



delmarva foundation



Improving Health in the Communities We Serve

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

Mountain Health Trust Annual Report

Calendar Year 2009

Submitted by
Delmarva Foundation
October 2010

EXTERNAL QUALITY
REVIEW ORGANIZATION



Table of Contents

Mountain Health Trust CY 2009 Annual Report	1
Overview	1
Background and Methodology	1
Quality	6
Quality Summary	37
Access	38
Access Summary	51
Timeliness	52
Timeliness Summary	60
Overall Strengths for the MHT Program	61
Recommendations for the MHT Program	62
References	64
Appendix 1-Trending Tables	A1-1
Appendix 2- PIP Indicator Results	A2-1

Mountain Health Trust Annual Report for CY 2009

Overview

The Mountain Health Trust Program (MHT) was developed by the Bureau for Medical Services (BMS), Department of Health and Human Resources of West Virginia (WV) and began in 1996. Mountain Health Trust is based upon the concept that each Medicaid consumer has a medical home - a primary care provider (PCP) who knows each enrollee's medical history. Knowing the medical history means that a doctor can plan preventive care services for example; children receive their well-child care and immunizations in a timely fashion and serious health threats are caught early.

In 2006, the West Virginia legislature established goals to increase access to health care services by having an integrated health care system that provides all West Virginians, regardless of their age, employment, economic status, or their town of residency, with access to affordable, high quality health care that is financed in a fair and equitable manner. To achieve these goals, MHT funds a variety of medical services for the state's most vulnerable children and adults. BMS has the responsibility to ensure MHT members enrolled in contracted managed care plans not only receive comprehensive services but also hold health plans accountable for the quality of care provided. To ensure the care and services provided meet acceptable standards for quality, access, and timeliness, MHT contracts with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This report provides an assessment of MHT's performance to members enrolled in managed care organizations (MCOs) during calendar year (CY) 2009.

During CY 2009, the following MHT MCOs provided health care services to WV Medicaid recipients:

- Carelink Health Plan, Inc. (CHP),
- The Health Plan of the Upper Ohio Valley (THP), and
- UniCare Health Plan of West Virginia, Inc. (UHP).

Background and Methodology

The federal Balanced Budget Act of 1997 (BBA) requires an annual assessment of health care provided to Medicaid MCO enrollees. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR), part 438 et seq. In accordance with the regulations, Delmarva conducted

a comprehensive review of the three MCOs, to assess each health plan's performance relative to the quality of care, access to services, and the timeliness of obtaining needed care and 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” (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*).

The annual report provides an assessment of MHT's managed care plans progress in meeting the goals of BMS. Delmarva's task is to assess how the MCOs perform in the areas of quality, access, and timeliness using data and information gathered from the following activities:

- Validating Healthcare Effectiveness Data and Information Set (HEDIS^{®1}) measures through the performance measure validation (PMV) process,
- Validating Performance Improvement Projects (PIPs), and
- Conducting a Systems Performance Review (SPR).

¹ HEDIS ® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Performance Measure Validation (PMV)

The BBA requires that performance measures be validated in a manner consistent with the EQRO protocol - *Validating Performance Measures*. Each audit was conducted as prescribed by NCQA's *HEDIS 2010, Volume 5: HEDIS Compliance Audit*²; *Standards, Policies, and Procedures*³ and is consistent with the validation methodology required by the EQRO protocols. CMS' protocols address the three following activities:

- 1) Review of the data management processes of the MCO,
- 2) Evaluation of algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the State, and
- 3) Verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on accurate source information.

Since its introduction in 1993, HEDIS has become the gold standard in managed care performance measurement. Conceived as a way to streamline measurement efforts and promote accountability in managed care, HEDIS measures are now used by approximately 90 percent of all managed care organizations to evaluate performance in areas ranging from preventive care and consumer experience to cardiovascular disease and cancer. This set of standardized performance measures is designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations. The NCQA maintains and directs the HEDIS program.

MHT MCOs are required to submit performance measures to BMS that address quality, access, and timeliness. The data included in this report have been audited by the NCQA-certified audit organization, MetaStar, through a subcontractor agreement with Delmarva. Required measures are categorized in the three domains below:

- Effectiveness of Care
- Access and Availability of Care
- Use of Services

Performance Improvement Projects (PIPs)

PIPs are designed to achieve significant improvement, sustained over time, in clinical and non-clinical care areas. The projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. According to BMS requirements, MCOs must achieve meaningful improvement in two focus areas during the PIP remeasurement phase. One or both of these focus areas may be selected by BMS.

PIPs must be designed, conducted, and reported in a methodologically sound manner. Delmarva uses the Centers for Medicare & Medicaid Services (CMS) protocol, *Validating Performance Improvement Projects—A*

² The NCQA HEDIS Compliance Audit is a trademark of NCQA.

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 the contractual requirements, and validated the activity for interventions as well as evidence of improvement.

Table 1. CY 2009 Summary of Project Topics by MCO

MCO	Performance Improvement Project Topics
Carelink Health Plan	<ul style="list-style-type: none"> ➤ Childhood Immunizations ➤ Well-Child Visits ➤ Emergency Department Collaborative
The Health Plan of the Upper Ohio Valley	<ul style="list-style-type: none"> ➤ Childhood Obesity ➤ Asthma ➤ Emergency Department Collaborative
UniCare Health Plan of West Virginia	<ul style="list-style-type: none"> ➤ Diabetes ➤ Asthma ➤ Emergency Department Collaborative

Systems Performance Review (SPR)

The CMS SPR protocol uses two main sources of information to determine compliance with the BBA requirements: 1) document review and 2) interviews with MCO staff. *Individually*, document review and interviews do not always give a complete picture of an organization’s compliance with regulatory provisions. However, when combined, they can lead to a better understanding of organization performance. The purpose of the SPR review is to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated both WV BMS contractual requirements and the regulations set forth under the final rule of the Balanced Budget Act (BBA). Delmarva evaluated and then assessed compliance for the following MCO systems:

- Enrollee Rights (ER)
- Grievance System (GS)
- Quality Assessment and Performance Improvement (QA)

Each SPR, element and component within a standard was rated as “met,” “partially met,” or “unmet” (see Table 2). Based on this rating scale each element was then assigned a numeric value. The total of all element ratings within a performance standard was averaged to determine overall compliance for the particular standard. For CY 2009, MCOs were required to achieve a minimum compliance rate of 90% for each standard in the review. It is expected that the MCOs will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Table 2. SPR Rating Scale.

Rating	Numerical Value
Met	100%
Partially Met	50%
Unmet	0%

Quality

Performance Measure Validation

The performance measure validation (PMV) process assesses the MCOs' information systems characteristics and capabilities and specification compliance for each measure. The systematic process used to validate the HEDIS measures ensures that the MCOs produce accurate and reliable data that can be used for plan-to-plan comparison and to measure the success of the MHT program.

HEDIS measures in the Effectiveness of Care (EOC) domain are used to assess the quality of care provided to MHT enrollees. The rates for all HEDIS Effectiveness of Care Measures are reported for each MCO for three years (where data was available). Additionally, the MHT Weighted Average, the National Medicaid Average and the National Medicaid 90th percentile are provided, for comparison and benchmarking purposes.

Two required HEDIS measures in the Effectiveness of Care domain, *Cholesterol Management for Patients with Cardiovascular Conditions* and *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*, received a report rating of "NA" or Not applicable as all three plans' denominators were too small (less than 30) to report a reliable rate.

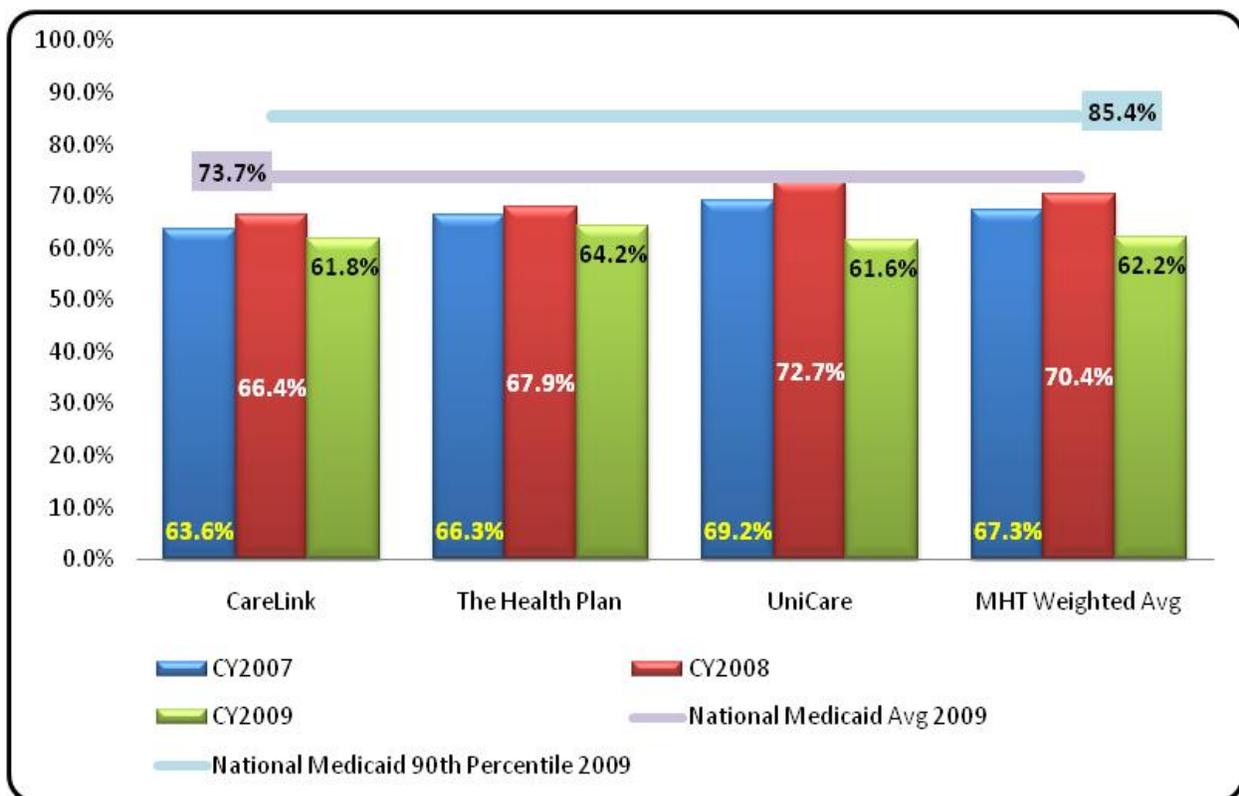
Measures in the Effectiveness of Care domain that relate to quality are analyzed in this section. The HEDIS results for all measures submitted by the three MCOs are found in Appendix 1.

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),
- 2 H influenza type B (HiB),
- 3 Hepatitis B (Hep B), and
- 1 Chicken pox (VZV)

Figure 1. Results: MHT 2009, Childhood Immunization Status – Combination 2



The results for *Childhood Immunization Status—Combination 2* are presented in Figure 1. In CY 2009, individual plan rates were lower than CY 2008 ranging from 61.6% to 64.2%. The Health Plan had the highest rate with 64.2%. All rates were lower than national benchmarks. The MHT Weighted Average shows continuous improvement from CY 2007-CY 2008 but dropped off in CY 2009. All three MCOs experienced decreased rates for Childhood Immunization Status Combination 2 from CY 2008 to CY 2009. The decrease in performance may be due partially to MCO access problems with the West Virginia Immunization Registry discovered during the performance measurement validation audits.

Childhood Immunization Status-Combination 3 (CIS 3)

The CIS 3 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),
- 2 H influenza type B (HiB),
- 3 Hepatitis B (Hep B),
- 1 Chicken pox (VZV), and
- 4 Pneumococcal conjugate (PCV)

Figure 2. Results: MHT 2009, Childhood Immunization Status – Combination 3

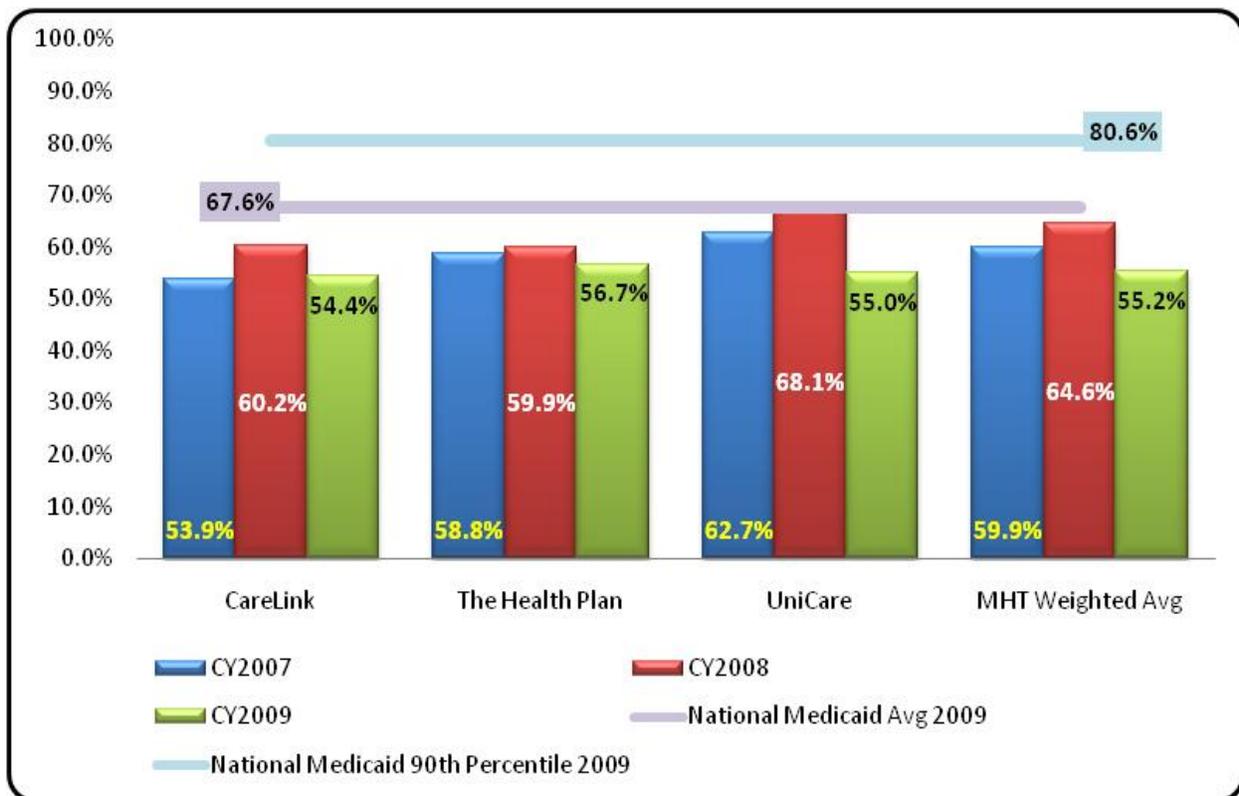


Figure 2 displays the results for *Childhood Immunization Status—Combination 3*. The CY 2009 performance rates ranged from 54.4% to 56.7%. Similar to the Childhood Immunization Status-Combination 2 rate, the Combination 3 rate for all MCOs decreased from CY 2008 to CY 2009. The decrease in performance may be due partially to MCO access problems with the West Virginia Immunization Registry discovered during the performance measurement validation audits.

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 3. Results: MHT 2009, Lead Screening in Children

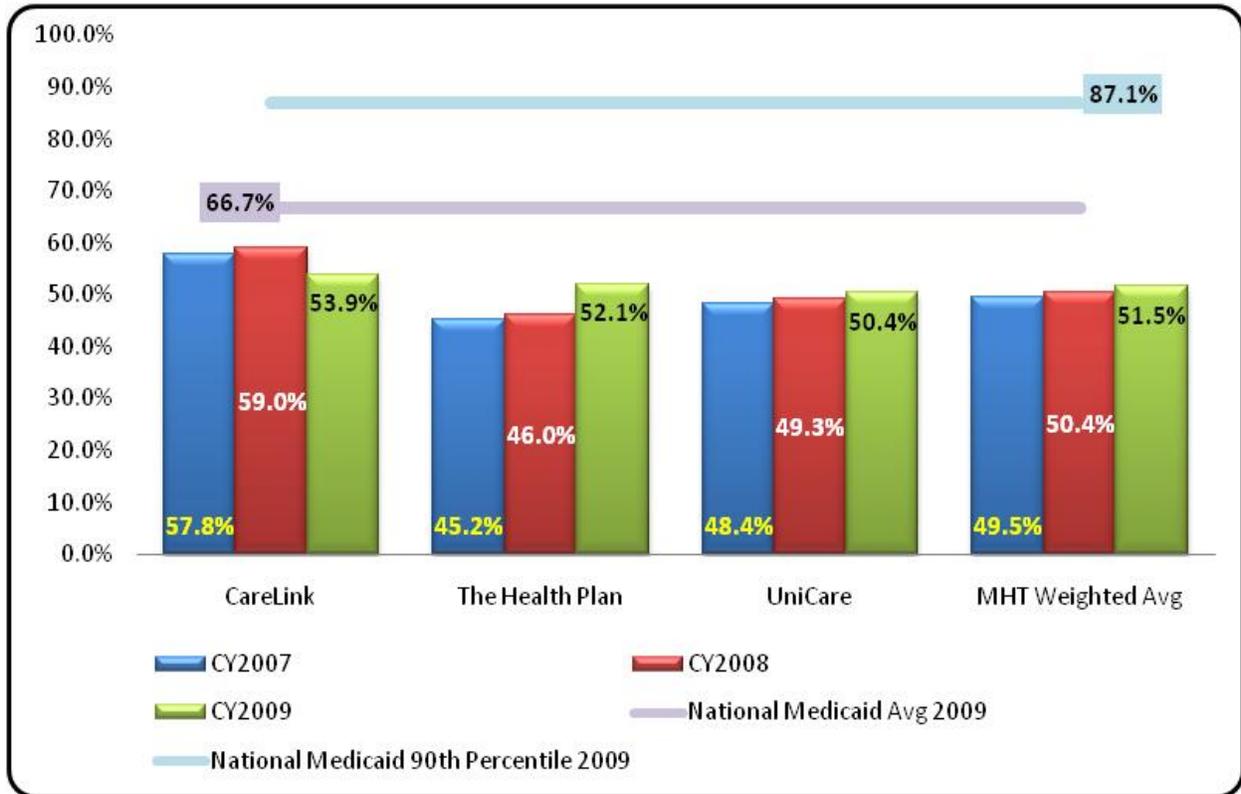


Figure 3 displays the results for *Lead Screening in Children*, which was a new measure in CY 2007. The CY 2009 performance rates ranged from 50.4 to 53.9%. Both THP and UniCare show improvement over the three year period from CY 2007-CY 2009. Carelink’s rate decreased between CY 2008 and CY 2009. The CY 2009 MHT Weighted Average improved, but did not meet the National Medicaid Average.

Breast Cancer Screening (BCS)

The BCS measure reports the percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.

Figure 4. Results: MHT 2009 Breast Cancer Screening

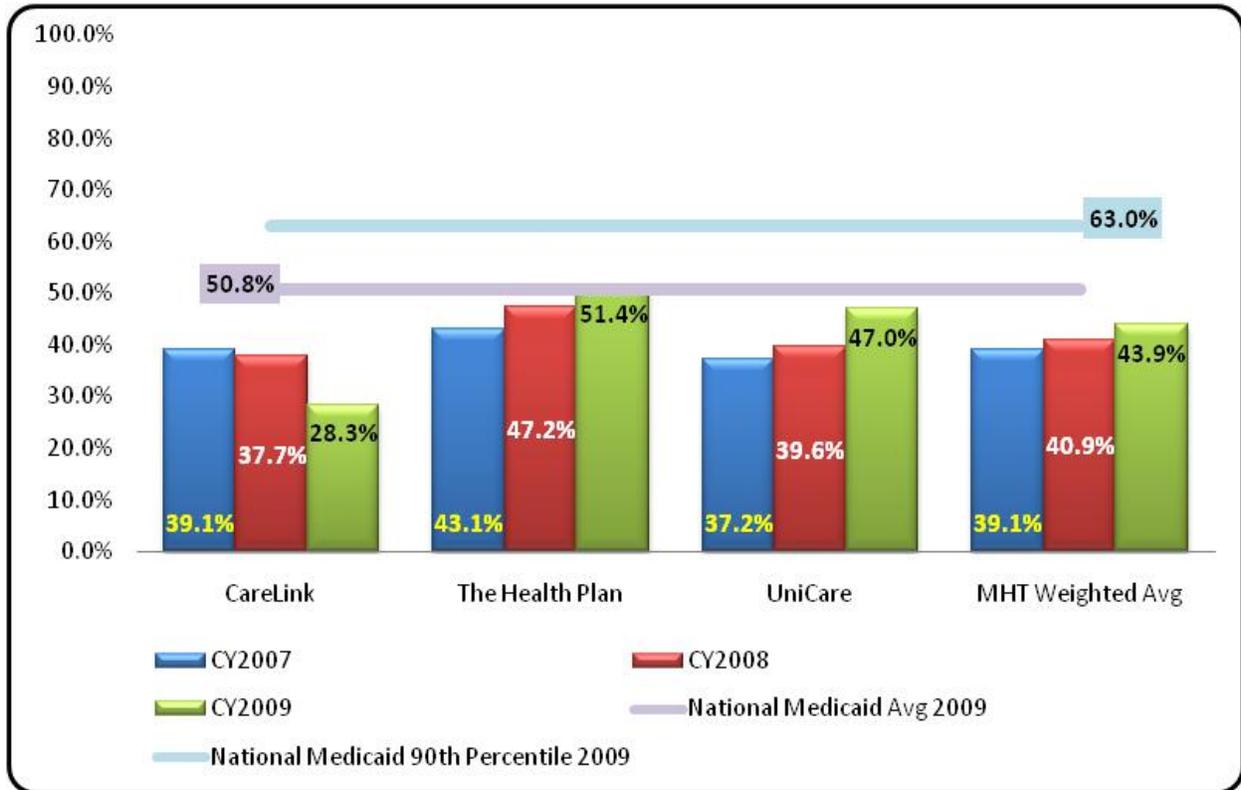


Figure 4 displays the results for the *Breast Cancer Screening* measure. In CY 2009, individual plan rates ranged from 28.3% to 51.4%. The Health Plan had the highest rate, which was above the National Medicaid Average of 50.8%. THP and UniCare rates improved from CY 2007 to CY 2009, while Carelink’s performance declined by 9.4 percentage points. The MHT Weighted Average also improved from CY 2007, but did not meet the National Medicaid Average.

Cervical Cancer Screening (CCS)

The CCS measure reports the percentage of women 24-64 years of age who received one or more Pap tests to screen for cervical cancer.

