



West Virginia Department of Health and Human Resources



Bureau for Medical Services

Managed Care Programs

Mountain Health Trust

Mountain Health Promise

2020 External Quality Review

Annual Technical Report

March 2021

Qlarant 

Table of Contents

- West Virginia Managed Care Programs 2020 Annual Technical Report i**
- Executive Summary..... i**
 - Introduction i
 - Key Findings ii
 - Conclusion..... iii
- 2020 Annual Technical Report 1**
- Introduction 1
 - Background 1
 - Purpose 2
- Performance Improvement Projects..... 3
 - Objective 3
 - Methodology..... 3
 - Results..... 4
 - Conclusion..... 17
- Performance Measure Validation 18
 - Objective 18
 - Methodology..... 19
 - Results..... 20
 - Conclusion..... 25
- Systems Performance Review 25
 - Objective 25
 - Methodology..... 25
 - Results..... 27
 - Conclusion..... 29
- Network Adequacy Validation 29
 - Objective 29
 - Methodology..... 29
 - Results..... 30
 - Conclusion..... 33
- Encounter Data Validation 33
 - Objective 33
 - Methodology..... 34
 - Results..... 34

Conclusion.....	36
Grievance, Denial, and Appeal Focused Study.....	36
Objective.....	36
Methodology.....	37
Results.....	37
Conclusion.....	39
MCP Quality, Access, Timeliness Assessment.....	39
Quality, Access, Timeliness.....	39
ABHWV.....	40
THP.....	41
UHP.....	43
ABHWV MHP.....	45
Assessment of Previous Recommendations.....	46
ABHWV.....	46
THP.....	46
UHP.....	47
State Recommendations.....	49
Conclusion.....	51
Appendix.....	A
HEDIS® Measures Collected and Reported to NCQA.....	A1
CAHPS® Survey Measure Results.....	A2

West Virginia Managed Care Programs

2020 Annual Technical Report

Executive Summary

Introduction

The West Virginia (WV) Department of Health and Human Resources' Bureau for Medical Services (BMS) contracts with Qlarant, an external quality review organization (EQRO), to evaluate its managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). The MHT program has served Medicaid beneficiaries since 1996 and, beginning in January 2021, also provides physical and behavioral health services to Children's Health Insurance Program (CHIP) beneficiaries. Managed care plans (MCPs) contracted to provide MHT services include:

- Aetna Better Health of West Virginia (ABHWV)
- The Health Plan of West Virginia (THP)
- UniCare Health Plan of West Virginia (UHP)

The MHP program serves Medicaid beneficiaries who are in foster care or receive adoption services and qualifying children with serious emotional disorders. The program provides comprehensive physical and behavioral health services, children's residential care services, and socially necessary services administration. ABHWV is contracted to provide these services. Operations for this program commenced on March 1, 2020.

As the WV EQRO, Qlarant evaluates MCP compliance with federal and state-specific requirements by conducting multiple external quality review (EQR) activities including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also known as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Grievance, Appeal, and Denial (GAD) Focused Study and Validation

Qlarant conducted EQR activities throughout 2020 and evaluated MCP compliance and performance for measurement years (MYs) 2019 and 2020, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.¹ This report summarizes results from all EQR activities and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs.

¹ [CMS EQRO Protocols](#)

Key Findings

Key findings are summarized below for the MHT MCPs and MHP ABHWV, where applicable. Only NAV and GAD focused studies were completed for the MHP program due to its March 1, 2020 start date. MCP-specific strengths, weaknesses, and recommendations are identified within the [MCP Quality, Access, Timeliness Assessment section](#) of the report. MCP findings correspond to performance related to the quality, accessibility, and timeliness of services provided to their members.

Performance Improvement Project Validation. MHT MCPs conducted three PIPs each and reported results for MY 2019. The MCPs reported improvement in at least one of their Annual Dental Visits PIP measures and received validation scores ranging from 88%-100%. The MCPs initiated a new PIP, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence, and reported baseline results. MCPs received scores for this new PIP ranging from 95%-100%. Each MCP's third PIP topic was self-selected and MCPs are at various stages of development with their projects. Scores ranged from 92%-100%. Most Qlarant recommendations encouraged MCPs to conduct a more comprehensive barrier analysis and implement more robust interventions.

Performance Measure Validation. MHT MCP Information Systems Capabilities Assessments determined MCPs had appropriate systems in place to process accurate claims and encounters. The MHT MCPs received overall PMV ratings ranging from 99%-100%. MY 2019 performance measure results were assessed as "reportable."

Systems Performance Review. Qlarant evaluated MHT MCP compliance with the following Code of Federal Regulations standards: Information Requirements, Availability of Services & Assurance of Adequate Capacity and Services, and Quality Assessment and Performance Improvement Program. MCP scores ranged from 94%-100%. THP and UHP were required to develop and implement corrective action plans (CAPs) to address noncompliant elements and components of the standards, most of which related to access to care. The MCPs successfully implemented all CAPs and demonstrated compliance.

Network Adequacy Validation. Surveyors, assessing 24/7 access, were successful in contacting provider offices after regular business hours 83% of the time. Unsuccessful contact was most frequently due to the phone number not reaching the intended provider. For successful provider contacts, MHT MCPs demonstrated compliance with directing members to care the majority of the time. MHT MCP compliance ranged from 97%-100%. MCP ABHWV was compliant 94% of the time.

Encounter Data Validation. MHT MCPs provided evidence of having the capability to produce accurate and complete encounter data. For claims paid during MY 2019, analysts found MCP claims volume was reasonable, most encounters were submitted timely, data was complete and included valid values, and diagnoses and procedure codes were appropriate based on member demographics. A medical record review concluded documentation supported encounter data. MHT MCPs encounter data accuracy ranged from 95%-98%.

Grievance, Appeal, and Denial Focused Study and Validation. A partial year assessment of 2020 grievances, denials, and appeals resulted in mixed MCP results; however, MHT MCP average assessments of compliance were 91% and higher. MHP ABHWV experienced a wide variation in compliance likely due to small numbers; caution is advised when interpreting results.

Conclusion

WV's MCPs are National Committee for Quality Assurance (NCQA) accredited, demonstrating their commitment to quality improvement.² The MHT MCPs are largely compliant with federal and state managed care requirements. When deficiencies are identified, the MCPs respond quickly with corrective actions. Quality of interventions targeting barriers to performance varies, but overall improvements are evident. The MHT MCPs, based on weighted averages, performed better than national average benchmarks in 63% of HEDIS measures and 53% of CAHPS survey measures. MCP performance has been trending in a positive direction and provides evidence of improved quality, accessibility, and timeliness of health care. BMS should continue to monitor performance and adjust goals to encourage the positive trend in performance.

² The WV MCP accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

West Virginia Managed Care Programs

2020 Annual Technical Report

Introduction

Background

The West Virginia (WV) Department of Health and Human Resources' Bureau for Medical Services (BMS) administers the state's two managed care programs: Mountain Health Trust (MHT) and Mountain Health Promise (MHP). These programs coordinate care and services for qualifying West Virginians meeting specific income or vulnerable population requirements and are described below.

MHT.³ This managed care program, operating under a 1915(b) waiver, provides physical and behavioral health services to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The MHT program has provided Medicaid services since 1996 and CHIP services were added January 1, 2021. The program emphasizes effective organization, financing, and delivery of health care services and aims to improve quality and access to coordinated services for qualifying beneficiaries through three managed care plans (MCPs). These plans, serving more than 430,000 members, include:

- Aetna Better Health of West Virginia (ABHWV)
- The Health Plan of West Virginia (THP)
- UniCare Health Plan of West Virginia (UHP)

MHP.⁴ This specialized managed care program provides comprehensive physical and behavioral health services, children's residential care services, and socially necessary services administration to select Medicaid managed care beneficiaries who are in foster care or receive adoption service, and children eligible for serious emotional disorder home and community based services. The program, effective March 2020, is operating under 1915(b) and 1915(c) waivers. MHP aims to reduce fragmentation and deliver supports and services in a seamless, integrated, and cost-effective manner. ABHWV is the sole MCP providing these services to approximately 23,000 members.

BMS strives to ensure the delivery of high quality, accessible care for both managed care programs. As outlined in their program quality strategies, BMS uses a three-pronged approach to meet goals including:

Monitoring. BMS monitors MCP compliance with managed care quality standards.

Assessment. BMS analyzes a variety of health care data to measure performance and identify areas for improvement.

Improvement. BMS and MCPs implement interventions targeting priority areas to maximize benefit to managed care program beneficiaries.

³ [Mountain Health Trust](#)

⁴ [Mountain Health Promise](#)

BMS targets five priority areas including:

- Making care safer by promoting the delivery of evidence based care
- Engaging individuals and families as partners in care by strengthening the relationship between managed care beneficiaries and their primary care providers (PCPs)
- Promoting effective communication and coordination of care
- Promoting effective prevention and treatment of diseases burdening managed care beneficiaries
- Enhancing oversight of MCP administration

BMS requires MCPs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA evaluates the quality of health care plans provide their members. Accreditation signifies a plan's commitment to quality improvement. The West Virginia MCP accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).^{5,6}

Table 1 provides the NCQA accreditation status of each MCP.

Table 1. MCP Accreditation Status

MCP	NCQA Accreditation	NCQA Distinction
ABHWV	Accredited	-
THP	Accredited	-
UHP	Accredited	Multicultural Health Care

- MCP did not obtain an NCQA distinction

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires BMS to contract with an external quality review organization (EQRO) to conduct annual, independent reviews of WV's managed care programs. To meet these requirements, BMS contracts with Qlarant. As the EQRO, Qlarant evaluates each WV MCP's compliance with federal and WV-specific requirements in a manner consistent with the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) Protocols. During 2020, Qlarant conducted the following EQR activities:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review also known as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Grievance, Appeal, and Denial (GAD) Focused Study and Validation

In addition to completing EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCPs. This Annual Technical Report (ATR) summarizes Qlarant's EQR findings based on MCP audits

⁵ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

⁶ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

conducted during 2020. The report describes objectives, methodologies, results, and conclusions for each EQR activity. Qlarant identifies MCP strengths and weaknesses relating to quality, access, and timeliness of care provided to managed care members. The report also includes recommendations for improvement, which if acted upon, may positively impact member outcomes and experiences.

Performance Improvement Projects

Objective

MCPs conduct PIPs as part of their quality assessment and performance improvement program. PIPs use a systematic approach to quality improvement and can be effective tools to assist MCPs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCP used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation provides BMS and other stakeholders a level of confidence in results.

Methodology

BMS required MCPs to report three PIPs during 2020. Two PIPs were statewide mandated initiatives and one was MCP selected, which required BMS and EQRO approval. MCPs reported measurement year (MY) 2019 PIP-related activities, improvement strategies, and measure results in their 2020 reports. The MCPs submitted their reports to Qlarant in July 2020 after MY 2019 performance measure rates were finalized. MCPs completed a data and barrier analysis and identified follow-up activities for each PIP submission. MCPs used Qlarant reporting tools and worksheets to report their PIPs. Qlarant provided MCP specific technical assistance, as requested.

Qlarant reviewed each PIP to assess the MCP's PIP methodology and to perform an overall validation of PIP results. Qlarant completed these activities in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.^{7, 8} PIP validation steps include:

- Topic
- Aim Statement
- Identified Population
- Sampling Method
- Variables and Performance Measures
- Data Collection Procedures
- Data Analysis and Interpretation of Results
- Improvement Strategies (Interventions)
- Significant and Sustained Improvement

Qlarant PIP reviewers evaluated each element of PIP development and reporting by answering a series of applicable questions, consistent with CMS protocol worksheets and requirements. Reviewers sought additional information and/or corrections from MCPs, when needed, during the evaluation. Qlarant

⁷ [CMS EQRO Protocols](#)

⁸ CMS released updated protocols in January 2020. Due to the timing of the release of the new protocol which includes assessing the early PIP planning and development process, Qlarant conducted the 2020 review and validation process using a blended approach which captured critical elements of the updated protocol, as well as the preceding protocol. This report reflects critical reporting elements of the new protocol.

determined a validation rating, or level of confidence, for each PIP based on the total validation score.⁹ Validation ratings include:

- ◆ 90% - 100%: high confidence in MCP results
- ◆ 75% - 89%: moderate confidence in MCP results
- ◆ 60% - 74%: low confidence in MCP results
- ◆ ≤59%: no confidence in MCP results

Results

PIP validation results for 2020 MCP reported PIPs, including MY 2019 activities and performance measure (PM) results, are included in this report. Table 2 highlights key elements of the two BMS mandated PIPs for the MHT program: (1) Annual Dental Visits and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence. Table 3 provides an overview of each MHT MCP selected PIP. Key MCP improvement strategies and results for each PIP for the year under review follow the tables.¹⁰ Due to the MHP program start date of March 1, 2020, ABHWV was not required to initiate PIPs during its first year of operation. The MHP MCP will begin PIP development in 2021.

Table 2. MHT State Selected PIPs

2020 PIPs	State Mandated PIP 1	State Mandated PIP 2
Program	MHT Medicaid	MHT Medicaid
Topic	Annual Dental Visits	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
Performance Measure(s), Measure Steward, & Population	PM 1: Annual Dental Visits for 2-3 Year Olds Measure steward: NCQA Population: Children 2-3 years of age PM 2: Percentage of Eligibles that Received Preventative Dental Services Measure steward: CMS Population: Children and adults 1-20 years of age	PM 1: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 30 Day Follow-Up (Total) Measure steward: NCQA Population: Children and adults 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence
Aim	Will implementation of targeted educational and outreach interventions increase the rate of annual dental visits for members 2-3 years old?	Will implementation of multi-faceted member, provider, and MCP interventions improve the annual Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (30 Day Follow-Up) rate for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence?
Phase	2 nd Remeasurement	Baseline

⁹ Validation rating refers to the overall confidence that a PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (CMS EQR Protocol 1 – Validation of Performance Improvement Projects).

¹⁰ Only key improvement strategies are listed. Comprehensive intervention lists may not be included due to CMS's preference for a succinct report.

Table 3. MHT MCP Selected PIPs

2020 PIPs	ABHWV	THP	UHP
Program	MHT Medicaid	MHT Medicaid	MHT Medicaid
Topic	Care for Adolescents	Promoting Health and Wellness in Children and Adolescents	Follow-Up After Hospitalization for Mental Illness
Performance Measure(s), Measure Steward, & Population	<p>PM 1: Immunizations for Adolescents (Combination 2) Measure steward: NCQA Population: Adolescents 13 years of age</p> <p>PM 2: Adolescent Well Care Visits Measure steward: NCQA Population: Adolescents and adults 12-21 years of age</p>	<p>PM 1: Adolescent Well Care Visits Measure steward: NCQA Population: Adolescents and adults 12-21 years of age</p> <p>PM 2 and 3: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents –</p> <ul style="list-style-type: none"> • Body Mass Index (BMI) Percentile Documentation • Counseling for Nutrition <p>Measure steward: NCQA Population: Children and adolescents 3-17 years of age</p>	<p>PM 1 and 2: Follow-Up After Hospitalization for Mental Illness</p> <ul style="list-style-type: none"> • Within 7 Days • Within 30 Days <p>Measure steward: NCQA Population: Children and adults 6 years of age and older who were hospitalized with select mental illness diagnoses</p>
Aim	Will multipronged interventions improve annual rates of adolescent care including immunizations and well visits for members 9-21 years of age?	Will system-level interventions focusing on children and adolescent well-being increase rates for the Adolescent Well Care Visits and BMI Percentile Documentation and Counseling for Nutrition measures by 10 percentage points over the course of the PIP?	Will member, provider, and MCP-targeted interventions improve follow-up compliance for members hospitalized with select mental illness diagnoses? The MCP aims to demonstrate statistically significant improvement by the 2 nd remeasurement year and to exceed the NCQA Quality Compass National Medicaid Average plus 5 percentage points for each measure.
Phase	Baseline	1 st Remeasurement	4 th Remeasurement

Annual Dental Visits PIP

ABHWV Interventions

Member-focused intervention(s):

- **Transportation for health care services and appointments.** Provided members the ability to schedule transportation for medical services and appointments, including dental visits, at no cost.
- **Gaps in care member outreach.** Called members with gaps in care and encouraged dental visits.
- **Member incentive.** Provided members with a \$25 gift card for completing a dental visit.

Provider-focused intervention(s):

- **Provider education.** Conducted biweekly meetings with high volume providers and/or practices with value-based contracts to provide education on measures and respond to questions.
- **Value-based solution provider arrangements.** Provided payment to high volume providers based on performance.

MCP-focused intervention(s):

- **Annual cultural/health disparity analysis.** Conducted annual member cultural/health disparity analysis to better understand and respond to member needs.

ABHWV PIP Measure Results

Table 4 displays ABHWV's Annual Dental Visits PIP measure results and level of improvement.

Table 4. ABHWV Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasurement Year MY 2019	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	37.73%	40.83%	Yes	Yes
Percentage of Eligibles that Received Preventative Dental Services	48.85%	49.83%	Yes	Yes

THP Interventions

Member-focused intervention(s):

- **Member education.** Mailed annual dental care awareness and education postcards to members. Completed quarterly social media posts focused on the importance of general health and dental well care.
- **Transportation for member appointments.** Provided members the ability to schedule transportation for medical services and appointments, including dental visits, at no cost.
- **Mobile dental services.** Educated members on dental health education and availability of mobile dental care services.

