EXTERNAL QUALITY REVIEW ORGANIZATION

West Virginia External Quality Review

Mountain Health Trust

Annual Technical Report
Final Report

Measurement Year 2015

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Bureau for Medical Services

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Commonly Used Acronyms in EQRO Reporting

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

Annual Technical Report
Executive Summary
MY 2015

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). For measurement year (MY) 2015, there were approximately 259,700 members enrolled in the MHT Managed Care Organizations (MCOs). The MCOs participating in MHT are:

- CoventryCares Health Plan, Inc. (CoventryCares)
- The Health Plan of the Upper Ohio Valley (The Health Plan)
- UniCare Health Plan of West Virginia, Inc. (UniCare)
- West Virginia Family Health (WVFH).

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

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

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

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

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

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

In accordance with 42 C.F.R. §438.364, External Quality Review Results, the State must ensure that the EQRO produces:

- A detailed technical report that describes the manner in which the data from all activities conducted were aggregated and analyzed. Based on results, assessments were made in regard to the timeliness, quality, and access to the care furnished by MCOs contracting with the State,
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's activities,
- Recommendations for improving the quality of health care services furnished by each MCO, and
- Comparative information about all MCOs, as determined by the State.

The annual detailed technical report (Annual Technical Report) is produced by Delmarva and provided to BMS. The Annual Technical Report provides information to BMS on the aggregate MHT performance for the SPR, PIP, and PMV activities, whereas this Annual Comparative Report provides the methodologically appropriate comparative information about the SPR, PIP, and PMV activities at the MCO level of analysis. This report also addresses the requirement of assessing the degree to which each MCO has effectively addressed recommendations for improving the quality of health care for its enrollees and includes recommendations for improving the quality of health care services provided to the MHT enrollees. Consistent with the detailed technical reporting requirements, the Annual Comparative Report provides a summary and comparison of each MCO's performance in the areas of quality, access and timeliness. These results can be used to promote accountability, improve important aspects of organizational achievement, and positively impact the quality and outcomes of services provided to MHT enrollees.

This report begins by providing the EQR methodology for each activity. Following the EQR methodology, the individual MCO findings are presented for the Systems Performance Reviews, Performance Improvement Projects, and Performance Measurement Validation activities respectively. Each of these sections concludes with a summary of recommendations made in the measurement year (MY) 2014 review and progress each MCO has made addressing each recommendation in MY 2015. The findings from the PIP, PMV, and SPR activities are then summarized according to quality, access and timeliness as required by the EQR regulations.

The report concludes with the strengths and recommendations that are provided for each individual MCO and the MHT program. The Appendices to this report provide detailed information to support the Annual Comparative Report findings.

Delmarva performs EQR activities in accordance with the requirements of the Balanced Budget Act (BBA) of 1997 and federal EQR regulations as outlined in Title 42 of the Code of Federal Regulations (CFR) part 438 et seq. Consistent with the regulations, Delmarva conducts a comprehensive review of the MHT MCOs and assesses their performance relative to quality of care, timeliness of obtaining needed care and services, and accessibility to those services.

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

- **Quality**, "as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge. (Centers for Medicare & Medicaid Services [CMS], 2016)

  Access (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" (National Committee for Quality Assurance [NCQA], 2015)

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes [utilization management] UM decisions in a timely manner to accommodate the clinical urgency of the situation." Further, the intent is that "the organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care." (NCQA, 2015)

Summary of Quality, Access, and Timeliness

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

Quality

The structural and operational characteristics are evaluated through the Systems Performance Review in the Quality Assessment and Performance Improvement (QA) standard. This standard is important because it assesses each MCO's internal Quality Improvement (QI) structure and its ability to improve the quality of care and services for its enrollees. Key components of the QI program such as goals and objectives, governing board oversight, quality improvement committee activity, provider participation in QI activities, clinical practice guidelines, and quality of care studies and measures are assessed as part of this standard. The MY 2015 SPR compliance rates for the QA standard for all four MHT MCOs are presented in Table 1.

Table 1. MCO SPR Compliance Rates for MY 2015- Quality Assessment and Performance Improvement

SPR Standard	MY 2015 Compliance Rate			
	CoventryCares	The Health Plan	UniCare	WVFH
Quality Assessment and Performance Improvement	100%	99%	98%	92%

All MCOs performed well in the area of quality. CoventryCares achieved full compliance while The Health Plan, UniCare had WVFH had compliance rates of 99%, 98%, and 92% respectively.

The MY 2015 SPR demonstrated the following MCO accomplishments related to quality. All four MCOs have:

- Well documented Quality Improvement Program (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- QIP plans that state that the ultimate authority of the QAPI Program rests with the MCO's governing body, the Board of Directors.
- Committee descriptions in the QIP documents that include all of the required components including committee responsibilities, a designated chairperson and responsibilities for each committee.
- Quality improvement (QI) and utilization management (UM) committees that met at least quarterly as required.
- Detailed committee meeting minutes that describe actions taken, problem identification, and resolution, as well as coordination and communication among committees.
- Completed their annual QI Program Evaluations; all were all reviewed and approved by the governing body.
- The required number of performance improvement projects (PIPs) in place.
- Participated in the mandatory Diabetes and Pediatric Asthma Emergency Department collaborative PIPs.
- Demonstrated that appropriate staff and committees are involved in the decision making process for Utilization Management (UM) and QI activities.
- UM procedures in place for making authorization decisions.
- UM procedures in place to identify over- and underutilization.

- Clinical practice guidelines (CPGs) in place, and update them at least every two years.
- CPGs and other industry acceptable criteria (e.g. InterQual and Milliman and Robertson) that are used to make UM decisions (e.g. pre-authorization of procedures).
- Procedures in place to monitor delegated credentialing entities. Delegates are held to the same standards as MCOs as demonstrated by the delegated credentialing audits and monitoring conducted by the MCOs.
- On-site pre-delegation audits are conducted prior to contracting with any delegate.
- Disease management programs in place for enrollees with special health care needs.
- Health education programs in place that are based on enrollee characteristics and needs.
- The appropriate policies and procedures in place to cover and pay for emergency and post-stabilization care services.
- Processes in place to collect the required performance data (HEDIS measures, Adult and Child Core Measures).
- Policies and procedures in place to report valid and reliable performance measures.
- Analyzed data collected in the QI and UM programs and use it for problem identification and resolution (e.g. interventions), and program planning (e.g. selection of areas for focused studies and PIPs).

MCOs have the appropriate structures and processes in place to monitor, evaluate, and improve the quality of services to the MHT enrollees using Performance Improvement Projects (PIPs). The MCOs are required to have three PIPs in place at all times. Two of the three PIPs are mandatory Collaborative PIPs including the Diabetes Collaborative and the Reducing Emergency Department (ED) Visits for Members with Asthma Collaborative. Each MCO selected its third PIP topic.

There were two PIPs related to quality in MY 2015. They are the Childhood Immunization Status (CIS) PIP conducted by UniCare, and the mandatory Diabetes Collaborative PIP conducted by all four MCOs.

In UniCare's Childhood Immunization Status - Combination 3 (CIS-3) PIP, the MCO aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. For HEDIS 2012 (MY 2011), the National Medicaid Average was 70.64%. The MCO's performance improved from the MY 2012 baseline rate of 62.04% to 68.06% for Remeasurement 3 (MY 2015). UniCare achieved sustained improvement with the third remeasurement period and is required to close this PIP.

The second PIP topic related to quality is the mandated Diabetes Collaborative in which all MCOs are required to participate. The mandatory indictor for the collaborative project is *Comprehensive Diabetes Care (CDC) - Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). All MCOs selected at least one additional HEDIS

indicator for their projects to include *Retinal Eye Exam Performed* (UniCare), and *HbA1c Testing* (CoventryCares, The Health Plan, UniCare, and WVFH) as recommended by Delmarva. The results for the mandatory indicator, *HbA1c Control <8%*, are found in Table 2.

Table 2. Mandatory Diabetes Collaborative Results

Diabetes Collaborative PIP- Mandatory Indicator Results HbA1c Control < 8%			
CoventryCares			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	41.32%
MY 2014	Remeasurement 1	45.52%	43.27%
MY 2015	Remeasurement 2	45.52%	43.16%
The Health Plan			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	45.34%
MY 2014	Remeasurement 1	46%	41.24%
MY 2015	Remeasurement 2	46%	39.63%
UniCare			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	28.73%
MY 2014	Remeasurement 1	45.52%	38.19%
MY 2015	Remeasurement 2	45.52%	46.06%
WVFH			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	39.58%

UniCare's MY 2015 rate of 46.06% for HbA1c Control < 8% exceeded the project goal of 45.52%. Both CoventryCares's and UniCare's rate for HbA1c Control < 8% improved from the Baseline (MY 2013) to Remeasurement 2 (MY 2015). Best practices for interventions for the Diabetes Collaborative that were implemented in 2015 are described below.