Figure 5. Results: MHT 2009 Cervical Cancer Screening

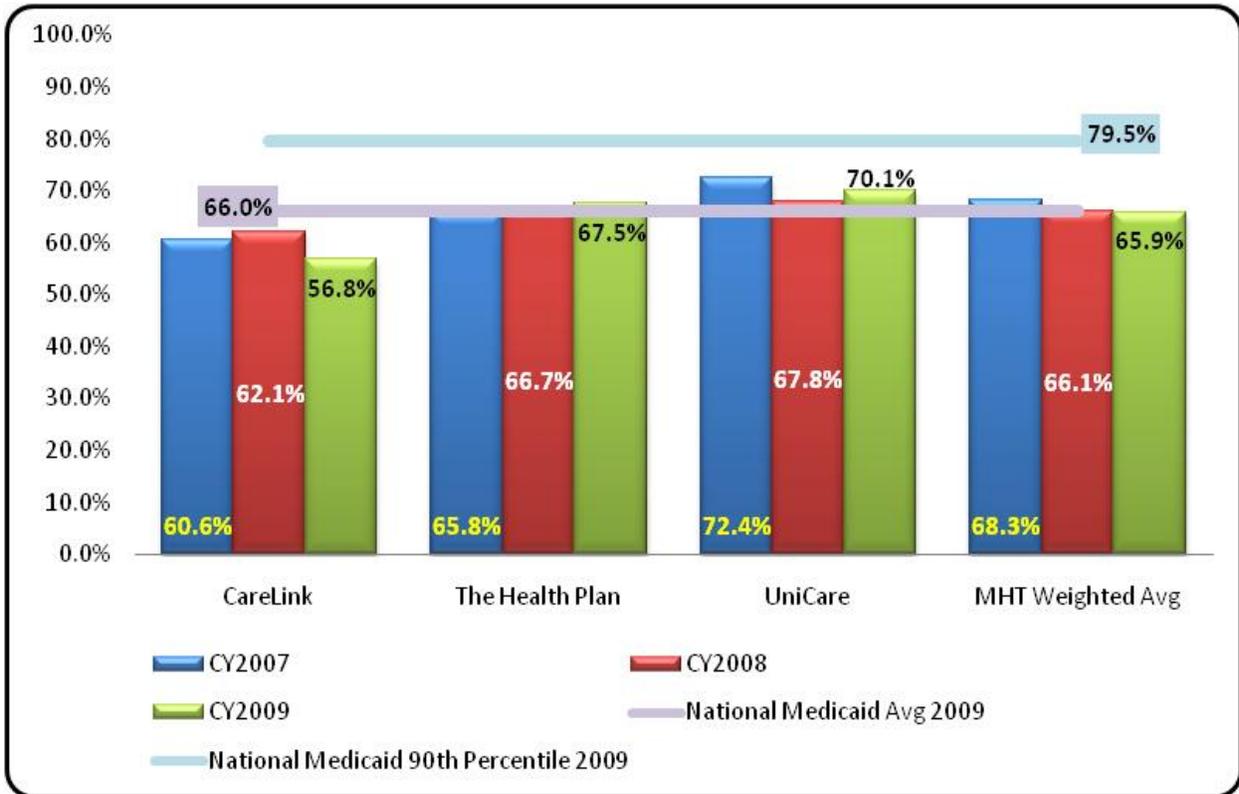
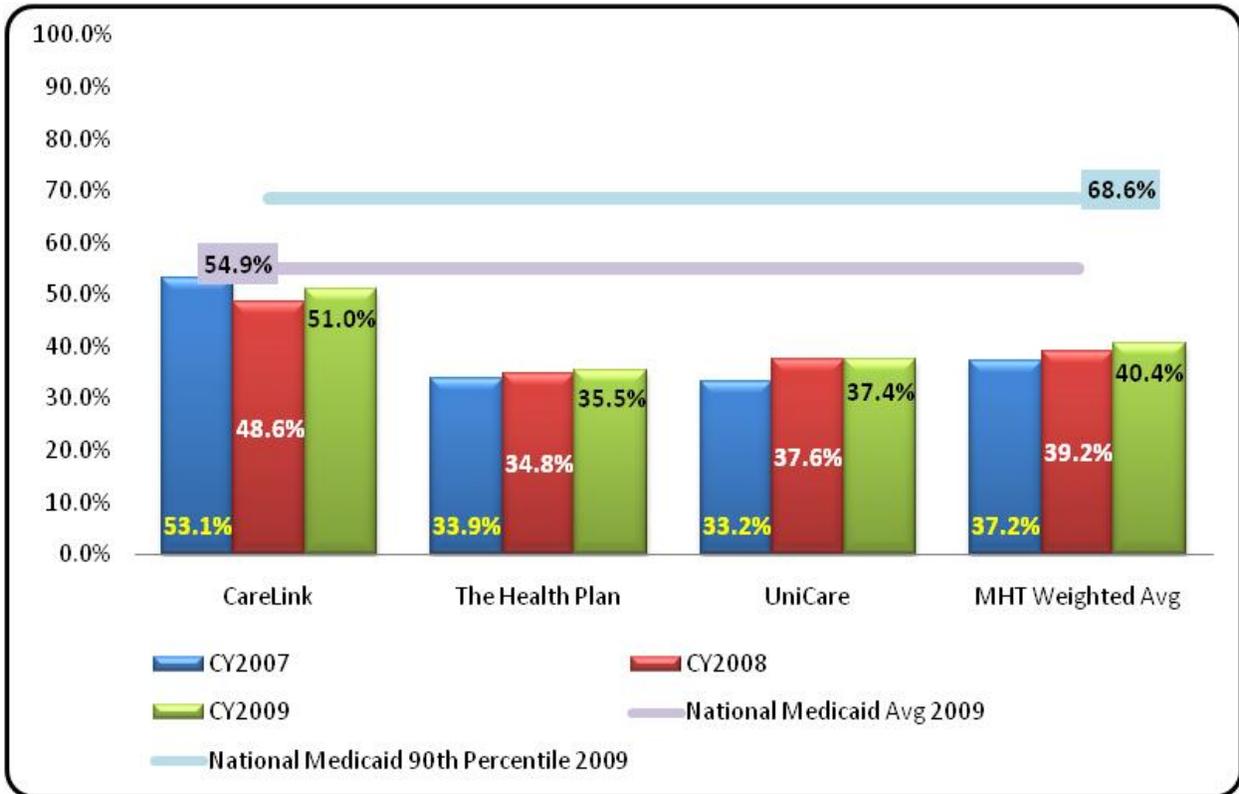


Figure 5 displays the results for the *Cervical Cancer Screening* measure. For CY 2009, performance rates ranged from 56.8% to 70.1%. THP and UniCare exceeded the National Medicaid Average of 66.0%. THP was the only plan to show improvement from CY 2007 to CY 2009. The MHT Weighted Average was within one tenth of a percentage point of the National Medicaid Average in CY 2009.

Chlamydia Screening in Women (CHL)

The CHL measure reports the percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.

Figure 6. Results: MHT 2009 Chlamydia Screening in Women

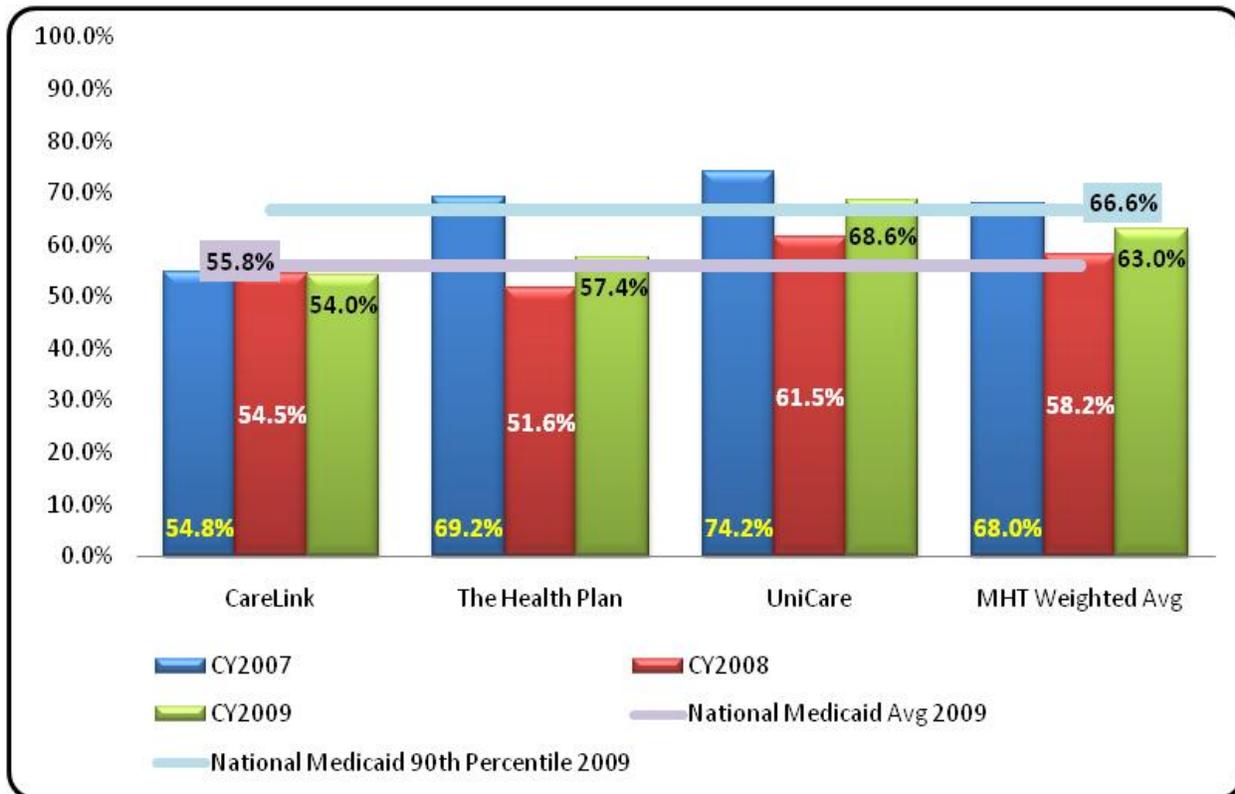


The results for *Chlamydia Screening in Women* are presented in Figure 6. In CY 2009, individual plan rates ranged from 35.5% to 51.0%. Carelink had the highest rate but did not meet the National Medicaid Average of 54.9%. The MHT Weighted average, THP, and UniCare improved all three years from CY 2007 through CY 2009. Carelink’s performance was mixed, decreasing CY 2007 to CY 2008 and increasing CY 2008 to CY 2009. None of the MCOs met 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 7. Results: MHT 2009 Controlling High Blood Pressure



The results for *Controlling High Blood Pressure* are presented in Figure 7. In CY 2009, individual plan rates ranged from 54.0% to 68.6%. The MHT Weighted Average, THP and UniCare exceeded the National Medicaid Average of 55.8%. UniCare also exceeded the National Medicaid 90th Percentile of 66.6%. Performance for THP and UniCare has been mixed for the three year period of CY 2007 through CY 2009. Carelink’s performance has been relatively stable with rates ranging from 54.0% to 54.8% CY 2007 through CY 2009.

Comprehensive Diabetes Care (CDC)

The CDC measure set includes eight 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:

- 1) Hemoglobin A1c (HbA1c testing)
- 2) HbA1c control (<7.0%)
- 3) Eye exam (retinal) performed
- 4) LDL-C screening
- 5) LDL-C control (<100 mg/dL)
- 6) Medical attention for Nephropathy
- 7) BP control (<130/80 mm Hg)
- 8) BP control (<140/90 mm Hg)

The results of each indicator 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 8. Results: MHT 2009 Comprehensive Diabetes Care—HbA1c Testing Indicator

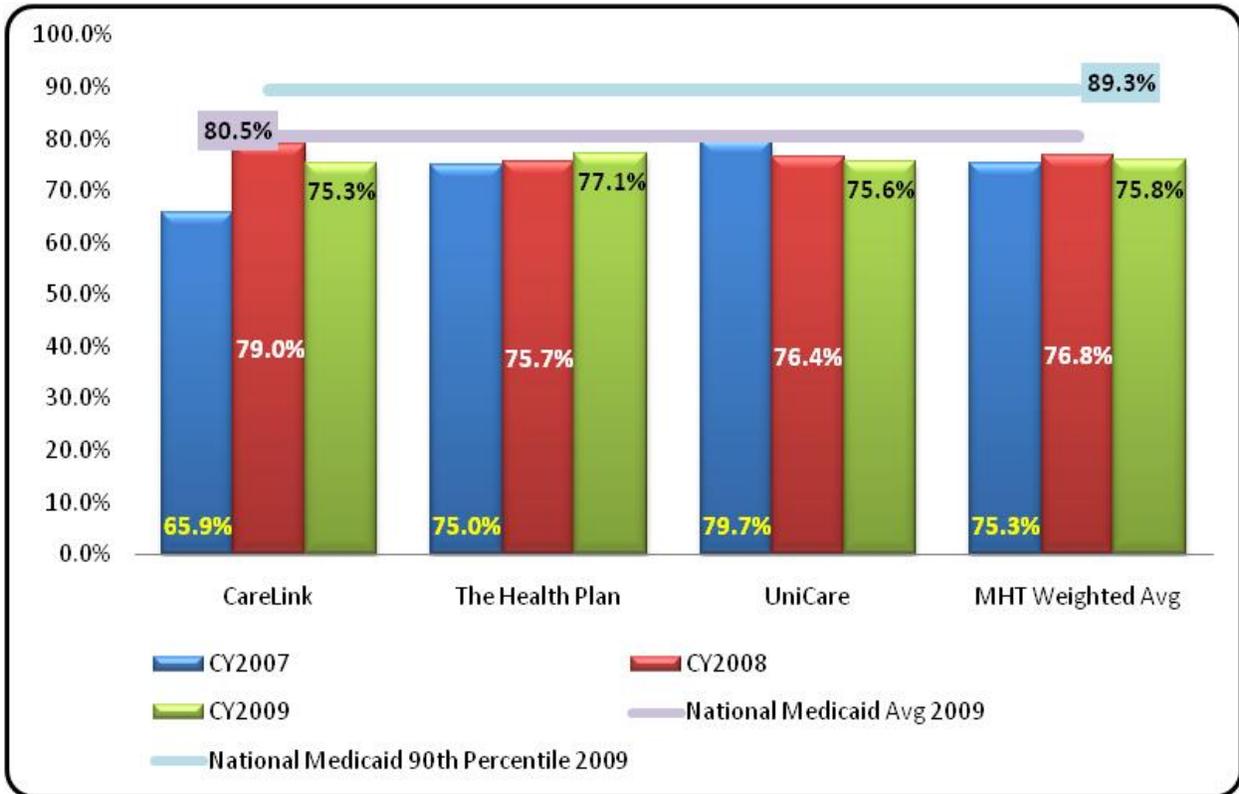


Figure 8 displays the indicator results for *Comprehensive Diabetes Care—HbA1c Testing*. For CY 2009, performance rates ranged from 75.3% to 77.1%. THP was the only plan to see an increase in its rate from CY 2008 to CY 2009. None of the MCOs met the National Medicaid Average.

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 9. Results: MHT 2009 Comprehensive Diabetes Care – Poor HbA1c Control Indicator

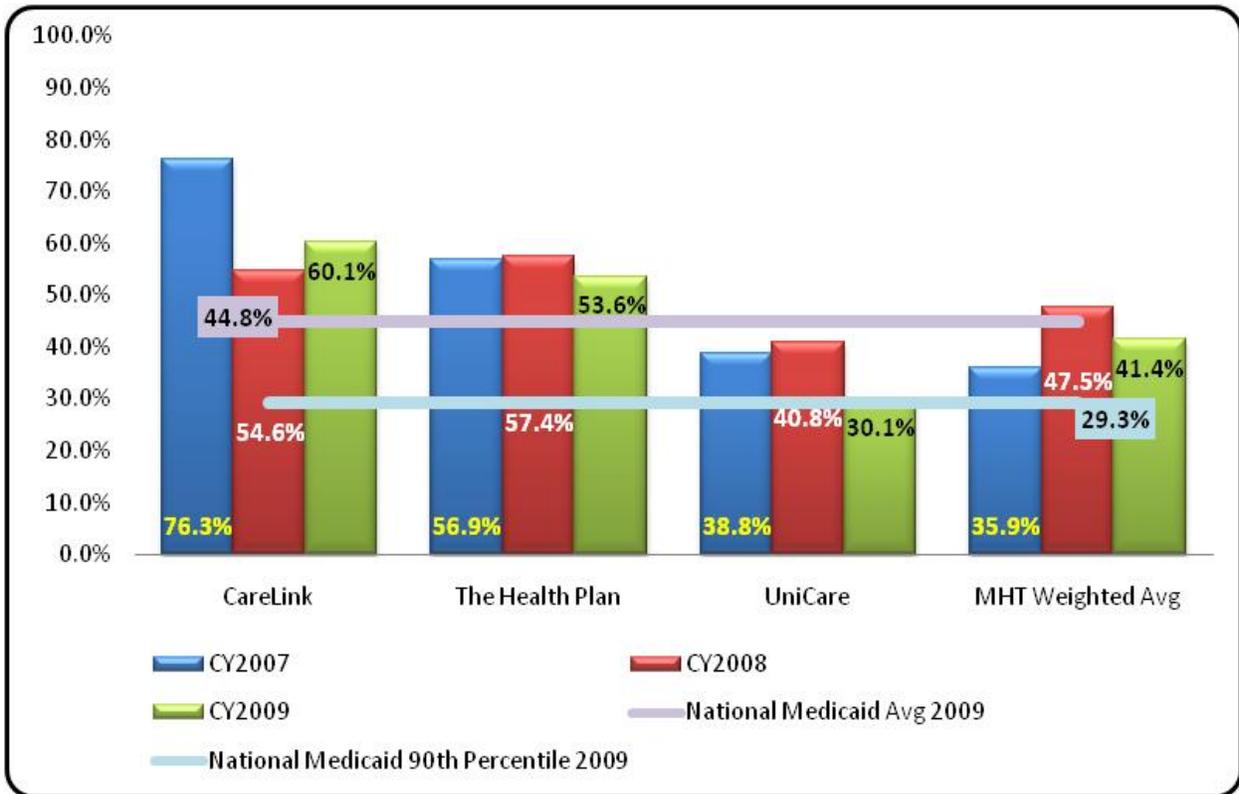


Figure 9 displays the indicator results for *Comprehensive Diabetes Care—Poor HbA1c Control >9%*. For this indicator, a lower rate is better. Individual plan rates ranged from 30.1% to 60.1%. UniCare performed almost 15 percentage points better than the National Medicaid Average of 44.8% and fell just short of the National Medicaid 90th Percentile (29.3%) with a rate of 30.1%. Carelink realized a decrease in performance while THP and Unicare experienced improvement from CY 2007 to CY 2009. The MHT Weighted Average improved (decreased) by over six percentage points to 41.4% when compared to last year’s average, and is below the National Medicaid Average.

Figure 10. Results: MHT 2009 Comprehensive Diabetes Care – HbA1c Control (<8%) Indicator

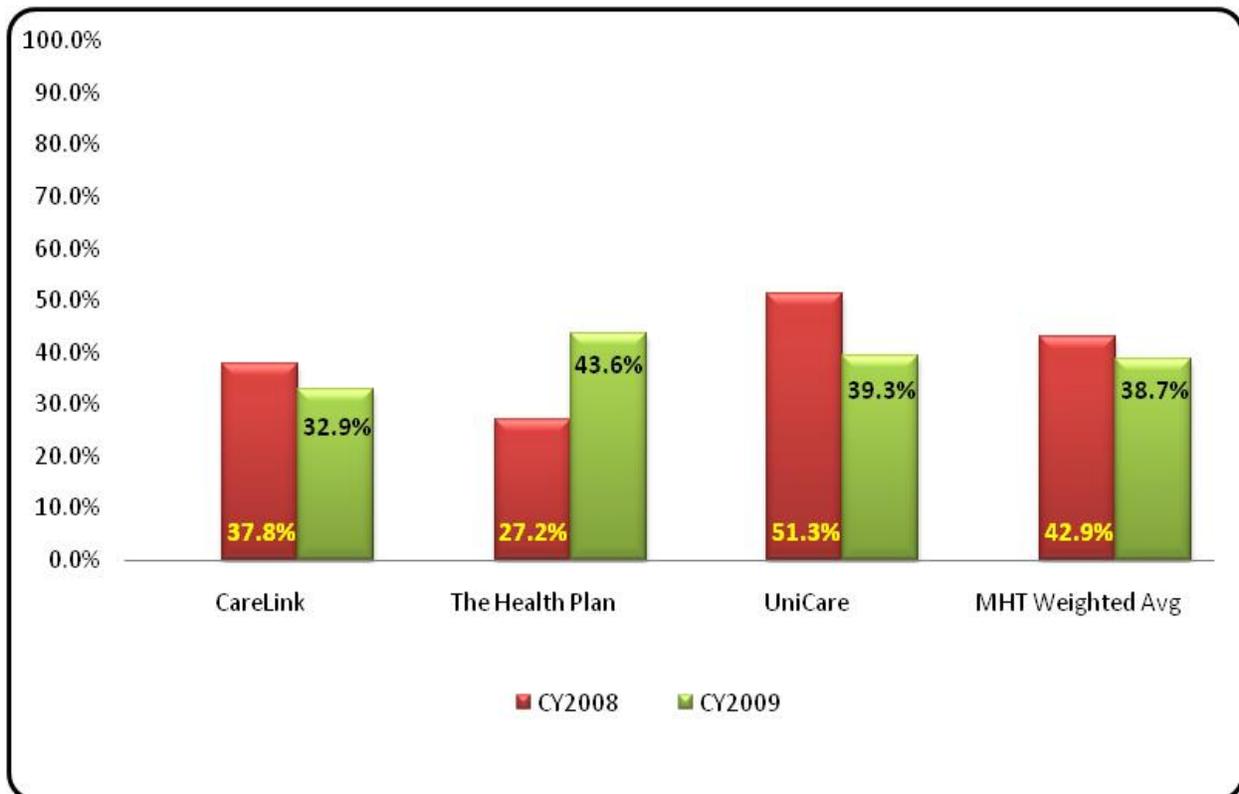


Figure 10 displays the indicator results for *Comprehensive Diabetes Care—Good HbA1c Control 8%*. Individual plan rates ranged from 27.2% to 51.3 in CY 2008 and 32.9% to 43.6% in CY 2009. This indicator was new in CY 2008 and there were no national benchmarks available at the time of this report.

Figure 11. Results: MHT 2009 Comprehensive Diabetes Care – HbA1c Control (<7%) Indicator

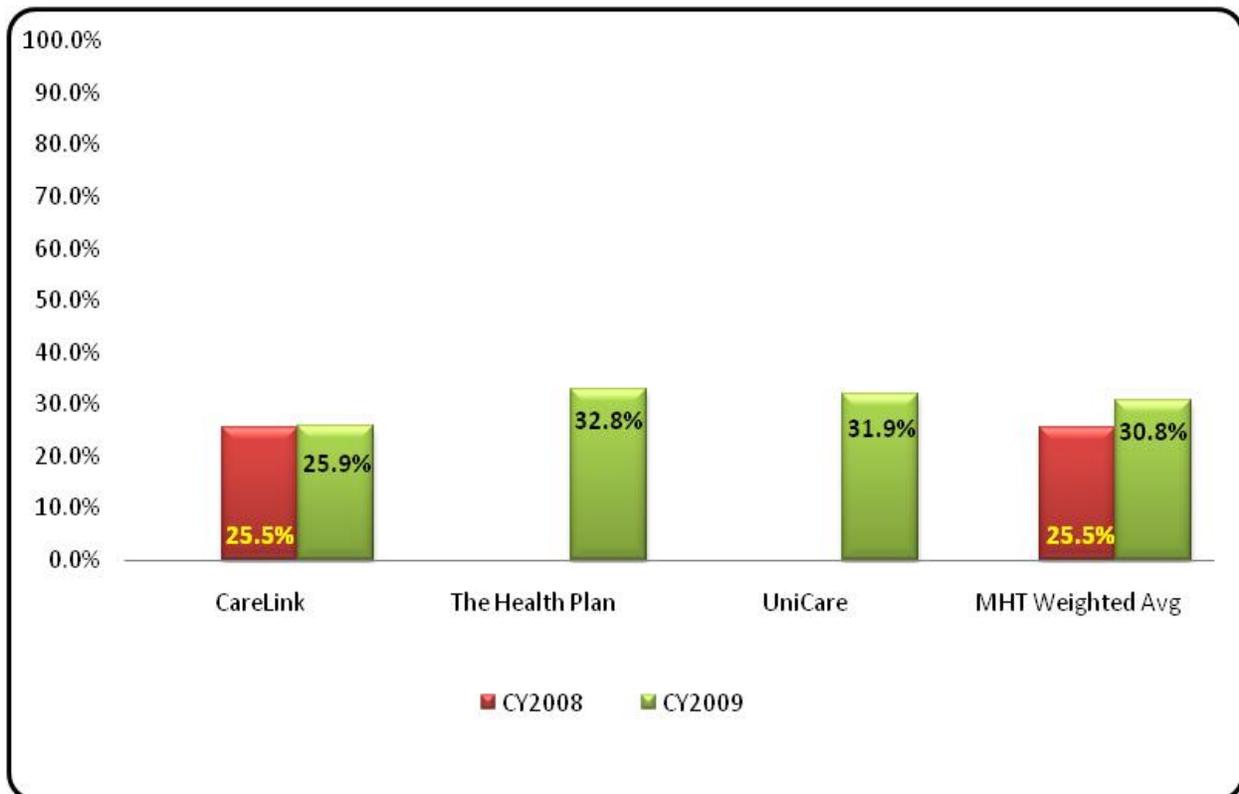


Figure 11 displays the indicator results for *Comprehensive Diabetes Care—Good HbA1c Control (<7%)*. Individual plan rates ranged from 25.9% to 32.8%. This indicator was new in CY 2008 and there were no national benchmarks available at the time of this report. THP and UniCare chose not to report the indicator in CY 2008.