Provider-focused intervention(s):

- **Provider education.** Completed provider education on the availability of member transportation services, which allows provider offices to remind members of this no cost service should they call to cancel an appointment due to lack of transportation.

MCP-focused intervention(s):

- There were no MCP-focused interventions in place during MY 2019.

THP PIP Measure Results

Table 5 includes THP’s Annual Dental Visits PIP measure results and level of improvement.

Table 5. THP Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasurement Year MY 2019	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	27.40%	36.81%	Yes	Yes
Percentage of Eligibles that Received Preventative Dental Services	34.89%	41.22%	Yes	Yes

UHP Interventions

Member-focused intervention(s):

- **Member outreach.** Conducted member outreach via text messaging and provided preventative dental services education and reminders.
- **Transportation for health care services and appointments.** Conducted outreach to members with gaps in preventative dental care and offered transportation services to aid members seeking care.

Provider-focused intervention(s):

- **Provider education.** Completed educational activities and encouraged providers to accept 2-3 year old children for dental appointments.

MCP-focused intervention(s):

- There were no MCP-focused interventions in place during MY 2019.

UHP PIP Measure Results

Table 6 reports UHP’s Annual Dental Visits PIP measure results and level of improvement.

Table 6. UHP Annual Dental Visits PIP Measure Results

Performance Measure	Baseline Year MY 2017	Last Remeasurement Year MY 2019	Improvement	Statistically Significant Improvement
Annual Dental Visits for 2-3 Year Olds	39.87%	41.14%	Yes	No
Percentage of Eligibles that Received Preventative Dental Services	51.33%	48.66%	No	-

- There was no improvement. Statistically significant improvement cannot be assessed.

MHT MCP Annual Dental Visits PIP Weighted Average Measure Results

Table 7 details MHT MCP Annual Dental Visits PIP measure weighted averages for MYs 2017-2019.

Table 7. MHT MCP Weighted Averages - Annual Dental Visits PIP

Performance Measure	MY	Eligible Population or Denominator	Numerator	MHT MCP Weighted Average
Annual Dental Visits for 2-3 Year Olds	2017*	15,210	5,444	35.79%
	2018*	14,190	5,428	38.25%
	2019	11,057	4,429	40.06%
Percentage of Eligibles that Received Preventative Dental Services	2017*	201,428	91,663	45.51%
	2018*	194,497	93,065	47.85%
	2019	183,083	86,672	47.34%

* WV MHT weighted average includes a fourth MCP, West Virginia Family Health (WVFH). BMS ended its contract with WVFH on 6/30/2019.

Figure 1 displays annual individual MCP rates and MHT MCP weighted averages for the Annual Dental Visits for 2-3 Year Olds measure for MYs 2017-2019. The MHT MCP weighted average demonstrates annual improvements.

Figure 1. Annual Dental Visits for 2-3 Year Olds - Annual Individual MCP Rates and MHT MCP Averages

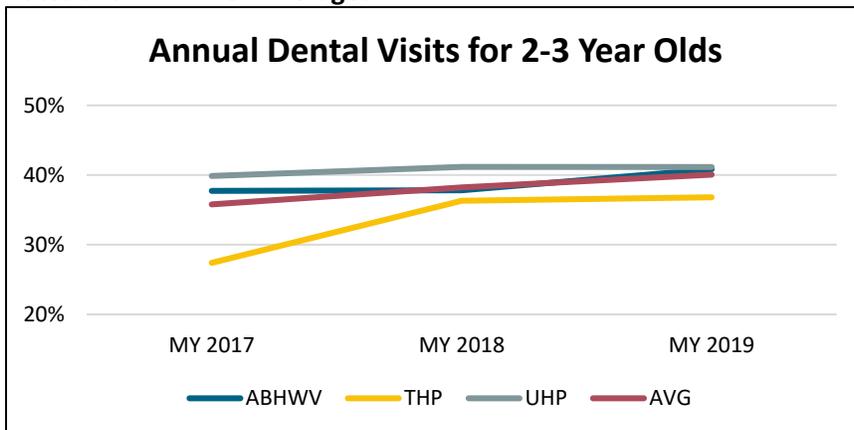
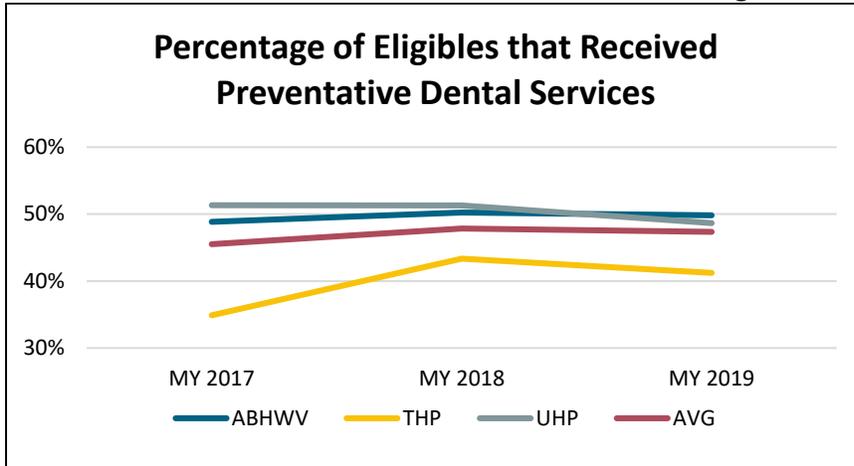


Figure 2 displays annual individual MCP rates and MHT MCP weighted averages for the Percentage of Eligibles that Received Preventative Dental Services measure for MYs 2017-2019. The MHT MCP weighted average remeasurements exceed baseline performance.

Figure 2. Percentage of Eligibles that Received Preventative Dental Services - Annual Individual MCP Rates and MHT MCP Averages



MHT MCP Annual Dental Visits PIP Validation Results

Table 8 includes 2020 validation results for each MCP’s Annual Dental Visits PIP.

Table 8. MHT MCP Validation Results - Annual Dental Visits PIP

2020 PIPs	ABHWV	THP	UHP	MHT MCP AVG
Validation Score	100%	93%	88%	94%
Confidence Level	High Confidence ◆	High Confidence ◆	Moderate Confidence ◆	High Confidence ◆

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

ABHWV Interventions

Member-focused intervention(s):

- **Case management outreach.** Contacted members with substance use disorders to provide education, offer resources, and address social determinants of health regarding access and treatment. Embedded case managers in behavioral health facilities, hospitals, and provider offices to assist members in accessing resources and obtaining needed services.
- **Text messaging campaign.** Conducted an opioid prevention text messaging campaign. Sent messages educating members on the dangers of opioids and encouraging members to contact ABHWV case managers within seven days of hospital discharge.
- **Transportation for health care services and appointments.** Provided members the ability to schedule transportation for medical services and appointments at no cost.

Provider-focused intervention(s):

- **Provider education.** Reviewed measure requirements with providers and offered best practice tips to improve compliance.

MCP-focused intervention(s):

- **Subject matter expert.** Utilized a substance use disorder nurse to support case managers in substance use disorder care coordination.
- **Trauma care training.** Completed trauma-informed care staff training to better support and engage members who have past/current trauma.
- **Electronic emergency department (ED) visit notification.** Received electronic notices of members with an ED visit providing opportunity for case management staff to conduct outreach to members with a substance use disorder diagnosis.

ABHWV PIP Measure Results

Table 9 displays ABHWV's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 9. ABHWV Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasure- ment Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	42.26%	NA	NA	NA

NA - Not Applicable - Only baseline results are available

THP Interventions

Member-focused intervention(s):

- **Member education (planned).**¹¹ Provide members access to the MCP's health library, which includes educational materials and resources to assist in alcohol and substance use disorders.

Provider-focused intervention(s):

- THP did not identify any planned provider-focused interventions for implementation after the baseline year.

MCP-focused intervention(s):

¹¹ Interventions were not required to be in place during the 2019 baseline measurement year. Interventions must be implemented during MY 2020 to impact performance.

- **Electronic member utilization notifications (planned).** Receive daily notifications of member inpatient admissions and discharges and ED visits. Provide case managers with notifications of member utilization for appropriate follow-up and engagement.
- **Health risk assessments (planned).** Complete new member health risk assessments including substance use disorder screenings. Refer members with substance use to case management and navigation teams.

THP PIP Measure Results

Table 10 reports THP’s Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 10. THP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	41.04%	NA	NA	NA

NA - Not Applicable - Only baseline results are available

UHP Interventions

Member-focused intervention(s):

- **Access to treatment (planned).** Partner with high volume EDs and service provider to deliver telemedicine access to behavioral health treatment and follow up.

Provider-focused intervention(s):

- **Provider education (planned).** Complete ED provider education and inform providers of member benefits including treatment for members with transportation barriers.

MCP-focused intervention(s):

- **Member identification for case management referrals (planned).** Identify members with an ED visit for alcohol or other drug dependence in the top three high volume counties. Refer these members to the case management team for engagement and follow up.

UHP PIP Measure Results

Table 11 includes UHP's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 11. UHP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasurement Year	Improvement	Statistically Significant Improvement
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	42.32%	NA	NA	NA

NA - Not Applicable - Only baseline results are available

MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Weighted Average Measure Results

Table 12 includes the MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP measure weighted average for baseline year, MY 2019.

Table 12. MHT MCP Weighted Average - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

Performance Measure	MY	Eligible Population or Denominator	Numerator	MHT MCP Weighted Average
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30 Day Follow-Up (Total)	2019	3,498	1,466	41.91%

MHT MCP Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP Validation Results

Table 13 reports 2020 validation results for each MCP's Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP.

Table 13. MHT MCP Validation Results - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

2020 PIPs	ABHWV	THP	UHP	MHT MCP AVG
Validation Score	100%	95%	95%	97%
Confidence Level	High Confidence ◆	High Confidence ◆	High Confidence ◆	High Confidence ◆

MHT MCP Selected PIPs

ABHWV Care for Adolescents PIP Interventions

Member-focused intervention(s):

- **Member incentive.** Provided members with a \$25 gift card for completing a well care visit.
- **Transportation for health care services and appointments.** Provided members the ability to schedule transportation for medical services and appointments, including well care visits, at no cost.
- **Gaps in care member outreach.** Called members with gaps in care and encouraged well care visits and adolescent immunizations.

Provider-focused intervention(s):

- **Provider notice of gaps in care.** Shared member gaps in care reports with providers and awarded providers with \$25 incentive payment for closing gaps.
- **Provider incentive.** Awarded providers with \$75 incentive payment for completing well care visit exams.

MCP-focused intervention(s):

- **Member demographic updates.** Conducted member outreach calls and obtained current demographic information to improve ability to contact, educate, and engage members.

ABHWV Care for Adolescents PIP Measure Results

Table 14 displays ABHWV's Care for Adolescents PIP measure results. Improvement cannot be assessed until the next annual remeasurement period.

Table 14. ABHWV Care for Adolescents PIP Measure Results

Performance Measure	Baseline Year MY 2019	Last Remeasurement Year	Improvement	Statistically Significant Improvement
Immunizations for Adolescents - Combination 2	30.41%	NA	NA	NA
Adolescent Well Care Visits	65.21%	NA	NA	NA

NA - Not Applicable - Only baseline results are available

Table 15 includes ABHWV's Care for Adolescents PIP measure baseline rates.

Table 15. ABHWV Care for Adolescents PIP Measure Annual Rates

Performance Measure	MY	Eligible Population or Denominator [^]	Numerator	Rate
Immunizations for Adolescents - Combination 2	2019	411	125	30.41%
Adolescent Well Care Visits	2019	411	268	65.21%

[^] Sampling denominator

THP Promoting Health and Wellness in Children and Adolescents PIP Interventions

Member-focused intervention(s):

- **Member incentive.** Provided \$25 gift cards to members completing an adolescent well care visit.
- **Social media campaign.** Completed education and encouragement of annual wellness exams using social media.
- **Access through school-based health clinics.** Encouraged members to utilize school-based health clinics for adolescent well care to improve access and utilization.

Provider-focused intervention(s):

- **Alternative payment model.** Encouraged provider compliance in completing and correctly coding for well visits, BMI assessments, and nutrition counseling using an alternative payment model.

MCP-focused intervention(s):

- **Member contact information.** Conducted member outreach through telephone and/or mail to ensure accurate demographic information on file for outreach and education. Researched recent claims data and collaborated with providers to obtain current contact information.

THP Promoting Health and Wellness in Children and Adolescents PIP Measure Results

Table 16 reports THP's Promoting Health and Wellness in Children and Adolescents PIP measure results and level of improvement.

Table 16. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Results

Performance Measure	Baseline Year MY 2018	Last Remeasurement Year MY 2019	Improvement	Statistically Significant Improvement
Adolescent Well Care Visits	42.82%	42.82% [↵]	No	-
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation	77.62%	81.51%	Yes	No
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	67.88%	67.15%	No	-

[↵] Provider site restrictions related to the COVID-19 public health emergency resulted in an incomplete HEDIS hybrid audit for MY 2019.

Following NCQA and BMS guidance, the MCP elected to report validated rates from MY 2018.

- There was no improvement. Statistically significant improvement cannot be assessed.

Table 17 includes THP’s annual Promoting Health and Wellness in Children and Adolescents PIP measure rates.

Table 17. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Annual Rates

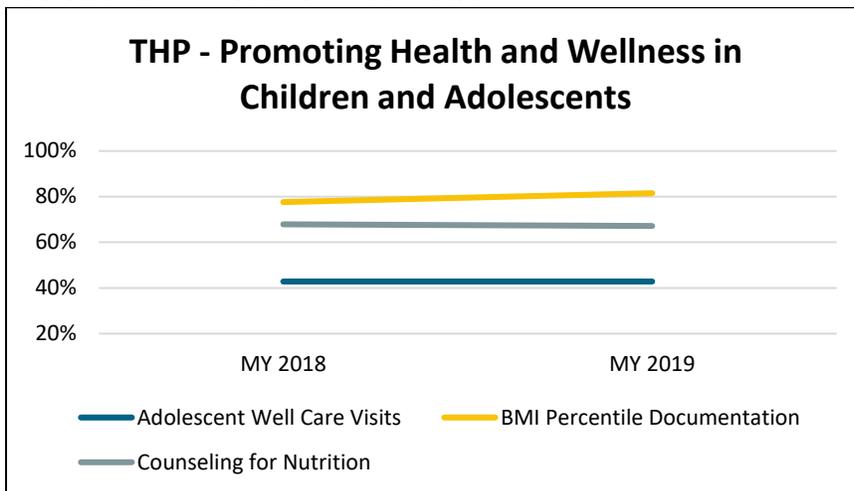
Performance Measure	MY	Eligible Population or Denominator [▲]	Numerator	Rate
Adolescent Well Care Visits	2018	411	176	42.82%
	2019	411	176	42.82% [◀]
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Documentation	2018	411	319	77.62%
	2019	411	335	81.51%
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition	2018	411	279	67.88%
	2019	411	276	67.15%

▲ Sampling denominator

◀ Provider site restrictions related to the COVID-19 public health emergency resulted in an incomplete HEDIS hybrid audit for MY 2019. Following NCQA and BMS guidance, the MCP elected to report validated rates from MY 2018.

Figure 3 illustrates THP’s Promoting Health and Wellness in Children and Adolescents PIP measure annual rates.

Figure 3. THP Promoting Health and Wellness in Children and Adolescents PIP Measure Annual Rates



UHP Follow-Up After Hospitalization for Mental Illness PIP Interventions

Member-focused intervention(s):

- **Member incentive.** Provided members a \$20 incentive for completing a follow-up care visit.
- **Case management.** Completed behavioral health case management services including educating members on medication, discharge, and treatment plans. Discussed barriers and goals to prevent readmissions.
- **Reminder calls.** Completed telephone reminder calls encouraging members to comply with follow-up care visits.

Provider-focused intervention(s):

- **Provider education.** Completed lunch and learns and new provider orientations to educate providers on standards of care, measure specifications, and their role in member care coordination.

MCP-focused intervention(s):

- **Daily census monitoring.** Reviewed daily census to monitor and communicate member status.

UHP Follow-Up After Hospitalization for Mental Illness PIP Measure Results

Table 18 displays UHP's Follow-Up After Hospitalization for Mental Illness PIP measure results and level of improvement.

Table 18. UHP Follow-Up After Hospitalization for Mental Illness PIP Measure Results

Performance Measure	Baseline Year MY 2015	Last Remeasurement Year MY 2019	Improvement	Statistically Significant Improvement
Follow-Up After Hospitalization for Mental Illness – Within 7 Days	15.48%	29.93%	Yes	Yes
Follow-Up After Hospitalization for Mental Illness – Within 30 Days	38.69%	54.94%	Yes	Yes

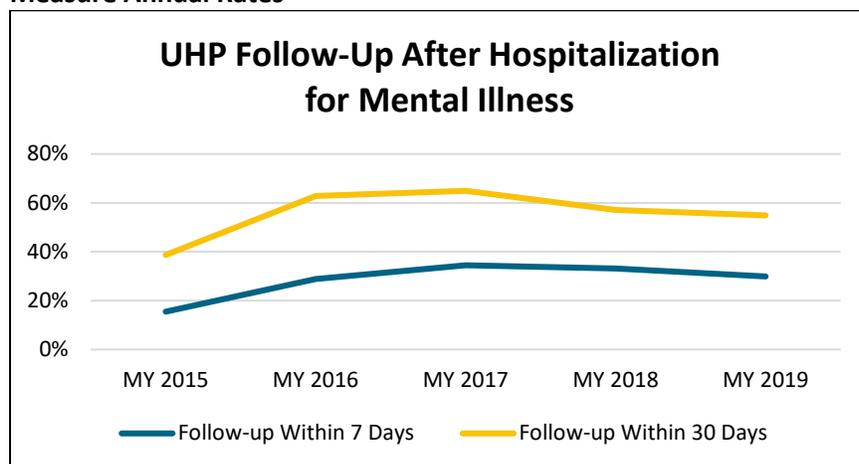
Table 19 includes UHP's Follow-Up After Hospitalization for Mental Illness PIP measure annual rates.