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

The Health Plan's Wellness and Health Promotion (WH&P) Call Center provides one-on-one personalized contact with diabetic members who are missing important services and/or testing. Claims histories are used to identify gaps in care that trigger members being placed in an outbound call queue that is updated weekly. Following the phone call from the nurse, a letter is sent to the member with a checklist of all missing services that were discussed on the call. A similar letter is sent to the member's PCP urging the PCP to assist the member in obtaining any services the member chooses to pursue.

UniCare also generates Provider Gaps in Care Reports that include member-level detail of gaps in care and distributes them to providers in hopes that they will follow-up with enrollees on the lists. In addition, the MCO has a Member Incentive Program which provides a $25 incentive for completing recommended diabetic screenings and a dilated eye exam.

WVFH implemented a member reward program in which members receive $25 gift card after completing an annual HbA1c screening with an in-network provider and $25 for completion of an annual retinal exam. The MCO began to develop a monthly HEDIS Surveillance Report which provides systematic collection, analysis, implementation, monitor and dissemination of data regarding the status of Comprehensive Diabetes Care measure.

Five measures from the PMV 2016 (MY 2015) set were used to assess quality provided by the MHT MCOs. They are:

- Immunizations for Adolescents – Combination 1
- Medication Management for People with Asthma – Total Compliance 75% or Greater
- Adult BMI Assessment
- Annual Monitoring for Patients on Persistent Medications – Total
- Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers To Quit

The MHT program performed well for three measures. The MHT-WA exceeded the 75th NMP for *Immunizations for Adolescents* and the 50th NMP for *Medication Management for People With Asthma* and *Adult BMI Assessment*. An opportunity for improvement was identified for *Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit* for CoventryCares and UniCare as the MHT-WA was below the 25th NMP and MCO rates declined between MY 2013 and MY 2015.

Access

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

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

MCOs are required to complete an annual report, supply a copy to the local DHHR offices, and inform enrollees how to access a copy. The Health Plan completed all steps, except the MCO did not inform enrollees how to access a copy of the report.

MCOs are required to maintain an advance directives policy and an appropriate treatment of minors policy. WVFH did not have a policy for either in 2015.

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

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

CoventryCares met all of the access standards. The Health Plan did not meet the 90% threshold for the Emergency Care and 24/7 access standards. UniCare did not meet the 90% threshold for Routine Primary Care, Initial Prenatal Care Visit, and 24/7 access. There is no data for WVFH as the MCO did not assess compliance for the access and availability standards in 2015 as required.

In 2014, Delmarva noted that the MCOs were not consistently meeting the threshold for the 24/7 access standard. A review of data for the five-year period from 2011-2015 shows that CoventryCares met the standard four times, The Health Plan met the standard one time, and UniCare did not meet this standard in any of the five years reviewed. As in 2014, Delmarva recommends that BMS work with the MCOs to focus on meeting this important access standard.

In regards to PIPs, all MCOs reported indicator rates for the mandatory Asthma Emergency Department (ED) Collaborative PIP. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)*, where a lower rate is better. Table 3 provides the MCO results for the Mandatory Reducing Emergency Department Visits for Members with Asthma Collaborative.

Table 3. Mandatory Reducing Emergency Department Visits for Members with Asthma Collaborative Results

Emergency Department Collaborative PIP - Mandatory Indicator Results Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits Ages 2 – 20			
CoventryCares			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	8.86%
MY 2014	Remeasurement 1	7.974%	8.67%
MY 2015	Remeasurement 2	7.974%	6.96%
The Health Plan			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	6.58%
MY 2014	Remeasurement 1	Decrease of 1 percentage point over prior year's rate	7.09%
MY 2015	Remeasurement 2	Decrease of 1 percentage point over prior year's rate	5.29%
UniCare			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	8.29%
MY 2014	Remeasurement 1	7.98%	8.38%
MY 2015	Remeasurement 2	7.98%	10.76%
WVFH			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To be determined	8.15%

Coventry Cares and The Health Plan achieved improvement from Baseline to Remeasurement 2 (where a lower rate is better). The robust interventions that were in place in MY 2015 were:

- Gaps in Care Reports (CoventryCares and UniCare).
- Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare).
- Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare).
- A Wellness and Health Promotion (WH&P) Call Center at The Health Plan allows for one-on-one personalized contact with members who are identified as having asthma. Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program.
- WVFH offered its Gateway to Life Management (GTLM) program to members with Asthma. Member interventions include a comprehensive asthma telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care (for high-risk members). Provider interventions include specific asthma training.

All MCOs are required to close this PIP due to the retirement of the mandatory Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance.

Four performance measures were validated and used to assess MCO performance for Access to Care:

- Prenatal and Postpartum Care (Postpartum Care)
- Percentage of Eligibles That Received Preventive Dental Services
- Dental Sealants for 6-9-Year-Old Children at Elevated Risk
- Annual Percentage of Asthma Patients 2 Through 20 with One or More Asthma-Related Emergency Room Visits

For Performance Measure Validation (PMV) an opportunity for improvement was identified for *Prenatal and Postpartum Care- Postpartum Care* for all MCOs as the MHT-WA did not meet the 50th National Medicaid Percentile (NMP) and the MCO rates did not improve between MY 2013 and MY 2015. The MHT-WA for *Percentage of Eligibles That Received Preventive Dental Services* improved between MY 2014 and MY 2015 but remained below the National Average of 46.0%. The MHT-WA for *Annual Percentage of Asthma Patients 2 Through 20 with One or More Asthma-Related Emergency Room Visits* did not improve between MY 2014 and MY 2015. *Dental Sealants for 6-9-Year-Old Children at Elevated Risk* is a new measure and does not provide enough information to determine opportunities for improvement.

Timeliness

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely in order not to disrupt or delay the provision of care or services

to their members. The SPR standards in place evaluate timeliness as it relates to both the provision of services and timely access to customer services. Findings for timeliness related to the MCOs are described below.

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For MY 2015, Delmarva reviewed cases, files, and logs to assess timeliness of:

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

Delmarva sampled 10 credentialing and 10 recredentialing files for each MCO. All initial credentialing applications in the sample were processed according to the MCOs policies and procedures. All provider recredentialing files in the sample were credentialed within the three-year time requirement.

A pre-delegation audit is conducted prior to contracting with any delegate. All delegated credentialing providers are held to the same timeliness standards. The MCOs provided the annual audit reports for all delegated credentialing entities.

For MY 2015, one MCO (The Health Plan) had issues with a delegated entity not responding to requests for information needed to conduct its oversight functions. The Health Plan provided a record of all correspondence with the delegate to demonstrate its attempts at securing the information needed for oversight functions. The breakdown in communication was due to a change in management. After the issue was identified, The Health Plan and the delegate worked together to bring the delegate back into compliance with its delegated credentialing responsibilities.

Delmarva reviewed each MCO's grievance log and selected a sample of 10 formal appeals cases from each MCO for review. In cases where an MCO did not have 10 appeals for MY 2015, all cases were reviewed.

The BMS/MCO contract requires MCOs to process and provide notice to affected parties regarding grievances and appeals in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance or appeal, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. All grievances reviewed were resolved timely.

All sampled appeals cases for 2015 were resolved timely, except two behavioral health cases for UniCare. The timeframe for resolution was extended beyond the timeline for the benefit of the enrollees in both cases. The MCO followed the procedures for notifying the enrollees that the MCO was extending the timeframe; Neither enrollee appealed the decision to extend the timeframe. The end result for both cases was an approval for services requested.

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

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

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported through the QAPI channels by the UM department. There were no cases on file for expedited authorizations in MY 2015.

For MY 2015, there were three PIPs that addressed timeliness. They are CoventryCares's Adolescent Well-Care Visits PIP, The Health Plan's Members' Establishment with their Primary Care Provider (PCP) PIP, and WVFH's Prenatal and Postpartum Care PIP.

CoventryCares's Adolescent Well-Care Visits PIP measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or Obstetrician/Gynecologist during the measurement year. CoventryCares realized a decrease from the baseline (42.13%) to remeasurement 4 (39.86%) and a statistically significant decrease from remeasurement 3 (50.47%) to remeasurement 4 (39.86%). Delmarva recommended that the MCO close this PIP in the last annual audit as Sustained Improvement was achieved in Remeasurement 3. The MCO did not close the PIP and realized a statistically significant decrease from Remeasurement 3 to Remeasurement 4. The MCO is now required to close this PIP, but encouraged to keep the interventions in place that the MCO has determined are effective.

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

- Well-visit drives – partnership with Marshall University Pediatrics for well-visit drives to occur several times through the end of 2015. Members completing a well-visit received a $25 Walmart gift card.

- Top 20 Provider Incentive – The top 20 PCP sites (by volume) were targeted for intensive outreach with possibility for earning a significant incentive (minimum $5,000) for improvement in their AWC rates. Provider Relations Representatives visited each of the provider sites to provide ongoing feedback, updated gaps-in-care lists for adolescent well-care, and assisted the offices in trending their own results.
- School Based Health Center (SBHC) Initiative – Two pilot sites were identified. The goal of this partnership will be to provide the SBHC with a list of the MCO's adolescents attending the school who are still in need of adolescent well-care. Permission slips were mailed to members in the area of the School Based Health Centers (SBHC) in November 2015.
- MedExpress Initiative – The plan partnered with MedExpress on a pilot program at 3 urgent care locations where PCPs working at the urgent care site would perform well care visit at the time the child was seen for sick visit, as appropriate.