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 12. Results: MHT 2009 Comprehensive Diabetes Care – Eye Exam (Retinal) Indicator

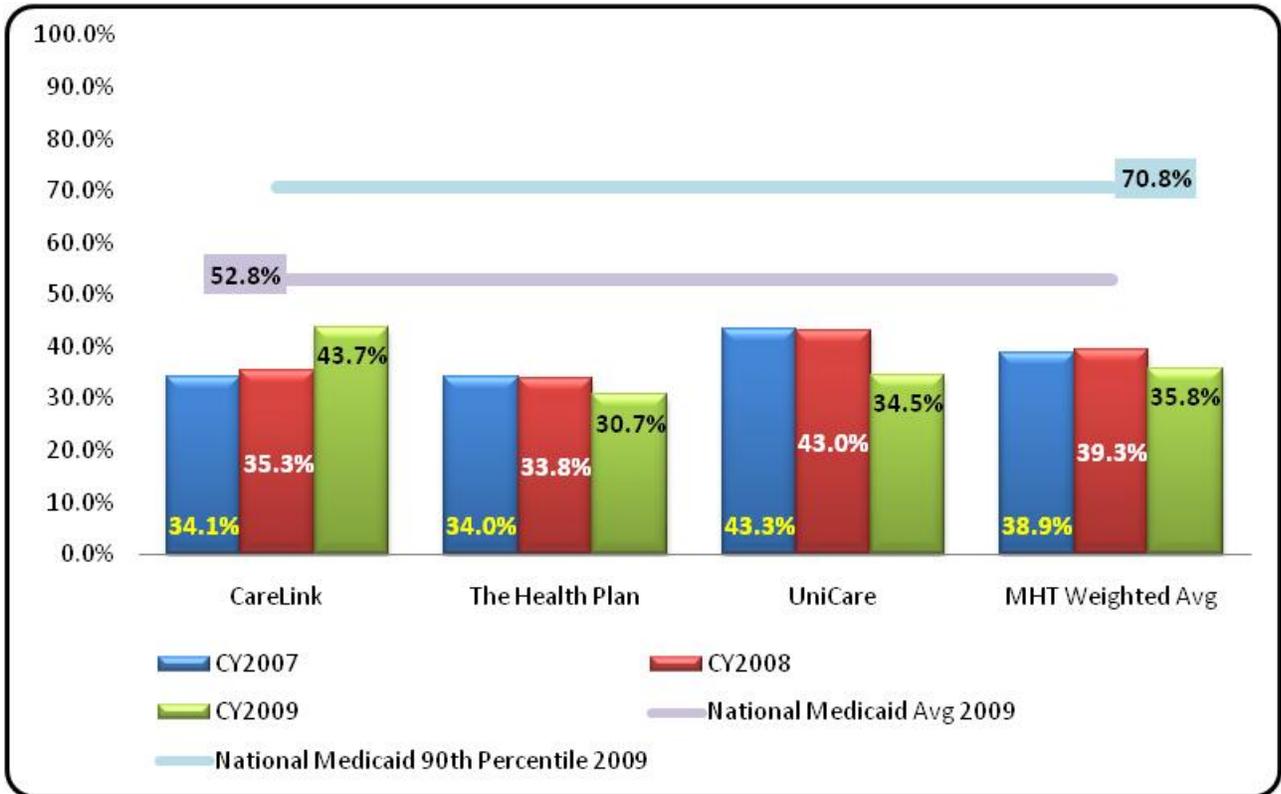


Figure 12 displays the results for the *Comprehensive Diabetes Care—Eye (Retinal) Exams* indicator. Performance rates ranged from 30.7% to 43.7% in CY 2009. All MCOs performed below than the National Medicaid Average. Only Carelink saw an improvement in performance since CY 2007.

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 13. Results: MHT 2009 Comprehensive Diabetes Care – LDL-C Screening Indicator

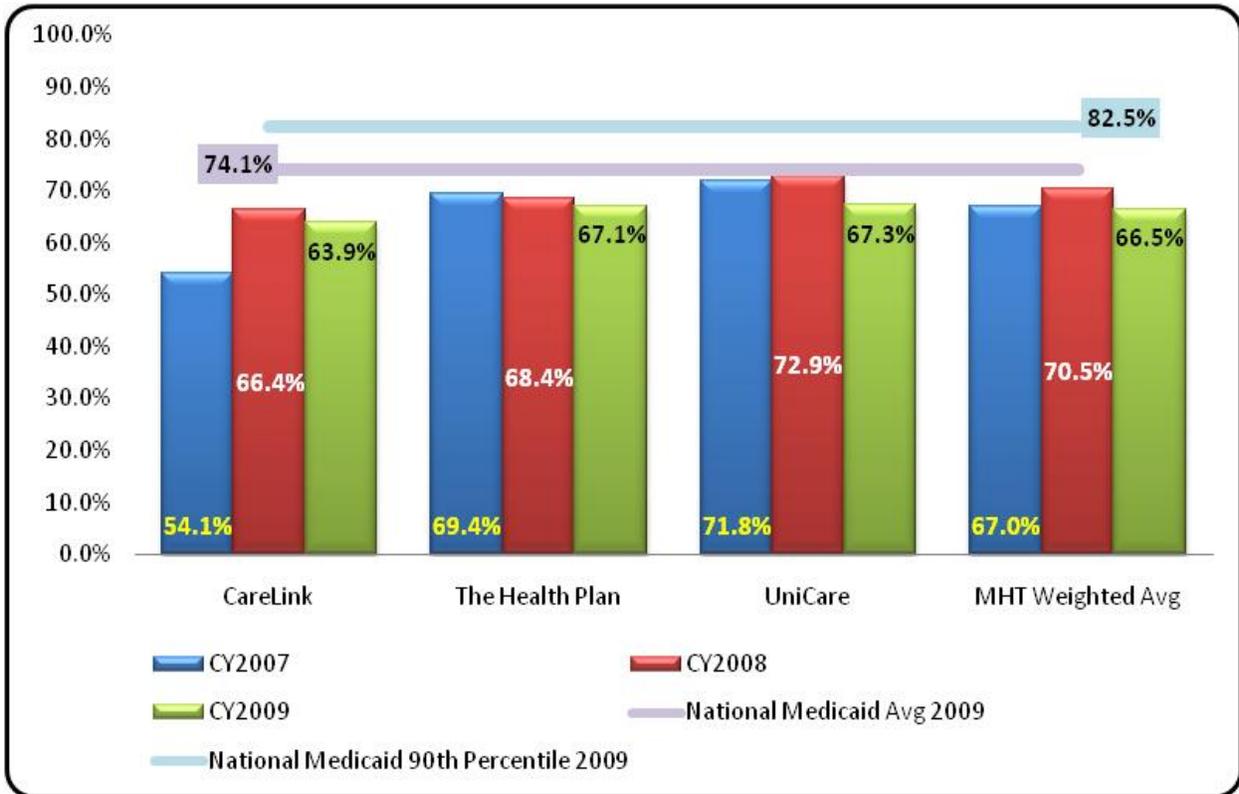


Figure 13 provides the indicator results for the *Comprehensive Diabetes Care—LDL-C Screening*. Individual plan rates ranged from 63.9% to 67.3% in CY 2009. All three MCOs saw their rates decrease from CY 2008 to CY 2009. None of the MCOs met the National Medicaid Average.

CDC- LDL-C Control (<100mg/dL)

The CDC-LDL-C indicator reports the percentage of diabetic members age 18-75 years with an LDL-C level <100 mg/dL in the most recent test in the measurement year.

Figure 14. Results: MHT 2009 Comprehensive Diabetes Care – LDL-C Control (<100 mg/dL) Indicator

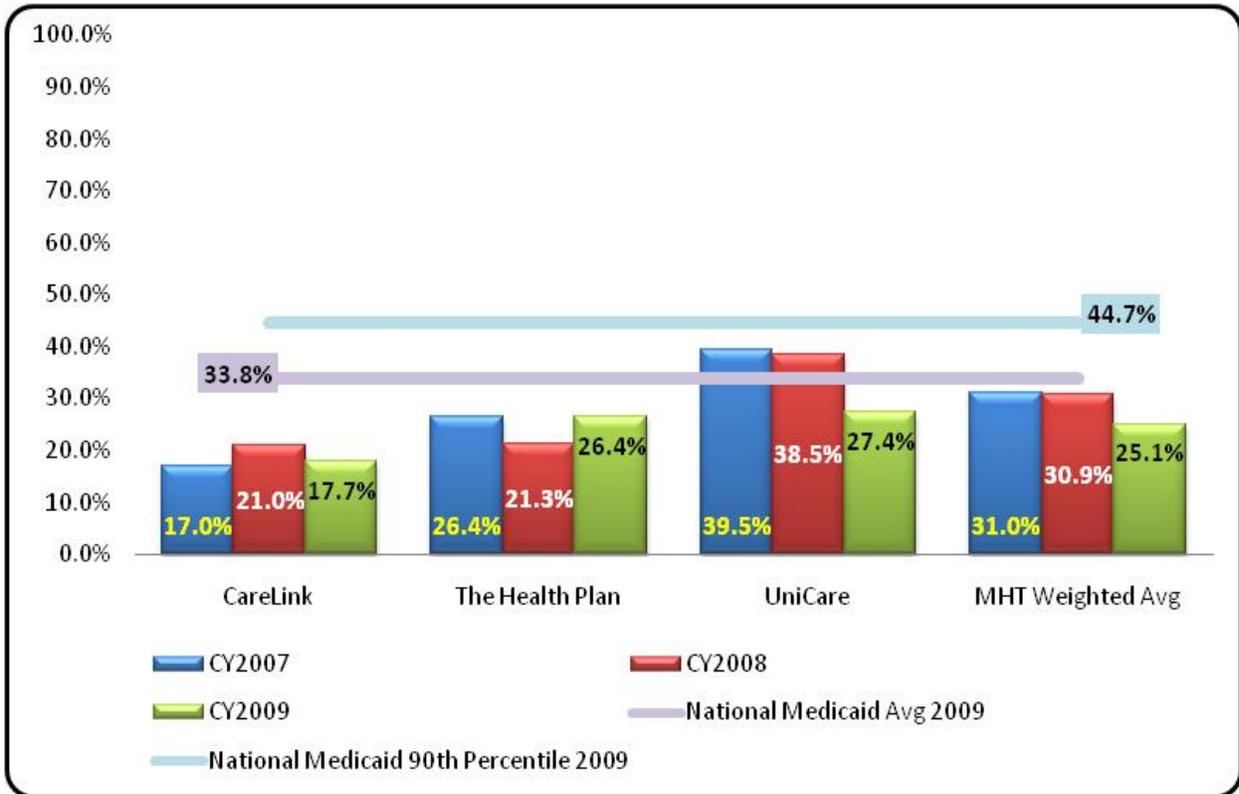


Figure 14 displays the indicator results for *Comprehensive Diabetes Care—LDL-C Control <100 mg/dL*. Individual MCO rates ranged from 17.7% to 27.4% in CY 2009. THP is the only plan that improved rates from CY 2008 to CY 2009. None of the MCOs met the National Medicaid Average.

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 15. Results: MHT 2009 Comprehensive Diabetes Care – Medical Attention for Nephropathy Indicator

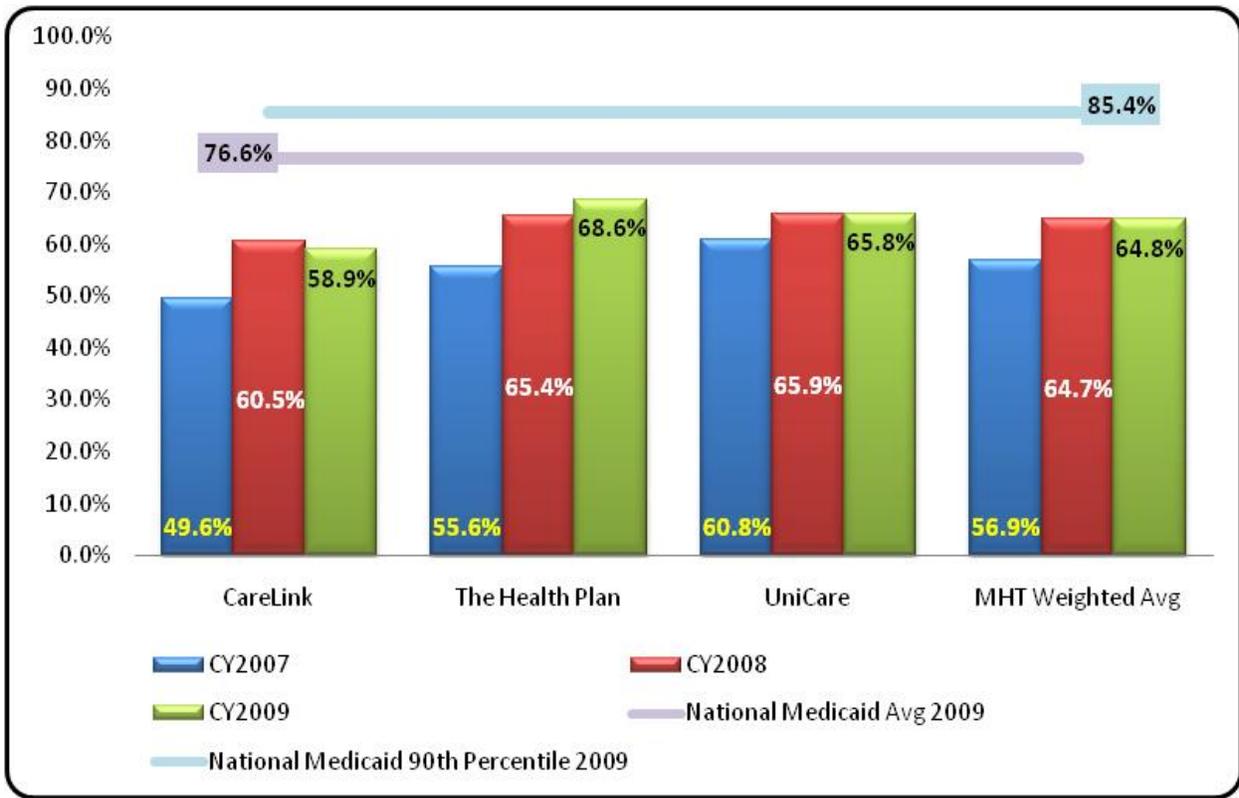


Figure 15 displays the indicator results for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator. Performance rates ranged from 58.9% to 68.6% in CY 2009. THP improved its rate from CY 2008 to CY 2009. For the same period, the MHT Weighted Average and UniCare rates were constant, but Carelink’s rate decreased.

CDC - Blood Pressure (BP) Control (<130/80 mm Hg)

The CDC-BP Control <130/80 indicator reports the percentage of diabetic members 18-75 years of age whose most recent BP in the measurement year was less than 130/80.

Figure 16. Results: MHT 2009 Comprehensive Diabetes Care – Blood Pressure Control (<130/80 mm Hg)

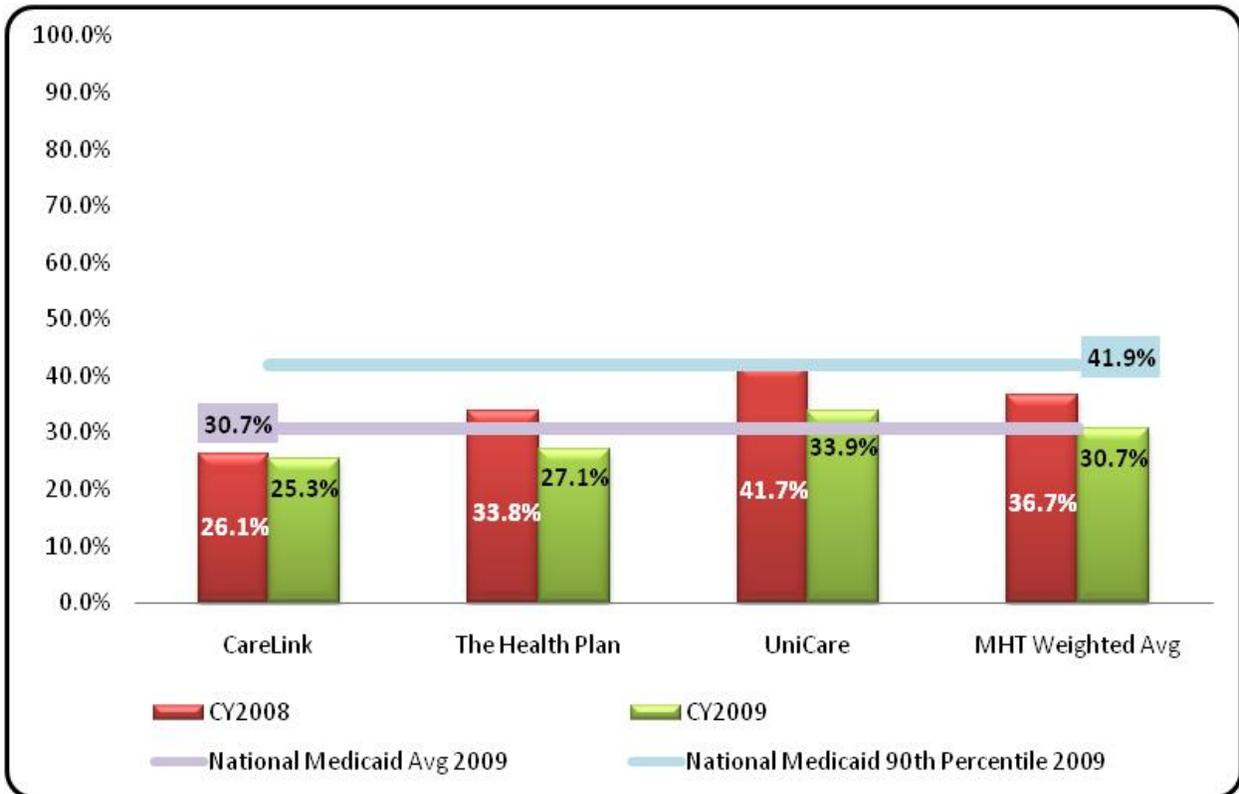


Figure 16 provides the indicator results for *Comprehensive Diabetes Control—Blood Pressure Control (<130/80 mm Hg)*. Individual plan rates ranged from 25.3% to 33.9% in CY 2009. UniCare exceeded and the MHT Weighted Average and the National Medicaid Average.

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

The CDC-BP Control <140/90 indicator reports the percentage of diabetic members 18-75 years of age whose most recent BP in the measurement year was less than 130/80.

Figure 17. Results: MHT 2009 Comprehensive Diabetes Care – Blood Pressure Control (<140/90 mm Hg)

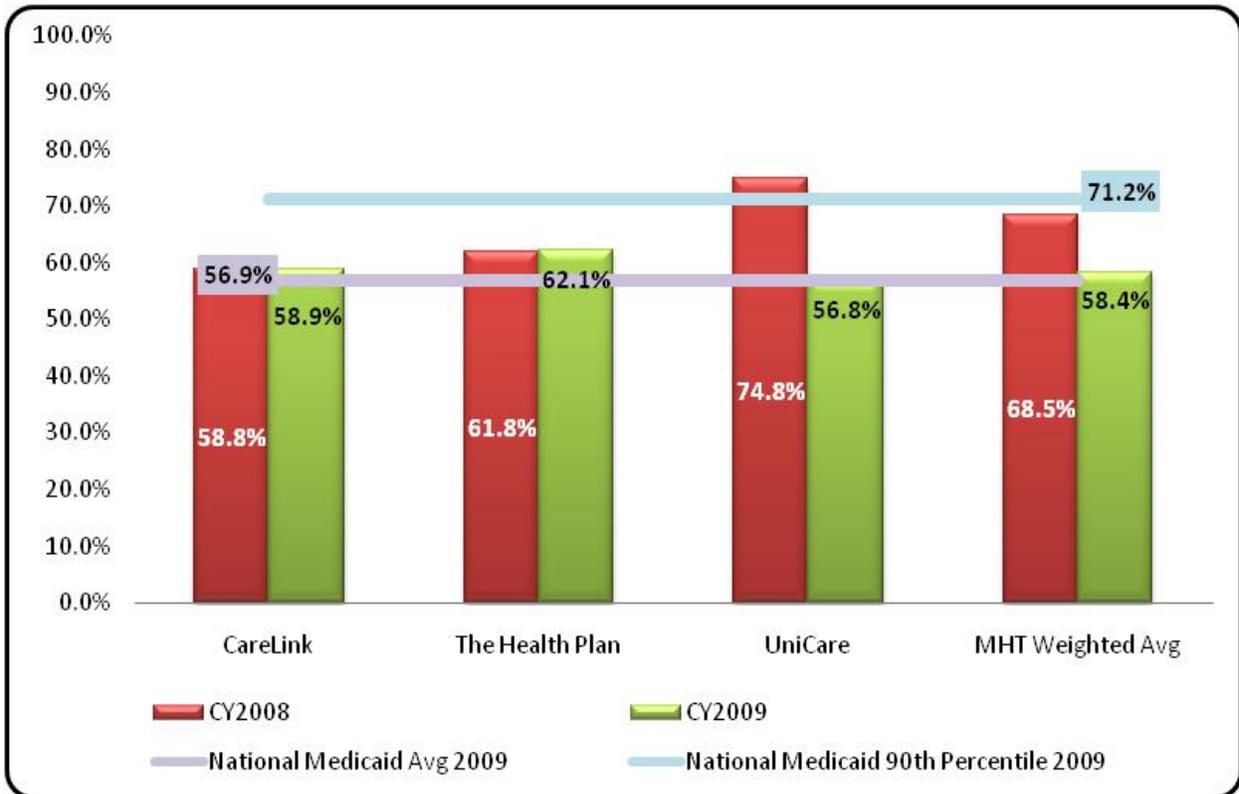


Figure 17 shows the indicator results for *Comprehensive Diabetes Control—Blood Pressure Control (<140/90 mm Hg)*. Performance rates ranged from 56.8% to 62.1% in CY 2009, with THP and Carelink exceeding the National Medicaid Average of 56.9%. UniCare fell just short of the Medicaid National Average by one-tenth of one percentage point.

