ER. Targeting these members presenting with back pain at the time of their initial visit and redirecting them to appropriate services for treatment should result in fewer ER visits and reduce drug seeking behavior.
Indicators and Goals	• Emergency Room visits per 1000 members (ages 0-5 years) with respiratory diagnosis, Goal: 5% annual reduction • Emergency Room visits per 1000 members (age 20 and older) with diagnosis of back pain, Goal: 5% annual reduction
Strengths	• Focused/narrowly defined project • Clearly defined project rationale • Significant improvement in indicator 1 (emergency room visits with a respiratory diagnosis)
Barriers	• Caregivers not feeling equipped to care for a sick child • Caregivers are unaware of after-hours alternatives for scheduling appointments • Lack of screening tools for acute low back pain assessment • Providers are not following guidelines for treatment of new diagnosis of low back pain
Interventions	• Initiated educational, outreach phone calls to caregivers of members 0-5 with ER diagnosis of upper respiratory condition • In addition to the above named intervention, a follow up letter and a book, *What To Do When Your Child is Sick*, are mailed to these members • Teamed up with ER physician champion to steer appropriate back pain related interventions • Identification of nationally recognized guidelines for the treatment of low back pain with emphasis on acute injury • Member and provider newsletter articles related to low back pain and appropriate treatment

PIP Results			
Indicator 1: Emergency Room visits per 1000 members (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
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000
Indicator 2: Emergency Room visits per 1000 members (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
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000

Findings. Steps 1-4, 6-7, and 9 were *met* for The Health Plan. Step 5, Sampling, was not applicable as the MCO studied the entire population. Step 8, Data Analysis, was *partially met*. The qualitative analysis did not identify barriers, causes for performance (positive or negative), or impact of interventions. Step 10, Sustained Improvement, was not applicable as one more reporting period is required before this assessment can occur. Of note, the MCO did achieve significant improvement in indicator 1: emergency room visits with a respiratory diagnosis. There was an 18% decrease in the rate of ER visits per 1000. There were no formal recommendations made in the previous review to follow up on.

Recommendations. The Health Plan's qualitative analysis should identify barriers, causes for performance (positive or negative), and impact of interventions. Completing this portion of the analysis will assist in identifying appropriate interventions. The MCO should continue this project for at least one additional year.

UniCare Health Plan, Inc.

PIP Summary: Improving Asthma Control	
Rationale	• UniCare's prevalence data (2010) ranks asthma 6th for all diagnostic claims, 9th for inpatient encounters, 11th for ER visits, and 24th for PCP visits, indicating an opportunity for asthma control
Indicators and Goals	• Persistent asthmatics (5-50 years of age) who were appropriately prescribed medication, Goal: National HEDIS Medicaid 90th percentile
Strengths	• Comprehensive project rationale • Commendable project indicator goal: National HEDIS Medicaid 90th percentile • Multifaceted interventions were implemented
Barriers	• Weak provider/patient partnership • Member lack of knowledge/education about disease • Poor provider strategies for improving member compliance with asthma medication

PIP Summary: Improving Asthma Control	
	regimens) • Providers not developing personalized written asthma action plans
Interventions	• *Healthy Habits Count with Asthma* disease management program • Feedback (including utilization information) to providers regarding members enrolled in the disease management program • Continuity and coordination of care (including 24 hr nurse line, health educational outreach, and case and utilization management functions)

PIP Results			
Indicator 1: Persistent asthmatics (5-50 years of age) who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		95.07%
CY 2010	Remeasurement 1	95.07%	93.84%

Findings. Steps 1-4, 6-8, and 10 were *met*. Step 5, Sampling, was not applicable as the entire population was studied. Step 9, Assess Real Improvement, was *partially met* as there was no reported improvement in the project indicator: persistent asthmatics appropriately prescribed medication. However, it should be noted that baseline and remeasurement 1 rates are at or near the national HEDIS Medicaid 90th percentile. As previously recommended, UniCare did identify an indicator goal.

Recommendations. UniCare's asthma project has been ongoing for several years. When pharmacy data became available, the MCO modified its project and selected the HEDIS asthma measure, Use of Appropriate Medications for People with Asthma. UniCare has usually demonstrated strong performance on this measure; however, a slight decline in performance has been noted when comparing remeasurement 1 to the baseline rate. Due to this decline and coupled with the need to enhance its qualitative analysis and include an assessment of performance, Delmarva recommends continuing this project for one final year.

PIP Summary: Reducing Inappropriate Emergency Room Utilization (Baseline)	
Rationale	• The emergency department utilization project is mandated by BMS. UniCare notes that 30% 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."
Indicators and Goals	• 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, Goal: Achieve a 10% reduction in ER Visits

PIP Summary: Reducing Inappropriate Emergency Room Utilization (Baseline)	
	• 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, Goal: Achieve a 10% reduction in ER Visits
Strengths	• Commendable indicator goal: 10% reduction in ER services
Barriers	• Lack of member awareness regarding the proper use of ER, associated costs, loss of continuity of care
Interventions	• Intervention analysis is not applicable for the baseline review

PIP Results			
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		88%
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		96%

Findings. Steps 1-4 and 6 were *met*. Step 5, Sampling, was not applicable as the entire population was studied. Steps 7-10 were not applicable as the project submission only included baseline data. UniCare experienced a delay in project implementation due to issues related to obtaining agreements with participating practices for the PIP. These delays impacted the timeliness of baseline data collection and subsequent remeasurement data collection.

Recommendations. The next annual submission *must* include a thorough barrier analysis as part of the qualitative analysis. A barrier analysis was requested at the time of the last review. It is important to understand barriers prior to implementing interventions. As recommended, UniCare did identify indicator goals. The MCO should continue this project for at least two more years.

Results for all PIP indicators are included in Appendix 2.

Performance Measure Validation

HEDIS measures are categorized and reported in several domains. The domains measure specific areas of care and service. The measures reported by the MHT MCOs are categorized into the following domains:

- **Effectiveness of Care.** This HEDIS domain assesses acute, chronic, and preventive care delivered by the MCOs. The assessment measures the quality of care provided to MHT enrollees. It includes the process and outcomes measures listed below.
  - Adult Body Mass Index (BMI) Assessment
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Lead Screening in Children
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening
  - Cholesterol Management
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care
  - Use of Imaging Studies for Low Back Pain
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

- **Access and Availability.** This HEDIS domain assesses whether care is available to MHT Medicaid recipients when and where they need it and whether it can be obtained in a timely and convenient manner. The assessment measures the sufficiency of health care and related services to advance the health status of beneficiaries. It includes the process measures listed below.
  - Adults' Access to Preventive/Ambulatory Health Services
  - Children's and Adolescents' Access to Primary Care Practitioners
  - Prenatal and Postpartum Care
  - Call Answer Timeliness
  - Call Abandonment

- **Use of Services.** This HEDIS domain assesses utilization of resources.
  - Frequency of Ongoing Prenatal Care
  - Well-Child Visits
  - Adolescent Well-Care Visits

MCO HEDIS measures and indicators rates, including trended rates, are found in Appendix 1. MCO rates are compared to the MHT Weighted Averages, National Medicaid Averages, and National Medicaid 90th percentiles for benchmarking purposes. The results for selected measures are presented in the remainder of this section within the categories of Quality, Access, and Timeliness.

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. This plan was updated in April 2010 with plans to update it again in 2012. The objectives, targets, and results for the objectives are found in Table 5.

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

Objective	Target (over the next two years)	Baseline (CY 2008)	CY 2009	CY 2010
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-Combination 2 measure)*	70.4%	62.2%	63.5%
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%
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%
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%
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%

Objective	Target (over the next two years)	Baseline◘ (CY 2008)	CY◘ 2009	CY◘ 2010
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%

* 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.

Of the six measures, the targets were 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)
- Promoting Adult Access to Preventive Health (HEDIS Adults' Access to Preventive/Ambulatory Health Services for Adults Age 20-44 Years measure)
- Ensuring Comprehensive Chronic Care (HEDIS Controlling High Blood Pressure measure)

The Adults' Access to Preventive Ambulatory Care measure achieved the largest improvement with a rate of 86.2% in the baseline (CY 2008) to 92.6% in both CY 2009 and CY 2010.

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

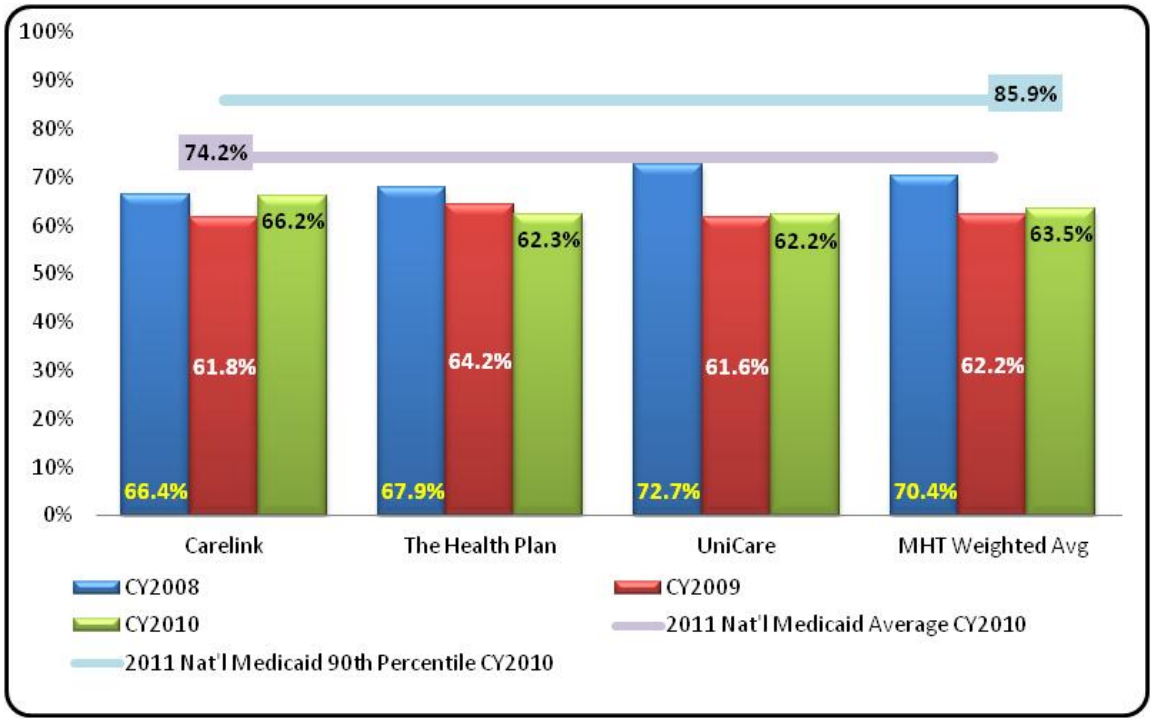
Quality

Childhood Immunization Status-Combination 2 (CIS 2)

The CIS 2 measure reports the percentage of children 2 years of age who, by their second birthday, had the following vaccines:

- 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), and
- 1 Chicken pox (VZV).

Figure 1. Results: MHT 2010, Childhood Immunization Status (CIS) – Combination 2*



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 1 displays the results for Childhood Immunization Status—Combination 2. The CY 2010 MCO performance rates ranged from 62.2% to 66.2%. The CIS Combination 2 rate for all MCOs decreased from CY 2008 to CY 2009. UniCare was the top performer in CY 2008, The Health Plan was the top performer in CY 2009, and Carelink was the top performer in CY 2010. The CY 2010 rate is below the CY 2008 rate for all three MCOs. All MCO rates are below the Medicaid National Average of 74.2%.

The WV MHT State Strategy for this measure was to improve five percentage points from the baseline rate of 70.4%. The CY 2009 and CY 2010 results reflect a decline in performance from the baseline rate.

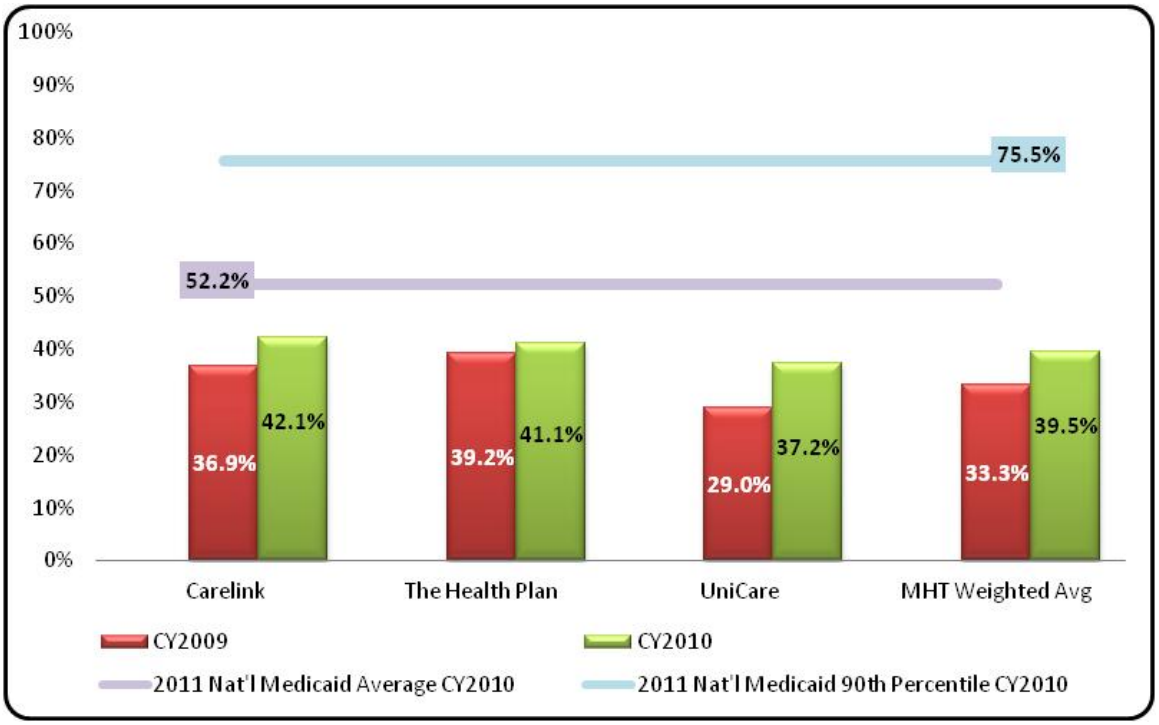
One reason that the Childhood Immunization measure may not meet the benchmark is the lack of MCO access to the West Virginia Statewide Immunization Information System (WVIIS). The WVIIS can be used as a supplemental database for this measure but the MCOs have been challenged in obtaining reasonable access to this data source. For example, The Health Plan was able to upload entire files to the WVIIS to check for immunizations for their enrollees. The other MCOs only had the ability to query one member at a time. When the other two plans requested access similar to The Health Plan, the Health Plan's access to upload files was rescinded. Because the WVIIS can be a rich source of supplemental data for the MCOs, and since the MCOs will likely have data to contribute to the WVIIS, it would be beneficial to both parties to work together to determine how to accomplish a reasonable transfer of data.

Immunizations for Adolescents – Combination 1(IMA)

Immunizations for Adolescents--Combination 1 measures the percentage of adolescents who by their thirteenth birthday have received the following:

- One dose of meningococcal vaccine
- One does of tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or tetanus, diphtheria toxoids vaccine (Td).