The Health Plan's Members' Establishment with PCP of Record PIP was implemented in the last quarter of 2015. The MCO aims to improve the *Adolescent Well-Care Visits* (as in CoventryCares's PIP) and the *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life* rates. By encouraging members to establish with their PCP of record, the MCO believed that enrollees will be more likely to obtain routine well exams and preventive services, and may use the ED and walk-in clinics less frequently. Both indicators improved from Baseline (MY 2014) to Remeasurement 1 (MY 2015). The rate for *Adolescent Well-Care Visit* rate increased from 46.47% to 47.20% and the rate for *Well-Child in the 3rd, 4th, 5th, and 6th Years of Life* improved from 70.56% to 73.97%.

The following are some of the notable member and provider interventions that address identified barriers improve the two indicators for the project:

- The MCO provides incentive to members with a qualifying well-visit claim.
- The Wellness and Health Promotion (W&HP) Call Center - Members who are identified through claims as not having well exams or other recommended services are called by an outbound call specialist. For members who may not be established, the outbound specialist is able to help the member get established with a PCP.
- The Health Plan implemented new HEDIS certified software in 2015. The software is used to develop provider specific reports that show members who are missing services in their rosters.

WVFH submitted its first PIP for Prenatal and Postpartum Care with baseline data in MY 2015. The HEDIS Frequency of Ongoing Prenatal Care measure and the Postpartum Care- Post Partum Care indicators were selected for this project. The MCO's goal is to meet or exceed the MHT-WA for HEDIS 2014 (MY 2013) by HEDIS 2016 (MY 2015) for both indicators. The MCO's Baseline rate of 72.75% for the Frequency of Prenatal Care (≥81%) indicator fell short of the HEDIS 2014 (MY 2013) MHT Weighted Average (MHT-WA) of 74.4%. The Prenatal and Postpartum Care - Postpartum Care measure baseline rate of 51.09% did not meet the HEDIS 2014 MHT-WA goal of 62.7%.

WVFH implemented the following member and provider interventions:

- Information is also provided on the member reward program including the WVFH Maternity Rewards Program where members receive up to $150 for completing all prenatal and postpartum visits.
- Provider interventions include a $200 incentive for providing postpartum care with in the 21 to 56-day window after delivery.

For MY 2015, six performance measures were validated and assessed to represent MCO performance in the area of timeliness:

- Adolescent Well-Care Visits
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate

The MHT-WA for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* exceeded the 50th NMP and MCO rates improved between MY 2013 and MY 2015. The MHT-WA for *Adolescent Well-Care Visits* improved between MY 2013 and MY 2015 but remained below the 50th NMP. An opportunity for improvement was identified for CoventryCares with the *Adolescent Well-Care Visits* measure where the MCO rate did not improve between MY 2013 and MY 2015 and the MHT-WA did not exceed the 50th NMP. The MHT-WA improved for three out of four PQI timeliness measures between MY 2014 and MY 2015.

MHT Program Strengths, Requirements and Recommendations

Table 4 outlines specific program strengths, requirements and recommendations for the MHT Program for each area of review by the EQRO.

Table.4 MHT Program Strengths, Requirements, and Recommendations – MY 2015

MHT Program Strengths, Requirements and Recommendations for MY 2015*	
Systems Performance Review	**Strengths** ➢ The MCOs achieved rates of 98% to 100% for the Enrollee Rights Standard. ➢ The MCOs achieved rates of 92% to 100% for the Grievance System Standard. ➢ The MCOs achieved rates of 98% to 100% for the Fraud and Abuse Standard. ➢ The MCOs achieved rates of 92% to 100% for the Quality Assessment and Performance Improvement Standard. ➢ Three of four MCOs achieved full compliance for the Grievance System standard. ➢ Three of four MCOs achieved full compliance for the Fraud and Abuse standard. ➢ As required, the MCOs completed internal Corrective Action Plans (CAPs) to address any areas that were not fully compliant. All CAPs addressed the non-compliant areas and provided interventions to address the deficiencies. CAP progress reports are submitted quarterly to Delmarva for monitoring of progress toward addressing deficiencies.

<table>
<tr><th colspan="2">MHT Program Strengths, Requirements and Recommendations for MY 2015*</th></tr>
<tr><td></td><td>Recommendation
➢ The MCOs must focus efforts on consistently meeting the 24/7 access standard. Over the last four trend years, the MCOs have not consistently met this standard. Each MCO measures the compliance to this standard differently and therefore the results are not comparable across MCOs. It is recommended that BMS develop a methodology for the MCOs to use to measure 24/7 access so that the results can be comparable.</td></tr>
<tr><td rowspan="2">Performance Improvement Projects</td><td>Strengths
➢ All MCOs understand the major components of PIPs. All MCO projects have (1) relevant study topics, (2) clear study questions, (3) meaningful and well-defined indicators, (4) well-defined study populations, (5) use appropriate and valid sampling methods, (6) data collection methods that provide for the collection of valid and reliable data, (7) interventions that are reasonable and address barriers, and (8) reported the study findings accurately and clearly.
➢ All MCOs continued the mandatory Diabetes and Emergency Department PIPs.
➢ CoventryCares and UniCare achieved improvement in the mandatory Diabetes PIP indicator, HbA1c<8%.
➢ CoventryCares and The Health Plan achieved improvement in the mandatory Pediatric ED Use PIP, Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits Ages 2-20.
➢ The MCOs all have some type of Gaps in Care Reports and Provider Profiles that they are using to identify members in need of care or services for the mandatory PIPs.
➢ WVFH submitted and received approval to implement the two mandatory PIPs (Pediatric Emergency Department Use and the Diabetes Collaborative) and its Prenatal and Postpartum Care PIP.
➢ WVFH submitted baseline data for all three PIPs.
➢ The Health Plan achieved improvement for both indicators in its Member Establishment with PCP PIP.
➢ UniCare achieved Sustained Improvement for its Childhood Immunization Status – Combination 3 PIP.</td></tr>
<tr><td>Requirements
➢ All MCOs are required to close Emergency Department Collaborative PIP due to the retirement of the mandatory Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) measure (used by three MCOs) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. All the MCOs are encouraged to keep interventions in place that have been determined to be effective.
Recommendation
➢ The Quality Unit of BMS is the recipient of an Adult Quality Measures Grant through the Centers for Medicare and Medicaid Services (CMS). The Grant has a project in place to improve the post-partum care visit rate. The MCOs are required to implement the new Postpartum Care Visit (PPC) Visit and Behavioral Health Risk Assessment (BRHA) PIP. The MCO will collaborate with the Quality Unit to enhance the State’s efforts to improve the rates for prenatal Behavioral Health Risk Assessments and Postpartum Care Visits.</td></tr>
<tr><td>Performance Measure Validation</td><td>Strengths
➢ All four MCOs have established data systems and processes to calculate and report performance measures.
➢ The MCOs successfully reported all HEDIS behavioral health measures required for HEDIS 2016.
➢ All MCOs use HEDIS certified software.</td></tr>
</table>

<table>
<tr><th colspan="2">MHT Program Strengths, Requirements and Recommendations for MY 2015*</th></tr>
<tr><td></td><td>
➢ All MCOs were timely in submitting performance measures to BMS for HEDIS, CAHPS, PMV, and the Adult and Child Core Sets.
➢ The MHT-WA for the Percentage of Eligibles That Received Preventive Dental Services improved between MY 2014 and MY 2015.
➢ The MHT-WA exceeded the 75th NMP for Immunizations for Adolescents.
➢ The MHT-WA exceeded the 50th NMP for Medication Management for People With Asthma.
➢ The MHT-WA exceeded the 50th NMP for Adult BMI Assessment.
</td></tr>
<tr><td></td><td>
Requirements
The MCOs:
➢ Must be fully prepared to provide a complete and updated ISCA for next reporting period.
➢ Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for performance measures selected for validation and those that are essential for the measures used in the Withhold Program.
➢ Be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV review.
➢ Must be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017.
➢ CoventryCares and UniCare must address the Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit measure. The MHT-WA was below the 25th NMP and MCO rates declined between MY 2013 and MY 2015.
➢ CoventryCares must address the Adolescent Well-Care Visit measure where the MCO rate did not improve between MY 2013 and MY 2015 and the MHT-WA did not exceed the 50th NMP.
➢ All MCOs must address the Prenatal and Postpartum Care - Postpartum Care measure MHT-WA did not meet the 50th National Medicaid Percentile (NMP) and the MCO rates did not improve between MY 2013 and MY 2015.
</td></tr>
</table>

***Only CoventryCares, The Health Plan, and UniCare are considered in analyses where historical data is needed as this is the first year for WVFH's PIP reporting.**

Mountain Health Trust Annual Technical Report MY 2015

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). Initiated in 1996, conceptually the program was based on each Medicaid beneficiary having a medical home—a primary care provider (PCP) knowing an enrollee's medical history and managing appropriate treatment and preventive services. BMS is responsible for assuring that all MHT beneficiaries receive comprehensive, high quality healthcare services. For measurement year (MY) 2015 there were approximately 259,700 members enrolled in the four MHT Managed Care Organizations (MCOs).