Use of Imaging Studies for Low Back Pain (LBP)

The Low Back Pain indicator reports the percentage of members with a primary diagnosis of low back pain that did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

Figure 18. Results: MHT 2009 Use of Imaging Studies for Low Back Pain

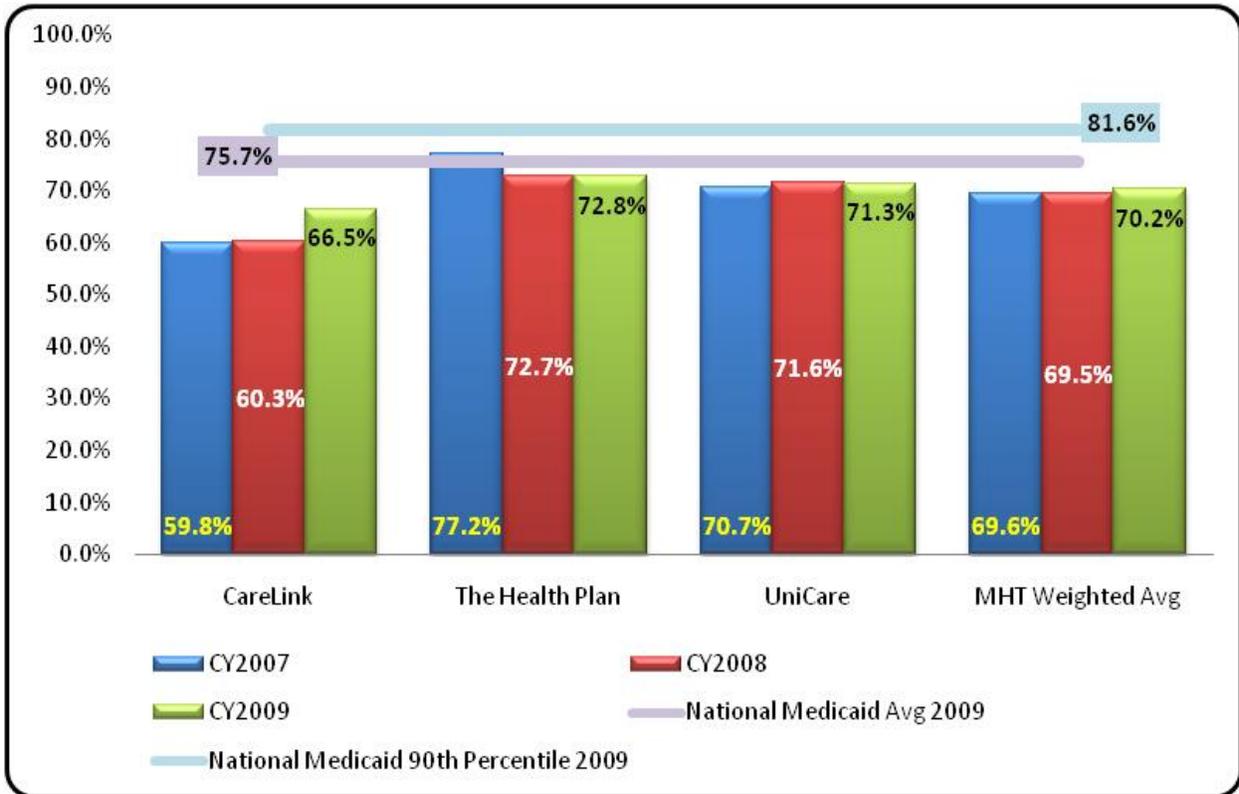


Figure 18 displays the indicator results for *Use of Imaging Studies for Low Back Pain*. A higher rate indicates appropriate treatment. In CY 2009, performance rates ranged from 66.5% to 72.8%. All three MCOs were below the National Medicaid Average. Both Carelink and the MHT Weighted Average showed an upward trend from CY 2007 to CY 2009. THP and UniCare’s rates remained relatively stable from CY 2008 to CY 2009.

Adult BMI Assessment which measures the percentage of adult members who had an outpatient visit who had their body mass index (BMI) was documented during the measurement year or prior year.

Figure 19. Results: MHT 2009 Adult BMI Assessment

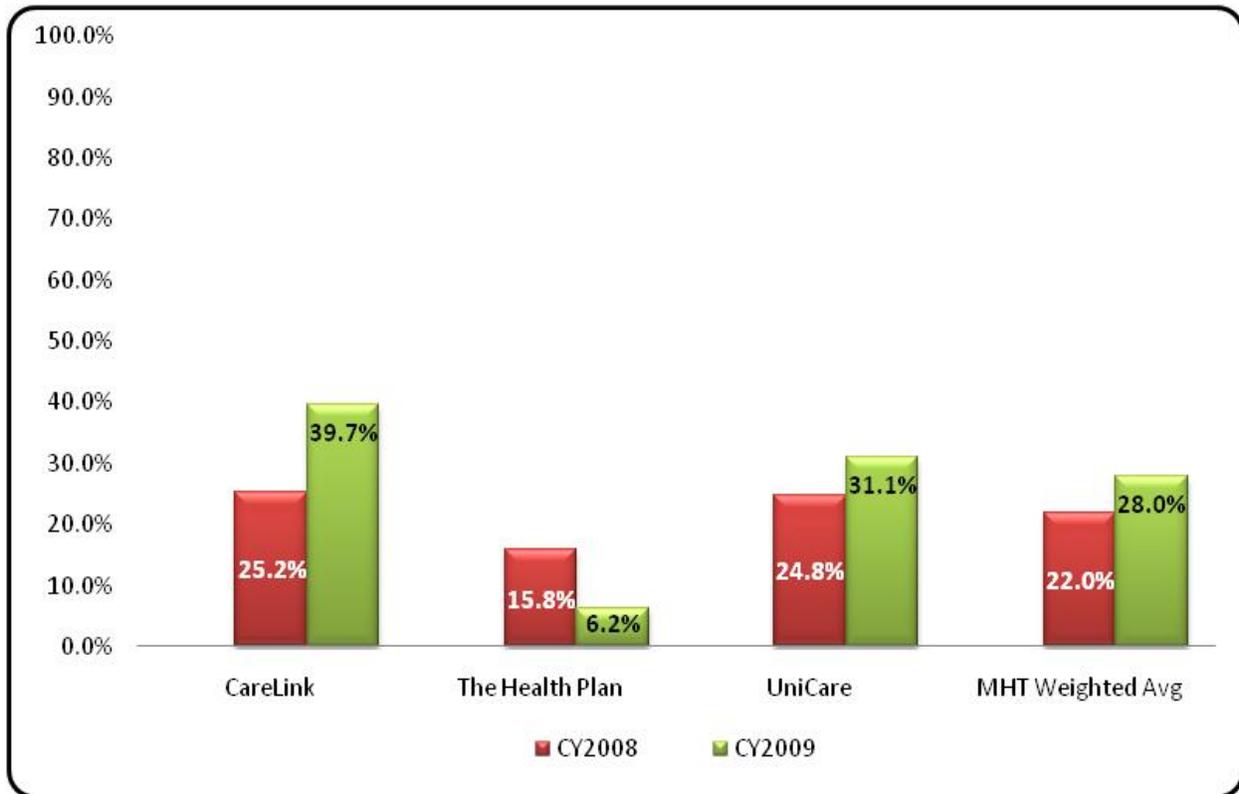


Figure 19 displays the indicator results for *Adult BMI Assessment*. This measure was new in CY 2008 and there were no national benchmarks available at time of this report. Carelink and UniCare saw dramatic increases between CY 2008 and CY 2009. THP's rate decreased primarily due to a change from using the hybrid methodology in CY 2008 to the administrative data collection methodology in CY 2009.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measures the percentage of children/adolescents who had an outpatient visit with a PCP or OB/GYN with evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year. The measure has three indicators:

- BMI Percentile
- Counseling for Nutrition
- Counseling for Physical Activity

Figure 20. Results: MHT 2009 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- BMI Percentile

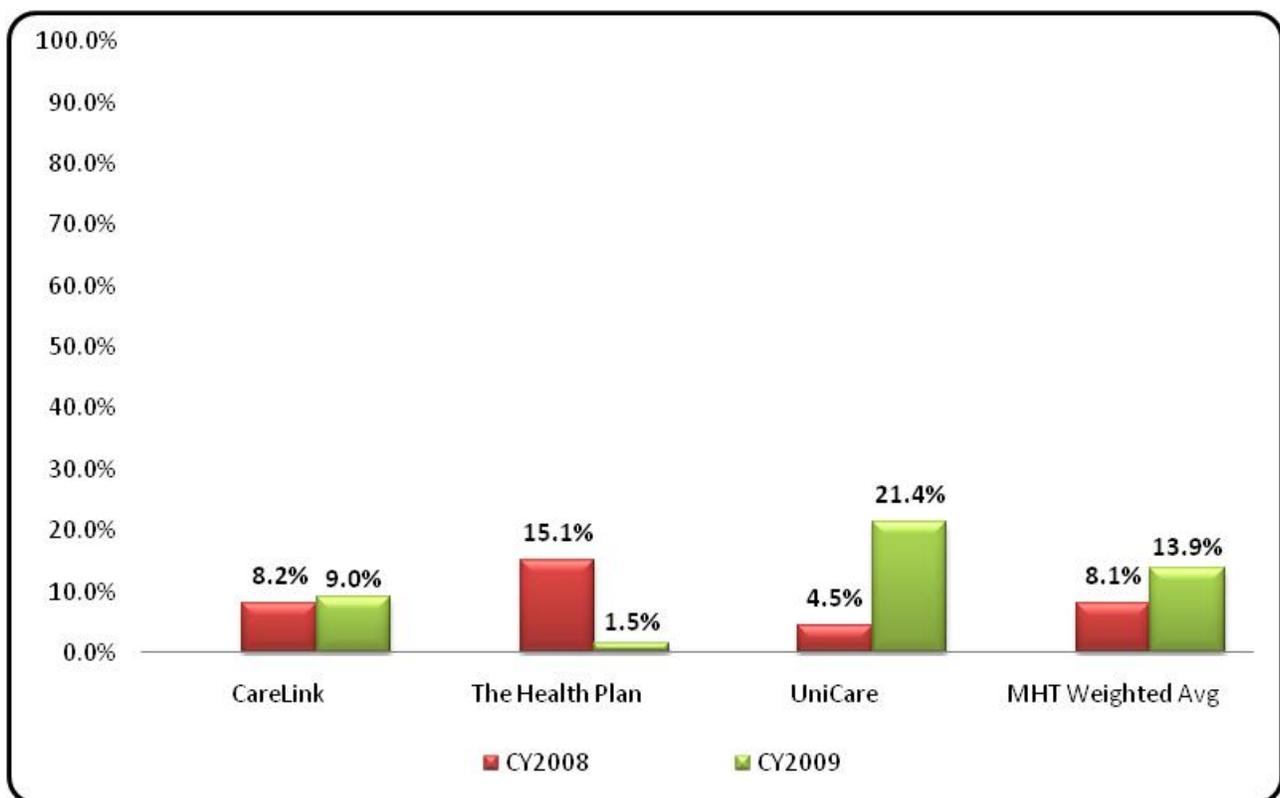


Figure 20 displays the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile*. The *BMI Percentile* indicator evaluates whether BMI percentile is assessed instead of an absolute BMI value because BMI norms for children/adolescents vary by age and gender. This measure was new for CY 2008 and there were no national benchmarks available at the time of this report. Carelink and UniCare improved between CY 2008 and CY 2009. THP’s rate decreased primarily due to a change from using the hybrid methodology in CY 2008 to the administrative data collection methodology in CY 2009.

Figure 21. Results: MHT 2009 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-Counseling for Nutrition

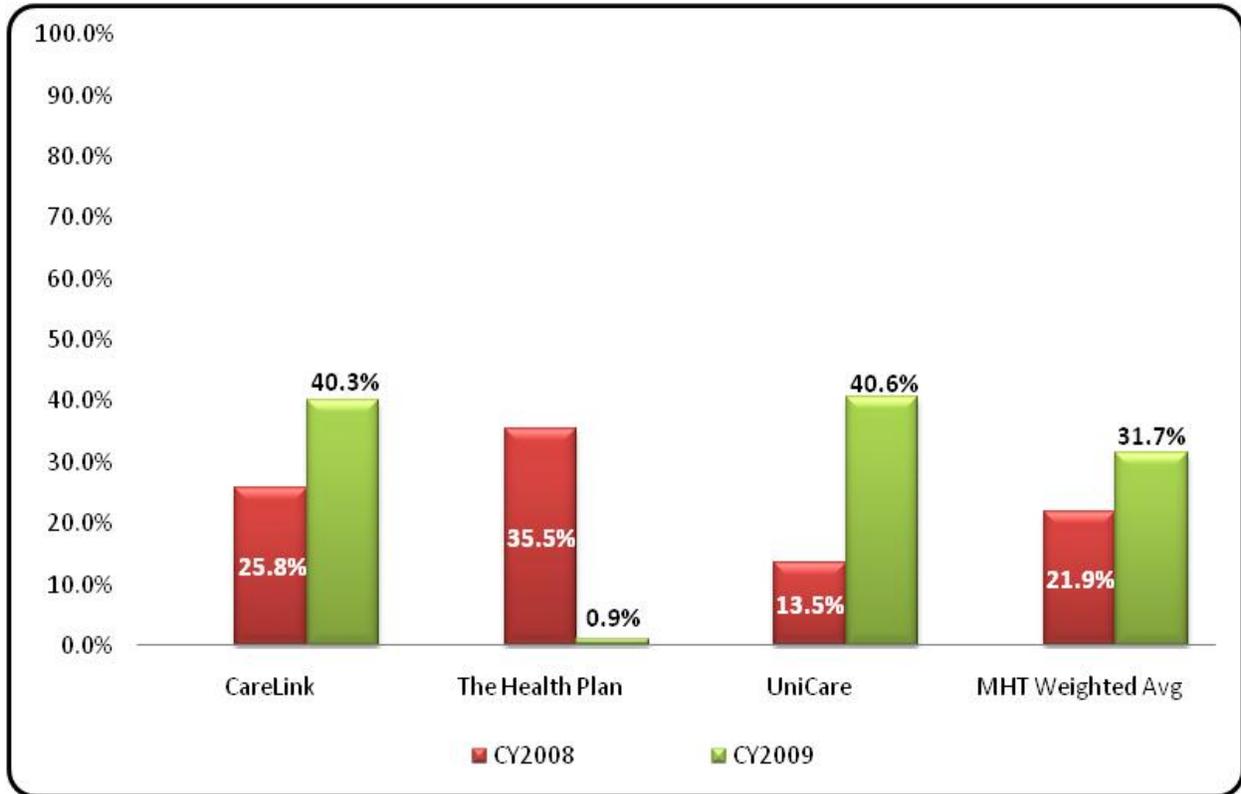


Figure 21 displays the indicator results for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition* indicator which measures if nutrition counseling was received during the year. Carelink and UniCare improved greatly between CY 2008 and CY 2009. THP's rate decreased primarily due to a change from using the hybrid methodology in CY 2008 to the administrative data collection methodology in CY 2009.

Figure 22. Results: MHT 2009 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-Counseling for Physical Activity

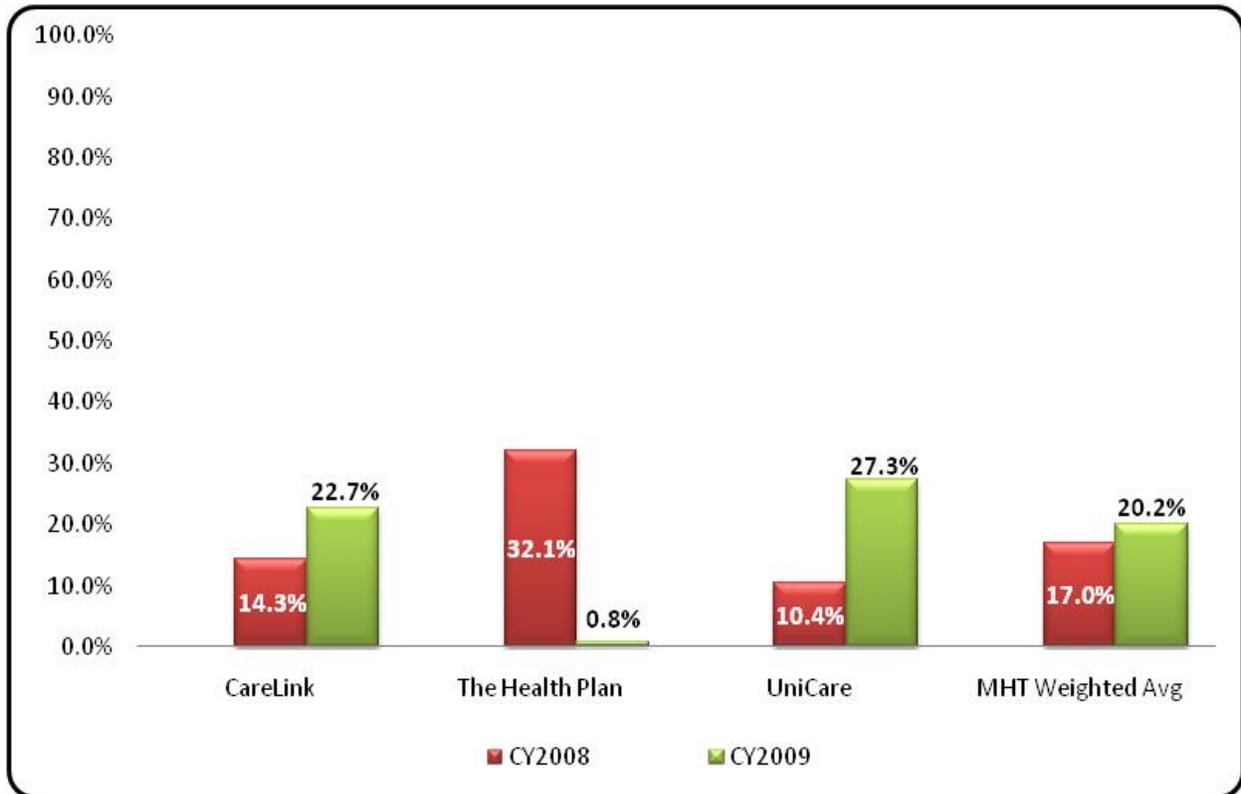


Figure 22 displays the indicator results for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Physical Activity* indicator which measures whether or not counseling for physical activity was provided received during the measurement year. Carelink and UniCare improved greatly from CY 2008 to CY 2009. THP’s rate decreased primarily due to a change from using the hybrid methodology in CY 2008 to the administrative data collection methodology in CY 2009.

In CY 2009, the MHT MCO HEDIS Effectiveness of Care performance was mixed. Results indicate that the MHT Weighted Average met or performed better than the National HEDIS Medicaid Average for the following measures/indicators:

- Controlling High Blood Pressure
- Comprehensive Diabetes Control—Poor HbA1c Control (>9.0%)
- Comprehensive Diabetes Control—Blood Pressure Control (<130/80 mm Hg)
- Comprehensive Diabetes Control—Blood Pressure Control (<140/90 mm Hg)

The MHT Weighted Average improved from CY 2007 to CY 2009 for the following measures:

- Lead Screening in Children
- Breast Cancer Screening
- Chlamydia Screening in Women

Measures that showed improvement over two years from CY 2008 to CY 2009 are Adult BMI Assessment, Comprehensive Diabetes Care- HbA1c Control (<7%), Use of Imaging Studies for Low Back Pain, and Weight Assessment and Counseling for Nutrition and Physical Activities for Children/Adolescents (all three measures).

The three MCOs had mixed performance for most measures but all three experienced decreased rates for Childhood Immunization Status Combination 2 and 3 from CY 2008 to CY 2009. The decrease in performance may be due partially to MCO access problems with the West Virginia Immunization Registry.

Performance Improvement Projects (PIPs)

Each Medicaid MCO developed PIPs relevant to their population and in areas that were in need of improvement. Reported PIPs included topics such as childhood immunizations, well-child visits, obesity, asthma, and emergency room utilization. The PIPs address system-wide issues (enrollee, provider, and administrative) that present barriers to improved enrollee health outcomes. Most of the PIP indicators are HEDIS measures.

Delmarva evaluates PIPs and determines if they were conducted in a methodical and sound manner and provides BMS confidence in the reported results. Using the CMS protocol as a guide, Delmarva assesses each PIP across a 10 step process. These 10 steps include:

- Step 1: Review the Selected Study Topics
- Step 2: Review the Study Questions
- Step 3: Review the Selected Study Indicators
- Step 4: Review the Identified Study Population
- Step 5: Review Sampling Methods
- Step 6: Review Data Collection Procedures
- Step 7: Assess Improvement Strategies
- Step 8: Review Data Analysis and Interpretation of Study Results
- Step 9: Assess Whether Improvement is *Real* Improvement
- Step 10: Assess Sustained Improvement.

As Delmarva staff conducts PIP reviews, each component within a standard (step) is rated as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. A final assessment is made for each of the 10 steps. A description of the ratings is provided below:

- Met – All required components are present
- Partially Met – At least one, but not all components are present
- Not Met – None of the required components are present
- Not Applicable – None of the components are applicable

PIP validation results for all three Medicaid MCOs are summarized in the tables below.

Table 3. Carelink Performance Improvement Project Results for CY 2009.

Performance Improvement Project	Validation Results	Findings	Recommendations
Childhood Immunizations	Steps 1-8 and 10: met Step 9: partially met	Carelink received a partially met due to a 6 percentage point decline in performance since the previous measurement period. Even so, the MCO has still managed to sustain improvement when compared to the baseline measurement.	The MCO should continue to implement multi-faceted interventions that will assist in sustaining improvement and meeting or exceeding project goals.
Well-Child Visits	Steps 1-10: met	Final measurements demonstrate project improvement and exceed or are near the national Medicaid 50 th percentile for both indicators: Well-Child Visits in the First 15 Months of Life and Well-Child Visits for Members Three to Six Years of Age.	Based on improvement demonstrated thus far and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements that are a component of well-visits, Delmarva is confident that improvement will continue and recommends closing this project.
Emergency Department Collaborative	Steps 1-4 and 6-8: met Step 9: partially met Steps 5 and 10: not applicable	Carelink received a partially met based on an increase in the number of members receiving emergency room services (a decrease in utilization is desirable).	The MCO should identify specific barriers for each project indicator and implement appropriately targeted interventions. A comprehensive data analysis including a review of diagnoses should assist in the process.

Carelink’s Childhood Immunization PIP utilizes a HEDIS indicator, Childhood Immunization Status—Combination 3. Successful implementation of multi-faceted interventions led to sustained improvement. The Well-Child Visits project also used HEDIS measures. The MCO’s success in this project is attributed to system-level interventions, as well. The Emergency Department Collaborative reported its first remeasurement data. Unfortunately a decline in performance was reported, as the MCO is still working to identify barriers and effective interventions. Specific PIP project measures and their respective results are provided in Appendix 2.

Table 4. The Health Plan Performance Improvement Project Results for CY 2009.