Figure 2. Results: MHT 2010, Immunizations for Adolescents (IMA) – Combination 1*



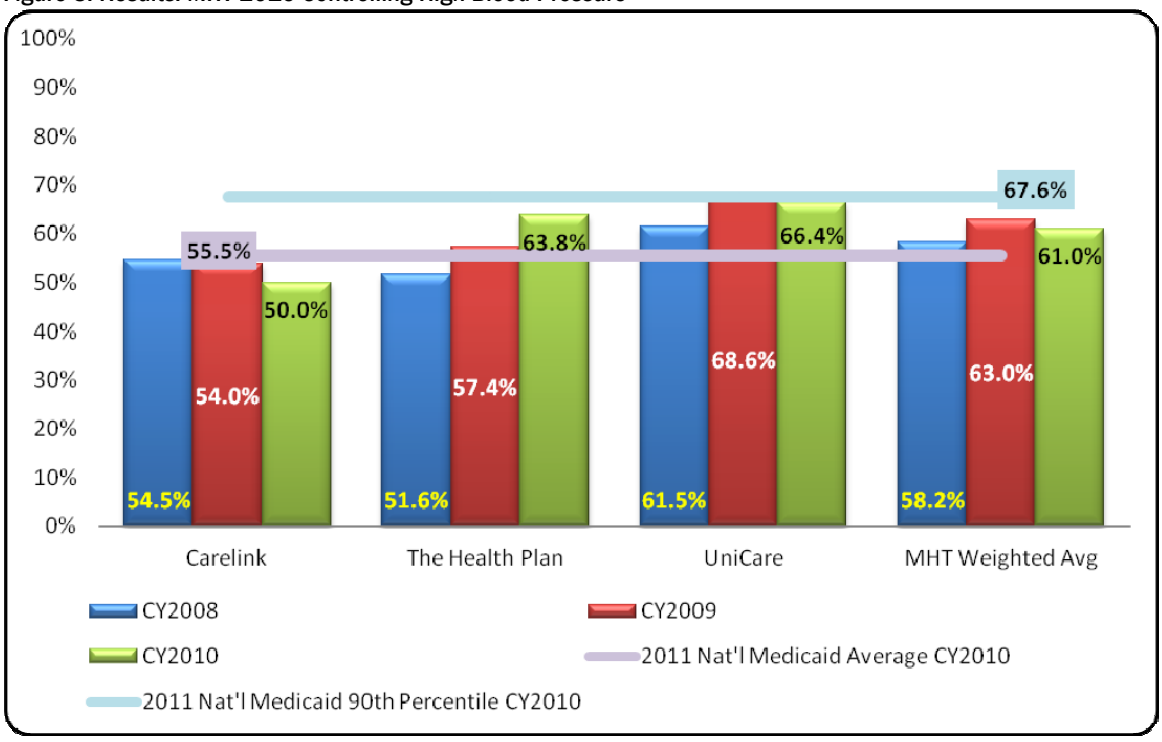
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 2 presents the results for Immunizations for Adolescents--Combination 1 for CY 2009 and CY 2010. The measure was introduced in CY 2009 and MCO rates ranged from 29.0% to 39.2%. Rates ranged from 37.2% to 42.1% in CY 2010. All three MCOs improved from CY 2009 to CY 2010. The Health Plan was the top performer in CY 2009 and Carelink was the top performer in CY 2010. The MHT average increased 6.2 percentage points between years but remained below the National Medicaid Average.

Controlling High Blood Pressure (CBP)

The CBP measure reports the percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Figure 3. Results: MHT 2010 Controlling High Blood Pressure*



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

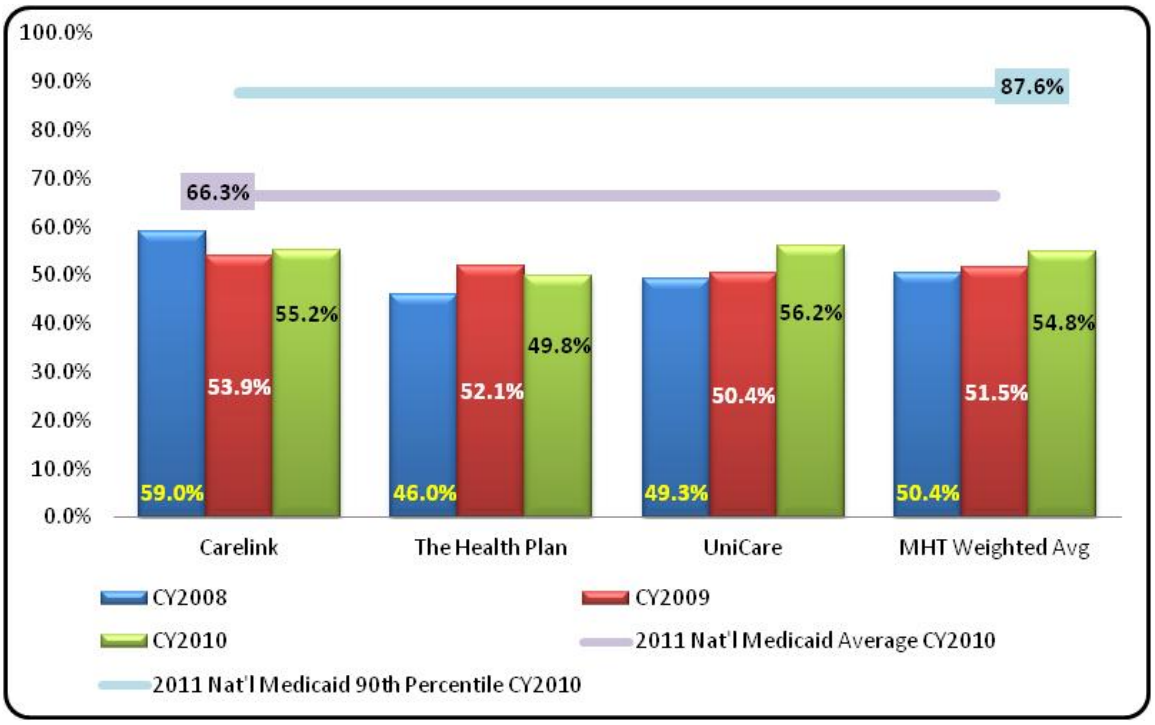
Figure 3 presents the results for *Controlling High Blood Pressure*. In CY 2010, MCO performance rates ranged from 50.0% to 66.4%. UniCare was the top performer in all three measurement years. THP, UniCare, and the MHT Weighted Average exceeded the National Medicaid Average of 55.5% with UniCare only 1.5 percentage points below the National Medicaid HEDIS 90th percentile. The Health Plan and UniCare performance improved from CY 2008 through CY 2010.

The State Strategy for Assessing and Improving Managed Care Quality target for this measure was 63.3% (the HEDIS 2008 75th percentile). The MHT aggregate rate for CY 2009 was only 0.3 of a percentage point below this target. In CY 2010, both The Health Plan and UniCare exceeded this benchmark with rates of 63.8% and 66.4%, respectively.

Lead Screening in Children (LSC)

The LSC measure reports the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.

Figure 4. Results: MHT 2010 Lead Screening in Children*



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 4 presents the results for *Lead Screening in Children.* In CY 2010, MCO performance rates ranged from 49.8% to 56.2% and were significantly lower than 2011 National Medicaid Average. Carelink was the top performer in CY 2008 and CY 2009, while UniCare was the top performer in CY 2010. The Health Plan and UniCare's rates were above the CY 2008 rates. The Health Plan's rate increased 3.8 percentage points and UniCare's rate increased 6.9 percentage points from the CY 2008 measurement period. Overall, the MHT program's rate increased steadily each year achieving a 4.4 percentage point improvement from CY 2008 through CY 2010.

Comprehensive Diabetes Care (CDC)

The CDC measure set includes seven indicators. The CDC indicators measure the percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had each of the following:

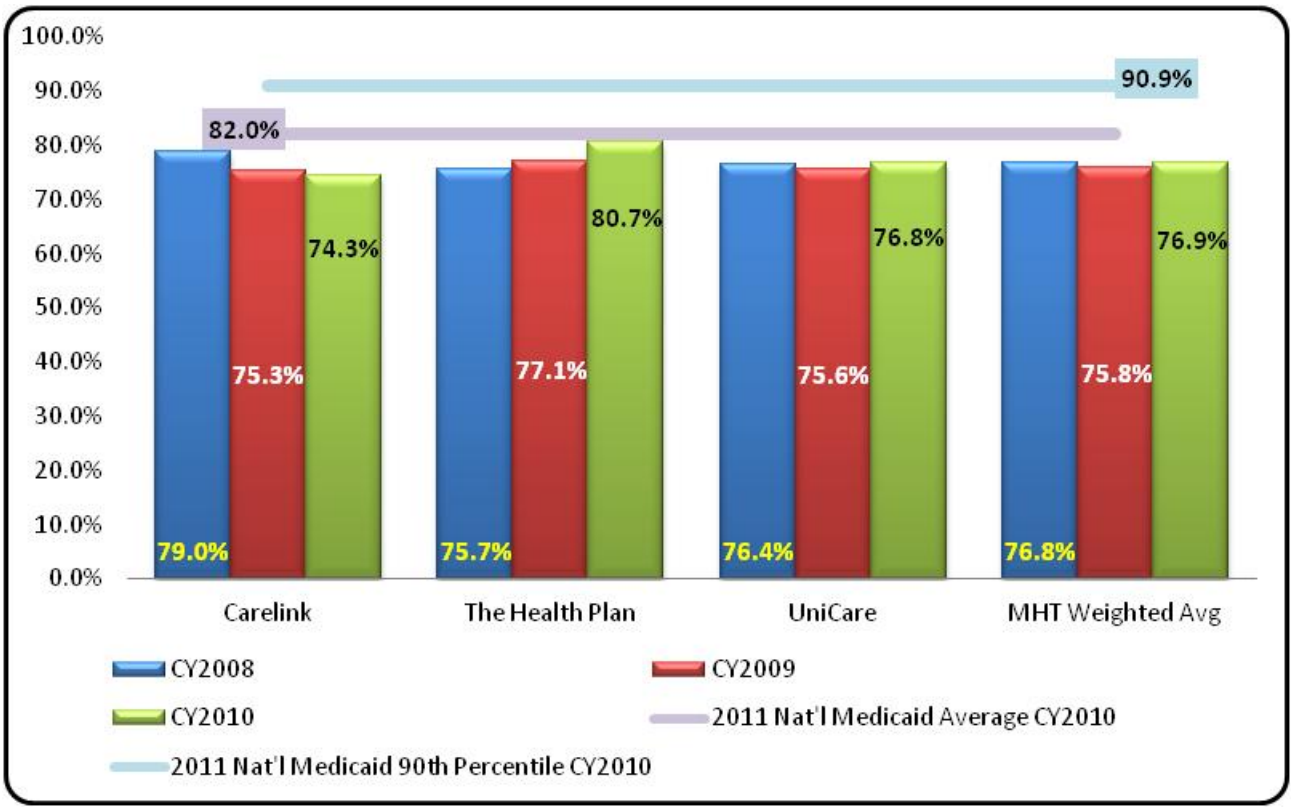
- Hemoglobin A1c (HbA1c testing)
- HbA1c poor control (>9.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for Nephropathy
- BP control (<140/90 mm Hg)

The results of selected CDC indicators are presented separately below.

CDC - Hemoglobin A1c (HbA1c) Testing

The CDC-HbA1c Testing indicator reports the percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had an HbA1c test during the measurement year.

Figure 5. Results: MHT 2010 Comprehensive Diabetes Care – HbA1c Testing*



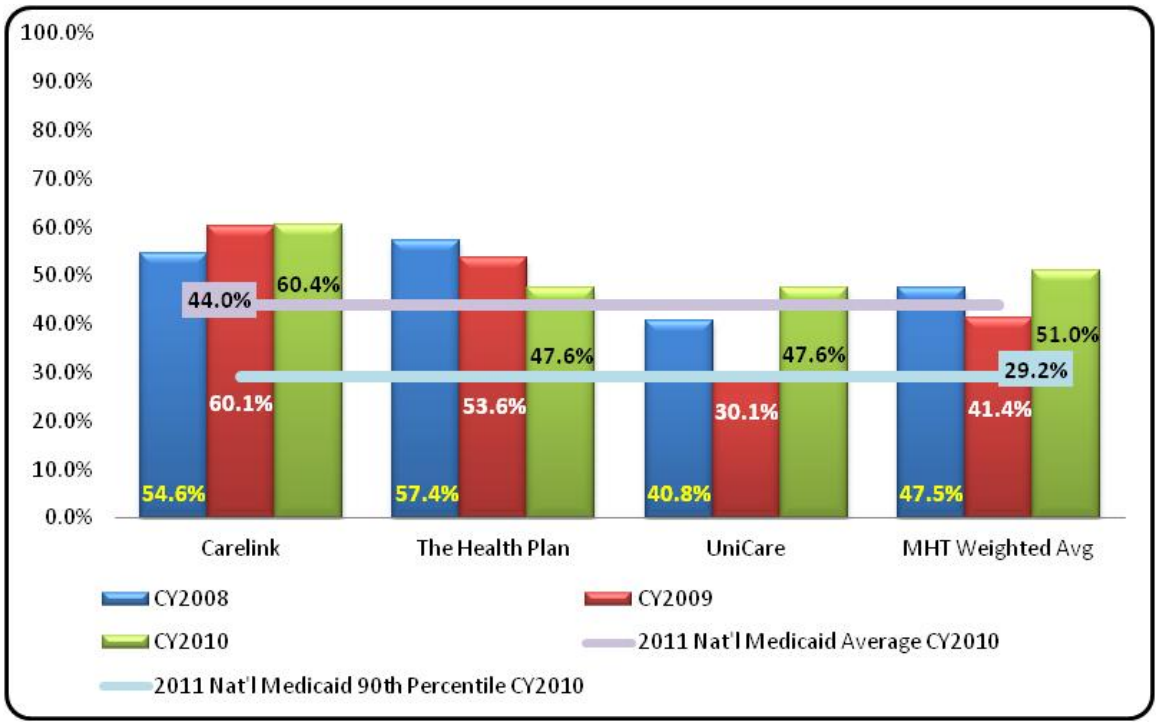
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 5 presents the results for *CDC-HbA1c Testing*. In CY 2010, MCO performance rates ranged from 74.3% to 80.7% and were below the National Medicaid Average. Carelink was the top performer in CY 2008 while The Health Plan was the top performer in CY 2009 and CY 2010. The MHT Weighted Average remained relatively stable from 76.8% in CY 2008 to 76.9% in CY 2010.

CDC- HbA1c Poor Control (>9.0%)

The CDC- *HbA1c Poor Control (>9.0%)* indicator reports the percentage of diabetic members 18-75 years of age with poor HbA1c control. A lower rate is better.