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

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

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

-West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality-

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

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

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

The MY 2015 Annual Technical Report (ATR) findings provide an assessment of the MHT program based on MCO performance, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Where applicable, the findings are compared to the goals and objectives

found in the *WV Mountain Health Trust Program (Full-Risk MCO) State Quality Strategy (QS) for Assessing and Improving Managed Care Quality*. The annual technical report provides an accurate and objective portrait of the MCOs' capabilities which can be used to promote accountability, improve important aspects of organizational achievement, and positively impact the quality of services provided to MHT beneficiaries.

This report provides the results of the EQR annual assessment of the SPR, PIP, and PMV activities for MY 2015. Following the EQR methodology, the individual MCO findings for the SPR, PIP Validation, and PMV activities are presented. The findings from these activities are then summarized according to quality, access and timeliness as required by the EQR regulations. Conclusions, recommendations, and requirements are then provided for both the individual MCOs and the MHT program.

The appendices provide detailed information to support the Annual Technical Report findings:

- Appendix 1 - PIP indicator results for all projects.
- Appendix 2 - PMV results.
- Appendix 3 - HEDIS 2014-2016 MCO Rates and the Mountain Health Trust Weighted Average (MHT-WA) for all measures reported to National Committee for Quality Assurance (NCQA).
- Appendix 4 - Consumer Assessment of Health Providers and Systems (CAHPS) Survey results for MY 2013 through MY 2015.
- Appendix 5 - Summary of the Status of Recommendations from the MY 2014 Review.
- Appendix 6 – SPR Compliance Matrix

EQR Methodology

Delmarva performs EQR activities in accordance with the requirements of the Balanced Budget Act (BBA) of 1997 and federal EQR regulations as outlined in Title 42 of the Code of Federal Regulations (CFR) part 438 et seq. The SPR, PIP, and PMV assessments are conducted using the required EQR Protocols (Centers for Medicare and Medicaid Services, EQR Protocols) which are referenced in this section for each activity.(CMS, 2012)

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

- **Quality**, "as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge. (Centers for Medicare & Medicaid Services [CMS], 2016)

Access (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" (National Committee for Quality Assurance [NCQA], 2015)

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes [utilization management] UM decisions in a timely manner to accommodate the clinical urgency of the situation." Further, the intent is that "the organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care." (NCQA, 2015)

Systems Performance Review

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

Key Delmarva SPR Activities

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

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

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

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

Delmarva uses a three-point scale for scoring: *Met—100%*, *Partially Met—50%*, and *Unmet—0%*. Components for each element are scored. The component scoring is rolled up to the element level, and finally the standard

level. Aggregated results are reported by standard. BMS sets the minimum MCO compliance rating. The MCOs are required to achieve 100% compliance for each standard. MCOs not achieving 100% on any of the four standards were required to develop and implement internal corrective action plans to address all deficiencies identified.

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

Performance Improvement Projects Validation

PIPs are designed to provide a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or administrative processes. These improvements can enhance the quality of, access to, or timeliness of services provided to Medicaid beneficiaries, leading to improved health outcomes.

Delmarva uses the CMS protocol, *Validating Performance Improvement Projects—A Protocol for use in Conducting Medicaid External Quality Review Activities*, as a guideline in PIP review activities. Delmarva reviewed each MCO's PIPs, assessed compliance with contractual requirements, and validated the activity for interventions as well as evidence of improvement. Table 1 summarizes the PIP validation activities.

Table 1. Delmarva's 10 Step PIP Validation Process

PIP Validation Steps
Step 1. The **study topic** selected should be appropriate and relevant to the MCO's population.
Step 2. The **study question(s)** should be clear, simple, and answerable.
Step 3. The **study indicator(s)** should be meaningful, clearly defined, and measurable.
Step 4. The **study population** should reflect all individuals to whom the study questions and indicators are relevant.
Step 5. The **sampling method** should be valid and protect against bias.
Step 6. The **data collection procedures** should use a systematic method of collecting valid and reliable data that represents the entire study population.
Step 7. The **improvement strategies**, or interventions, should be reasonable and address barriers on a system-level.
Step 8. The **study findings**, or results, should be accurately and clearly stated. A comprehensive quantitative and qualitative analysis should be provided.
Step 9. Project results should be assessed as **real improvement**.
Step 10. Sustained improvement should be demonstrated through repeated measurements.

Performance Measure Validation

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

In an effort to uniformly measure MCO quality of care, BMS requires MCOs to report measures from nationally recognized measure sets such as CMS Adult and Child Quality Core Sets and Healthcare Effectiveness Data and Information Set (HEDIS®) measures.[1] The NCQA maintains and directs the HEDIS program.

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

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

Performance Measure Validation activities occur in three phases which are summarized in Table 2.

Table 2. Performance Measure Validation Activities

PMV Phase	Validation Activity
Pre-site Visit	Pre-site visit activities revolve around preparing for the MCO site visit. To begin the process, the auditor confirms the performance measures for review with BMS. Next, a kick-off teleconference call occurs between the auditor and the MCO to confirm the measures, measure specifications, the date for the site visit, and the agenda items for the audit. Additionally, the auditor discusses the ISCA tool and supporting documentation. The MCO completes and submits the ISCA along with program source code and other supporting documents to Delmarva. The auditor evaluates the information in the ISCA for consistency to findings reported in previous assessments, when available. Source code may be reviewed during the pre-site visit phase. Source code is the review of programming used to integrate data and calculate the rates for the performance measures. A summary of ISCA and source code issues are compiled and provide direction and points of discussion for the on-site visit.

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

On-site Visit	The auditor conducts the on-site visit and investigates any potential issues identified during the pre-site visit activities and observes the systems used by the MCO to collect and produce performance measure data. The on-site visit begins with an entrance meeting between the auditor and relevant quality and technical MCO staff. The auditor explains the validation purpose, identifies staff for interviews, and requests additional documentation where needed. Interviews are conducted and additional documentation is requested that provides insight into the accuracy and reliability of the reporting processes. The MCO is allowed to clarify any concerns and demonstrate processes. Source code may also be reviewed during the site visit. Throughout the visit, the auditor reviews the information systems structure, protocols, procedures, and data collection methodology for each specific performance measure. The on-site visit concludes with a closing conference between the auditor and MCO staff. The purpose of the closing session is to review preliminary findings, identify follow-up items, and provide guidance on areas requiring action.
Post-site Visit	After the on-site visit, all necessary action items are forwarded to the MCO with the expectation that they will be resolved before the issuance of the final report. Source code review may also be conducted post-site visit. Medical record over-read may also be conducted during the post-site visit. The auditor randomly selects a sample of 30 records each for two or more hybrid measures. The MCOs upload the selected records to the Delmarva portal where a nurse-reviewer conducts the over-read. A sample passes if the error rate is 10% or less. A sample that does not pass may lead to a corrective action plan that must be completed before the final rates are submitted. The final report reflects the final rates and whether or not the MCO has addressed all of the outstanding action items. If the MCO does not address all action items, the report will note the impact on the overall validation outcome.

All four MHT MCOs participated in the MY 2015 PMV activities. The participating MCOs were required to report sixteen performance measures from the Performance Withhold Program, Adult and Child Core Measures, and PIPs. BMS requires the submission of all Medicaid performance measures with the exception of measures that are based on carve out services such as behavioral health. Measures must be calculated according to specifications outlined in the *CMS Adult and Child Quality Core Set Specifications* and NCQA's *HEDIS*[2] *2015, Volume 2: Technical Specifications.*

The four MCOs proved to have appropriate systems and capabilities to accurately collect, calculate and report all the measures according to specifications. The MCO final rates were designated "Reportable" and approved for submission to BMS.

The sixteen performance measures validated for MY 2015 are used to assess quality, access, or timeliness of care in this report. MCO rates, the Mountain Health Trust Weighted Averages (MHT-WA), and national benchmarks for all sixteen performance measures are available in Appendix 2. The individual MCO Annual

[2] The relationship of measurement year (MY) to the HEDIS year is that the HEDIS year is always the MY plus one. For example, HEDIS 2016 (MY 2015) measures performance.

Performance Measure Validation Reports contain detailed information on the PMV findings and are available through BMS.

MHT MCO Findings

Systems Performance Review

The structural and operational characteristics of the MCOs are evaluated through the Systems Performance Review in the areas of Enrollee Rights (ER), Grievance Systems (GS), Quality Assessment and Performance Improvement (QA) and Fraud and Abuse (FA). In this section of the report, comparisons are provided for the overall MCO performance on each standard, a comparison of MCO performance on each element within each of the four standards, and finally a comparison of MCO performance across the past three measurement years (MY 2013-MY 2015). The findings for all MCOs, by standard, can be found in the Appendix.