Table 19. UHP Follow-Up After Hospitalization for Mental Illness PIP Measure Annual Rates

Performance Measure	MY	Eligible Population or Denominator	Numerator	Rate
Follow-Up After Hospitalization for Mental Illness – Within 7 Days	2015	336	52	15.48%
	2016	941	272	28.91%
	2017	1,346	464	34.47%
	2018	1,374	455	33.11%
	2019	1,527	457	29.93%
Follow-Up After Hospitalization for Mental Illness – Within 30 Days	2015	336	130	38.69%
	2016	941	591	62.81%
	2017	1,346	874	64.93%
	2018	1,374	785	57.13%
	2019	1,527	839	54.94%

Figure 4 displays annual UHP Follow-Up After Hospitalization for Mental Illness PIP measure rates.

Figure 4. UHP Follow-Up After Hospitalization for Mental Illness PIP Measure Annual Rates



MHT MCP Selected PIP Validation Results

Table 20 reports 2020 validation results for each MHT MCP's selected PIP.

Table 20. MHT MCP Selected PIP Validation Results

2020 PIPs	ABHWV	THP	UHP
MHT MCP Selected Topic	Care for Adolescents	Promoting Health and Wellness in Children and Adolescents	Follow-Up After Hospitalization for Mental Illness
Validation Score	100%	95%	92%
Confidence Level	High Confidence ◆	High Confidence ◆	High Confidence ◆

Conclusion

Summary conclusions for the MHT State selected and MCP selected PIPs are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report. ABHWV will implement PIPs for the MHP program in 2021.

Annual Dental Visits PIP

- The MHT MCPs reported their second remeasurement rates for the Annual Dental Visits PIP.
- The MCP weighted averages demonstrated sustained improvement in both PIP measures, Annual Dental Visits for 2-3 Year Olds and Percentage of Eligibles that Received Preventative Dental Services.¹²
- The MCPs received an average PIP validation score of 94%, indicating (overall) stakeholders can have high confidence the MCPs adhered to acceptable methodology for all phases of design,

¹² Sustained improvement means all remeasurements demonstrated improvement compared to baseline performance.

data collection, and analysis with results yielding improvement. Individual MCP validation results ranged from 88%-100%.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP

- The MHT MCPs reported baseline measurement rates for the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP.
- The MCPs received an average PIP validation score of 97% (high confidence). Individual MCP validation scores ranged from 95%-100%.

MHT MCP Selected PIPs

ABHWV Care for Adolescents PIP

- ABHWV reported baseline results for its Care for Adolescents PIP measures, Immunizations for Adolescents (Combination 2) and Adolescent Well Care Visits.
- ABHWV's validation score was 100% (high confidence).

THP Promoting Health and Wellness in Children and Adolescents PIP

- THP reported remeasurement one results for its Promoting Health and Wellness in Children and Adolescents PIP measures: Adolescent Well Care Visits, BMI Percentile Documentation, and Counseling for Nutrition. THP improved in one measure, BMI Percentile Documentation.
- THP's validation score was 95% (high confidence).

UHP Follow-Up After Hospitalization for Mental Illness PIP

- UHP reported remeasurement four results for its Follow-Up After Hospitalization for Mental Illness PIP measures, Follow-Up within 7 Days and 30 Days. UHP closed out this PIP and demonstrated sustained and statistically significant improvement in both measures during this last reporting period.
- UHP's validation score was 92% (high confidence).

Performance Measure Validation

Objective

BMS uses PMs to monitor performance of individual MCPs at a point in time, track performance over time, and compare performance among MCPs. The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCP and determines the extent to which the MCP followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates is essential to ascertaining whether the MCP's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows BMS to have confidence in MCP measure results.

Methodology

Qlarant validated BMS-selected PMs during the 2020 PMV activity. Select HEDIS, CAHPS, and CMS Core Set measures were used to calculate MY 2019 performance. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.¹³

The validation process was interactive and concurrent to the MCP calculating the measures. Validation activities occurred before, during, and after an onsite visit to the MCP and included two principle components:

- An overall assessment of the MCP's information systems (IS) capability to capture and process data required for reporting
- An evaluation of the processes (e.g. source code programs) the MCP used to prepare each measure

Essential PMV activities included:

- Review of the MCP's data systems and processes used to construct the measures
- Assessment of the calculated rates for algorithmic compliance to required specifications
- Verification the reported rates were reliable and based on accurate sources of information

Information from several sources was used to satisfy validation requirements. These sources included, but were not limited to, the following documents provided by the MCP:

- Information Systems Capabilities Assessment
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies and procedures)
- Observations made during the onsite visit
- Interviews with MCP staff
- Information submitted as part of the follow-up items requested after the onsite visit

Qlarant conducted onsite MCP PMV review activities via virtual desk audit in March 2020 and concluded all post-onsite review activities in July 2020 when MCPs reported final measure rates. After Qlarant approved final rates, Qlarant reported findings for the following audit elements including: documentation, denominator, numerator, sampling (if applicable), and reporting. Audit element descriptions are provided below.

Documentation. Assessment of data integration and control procedures determine whether the MCP had appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. Evaluation includes reviewing and assessing documentation of measurement procedures and programming specifications including data sources, programming logic, and computer source codes.

¹³ [CMS EQRO Protocols](#)

Denominator. Validation of measure denominator calculations assesses the extent to which the MCP used appropriate and complete data to identify the entire population and the degree to which the MCP followed measure specifications for calculating the denominator.

Numerator. Validation of the numerator determines if the MCP correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCP followed measure specifications for calculation of the numerator.

Sampling. Evaluation of sample size and replacement methodology specifications confirms the sample was not biased, if applicable.

Reporting. Validation of measure reporting confirms if the MCP followed BMS specifications.

Qlarant calculated a validation rating for the MCP based on audit element findings. The rating provides a level of confidence in the MCP's reported PM results. Validation ratings include:

- ◆ 95% - 100%: high confidence in MCP results
- ◆ 80% - 94%: moderate confidence in MCP results
- ◆ 75% - 79%: low confidence in MCP results
- ◆ ≤74%: no confidence in MCP results

The 2020 PMV audits focused on the MHT program only. The MHP program operationalized March 1, 2020.

Results

Performance Measure Validation Results

All MHT MCPs had appropriate systems in place to process accurate claims and encounters. Table 21 includes 2020 MHT PMV results based on MCP calculation of MY 2019 measure rates. Compliance with each PMV element is reported by MCP and MHT MCP average.

Table 21. MHT MCP PMV Results

PMV Element	ABHWV	THP	UHP	MHT MCP Average
Documentation	100%	100%	95%	98%
Denominator	100%	100%	100%	100%
Numerator	100%	100%	100%	100%
Sampling	100%	100%	100%	100%
Reporting	100%	100%	100%	100%
Overall Rating	100%	100%	99%	100%
Reporting Designation	R	R	R	R ^{**}
Level of Confidence	High Confidence ◆	High Confidence ◆	High Confidence ◆	High Confidence ◆

R – Reportable; measures were compliant with BMS specifications

** All MCPs received a reportable designation

Table 22 displays the MCP MY 2019 measure rates. The table reports each measure's data collection methodology for informational purposes.

Table 22. MHT MCP Performance Measure Rates for MY 2019

Performance Measure	Data Collection Method*	ABHWV MY 2019 Rate	THP MY 2019 Rate	UHP MY 2019 Rate
Adolescent Well-Care Visits	Hybrid	65.21%	42.82% ^{<}	70.07% ^{<}
Annual Dental Visits for 2-3 Year Olds	Administrative	40.83%	36.81%	41.14%
Cervical Cancer Screening	Hybrid	60.10%	51.82%	56.93% ^{<}
Childhood Immunization Status: Combination 3	Hybrid	71.29%	70.80% ^{<}	71.53% ^{<}
Comprehensive Diabetes Care: Eye Exams	Hybrid	47.69%	39.42% ^{<}	46.96% ^{<}
Dental Sealants for 6-9 Year Old Children at Elevated Risk	Administrative	21.71%	21.77%	61.29%
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	Administrative	42.26%	41.04%	42.32%
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	Administrative	42.79%	46.06%	48.67%
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	Administrative	59.38%	57.26%	54.94%
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	Survey	73.87%	74.10%	78.14%
Percentage of Eligible (Children) that Received Preventive Dental Services	Administrative	49.83%	41.22%	48.66%
PQI 01: Diabetes Short-Term Complications Admission Rate <i>Lower rate is better</i>	Administrative	16.96	20.26	24.86
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate <i>Lower rate is better</i>	Administrative	51.27	30.54	58.40
PQI 08: Congestive Heart Failure (CHF) Admission Rate <i>Lower rate is better</i>	Administrative	20.16	20.69	14.19
PQI 15: Asthma in Younger Adults Admission Rate <i>Lower rate is better</i>	Administrative	1.29	1.46	1.43
Prenatal and Postpartum Care: Postpartum Care	Hybrid	78.10%	70.07%	68.86% ^{<}

Performance Measure	Data Collection Method*	ABHWV MY 2019 Rate	THP MY 2019 Rate	UHP MY 2019 Rate
Use of Imaging Studies for Low Back Pain	Administrative	65.48%	64.05%	66.15%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Hybrid	77.62%	74.94% ^{<}	77.37% ^{<}

* Administrative data collection: rates are calculated using claims and other supplemental data. Hybrid data collection: rates are calculated using administrative and medical record data.

[<] Provider site restrictions related to the COVID-19 public health emergency resulted in an incomplete HEDIS hybrid audit for MY 2019. Following NCQA and BMS guidance, the MCP elected to report validated rates from MY 2018.

Table 23 details the MY 2019 MHT MCP Weighted Average for each measure and compares performance to national benchmarks. The table includes the aggregate eligible population and numerator for each measure.

Table 23. MHT MCP Performance Measure Rates for MY 2019

Performance Measure	Eligible Population	Numerator	MHT MY 2019 Weighted Average	Comparison to Benchmarks*
Adolescent Well-Care Visits	49,208	30,977	62.95%	◆◆
Annual Dental Visits for 2-3 Year Olds	11,057	4,429	40.06%	◆
Cervical Cancer Screening	70,970	40,240	56.70%	◆
Childhood Immunization Status: Combination 3	5,696	4,060	71.28%	◆◆
Comprehensive Diabetes Care: Eye Exams	15,885	7,154	45.04%	◆
Dental Sealants for 6-9 Year Old Children at Elevated Risk	18,840	7,576	40.21%	◆◆◆~
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	3,498	1,466	41.91%	◆◆◆
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	1,878	864	46.01%	◆
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	3,880	2,213	57.04%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	survey	survey	75.37%	◆
Percentage of Eligible (Children) that Received Preventive Dental Services	183,083	86,672	47.34%	◆~

Performance Measure	Eligible Population	Numerator	MHT MY 2019 Weighted Average	Comparison to Benchmarks*
PQI 01: Diabetes Short-Term Complications Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	2,499,635	523	20.92	◆ [^]
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	1,473,484	641	43.50	◆◆◆ [^]
PQI 08: Congestive Heart Failure (CHF) Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	2,499,635	450	18.00	◆◆◆ [^]
PQI 15: Asthma in Younger Adults Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	1,712,905	24	1.40	◆◆◆ [^]
Prenatal and Postpartum Care: Postpartum Care	6,878	4,962	72.14%	◆
Use of Imaging Studies for Low Back Pain	4,100	1,419	65.39%	◆
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	25,701	19,778	76.96%	◆◆

* Benchmark data source: Quality Compass 2020 (MY 2019 data) National Medicaid Average for Health Maintenance Organizations

~ Benchmark data source: Quality of Care for Children in Medicaid and CHIP: Findings from the 2020 Child Core Set Chart Pack, October 2020

^ Benchmark data source: Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart, October 2020

◆ The MHT Average is below the National Average

◆◆ The MHT Average is equal to or exceeds the National Average, but does not meet the 75th Percentile

◆◆◆ The MHT Average is equal to or exceeds the 75th Percentile

Table 24 trends the MHT MCP weighted averages for each measure for MYs 2017-2019. Positive and negative trends, demonstrated by consecutive annual movement, are noted.

Table 24. MHT MCP Performance Measure Weighted Averages – MYs 2017-2019

Performance Measure	MHT MCP MY 2017 Weighted Average	MHT MCP MY 2018 Weighted Average	MHT MCP MY 2019 Weighted Average	Trend
Adolescent Well-Care Visits	56.70%	59.88%	62.95%	↑
Annual Dental Visits for 2-3 Year Olds	35.79%	38.25%	40.06%	↑
Cervical Cancer Screening	NR	NR	56.70%	-
Childhood Immunization Status: Combination 3	67.07%	69.07%	71.28%	↑
Comprehensive Diabetes Care: Eye Exams	NR	NR	45.04%	-

Performance Measure	MHT MCP MY 2017 Weighted Average	MHT MCP MY 2018 Weighted Average	MHT MCP MY 2019 Weighted Average	Trend
Dental Sealants for 6-9 Year Old Children at Elevated Risk	23.48%	29.69%	40.21%	↑
Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up	NR	NR	41.91%	-
Follow-Up After Emergency Department Visit for Mental Illness: 30 Days Follow-Up	NR	NR	46.01%	-
Follow-Up After Hospitalization for Mental Illness: 30 Days Follow-Up	NR	NR	57.04%	-
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit	74.59%	75.71%	75.37%	-
Percentage of Eligible (Children) that Received Preventive Dental Services	45.51%	47.85%	47.34%	-
PQI 01: Diabetes Short-Term Complications Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	18.45	22.44	20.92	-
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	76.86	64.35	43.50	↑
PQI 08: Congestive Heart Failure (CHF) Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	16.73	17.83	18.00	↓
PQI 15: Asthma in Younger Adults Admission Rate (observed rate*100,000) <i>Lower rate is better</i>	2.93	2.45	1.40	↑
Prenatal and Postpartum Care: Postpartum Care	65.36%	65.03%	72.14%	-
Use of Imaging Studies for Low Back Pain	NR	NR	65.39%	-
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	75.12%	75.38%	76.96%	↑

NR - Not Reported

↑ Positive annual trend (consecutive annual improvement)

↓ Negative annual trend (consecutive annual decline in performance)

- No trend detected or three measurement periods are not available for analysis

Conclusion

Aggregate summary conclusions for the PMV activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report.

- The MHT MCPs received overall PMV ratings ranging from 99%-100%. The MHT MCP average was 100%, providing high confidence in MCP measure calculations and reporting.
- An analysis of MY 2019 MHT MCP weighted averages demonstrates 50% of measures (9 of 18) met or exceeded national average benchmarks. The following measures met or exceeded the 75th percentile benchmarks:
 - Dental Sealants for 6-9 Year Old Children at Elevated Risk
 - Follow-Up After Emergency Department Visit for Alcohol Other Drug Abuse or Dependence: 30 Days Follow-Up
 - Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
 - Congestive Heart Failure (CHF) Admission Rate
 - Asthma in Younger Adults Admission Rate
- Twelve (12) of 18 measures had rates available for MYs 2017-2019 and allowed for a trending analysis. Fifty-eight percent (58%) or 7 of 12 measures demonstrated a positive trend. Only one measure demonstrated a negative trend. Remaining measures did not produce a trend.

Systems Performance Review

Objective

SPRs, also referred to as compliance reviews, assess MCP compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of health care services provided to managed care beneficiaries. The comprehensive review determines compliance with federal and state managed care program requirements. The SPR provides BMS an independent assessment of MCP capabilities, which can be used to promote accountability and improve quality related processes and monitoring.

Methodology

Qlarant conducts a comprehensive review of applicable managed care standards within a three year period in compliance with 42 CFR §438.358(b)(iii). Qlarant reviews the following 42 CFR §438 standards:

- Subpart A §438.10: Information Requirements
- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System
- Subpart H §438.608: Program Integrity Requirements Under the Contract

Table 25 identifies the three year review schedule Qlarant follows for the SPR.