Performance Improvement Project	Validation Results	Findings	Recommendations
Obesity	Steps 1-4 and 6-8: met Steps 5 and 9-10: not applicable	All applicable steps were met; the project reported baseline data only. THP has initiated system-level interventions that are expected to improve outcomes.	THP has identified a pediatric champion for the project. There is a significant opportunity to change provider behavior using this influential peer. THP is strongly encouraged to maximize this opportunity and set the tone for change using the pediatric champion.
Asthma	Steps 1-4 and 6-10: met Step 5: not applicable	THP reported improvement in the number of persistent asthmatics who had an inpatient stay (decrease in admissions). Sustained improvement was achieved in the number of persistent asthmatics who were appropriately prescribed medication and the number of persistent asthmatics who had an emergency room encounter. Four new project indicators were introduced. They appear more relevant to the study and will replace some of the original study indicators.	Identify specific barriers for measures not achieving improvement. Interventions should address these barriers. Some of the current interventions may need to be dropped or modified. Continue to assess effectiveness and modify initiatives as necessary. The new project indicators will provide more meaningful results and insight in controlling asthma.
Emergency Department Collaborative	All applicable steps were met	THP submitted a proposal project submission. Baseline data was not included. All applicable steps were assessed and met requirements. The project topic has been narrowed and targets members 0-5 with a respiratory diagnosis and members 20 and older with a diagnosis of back pain.	THP should complete a thorough barrier analysis and implement targeted interventions.

Only one of THP's projects reported remeasurement data. The MCO's Asthma PIP utilizes HEDIS indicators and documented improvement in them. System-level interventions appear to contribute to improved outcomes. Several new indicators were introduced in the study and are limited to persistent asthmatics with respiratory specific diagnoses. The Obesity project reported baseline data only and the Emergency Department (ED) Collaborative was a project proposal. The previous ED PIP was closed after two remeasurement periods and having achieved significant improvement in reducing the number of members with three or more ED visits within a 90 day period (decrease of 13.11 members per 1000). The new PIP is narrowly defined and focuses on specific conditions and their associated ED visits. Specific PIP project measures and their respective results are provided in Appendix 2.

Table 5. UniCare Performance Improvement Project Results for CY 2009.

Performance Improvement Project	Validation Results	Findings	Recommendations
Diabetes	Steps 1-4 and 6-8: met Step 9: partially met Step 10: unmet Step 5: not applicable	Indicator rates continued to decline. Sustained improvement was not achieved in either project indicator (HbA1c screening and retinal eye exams). Project success was limited. UHP was never able to improve the HbA1c screening rate over baseline (86%). However, it should be noted that the baseline data year's denominator was extremely small (37). For the retinal eye exam indicator, performance peaked with the 2 nd remeasurement period at 43%. Overall, there was marginal improvement for this indicator, as the final remeasurement exceeded the baseline rate by 7 percentage points.	Based on 5 remeasurement periods, Delmarva recommends closing this project. During the last assessment, UHP identified very specific barriers and implemented interventions to target them. The MCO should continue this project internally and monitor the success and impact of these interventions, making adjustments accordingly. UHP should spread any lessons learned to other PIPs.
Asthma	Steps 1-4 and 6-8: met Steps 5 and 9-10: not applicable	UniCare created a new project indicator and only baseline data has been reported.	The project indicator baseline results exceed the Medicaid 90 th percentile, leaving little room for improvement. UHP may continue this project for an additional year; however, if current performance is maintained, Delmarva will require the MCO to close this project and identify another area requiring improvement.
Emergency Department Collaborative	All applicable steps were met	The project was a proposal submission only; no baseline data was provided.	Identify project goals and complete a comprehensive barrier analysis and implement interventions accordingly.

UniCare's Diabetes PIP included two HEDIS measures. Both indicators demonstrated a decline in performance when compared to the previous measurement period. After five remeasurement periods, Delmarva recommends closing the project; success was limited. However, UHP is on the right track. During the last analysis, the MCO identified very specific barriers and implemented interventions to address them. UniCare should continue to monitor progress internally. Only baseline data was reported for the MCO's Asthma PIP. And lastly, the Emergency Department Collaborative is still in the proposal phase. The extended proposal period is due to delays in identifying primary care practices to partner with on the project. In addition to baseline data, goals, barriers, and interventions need to be identified. Specific PIP project measures and their respective results are provided in Appendix 2.

Systems Performance Review (SPR) Findings

For the CY 2009 review, all plans were required to achieve a 90% compliance rate for the QA standards. The compliance rates for all three MCOs for CY 2006 through CY 2009 are found in Table 6.

Table 6. MHT Systems Performance Review Ratings for QA Standards CY 2006-CY 2009

MCO	QA Compliance Rate CY 2006	QA Compliance Rate CY 2007	QA Compliance Rate CY 2008	QA Compliance Rate CY 2009
Carelink	98%	99%	97%	98%
The Health Plan	99%	100%	100%	100%
UniCare Health Plan	100%	99%	98%	97%

As shown in Table 4, all MCOs performed exceptionally well for the QA standard, achieving commendable compliance rates ranging from 97% to 100% in CY 2009. All three MCOs have consistently achieved high compliance rates of 97% or greater in all review years. In CY 2009, the minimum threshold was increased to 90% from 85% in CY 2008. All MCO's surpassed the 90% threshold for the QA standards and therefore no corrective action plans were required.

In general, the MCOs were able to demonstrate that they have comprehensive Quality Improvement (QI) and Utilization Review (UR) programs in place. The QI and UR programs consist of written program descriptions that describe the program objectives, goals, organization, staff, and committee structure. An annual work plan is also a part of the MCOs' QI/UR programs. In general, the work plans are living documents that list the program goals, tasks to be completed, target completion dates, and responsible parties. The work plans are updated at least quarterly and are used by the MCOs to complete their annual QI/UR program evaluations. All MCOs' committee meeting minutes documented involvement of the medical director and Board of Directors review and approval of program documents.

All MCOs have appropriate job descriptions for staff and a comprehensive set of policies and procedures to guide staff in performing their duties. The MCOs have Clinical Practice Guidelines (CPGs) in place and there is documented evidence that the guidelines are reviewed and updated regularly per the requirements. 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. Female enrollees have direct access to women's health specialists for routine and preventive health services as required.

Performance Improvement Projects (PIPs) are in place and are routinely monitored through the quality improvement channels at each MCO. Topics are selected based upon data analysis. All MCOs are participating in the statewide Emergency Department (ED) Collaborative coordinated by Delmarva.

Comprehensive policies and procedures are in place for the MCOs to credential and recredential providers. These procedures address all requirements. Delegated credentialing agreements are in place at each MCO and meet the contract requirements. All three MCOs were able to demonstrate that the duties of each delegated provider were contained within their contracts and that routine monitoring occurs. The monitoring of delegates is documented in routine reports provided to the MCOs by the delegate and in the meeting minutes of the appropriate committee(s) within the MCO.

Enrollees with special needs are identified by the MCOs. Disease management (DM) and case management (CM) programs are in place for these members. CM and DM case files were reviewed as part of the on-site visit conducted by Delmarva. The review of individual case files did not reveal any deficiencies.

In their contract with BMS, the MCOs are required to implement an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) tracking system for all eligible enrollees. Specifically, the EPSDT tracking system must:

- provide notification of screening due dates,
- require a process to make necessary referrals,
- track referrals and treatments resulting from an EPSDT screening,
- provide up-to-date information on initial visits for newborns,
- provide up-to-date information on preventive pediatric visits, and
- provide up-to-date information diagnosis, treatment and referrals.

All MCOs provide notification of screening due dates in member handbooks, enrollee newsletters, and individual reminder card mailings to enrollees. Not all MCOs require referrals for specialist treatment, and therefore, it becomes difficult to track referrals and treatments. For the MCOs that do not require referrals for specialist treatment, Delmarva recommended that the MCOs review claims/encounters for utilization of specialist services to determine whether or not children are accessing specialist services. Preventive pediatric visits rates are captured through the required HEDIS measures and reported annually. Other EPSDT services, such as lead screening and immunizations, are captured annually using HEDIS measures.

One MCO, The Health Plan, developed its own program to track each eligible child individually and report all required components. CHP and UHP are able to report the volume of services received by EPSDT eligible children, but are not able to track services by individual child as required in the standards. CHP and UHP have many of the required tracking elements in place, but do not have a fully coordinated tracking system to provide up-to-date information at the individual enrollee level. Carelink and UniCare continue to develop solutions but did not make any major progress in addressing the deficiencies the CY 2009 review.

The UR programs at the MCOs have preauthorization, concurrent, and continuing authorization policies and procedures in place. All MCOs monitor the timelines of the completion of authorizations. The complaint, appeals, and grievance policies and procedures are also in place at the MCOs. The MCOs have developed and implemented policies and procedures that meet the requirements of the WV Department of Insurance, BMS, and the Code of Federal Regulations. All MCOs grievance and appeals policies and procedures have been approved by BMS as required by the QA standards. In the past two review periods (CY 2008 and CY 2009) the MCOs have made great strides in informing enrollees of all of their rights during the grievance process and documenting such efforts as evidenced by a review of complaints, grievances and denials completed on-site.

All MCOs have processes in place to review services for under and over utilization of services. Inter-rater reliability is performed for staff completing UR activities to ensure sound utilization review decisions.

Quality Summary

The overall evaluation of the QI program through the PIP, PMV, and SPR 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 a measurement goal, obtaining a baseline measurement, and performing interventions aimed at improving the performance. MCOs are becoming better 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 on their analyses and identify very specific barriers for each project indicator. Developing interventions based on these identified barriers should assist the MCOs in further improving project outcomes.

The validation of performance measures related to quality revealed that the MHT Weighted Average for the *Controlling High Blood Pressure*, *Comprehensive Diabetes Care- Poor HbA1c Control (>9%)*, *Comprehensive Diabetes Care- Blood Pressure Control (<130/80 mm Hg)* and *Blood Pressure Control (<140/90 mm Hg)* measures all exceeded the HEDIS Medicaid Average for CY 2009. There was also improvement noted in the MHT Weighted Average for *Lead Screening in Children*, *Breast Cancer Screening* and *Chlamydia Screening in Women*.

All MCOs performed well in the area of quality for the Systems Performance Review with compliance rates ranging from 97% to 100% in the Quality Assessment and Performance Improvement domain for CY 2009. The compliance rates across the four measurement periods are commendable. The MCOs have the appropriate systems and processes in place to measure and monitor quality, timeliness, and

over/underutilization of services. The area that was identified for improvement is the enhancement of the EPSDT tracking systems for both Carelink and UniCare.

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.

Performance Measure Validation (PMV)

Five measures are required by MHT and are included in the access/availability of services of services domain. MCO and MHT performance are summarized below. The HEDIS results for all measures submitted by the three MCOs are found in Appendix 1.

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 23. Results: MHT 2009 Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years

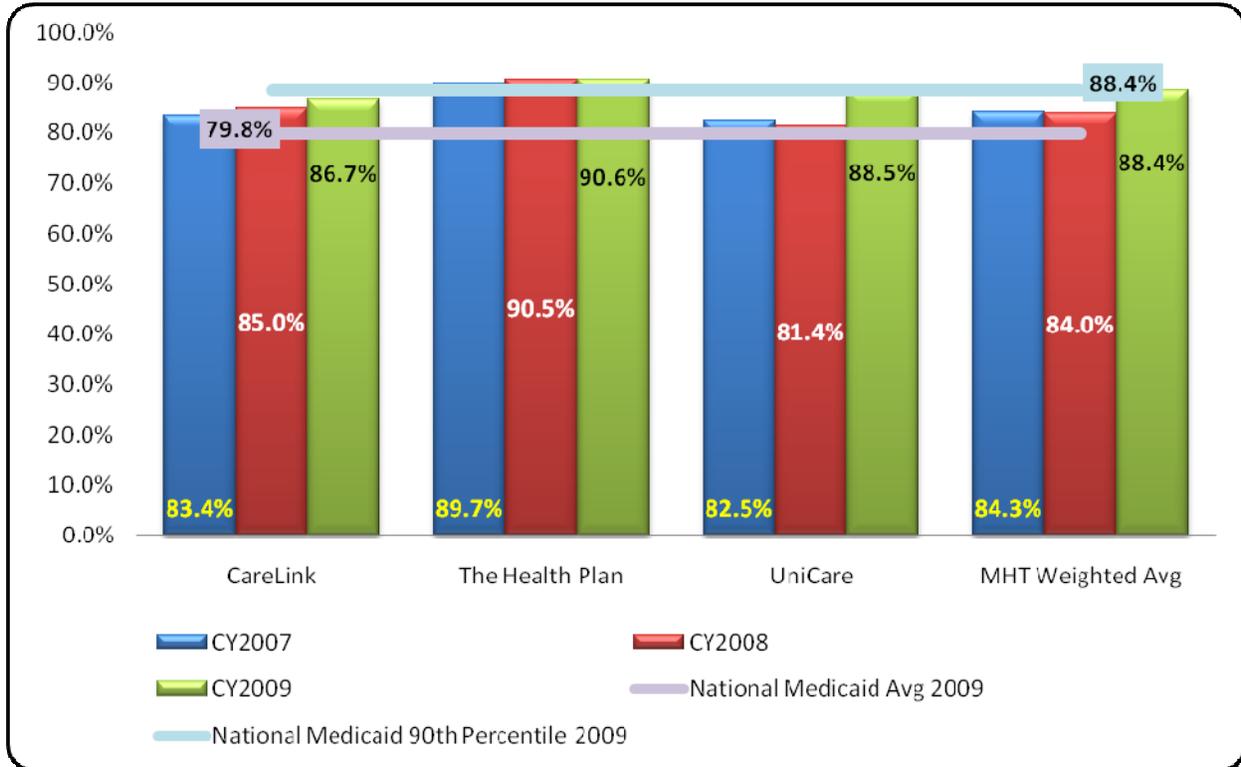


Figure 23 displays the results for *Adults' Access to Preventive/Ambulatory Health Services—20-44 Years*. Plan performance rates ranged from 86.7% to 90.6%. All three plans exceeded the National HEDIS Medicaid Average of 79.8%. THP and UniCare surpassed the National Medicaid 90th percentile. Carelink and THP performance improved steadily since CY 2007. Overall, the MHT Weighted Average met the National Medicaid 90th percentile.

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 24. Results: MHT 2009 Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years

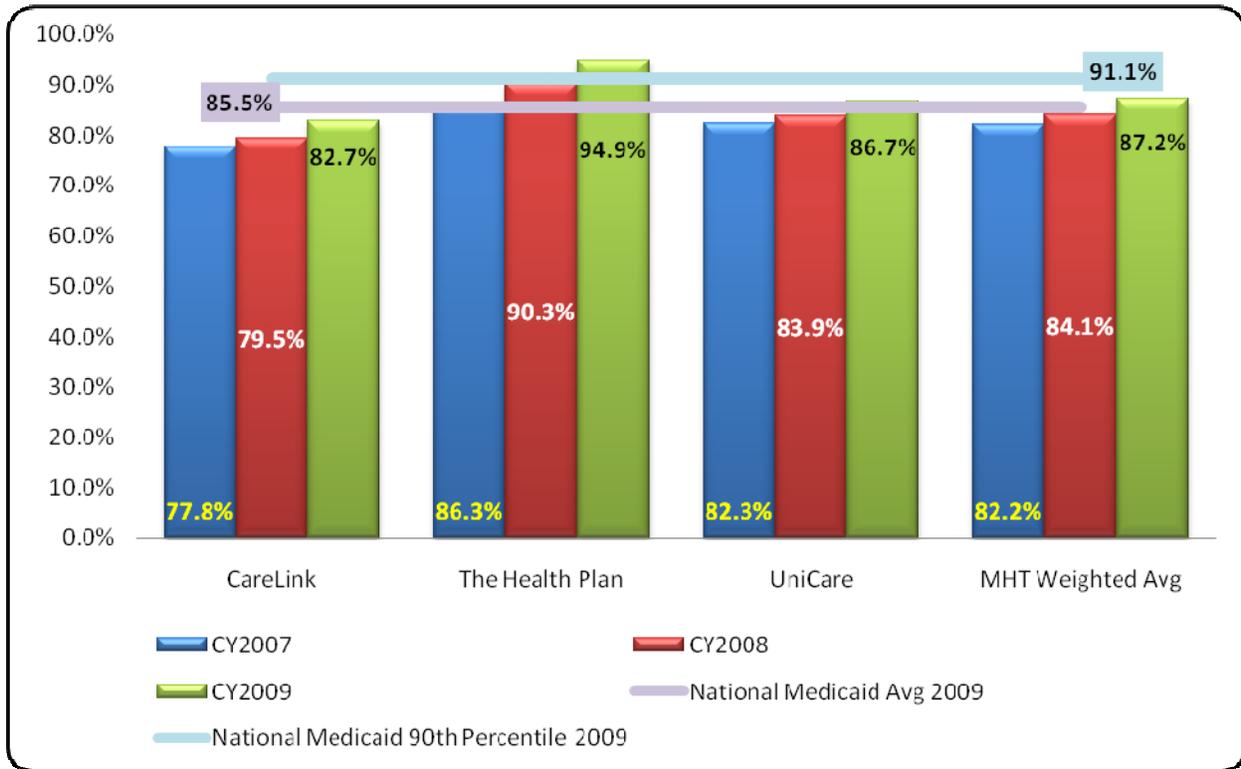


Figure 24 displays the indicator results for *Adults' Access to Preventive/ Ambulatory Health Services—45-64 Years*. Individual plan performance rates ranged from 82.7% to 94.9%. THP exceeded the National Medicaid 90th Percentile of 91.1%, while UniCare and the MHT Weighted average exceeded the National Medicaid Average of 85.5%. Rates for all three plans improved over the three year period from CY 2007 through CY 2009.

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

The CAP 12-24 Months indicator reports the percentage of members 12 through 24 months who had a visit with a primary care provider (PCP) in the measurement year.

Figure 25. Results: MHT 2009 Children and Adolescents' Access to Primary Care Practitioners – 12-24 Months

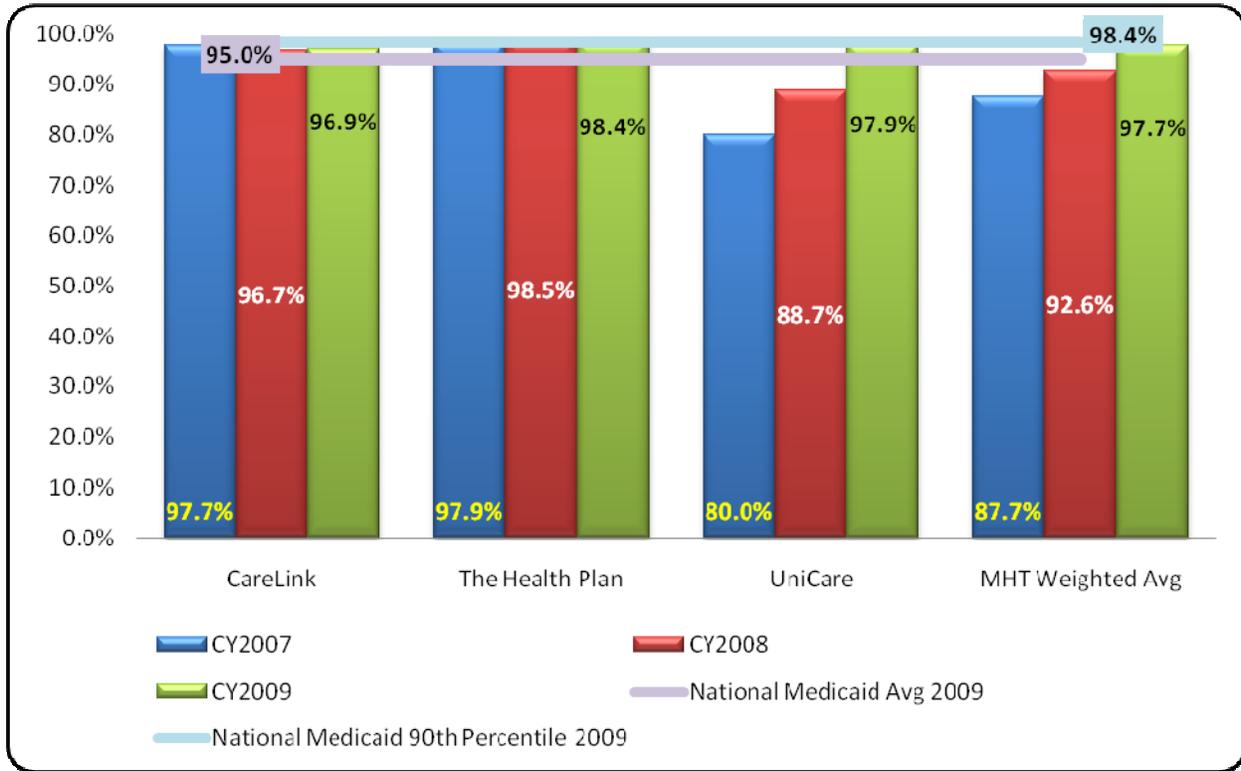


Figure 25 displays the indicator results for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*. Performance rates ranged from 96.9% to 97.9%, with THP meeting the National Medicaid 90th Percentile. Carelink and UniCare performed better than the National Medicaid Average of 95.0%. The MHT Weighted Average showed three years of improvement and was above the National Medicaid Average of 95.0% for CY 2009.

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

The CAP 25 Months -6 Years indicator reports the percentage of members 12 through 24 months who had a PCP visit in the measurement year.

Figure 26. Results: MHT 2009 Children and Adolescents' Access to Primary Care Practitioners – 25 Months-6 Years

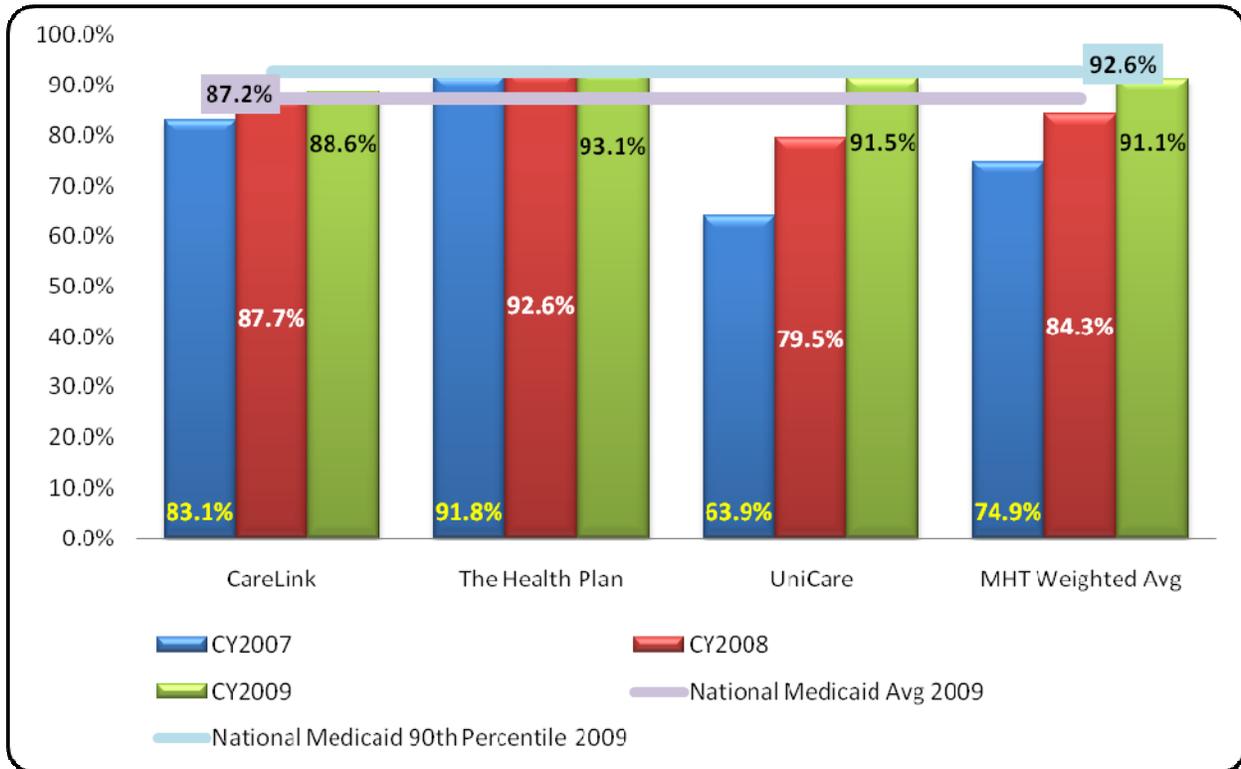


Figure 26 displays the indicator results for *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*. Health plan performance ranged from 88.6% to 93.1%. Carelink and UniCare exceeded the National Medicaid Average of 87.2% while THP exceeded the National Medicaid 90th Percentile of 92.6%. The rate for all three plans and the MHT Weighted Average improved from CY 2007 to CY 2009.