Comparison of Overall Results by Standard

A full review of the SPRs standards was conducted to assess MCO compliance with the ER, GS, QA, and FA standards for MY 2015. The MY 2015 SPR compliance rates for all four MCOs are presented in Table 3.

Table 3. MCO SPR Compliance Rates for MY 2015

SPR Standard	MY 2015 Compliance Rate			
	CoventryCares	The Health Plan	UniCare	West Virginia Family Health
Enrollee Rights (ER)	100%	99%	100%	98%
Grievance Systems (GS)	100%	100%	100%	92%
Quality Assessment and Performance Improvement (QA)	100%	99%	98%	92%
Fraud and Abuse (FA)	100%	100%	100%	98%

Program-wide the MHT program has performed well in meeting the EQR regulatory and contract requirements for the systems performance review. Results follow:

- Overall, compliance rates across all four standards for the MCOs were 92% or greater.
- Compliance rates for the **Enrollee Rights (ER)** standard ranged from 98% to 100%.
- Compliance rates for the **Grievance System (GS)** standard ranged from 92% to 100%.
- Compliance rates for the **Quality Assessment and Performance Improvement (QA)** standard ranged from 92% to 100%.
- Compliance rates for the **Fraud and Abuse (FA)** standard ranged from 98% to 100%.
- CoventryCares achieved full compliance for all four standards.
- UniCare achieved full compliance for three of the four standards (**ER**, **GS** and **FA)**.

- CoventryCares, The Health Plan, and UniCare achieved full compliance rating for the **GS** standard,
- CoventryCares, The Health Plan, and UniCare achieved full compliance rating for the **FA** standard.
- West Virginia Family Health's (WVFH) compliance rates ranged from 92% for **GS** and **QA** to 98% for the **ER** and **FA** standards for its first on-site SPR.

These high performance rates demonstrate the MCOs' and BMS' commitment to meeting the structural and operational standards that are demonstrative of a high-quality program for the MHT enrollees. Individual MCO rates are presented below in Tables 4-7.

CoventryCares, Inc.

CoventryCares's SPR results for MY 2013-MY 2015 are presented in Table 4.

Table 4. CoventryCares SPR Compliance Rates for MY 2013-2015

Standard	Compliance Rate		
	2013	2014	2015
Enrollee Rights	98%	100%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	97%	100%	100%
Fraud and Abuse	100%	100%	100%

CoventryCares achieved SPR compliance ratings of 100% for all four standards in 2015. This is the second year in a row that the MCO achieved full compliance on all four standards.

Trending of results shows that:

- The **Enrollee Rights** standard achieved full compliance in 2014 and 2015. The issues identified in 2013 were that the Member Handbook section on Emergency Services implies, but did not specifically state that emergency services do not require preauthorization, and there was no mechanism in place to notify members how to request a copy of the MCO's Annual Report.
- CoventryCares achieved full compliance for the **Grievance Systems** standard across all three trend years.
- The **Quality Assessment and Performance Improvement** standard achieved full compliance in 2014 and 2015. The issue in 2013 was that the MCO retired case management (CM) policies and procedures. The MCO remedied this by implementing new CM procedures in 2014.
- CoventryCares achieved full compliance for the **Fraud and Abuse** standard across the three trend years.

The Health Plan

Results for The Health Plan's SPR results for MY 2013-MY 2015 are presented in Table 5.

Table 5. The Health Plan's SPR Compliance Rates for MY 2013-2015

Standard	Compliance Rate		
	2013	2014	2015
Enrollee Rights	100%	100%	99%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	99%	99%	99%
Fraud and Abuse	100%	100%	100%

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

- The Enrollee Rights standard has achieved a compliance rate of 100% for two of the last three years.
- The Grievance System Standard has maintained a 100% compliance rate for all three trend years.
- The Quality Assessment and Performance Improvement standard remained constant at 99%.
- The Fraud and Abuse standard maintained a 100% compliance rate for all three trend years.

MCOs are required to achieve a 100% compliance rate for all four standards. The Health Plan met the BMS performance requirement of 100% compliance for the **Grievance Systems** and **Fraud and Abuse** standards. The Health Plan will be required to complete an action plan to address deficiencies identified in the **Enrollee Rights** and **Quality Assessment** and **Performance Improvement** standards which both achieved a commendable 99%, falling just one percentage point short of the 100% required compliance rating.

For the **ER** standard, there was one deficiency. MCO's are required to submit their annual report to BMS by April 1 of each year and make copies of the annual report available at the local Department of Health and Human Resources offices in which it operates. The MCO must also make copies of the annual report available to its members upon request. The annual report was submitted to BMS by April 1 and copies were made available to the local DHHR offices. However, enrollees were not notified that the annual report was available upon request in 2015. It was suggested that the MCO notify members of the availability of the report and how to request a copy through the Member Handbook or enrollee newsletter.

The two deficiencies identified in the **QAPI** standard were in the area of access. There is an opportunity to improve access to emergency care and after-hours accessibility to primary care providers (PCPs) as evidenced by the 2015 compliance rates below.

Current BMS standards for timeliness and The Health Plan's 2015 compliance rates follow:

- Emergency Cases must be seen immediately or referred to an emergency facility: **85.71%**
- Urgent cases must be seen within 48 hours: **95.49%**
- Routine cases other than clinical preventive services must be seen within 21 days: **99.21%**

- An initial prenatal care visit must be scheduled within 14 days of the date on which the woman is found to be pregnant: **100%**
- 24/7 access to primary care – 76.5%

Interventions put into place following the 2015 survey are summarized below:

- Individualized letters were written to the three non-compliant providers stating reasons why they were non-compliant with after-hours access; a corrective action plan will be required from these providers.
- Follow-up after-hours calls will be completed in 1st quarter 2016.
- Individual occurrences will be entered into their respective provider files for review during recredentialing.
- Results of the survey will go to the Focus Group, a working committee of the CQI.
- Results of the survey will be reported to the QIC with recommendations from the Focus Group for any additional interventions.
- Seek Quality Improvement Committee direction for providers who remain noncompliant after 2016 follow-up and are repeat offenders.

A Corrective Action Plan (CAP) was requested by Delmarva in its Exit Letter to the MCO following the on-site Systems Performance Review. The CAP was required to address all standards that did not achieve full compliance (one in ER and two in AA). The MCO provided the required CAPs to address the non-compliant standards. The MCO is required to submit progress reports each quarter which Delmarva will review to ensure that the MCO is taking the steps outlined in its CAPs.

UniCare

The Health Plan's SPR results for MY 2013-MY 2015 are presented in Table 6.

Table 6. UniCare's SPR Compliance Rates for MY 2013-2015

Standard	Compliance Rate		
	2013	2014	2015
Enrollee Rights (ER)	99%	100%	100%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QAPI)	99%	98%	98%
Fraud and Abuse (FA)	98%	100%	100%

UniCare performed well for the 2015 review, achieving compliance rates ranging from 98% to 100%. Trending of results shows that the:

- **Enrollee Rights** standard compliance rate has remained at 100% compliance for the last two review periods.
- **Grievance Systems** standard has maintained its 100% compliance rate for the last three review periods.
- **Quality Assessment and Performance Improvement** standard compliance rate has remained consistently high across all trend years with compliance rates of 98% to 99%.
- Timeliness of scheduling appointments and PCP accessibility 24/7 have been issues for UniCare for all three trend years in the **QA** standard.
- The **Fraud and Abuse** standard maintained a high compliance rate across all three trend years ranging from 98% to 100%.

UniCare conducted an appointment wait time survey in 2015 to assess compliance with the BMS/MCO contractual appointment access standards. The appointment access standards and MCO reported compliance rates for MY 2015 are shown below.

- Urgent Care Appointment within 48 Hours: 94% (increase from 88% in 2014)
- Routine Primary Care Provider Appointment: 85% (increase from 84% in 2014)
- Prenatal Care within 14 Days of the date on which the woman was found to be pregnant: 80% (decrease from 84% in 2014)
- 24/7 Access to Primary Care: 61%

UniCare began to implement its Quality and Access to Care Incentive (QACI) Program in 2015. One part of the program is aimed at incentivizing providers to being accessible and available to its members. Provider education including face-to-face contact (via town hall meetings) and webinars are a few of the approaches to help improve compliance.

Compliance with the 24/7 standard was 61% in 2015. This compliance rate is 6 percentage points lower than 2014 and below the required compliance rate of 90%. It was noted that 39% of the providers who were non-compliant in the 2014 review were compliant in the 2015 survey.

Delmarva requested and UniCare provided a Corrective Action Plan (CAP) to address the non-compliant appointment access standards. The CAP states that UniCare has implemented a new incentive program that will pay providers a Per Member Per Month (PMPM) rate of $.25 for passing the After-hours audit and $.25 for passing the Appointment Availability audits ($.50 PMPM total). 100% of PCPs will be audited. UniCare provided several policies, procedures and documents to provide evidence that credentialing policies and procedures are in place. During the review of credentialing and recredentialing files, UniCare staff noted that the search of the SAM/EPLS database began in late 2015. However, the query of this database has been a contractual requirement for several years. A document entitled SAM Process Flowchart, V1.1 dated 8/8/14, outlined the process that is supposed to be taking place as part of the credentialing and recredentialing

process. A SAM/EPLS report for December 2015 was provided to the reviewers to demonstrate that this process was being done late in 2015.