Table 25. Three Year SPR Schedule

Standard	Year 1	Year 2	Year 3
Information Requirements			✓
Disenrollment Requirements and Limitations			✓
Enrollee Rights and Protections			✓
MCO Standards	✓		
Quality Assessment and Performance Improvement Program			✓
Grievance and Appeal System		✓	
Program Integrity Requirements Under the Contract	✓		

Standards are comprised of elements and components, all of which are individually reviewed and scored. Qlarant uses the following scale when evaluating MCP compliance for each element and/or component:

- **Met.** Demonstrates full compliance. 1 point.
- **Partially Met.** Demonstrates at least some, but not full, compliance. 0.5 point.
- **Not Met.** Does not demonstrate compliance on any level. 0 points.
- **Not Applicable.** Requirement does not apply and is not scored.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally an overall SPR compliance score is calculated. Based on this overall score, a level of confidence in the MCP's SPR results is determined. Compliance ratings include:

- ◆ 95% - 100%: high confidence in MCP compliance
- ◆ 85% - 94%: moderate confidence in MCP compliance
- ◆ 75% - 84%: low confidence in MCP compliance
- ◆ ≤74%: no confidence in MCP compliance

Qlarant reviewed Year 3 standards during the 2020 SPR.¹⁴ The 2020 SPR evaluated MY 2019 compliance. Qlarant completed review activities in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations*. Review activities were interactive and occurred before, during, and after the onsite visit to the MCP in March 2020. Pre-onsite visit activities included evaluating policies, reports, meeting minutes, and other supporting documents shared by the MCP. Onsite visit activities focused on MCP staff interviews, process demonstrations, and record reviews. Post-onsite visit activities included an opportunity for the MCP to respond to preliminary findings and provide additional evidence of compliance, if available.

¹⁴ For the 2020 SPR, Qlarant reviewed: 438.10 - Information Requirements, §438.206-§438.207 - Availability of Services & Assurance of Adequate Capacity and Services, and §438.330: Quality Assessment and Performance Improvement Program. The schedule displayed in the table reflects adjustments made after the 2020 SPR was complete which will be followed for future SPRs. Adjustments include scheduling the Availability of Services & Assurance of Adequate Capacity and Services elements during Year 1 under the MCO Standards (§438.206-§438.242) and completing §438.56 - Disenrollment Requirements and Limitations and §438.100-§438.114 - Enrollee Rights and Protections during Year 3 of the SPR.

Results

Table 26 displays 2020 MHT MCP SPR results by standard and total. A level of confidence in each MCP’s compliance is assigned based on the overall weighted score. The table also includes MCP averages.

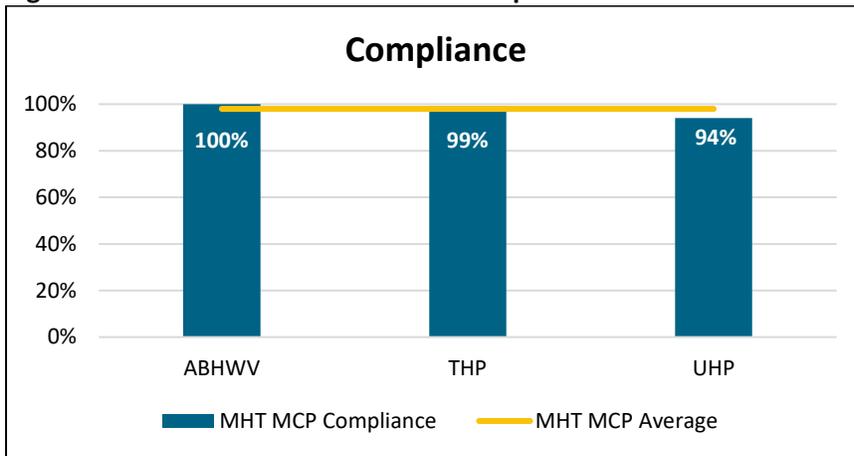
Table 26. 2020 MHT MCP SPR Results

Standard	ABHWV	THP	UHP	MHT MCP AVG
Information Requirements	100%	100%	100%	100%
Availability of Services & Assurance of Adequate Capacity and Services*	100%	97%	86%	94%
Quality Assessment and Performance Improvement Program	100%	100%	93%	98%
Overall Weighted Score	100%	99%	94%	98%
Level of Confidence	High Confidence ◆◆	High Confidence ◆◆	Moderate Confidence ◆◆	High Confidence ◆◆

* Availability of Services & Assurance of Adequate Capacity and Services (\$438.206 - \$438.207) were reviewed separate from the MCO Standards.

Figure 5 illustrates 2020 MHT MCP SPR scores including the MHT MCP weighted average of 98%.

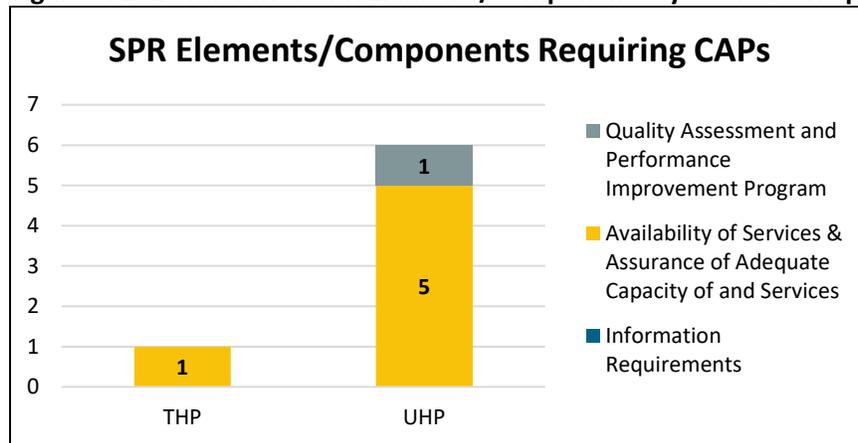
Figure 5. 2020 MHT MCP SPR Overall Compliance Scores



ABHWV scored 100% compliance in the 2020 SPR evaluating MY 2019 standards. THP and UHP had overall scores of 99% and 94%, respectively. In response to these results, THP and UHP were required to develop corrective action plans (CAPs) for the elements/components not meeting full compliance.

Figure 6 identifies the number of elements/components per standard in which a MCP CAP was required.

Figure 6. 2020 MHT MCP SPR Elements/Components by Standard Requiring CAPs



THP had one CAP and UHP had a total of six CAPs. The MCPs developed and completed CAPs, as required. Qlarant and BMS approved the CAPs and Qlarant monitored them quarterly until each CAP was closed. Figure 7 illustrates all CAPs were closed or resolved during 2020.

Figure 7. 2020 MHT MCP SPR CAP Status

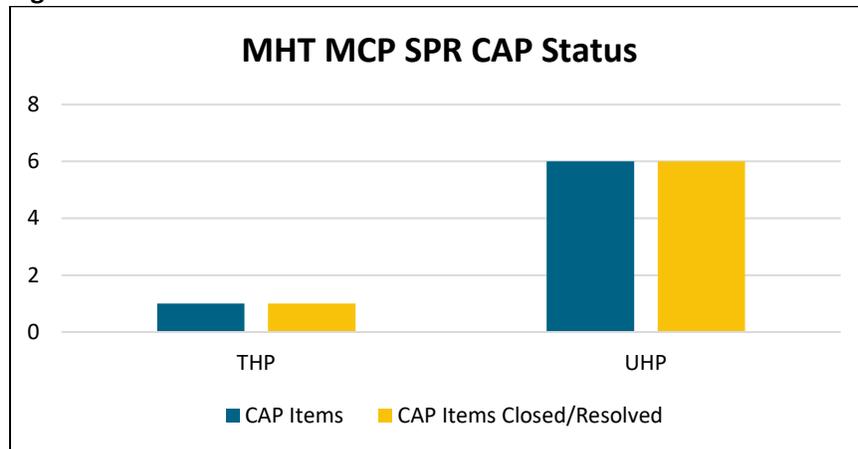


Table 27 includes MHT MCP SPR results of all standards within the last three-year review period.

Table 27. MHT MCP SPR Results of All Standards

Standard	ABHWV	THP	UHP	MHT MCP AVG
Information Requirements	100%	100%	100%	100%
Enrollee Rights and Protections	100%	100%	100%	100%
Availability of Services & Assurance of Adequate Capacity and Services*	100%	97%	86%	94%
MCO Standards	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program	100%	100%	93%	98%
Grievance and Appeal System	100%	95%	92%	96%
Program Integrity Requirements	97%	100%	100%	99%

*Availability of Services & Assurance of Adequate Capacity and Services (§438.206-§438.207) were reviewed separate from the MCO Standards.

Conclusion

Summary conclusions for the SPR activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report.

- The MHT MCPs received overall weighted scores ranging from 94%-100% for the 2020 SPR evaluating MY 2019 compliance. The MHT MCP average was 98%. Stakeholders can have high confidence in ABHWV and THP's level of compliance and moderate confidence in UHP's level of compliance.
- THP and UHP effectively developed and completed CAPs based on 2020 SPR findings. These CAPs are detailed in the [MCP Quality, Access, Timeliness Assessment section](#).

Network Adequacy Validation

Objective

NAV evaluates whether MCPs are maintaining adequate provider networks and meeting availability service requirements. The Code of Federal Regulations, 42 CFR §438.206 - Availability of Services, requires MCPs to make services included in its contract available 24 hours a day, 7 days a week (24/7), when medically necessary. If providers are not readily available after regular business hours, they should have a process in place to direct members to care. NAV results provide BMS and other stakeholders with a level of confidence in provider compliance with the 24/7 requirement including directing members to care during nonbusiness hours.

Methodology

Qlarant completed quarterly validation activities by selecting and surveying a random sample of providers from each MCP's provider directory.¹⁵ For the MHT program, Qlarant surveyed a mix of PCPs providing services to all members and PCPs providing services to children. For the MHP program, Qlarant surveyed a mix of PCPs and behavioral health providers serving children. Qlarant surveyors called each provider office after business hours and/or on weekends to determine provider compliance with the access standard. Information collected during telephone surveys evaluated the accessibility of each MCP's network of PCPs and instructions given to members after the provider offices closed for the day.

Compliance is assessed as meeting one of the following criteria. Calls are answered by a(n):

- Live person employed by the practice who provided guidance to the caller seeking care
- Answering service (live person provided guidance to the caller seeking care)
- On-call provider who provided guidance to the caller seeking care
- Recorded or automated message which provided instruction to go to the nearest emergency room or call 911 for an emergency situation, call a nurse line, or similar instruction on how to obtain care

¹⁵ MCPs submitted their provider directories to Qlarant on a quarterly basis to ensure surveyors accessed the most up-to-date information.

Results

Table 28 includes the percentage of 2020 provider surveys resulting in successful contact for each MHT MCP. Surveys were deemed successful if contact was made with a live person, answering service, on-call provider, or recorded/automated message. Each MCP had a contact success rate greater than 80%.

Table 28. Successful Contact Per MHT MCP

2020 NAV	ABHWV	THP	UHP	MHT MCP AVG
Successful Contact	81%	84%	83%	83%

Figure 8 illustrates the percentage of provider surveys that resulted in successful contact for 2020. MHT MCP results are compared to the MHT MCP average.

Figure 8. Successful Contact Per MHT MCP

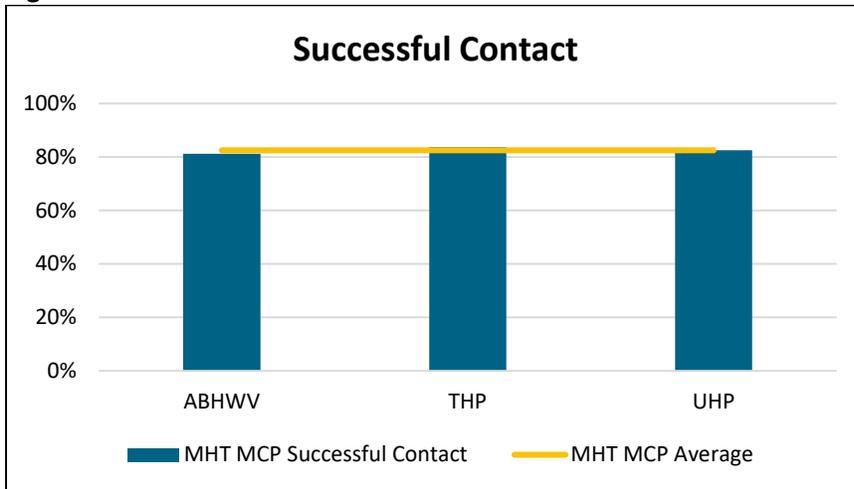
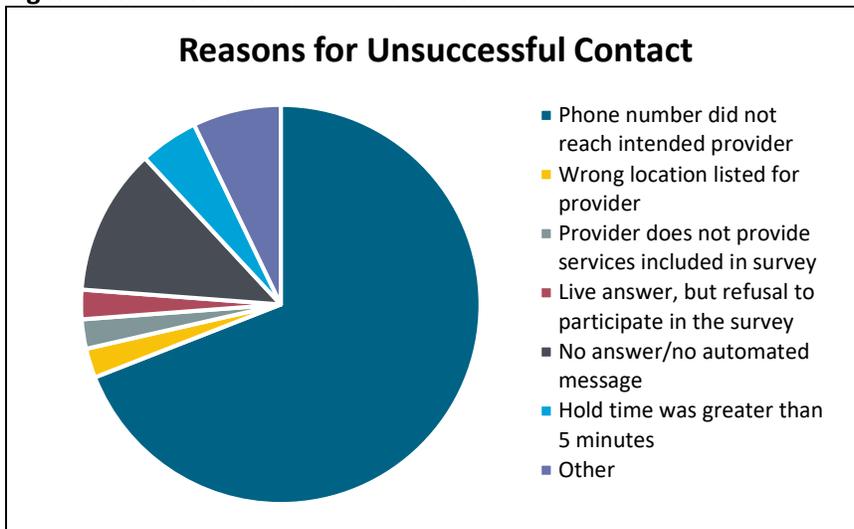


Figure 9 displays reasons, in aggregate, for unsuccessful contact. Most unsuccessful surveys (69%) were due to the phone number not reaching the intended provider. This was followed by no answer/no automated message (12%).

Figure 9. Reasons for Unsuccessful Contact



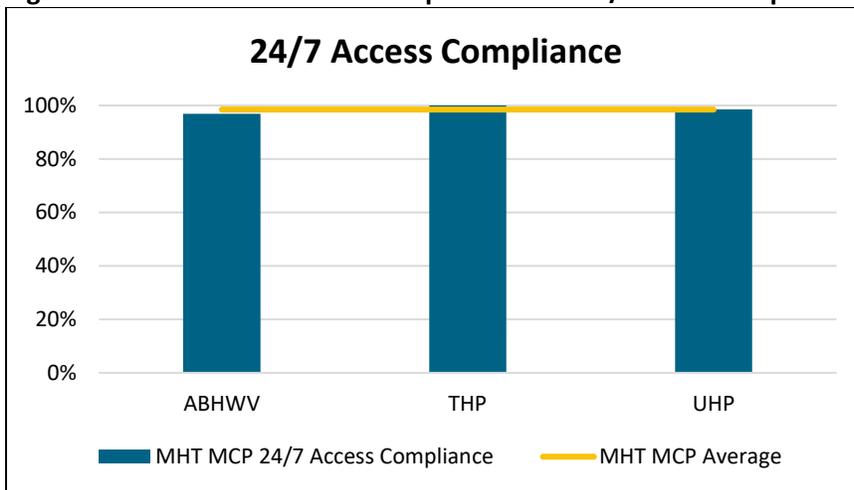
For each successful contact, Qlarant evaluated the provider’s compliance with the 24/7 access requirement. Table 29 reports each MHT MCP’s rate of provider compliance.

Table 29. MHT MCP Provider Compliance with 24/7 Access Requirements

2020 NAV	ABHWV	THP	UHP	MHT MCP AVG
Compliance with 24/7 Access Requirements	97%	100%	98%	98%

Figure 10 displays 2020 MHT MCP provider compliance with 24/7 access requirements compared to the MHT MCP average.

Figure 10. MHT MCP Provider Compliance with 24/7 Access Requirements



All occurrences of noncompliance were due to a recorded/automated message not directing the member to care.

Figure 11 displays the percentage of 2020 MHP provider surveys resulting in successful contact, 83%.

Figure 11. MHP ABHWV Successful Contact

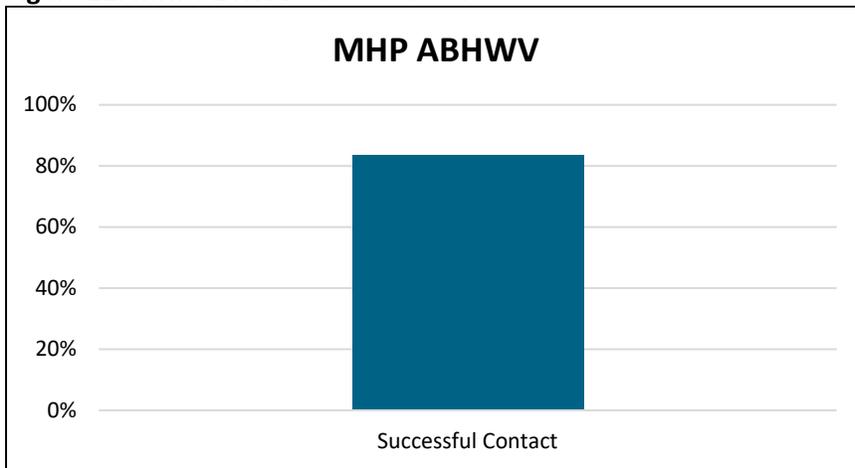


Figure 12 illustrates reasons for unsuccessful contact. Similar to the MHT survey findings, most MHP ABHWV unsuccessful surveys were due to the phone number not reaching the intended provider (70%). This was followed by wrong location listed by provider (20%) and no answer/no automated message (10%).