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 27. Results: MHT 2009 Children and Adolescents' Access to Primary Care Practitioners – 7-11 Years

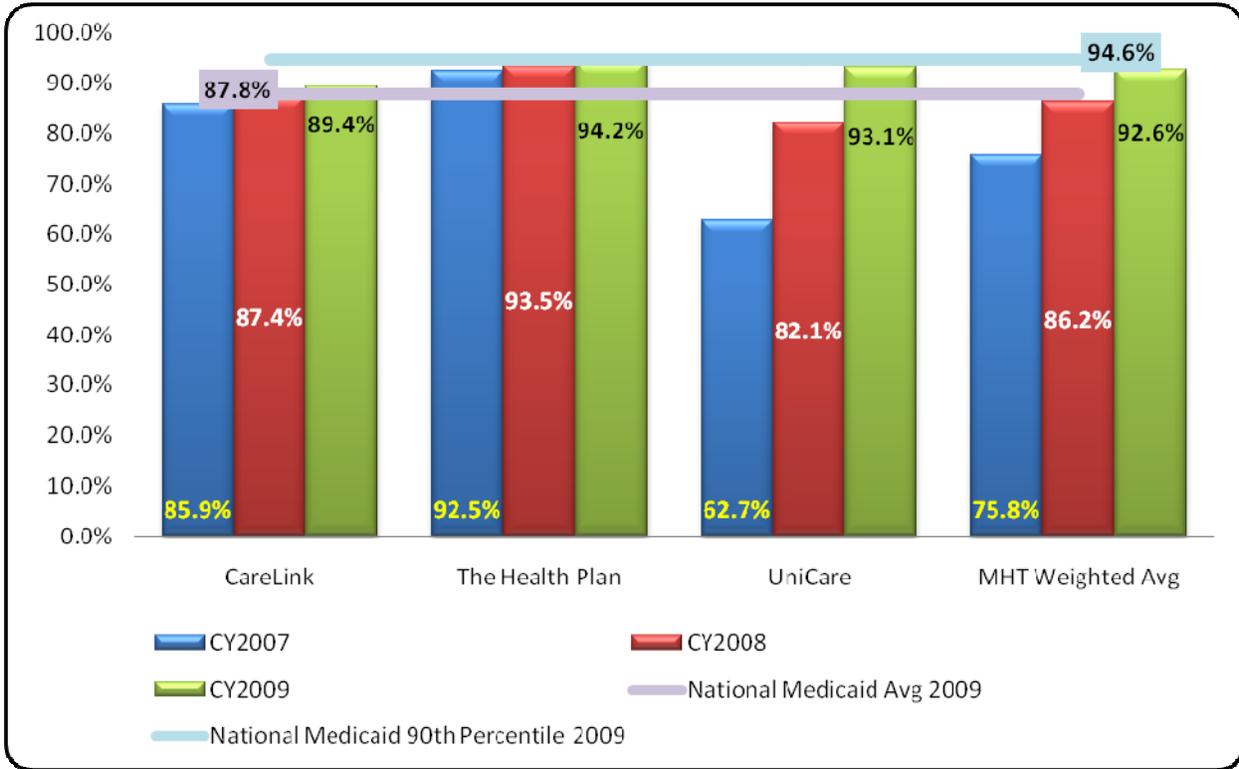


Figure 27 provides the indicator results for *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*. Individual plan performance rates ranged from 89.4% to 94.2%. All three MCOs exceeded the National Medicaid Average of 87.8% and achieved an increase in their rates from CY 2007 to CY 2009. The MHT Weighted Average exceeded the National Medicaid Average.

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 28. Results: MHT 2009 Children and Adolescents' Access to Primary Care Practitioners – 12-19 Years

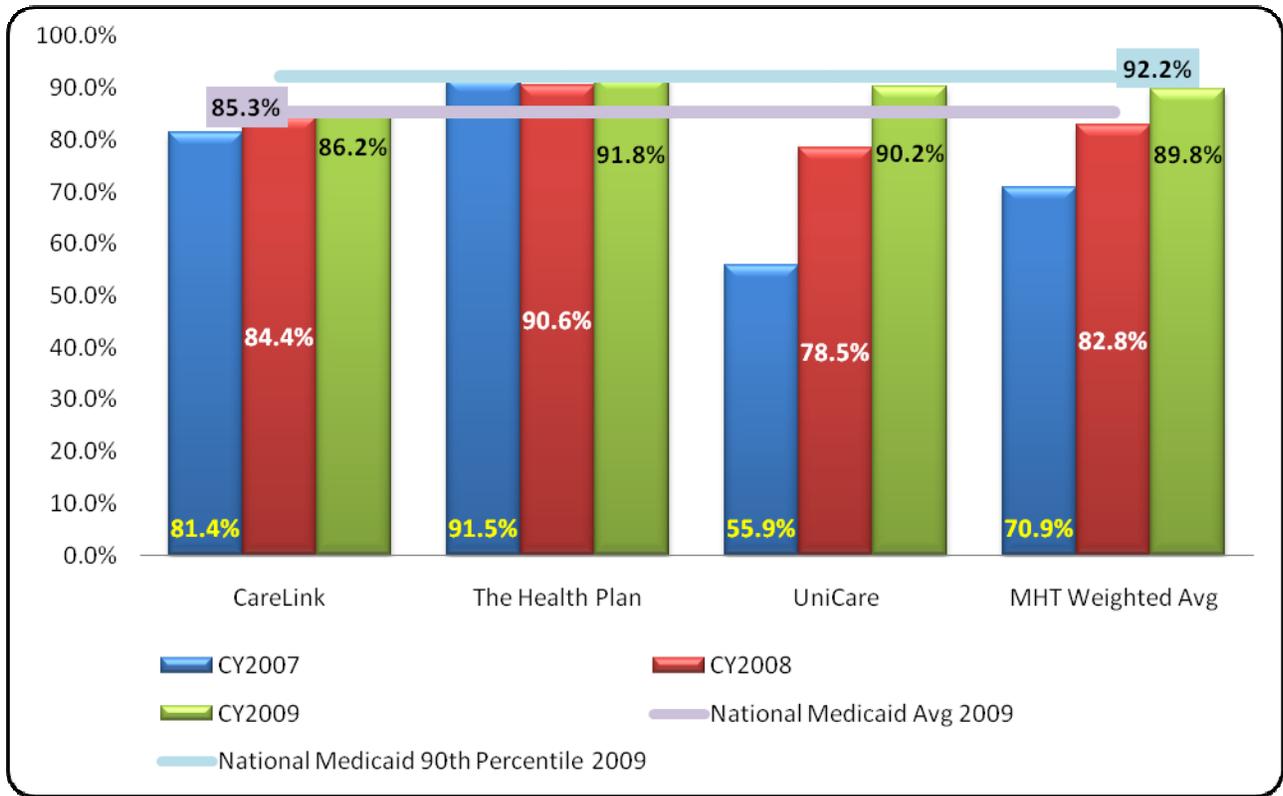


Figure 28 displays the indicator results for *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*. Individual MCO performance rates ranged from 86.2% to 91.8%. All three plans performed better than the National Medicaid Average of 85.3%. Carelink, UniCare, and the MHT Weighted averages showed continuous improvement over the three years from CY 2007 through CY 2009.

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 29. Results: MHT 2009 Prenatal and Postpartum Care - Timeliness of Prenatal Care Indicator

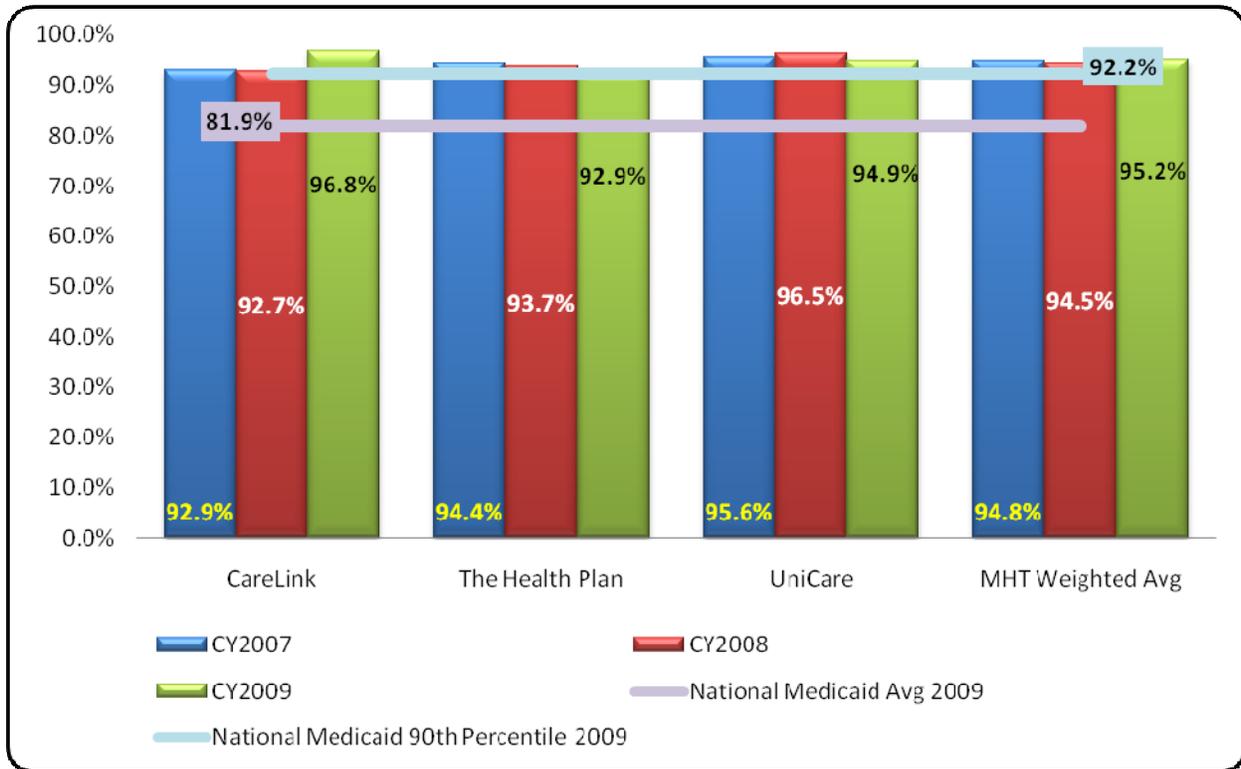


Figure 29 displays the results for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator. Performance ranged from 92.9% to 96.8%. All three plans exceeded the National Medicaid 90th Percentile of 92.2%. The MHT Weighted Average increased from CY 2008 and CY 2009. Carelink was the only plan to improve from CY 2008 to CY 2009.

Prenatal and Post Partum Care (PPC)-Postpartum Care

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

Figure 30. Results: MHT 2009 Prenatal and Postpartum Care - Postpartum Care Indicator

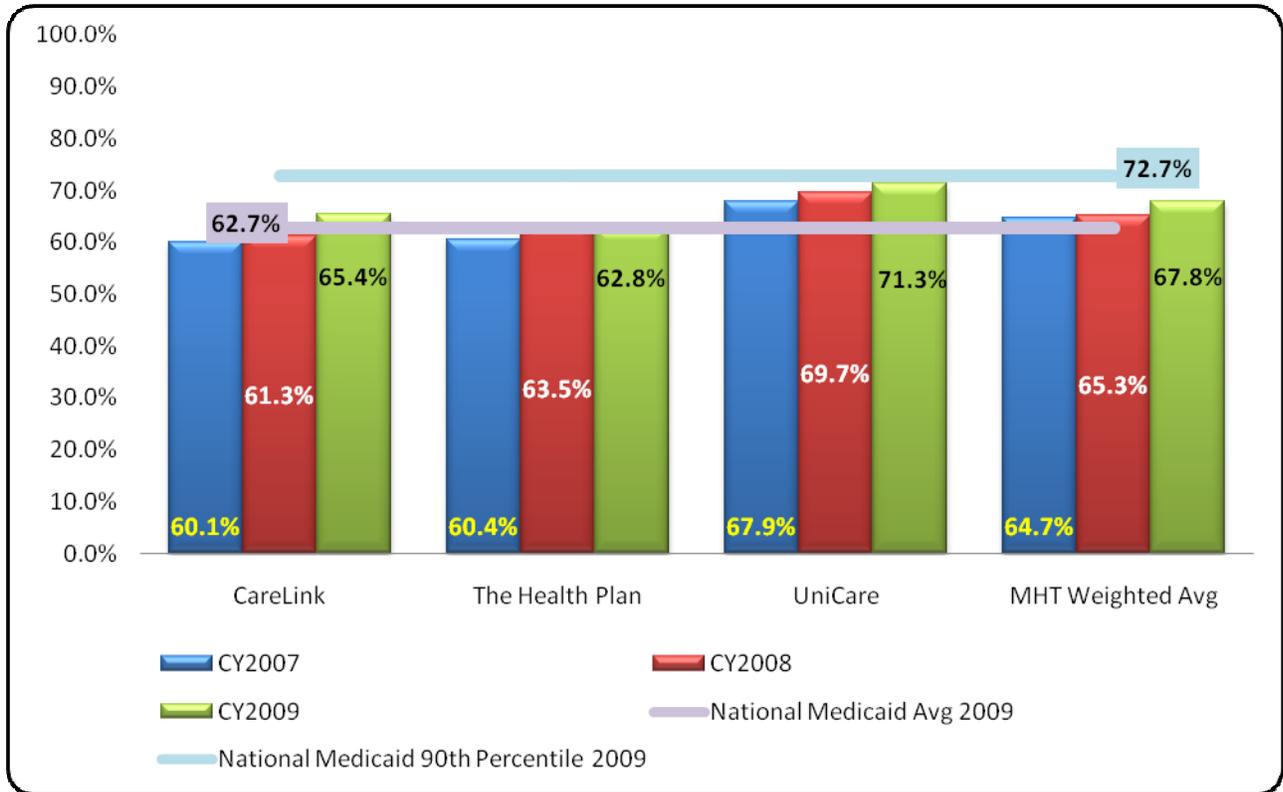
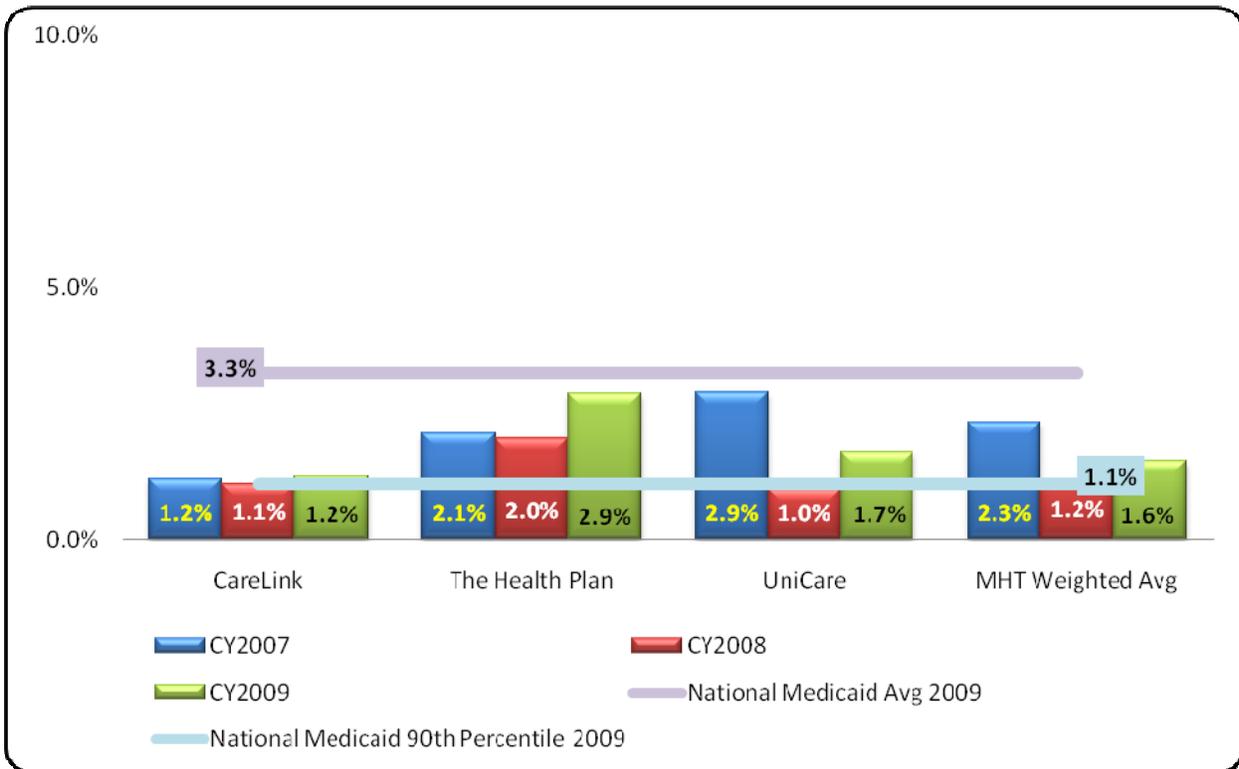


Figure 30 displays the indicator results for *Prenatal and Postpartum Care—Postpartum Care*. Health plan performance ranged from 62.8% to 71.3%. Rates for all three plans exceeded the National Medicaid Average of 62.7%. Carelink and UniCare improved steadily since CY 2007. The MHT Weighted Average improved over the CY 2007 rate and exceeded the National Medicaid Average.

Call Abandonment Rate (CAB)

The Call Abandonment Rate measure reports the percentage of calls received by the health plan’s Member Services call centers during operational hours that were abandoned by the caller before being answered by a live voice. A lower rate indicates better performance.

Figure 31. Results: MHT 2009 Call Abandonment*



*The scale on this graphic was changed to provide a clearer view of the rates. For this measure, lower rates are desired.

Figure 31 displays the results for the *Call Abandonment* measure. For this measure, a lower rate indicates better performance. Plan performance rates ranged from 1.2% to 2.9%. Carelink fell only one tenth of one percentage point above the National Medicaid 90th Percentile of 1.1%. All MCOs performed better than the National Medicaid Average of 3.3%. The MHT Weighted Average and the performance for all three plans declined between CY 2008 and CY 2009.

Call Answer Timeliness (CAT)

The Call Answer Timeliness measure reports the percentage of calls received by the health plan’s Member Services call centers during operational hours that were answered by a live voice within 30 seconds.

Figure 32. Results: MHT 2009 Call Answer Timeliness

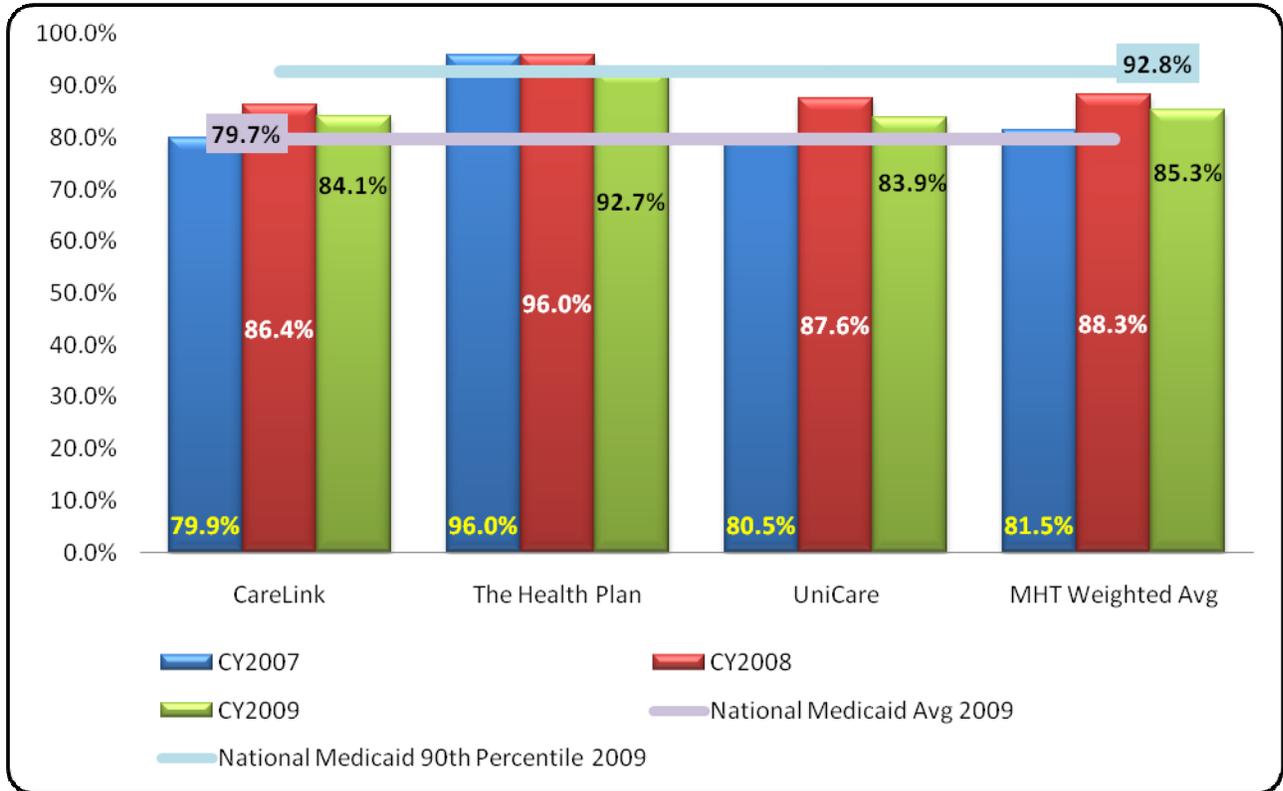


Figure 32 displays the results for *Call Answer Timeliness*. Health plan performance ranged from 83.9% to 92.7%. THP fell one tenth of one percentage point below the National Medicaid 90th Percentile. All MCOs and the MHT Weighted Average exceeded the Medicaid National Average of 79.7%. Rates for all three plans declined from CY 2008 to CY 2009.

All MHT MCOs exceeded the National Medicaid HEDIS 90th percentile for the *Adult's Access to Preventive/Ambulatory Health Services, ages 20-44 Years* and *Prenatal and Postpartum Care- Timeliness of Prenatal Care* indicators. All MCOs outperformed the National HEDIS Medicaid Average for the following indicators related to access:

- Adults' Access to Preventive/Ambulatory Health Services ages 44-64 Years
- Childrens' and Adolescent Access to Primary Care Pratictioners (all four indicators)
- Prenatal and Postpartum Care (both indicators)
- Call Answer Timeliness
- Call Abandonment

The MHT Weighted Average improved from CY 2007 to CY 2009 for all the indicators of the *Adults' Access to Preventive/Ambulatory Health Services* and *Childrens' and Adolescent Access to Primary Care Pratictioners* measures. The MHT weighted averages decreased between CY 2008 and CY 2009 for *Call Abandonment* and *Call Answer Timeliness*.