Delmarva requested and the MCO provided a (CAP) to address the non-compliant credentialing and recredentialing issue. The CAP stated the MCO did not complete the SAMS database search on a monthly basis in 2015, but completed extracts in January, May, August, September, November, and December, 2015. The CAP also stated that the process has been established and the MCO will now complete a monthly extract/review of this database. The MCO provided progress reports on CAP quarterly in 2016 to demonstrate that the CAP has been implemented and that the required reports are being produced on a monthly basis.

WV Family Health

This is the first year that WVFH has participated in the Systems Performance Review activity.
Results for WVFH's 2015 SPR are provided in Table 7.

Table 7. MCO SPR Compliance Rates for MY 2015

Standard	Compliance Rate 2015
Enrollee Rights (ER)	98%
Grievance Systems (GS)	92%
Quality Assessment and Performance Improvement (QA)	92%
Fraud and Abuse (FA)	98%

The MCO achieved SPR compliance ratings ranging from 92% for **GS** and **QA** to 98% for **ER** and **FA**. A summary of the areas identified for improvement follow.

Enrollee Rights

The MCO achieved 98% for the **Enrollee Rights** standard. The member rights and responsibilities statement must include the right to not be discriminated against in the delivery of health care services, on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. The Your Rights and Responsibilities section of the WVFH Member Handbook does not include religion, mental or physical disability, sexual orientation, genetic information, and source of payment.

MCOs are required to maintain written policies and procedures with respect to advance directives. The 2015 WVFH Member Handbook contained a section that addressed advance directives, but there was no formal policy and procedure in place in 2015. The MCO did provide an Advance Directives policy dated January 2016, which should address this issue for 2016.

The Treatment of Minors section of the WVFH Member Handbook contains information regarding appropriate treatment of minors. However, there was no formal policy and procedure in place as required.

Grievance Systems

The MCO Achieved 92% for the **Grievance Systems** standard.

For all denials, the MCO must send a written notice to the enrollee. The MCO must adhere to the State's regulations regarding the content of the notice of action (NOA). The written NOA must include the:

- Action the MCO or its contractor has taken or intends to take.
- Reason(s) for the action.
- Enrollee's or the provider's right to file an MCO appeal.
- Procedures for exercising the rights of appeal, expedited appeal, and right to request a State Fair Hearing.
- Circumstances under which expedited resolution is available and how to request it be continued.
- The enrollees right to have benefits continue pending resolution of the appeal, how to request that benefits be continues, and the circumstances under which the enrollee may be required to pay the costs of services rendered.
- The right to include the enrollee and his or her representative or the legal representative of a deceased enrollee's estate as parties to the appeal.
- The MCO must provide to the enrollee a written notice of the resolution that includes the results of the resolution process and the date it was completed.

While the notification letters contain the majority of these components, there is no policy and procedure in place that documents the required components for the NOA. The MCO must include the required components of the NOAs in the appropriate authorization/appeals policies.

The enrollee's right to have benefits continued is explained in the attachment to the NOA, but it does not fully address the circumstances under which the enrollee can request benefits to be continued. The section entitled, To Keep Getting Your Benefits, states that members can continue to receive benefits if: an appeal is filed within 10 days of the date of the NOA, a doctor ordered the services being appealed, the time period of the original authorization has not ended, and the enrollee has notified WVFH that he/she wants to continue services. It does not state that benefits can continue if (1) the services being appealed were ordered by an authorized provider and (2) the enrollee or provider is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment.

As part of the appeal process, members must be notified that parties to the appeal can include the member, member's representative, or the legal representative of a deceased enrollee's estate. The WVFH Formal and Informal Appeals Policy states acknowledgement letter will include the member's right to meet with WVFH

during the appeal process. The policy must also state that parties may include the member's representative or the legal representative of a deceased enrollee's estate.

The MCO must provide a written notice of the resolution for all appeals that contains the resolution and the date it was completed. The WVFH Formal and Informal Appeal Policy states that the notice will include the results of the resolution, but does not address the date of the resolution. This must be added to the policy. Additionally, it is not clear if the date on the notification letter is the date the appeal was completed or the date the notice was mailed.

The MCO achieved 92% for the **Quality Assessment and Performance Improvement** standard. Areas that require improvement are listed by category below.

Access and Availability

The MCO did not have all of the required access and availability standards in the relevant documents. Although policies and procedures are in place to conduct an annual assessment, none was completed in 2015. When completed, the results should be included in WVFH's Annual Analysis of Access and Availability and in the Annual Quality Management Program Evaluation. Additionally, the MCO set 80% as its target for compliance with standards; BMS requires a 90% compliance rate.

Coordination of Care

The access standards require the MCOs to allow obstetrics and gynecology (Ob/Gyn) providers as primary care providers. The 2015 Member Handbook does not include Ob/Gyns in its list of providers available to be a PCP.

Utilization Management

The Timeframes and Procedures for Standard and Expedited Requests Notifications Policy provided for review does not address the requirement that the notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered services must be mailed at least 10 days prior to the action.

The MCO must disseminate the clinical practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. The Clinical Practice and Preventive Health Guidelines Policy describes how providers receive or can request guidelines. The policy does not address how enrollees and potential enrollees can access the guidelines. It was stated that the guidelines and criteria are available on the member website which was confirmed. However, there is no evidence that members are informed of the availability of the criteria and where to locate it.

Credentialing and Recredentialing

Credentialing and recredentialing criteria for PCPs, Ob/Gyns, and other high-volume specialists must include a visit to the provider's office, documenting a structured review of the site and medical record keeping practices to ensure conformance with the MCO standards. The Credentialing/Recredentialing of Practitioners Desktop Procedure requires PCPs and OB/GYNs to undergo a site visit to the provider's office at the time of credentialing and recredentialing. It does not include other high-volume specialists.

Additional credentialing and recredentialing criteria for dental providers must include and anesthesia permit and/or certificate from the West Virginia Board of Dental Examiners for those dental providers who induce central nervous system anesthesia. The Credentialing/Recredentialing of Practitioners Desktop Procedure addresses the dental anesthesia requirements for Pennsylvania; it does not address providers in WV.

Enrollment and Disenrollment

The Disenrollment Processing Desktop Procedure does not address the reasons the MCO cannot request disenrollment (e.g. uncooperative behavior, adverse changes in health status). In addition, the policy does not address how the MCO assures that it does not request disenrollment for reasons other than those permitted under the contract.

Member Satisfaction

The MCO did not have enough enrollees to conduct the CAHPS survey, so the MCO conducted its own survey. Survey results were shared with the Quality Improvement Committee, but not with the general provider population as required.

Medical Records

The MCO has a Medical Record Review policy that outlines the process to monitor conformance to the medical record documentation standards. The standards include the required components. Although the standards and processes are in place, medical record review was not conducted in 2015.

The MCO achieved a compliance rate of 98% for the **Fraud and Abuse** standard.

Through WVFH's management services agreements, Highmark Corporate is responsible for compliance activities, while Gateway Health Plan is responsible for fraud, waste, and abuse (FWA) activities. All FWA and compliance activities are reported through the WVFH Audit Committee which reports directly to the WVFH Board of Directors. The Gateway Fraud, Waste, and Abuse Compliance Plan (Compliance Plan) was approved by the WVFH Audit Committee in September 2015. The Compliance Plan does not refer to WVFH. Additionally, it does not describe the relationship among the entities conducting the FWA and compliance activities to WVFH. It is difficult to determine which entity is responsible for what activities and

how this relates to WVFH. The FWA and Compliance Plan documents should describe the relationship of the entities performing these activities.

The 2015 review of the Fraud, Waste, and Abuse standards was primarily a policy and procedure review as the MCO did not have enough data (small enrollment) to conduct meaningful analysis. The 2016 review will require the MCO to provide documentation (e.g. data, reports, Compliance and Audit Committee meeting minutes) to demonstrate that the required processes and procedures are in place and functioning.

Performance Improvement Projects

The BMS/MCO contract requires the MCOs to "conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction." For MY 2015 the MCOs were required to have three PIPs in place. All MCOs were required to participate in the mandatory Asthma Emergency Department (ED) Collaborative PIP and the mandatory Diabetes Collaborative PIP for MY 2015.

All four MCOs have the required three PIPs in place as summarized in Table 8. Indicator rates for all PIPs can be found in Appendix 1.