Figure 6. Results: MHT 2010 Comprehensive Diabetes Care – Poor HbA1c Control (>9.0%)*▪



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

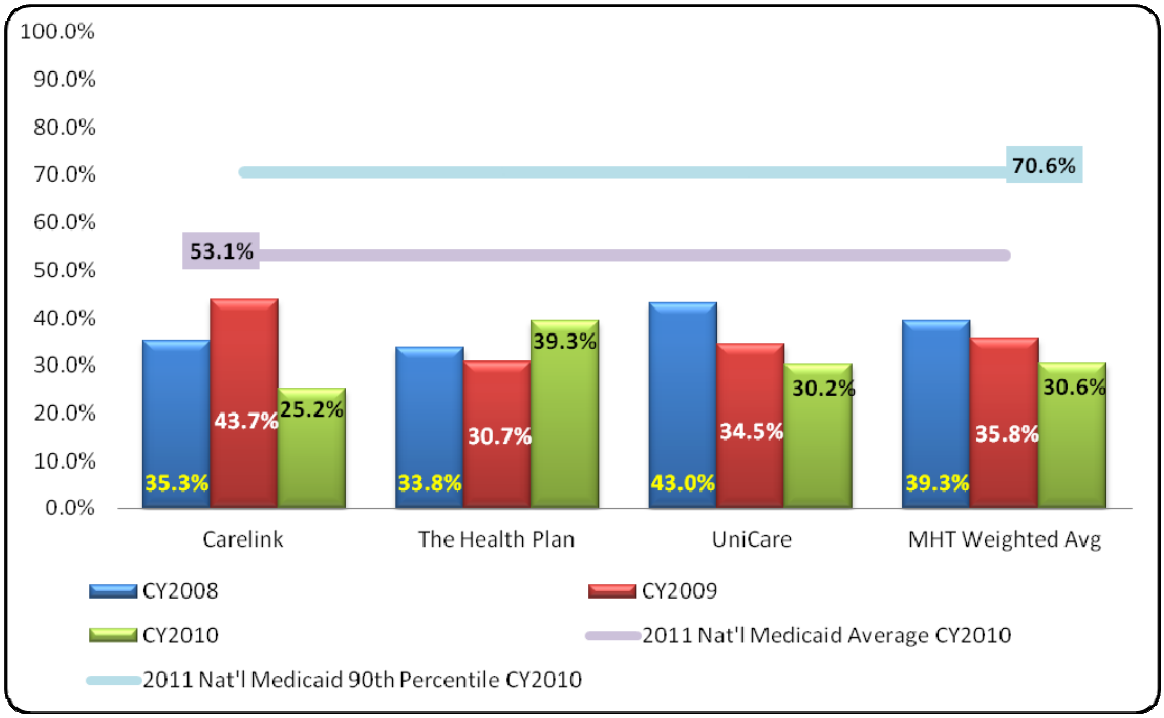
▪A lower rate indicates better performance

Figure 6 presents the results for *CDC-Poor HbA1c Control (>9.0%)*. In CY 2010, MCO performance rates ranged from 60.4 % to 47.6% (lower rate is better). CY 2010 MCO rates exceeded the National Medicaid Average indicating unfavorable performance. UniCare was the best performer in CY 2008 and CY 2009 and tied with The Health Plan for top performance in CY 2010 with a rate of 47.6%. The MHT Weighted Average decreased 6.1 percentage points (positive performance) from CY 2008 to CY 2009, but then increased in CY 2010 to 51.0%.

CDC- Eye Exam (retinal) Performed

The CDC-Eye Exam (retinal) Performed indicator reports the percentage of diabetic members 18-75 years of age who had evidence of a retinal eye exam performed in the measurement year.

Figure 7. Results: MHT 2010 Comprehensive Diabetes Care – Eye Exams*



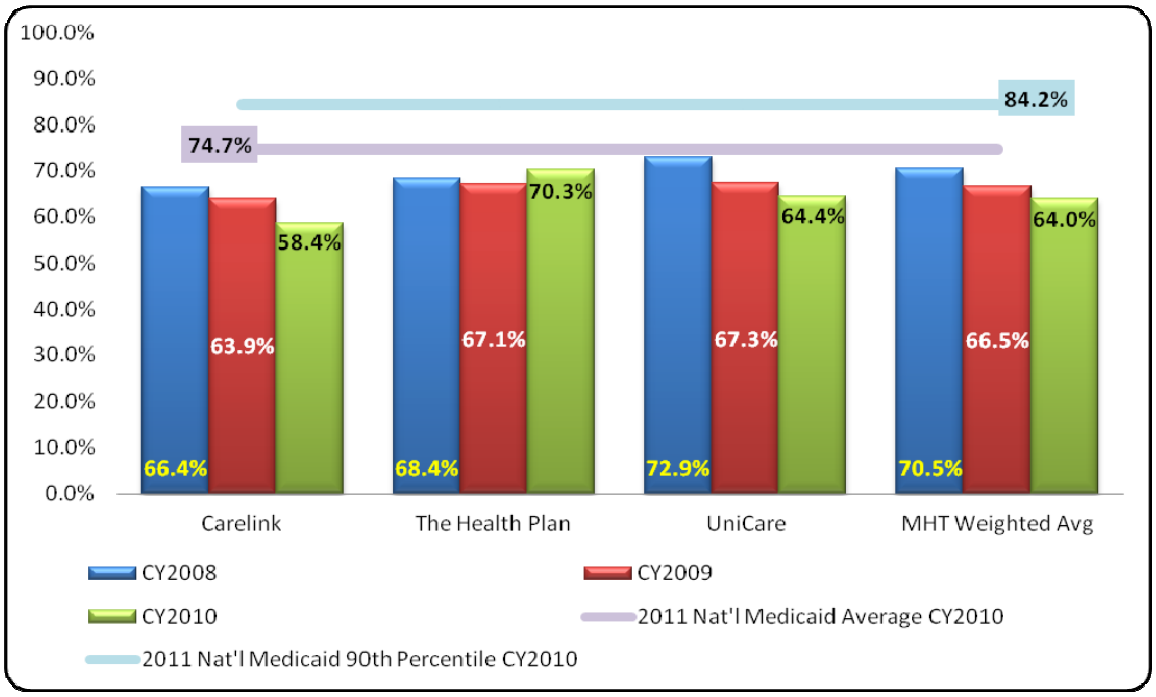
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 7 presents the results for *CDC-Eye Exam*. In CY 2010, individual MCO performance rates ranged from 25.2% to 39.3% and all were below the National Medicaid Average. UniCare was the top performer in CY 2008, Carelink in CY 2009, and The Health Plan in CY 2010. Both Carelink's and UniCare's rates for CY 2010 are lower than their CY 2008 rates. Conversely, The Health Plan achieved a 5.5 percentage point increase from CY 2008 to CY 2010. The MHT Weighted Average decreased from 39.3% to 30.6% from CY 2008 to CY 2010.

CDC- LDL-C Screening

The CDC-LDL-C Screening indicator reports the percentage of diabetic members 18-75 years of age who had evidence of an LDL-C screening performed in the measurement year.

Figure 8. Results: MHT 2010 Comprehensive Diabetes Care – LDL-C Screening*



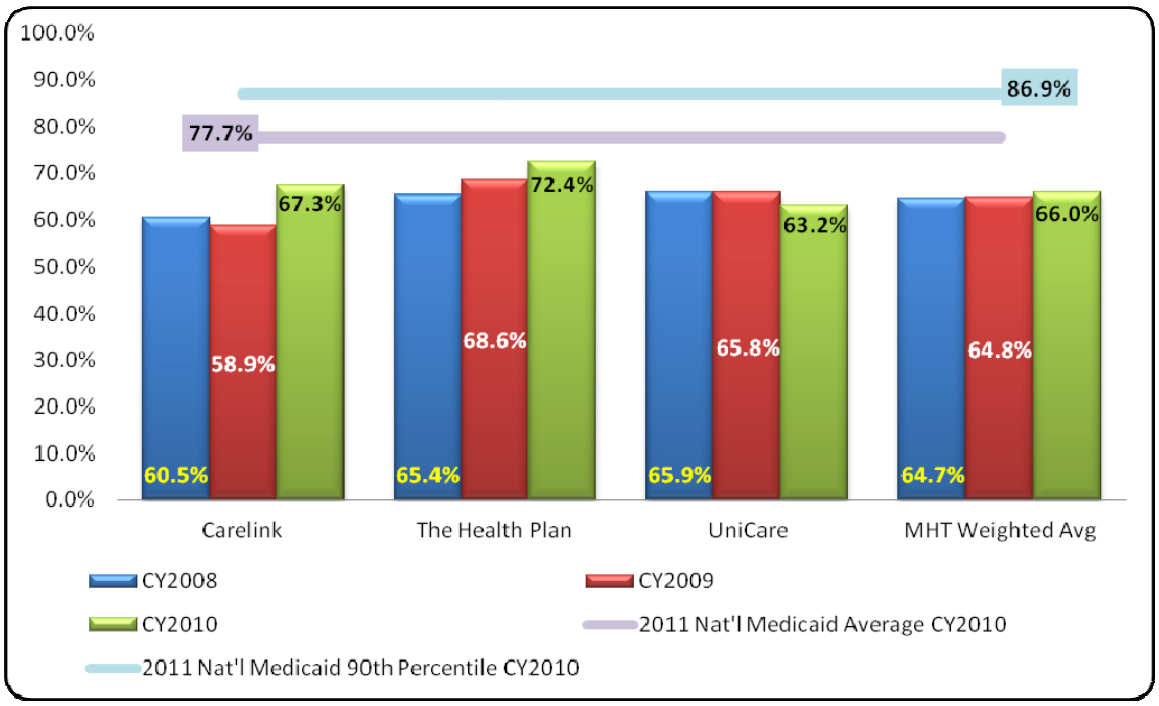
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 8 presents the results for CDC-LDL-C Screening rates. In CY 2010, individual MCO performance rates ranged from 58.4% to 70.3%. UniCare was the top performer is CY 2008 and CY 2009. The Health Plan was the top performer in CY 2010 reporting a rate (70.3%) greater than its CY 2008 rate (68.4%). The MHT Weighted Average decreased from 70.5% in CY 2008 to 64.9% in CY 2010.

CDC - Medical Attention for Nephropathy

The CDC-Medical Attention for Nephropathy indicator reports the percentage of diabetic members 18-75 years of age who had evidence of a nephropathy screening test or evidence of nephropathy in the measurement year.

Figure 9. Results: MHT 2010 Comprehensive Diabetes Care – Medical Attention for Nephropathy *



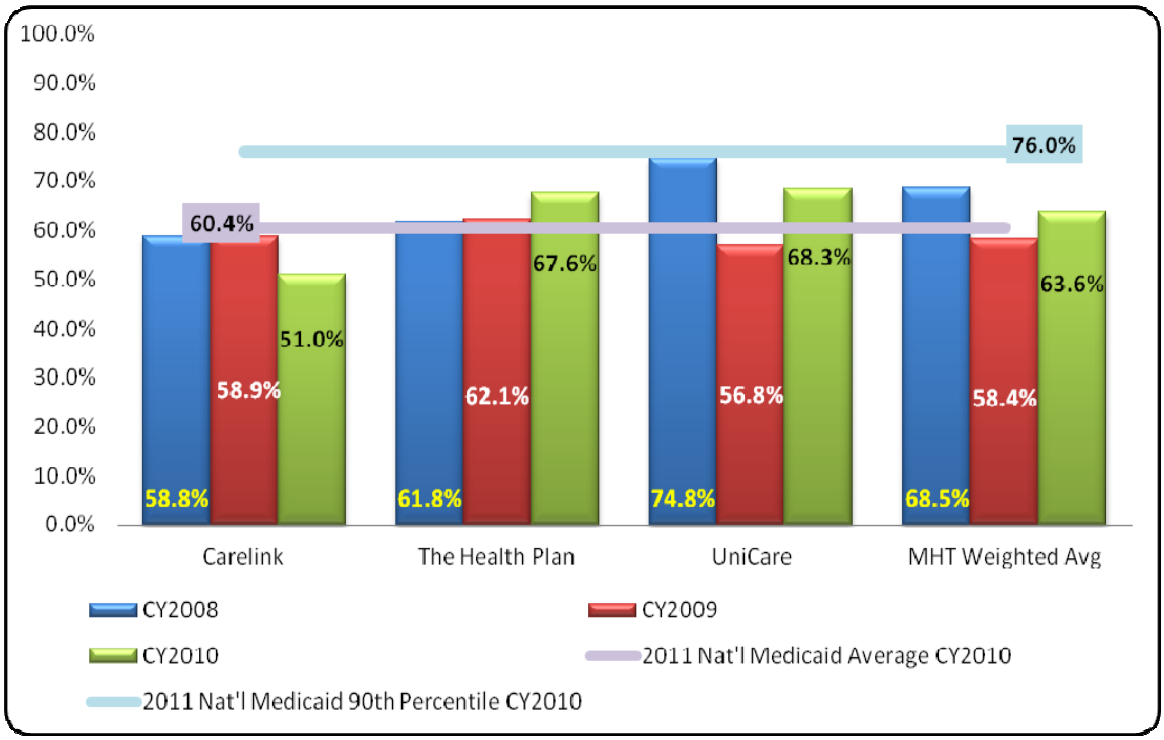
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 9 presents the results for CDC-Medical Attention for Nephropathy. In CY 2010, individual MCO performance rates ranged from 63.2% to 72.4%. UniCare was the top performer in CY 2008, while The Health Plan was the top performer in CY 2009 and CY 2010. None of the MCOs achieved the National Medicaid Average, but Carelink and The Health Plan improved their rates from CY 2008 to CY 2010. Overall, the MHT Weighted Average improved from 64.7% in CY 2008 to 66.0% in CY 2010.

CDC - Blood Pressure (BP) Control (<140/90 mm Hg)

The CDC-BP Control <140/90 mm Hg indicator reports the percentage of diabetic members 18-75 years of age whose most recent BP in the measurement year was less than 140/90 mm Hg.

Figure 10. Results: MHT 2010 Comprehensive Diabetes Care – Blood Pressure Control *



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

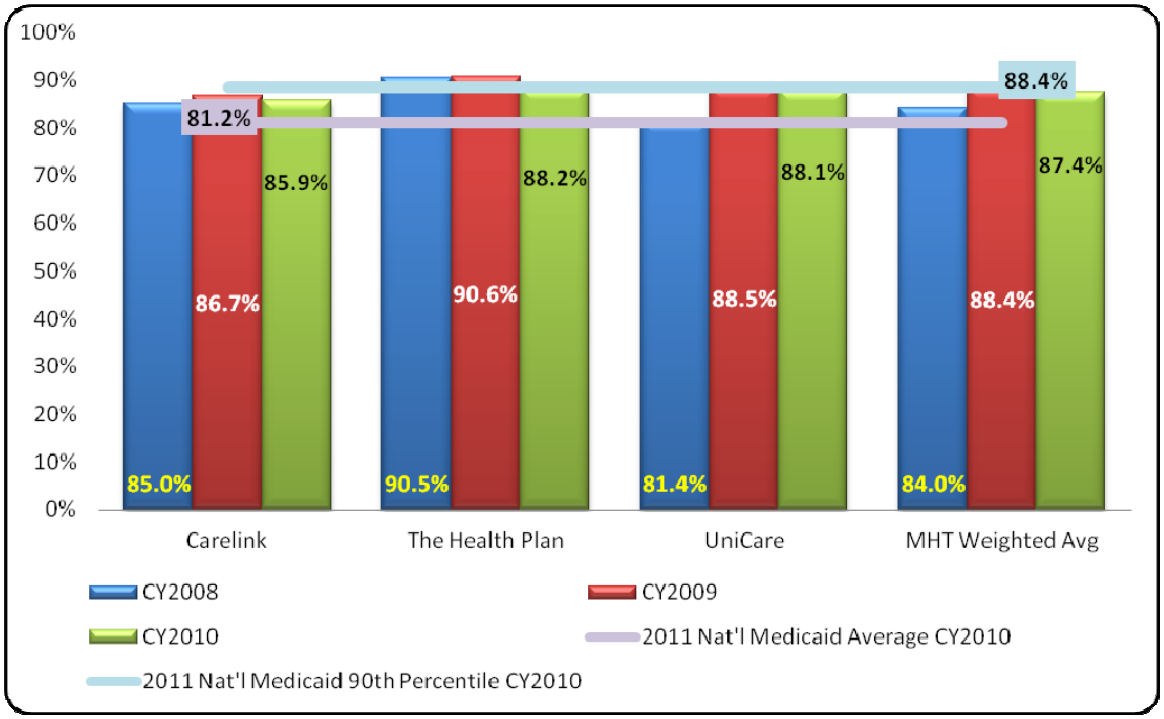
Figure 10 presents the results for *CDC - Blood Pressure (BP) Control (<140/90 mm Hg)*. In CY 2010, individual MCO performance rates ranged from 51.0% to 68.3%. UniCare was the top performer in CY 2008 and CY 2010 while The Health Plan was the top performer in CY 2009. Both The Health Plan and UniCare exceeded the National Medicaid Average in CY 2010. Overall, the MHT Weighted Average decreased from CY 2008 to CY 2010, but the CY 2010 rate of 63.6% exceeded the Medicaid National Average of 60.4%.