Figure 12. Reasons for Unsuccessful Contact

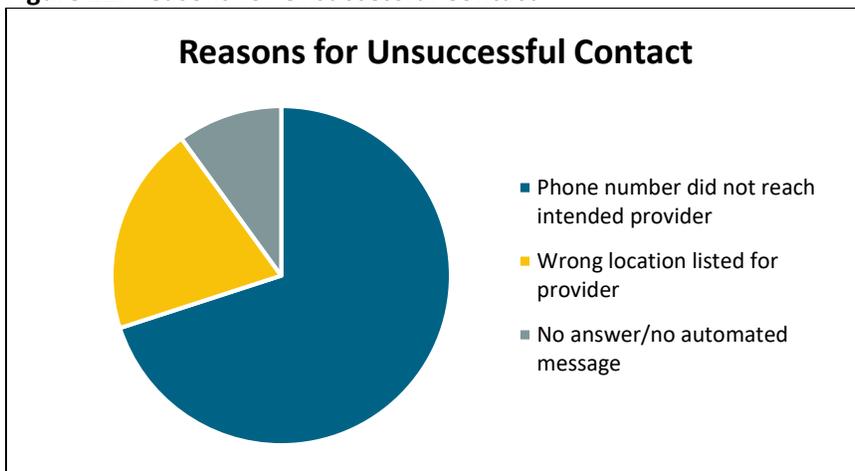
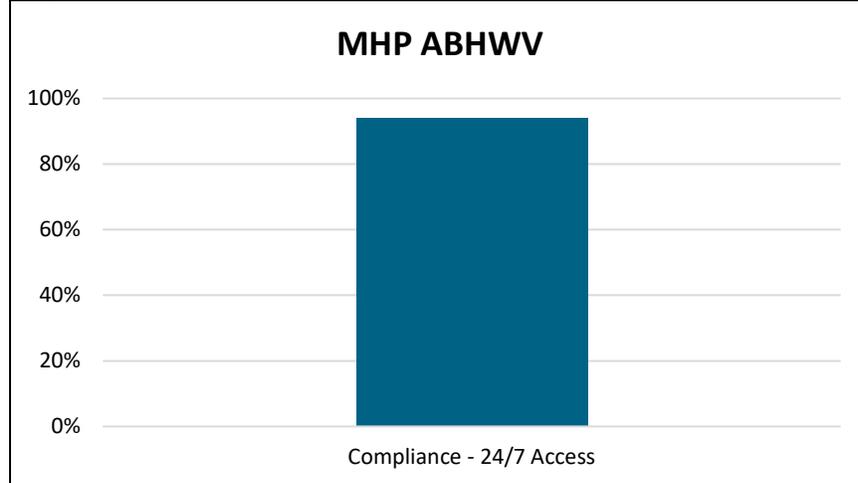


Figure 13 displays the 2020 MHP ABHWV level of provider compliance with the 24/7 access requirement, 94%.

Figure 13. MHP ABHWV Provider Compliance with 24/7 Access Requirements



Consistent with the MHT MCP findings, all MHP ABHWV provider noncompliance was due to a recorded/automated message not directing the member to care.

No comparison results are available for trending as this EQR activity was initiated in 2020.

Conclusion

Qlarant conducted quarterly surveys evaluating provider compliance with 24/7 access requirements. Aggregate summary conclusions for the NAV activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report.

- The MHT MCP average rate for successful contact with the intended provider was 83%. MHT MCP performance ranged from 81%-84%. For the MHP ABHWV survey, the success contact rate was 83%.
- The MHT MCP average rate for provider compliance with 24/7 access requirements was 98%. MHT MCP performance ranged from 97%-100%. For the MHP WBHWV survey, the success rate was 94%.

Encounter Data Validation

Objective

States rely on valid and reliable encounter/claims data submitted by MCPs to make key decisions.¹⁶ For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. As payment methodologies evolve and incorporate value-based payment elements, collecting complete and accurate encounter data is critical. Results of

¹⁶ Encounter data consists of claims; therefore, these terms, encounter data and claims, are used interchangeably in this report.

the EDV study provide BMS with a level of confidence in the completeness and accuracy of encounter data submitted by the MCPs.

Methodology

Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.¹⁷ Qlarant’s 2020 review and validation activities focused on provider office claims paid during MY 2019. Qlarant obtained the necessary claims data from BMS’s fiscal agent. To assess the completeness and accuracy of MCP encounter data, Qlarant completed the following activities:

- Reviewed state requirements for collecting and submitting encounter data
- Reviewed each MCP’s capability to produce accurate and complete encounter data, which included an evaluation of the MCP’s Information Systems Capabilities Assessment and interviews with key MCP staff
- Analyzed MCP electronic encounter data for accuracy and completeness including an examination for consistency, accuracy, and completeness
- Reviewed medical records gathered from provider offices to confirm electronic encounter data accuracy

Results

Qlarant found all MHT MCPs had the capability to produce accurate and complete encounter data. Analysis of the electronic claims data determined:

- The volume of encounters submitted was reasonable.
- Most encounters were submitted on a timely basis.
- Required data fields contained complete and/or valid values.
- The use of diagnosis and procedure codes was appropriate according to members’ age and/or gender.

Qlarant’s medical record review evaluated the accuracy of diagnoses and procedure codes in the electronic encounter data. Table 30 displays MHT MCP accuracy or “match rates.” A match occurs when the electronic diagnosis and procedure codes are supported by medical record documentation. The 2020 medical record reviews, evaluating claims paid during MY 2019, confirmed high encounter data accuracy with all MCPs scoring 95% and above. The MHT MCP average match rate was 97%.

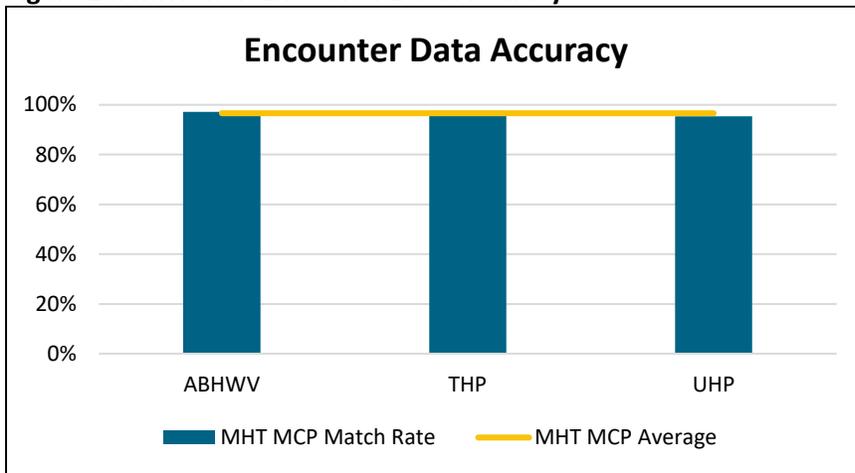
Table 30. MHT MCP Encounter Data Accuracy

2020 EDV	ABHWV	THP	UHP	MHT MCP AVG
Accuracy or Match Rate	97%	98%	95%	97%

Figure 14 illustrates MHT MCP encounter data accuracy compared to the average.

¹⁷ [CMS EQRO Protocols](#)

Figure 14. MHT MCP Encounter Data Accuracy



Fewer than 5% of record elements reviewed had errors. Figure 15 illustrates reasons for “no match” in diagnosis codes based on the medical record review activity. Most errors were due to lack of documentation in record (60%).

Figure 15. Reasons for “No Match” in Diagnosis Codes

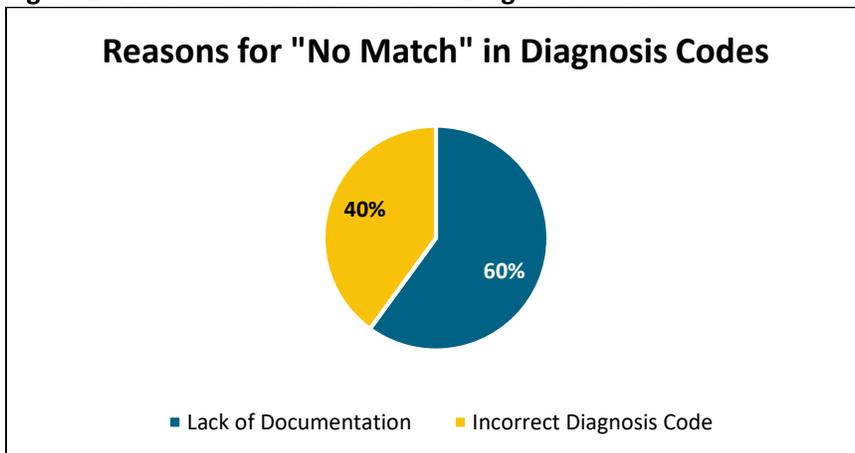
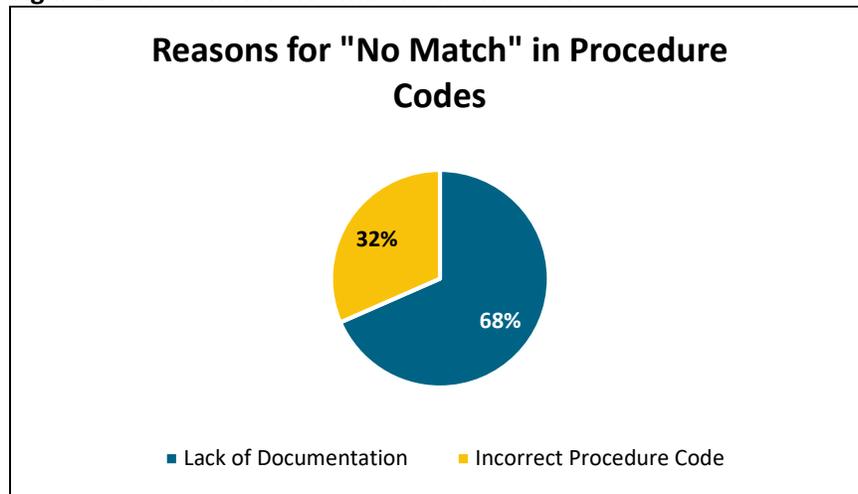


Figure 16 displays reasons for “no match” in procedure codes based on the medical record review activity. Most errors were due to lack of documentation in the record (68%).

Figure 16. Reasons for “No Match” in Procedure Codes

No comparison results are available for trending as this EQR activity commenced in 2020. The task was not conducted for the MHP program due to the operational start date of March 1, 2020.

Conclusion

Aggregate summary conclusions for the EDV activity are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report.

- An evaluation of each MHT MCP’s Information Systems Capabilities Assessment determined all MCPs had the capability to produce accurate and complete encounter data for MY 2019.
- Analysis of provider office claims paid in MY 2019 confirmed reasonable encounter volume, timely submission, complete and/or valid values, and appropriate usage of codes.
- A medical record review determined a high level of encounter data accuracy. The MHT MCP average match rate was 97%. MCP performance ranged from 95% to 98%.

Grievance, Denial, and Appeal Focused Study

Objective

MCP members have the right to file a grievance when they are not satisfied with care or services and the right to file a request to appeal when they do not agree with a decision made by the MCP. The MCPs must follow federal and state requirements when:

- Responding to a member grievance
- Making a decision to deny, reduce, or terminate a member service or benefit (adverse determination)
- Reviewing a member appeal and upholding or overturning a decision to deny, reduce, or terminate a service or benefit

Qlarant conducts a focused study by collecting information on MCP grievances, denials, and appeals; completing random sample record reviews; and evaluating MCP compliance with federal and state requirements. The focused study and validation activities provides BMS with a level of confidence in MCP procedures and compliance with requirements.

Methodology

MCPs submitted their grievance, denial, and appeal “universes” to Qlarant on a quarterly basis. Qlarant collected all information and selected random sample records for each category. MCPs were notified of the selected sample and provided the full records to Qlarant for review and validation activities. Qlarant examined records and evaluated MCP compliance with federal and state requirements. Grievance records were evaluated to ensure the MCP provided timely acknowledgement and resolution notification. Denials, or adverse determination records, were reviewed to assess compliance with timely notification of decisions and required letter content such as communication of a member’s right to file an appeal and procedures on how to do so. Appeal records were evaluated to ensure the MCP provided timely member acknowledgement and resolution notification and required letter content such as communication of a member’s right to request a state fair hearing and procedures on how to make such request.

MCPs are permitted 90 calendar days to resolve grievances. Therefore, MCPs did not submit their grievance, denial, and appeal universes to Qlarant until approximately 105 days after the quarter ended. Reporting in this ATR only captures results based on quarters 1 and 2 of 2020. This focused study, implemented in 2020, is a new task and previous annual results are not available.

Results

Table 31 includes MHT MCP grievance, denial, and appeal results for 2020. Results are displayed by MCP and by MHT MCP average for each category. As explained above, only quarters 1 and 2 are included in results. This focused study was a new task in 2020.

Table 31. MHT MCP Grievance, Denial, and Appeal Compliance

2020 Assessment	ABHWV Compliance	THP Compliance	UHP Compliance	MHT MCP AVG Compliance
Grievances	73%	100%^	100%	91%
Denials	99%	96%	96%	97%
Appeals	100%	98%^	92%	96%

^ At least one quarter had less than 10 grievances or appeals

Figure 17 graphically displays MHT MCP 2020 results for the grievance, denial, and appeal focused study. All MHT MCP averages exceed 90% compliance.

Figure 17. MHT MCP Grievance, Denial, and Appeal Compliance

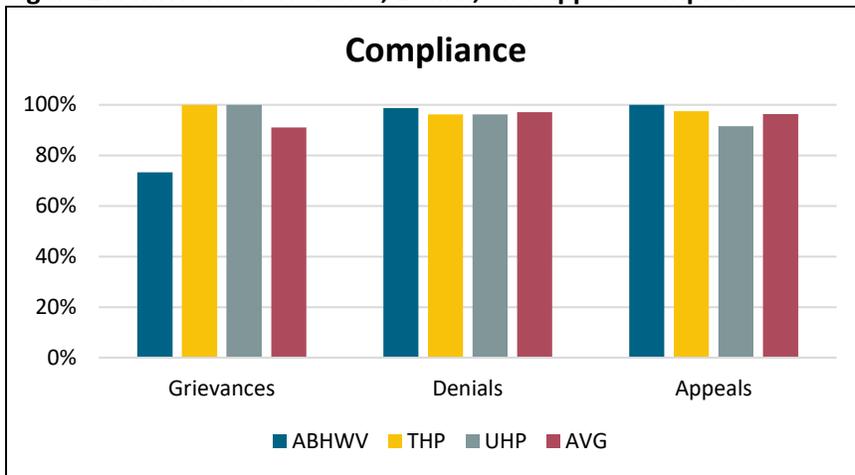


Table 32 reports MHP ABHWV grievance, denial, and appeal results for 2020. Results include findings for quarters 1 and 2. The quarter 1 evaluation was limited to one month due to the March 1, 2020 start date for the MHP program. Due to small numbers, caution is advised when interpreting results.

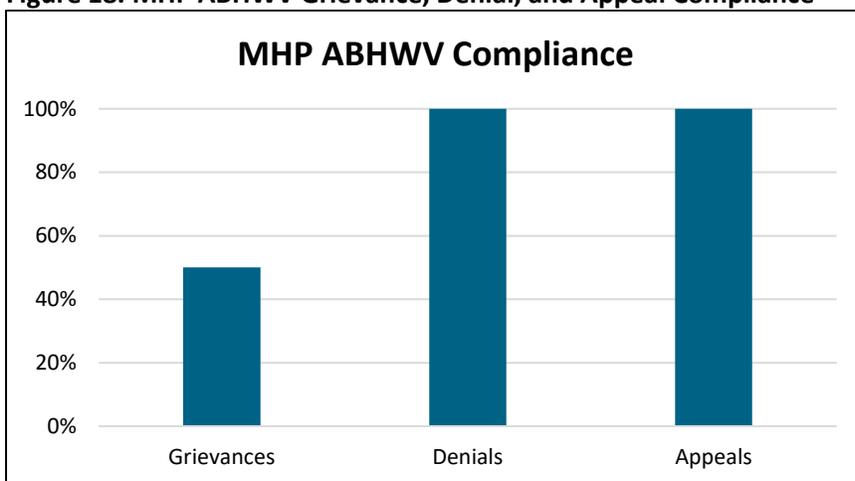
Table 32. MHP ABHWV Grievance, Denial, and Appeal Compliance

2020 Assessment	MHP ABHWV Compliance
Grievances	50%^
Denials	100%
Appeals	100%^

^ At least one quarter had less than 10 grievances or appeals. ABHWV received one grievance in quarter 1 and quarter 2 and no appeals in quarter 1.

Figure 18 graphically displays MHP ABHWV 2020 results for the grievance, denial, and appeal focused study.

Figure 18. MHP ABHWV Grievance, Denial, and Appeal Compliance



Conclusion

Aggregate summary conclusions for the focused study are below. Specific MCP strengths, weaknesses, and recommendations are included in Tables 33-35 within the [MCP Quality, Access, Timeliness Assessment section](#), later in the report.