Table 8. MCO PIP Topics and Goals

MCO	PIP Topics and Goals
CoventryCares	**Improving Adolescent Well Care (AWC) Rates** – This is the third year for CoventryCares's Adolescent Well-Care visits (AWC) PIP which aims to improve the Adolescent Well-Care Visit rate. The MCO's goal is to increase the indicator rate by 5 percentage points over the prior year's rate. **Emergency Department (ED) Collaborative** – All MHT MCOs are required to participate in the Emergency Department Collaborative Project. The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* CoventryCares also selected and additional indicator for this project, *Use of Appropriate Medications for People With Asthma, ages 5-11 and 12-18.* **Diabetes Collaborative Project** – All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is *Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 (MY2013) National Medicaid Average by HEDIS 2016 (MY2015). They replaced the *Comprehensive Diabetes Care LDL-C level Control* indicator with *Comprehensive Diabetes Care – HbA1c Testing* indicator.
The Health Plan	**Member Establishment with Primary Care Provider of Record** – By encouraging members to establish with their PCP of record, the MCO hopes to improve the HEDIS rates for the *Adolescent Well-Care Visits* and the *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life* measures. Members who establish with their PCP may be more likely to obtain well exams and preventive services and may be more likely to use the ED and walk-in clinics less frequently. **Emergency Department Collaborative** – All MHT MCOs are required to participate in the Emergency Department Collaborative Project. The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* The MCO also selected an additional indicator for this project, the HEDIS *Asthma Medication Ratio.* **Diabetes Collaborative Project** – All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is *Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 (MY2013) National Medicaid Average by HEDIS 2016 (MY2015). The Health Plan also selected an additional measure, *Comprehensive Diabetes Care – HbA1c Testing,* for this project.
UniCare	**Childhood Immunization Status (CIS) Combination 3** – UniCare aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the *Childhood Immunization Status (CIS)-Combination 3* indicator. This indicator is the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influence type B (HiB); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. **Emergency Department Collaborative** – All MHT MCOs are required to participate in the Emergency Department Collaborative Project. The mandatory indicator is *Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).* The MCO also selected the HEDIS *Use of Appropriate Medications for People with Asthma* (MMA) indicators for use in this project. **Diabetes Collaborative Project** – All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is *Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 (MY2013) National Medicaid Average by HEDIS 2016 (MY2015). UniCare also selected two additional indicators for this project: *HbA1c Testing* and *Eye (Retinal) Exam Performed* and *Comprehensive Diabetes Care – HbA1c Testing.*

MCO	PIP Topic and Goals
WVFH	**Prenatal and Postpartum** Care – West Virginia lags behind national averages and Healthy People 2020 objectives in terms of preterm births and low birth weight babies. The delivery of prenatal and postpartum care services is relevant to WVFH as 36.1% of enrolled members are women of child-bearing age (ages 14-45) and prenatal care can have an impact on birth outcomes. The two indicators selected are Frequency of Ongoing Prenatal Care ≥ 81% and Prenatal Postpartum Care- Postpartum Care. The project goal is to meet or exceed the MHT Weighted Average (MHT-WA) for HEDIS 2014 (MY 2013) by HEDIS 2016 (MY 2015) for both indicators. **Emergency Department Collaborative** – All MHT MCOs are required to participate in the Emergency Department Collaborative Project. The mandatory indicator is Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20). WVFH also selected an additional indicator for this project, Medication Management for People With Asthma (MMA). For the ER indicator, WVFH's goal will be determined after baseline data is collected. WVFH's goal is to meet or exceed the HEDIS 2014 (MY 2013) MHT Weighted Average by HEDIS 2016 (MY 2015) for the MMA indicator. **Diabetes Collaborative Project** – All MHT MCOs are required to participate in the Diabetes Collaborative Project. The mandatory indicator is Comprehensive Diabetes Care-Hemoglobin A1c (HbA1c) Control (<8%). WVFH also selected an additional indicator for this project, Comprehensive Diabetes Care- HbA1c Testing.

As described in the Methodology section, the PIP Validation is a 10-step process. MCO validation results are summarized in Tables 9 through 11.

Table 9. MCO Emergency Department Collaborative PIP Validation Results for MY 2015 (Remeasurement 2)

Validation Step	Asthma Emergency Department (ED) Collaborative Results			
	CoventryCares	The Health Plan	UniCare	WVFH
1. Study topic	M	M	M	M
2. Study question(s)	M	M	M	M
3. Study indicator(s)	M	M	M	M
4. Study population	M	M	M	M
5. Sampling method	N/A	N/A	N/A	N/A
6. Data collection procedures	M	M	M	M
7. Improvement strategies	M	M	M	M
8. Study findings	M	M	M	M
9. Real improvement	M	PM	PM	N/A
10. Sustained improvement	M	U	M	N/A

M=Met: project met all requirements. PM=Partially Met: project met at least one, but not all of the requirements. U=Unmet: project did not meet any of the requirements. N/A=Not Applicable for this project.

All four MHT MCOs submitted data for the mandatory Asthma ED Collaborative PIP for MY 2015. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department*

Visits (ages 2-20). The robust interventions that were in place in MY 2015 include Gaps in Care Reports (CoventryCares and UniCare), Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare), and Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare). The Health Plan's Wellness and Health Promotion Call Center (WH&P) allows for one-on-one personalized contact with members. Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program. WVFH offered its Gateway to Lifestyle Management (GTLM) program to members with Asthma. GTLM member interventions include a comprehensive asthma telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care (for high-risk members). Case management is provided to high-risk members and provider interventions include specific training on asthma. Indicator rates can be found in Appendix 1.

Table 10. MCO Diabetes Collaborative PIP Validation Results for MY 2015

Validation Steps	MY 2015 Diabetes Collaborative Results			
	CoventryCares	The Health Plan	UniCare	WVFH
1. Study topic	M	M	M	M
2. Study question(s)	M	M	M	M
3. Study indicator(s)	M	M	M	M
4. Study population	M	M	M	M
5. Sampling method	N/A	N/A	M	M
6. Data collection procedures	M	M	M	M
7. Improvement strategies	M	M	M	M
8. Study findings	M	M	M	M
9. Real improvement	PM	PM	M	N/A
10. Sustained improvement	M	M	M	N/A

M=Met: project met all requirements. PM=Partially Met: project met at least one, but not all of the requirements. U=Unmet: project did not meet any of the requirements. N/A=Not Applicable for this project.

The mandatory indictor for the Diabetes Collaborative Project is *Comprehensive Diabetes Care (CDC)-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). For HEDIS 2012 (MY 2011), the Mountain Health Trust (MHT) Weighted Average (MHT-WA) for the *CDC - HbA1c Control (<8%)* measure was 41.3% compared to the National Medicaid Average (NMA) of 48.0%. The 6.7 percentage point difference provides an opportunity for improvement.

All MCOs have selected at least one additional HEDIS indicator for their projects to include *Retinal Eye Exam Performed* (UniCare), and *HbA1c Testing* (CoventryCares, The Health Plan, UniCare, and WVFH).

The mandatory Diabetes Collaborative PIP was developed in MY 2012 and was implemented by three MCOs in MY 2013. WVFH implemented the PIP in MY 2015. Best practices for interventions in place in MY 2015 for the Diabetes Collaborative have been identified in the MCO annual project submissions are summarized below.

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

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

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

WVFH implemented a member reward program in which members receive a $25 gift card after completing their annual HbA1c screening with an in-network provider and $25 for completion of an annual retinal exam. The MCO developed a Diabetes Surveillance Report which includes systematic collection, analysis, implementation, and dissemination of data regarding the status of Comprehensive Diabetes Care measure. These reports also aid in assessing intervention success.

Table 11. MCO Selected PIP Projects

Validation Steps	Coventry Cares	The Health Plan	UniCare	WVFH
	Adolescent Well-Care Visits	Members Establishment with PCP of Records	Childhood Immunization Status – Combination 3	Prenatal and Postpartum Care
1. Study topic	M	M	M	M
2. Study question(s)	M	M	M	M
3. Study indicator(s)	M	M	M	M
4. Study population	M	M	M	M
5. Sampling method	M	M	M	M
6. Data collection procedures	M	M	M	M
7. Improvement strategies	M	M	M	M
8. Study findings	M	M	M	M
9. Real improvement	M	PM	PM	N/A
10. Sustained improvement	U	N/A	M	N/A

M=Met: project met all requirements. PM=Partially Met: project met at least one, but not all of the requirements.
U=Unmet: project did not meet any of the requirements. N/A=Not Applicable for this project.

CoventryCares's Adolescent Well-Care (AWC) Visits project measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well care visit with a PCP or Obstetrician/Gynecologist during the measurement year. CoventryCares achieved an increase in the indicator rate from a baseline rate of 42.13% in MY 2011 to the Remeasurement 2 rate of 50.47% in MY 2014. CoventryCares realized a decrease from the baseline (42.13%) to remeasurement 4 (39.86%) and a statistically significant decrease from remeasurement 3 (50.47%) to remeasurement 4 (39.86%). Interventions such as face-to-face education of providers about medical record documentation, outreach calls to non-compliant members, provider report cards, and EPSDT reminder systems target identified barriers and the MCO achieved improvement for three out of four remeasurement periods. The MCO was required to close this project and submit a new proposal to Delmarva.