Access

Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 Years

The AAP 20-44 Years indicator reports the percentage of members age 20-44 years who had an ambulatory or preventive care visit in the measurement year.

Figure 11. Results: MHT 2010 Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years*



* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

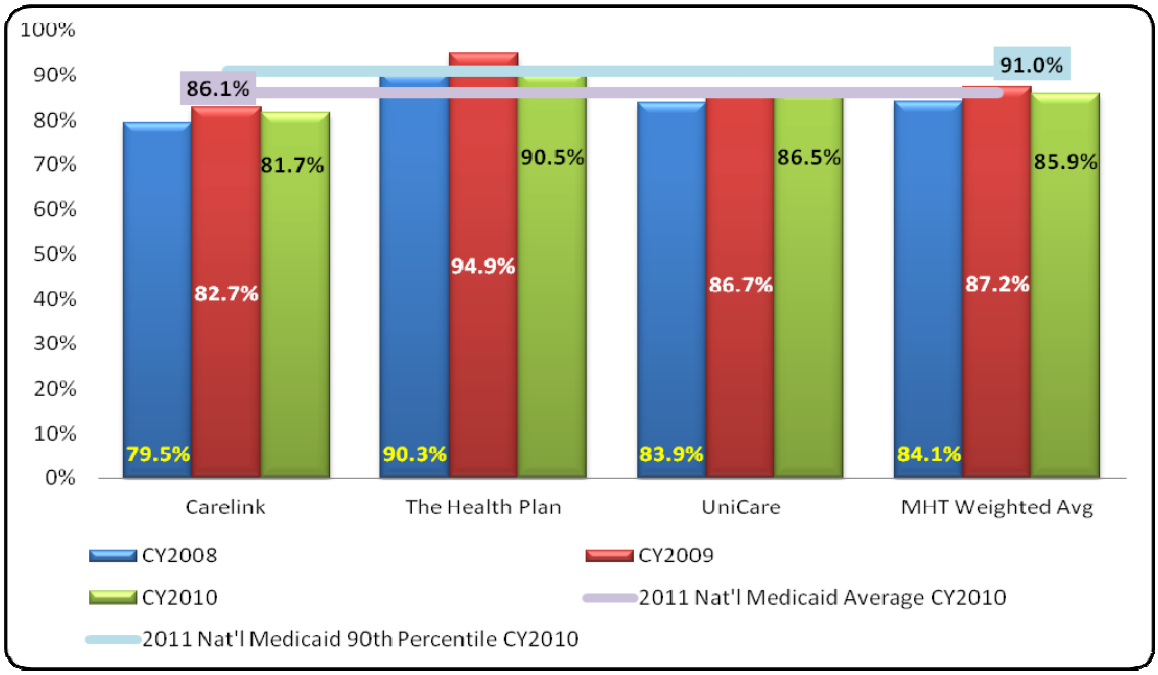
Figure 11 presents the results for *Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 Years*. In CY 2010, individual MCO rates ranged from 85.9% to 88.2% and were above the National Medicaid Average of 81.2%. The Health Plan and UniCare fell just short of the National Medicaid 90th percentile of 88.4% with rates of 88.2% and 88.1%, respectively. The Health Plan was the top performer for this measure from CY 2008 through CY 2010. Overall, the MHT Weighted Average increased from CY 2008 to CY 2010. The MHT Weighted Average also exceeded the National Medicaid Average and fell only one percentage point below the National Medicaid 90th percentile.

The State Strategy for Assessing and Improving Managed Care Quality set the goal for this measure at 88.4%. This goal was met in CY 2009 with the MHT Weighted Average rate of exactly 88.4%. In CY 2010, the MHT Weighted Average fell just one percentage point shy of meeting the goal with a rate of 87.4%.

Adults' Access to Preventive/Ambulatory Health Services (AAP) 45-64 Years

The AAP 45-64 Years indicator reports the percentage of members age 45-64 years who had an ambulatory or preventive care visit in the measurement year.

Figure 12. Results: MHT 2010 Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years*



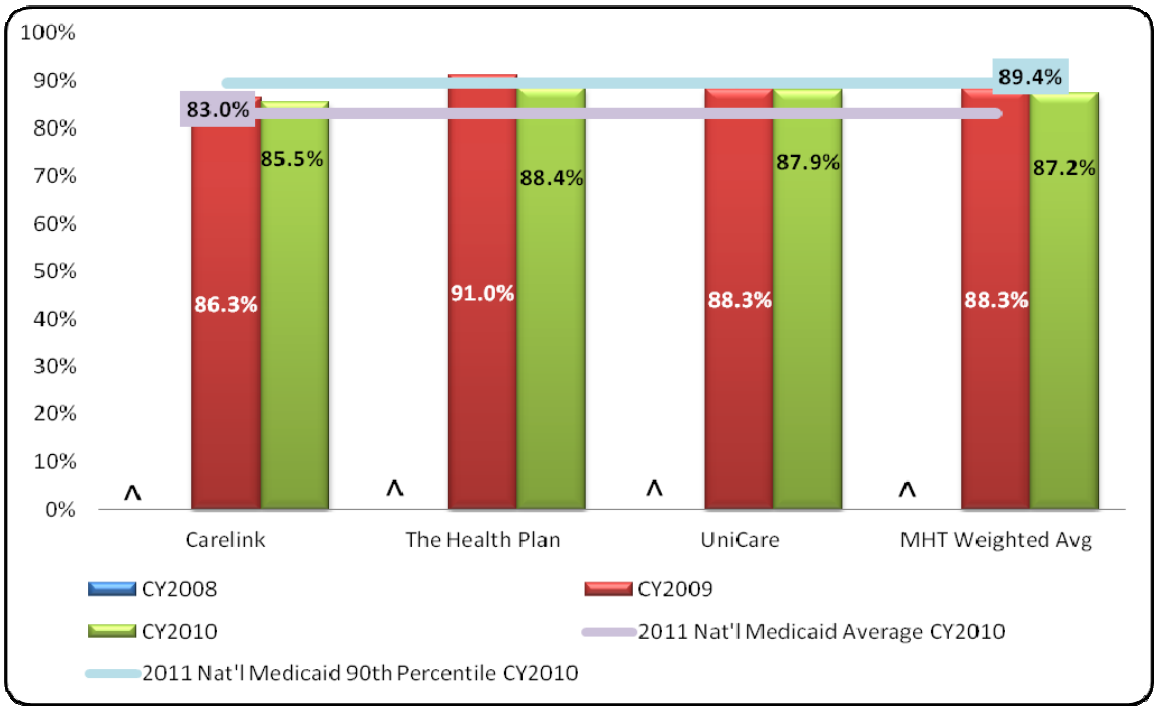
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 12 presents the results for *Adults' Access to Preventive/Ambulatory Health Services (AAP) 45-64 Years.* Individual MCO performance rates ranged from 81.7% to 90.5%. The Health Plan and UniCare exceeded the National Medicaid Average and The Health Plan fell just 0.5 of a percentage point below the National Medicaid 90th percentile of 91.0%. The Health Plan was the top performer from CY 2008 through CY 2010. Overall, the MHT Weighted Average improved from CY 2008 to CY 2010, and the CY 2010 rate of 85.9% was 0.2 of a percentage point below the National Medicaid Average of 86.1%.

Adults' Access to Preventive/Ambulatory Health Services (AAP) Total

The AAP Total indicator reports the percentage of members 20 years and older who had an ambulatory or preventive care visit in the measurement year.

Figure 13. Results: MHT 2010 Adults' Access to Preventive/Ambulatory Health Services – Total*^



*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

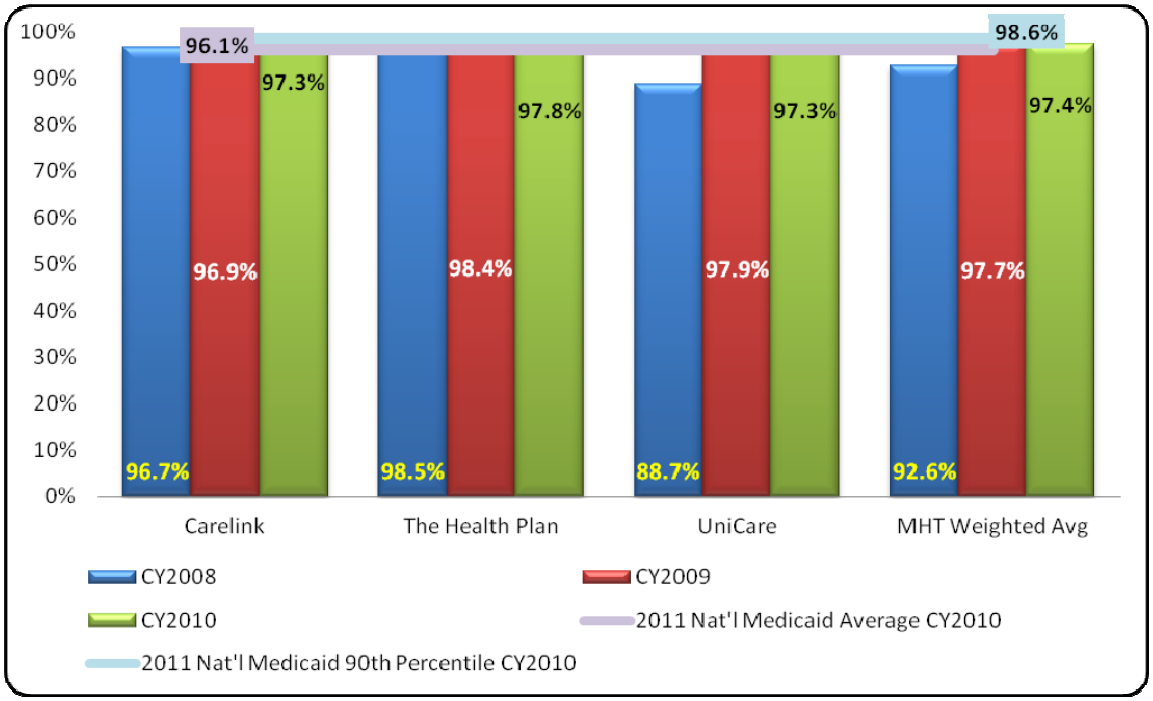
^ Measure not collected

Figure 13 presents the results for *Adults' Access to Preventive/Ambulatory Health Services -Total.* In CY 2010, MCO performance rates ranged from 85.5% to 88.4% and exceeded the National Medicaid Average. The Health Plan was one percentage point below the National Medicaid 90th percentile rate of 89.4%. The Health Plan was the top performer in both measurement years. Overall, the MHT Weighted Average of 87.2% decreased from CY 2009, but remained above the National Medicaid Average of 83.0%.

Children and Adolescents' Access to Primary Care Practitioners (CAP) 12-24 Months

The CAP 12-24 Months indicator reports the percentage of members age 12-24 months who had a PCP visit in the measurement year.

Figure 14. Results: MHT 2010 Children and Adolescents' Access to Primary Care Practitioners (CAP) 12-24 Months *



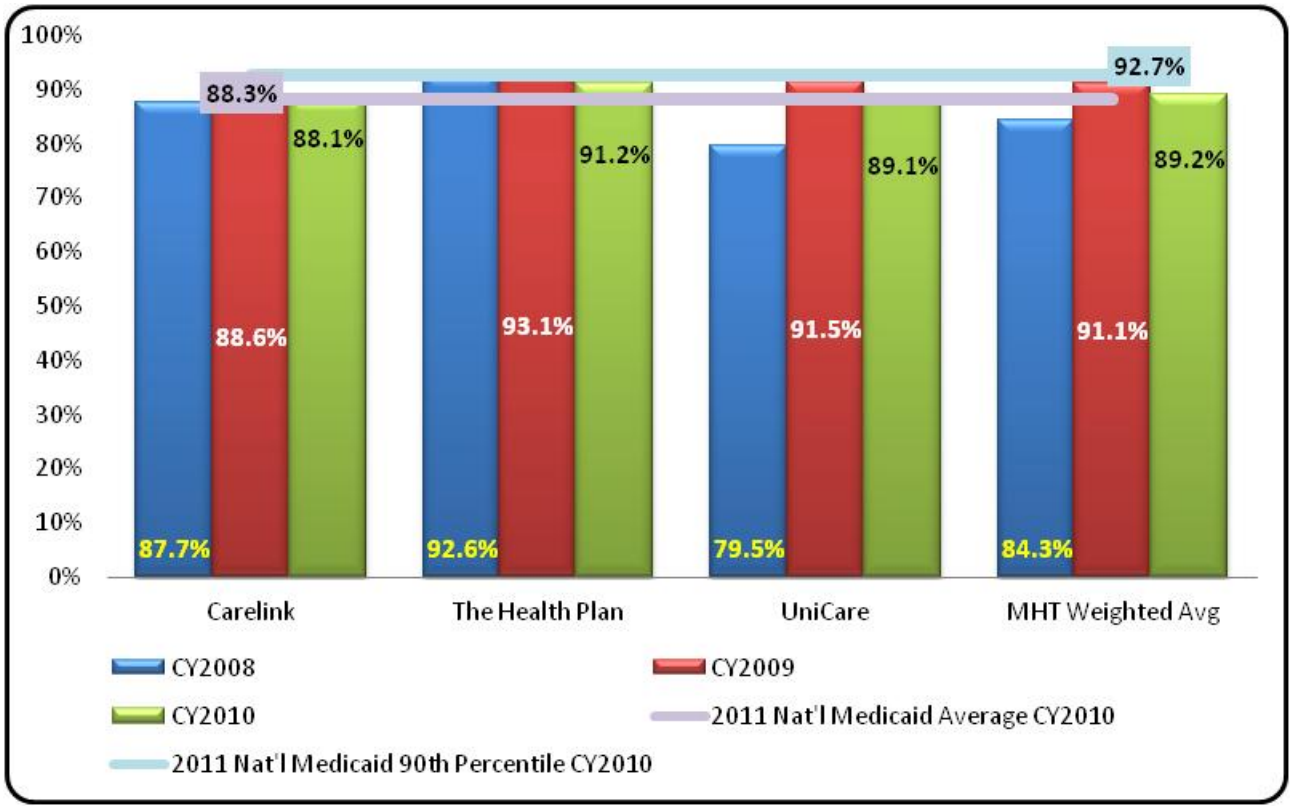
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 14 presents the results for *Children and Adolescents' Access to Primary Care Practitioners (CAP) 12-24 Months.* In CY 2010, the individual MCO performance rates ranged from 97.3% to 97.8%. All MCOs and the MHT Weighted Average exceeded the National Medicaid Average in CY 2010. The Health Plan was 0.8 of a percentage point short of the National Medicaid 90th percentile rate of 98.6%. The Health Plan was the top performer for all three measurement years. Overall, the CY 2010 MHT Weighted Average of 97.4% is greater than the CY 2008 rate of 92.6% and is above the National Medicaid Average of 96.1%.

Children and Adolescents' Access to Primary Care Practitioners (CAP) 25 Months-6 Years

The CAP 25 Months-6 Years indicator reports the percentage of members age 25 months-6 years who had a PCP visit in the measurement year.