Performance Improvement Projects (PIPs)

For CY 2009, there were no PIPs that specifically focused on access. Primarily the topics were clinical in nature and addressed quality issues. However, Carelink's Emergency Department Collaborative PIP did reference access issues as a barrier and cause for overutilization of emergency services. Specifically, limited access to same day appointments and provider availability were noted. The MCO continues to develop interventions that address barriers. CHP's Emergency Department Collaborative Project is described in the Quality section of this report.

Systems Performance Review (SPR)

SPR standards related to access are found throughout the Enrollee Rights (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QA) standards. The compliance rates for all three standards for all MCOs are found in Table 7.

Table 7. MHT Systems Performance Review Ratings CY 2009

MCO	Enrollee Rights	Grievance Systems	Quality Assessment and Performance Improvement
Carelink	99%	100%	98%
The Health Plan	99%	99%	100%
UniCare Health Plan	88%	100%	97%

In general, the MCOs performed well for standards and elements related to access. Specifically, the MCOs were able to demonstrate that members have access to:

- Their rights and responsibilities,
- An adequate primary care provider networks,
- A grievance and appeals process approved by BMS as required by contract,
- Comprehensive information on and access to required benefits and services,
- Health education programs, and
- Their personal medical records.

All MCOs demonstrated that enrollee access to benefits and services is monitored. Systems are in place to monitor enrollee 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,
- An adequate network of providers,
- Authorization decisions (preauthorization, concurrent and continuing authorizations), and

MCOs are required to have policies and procedures in place to request internal CAPs when a provider or delegated entity does not meet MCO performance standards. All MCOs have these procedures documented in their Quality Improvement (QI) and Utilization Review (UR) program documents. The MCOs requested, received, and monitored internal CAPs in CY 2009. Delmarva reviewed all CAPs and MCO monitoring efforts in the review period. All CAPs were timely, addressed the access issue(s) and progress was documented in the appropriate committee meeting minutes.

Prior SPRs indicated MCOs had the greatest challenge informing enrollees about the timeframes and their rights through the appeals and fair hearings processes. In most cases, the appeals and state fair hearings processes were adequately detailed in the MCO policies and procedures; however, procedures were not always followed. The MCOs implemented Delmarva's recommendations and refined their grievance and appeals policies, provided more detail in the notices of action (NOAs), and documented their efforts in resolving appeals and grievances. As a result, the MCOs have achieved compliance rates of 99% to 100%.

In CY 2007 member materials were not always clear in stating that interpretation services are provided *free of charge*, that a second opinion is covered, or defining all of the specific preventive services members that are covered (e.g. colorectal screening and mammography for women). Delmarva provided and the MCOs implemented recommendations to address this issue at the time of the on-site reviews. The MCOs addressed this issue and were fully compliant in CY 2009.

In the CY 2007 review, it was evident that the MCOs provided members access to oral interpretation and translation services. However, not all member handbooks or member materials noted that these services are required to be provided free-of-charge to enrollees for medical appointments. The MCOs revised their member materials and now all have met the requirement to inform members that these services are provided free-of-charge.

Access issues were identified in the CY 2009 SPR. For UHP, issues regarding timely appointment scheduling, 24/7 availability of providers and geographic access of providers were identified. UHP's goal for timely appointment scheduling is 95% but only achieved 81% compliance. However, overall compliance with appointment scheduling increased from the CY 2008 review. Monitoring of the 24/7 availability standard showed a decrease in compliance from 64% in CY2008 to 62% in CY 2009. The survey results indicated that many providers' have answering machines and/or answering services did not provide enrollees with the correct information for after-hours or instructions for emergency care. UHP is working with providers one-on-one to correct this problem.

In regards to geographic access, the data UniCare exceeds the member to provider ratio standards. UniCare is within the ratios of one Obstetrics and Gynecology (OB/GYN2) provider for every 2,000 members in 96% of operational counties; and one high volume specialist (HVS) for every 4,000 members in 72% of operational counties. When measuring time/distance availability, UniCare exceeds the 90% threshold of PCP availability, and meets this 90% threshold in 21 of 47 counties for HVS availability. UHP must attempt to recruit providers in high volume specialties to meet the access standards.

Access Summary

Access to services and benefits can be assessed using the results of the PIPs, performance measures, and Systems Performance Review activities.

For CY 2009, there were no PIPs that specifically focused on access. Primarily the topics were clinical in nature and addressed quality-related issues.

For performance measure validation, the CY 2009 results indicate that the MHT Weighted Average *and* all MCOs outperformed the national Medicaid 90th Percentile for the Adults' Access to Preventive/Ambulatory Health Services (ages 20-44 Years and, Prenatal and Postpartum Care-Timeliness of Care. The MHT weighted average and all three plans exceed the national Medicaid average for Adults' Access to Preventive/Ambulatory Health Services (ages 45-64 Years), Childrens' and Adolescent Access to Primary Care Practitioners (all four indicators), Prenatal and Postpartum Care-Postpartum Care, Call Answer Timeliness, and Call Abandonment measures. The MHT Weighted Average improved or was consistent from CY 2007 to CY 2009 for three measures: Access to Preventive/Ambulatory Health Services (both

indicators), Children's and Adolescent Access to Primary Care Practitioners (all four indicators), Prenatal and Postpartum Care (both indicators).

THP and CHP performed strongly meeting all access related standards. UHP identified issues with timeliness of appointment scheduling, 24/7 availability of providers, and compliance with its geographic access standard for high-volume specialists. UHP is working with providers on-on-one to correct both the timeliness of scheduling appointments and the 24/7 availability issue. UHP must assess its geographic access standards and determine how it will improve compliance with the geographic access standard for high-volume specialists.

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 in the sections to follow.

Performance Measure Validation (PMV)

Timeliness of care was investigated using the results of HEDIS measures in both the Use of Services and the Access and Availability of Care domains. MCO and MHT performance are outlined in the following graphs.

Well Child Visits in the First 15 Months of Life (W15)-Six or More Visits

The Well Child Visits in the First 15 Months of Life-Six or More Visits measure reports the percentage of members who turned 15 months old during the measurement year and who had six or more well child visits with a PCP during their first 15 months of life.

Figure 33. Results: MHT 2009 Well-Child Visits in the 1st 15 Months of Life – Six or More Visits

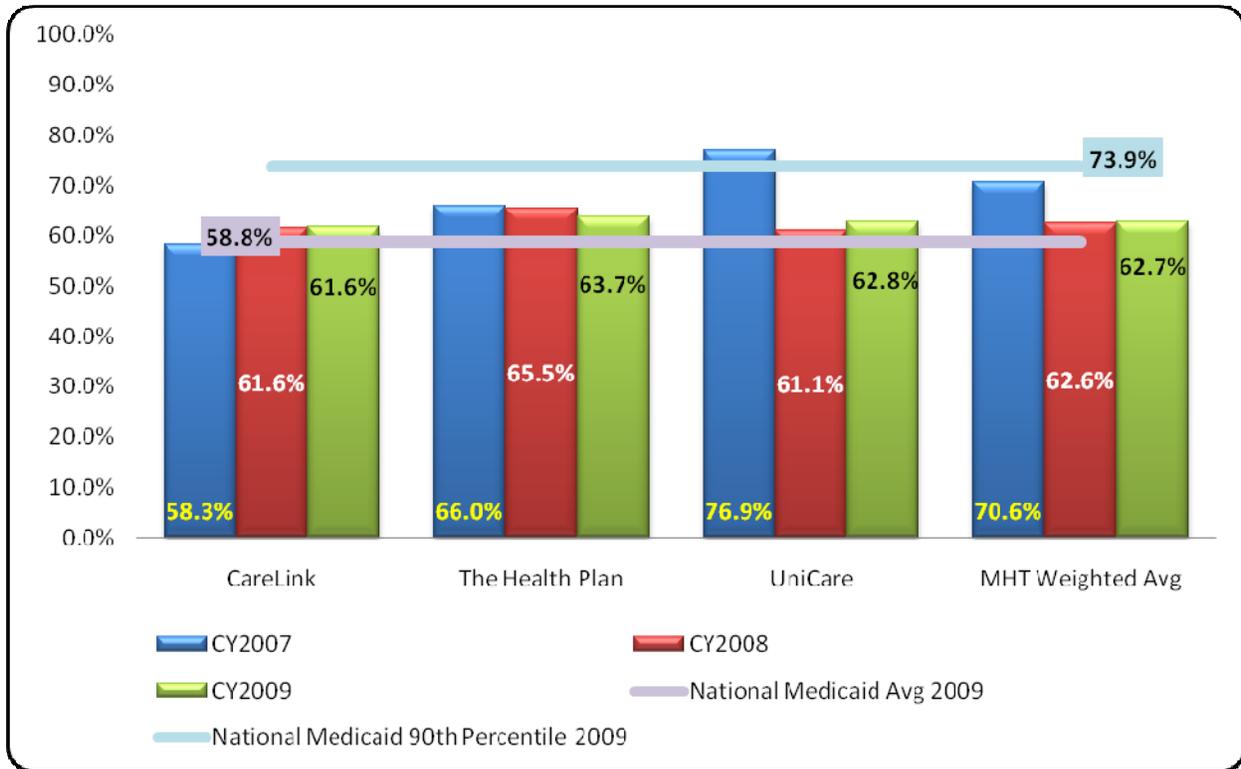


Figure 33 displays the results for *Well-Child Visits in the 1st 15 Months of Life—Six or More Visits*. Rates for this measure ranged from 61.6% to 63.7%. All three plans exceeded the National Medicaid Average of 58.8%. Between CY 2008 and CY 2009, Unicare’s rate improved, Carelink’s rate remained the same, and THP’s rate decreased. The MHT Weighted Average was consistent for CY 2008 and CY 2009 and remained above the National Medicaid Average.

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 34. Results: MHT 2009 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

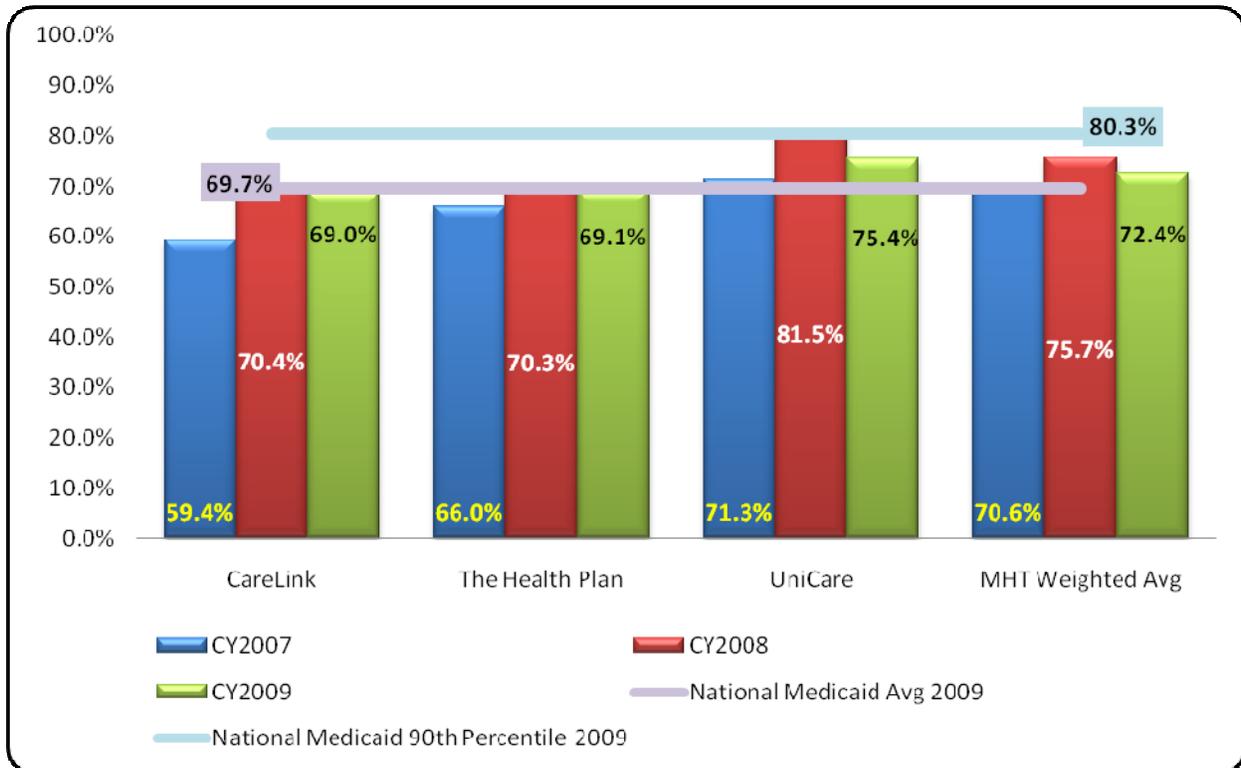


Figure 34 displays the results for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life* measure. Plan performance rates ranged from 69.0% to 75.4%. Carelink and THP rates were slightly below the National Medicaid Average of 69.7% while UniCare exceeded this average with a rate of 75.4%. Rates for all three plans decreased from CY 2008 to CY 2009.

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 visits with a PCP or an OB/GYN practitioner during the measurement year.

Figure 35. Results: MHT 2009 Adolescent Well Care Visits

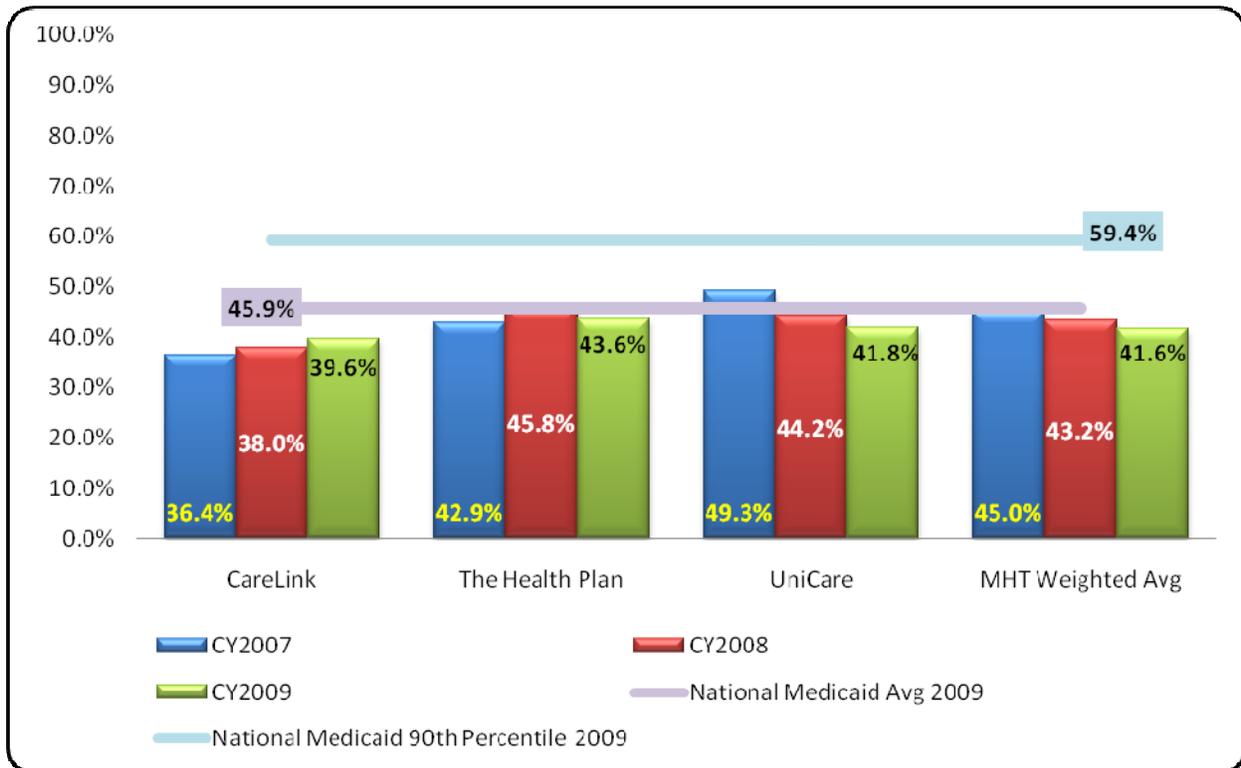
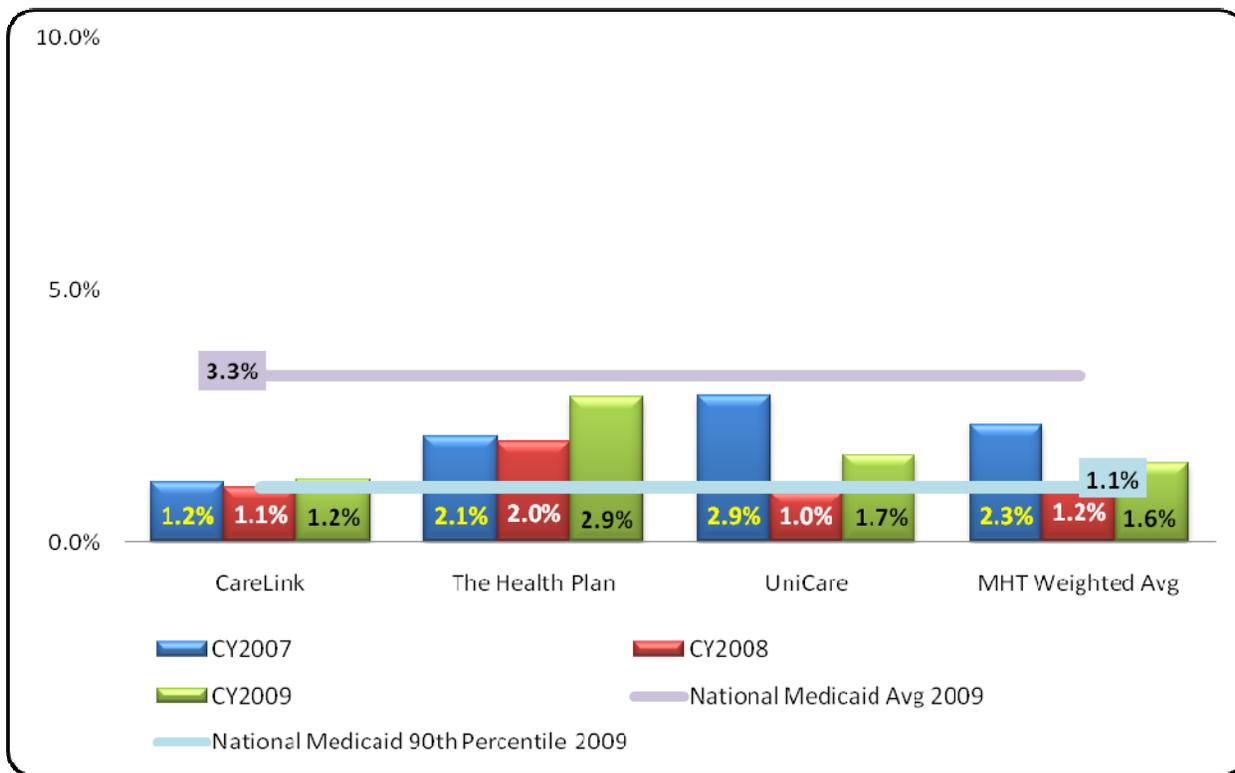


Figure 35 displays the results for the *Adolescent Well-Care Visits* measure. Individual plan performance ranged from 39.6% to 41.8%. None of the plans met the national Medicaid average of 45.9%. Carelink’s rate steadily improved performance since CY 2007, while UniCare has seen a steady decline in performance. The MHT Weighted Average decreased from CY 2007 to CY 2009.

Call Abandonment Rate (CAB)

The Call Abandonment Rate measure reports the percentage of calls received by the health plan’s Member Services call centers during operational hours that were abandoned by the caller before being answered by a live voice.

Figure 36. Results: MHT 2009 Call Abandonment*



*The scale on this graphic was changed to provide a clearer view of the rates. For this measure, lower rates are desired.

Figure 36 displays the results for the Call Abandonment measure. For this measure, a lower rate indicates better performance. Plan performance rates ranged from 1.2% to 2.9%. Carelink fell one tenth of one percentage point above the National Medicaid 90th Percentile of 1.1%. All MCOs performed better than the National Medicaid Average of 3.3%. The MHT Weighted Average and the performance for all three plans declined between CY 2008 and CY 2009.

Call Answer Timeliness (CAT)

The Call Answer Timeliness measure reports the percentage of calls received by the health plan’s Member Services call centers during operational hours that were answered by a live voice within 30 seconds.

Figure 37. Results: MHT 2009 Call Answer Timeliness

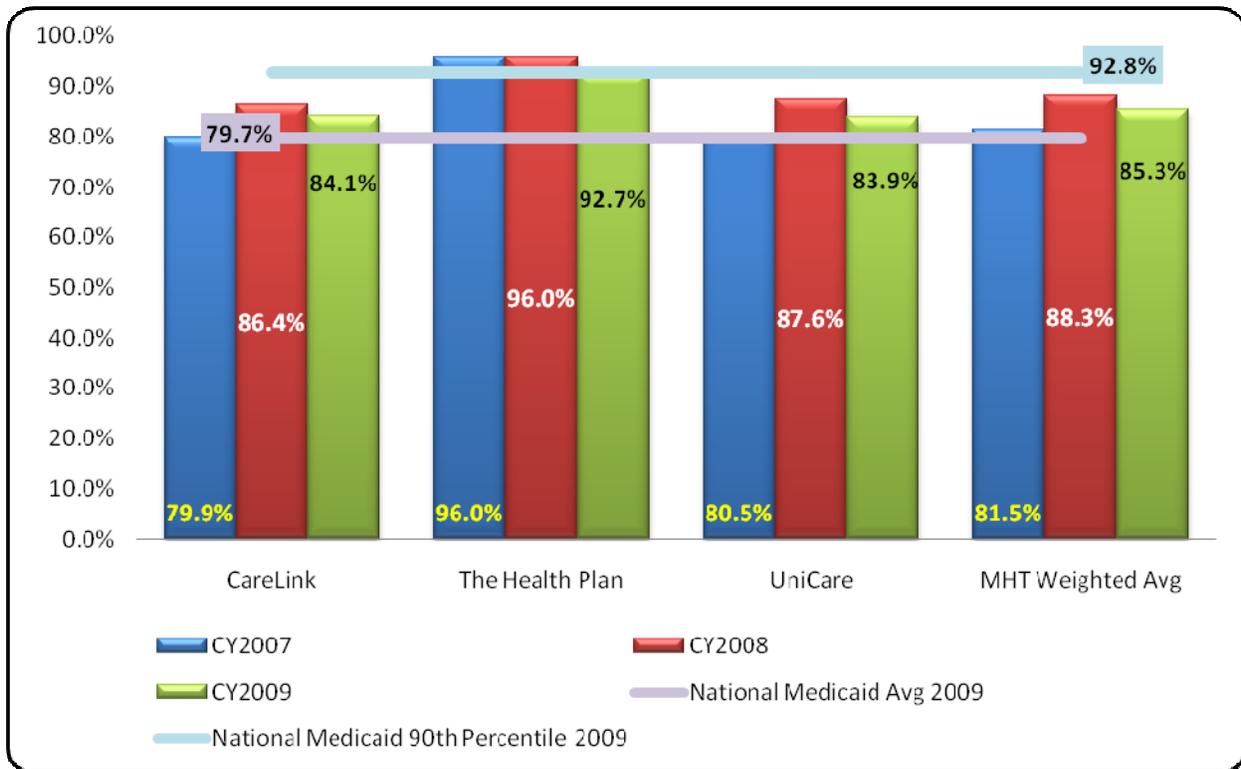


Figure 37 displays the results for the Call Answer Timeliness measure. THP met the National Medicaid 90th Percentile. Both Carelink and UniCare exceeded the national average of 79.7%. Rates for all three plans declined from CY 2008 and CY 2009.