At the time of this reporting, only partial year results are available due to the lag in reporting which permits 90 days to resolve grievances. Qlarant's record reviews for quarters 1 and 2 2020 concluded the following:

- The grievance MHT MCP average compliance was 91% with MCP performance ranging from 73% (ABHWV) to 100% (THP and UHP).
- The denial MHT MCP average compliance was 97%. MCP compliance ranged from 96% (THP and UHP) to 99% (ABHWV).
- The appeal MHT MCP average compliance was 96% with MCP performance ranging from 92% (UHP) to 100% (ABHWV).
- MHP ABHWV compliance included: 50% for grievances and 100% for both denials and appeals. Limited data, which included small numbers, resulted in findings with a wide variance. For example, ABHWV only received one grievance during quarter 1 and quarter 2 2020. Caution is advised when interpreting results.

MCP Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths and weaknesses for each MCP based on results of the EQR activities. These strengths and weaknesses correspond to the quality, access, and timeliness of services provided to members. Qlarant adopted the following definitions for these domains:

Quality, as stated in the federal regulations as it pertains to EQR, is the degree to which a MCP "...increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement." (CFR §438.320).

Access (or accessibility), as defined by 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. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" (*NCQA Health Plan Standards and Guidelines*).

Timeliness, as stated by the Institute of Medicine is "reducing waits and sometimes harmful delays" and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in provider offices or EDs and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

Tables 33-35 highlight strengths and weaknesses for each MHT MCP. Table 36 includes ABHWV's strengths and weaknesses for the MHP program. Qlarant correlated each strength and weakness to the

quality, access, and/or timeliness of services delivered to MCP members. Only applicable domains impacted by performance are checked. Domain strengths are identified with a green check (✓). Domain weaknesses are identified with a red check (✓). In the absence of a check, the domain was not impacted by performance. Where appropriate, weaknesses include recommendations.

ABHWV

Table 33. ABHWV Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
Annual Dental Visits Care PIP			
✓	✓	✓	Strength. ABHWV received a score of 100% (high confidence). The MCP demonstrated sustained and statistically significant improvement in both PIP measures.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
✓	✓	✓	Strength. ABHWV met all PIP requirements and received a score of 100% (high confidence) for its baseline PIP submission. The PIP was methodologically sound.
Care for Adolescents PIP			
✓	✓	✓	Strength. ABHWV met all PIP requirements and received a score of 100% (high confidence) for its baseline PIP submission. The PIP was methodologically sound.
Performance Measure Validation			
✓	✓	✓	Strength. ABHWV received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
Systems Performance Review			
Information Requirements			
✓	✓	✓	Strength. ABHWV received a score of 100%. Member materials met requirements.
Availability of Services & Assurance of Adequate Capacity and Services			
	✓	✓	Strength. ABHWV provided evidence of an adequate provider network and received a score of 100%.
Quality Assessment and Performance Improvement Program			
✓			Strength. ABHWV received a score of 100% based on its quality program structure and commitment to quality improvement.
Network Adequacy Validation			
	✓	✓	Strength. ABHWV received a score of 97% with the 24/7 access requirement. Overall, survey results determined members were directed to care during non-business hours.
	✓	✓	Weakness. ABHWV scored 81% in successful provider contact. Recommendation. ABHWV should follow up with providers who could not be contacted and providers who did not comply with the 24/7 access requirement. Provider education and/or corrective action may be required.
Encounter Data Validation			
✓			Strength. ABHWV achieved an encounter data accuracy, or match rate, of 97%.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Grievance, Denial, and Appeal Focused Study			
Grievance Acknowledgement and Resolution Notification			
✓	✓	✓	<p>Weakness. ABHWV scored a 73% compliance rating for processing grievances. In many cases resolution was timely; however, member notification was not.</p> <p>Recommendation. ABHWV should determine the root cause of the lag in providing timely notification to members and make process adjustments accordingly.</p>
Denial Resolution Notification			
✓	✓	✓	<p>Strength. ABHWV scored a 99% compliance rating for processing denials.</p>
Appeal Acknowledgement and Resolution Notification			
✓	✓	✓	<p>Strength. ABHWV scored a 100% compliance rating for processing appeals.</p>

THP

Table 34. THP Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
Annual Dental Visits Care PIP			
✓	✓	✓	<p>Strength. THP received a score of 93% (high confidence). The MCP demonstrated sustained and statistically significant improvement in both PIP measures.</p>
✓			<p>Weakness. THP's interventions were not system level as they primarily targeted members. There was limited focus on provider and MCP interventions.</p> <p>Recommendation. THP should conduct a thorough barrier analysis examining member, provider, and MCP barriers. Develop and implement strategies targeting the whole system which may further influence outcomes. THP should consider engaging and partnering with federally qualified health centers or large dental providers and target members in need of preventive dental care.</p>
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
✓	✓	✓	<p>Strength. THP received a score of 95% (high confidence) for its baseline PIP submission. Overall, the PIP was methodologically sound.</p>
✓			<p>Weakness. THP's barrier analysis was limited. Only one member barrier was identified which provided limited opportunity to develop robust interventions.</p> <p>Recommendation. THP should conduct a comprehensive barrier analysis examining member, provider, and MCP barriers. The MCP should identify barriers of change so effective improvement strategies can be developed to address them.</p>

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Promoting Health and Wellness in Children and Adolescents PIP			
✓	✓	✓	Strength. THP received a score of 95% (high confidence). The MCP demonstrated improvement in one measure, BMI Percentile Documentation.
✓			Weakness. THP's PIP report included errors in results and required resubmission. Recommendation. THP should add a validation step to its reporting process to ensure accuracy of results prior to report submission.
Performance Measure Validation			
✓	✓	✓	Strength. THP received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."
Systems Performance Review*			
Information Requirements			
✓	✓	✓	Strength. THP received a score of 100%. Member materials met requirements.
Availability of Services & Assurance of Adequate Capacity and Services			
	✓	✓	Strength. THP received a score of 97%. The MCP provided evidence of an adequate provider network.
	✓		Weakness. THP did not have a policy or provider agreement requiring the provider to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. Recommendation. THP should add this requirement, noted above, to an access-related policy and the provider agreement.
Quality Assessment and Performance Improvement Program			
✓			Strength. THP received a score of 100%. The MCP's quality program demonstrated a commitment to quality improvement.
Network Adequacy Validation			
	✓	✓	Strength. THP received a score of 100% with the 24/7 access requirement. All provider offices surveyed directed members to care during non-business hours.
	✓	✓	Weakness. THP scored 84% in successful provider contact. Recommendation. THP should follow up with providers who could not be contacted. Provider education and/or corrective action may be required.
Encounter Data Validation			
✓			Strength. THP achieved an encounter data accuracy, or match rate, of 98%.
Grievance, Denial, and Appeal Focused Study			
Grievance Acknowledgement and Resolution Notification			
✓	✓	✓	Strength. THP scored a 100% compliance rating for processing grievances.
Denial Resolution Notification			
✓	✓	✓	Strength. THP scored a 96% compliance rating for processing denials.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Appeal Acknowledgement and Resolution Notification			
✓	✓	✓	Strength. THP scored a 98% compliance rating for processing appeals.

* THP developed CAPs for all noncompliant elements/components of the SPR. CAPs were approved and closed out during 2020.

UHP

Table 35. UHP Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
Annual Dental Visits Care PIP			
✓	✓	✓	Strength. UHP demonstrated sustained improvement in one measure, Annual Dental Visits for 2-3 Year Olds.
✓			Weakness. UHP executed weak interventions during MY 2019. Recommendation. UHP should implement interventions that are more rigorous, including evidence-based strategies creating change(s) in behavior. UHP should consider instituting a “gaps in care” intervention with large dental providers. By identifying members missing their annual dental visit, targeted outreach can be conducted by both the MCP and dental providers. UHP may want to engage these dental providers with incentives for reaching identified goals for routine dental visits.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence PIP			
✓	✓	✓	Strength. UHP received a score of 95% (high confidence) for its baseline PIP submission. Overall, the PIP was methodologically sound.
Follow-Up After Hospitalization for Mental Illness PIP			
✓	✓	✓	Strength. UHP received a score of 92% (high confidence). The MCP demonstrated sustained and statistically significant improvement in both PIP measures.
✓			Weakness. UHP did not demonstrate interventions were culturally or linguistically appropriate through a subpopulation analysis or identification of disparities. Recommendation. UHP should conduct appropriate subpopulation analyses; identify member demographics based on geographic area, race/ethnicity/language, health conditions, etc.; and provide evidence interventions are targeting member disparities.
Performance Measure Validation			
✓	✓	✓	Strength. UHP received an overall score of 99% (high confidence). Information systems were adequate and all measure rates were assessed as “reportable.”
✓			Weakness. UHP had data entry errors in its final rate worksheet and had to resubmit rates. Recommendation. UHP should introduce a validation step as part of the final rate submission process. This should eliminate errors in reporting rates.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Systems Performance Review*			
Information Requirements			
✓	✓	✓	Strength. UHP received a score of 100%. Member materials met requirements.
Availability of Services & Assurance of Adequate Capacity and Services			
	✓		Weakness. UHP's policy on provider network standards does not require monitoring of networks for members with limited English proficiency or physical or mental disabilities. Recommendation. UHP should amend its policy on provider network standards and require monitoring of networks for members with limited English proficiency or physical or mental disabilities.
	✓		Weakness. UHP's Member Handbook does not explain second opinions may be obtained at no cost to the member. Recommendation. UHP should add language to its Member Handbook specifying the MCP provides for a second opinion from a network provider, or arranges for the member to obtain one out-of-network, at no cost to the member.
	✓		Weakness. UHP did not have a policy requiring the MCP to coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would be if the services were furnished within the network. Recommendation. UHP should develop a policy addressing the requirement to coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would be if the services were furnished within the network.
	✓	✓	Weakness. UHP did not provide clear and consistent evidence of targeting corrective actions toward providers failing to meet network adequacy standards. Recommendation. UHP should require corrective actions of providers failing to meet network adequacy standards. The MCP should provide evidence of corrective actions. UHP should consider a tracking system such as a spreadsheet with the date the issue was identified, provider name, nature of issue, date letter sent, date resurveyed, results of resurveying, and additional follow up, if required.
	✓		Weakness. UHP did not have a policy addressing how the MCP collects and reports network changes to the State. Recommendation. UHP should develop a policy describing how the MCP collects and reports network changes to BMS.
Quality Assessment and Performance Improvement Program			
✓			Weakness. UHP submitted PIPs with errors in results. Recommendation. UHP should add a validation step in its PIP reporting process to ensure accurate results are included in reports.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Network Adequacy Validation			
	✓	✓	Strength. UHP received a score of 98% with the 24/7 access requirement. Provider offices directed members to care during non-business hours.
	✓	✓	Weakness. UHP scored 83% in successful provider contact. Recommendation. UHP should follow up with providers who could not be contacted and providers who did not comply with the 24/7 access requirement. Provider education and/or corrective action may be required.
Encounter Data Validation			
✓			Strength. UHP achieved an encounter data accuracy, or match rate, of 95%.
Grievance, Denial, and Appeal Focused Study			
Grievance Acknowledgement and Resolution Notification			
✓	✓	✓	Strength. UHP scored a 100% compliance rating for processing grievances.
Denial Resolution Notification			
✓	✓	✓	Strength. UHP scored a 96% compliance rating for processing denials.
Appeal Acknowledgement and Resolution Notification			
✓	✓	✓	Weakness. UHP did not consistently acknowledge appeals in a timely manner, nor did it consistently include all required content in the appeal notification letters. Recommendation. UHP should ensure consistent timely acknowledgement of requests for appeal and include all required documentation in the resolution notices. Specifically, for appeals not resolved wholly in favor of members, notification should include the right to request a fair hearing and other rules related to rights and procedures.

* UHP developed CAPs for all noncompliant elements/components of the SPR. CAPs were approved and closed out during 2020.

ABHWV MHP

Table 36. ABHWV MHP Strengths, Opportunities, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
This task was not completed due to the start date of the MHP program: March 1, 2020.			
Performance Measure Validation			
This task was not completed due to the start date of the MHP program: March 1, 2020.			
Systems Performance Review			
This task was not completed due to the start date of the MHP program: March 1, 2020.			
Network Adequacy Validation			
	✓	✓	Strength. ABHWV received a score of 94% with the 24/7 access requirement.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
	✓	✓	<p>Weakness. ABHWV scored 83% in successful provider contact.</p> <p>Recommendation. ABHWV should follow up with providers who could not be contacted and providers who did not comply with the 24/7 access requirement. Provider education and/or corrective action may be required.</p>
Encounter Data Validation			
This task was not completed due to the start date of the MHP program: March 1, 2020.			
Grievance, Denial, and Appeal Focused Study			
Grievance Acknowledgement and Resolution Notification			
✓	✓	✓	<p>Weakness. ABHWV scored a 50% compliance rating for processing grievances. Only 1 grievance was received during quarter 1 and quarter 2. Caution is advised when interpreting results.</p> <p>Recommendation. ABHWV should ensure timely grievance resolution and notice for all grievances.</p>
Denial Resolution Notification			
✓	✓	✓	<p>Strength. ABHWV scored a 100% compliance rating for processing denials.</p>
Appeal Acknowledgement and Resolution Notification			
✓	✓	✓	<p>Strength. ABHWV scored a 100% compliance rating for processing appeals.</p>

Assessment of Previous Recommendations

During the course of conducting 2020 EQR activities, Qlarant evaluated MCP compliance in addressing 2019 recommendations.¹⁸ Assessment outcomes are illustrated in Figures 19-20. MCP-specific recommendations and follow-up assessments are summarized in Tables 37-38. Assessments identify if the MCP adequately addressed 2019 recommendation. Green and red arrow symbols specify results:

- ▲ The MCP adequately addressed the recommendation.
- ▼ The MCP did not adequately address the recommendation.

ABHWV

ABHWV achieved 100% compliance in all EQR tasks conducted during 2019: PIP review and validation, PMV, and SPR. There were no previous annual recommendations to assess during 2020.

THP

THP complied with five of six recommendations, demonstrating an 83% compliance rating.

¹⁸ In some instances one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations per MCP should not be used to gauge MCP performance alone.

Figure 19. Assessment of THP 2019 Recommendations

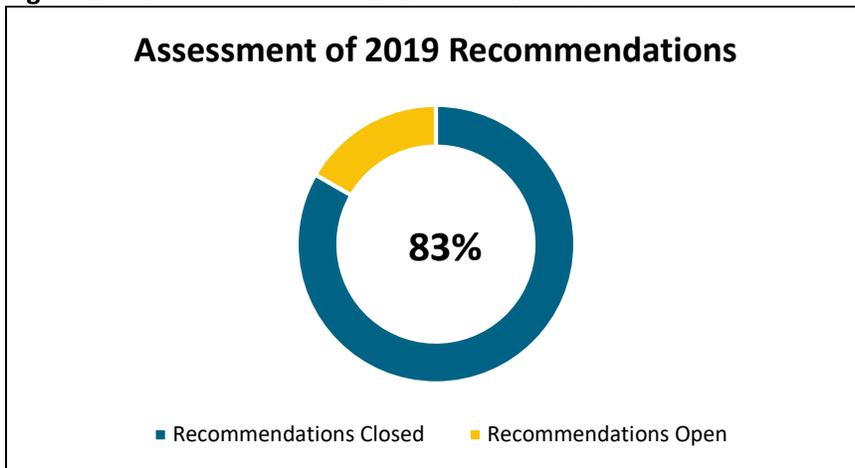


Table. 37 Assessment of THP’s Previous Annual Recommendations

2019 Recommendations	2020 Assessment
Performance Improvement Projects	
Annual Dental Visits PIP	
THP should initiate more robust interventions to drive performance improvement and provide evidence of targeting underserved subpopulations.	⚠ THP initiated additional interventions, but there was limited focus targeting provider barriers. This recommendation remains in place for 2020.
Promoting Health and Wellness in Children and Adolescents PIP	
THP should conduct a more thorough barrier analysis and identify disparities, which may need targeting. The MCP should ensure interventions are culturally and linguistically appropriate.	✅ THP addressed recommendations and met intervention requirements.
Performance Measure Validation	
THP achieved a score of 100%.	Not applicable.
Systems Performance Review	
Grievance and Appeal System	
THP should revise its grievance policy and explicitly state the member may file a grievance at any time. This language was omitted from the policy.	✅ THP updated its grievance policy as recommended.
THP should amend its appeal policy and ensure oral appeals are followed by written, signed appeals.	✅ THP revised its appeal policy as recommended.
THP should identify a grievance resolution timeframe within its grievance policy.	✅ THP updated its grievance policy as recommended.
THP should amend its appeal policy and related materials to reflect the requirement: if the MCP fails to adhere to the notice and timing requirements, the member is deemed to have exhausted the MCP’s appeal process and may initiate a state fair hearing.	✅ THP amended its appeal policy, Member Handbook, Provider Manual, and appeal letter as recommended.

UHP

UHP complied with seven of ten recommendations, demonstrating a 70% compliance rating.