Figure 15. Results: MHT 2010 Children and Adolescents' Access to Primary Care Practitioners (CAP) 25 Months 6 Years *



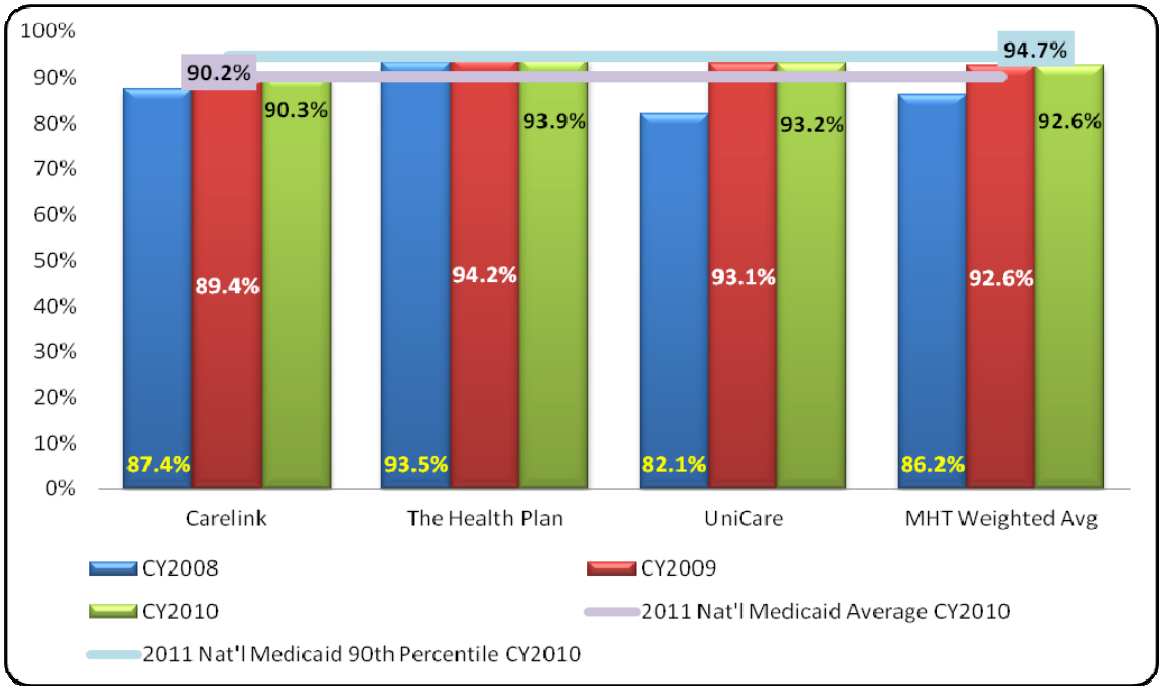
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 15 presents the results for *Children and Adolescents' Access to Primary Care Practitioners (CAP) 25 months – 6 years.* In CY 2010, the MCO performance rates ranged from 88.1% to 91.2%. The Health Plan was the top performer for all three measurement years. Carelink fell 0.2 percentage points short of the National Medicaid Average. The Health Plan, UniCare and the MHT Weighted Average exceeded the National Medicaid Average. Overall, the CY 2010 MHT Weighted Average of 89.2% exceeded the CY 2008 rate of 84.3% and the National Medicaid Average of 88.3%.

Children and Adolescents' Access to Primary Care Practitioners (CAP) 7-11 Years

The CAP 7-11 Years indicator reports the percentage of members age 7-11 years who had a PCP visit in the measurement year.

Figure 16. Results: MHT 2010 Children and Adolescents' Access to Primary Care Practitioners – 7-11 Years*



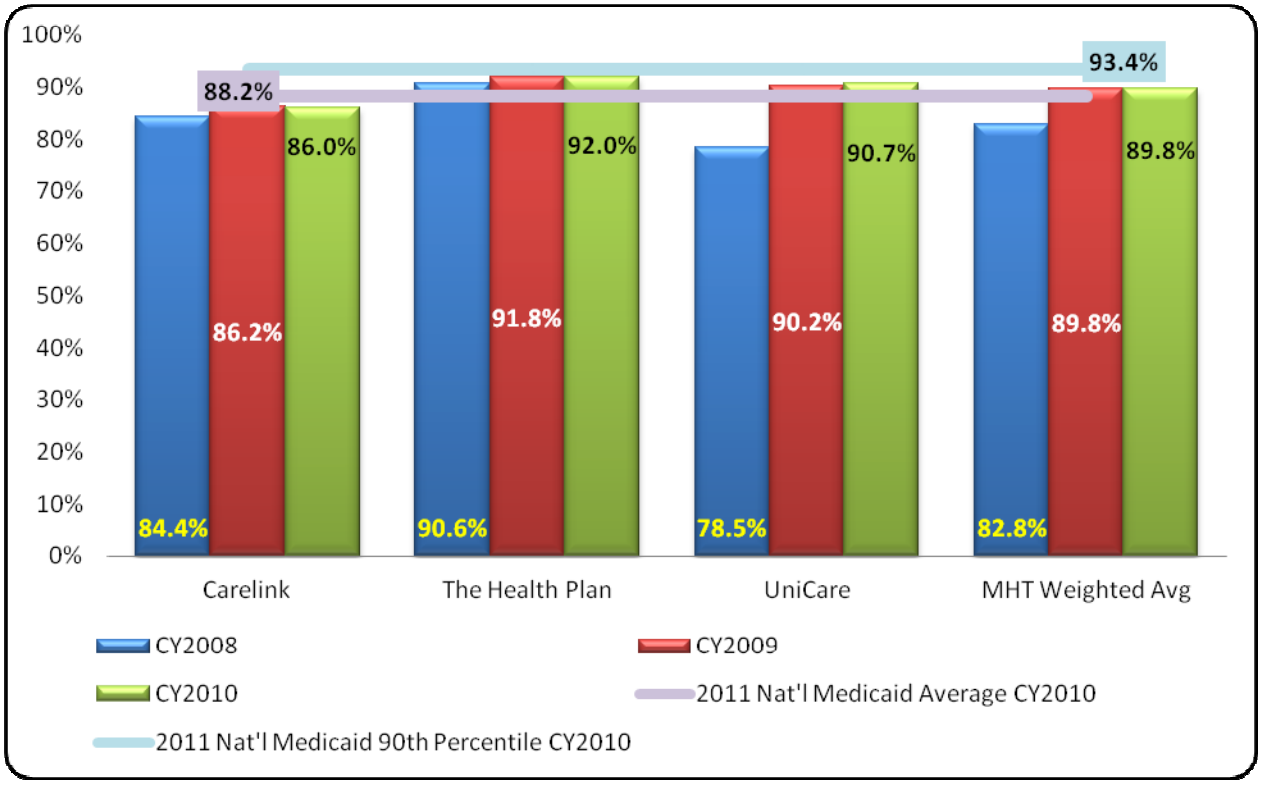
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 16 provides the indicator results for *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*. In CY 2010, health plan performance rates ranged from 90.3% to 93.9%. The Health Plan was the top performer for all three measurement years. All three MCOs exceeded the National Medicaid Average of 90.2% in CY 2010. Carelink and UniCare achieved an increase in their rates from CY 2008 to CY 2010. The Health Plan's rate decreased slightly from 94.2% in CY 2009 to 93.9% in CY 2010, but remained above the CY 2008 rate of 93.5%. Overall, the MHT Weighted Average remained constant from CY 2009 to CY 2010 at 92.6%, and exceeded both the CY 2008 rate of 86.2% and National Medicaid Average of 90.2%. The State Strategy for Assessing and Improving Managed Care Quality goal is 91.6%. The MHT Weighted Average exceeded this goal with a rate of 92.6% in CY 2009 and CY 2010.

Children and Adolescents' Access to Primary Care Practitioners (CAP) 12-19 Years

The CAP 12-19 Years indicator reports the percentage of members age 12-19 years who had a PCP visit in the measurement year.

Figure 17. Results: MHT 2010 Children and Adolescents' Access to Primary Care Practitioners – 12-19 Years*



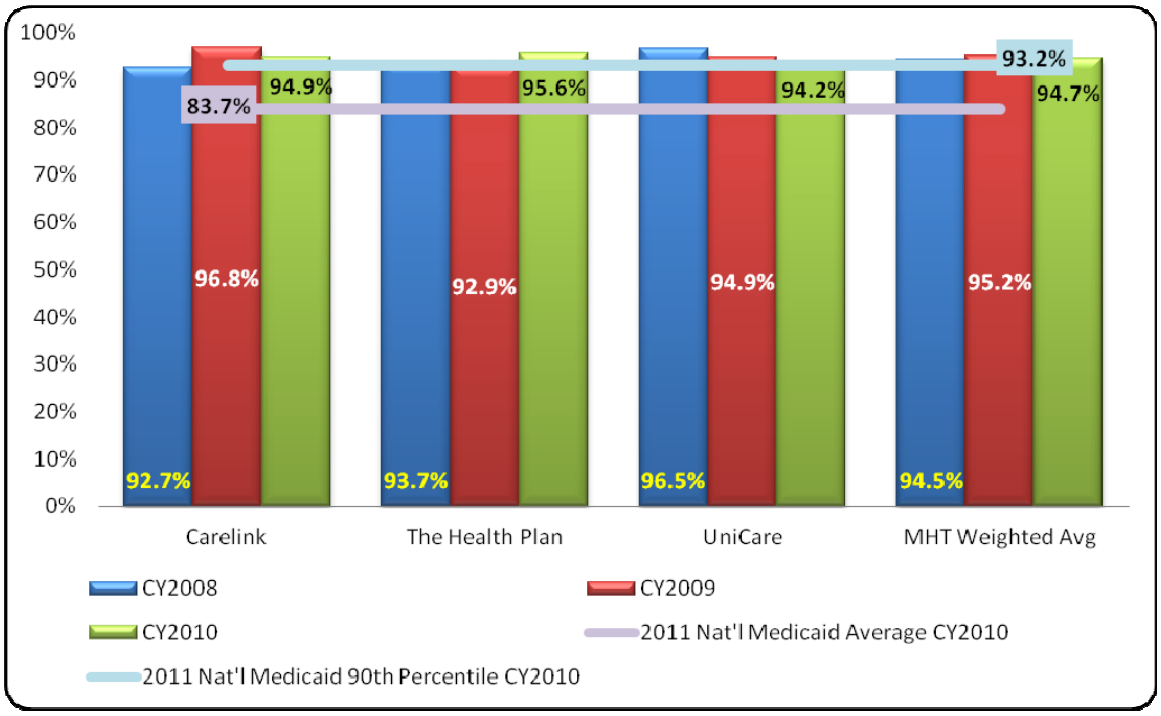
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Figure 17 provides the rates for *Children and Adolescents' Access to Primary Care Practitioners—12-19 Years*. In CY 2010, health plan performance rates ranged from 86.0% to 92.0%. The Health Plan was the top performer in all three measurement years. In CY 2010, The Health Plan and UniCare exceeded the National Medicaid Average of 88.2%. All three MCOs' CY 2010 rates were above their respective CY 2008 rate for this indicator. Overall, the MHT Weighted Average remains consistent between CY 2009 and CY 2010, and above both the CY 2008 rate and the National Medicaid Average.

Prenatal and Post Partum Care (PPC) - Timeliness of Prenatal Care

The PPC-Timeliness of Prenatal Care indicator reports the percentage of pregnant women who received a prenatal care visit in the first trimester or within 42 days of enrollment in the MCO.

Figure 18. Results: MHT 2010 Prenatal and Post Partum Care (PPC) - Timeliness of Prenatal Care*



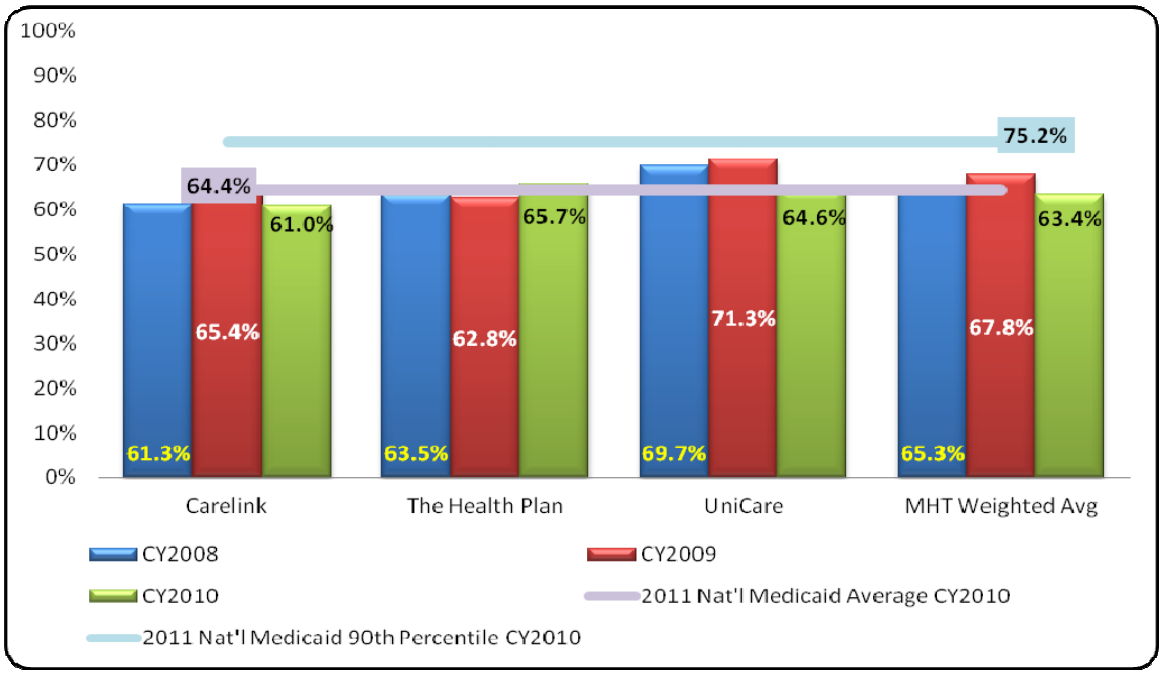
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 18 provides the measurement rates for *Prenatal and Post Partum Care (PPC) - Timeliness of Prenatal Care.* MCO rates ranged from 94.2% to 95.6% for CY 2010 and all exceeded the National Medicaid 90th percentile. In CY 2010, the MHT average was lower than CY 2009 but remained above the CY 2008 average and the National Medicaid 90th percentile.

Prenatal and Post Partum Care (PPC)-Postpartum Care

The PPC- Post Partum Care indicator reports the percentage of women who had a postpartum visit on or between 21 and 56 days of delivery.

Figure 19. Results: MHT 2010 Prenatal and Postpartum Care - Postpartum Care Indicator*



*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 19 displays the visit rates for *Prenatal and Postpartum Care—Postpartum Care*. In CY 2010, MCO performance rates ranged from 61.0% to 65.7%. UniCare was the top performer in CY 2008 and CY 2009, while The Health Plan was the top performer in CY 2010. The Health Plan and UniCare exceeded the National Medicaid Average of 64.4%. Overall, the MHT Weighted Average in CY 2010 trended lower than preceding years, and fell below the Medicaid National Average.