Overall, the MCOs and the MHT program performed well the measures of timeliness. The MHT Weighted Average is above the National Medicaid Average for Well-Child Visits in the First 15 Months of Life- 6 or More Visits, Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Call Answer Timeliness, and Call Abandonment measures. The only measure that did not meet or exceed the National Medicaid Average was Adolescent Well Care.

Performance Improvement Projects (PIPs)

Two of CHP’s PIPs focused on timeliness: Childhood Immunizations and Well-Child Visits.

The Childhood Immunizations PIP focused on the Childhood Immunizations—Combo 3 indicator, which tracks children who received the following immunizations: four diphtheria, tetanus, and acellular pertussis (DTaP), three polio (IPV), one measles, mumps (MMR), three H influenza type B (HiB), three Hepatitis B, one chicken pox (VZV) and four pneumococcal conjugate vaccines by their second birthday. Results are displayed in the table below.

Table 7. Childhood Immunization Status, Combo 3 Results for CHP.

Measure	CY 2006	CY 2007	CY 2008	CY 2009
Childhood Immunization Status (Combination 3)	45.0%	53.9%	60.2%	54.4%

CHP’s CY 2009 performance in the Childhood Immunization Status—Combo 3 indicator declined by almost 6 percentage points when compared to CY 2008. However, it has sustained improvement over baseline; performance has improved by 9.4 percentage points when compared to the indicator baseline rate. Even with marked improvement, it is still more than 13 percentage points below the National HEDIS Medicaid Average of 67.6%. CHP plans to continue implementing interventions that target noncompliant members. Additionally, provider knowledge and practice deficits have been identified as a barrier. Provider education has been identified as an opportunity for improvement, as many children are receiving vaccinations that are not consistent with the technical specifications.

CHP’s Well-Child Visits PIP includes two indicators: Well-Child Visits for Children During the First 15 Months of Life (6 or More Visits) and Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life. Results are displayed in the table below.

Table 8. Well Child Visits Results for CHP.

Measure	CY 2006	CY 2007	CY 2008	CY 2009
Well Child Visits (First 15 Months of Life)	53.4%	58.3%	61.6%	61.6%
Well Child Visits (3 rd , 4 th , 5 th , and 6 th years)	64.5%	59.4%	70.4%	69.0%

For the Well-Child Visits in the First 15 Months of Life (6 or more visits) indicator, CHP has sustained improvement and exceeded the National HEDIS Medicaid Average of 58.8% by almost three percentage points. For the Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life measure, a slight decline in performance was noted when comparing CY 2009's rate to the previous measurement. Performance almost meets the HEDIS Medicaid Average of 69.7%. CHP met all requirements for this PIP and the project is being closed after three years of remeasurement data.

Systems Performance Review Findings (SPRs)

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely so as 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 are found throughout the Enrollee Rights (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QA) standards. Please refer to Table 6 for the CY 2009 MHT SPR compliance ratings.

During the SPR on-site review, the actual cases, files, and logs are reviewed to assess the timeliness of MCO activities. Specifically for CY 2009, Delmarva reviewed individual files and cases for timeliness of:

- Credentialing and recredentialing of providers,
- Resolution of complaints, grievances and appeals,
- Authorization, pre-authorization, and continuing authorization activities, and
- Case management 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.
- Providers are credentialed timely.
- Enrollees have timely access to Customer Services staff through telephone and written correspondence.
- All delegated providers are held to the same timeliness standards.

Through its monitoring activities, UniCare identified a lack of compliance with providers being available 24/7. The major issue was the answering machine messages or answering service responses to enrollees. UHP implemented system-level and individual provider corrective action plans to address this timeliness issue

as described in the Access section of this report. Each MCO has corrective action plan (CAP) procedures in place to address situations where required time frames or standards are not met. These procedures address both MCO timeliness and provider timeliness issues. UHP has required individual providers to complete CAPs to address issues identified in regards to 24/7 access.

Timeliness Summary

CHP submitted two projects related to timeliness including Childhood Immunizations and Well-Child Visits. For the Childhood Immunizations PIP, CHP has sustained improvement in the Combo 3 indicator. The MCO will continue to address barriers and implement system-level interventions to encourage further improvement. The Well-Child Visits PIP final performance rates exceed their respective baseline rates. Performance for both measures border the National Medicaid Averages. This project is being closed out after three years of remeasurement data.

The Performance Measure Validation activities confirmed that the MCOs and the MHT program did well as a whole on *all* timeliness measures. All three plans exceeded the Medicaid HEDIS Average for the Well-Child Visits in the First 15 Months of Life 6 or More Visits, Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Call Answer Timeliness and Call Abandonment measures. The MHT Weighted Average performance was mixed between CY 2007 to CY 2009. The MHT Weighted Average exceeded the Medicaid HEDIS Average for all measures of timeliness except for Adolescent Well Care.

Finally, the MCOs were able to demonstrate that they have plans and procedures to address the major requirements for timeliness. Timeliness standards were documented in the relevant procedures and policies. UHP identified a timeliness issue in regards to provider non-compliance with the 24/7 availability requirement. UHP has implemented a systems CAP and required non-compliant providers to submit a CAP to address this issue.

Overall Strengths for the MHT Program

Quality

- CY 2009 PIP reviews reveal that the MCOs understand how to develop, implement, and document PIPs.
- MCOs have demonstrated improvement in documenting project rationale and relating the PIPs to their specific populations.
- PIP interventions have become more rigorous leading to improved outcomes.
- The MCOs' information system capabilities for performance measures include data capture, general information systems, centralized processing of data, provider data, data sharing, and eligibility programming.
- The MCOs' strengths in reporting performance measures include staff experience, communication, documentation, and using a team approach.
- The MHT Weighted Average for Controlling High Blood Pressure, Comprehensive Diabetes Care- Poor HbA1c Control (>9%) and Comprehensive Diabetes Care- Blood Pressure Control (<130/80 mm Hg and <140/90 mm Hg) measures all exceeded the national Medicaid Average for CY 2009.
- The MHT Weighted Average improved from CY 2007 to CY 2009 for three measures: Lead Screening in Children, Breast Cancer Screening, and Chlamydia Screening in Women.
- All three MCOs performed well in the Quality Assessment and Performance Improvement standards, with rates ranging from 97% to 100% from for all review years (CY 2006-CY 2009).
- Quality Improvement and Utilization Review programs are well established, documented, and monitored.
- All three MCOs implemented Delmarva's recommendations to improve systems performance review compliance rates.

Access

- All MCOs outperformed the HEDIS Medicaid Average for the Adults' Access to Preventive/Ambulatory Health Services ages 20-44 Years, Prenatal and Postpartum Care-Timeliness of Care, Prenatal and Postpartum Care-Postpartum Care, Call Answer Timeliness, and Call Abandonment measures.
- All individual MCO performance rates exceeded the 90th percentile for Adults' Access to Preventive/Ambulatory Health Services_ages 24-44 Years and Prenatal and Postpartum Care- Timeliness of Prenatal Care.
- The MHT Weighted Average improved from CY 2007 to CY 2009 for all indicators for Adults 'Access to Preventive/Ambulatory Health Services, Children's' and Adolescent Access to Primary Care Practitioners, and Prenatal and Postpartum Care.
- All MCOs have systems in place to monitor access to providers, benefits, and services.
- Corrective action plans are in place when system or provider barriers related to timeliness and access are identified.

Timeliness

- The MHT MCOs performed well on *all* timeliness measures.
- CHP's timeliness-related PIPs (Childhood Immunizations and Well-Child Visits) reported improvement. CHP addressed barriers and implemented system-level interventions which led to project success.
- All three plans exceeded the Medicaid HEDIS Average for the Well-Child Visits in the First 15 Months of Life 6 or More Visits, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Call Answer Timeliness and Call Abandonment measures.
- Operationally, the MCOs were able to demonstrate that they have plans and procedures addressing the CFR and BMS contract specific requirements for timeliness.
- Timeliness standards were documented in the relevant policies, procedures and provider contracts.
- Corrective action procedures were in place where timeliness or access requirements are not met.

Recommendations for the MHT Program

This section offers MHT a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of data sources individually and in the aggregate. Delmarva's recommendations include:

- Being proactive in efforts to validate supplemental data used to help complete data for HEDIS reporting.
- Continuing successful strategies exhibited in regard to management of internal and external systems for collecting and reporting HEDIS data.
- Continuing using successful performance measure reporting tactics.
- Documenting data processes and methods. Having documentation in place will assist MCOs particularly during staffing transitions and changes.
- Performing further investigation into low-rated measures identified by HEDIS and consider developing PIPs and/or collaborative PIPs based on HEDIS results.
- For PIP indicators not achieving improvement, perform a root-cause analysis and identify very specific barriers for each indicator. Implement interventions that specifically target those barriers.
- Assess the effectiveness of interventions on an annual basis. Continue those that appear to be effective and eliminate or modify those interventions that do not make a positive impact.
- Complete thorough data analyses for the Emergency Department Collaborative PIPs. Scrutinize and identify trends in diagnoses or other relevant demographic information. This thorough examination of data may identify specific conditions or areas requiring more focused interventions or resources.
- Reviewing the MCO specific SPR report to identify areas that were deficient in the last two review cycles. Specific attention should be focused on addressing enrollee notification timeframes.
- Ensuring that there are systems in place to evaluate the timeliness of appointment scheduling, especially for emergency, urgent, and prenatal care appointments.
- Ensuring the Board of Directors participate in the review and approval of QI and UR program is well documented and occurs at regular intervals (at least annually).

References

- 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). (2006). *Standards and Guidelines for the Accreditation of MCOs*.

Appendix 1 - Trending Tables

Table A1-1 below provides a comparison of the MCO and National rates for HEDIS 8(CY 2007) through HEDIS 2010 (CY 2009).

Table A1-1. Trending Information

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Effectiveness of Care												
Adult BMI Assessment [■]	^	25.2%	39.7%	^	15.8%	6.2%	^	24.8%	31.1%	^	^	^
Childhood Immunization Status Combination 2	63.6%	66.4%	61.8%	66.3%	67.9%	64.2%	69.2%	72.7%	61.6%	73.3%	73.7%	85.4%
Childhood Immunization Status Combination 3	53.9%	60.2%	54.4%	58.8%	59.9%	56.7%	62.7%	68.1%	55.0%	60.0%	67.6%	80.6%
Lead Screening in Children	57.8%	59.0%	53.9%	45.2%	46.0%	52.1%	48.4%	49.3%	50.4%	0.0%	66.7%	87.1%
Breast Cancer Screening	39.1%	37.7%	28.3%	43.1%	47.2%	54.1%	37.2%	39.6%	47.0%	49.1%	50.8%	63.0%
Cervical Cancer Screening	60.6%	62.1%	56.8%	65.8%	66.7%	67.5%	72.4%	67.8%	70.1%	65.7%	66.0%	79.5%
Chlamydia Screening in Women	53.1%	48.6%	54.0%	33.9%	34.8%	35.5%	33.2%	37.6%	37.4%	52.4%	54.9%	68.6%
Cholesterol Management for Patients With Cardiovascular Conditions - LDL-C Screening [■]	^	NA	%	^	NA	%	^	NA	%	75.5%	79.6%	87.2%

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Cholesterol Management for Patients With Cardiovascular Conditions - LDL-C level <100 mg/DL [■]	^	NA	%	^	NA	%	^	NA	%	35.5%	40.1%	54.5%
Controlling High Blood Pressure	54.8%	54.5%	54.0%	69.2%	51.6%	57.4%	74.2%	61.5%	68.6%	52.9%	58.8%	66.6%
Comprehensive Diabetes Care – HbA1c Testing	65.9%	79.0%	75.3%	75.0%	75.7%	77.1%	79.7%	76.4%	75.6%	78.0%	80.5%	89.3%
Comprehensive Diabetes Care – Poor HbA1c Control >9% (lower rate is better)	76.3%	54.6%	60.1%	56.9%	57.4%	53.6%	38.8%	40.8%	30.1%	48.7%	44.8%	29.3%
Comprehensive Diabetes Care – HbA1c Control <7% [■]	^	25.5%	25.9%	^	^	32.8%	^	^	31.9%	^	^	^
Comprehensive Diabetes Care – HbA1c Control <8% [■]	^	37.8%	32.9%	^	27.2%	43.6%	^	51.3%	39.3%	^	^	^
Comprehensive Diabetes Care – Eye (Retinal) Exams	34.1%	35.3%	43.7%	34.0%	33.8%	30.7%	43.3%	43.0%	34.5%	51.4%	52.8%	70.8%
Comprehensive Diabetes Care – Lipid Profile LDL-C Screening	54.1%	66.4%	63.9%	69.4%	68.4%	67.1%	71.8%	72.9%	67.3%	71.1%	74.1%	82.5%

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Comprehensive Diabetes Care – LDL-C Control (<100 mg /dL)	17.0%	21.0%	17.7%	26.4%	21.3%	26.4%	39.5%	38.5%	27.4%	30.6%	33.8%	44.7%
Comprehensive Diabetes Care – Medical Attention to Nephropathy	49.6%	60.5%	58.9%	55.6%	65.4%	68.6%	60.8%	65.9%	65.8%	74.6%	76.6%	85.4%
Comprehensive Diabetes Care – Blood Pressure Control (<130/80mm Hg) [■]	^	26.1%	25.3%	^	33.8%	27.1%	^	41.7%	33.9%	^	30.7%	41.9%
Comprehensive Diabetes Care – Blood Pressure Control (<140/90mm Hg) [■]	^	58.8%	58.9%	^	61.8%	62.1%	^	74.8%	56.8%	^	56.9%	71.2%
Use of Imaging Studies for Low Back Pain	59.8%	60.3%	66.5%	77.2%	72.7%	72.8%	70.7%	71.6%	71.3%	78.3%	75.7%	81.6%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	^	NA	NA	^	NA	NA	^	NA	NA	27.3%	29.3%	42.6%

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total) [■]	^	8.2%	%	^	15.1%	%	^	4.5%	%	^	^	^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total) [■]	^	25.8%	%	^	35.5%	%	^	13.5%	%	^	^	^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total) [■]	^	14.3%	%%	^	32.1%	%	^	10.4%	%	^	^	^
Access and Availability of Care												
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	83.4%	85.0%	86.7%	89.7%	90.5%	90.6%	82.5%	81.4%	88.5%	78.2%	79.8%	88.4%

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	77.8%	79.5%	82.7%	86.3%	90.3%	84.9%	82.3%	83.9%	86.7%	83.1%	85.5%	91.1%
Children's and Adolescents' Access to Primary Care Practitioners – 12-24 Months	97.7%	96.7%	96.9%	97.9%	98.5%	98.4%	80.0%	88.7%	97.9%	94.1%	95.0%	98.4%
Children's and Adolescents' Access to Primary Care Practitioners – 25 Months-6 Years	83.1%	87.7%	88.6%	91.8%	92.6%	93.1%	63.9%	79.5%	91.5%	84.9%	87.2%	92.6%
Children's and Adolescents' Access to Primary Care Practitioners – 7-11 Years	85.9%	87.4%	89.4%	92.5%	93.5%	94.2%	62.7%	82.1%	93.1%	86.0%	87.8%	94.6%
Children's and Adolescents' Access to Primary Care Practitioners – 12-19 Years	81.4%	84.4%	86.2%	91.5%	90.6%	91.8%	55.9%	78.5%	90.2%	83.2%	85.3%	92.2%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.9%	92.7%	96.8%	94.4%	93.7%	92.9%	95.6%	96.5%	94.9%	81.2%	81.9%	92.2%
Prenatal and Postpartum Care – Postpartum Care	60.1%	61.3%	65.4%	60.4%	63.5%	62.8%	67.9%	69.7%	71.3%	59.1%	62.7%	72.7%
Call Answer Timeliness	79.9%	86.4%	84.1%	96.0%	96.0%	92.7%	80.5%	87.6%	83.9%	74.4%	79.7%	92.8%

Measure	CHP HEDIS 2008	CHP HEDIS 2009	CHP HEDIS 2010	THP HEDIS 2008	THP HEDIS 2009	THP HEDIS 2010	UHP HEDIS 2008	UHP HEDIS 2009	UHP HEDIS 2010	National Medicaid Average HEDIS 2009*	National Medicaid Average HEDIS 2010	National Medicaid 90 th Percentile HEDIS 2010
Call Abandonment (lower rate is better)	1.2%	1.1%	1.2%	2.1%	2.0%	2.9%	2.9%	1.0%	1.7%	5.8%	3.3%	1.1%
Use of Services												
Frequency of Ongoing Prenatal Care – 81%+	76.9%	75.3%	78.4%	85.3%	81.3%	85.4%	43.2%	49.2%	64.2%	58.6%	58.7%	81.0%
Well-Child Visits in the First 15 Months of Life Six or more visits	58.3%	61.6%	61.6%	66.0%	65.5%	63.7%	76.9%	61.1%	62.8%	55.6%	58.8%	73.9%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	59.4%	70.4%	69.0%	66.0%	70.3%	69.1%	71.3%	81.5%	75.4%	66.8%	69.7%	80.3%
Adolescent Well-Care Visit	36.4%	38.0%	39.6%	42.9%	45.8%	43.6%	49.3%	44.2%	41.8%	43.7%	45.9%	59.4%

- No comparative benchmarks available

■ New measure for 2009-not for public reporting

*National Medicaid Average HEDIS 2009 (CY 2007) column reflects Quality Compass 2007 (CY 2006), the most current benchmarks at the time the 2009 reports were created

^ Measure not collected

Appendix 2 - PIP Results

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

Carelink Health Plan PIPs			
Improving Compliance with Childhood Immunizations in Carelink Medicaid Children			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
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)	1/1/06-12/31/06	Baseline	45.03%
	1/1/07-12/31/07	Remeasurement 1	53.86%
	1/1/08-12/31/08	Remeasurement 2	60.19%
	1/1/09-12/31/09	Remeasurement 3	54.40%
Increasing Carelink Medicaid Member Compliance with Appropriate Well-Child Visits for Children during the First 15 Months of Life and for those 3 - 6 Years of Age			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Well-Child Visits in the First 15 Months of Life	1/1/06-12/31/06	Baseline	53.42%
	1/1/07-12/31/07	Remeasurement 1	58.28%
	1/1/08-12/31/08	Remeasurement 2	61.61%
	1/1/09-12/31/09	Remeasurement 1	61.63%
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life	1/1/06-12/31/06	Baseline	64.46%
	1/1/07-12/31/07	Remeasurement 1	59.38%
	1/1/08-12/31/08	Remeasurement 2	70.37%
	1/1/09-12/31/09	Remeasurement 3	68.98%

Carelink Health Plan PIPs (continued)			
Decreasing Emergency Room Utilization Rates (Emergency Department Collaborative)			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Medicaid Members 20-44 Years of Age who have Received ER Services Reported per 1,000 Member Months	1/1/08-12/31/08	Baseline	146.45 per 1,000 MM
	1/1/09-12/31/09	Remeasurement 1	151.37 per 1,000 MM
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Medicaid Members (all ages) who have Received ER Services Reported per 1,000 Member Months	1/1/08-12/31/08	Baseline	74.66 per 1,000 MM
	1/1/09-12/31/09	Remeasurement 1	81.70 per 1,000 MM

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

The Health Plan of the Upper Ohio Valley PIPs			
Childhood Obesity			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Members (2-17 years of age) who had an outpatient visit with a PCP or OB/GYN and who had <u>evidence of BMI percentile documentation</u> during the measurement year	1/1/09-12/31/09	Baseline	1.45%
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Members (2-17 years of age) who had an outpatient visit with a PCP or OB/GYN and who had <u>evidence of counseling for nutrition</u> during the measurement year	1/1/09-12/31/09	Baseline	0.94%
Indicator #3	Time Period Measurement Covers	Measurement	Rate or Results
Members (2-17 years of age) who had an outpatient visit with a PCP or OB/GYN and who had <u>evidence of counseling for physical activity</u> during the measurement year	1/1/09-12/31/09	Baseline	0.78%

The Health Plan of the Upper Ohio Valley PIPs (continued)			
Asthma			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who were Appropriately Prescribed Medication	1/1/07-12/31/07	Baseline	80.62%
	1/1/08-12/31/08	Remeasurement 1	85.87%
	1/1/09-12/31/09	Remeasurement 2	83.77%
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Average number of Asthma Prescriptions for Asthmatics	1/1/09-12/31/09	Baseline	6.04 prescriptions
Indicator #3	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who had an Inpatient Stay	1/1/07-12/31/07	Baseline	17.10/K/month
	1/1/08-12/31/08	Remeasurement 1	19.51/K/month
	1/1/09-12/31/09	Remeasurement 2	12.45/K/month
Indicator #4	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who had an Emergency Room Encounter	1/1/07-12/31/07	Baseline	161.90/K/month
	1/1/08-12/31/08	Remeasurement 1	143.32/K/month
	1/1/09-12/31/09	Remeasurement 2	146.19/K/month
Indicator #5	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who had Physician Management	1/1/09-12/31/09	Baseline	83.54%
Indicator #6	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who had an inpatient visit (with respiratory specific diagnosis)	1/1/09-12/31/09	Baseline	6.90%
Indicator #7	Time Period Measurement Covers	Measurement	Rate or Results
Persistent Asthmatics who had an emergency room encounter (with respiratory specific diagnosis)	1/1/09-12/31/09	Baseline	44.64%

The Health Plan of the Upper Ohio Valley PIPs (continued)			
Emergency Room Diversion (Emergency Department Collaborative)			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Emergency Room visits per 1,000 members (ages 0-5 years) with respiratory diagnosis	1/1/10-12/31/10	Baseline	Not yet available
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Emergency Room visits per 1,000 members (age 20 and older) with new diagnosis of back pain	1/1/10-12/31/10	Baseline	Not yet available

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

UniCare Health Plan PIPs			
Improving Diabetes Control			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
HbA1c Screening	1/1/04-12/31/04	Baseline	86.49%
	1/1/05-12/31/05	Remeasurement 1	70.71%
	1/1/06-12/31/06	Remeasurement 2	84.26%
	1/1/07-12/31/07	Remeasurement 3	79.73%
	1/1/08-12/31/08	Remeasurement 4	76.43%
	1/1/09-12/31/09	Remeasurement 5	75.60%
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
Retinal Eye Exam	1/1/04-12/31/04	Baseline	27.03%
	1/1/05-12/31/05	Remeasurement 1	24.29%
	1/1/06-12/31/06	Remeasurement 2	43.40%
	1/1/07-12/31/07	Remeasurement 3	43.30%
	1/1/08-12/31/08	Remeasurement 4	42.99%
	1/1/09-12/31/09	Remeasurement 5	34.52%

UniCare Health Plan PIPs (continued)			
Improving Asthma Control			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
Appropriate Use of Asthma Medication	1/1/09-12/31/09	Baseline	95.07%
Reducing Inappropriate Emergency Room Utilization (Emergency Department Collaborative)			
Indicator #1	Time Period Measurement Covers	Measurement	Rate or Results
The rate of emergency room visits per thousand Medicaid members from participating primary care practices (Princeton/Bluefield community), using total ED visits.	9/1/09-8/31/10	Baseline	Not yet available
Indicator #2	Time Period Measurement Covers	Measurement	Rate or Results
The rate of emergency room visits per thousand Medicaid members from participating primary care practices (Princeton/Bluefield community), using total unique member count.	9/1/09-8/31/10	Baseline	Not yet available