Figure 20. Assessment of UHP 2019 Recommendations

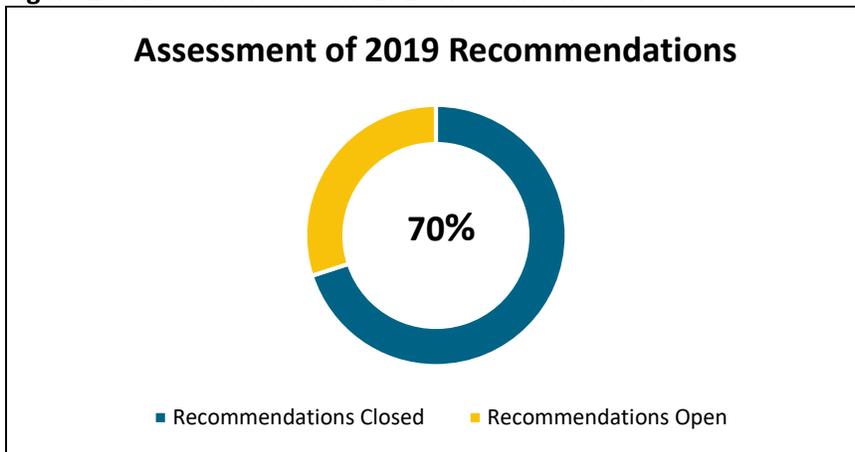


Table. 38 Assessment of UHP’s Previous Annual Recommendations

2019 Recommendations	2020 Assessment
Performance Improvement Projects	
Annual Dental Visits PIP	
UHP should develop and implement more robust interventions. UHP should conduct appropriate subpopulation analyses and identify gaps in care or disparities impacting members. Interventions should target these members.	❌ UHP did not address recommendations and they remain in place for 2020.
Follow-Up After Hospitalization for Mental Illness	
UHP should conduct appropriate subpopulation analyses and demonstrate interventions target underserved members or members with health disparities.	❌ UHP did not address the recommendation and it remains in place for 2020.
Performance Measure Validation	
UHP had data entry errors in its final rate worksheet. The MCP should implement a validation step prior to submitting rates. This validation step should improve accuracy of rates.	❌ UHP continued to include errors in its final rate worksheet. The recommendation remains in place for 2020.
Systems Performance Review	
Grievance and Appeal System	
UHP should revise its Member Handbook and grievance policy to explicitly state a member may file a grievance at any time. This requirement was omitted from materials.	✅ UHP updated its Member Handbook and grievance policy as recommended.
UHP should correct language in its grievance policy to reflect individuals making decisions on grievances and appeals are individuals who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.	✅ UHP updated its grievance policy as recommended.

2019 Recommendations	2020 Assessment
UHP should revise its appeal policy to ensure individuals who make clinical decisions on grievances and appeals are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease.	▲ UHP updated its appeal policy as recommended.
UHP should include in the language for standard appeals that the individuals who make decisions on standard appeals take into account all comments, documents, records, and other information submitted by the member or their authorized representative without regard to whether the information was submitted or considered in the initial adverse benefit determination.	▲ UHP updated its appeal policy as recommended.
UHP should revise its appeal policy and require oral appeals be confirmed in writing, unless the member or the provider requests expedited resolution.	▲ UHP updated its appeal policy as recommended.
UHP should amend its appeal policy and require appeal resolution as expeditiously as the enrollee's health condition requires and no later than the date the extension expires, if an extension is required.	▲ UHP updated its appeal policy as recommended.
UHP should document its requirement to accurately maintain records in a manner accessible to the State and CMS.	▲ UHP updated relevant policies as recommended.

State Recommendations

As identified in the Introduction of this report, BMS aims to deliver high quality, accessible care. To achieve this goal, BMS developed state quality strategies for the managed care programs. State strategies to assess and improve managed care quality are defined in Table 39.

Table 39. State Strategy for Assessing and Improving Managed Care Quality

Approach
<ul style="list-style-type: none"> Monitoring MCP compliance with managed care quality standards Assessing a variety of health care data and performance measure results Improving priority areas to maximize benefit to managed care beneficiaries
Priorities
<ul style="list-style-type: none"> Making care safer by promoting the delivery of evidence based care Engaging individuals and families as partners in care by strengthening the relationship between managed care beneficiaries and their PCPs Promoting effective communication and coordination of care Promoting effective prevention and treatment of diseases burdening managed care beneficiaries Enhancing oversight of MCP administration
Goals
<ul style="list-style-type: none"> Achieving national Medicaid average benchmarks (or higher) Improving performance by five percent (compared to baseline) Achieving 100% compliance with standards

Activities and Interventions*

- Requiring use of clinical practice guidelines
- Ensuring access to a PCP
- Reviewing member grievances and appeals
- Administering CAHPS surveys and monitoring results
- Promoting patient centered medical homes
- Promoting use of electronic health records
- Implementing performance incentives
- Conducting PIPs
- Assessing HEDIS measure results
- Conducting EQR activities
- Monitoring reporting activities and outcomes

Source: State Strategy for Assessing and Improving Managed Care (last updated October 1, 2019)¹⁹

* This list of activities and interventions is summarized. Refer to the source document for a comprehensive list.

Qlarant's EQR results assist BMS in evaluating MCP performance and progress in achieving goals. Qlarant's findings provide BMS with MCP results in many of the activities outlined in West Virginia's managed care program quality strategies. Qlarant also provides guidance on actions the MCPs should take to improve outcomes and operations. These actions, if implemented, may assist the MCPs in achieving and exceeding goals. In addition to providing MCP-specific guidance, Qlarant offers BMS the following recommendations, which should positively impact the quality, accessibility, and timeliness of services provided to MHT members:

- Continue efforts to enroll and integrate CHIP members into the MHT program, which provides opportunity to deliver high quality, accessible care to more West Virginians in a coordinated manner.
- Collaborate with Qlarant and ABHWV to identify and approve PIP topics for the MHP program.
- Review and revise quality strategy goals to continue to promote quality improvement. In some instances, the MCPs met and exceeded targets.
- Consider implementing a new PIP targeting children after closing the Annual Dental Visits project, which has been successful and should conclude within the next reporting cycle. A new PIP will allow BMS to engage the CHIP population in quality improvement activities and meet quality strategy goals.
- Promote collaboration with community partners to address social determinants of health. Encourage MCPs to screen and provide referrals for social needs. Addressing social determinants of health is critical for improving health and reducing disparities in health and health care.
- Encourage and promote use of telehealth during the COVID-19 public health emergency and beyond. Utilization of telehealth services supports multiple quality strategy priority areas. AHRQ reported clinical outcomes with telehealth are as good as or better than usual care and telehealth improves intermediate outcomes and satisfaction. Evidence of benefit is concentrated in specific areas:²⁰
 - Monitoring patients with chronic conditions
 - Communicating and counseling patients with chronic conditions
 - Providing psychotherapy as part of behavioral health

¹⁹ [State Strategy for Assessing and Improving Managed Care Quality](#)

²⁰ [Evidence Base for Telehealth](#)

- Require MCPs to identify improvement strategies for measures not meeting national Medicaid average benchmarks. Qlarant reports MCP HEDIS and CAHPS survey performance compared to benchmarks in Appendix 1 and Appendix 2. The MHT MCP averages performed better than the national averages in 63% of HEDIS measures and 53% of CAHPS survey measures. While the MCPs are outperforming national average benchmarks, opportunity for improvement continues and MCPs should strive to continuously improve performance. Results are illustrated in Figures 21 and 22.

Figure 21. MY 2019 HEDIS MCP Average Performance Compared to Benchmarks

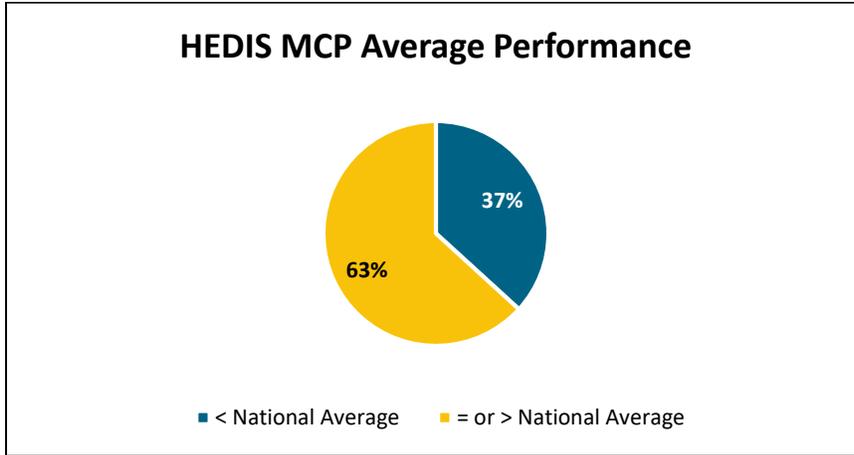
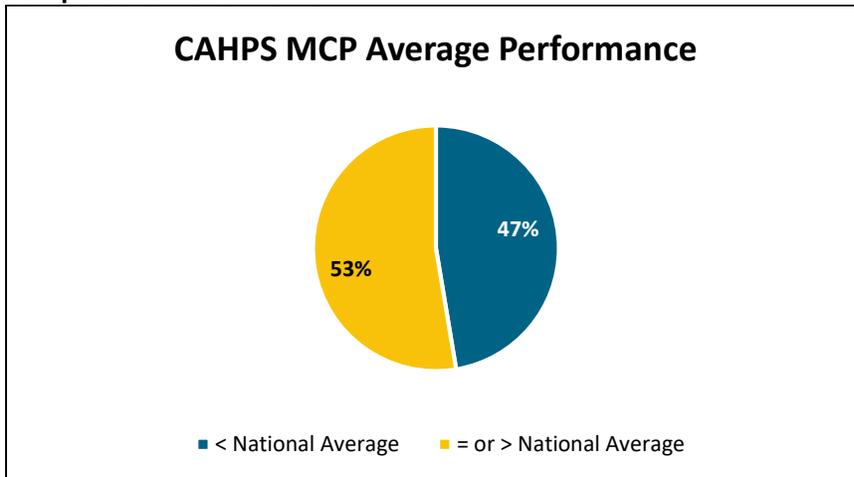


Figure 22. MY 2019 CAHPS Survey MCP Average Performance Compared to Benchmarks



Conclusion

As West Virginia’s contracted EQRO, Qlarant evaluated the MHT and MHP managed care programs to assess compliance with federal and state-specific requirements. Review and validation activities occurred over the course of 2020 and assessed MY 2019 and MY 2020 performance, as applicable. Qlarant evaluated each participating MCP and found:

- Overall, MCPs understand how to conduct PIPs in a methodical manner and achieved improvement in the BMS mandated PIP, Annual Dental Visits. In the MCP selected PIPs reporting remeasurement results, improvement was achieved in at least one project measure per MCP.
- MCPs had appropriate systems in place to process accurate claims and encounters. Measure results were assessed as “reportable.” Fifty-eight percent (58%) of audited measures, with reported results from MY 2017 to MY 2019, demonstrated a positive annual trend (consecutive annual improvement).
- MCPs demonstrated compliance with federal and state requirements in the SPR ranging from 94% to 100%. MCPs not achieving full compliance conducted CAPs, which were approved and closed through quarterly monitoring.
- There is opportunity to improve successful contact with providers after regular business hours. The MCP average was 83% and the most frequent reason for unsuccessful contact was due to the phone number not reaching the intended provider. In instances where successful provider contact was achieved, Qlarant determined provider offices appropriately directed members to care.
- An evaluation of claims data yielded a high level of encounter data accuracy as evidenced by supporting medical record documentation.
- A partial year assessment of grievances, denials, and appeals resulted in mixed MCP results; however, MHT MCP average assessments of compliance were 91% and higher. MHP ABHWV experienced a wide variation in compliance likely due to small numbers; caution is advised when interpreting results.
- MHT MCP weighted averages for HEDIS and CAHPS survey results compared favorably to national average benchmarks.

West Virginia’s MHT program continues to make strides and improve the quality of and access to health care services for its Medicaid members. These beneficial gains are expected to transfer over to the new CHIP membership. The MHP program is positioning itself to effectively engage its specialized populations. ABHWV developed the foundation required to positively impact its MHP member outcomes. BMS should continue to monitor, assess, and improve priority areas. Current efforts are resulting in improvements. Should MCPs address all recommendations, additional improvements are expected.

Appendix 1 - HEDIS® Measures Collected and Reported to NCQA

The HEDIS performance measure tables include 2020 (MY 2019) results. Results for each MCP and the Mountain Health Trust Weighted Averages (MHT - WA) are displayed. Each MCP average is also compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The MHT Weighted Average is below the NCQA Quality Compass National Medicaid HMO Average.	◆
The MHT Weighted Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75th Percentile.	◆◆
The MHT Weighted Average is equal to or exceeds the NCQA Quality Compass 75th Percentile for Medicaid HMO.	◆◆◆

Effectiveness of Care Domain

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	58.80	75.93	71.12	69.14	◆◆◆
Adult BMI Assessment	96.59	86.62	96.84	93.99	◆◆
Antidepressant Medication Management - Effective Acute Phase Treatment	52.74	61.37	56.26	56.41	◆◆
Antidepressant Medication Management - Effective Continuation Phase Treatment	36.16	47.71	40.88	41.08	◆◆
Appropriate Testing for Pharyngitis (3-17 Yrs)*	77.19	79.08	74.90	76.33	◆
Appropriate Testing for Pharyngitis (18-64 Yrs)*	63.53	62.54	59.47	61.47	◆
Appropriate Testing for Pharyngitis (65+ Yrs)*	NA	NA	^	^	NC
Appropriate Testing for Pharyngitis (Total)	73.60	73.78	71.22	72.45	◆
Appropriate Treatment for Upper Respiratory Infection (3 months-17 Yrs)*	80.40	84.78	79.09	80.57	◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Appropriate Treatment for Upper Respiratory Infection (18-64 Yrs)*	59.87	60.86	59.62	59.98	♦
Appropriate Treatment for Upper Respiratory Infection (65+ Yrs)*	NA	NA	NA	NA	NC
Appropriate Treatment for Upper Respiratory Infection (Total)	74.78	77.10	74.01	74.87	♦
Asthma Medication Ratio (5-11 Yrs)	80.52	70.83	74.48	76.19	♦♦
Asthma Medication Ratio (12-18 Yrs)	72.78	68.84	64.26	67.60	♦♦
Asthma Medication Ratio (19-50 Yrs)	59.53	57.84	55.77	57.55	♦♦♦
Asthma Medication Ratio (51-64 Yrs)	57.35	59.44	54.39	56.95	♦♦
Asthma Medication Ratio (Total)	66.15	61.73	61.55	63.12	♦♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 months-17 Yrs)*	45.13	54.73	46.22	47.71	♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64 Yrs)*	27.89	29.48	30.57	29.38	♦
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+ Yrs)*	NA	NA	NA	NA	NC
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	36.43	41.49	39.08	38.76	♦
Breast Cancer Screening	48.15	49.27	52.43	50.05	♦
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	80.00	80.00	82.02	♦♦
Cervical Cancer Screening	60.10	51.82	56.93	56.70	♦
Childhood Immunization Status - Combination 2	73.72	73.24	73.97	73.71	♦♦
Childhood Immunization Status - Combination 3	71.29	70.80	71.53	71.28	♦♦
Childhood Immunization Status - Combination 4	71.05	70.32	70.07	70.46	♦♦
Childhood Immunization Status - Combination 5	58.64	59.85	60.34	59.65	♦
Childhood Immunization Status - Combination 6	37.23	36.50	35.04	36.12	♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Childhood Immunization Status - Combination 7	58.39	59.85	59.37	59.16	♦
Childhood Immunization Status - Combination 8	37.23	36.50	34.79	36.02	♦
Childhood Immunization Status - Combination 9	32.85	33.09	31.39	32.28	♦
Childhood Immunization Status - Combination 10	32.85	33.09	31.14	32.18	♦
Childhood Immunization Status - DTaP	77.86	75.67	78.35	77.55	♦♦
Childhood Immunization Status - Hepatitis A	89.54	89.29	88.81	89.17	♦♦
Childhood Immunization Status - Hepatitis B	94.40	92.21	92.70	93.15	♦♦♦
Childhood Immunization Status - HiB	90.75	91.73	91.48	91.29	♦♦♦
Childhood Immunization Status - Influenza	45.99	41.36	39.42	42.09	♦
Childhood Immunization Status - IPV	92.94	89.05	93.67	92.33	♦♦♦
Childhood Immunization Status - MMR	89.78	89.05	89.78	89.61	♦♦
Childhood Immunization Status - Pneumococcal Conjugate	80.05	77.62	80.54	79.68	♦♦
Childhood Immunization Status - Rotavirus	73.24	72.02	72.26	72.53	♦♦
Childhood Immunization Status - VZV	90.51	89.54	88.08	89.24	♦♦
Chlamydia Screening in Women (16-20 Yrs)	43.62	39.26	38.49	40.27	♦
Chlamydia Screening in Women (21-24 Yrs)	57.21	49.56	54.51	54.21	♦
Chlamydia Screening in Women (Total)	49.46	44.13	45.33	46.37	♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	71.05	63.75	69.83	68.49	♦♦
Comprehensive Diabetes Care - Eye Exams	47.69	39.42	46.96	45.04	♦
Comprehensive Diabetes Care - HbA1c Testing	87.10	86.13	88.81	87.48	♦
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	NR	NR	NR	NR	NC
Comprehensive Diabetes Care - HbA1c Control (<8%)	52.07	49.88	52.80	51.72	♦♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) <i>Lower is Better</i>	36.01	42.09	33.58	36.82	♦♦
Comprehensive Diabetes Care - Medical Attention for Nephropathy	89.05	84.67	93.43	89.47	♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Controlling High Blood Pressure	67.88	61.56	68.86	66.44	◆ ◆
Diabetes Monitoring for People with Diabetes and Schizophrenia	72.13	71.90	78.61	74.55	◆ ◆
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	82.91	81.62	82.10	82.19	◆ ◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (13-17 Yrs)	NA	NA	NA	4.84	◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (18+ Yrs)	35.09	32.86	35.25	34.46	◆ ◆ ◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 7-Day Follow-Up (Total)	34.56	32.56	34.52	33.93	◆ ◆ ◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (13-17 Yrs)	NA	NA	NA	6.45	◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (18+ Yrs)	42.93	41.45	43.14	42.55	◆ ◆ ◆
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - 30-Day Follow-Up (Total)	42.26	41.04	42.32	41.91	◆ ◆ ◆
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (6-17 Yrs)	47.41	43.18	44.30	45.00	◆
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (18-64 Yrs)	25.60	28.50	25.49	26.39	◆
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness - 7-Day Follow-Up (Total)	30.27	31.11	31.52	30.99	◆
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (6-17 Yrs)	68.89	69.32	64.98	66.96	◆ ◆
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (18-64 Yrs)	35.69	41.03	41.05	39.17	◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness - 30-Day Follow-Up (Total)	42.79	46.06	48.67	46.01	♦
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (13-17 Yrs)*	NA	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (18-64 Yrs)*	36.44	27.53	29.02	30.68	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (65+ Yrs)*	NA	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 7-Day Follow-Up (Total)*	36.15	27.53	28.95	30.59	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (13-17 Yrs)*	NA	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (18-64 Yrs)*	53.72	51.61	47.00	50.72	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (65+ Yrs)*	NA	NA	NA	NA	NC
Follow-Up After High-Intensity Care for Substance Use Disorder - 30-Day Follow-Up (Total)*	53.56	51.61	46.89	50.63	NC
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (6-17 Yrs)	43.00	41.05	35.64	39.32	♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (18-64 Yrs)	28.71	31.60	27.97	29.30	♦
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Hospitalization For Mental Illness - 7-Day Follow-Up (Total)	32.11	33.24	29.93	31.57	♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (6-17 Yrs)	77.67	72.11	66.41	71.48	◆◆
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (18-64 Yrs)	53.65	54.14	51.01	52.80	◆◆
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (65+ Yrs)	NA	NA	NA	NA	NC
Follow-Up After Hospitalization For Mental Illness - 30-Day Follow-Up (Total)	59.38	57.26	54.94	57.04	◆◆
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	58.83	52.14	47.65	52.41	◆◆◆
Follow-Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	73.31	69.23	57.10	64.51	◆◆◆
Immunizations for Adolescents - Combination 1	87.10	86.37	83.70	85.29	◆◆
Immunizations for Adolescents - Combination 2	30.41	26.03	28.95	28.88	◆
Immunizations for Adolescents - HPV	30.66	27.01	28.95	29.14	◆
Immunizations for Adolescents - Meningococcal	88.32	87.10	84.67	86.30	◆◆
Immunizations for Adolescents - Tdap/Td	88.32	87.35	85.40	86.70	◆
Lead Screening in Children	60.10	52.52	57.18	57.12	◆
Medication Management for People With Asthma - Medication Compliance 50% (5-11 Yrs)	64.26	77.86	70.70	69.41	NC
Medication Management for People With Asthma - Medication Compliance 50% (12-18 Yrs)	61.46	78.74	64.56	66.16	NC
Medication Management for People With Asthma - Medication Compliance 50% (19-50 Yrs)	70.62	82.05	74.23	75.10	NC
Medication Management for People With Asthma - Medication Compliance 50% (51-64 Yrs)	80.54	86.46	86.91	84.68	NC
Medication Management for People With Asthma - Medication Compliance 50% (Total)	68.46	81.71	71.97	73.06	NC