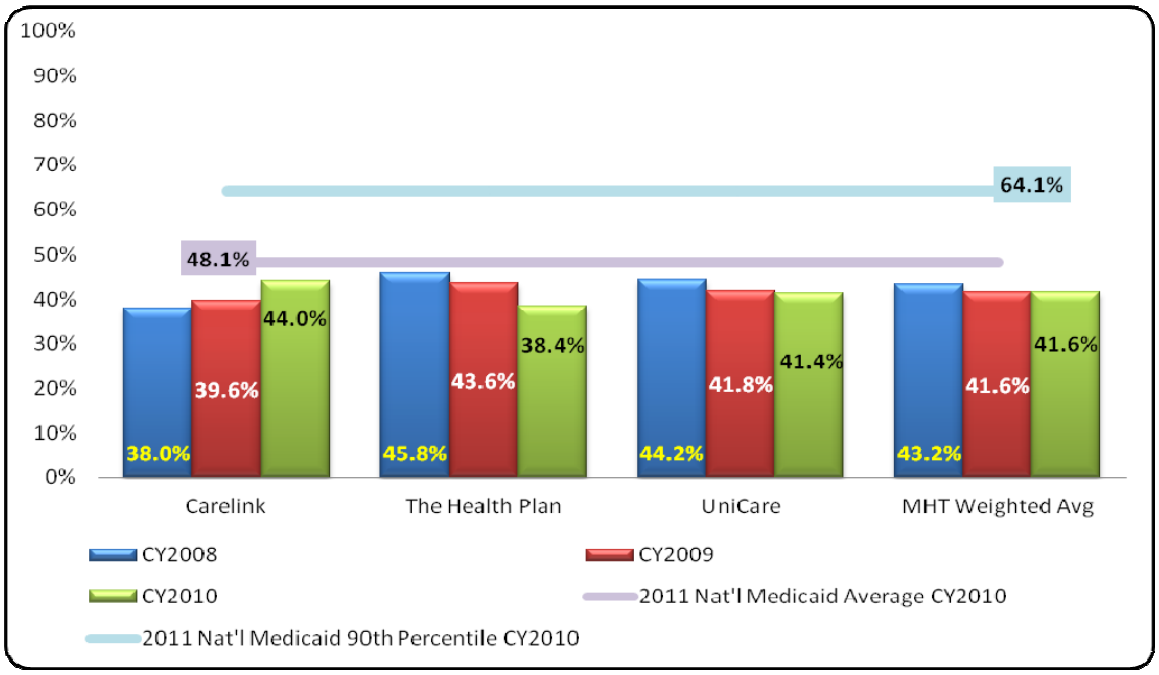
The State Strategy for Assessing and Improving Managed Care Quality sets a goal of 68.5% for this measure. The MHT Weighted Average of 63.4% is below this benchmark indicating unfavorable performance.

Timeliness

Adolescent Well- Care Visits (AWC)

The Adolescent Well-Care Visits Measure reports the percentage of enrolled members age 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Figure 20. Results: MHT 2010 Adolescent Well- Care Visits (AWC)*



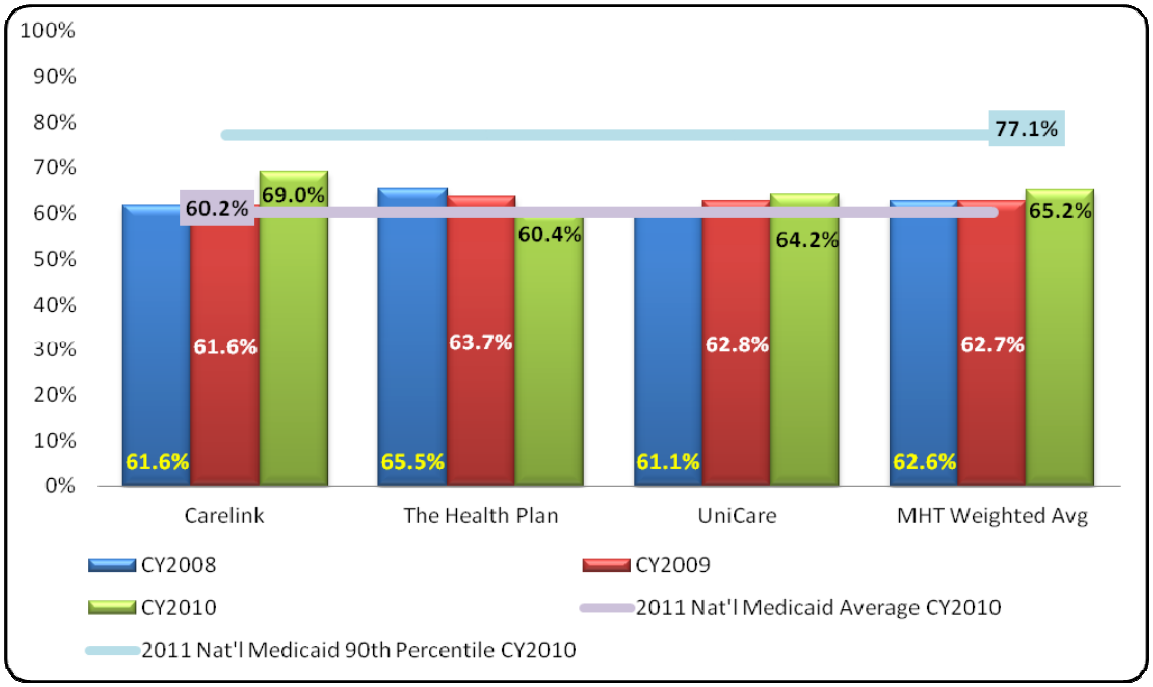
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 20 displays the results for *Adolescent Well Care Visit*. In CY 2010, MCO performance rates ranged from 38.4% to 44.0%. The Health Plan was the top performer in CY 2008 and CY 2009, while Carelink was the top performer in CY 2010. None of the MCOs rates met the National Medicaid Average. Carelink's rate increased steadily from 38.0% to 44.0% over the course of the three measurement periods. Both The Health Plan and UniCare's rates decreased from CY 2008 to CY 2010. The MHT Weighted Average decreased from 43.2% in CY 2008 to 41.6% in CY 2010.

Well-Child Visits in the First Fifteen Months of Life, Six or More Visits

The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with their PCP during the first 15 months of life.

Figure 21. Results: MHT 2010 Well-Child Visits in the First 15 Months of Life *



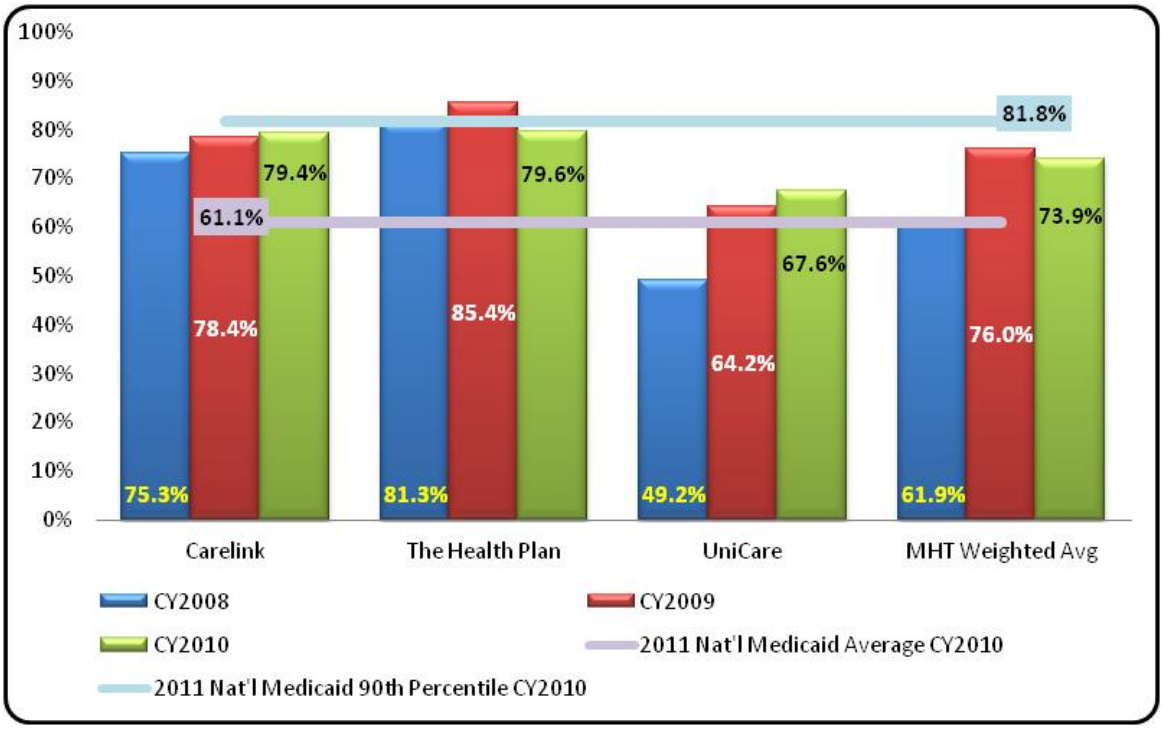
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 21 displays the results for *Well-Child Visits in the First 15 Months of Life, Six or More Visits*. In CY 2010, individual MCO performance rates ranged from 60.4% to 69.0%. The Health Plan was the top performer for in CY 2008 and CY 2009, while Carelink was the top performer in CY 2010. All three MCOs and the MHT Weighted Average compared favorably to the National Medicaid Average of 60.2%. Carelink and UniCare's rates improved steadily from CY 2008 through CY 2010. Overall, The MHT Weighted Average increased from 62.6% to 65.2% from CY 2008 to CY 2010.

Frequency of Ongoing Prenatal Care (FPC) - ≥ 81 Percent of Expected Prenatal Visits

The FPC ≥ 81 Percent of Expected Prenatal Visits measures the percentage of deliveries that had ≥ 81 percent of the expected prenatal visits.

Figure 22. Results: MHT 2010 *Frequency of Prenatal Care ≥ 81 Percent of Expected Prenatal Visits*.*



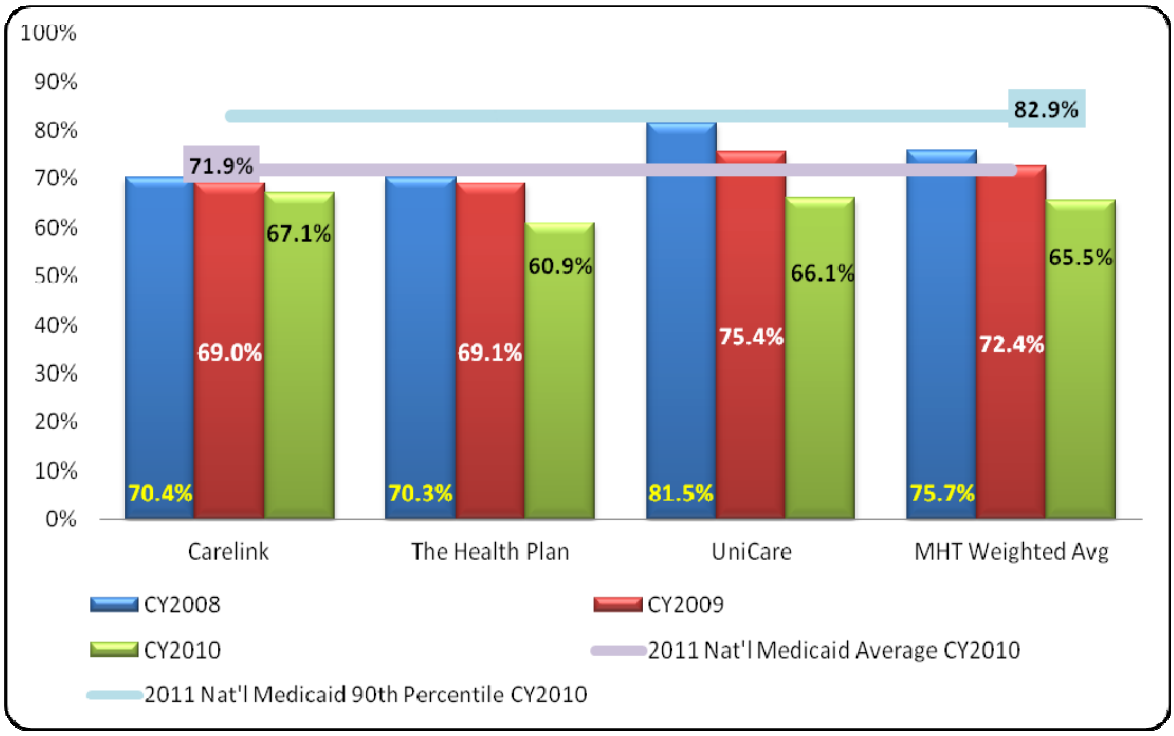
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 22 displays the results for *Frequency of Prenatal Care ≥ 81 Percent of Expected Prenatal Visits*. In CY 2010, MCO performance rates ranged from 67.6% to 79.6%. The Health Plan was the top performer for all three measurement years. All three MCOs and the MHT Weighted Average compared favorably with the National Medicaid Average benchmark in CY 2010. Carelink and UniCare's rates improved steadily from CY 2008 to CY 2010. Although The Health Plan was the top performer, its performance rate in CY 2010 (79.6%) dropped. Overall, The MHT Weighted Average decreased between CY 2009 and CY 2010 but remained favorable when compared to the CY 2008 rate of 61.9%.

Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

The Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure reports the percentage of members age 3-6 years who received one or more well-child visits with a PCP during the measurement year.

Figure 23. Results: MHT 2010 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*



*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

Figure 23 displays the results for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life* measure. In CY 2010, MCO performance rates ranged from 60.9% to 67.1%. UniCare was the top performer in CY 2008 and CY 2009 and Carelink was the top performer in CY 2010. All MCO rates and the MHT Weighted Average decreased from CY 2008 to CY 2010 and were below the National Medicaid Average of 71.9%.

The State Strategy for Assessing and Improving Managed Care Quality sets a goal of 80.3% for this measure. The MHT Weighted Average fell below this benchmark all three years.

Summary of Quality, Access, and Timeliness

Quality

PIP

The overall evaluation of the QI program through the SPR, PIP, and PMV reviews demonstrated that the MCOs have the appropriate structures and processes in place to monitor, evaluate and improve the quality of services to the MHT enrollees.

The MHT MCOs used the PIP quality improvement process of identifying problems relevant to their population, setting measurement goals, obtaining baseline measurements, and performing interventions aimed at improving performance. As a whole, MCOs are becoming more skilled at providing an appropriate project rationale that is specific to their population. They are following through on the recommendations that relate to developing and implementing more rigorous interventions. MCOs should continue to focus their efforts on data and barrier analyses. Developing interventions based on identified barriers should assist the MCOs in further improving project outcomes. The PIP topics were largely clinical in nature and focused on quality-related issues, including: Childhood Immunizations, Asthma, and Childhood Obesity.

Carelink's quality-related PIP, Improving Compliance with Childhood Immunizations, used the HEDIS measure, Childhood Immunization Status—Combo 3. After five years of reporting, this was the last reporting year for this PIP. While the MCO did not achieve its goal of meeting the national HEDIS Medicaid average, it did improve performance by almost 16 percentage points when compared to the baseline measurement. The final measurement of 60.93% demonstrated significant and sustained improvement for the project indicator.

The Health Plan's Asthma PIP constantly evolved over the course of four years. There were numerous indicator specification changes which negatively impacted the ability to assess the project over time. However, there was one indicator that remained constant and did demonstrate sustained improvement. The Persistent Asthmatics Who Were Appropriately Prescribed Medication indicator achieved a final rate of 86.41%, a 6 percentage point improvement over baseline. UniCare also reported on an Asthma PIP. Its first remeasurement was near the HEDIS Medicaid 90th percentile for the Persistent Asthmatics Appropriately Prescribed Medication indicator.

The Health Plan's Childhood Obesity PIP reported its first remeasurement data. While there was no reported improvement in performance, it should be noted that The Health Plan had developed strong interventions that target identified barriers. With current initiatives in place, it is expected that improvement will be reported in the next measurement cycle.