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Medication Management for People With Asthma - Medication Compliance 75% (5-11 Yrs)	37.54	55.71	45.52	44.13	◆◆◆
Medication Management for People With Asthma - Medication Compliance 75% (12-18 Yrs)	34.38	62.07	38.70	41.57	◆◆◆
Medication Management for People With Asthma - Medication Compliance 75% (19-50 Yrs)	46.35	63.41	52.43	53.33	◆◆◆
Medication Management for People With Asthma - Medication Compliance 75% (51-64 Yrs)	67.03	72.40	71.73	70.42	◆◆◆
Medication Management for People With Asthma - Medication Compliance 75% (Total)	44.46	63.85	48.92	50.89	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11 Yrs)*	81.20	77.17	77.55	78.52	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17 Yrs)*	81.98	72.59	76.57	76.77	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)*	81.66	74.05	76.92	77.40	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11 Yrs)*	70.94	69.57	71.94	71.11	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17 Yrs)*	70.93	58.88	61.71	63.14	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)*	70.93	62.28	65.38	66.01	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11 Yrs)*	70.09	66.30	71.43	69.88	◆◆◆
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17 Yrs)	69.77	58.38	61.14	62.45	◆◆◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)	69.90	60.90	64.84	65.12	◆◆◆
Non-Recommended Cervical Cancer Screening in Adolescent Females <i>Lower is Better</i>	2.68	2.08	2.24	2.34	◆
Persistence of Beta-Blocker Treatment after a Heart Attack	87.27	89.22	87.93	88.11	◆◆◆
Pharmacotherapy for Opioid Use Disorder (16-64 Yrs)*	31.32	35.16	26.56	30.86	NC
Pharmacotherapy for Opioid Use Disorder (65+ Yrs)*	NA	NA	NA	NA	NC
Pharmacotherapy for Opioid Use Disorder (Total)*	31.32	35.16	26.56	30.87	NC
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	84.82	88.03	83.61	85.36	◆◆
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	85.53	83.53	70.90	79.38	◆◆◆
Risk of Continued Opioid Use >= 15 Days (18-64 Yrs) <i>Lower is Better</i>	7.33	9.60	7.11	7.83	◆
Risk of Continued Opioid Use >= 15 Days (65 Yrs) <i>Lower is Better</i>	NA	NA	^	^	NC
Risk of Continued Opioid Use >= 15 Days (Total) <i>Lower is Better</i>	7.33	9.60	7.11	7.83	◆
Risk of Continued Opioid Use >= 30 Days (18-64 Yrs) <i>Lower is Better</i>	3.59	5.10	3.30	3.87	◆
Risk of Continued Opioid Use >= 30 Days (65 Yrs) <i>Lower is Better</i>	NA	NA	NA	NA	NC
Risk of Continued Opioid Use >= 30 Days (Total) <i>Lower is Better</i>	3.59	5.10	3.30	3.87	◆
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 Yrs Male)	82.65	84.01	82.23	82.91	◆◆
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 Yrs Female)	79.89	80.92	77.86	79.39	◆◆
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	81.32	82.50	79.92	81.15	◆◆
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (21-75 Yrs Male)	68.31	74.77	74.55	72.48	◆◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (40-75 Yrs Female)	64.07	78.66	71.95	71.41	◆◆
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)	66.31	76.64	73.21	71.95	◆◆
Statin Therapy for Patients With Diabetes - Received Statin Therapy	65.69	67.07	65.73	66.09	◆◆
Statin Therapy for Patients With Diabetes - Statin Adherence 80%	64.48	72.93	68.87	68.58	◆◆
Use of Imaging Studies for Low Back Pain	65.48	64.05	66.15	65.39	◆
Use of Opioids at High Dosage (HDO) <i>Lower is Better</i>	1.49	2.24	1.54	1.73	◆◆◆
Use of Opioids From Multiple Providers - Multiple Pharmacies <i>Lower is Better</i>	3.80	2.91	1.70	2.76	◆◆◆
Use of Opioids From Multiple Providers - Multiple Prescribers <i>Lower is Better</i>	10.45	10.48	11.79	10.95	◆◆◆
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies <i>Lower is Better</i>	1.47	2.02	0.92	1.43	◆◆◆
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.02	30.91	24.68	26.87	◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (3-11 Yrs)	86.21	79.25	85.37	84.60	◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (12-17 Yrs)	84.00	85.62	85.45	85.00	◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	85.40	81.51	85.40	84.71	◆◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 Yrs)	82.38	67.92	76.42	77.04	◆◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 Yrs)	82.67	65.75	67.88	72.36	◆ ◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	82.48	67.15	72.99	75.22	◆ ◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 Yrs)	80.46	58.11	69.11	71.20	◆ ◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 Yrs)	80.67	60.96	72.73	73.17	◆ ◆
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	80.54	59.12	70.56	71.96	◆ ◆
* – New Measure introduced in MY 2019 NA – Not Applicable (Small denominator < 30) NC – No Comparison was made due to no District average rates or benchmarks NR – No Reported					

Access and Availability Domain

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Adults' Access to Preventive/ Ambulatory Health Services (20-44 Yrs)	81.75	79.14	82.07	81.21	◆ ◆
Adults' Access to Preventive/ Ambulatory Health Services (45-64 Yrs)	86.26	86.11	87.33	86.61	◆ ◆
Adults' Access to Preventive/ Ambulatory Health Services (65+ Yrs)	NA	73.58	87.18	81.13	◆
Adults' Access to Preventive/ Ambulatory Health Services (Total)	83.46	81.94	83.94	83.24	◆ ◆
Annual Dental Visit (2-3 Yrs)	40.83	36.81	41.14	40.06	◆
Annual Dental Visit (4-6 Yrs)	74.72	71.00	73.85	73.59	◆ ◆ ◆
Annual Dental Visit (7-10 Yrs)	74.55	71.41	75.11	74.27	◆ ◆
Annual Dental Visit (11-14 Yrs)	69.39	68.04	71.25	70.05	◆ ◆
Annual Dental Visit (15-18 Yrs)	61.98	59.26	61.90	61.40	◆ ◆
Annual Dental Visit (19-20 Yrs)	42.70	45.16	42.86	43.28	◆ ◆
Annual Dental Visit (Total)	65.65	62.25	66.18	65.24	◆ ◆
Children and Adolescents' Access to PCP (12-24 Months)	97.97	96.82	97.51	97.52	◆ ◆ ◆
Children and Adolescents' Access to PCP (25 Months-6 Yrs)	92.84	88.69	91.30	91.30	◆ ◆ ◆
Children and Adolescents' Access To PCP (7-11 Yrs)	96.53	91.70	93.30	94.15	◆ ◆ ◆
Children and Adolescents' Access to PCP (12-19 Yrs)	95.23	89.97	92.77	92.99	◆ ◆ ◆
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NA	NA	NA	33.33	◆
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+ Yrs)	36.31	40.13	42.38	39.64	◆

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)	36.26	39.93	42.27	39.54	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+ Yrs)	70.15	67.53	70.60	69.58	♦♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)	69.94	67.50	70.32	69.40	♦♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	26.98	25.00	34.23	30.37	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+ Yrs)	40.77	43.21	44.89	43.01	♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD – Other Drug Abuse or Dependence (Total)	40.36	42.81	44.39	42.58	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17 Yrs)	25.00	23.08	34.29	29.35	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+ Yrs)	51.24	50.57	53.35	51.81	♦♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)	50.77	50.20	52.80	51.34	♦♦♦♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17 Yrs)	NA	NA	NA	1.67	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+ Yrs)	11.22	13.60	13.32	12.70	♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)	11.06	13.43	13.10	12.51	♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17 Yrs)	NA	NA	NA	NA	NC
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18 + Yrs)	53.06	50.17	51.07	51.56	♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)	52.87	50.10	50.85	51.39	♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17 Yrs)	7.94	0.00	11.71	8.41	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+ Yrs)	11.78	13.86	14.74	13.48	♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)	16.67	13.55	14.60	13.31	♦♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA %	Comparison to Benchmarks
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17 Yrs)	5.95	0.00	10.00	6.88	♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+ Yrs)	28.48	26.70	27.22	27.51	♦♦♦
Initiation & Engagement of Alcohol & Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)	28.07	26.34	26.72	27.09	♦♦♦
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.89	94.40	88.81	92.14	♦♦
Prenatal and Postpartum Care - Postpartum Care	78.10	70.07	68.86	72.14	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11 Yrs)*	42.86	48.78	54.10	49.64	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17 Yrs)	45.10	50.67	51.03	49.82	♦
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	44.19	50.00	51.94	49.75	♦
<small>* – New Measure introduced in MY 2019 NA – Not Applicable (Small denominator < 30) NC – No Comparison was made due to no District average rates or benchmarks</small>					

Utilization Domain

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA Average %	Comparison to Benchmarks
Adolescent Well-Care Visits	65.21	42.82	70.07	62.95	♦♦
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	77.62	74.94	77.37	76.96	♦♦
Well-Child Visits in the First 15 Months of Life (0 visits)	0.97	1.44	0.24	0.77	♦
Well-Child Visits in the First 15 Months of Life (1 visit)	0.24	0.99	1.46	0.94	♦
Well-Child Visits in the First 15 Months of Life (2 visits)	2.43	2.16	3.89	3.00	♦♦
Well-Child Visits in the First 15 Months of Life (3 visits)	4.38	4.86	3.41	4.08	♦

HEDIS Performance Measures	ABHWV %	THP %	UHP %	MHT - WA Average %	Comparison to Benchmarks
Well-Child Visits in the First 15 Months of Life (4 visits)	5.84	8.73	7.54	7.26	♦
Well-Child Visits in the First 15 Months of Life (5 visits)	11.19	14.13	17.52	14.61	♦ ♦
Well-Child Visits in the First 15 Months of Life (6 or more visits)	74.94	67.69	65.94	69.34	♦ ♦

Appendix 2 – CAHPS® Survey Measure Results

The CAHPS survey measure tables include 2020 (MY 2019) results. Results for each MCP and the Mountain Health Trust Averages (MHT Averages) are displayed. Each MHT average is also compared to the NCQA Quality Compass Medicaid HMO benchmarks. Results of this comparison are made via a diamond rating system.

NCQA Quality Compass National Medicaid Percentile Ranges	Comparison to Benchmarks
The MHT Average is below the NCQA Quality Compass National Medicaid HMO Average.	♦
The MHT Average is equal to or exceeds the NCQA Quality Compass National Medicaid HMO Average, but does not meet the 75 th Percentile.	♦♦
The MHT Average is equal to or exceeds the NCQA Quality Compass 75 th Percentile for Medicaid HMO.	♦♦♦

Adult CAHPS Measures

Adult CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHT Average %	Comparison to Benchmarks
Getting Care Quickly Composite (Always+Usually)	85.83	88.04	84.14	86.00	♦♦
Getting Needed Care Composite (Always+Usually)	87.45	84.94	89.77	87.39	♦♦♦
How Well Doctors Communicate Composite (Always+Usually)	93.32	94.00	93.70	93.67	♦♦
Customer Service Composite (Always+Usually)	NA	NA	NA	NA	NC
Coordination of Care Composite (Always+Usually)	83.46	87.70	88.43	86.53	♦♦
Rating of All Health Care (8+9+10)	65.83	73.73	73.71	71.09	♦
Rating of Personal Doctor (8+9+10)	81.93	82.69	86.09	83.57	♦♦
Rating of Specialist Seen Most often (8+9+10)	76.87	81.82	81.67	80.12	♦
Rating of Health Plan (8+9+10)	70.19	76.59	78.95	75.24	♦
Flu measure - Had flu shot or spray in the nose since July 1, 2019	36.91	33.99	39.72	36.87	♦
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	73.87	74.10	78.14	75.37	♦

Adult CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHT Average %	Comparison to Benchmarks
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	48.59	49.60	51.47	49.89	◆
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	42.96	40.63	50.33	44.64	◆
*These CAHPS Measures were retired for 2020 (MY 2019) NA – Responses <100, too small to calculate a reliable rate NC – No Comparison					

Child CAHPS for General Population (GP)

Child CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHT Average %	Comparison to Benchmarks
Child Survey - General Population: Getting Care Quickly Composite (Always+Usually)	96.96	96.26	94.38	95.87	◆◆◆
Child Survey - General Population: Getting Needed Care Composite (Always+Usually)	92.60	88.55	93.15	91.43	◆◆◆
Child Survey - General Population: How Well Doctors Communicate Composite (Always+Usually)	97.30	96.41	98.15	97.29	◆◆◆
Child Survey - General Population: Customer Service Composite (Always+Usually)	NA	NA	NA	NA	NC
Child Survey - General Population- Coordination of Care Composite (Always+Usually)	90.00	82.69	90.65	87.78	◆◆
Child Survey - General Population: Rating of All Health Care (8+9+10)	83.09	85.96	89.89	86.31	◆
Child Survey - General Population: Rating of Personal Doctor (8+9+10)	91.22	91.48	92.11	91.60	◆◆
Child Survey - General Population: Rating of Specialist Seen Most often (8+9+10)	NA	NA	NA	NA	NC

Child CAHPS Survey Measures	ABHWV %	THP %	UHP %	MHT Average %	Comparison to Benchmarks
Child Survey - General Population: Rating of Health Plan (8+9+10)	81.73	88.15	85.71	85.20	♦
These CAHPS Measures were retired for 2020 (MY 2019) NA – Responses <100, too small to calculate a reliable rate NC – No Comparison					