PMV

In the area of quality, the Controlling High Blood Pressure and the Comprehensive Diabetes Care Blood Pressure Control <140/80 mm HG measures exceeded the National Medicaid Average. Although the Lead Screening in Children measure did not meet the benchmark, the MHT Weighted Average improved from 50.4% to 54.8% from CY 2008 to CY 2010.

SPR

The SPR findings for CY 2008 are displayed in Table 6.

Table 6. MCO Compliance Rates for Quality Assessment and Performance Improvement (QA) CY 2008-CY 2010

SPR Standard	Compliance Rate		
	CY 2008	CY 2009	CY 2010
Carelink	97%	98%	99%
The Health Plan	100%	100%	99%
UniCare	98%	97%	98%

As shown in Table 6, all MCOs performed exceptionally well for the QA standard, achieving commendable compliance rates ranging from 97% to 100% across the measurement years. All MCO's surpassed the 90% threshold in CY 2010 for the QA standards thus obviating the need for any internal corrective action plans.

The QA standards address both the quality improvement (QI) and utilization management (UM) programs. In general, the MCOs provided well documented Quality Improvement (QI) and Utilization Review (UM) programs. The QI and UR programs consist of written program descriptions that describe the program objectives, goals, organization (organizational charts), staff, and committee structures. Work plans were included as part of the QI programs and typically include measurable goals and objectives, action plans to achieve goals, responsible party for each task and time tables for completion of tasks. The work plans are updated at least quarterly and are used by the MCOs to complete their annual QI/UM program evaluations, which must be reviewed and approved by the Board of Directors (BOD). Appropriate job descriptions are in place for key QI/UM staff. Policies and procedures are in place to guide the activities of the QI and UM staff.

A key component of successful QI programs is involvement of appropriate staff and committees in the decision making process. All MCOs provided documentation of annual reviews and approval of the QI Program documents by the BOD. Committee meeting minutes were kept and documented involvement of appropriate persons in the process (e.g. nurses, medical director, physician consultants).

The MCOs have Clinical Practice Guidelines (CPGs) in place and there is documentation that guidelines are reviewed and updated regularly per the requirements. CPGs are disseminated to providers in several different ways including fax blasts, provider newsletters, posting on the provider portion of the MCO website, and educational sessions. Preventive guidelines are in place and are distributed to members in the member handbook and/or member newsletters. Health promotion activities are offered by the MCOs.

All MCOs met the credentialing and recredentialing requirements, which include a review of practitioner credentialing/recredentialing files. Delegates are held to the same standards as the MCOs. The MCOs monitor all delegates at least annually for compliance with the MCO's standards.

In regards to the QA standards, two of the three MCOs continue to have issues tracking referrals and treatments made as a result of an EPSDT screen. Inter-rater reliability thresholds need to be increased to demonstrate a commitment to reliable and accurate application of guidelines. MCOs should ensure that all goals are measurable in the program documents. It is difficult to determine whether or not something was successful if it cannot be measured.

Access

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.

PIP

The Emergency Department Utilization-related PIPs fall under the category of access due to accessibility barriers identified in the process. For example, limited access to same day appointments with primary care practitioners was noted. Additionally, after hours appointments are very limited. Carelink's PIP, which focuses on utilization for all of its members, was unable to improve upon its baseline rates, even with an improved barrier analysis and strong case management initiatives. The Health Plan's PIP focused on children with respiratory diagnoses and adults with back pain. The MCO improved its ER visits performance for respiratory diagnoses with an 18% decrease in the ER visits rate. Finally, UniCare's PIP focused on reducing ER utilization for members within specific primary care practices. Remeasurement will occur in the next reporting cycle and only baseline data is available.

PMV

CY 2010 results indicate that the MHT Weighted Average *and* all MCOs outperformed the national Medicaid Average for the following measures of access:

- Adults' Access to Preventive/Ambulatory Health Servicesages 20-44 Years
- Adults' Access to Preventive/Ambulatory Health Services-Total

- Children and Adolescents' Access to Primary Care Practitioners 12-24 Months
- Children and Adolescents' Access to Primary Care Practitioners 25 Months-6 Years
- Children and Adolescents' Access to Primary Care Practitioners 7-11 Years
- Children and Adolescents' Access to Primary Care Practitioners 12-19 Years
- Prenatal and Post Partum Care-Timeliness of Prenatal Care

The Prenatal and Postpartum Care-Timeliness of Prenatal Care Measure rate for all MCOs and the MHT Wieghted Average also exceeded both the National Medicad Average and the National Medicaid 90th percentile of 93.2% in CY 2010.

SPR

Access standards are found throughout the Enrollee Rights, Grievances, and QA standards. The MCOs performed well for standards and elements related to access and were able to demonstrate that members have access to:

- Comprehensive member materials (new member welcome packet, enrollee rights and responsibilities, description of benefits and services),
- Oral interpretation and translator service free of charge,
- An adequate primary care provider network,
- A grievance and appeals process approved by BMS as required by contract,
- Customer Services,
- Health education programs, and
- Their personal medical records.

To ensure that enrollees have access to the required benefits and services requires monitoring. The MCOs have systems in place to monitor access to:

- Providers 24 hours a day, 7 days per week,
- Customer services (time to answer call and call abandonment rates),
- The complaint, grievance and appeals systems(timely acknowledgment and resolution of disputes),
- Timely authorization decisions (preauthorization, concurrent and continuing authorizations), and
- An adequate network of providers.

MCOs are required to have policies and procedures in place to request internal CAPs when a provider or delegated entity does not meet MCO care or timeliness performance standards. All MCOs have these procedures documented in their QI and UM program documents.

In CY 2010, Carelink did not meet its internal standards for PCP/Pediatrician and OB/GYN access.

While compliance rates for high-volume specialists ranged from 85.1% - 99.8%, Hematology/Oncology dropped from 93.5% in 2009 to 85.1% in 2010. Cardiology and Dermatology also presented opportunities for improvement, scoring 86.3% and 88.5%, respectively. Carelink met the program's network access standards during the BMS annual review. As a result it is noted that Carelink is compliant with West Virginia's requirements; however, it is recommended that the MCO recruit additional specialists to meet its internal standards.

THP identified an access issue when monitoring the 24/7 access to PCP standard. The 2010 After Hours PCP Accessibility Report included the results of information gleaned from offices being called after hours. Of 24 offices telephoned, only 16 offices (66.7%) returned the call within an hour. Only 3 (12.5%) of the provider offices not responding had appropriate recorded messages that informed enrollees how to obtain after-hours assistance. As part of the QI process, the following interventions were implemented:

- Individualized letters were written to the eight (8) offices that were non-compliant with after-hours access.
- Corrective action was required with provider follow-up in the first quarter of 2011.
- Follow-up after-hours calls were to be made to these offices 1st quarter 2011.
- Individual occurrences were to be entered into their respective provider files for review during recredentialing.

Through monitoring its access standards, UniCare identified an access issue in CY 2010. The MCO completed a GeoAccess survey which included a geographic assessment against the MCO's internal standards. For CY 2010, UniCare exceeded the 90% threshold of PCP availability. However, only 40% of counties met the threshold for high-volume specialist availability. An inadequate number of Allergy/Immunology specialists was noted for over half of the counties in UniCare's service area. UniCare met the program's network access standards during the BMS annual review. As a result, it is noted that UniCare is in compliance with West Virginia's requirements, but it is recommended that the MCO should recruit additional specialists to meet its internal standards.

UniCare completed a telephone survey to assess compliance with appointment scheduling standards and results indicated that the MCOs did not achieve its goal of 95%. Compliance for internal standards for non-urgent/sick appointment within 72 hours was 63%, and prenatal appointment within 7 days showed a dramatic drop (67%) when compared to 90% in 2009. It is noted that UniCare's internal standard for prenatal appointment is 7 days whereas the contractual standard is within 14 days.

Timeliness

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.

PIP

For CY 2010, there were no PIPs that specifically focused on timeliness. The topics were primarily clinical in nature and addressed quality-related issues.

PMV

The four measures used to assess timeliness of services are:

- Adolescent Well-Care Visits
- Well-Child Visits in the First 15 Months of Life, Six or More Visits
- Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Frequency of Ongoing Prenatal Care ≥81% of Expected Visits

All three MCOs and the MHT Weighted Average exceeded the National Medicaid Average on the Well-Child Visits in the First Fifteen Months of Life and Frequency of Ongoing Prenatal Care measures. None of the MCOs met or exceeded the National Medicaid Average for the Adolescent Well-Care Visits or Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of life measures.

SPR

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. These standards are found throughout the Enrollee Rights (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QA) standards.

During the SPR on-site review, the cases, files, and logs are reviewed to assess the timeliness of MCO activities. Specifically for CY 2010, Delmarva reviewed individual files and cases for timeliness of:

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

All three MCOs were able to demonstrate:

- A comprehensive utilization management plan is in place and addresses timeliness of services,
- Pre-authorization procedures are in place and include standards for timely completion of requests,
- Procedures are in place for initial and continuing authorizations and include standards for timely completion for all requests,
- The appropriate time frames are in place for processing and resolving complaints, grievances, and appeals,
- Complaints, grievances, and appeals are resolved timely according to required timelines,
- Appointment access standards are in place and they are monitored,
- Providers are credentialed timely,
- Enrollees have timely access to Customer Services staff through telephone and written correspondence, and
- All delegated providers are held to the same timeliness standards.

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported to the designated QI/UM committee. The complaint, grievance, and appeal policies and procedures have been reviewed and approved by BMS as required. The majority of complaints and grievances are resolved within one day. Ten appeals cases were reviewed per MCO while on-site. If an MCO had fewer than ten cases, all the files were reviewed. In CY 2010, all appeals cases were completed well within the required time-frame.

Appointment access standards are found in the MCO contracts. MCOs monitor both the time it takes to schedule an appointment and office wait-time. The MCOs either call the providers' offices to check the availability of the next appointment or assess this using an enrollee satisfaction survey such as the Consumer Assessment of Health Providers and Systems (CAHPS) survey. There were no identified appointment access issues in CY 2010. In regards to credentialing/recredentialing, there were no timeliness issues identified in the review of provider files. In general, files contained the required information, were verified using acceptable sources, and were approved/denied according to the required timeframe. Timely access to customer service staff is monitored daily at each MCO using the phone system. Call answer timeliness and abandonment rates are captured in the PMV portion of the annual audit and will be discussed in that section. Finally all MCOs have processes and procedures in place to monitor delegate providers. The delegated provider audits did not reveal any major issues in CY 2010.

MHT MCO Strengths and Recommendations

Carelink Strengths and Recommendations

Strengths

- Carelink improved its Childhood Immunizations PIP by providing a more comprehensive assessment. Additionally, sustained improvement was achieved in the Childhood Immunizations (Combo 3) indicator. Improvement was statistically significant when compared to baseline.
- Carelink has adopted recommendations provided by Delmarva to improve its compliance ratings. This has resulted in a 100% compliance rate for the Enrollee Rights, Grievances Systems, and Fraud and Abuse standards. Its Quality Assessment and Performance Improvement compliance rate was 99%.
- Production of the organization's HEDIS reports was a well-coordinated and shared responsibility between Coventry Health Care corporate and local Carelink of West Virginia, Inc. staff. Corporate staff maintained responsibility for transaction systems, data integration, HEDIS report production, while local health plan staff coordinated medical record retrieval, abstraction, and data entry, as well as HEDIS report production. These arrangements enabled the organization to recognize efficiencies through centralization at the corporate level and through market familiarity at the local level.
- For the 2011 HEDIS report, West Virginia required all Medicaid health organizations to report on the Use of Appropriate Medications for People with Asthma (ASM) and Medical Assistance with Smoking Cessation and Tobacco Use (MSC) measures. The ASM measure required that the organization obtain and integrate pharmacy data from the state. Carelink of West Virginia, Inc. successfully reported both measures in 2011.

Recommendations

- The MCO should enhance its data analysis for the Emergency Department Utilization PIP. A more concentrated, refined analysis (including assessment of diagnoses) should provide opportunity for targeted interventions.
- Carelink meets the West Virginia MCO program access requirements, but it is recommended that the MCO recruit additional specialists to meet its internal standards.
- Tracking and referrals and results of treatments resulting from EPSDT visit have been problematic for Carelink. The MCOs are now required to provide this information to BMS quarterly. It recommended that Carelink adopt the methodology provided by the data contractor to report the EPSDT measures.
- Due to issues and challenges identified in obtaining data from the West Virginia Statewide Immunization Information System (WVSIIS), Carelink 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 WVIIS to obtain reasonable access to the data.

- While Carelink 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.

The Health Plan Strengths and Recommendations

Strengths

- The Health Plan sustained improvement in its Asthma PIP indicator: persistent asthmatics who were appropriately prescribed medication.
- The Health Plan readily adopts recommendations made by Delmarva. This has resulted in 100% compliance rate for Enrollee Rights and Grievance Systems and a 99% compliance rate for Quality Assessment and Performance Improvement and Fraud and Abuse standards.
- Despite issues identified with the WVSIIS the organization was the only MHT MCO organization that was able to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011.
- The Health Plan of the Upper Ohio Valley utilized team member assignments and peer reviews to develop and test source code and data collection tools prior to implementation.
- The organization continued to standardize its source code documentation, including flowcharts, pseudo-code, and business specifications for HEDIS 2011 reporting.

Recommendations

- The Health Plan should maintain consistency in PIP indicators as much as possible. Specification changes negatively impact the opportunity to trend data.
- The Health Plan should enhance its Childhood Obesity PIP analysis and include comparisons to baseline and previous measurements. Additionally, comparisons should be made to respective project indicator goals.
- The qualitative analysis for the Emergency Department Utilization PIP should identify barriers, causes for performance (positive or negative), and impact of interventions. Completing this portion of the analysis will assist in identifying the next steps in the process; it facilitates and provides direction for the intervention course of action.
- Continue to monitor the providers who were non-compliant with after-hours access requirements and evaluate the effectiveness of the interventions implemented to address the issue.
- Inter-rater reliability (IRR) assessed the extent to which two or more individuals (raters, coders, medical record abstractors etc.) agree on the application of review criteria. Typically MCOs complete IRR at least annually to ensure criteria are being applied accurately and consistently. It is recommended that the inter-

rater reliability standard of 80% be increased to a minimum of 90% to demonstrate commitment to accurate application of review criteria.

- Continue efforts to enhance the Fraud and Abuse program. THP took the feedback provided during the baseline review (CY 2009) and substantially improved the program (and compliance rate). THP must provide BMS monthly Fraud and Abuse report whether or not any cases were identified during the reporting period.
- For the 2011 HEDIS report, BMS required all Medicaid organizations to report on the Use of Appropriate Medications for People with Asthma (ASM) and Medical Assistance with Smoking Cessation and Tobacco Use (MSC) measures. The ASM measure required that the organization obtain and integrate pharmacy data from the state. The Health Plan successfully reported the ASM measure and a proxy measure for the MSC measure using its proprietary customer satisfaction survey in 2011.

UniCare Strengths and Recommendations

Strengths

- UniCare has performed at or near the HEDIS Medicaid 90th percentile in its Asthma PIP indicator, persistent asthmatics appropriately prescribed medication.
- UniCare has consistently adopted Delmarva's recommendations which resulted in compliance rates of 100% for Enrollee Rights, Grievance Systems, and Fraud and Abuse standards. The Quality Assessment and Performance Improvement standard remains consistent at a respectful 98%.
- In 2010, the UniCare successfully migrated its West Virginia health plan business to a new transaction system, and a new provider data system, with real time interfaces.
- Production of the organization's HEDIS reports was a well-coordinated and shared responsibility between WellPoint corporate and the UniCare Health Plan of West Virginia, Inc. local staff. Corporate staff maintained responsibility for transaction systems, data integration, and HEDIS report production, while local health plan 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 the 2011 HEDIS report, the West Virginia BMS required all Medicaid health organizations to report on the Use of Appropriate Medications for People with Asthma (ASM) and Medical Assistance with Smoking Cessation and Tobacco Use (MSC) measures. The ASM measure required that the organization obtain and integrate pharmacy data from the state. UniCare Health Plan of West Virginia, Inc. successfully reported both measures in 2011.

Recommendations

- UniCare should include an assessment of performance in its qualitative analysis for the Asthma PIP.
- A barrier analysis should be completed for PIPs prior to intervention implementation. Barrier identification assists in the process of selecting the most appropriate interventions.
- Although UniCare is compliant with the West Virginia MCO program access requirements, it is recommended the MCO should recruit additional specialists to meet its internal standards.
- UniCare's monitoring of its internal access standard of scheduling prenatal care appointments within 7 days and non-urgent/sick appointments within 72 hours resulted in compliance rates of 67% and 63%, respectively. In order to meet its internal standards, UniCare should focus efforts on improving timely access to providers for non-urgent/sick and prenatal care visits.
- Due to issues and challenges identified in obtaining data from the WVSIIS, the MCO 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 WVIIS to obtain reasonable access to the data.
- The organization created two separate hybrid samples for Childhood Immunization Status and Lead Screening in Children, with one reduced and the other not reduced. The audit team recommended that UniCare combine samples for these measures, which will reduce the burden on the MCO.

MHT Program Strengths and Recommendations

Strengths

The MCOs continue to improve the PIP reporting of results. In CY 2010 the MCOs provided a more comprehensive qualitative and quantitative analysis of the indicator results and evaluation of the effectiveness of interventions.

The MHT managed care plans continue to do well in the Systems Performance Review. The MCOs take the recommendations offered by Delmarva and implement systems changes. This commitment to improvement resulted in the following compliance rates for the CY 2010 review.

Table7. MCO SPR Compliance Rates for CY 2010

SPR Standard	CY 2010 Compliance Rate		
	Carelink	The Health Plan	UniCare
Enrollee Rights (ER)	100%	100%	100%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	99%	99%	98%
Fraud and Abuse (FA)	100%	96%	100%

Documentation of policies, procedures and program activities (e.g. meeting minutes, annual program evaluations) has improved overall compliance with the standards.

Performance measure validation activities demonstrate MCOs have the systems in place to accurately report the HEDIS measures required by BMS. All MCOs were able to submit their HEDIS data by the June 15, 2010 deadline.

Recommendations

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 CY 2010, BMS established algorithms and reporting templates for reporting these indicators. These data are now collected and submitted to BMS on a quarterly basis. It is recommended that the rates submitted be monitored for reasonability early in the process to detect any issues with the algorithms.

As in the CY 2009 review, the performance measure validation process uncovered an issue with the MCOs gaining reasonable access to the West Virginia Statewide Immunization Information System (WVSIIS). 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.

References

Bureau for Medical Services, *West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality, April 2010*

Centers for Medicare and Medicaid Services (CMS). (2002, June). Final Rule: Medicaid Managed Care; 42 C.F.R. Part 400 et seq. Subpart D. Quality Assessment and Performance Improvement. Retrieved December 4, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/f4289.pdf

Centers for Medicare and Medicaid Services (CMS). (2003, January). Final Rule: External Quality Review of Managed Care Organizations and Prepaid Inpatient Health Plans, 42 C.F.R. Part 438.300 et seq. Retrieved November 1, 2004, from CMS website: http://www.cms.hhs.gov/medicaid/managedcare/eqr12403.pdf

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

National Committee for Quality Assurance (NCQA). (2010). *Standards and Guidelines for the Accreditation of MCOs.*

Appendix 1 - Trending Tables

Tables A1-1through A1-3 below provide a comparison of the MCO (CY 2010), MHT Average (CY 2010), and National rates for HEDIS 2009 (CY 2008) through HEDIS 2011 (CY 2010).

Table A1-1. Trending Information for the Effectiveness of Care Domain*

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Adult BMI Assessment	25.2%	39.7%	45.4%	15.8%	6.2%	10.3%	24.8%	31.1%	41.4%	36.7%	42.1%	70.5%
Childhood Immunization Status Combination 2	66.4%	61.8%	66.2%	67.9%	64.2%	62.3%	72.7%	61.6%	62.2%	63.5%	74.2%	85.9%
Childhood Immunization Status Combination 3	60.2%	54.4%	60.9%	59.9%	56.7%	56.0%	68.1%	55.0%	55.1%	57.1%	70.0%	82.5%
Immunizations for Adolescents Combination 1	^	36.9%	46.1%	^	39.2%	44.5%	^	29.0%	37.2%	39.5%	52.2%	75.5%
Lead Screening in Children	59.0%	53.9%	55.2%	46.0%	52.1%	49.8%	49.3%	50.4%	56.2%	54.8%	66.3%	87.6%
Breast Cancer Screening	37.7%	28.3%	31.2%	47.2%	54.1%	51.1%	39.6%	47.0%	45.9%	43.6%	51.4%	62.9%
Cervical Cancer Screening	62.1%	56.8%	58.8%	66.7%	67.5%	64.7%	67.8%	70.1%	70.4%	65.7%	67.2%	78.7%
Chlamydia Screening in Women	48.6%	54.0%	40.7%	34.8%	35.5%	43.2%	37.6%	37.4%	36.6%	39.1%	57.3%	69.1%
Cholesterol Management for Patients With	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	82.0%	89.1%

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Cardiovascular Conditions - LDL-C Screening												
Cholesterol Management for Patients With Cardiovascular Conditions - LDL-C level <100 mg/DL	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	42.8%	57.1%
Controlling High Blood Pressure	54.5%	54.0%	50.0%	51.6%	57.4%	63.8%	61.5%	68.6%	66.4%	61.0%	55.5%	67.6%
Comprehensive Diabetes Care – HbA1c Testing	79.0%	75.3%	74.3%	75.7%	77.1%	80.7%	76.4%	75.6%	76.8%	76.9%	82.0%	90.9%
Comprehensive Diabetes Care – Poor HbA1c Control >9% *(lower rate is better)*	54.6%	60.1%	60.4%	57.4%	53.6%	47.6%	40.8%	30.1%	47.6%	51.0%	44.0%	29.2%
Comprehensive Diabetes Care – HbA1c Control <7%	25.5%	25.9%	21.0%	^	32.8%	33.3%	^	31.9%	30.8%	28.8%	34.7%	44.4%
Comprehensive Diabetes Care – HbA1c Control <8%	37.8%	32.9%	29.7%	27.2%	43.6%	44.8%	51.3%	39.3%	43.5%	40.1%	46.9%	59.1%
Comprehensive Diabetes Care – Eye (Retinal) Exams	35.3%	43.7%	25.2%	33.8%	30.7%	39.3%	43.0%	34.5%	30.2%	30.6%	53.1%	70.6%
Comprehensive Diabetes Care – Lipid Profile LDL-C Screening	66.4%	63.9%	58.4%	68.4%	67.1%	70.3%	72.9%	67.3%	64.4%	64.0%	74.7%	84.2%

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Comprehensive Diabetes Care – LDL-C Control (<100 mg /dL)	21.0%	17.7%	17.3%	21.3%	26.4%	28.3%	38.5%	27.4%	27.0%	24.7%	34.6%	45.9%
Comprehensive Diabetes Care – Medical Attention to Nephropathy	60.5%	58.9%	67.3%	65.4%	68.6%	72.4%	65.9%	65.8%	63.2%	66.0%	77.7%	86.9%
Comprehensive Diabetes Care – Blood Pressure Control (<140/80mm Hg) ◘	^	^	30.2%	^	^	44.1%	^	^	42.9%	39.7%	—	—
Comprehensive Diabetes Care – Blood Pressure Control (<140/90mm Hg)	58.8%	58.9%	51.0%	61.8%	62.1%	67.6%	74.8%	56.8%	68.3%	63.6%	60.4%	76.0%
Use of Imaging Studies for Low Back Pain	60.3%	66.5%	67.3%	72.7%	72.8%	65.5%	71.6%	71.3%	71.9%	69.3%	75.4%	82.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	8.2%	9.0%	24.3%	15.1%	1.5%	1.1%	4.5%	21.4%	14.1%	14.1%	37.4%	69.8%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	25.8%	40.3%	44.4%	35.5%	0.9%	0.5%	13.5%	40.6%	34.5%	30.0%	45.6%	72.0%

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	14.3%	22.7%	40.5%	32.1%	0.8%	0.5%	10.4%	27.3%	19.5%	21.2%	36.7%	60.6%

* HEDIS percentile and mean rates are from NCQA Quality Compass 2011
— No comparative benchmarks available
◘ New measure for 2010-not for public reporting
^ Measure not collected
NA indicates the denominator was too small to calculate a reliable rate

Table A1-2. Trending Information for the Access and Availability of Care Domain*

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	85.0%	86.7%	85.9%	90.5%	90.6%	88.2%	81.4%	88.5%	88.1%	87.4%	81.2%	88.4%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	79.5%	82.7%	81.7%	90.3%	84.9%	90.5%	83.9%	86.7%	86.5%	85.9%	86.1%	91.0%
Adults' Access to Preventive/Ambulatory Health Services – Total	^	86.3%	85.5%	^	91.0%	88.4%	^	88.3%	87.9%	87.2%	83.0%	89.4%
Children's and Adolescents' Access to Primary Care Practitioners – 12-24 Months	96.7%	96.9%	97.3%	98.5%	98.4%	97.8%	88.7%	97.9%	97.3%	97.4%	96.1%	98.6%
Children's and Adolescents' Access to Primary Care Practitioners – 25 Months-6 Years	87.7%	88.6%	88.1%	92.6%	93.1%	91.2%	79.5%	91.5%	89.1%	89.2%	88.3%	92.7%
Children's and Adolescents' Access to Primary Care Practitioners – 7-11 Years	87.4%	89.4%	90.3%	93.5%	94.2%	93.9%	82.1%	93.1%	93.2%	92.6%	90.2%	94.7%

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Children's and Adolescents' Access to Primary Care Practitioners – 12-19 Years	84.4%	86.2%	86.0%	90.6%	91.8%	92.0%	78.5%	90.2%	90.7%	89.8%	88.2%	93.4%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.7%	96.8%	94.9%	93.7%	92.9%	95.6%	96.5%	94.9%	94.2%	94.7%	83.7%	93.2%
Prenatal and Postpartum Care – Postpartum Care	61.3%	65.4%	61.0%	63.5%	62.8%	65.7%	69.7%	71.3%	64.6%	63.4%	64.4%	75.2%
Call Answer Timeliness	86.4%	84.1%	82.7%	96.0%	92.7%	96.7%	87.6%	83.9%	79.3%	84.1%	82.7%	94.7%
Call Abandonment *(lower rate is better)*	1.1%	1.2%	1.7%	2.0%	2.9%	1.9%	1.0%	1.7%	4.4%	2.2%	2.9%	0.9%

* HEDIS percentile and mean rates are from NCQA Quality Compass 2011
^ Measure not collected

Table A1-3. Trending Information for the Use of Services Domain*

Measure	CHP HEDIS 2009	CHP HEDIS 2010	CHP HEDIS 2011	THP HEDIS 2009	THP HEDIS 2010	THP HEDIS 2011	UHP HEDIS 2009	UHP HEDIS 2010	UHP HEDIS 2011	MHT Average	National Medicaid Average HEDIS 2011	National Medicaid 90th Percentile HEDIS 2011
Frequency of Ongoing Prenatal Care – 81%+	75.3%	78.4%	79.4%	81.3%	85.4%	79.6%	49.2%	64.2%	67.6%	73.9%	61.1%	81.8%
Well-Child Visits in the First 15 Months of Life Six or more visits	61.6%	61.6%	69.0%	65.5%	63.7%	60.4%	61.1%	62.8%	64.2%	65.2%	60.2%	77.1%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	70.4%	69.0%	67.1%	70.3%	69.1%	60.9%	81.5%	75.4%	66.1%	65.5%	71.9%	82.9%
Adolescent Well-Care Visit	38.0%	39.6%	44.0%	45.8%	43.6%	38.4%	44.2%	41.8%	41.4%	41.6%	48.1%	64.1%

* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

Appendix 2 - PIP Results

Table A2-1. Carelink Performance Improvement Project (PIP) Results.

Improving Compliance with Childhood Immunizations			
Indicator 1: Childhood Immunizations (Combo 3) (4 Diphtheria, tetanus and acellular pertussis (DTaP), 3 polio (IPV), 1 Measles, mumps, and rubella (MMR,) 2 H influenza type B (HiB), 3 Hepatitis B (Hep B), 1 Chicken pox (VZV), and 4 Pneumococcal conjugate (PCV) vaccines)			
Time Period	Measurement	Goal	Rate or Results
CY 2006	Baseline		45.03%
CY 2007	Remeasurement 1	65.40%	53.86%
CY 2008	Remeasurement 2	67.52%	60.19%
CY 2009	Remeasurement 3	69.29%	54.40%
CY 2010	Remeasurement 4	69.29%	60.93%
Emergency Department Utilization			
Indicator 1: Medicaid Members (20-44 years of age) Who Have Received ER Services Reported Per 1000 Member Months			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline		146.45/1000 member months
CY 2009	Remeasurement 1	2.5% reduction	151.37/1000 member months
CY 2010	Remeasurement 2	2.5% reduction	147.10/1000 member months
Indicator 2: Medicaid Members (all ages) Who Have Received ER Services Reported Per 1000 Member Months			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline	(HEDIS regional averages)	74.66/1000 member months
CY 2009	Remeasurement 1	71.51/1000 member months	81.70/1000 member months
CY 2010	Remeasurement 2	75.16/1000 member months	74.64/1000 member months

Table A2-2. The Health Plan of the Upper Ohio Valley Performance Improvement Project (PIP) Results.

Asthma			
Indicator 1: Persistent asthmatics who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2007	Baseline		80.62%
CY 2008	Remeasurement 1	5% annual increase	85.87%
CY 2009	Remeasurement 2	5% annual increase	83.77%
CY 2010	Remeasurement 3	5% annual increase	86.41%
Indicator 2: Average number of asthma prescriptions (for asthmatics)			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		6.43 prescriptions/member

Indicator 3: Persistent asthmatics who had physician management			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		83.54%
CY 2010	Remeasurement 1	5% annual increase	83.01%
Indicator 4: Persistent asthmatics who had an inpatient visit (with respiratory specific diagnosis)—visits per 1000			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		57.61 k/month
Indicator 5: Persistent asthmatics who had an emergency room encounter (with respiratory specific diagnosis)—visits per 1000			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		11.69 k/month
Childhood Obesity			
Indicator 1: Members with evidence of BMI documentation			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		1.45%
CY 2010	Remeasurement 1	5% increase	1.12%
Indicator 2: Members with evidence of nutritional counseling			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.94%
CY 2010	Remeasurement 1	5% increase	0.54%
Indicator 3: Members with evidence of physical activity counseling			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.78%
CY 2010	Remeasurement 1	5% increase	0.45%
Emergency Department Utilization Diversion			
Indicator 1: Emergency Room visits per 1000 members (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
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000
Indicator 2: Emergency Room visits per 1000 members (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
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000

Table A2-3. UniCare Health Plan Performance Improvement Project (PIP) Results.

Improving Asthma Control			
Indicator 1: Persistent asthmatics (5-50 years of age) who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		95.07%
CY 2010	Remeasurement 1	95.07%	93.84%
Reducing Inappropriate 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		88%
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		96%