Interventions identified as best practices in the review of CoventryCares's AWC project are listed below:

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

The Health Plan's Member Establishment with PCP of Record aims to encourage members to establish with their PCP of record. The MCO hopes that this will improve the HEDIS rates for the *Adolescent Well-Care Visits* (AWC) and the *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34)* measures. Members who establish with their PCP may be more likely to obtain well exams and preventive services and may be more likely to use the ED and walk-in clinics less frequently. Baseline data for MY 2014 was provided for this PIP as it was implemented in the second half of 2015. Both indicators showed slight improvement from Baseline to the first remeasurement period. AWC increased from 46.47% to 47.20% and W34 increased from 70.56% to 73.97%.

Notable interventions from the project include:

- Incentive Program - The MCO provides incentives to members with a qualifying well-visit claim. When a qualifying claim is received, a letter is sent to the member notifying them that they are eligible for the incentive and directions are provided on how to claim the incentive.
- The Wellness and Health Promotion (W&HP) Call Center - Members who are identified through claims as not having well exams or other recommended services are called by an outbound call specialist. The call specialist discusses missing services and verifies the member's PCP. When PCPs of record are identified as being wrong, THP changes and updates to the member's correct PCP. For members who may not be established, the outbound specialist is able to help the member get established with a PCP.
- Use of HEDIS Certified Software - In late 2015, The Health Plan implemented new HEDIS certified software. The software provides detailed information specific to providers or provider groups to show which members need well exams, as well as other services. Analysts use the software to drill down to the provider level to produce reports that show providers the specific members on their rosters that are missing services.

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

Medicaid Average was 70.64%. The MCO's performance improved from the MY 2012 baseline rate of 62.04% to 68.06% for Remeasurement 3 (MY 2015). The MCO is required to close the PIP since sustained improvement was achieved in Remeasurement 3. The MCO was required select a new topic to replace the PIP and submit a proposal to Delmarva for approval.

Most notable interventions for this PIP include:

- Well-Baby Care Visit Incentive Program which provides a $50 incentive for parents/caregivers when a child completes six of eight well visits by 15 months of age.
- Clinic Days were scheduled. Providers block appointment times (sometimes outside of regular office hours to improve access/availability) and UniCare conducts member outreach to fill appointment slots. UniCare reminds members of appointments in advance and addresses potential barriers, such as transportation. On the day of the event, UniCare coordinates the schedule and provides additional health education to members.
- The Quality and Access to Care Initiative (QACI) Program was implemented. One part of the program is aimed at incentivizing providers to being accessible and available to its members. Provider education including face-to-face contact (via town hall meetings) and webinars are used to educate and improve compliance with specific HEDIS measures.

WVFH submitted its first PIP for Prenatal and Postpartum Care with baseline data in MY 2015. The MCO chose two HEDIS indicators, Frequency of Ongoing Prenatal Care (FOP) Postpartum Care- Post Partum Care (PPC) indicator. The MCO's goal was to meet or exceed the MHT-WA for HEDIS 2014 (MY 2013) by HEDIS 2016 (MY 2015) for both indicators. The MCO's rate of 72.75% for the Frequency of Prenatal Care (≥81%) indicator fell short of the HEDIS 2014 (MY 2013) MHT Weighted Average (MHT-WA) of 74.4%. The Prenatal and Postpartum Care - Postpartum Care measure rate of 51.09% did not meet the HEDIS 2014 MHT-WA goal of 62.7%.

WVFH implemented the following member and provider interventions:

- The Gateway to Lifestyle Management (GTLM) MOM Matters® program which includes a welcome packet to qualified members. The packet includes a welcome letter, education material on pregnancy, depression through pregnancy, smoking cessation and domestic violence.
- Information is also provided on the member reward program including the WVFH Maternity Rewards Program where members receive up to $150 for completing all prenatal and postpartum visits.
- The provider intervention is a $200 incentive for providing postpartum care with in the 21 to 56-day window after delivery.

The indicator rates for all PIPs can be found in Appendix 1.

Overall Comparison of MCO Performance on Validation Steps

A comparison of the MCOs' performance on the PIP Validation process shows that all twelve projects in place (three for each MCO) for MY 2015 fully met the requirements for Steps 1-8, where applicable. Specifically, this means that all four MCOs:

- Selected study topics that were appropriate and relevant to their populations.
- Developed study questions that were clear, simple, and answerable.
- Selected study indicators that are meaningful, clearly defined, and measurable.
- Defined the study population by describing the individuals who are eligible for and relevant to the topic.
- Used an appropriate sampling methodology.
- Have data collection procedures in place that include a systematic method of collecting valid and reliable data that represents the entire population.
- Have improvement strategies, or interventions, in place that are reasonable and address barriers on a system-level.
- The study findings, or results, are accurately and clearly stated.

Two of the MCOs did not achieve Real Improvement (Step 9). The Health Plan's Members Establishment with PCP of Record PIP achieved improvement in both indicators (AWC and W34) from Baseline to Remeasurement 1, but the improvement was not significant. UniCare's Childhood Immunization Status – Combination 3 indicator achieved improvement each year, but the improvement was not statistically significant.

Two of the MCO selected PIPs failed to meet the requirement targeting Sustained Improvement (Step 10). The Health Plan's Emergency Department PIP achieved improvement between Remeasurement 1 and Remeasurement 2 for the Annual Percentage of Asthma with One or More Asthma-Related Emergency Department Visits (age 2-20) indicator. However, the improvement was not sustained as the indicator decreased between Baseline and Remeasurement 1. CoventryCares's Adolescent Well-Care PIP also did not achieve Sustained Improvement. The rate decreased significantly between Remeasurement 3 and Remeasurement 4.

Status of Recommendations from the MY 2014 Review and MY 2015 Current Status

Delmarva provided recommendations to all three MCOs in the MY 2014 review for the PIP activities with the expectation that these would be considered by the MCOs. A summary of the recommendations made and the actions, if any, that have been undertaken by each MCO in MY 2015 to address the recommendations made in the MY 2014 review are summarized in Appendix 4. The detailed PIP Validation findings for MY 2015 can be found in each MCOs PIP Validation Report available through BMS. The indicator rates for all PIP projects are provided in Appendix 1 of this report.

Performance Measure Validation

All four MHT MCOs were required to participate in the PMV for MY 2015. The MCOs successfully reported all performance measures required by BMS. The following analysis compares MCO results for Withhold and other PMV performance measures used to represent quality, access, and timeliness.

MHT Quality Strategy (QS) and Performance Withhold Program

The *West Virginia Mountain Health Trust Program State Quality Strategy for Assessing and Improving Managed Care Quality* (Quality Strategy) was updated in 2013 and identified the following five priorities:

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

Recognizing that performance measurement is essential to monitoring and improving quality, BMS selected performance measures that align its requirements with national, state, and local objectives. The performance measures are chosen from national sources and reflect the priorities outlined in the Quality Strategy. The 12 measures selected for PMV are implemented in different programs, such as the Performance Withhold Program, to monitor and improve quality of services provided by the MCOs. The Performance Withhold Program objective is for MCOs to improve performance for the selected measures in order to earn back the 5% of their capitation payments that are withheld.

For MY 2015, BMS selected eight HEDIS measures for the program (*Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, Adolescent Well-Care Visits, Immunizations for Adolescents, Medication Management for People with Asthma - 75% Compliance, Prenatal and Postpartum Care - Postpartum Care, Adult BMI Assessment, Annual Monitoring for Patients on Persistent Medications - Total,* and *Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit)*. Each MCO received a portion of its withhold for each MY 2015 measure that met or exceeded the corresponding 2015 HEDIS (MY 2014) National Medicaid Average (NMA).

Table 12 provides the MCO rates for MY 2013-MY 2015 and their corresponding MY 2014 NMA.

Table 12. WV MHT Withhold Measures.

Measure	CoventryCares			The Health Plan			UniCare			WVFH	NMA MY 2014* %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %	
Medication Management for People With Asthma: Medication Compliance 75% (Total)	30.7%	32.3%	31.1%	37.5%	33.8%	37.0%	42.4%	38.5%	32.6%	^	30.6%
Immunizations for Adolescents - Combination 1	83.4%	84.3%	83.9%	83.2%	84.4%	81.3%	78.0%	80.5%	84.3%	^	71.3%
Prenatal and Postpartum Care - Postpartum Care	60.6%	55.0%	59.4%	62.8%	61.6%	63.0%	64.9%	61.7%	57.1%	51.1%	61.8%
Adolescent Well-Care Visits	47.2%	50.5%	39.9%	43.1%	46.5%	47.2%	41.2%	41.9%	51.9%	49.9%	50.0%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	73.7%	77.8%	72.1%	71.3%	70.6%	74.0%	66.9%	69.0%	74.9%	62.5%	71.9%
Adult BMI Assessment (ABA)	71.5%	85.0%	90.6%	67.9%	72.0%	83.0%	63.1%	75.7%	90.3%	^	79.8%
Annual Monitoring for Patients on Persistent Medications - Total (MPM) - Total	^	81.8%	82.4%	^	84.2%	84.5%	^	85.8%	84.8%	93.2%	86.8%
Medical Assistance with Smoking and Tobacco Use Cessation - (MSC) Advising Smokers To Quit	75.0%	69.3%	67.7%	74.6%	77.4%	75.0%	73.6%	74.2%	69.1%	74.8%	75.8%

*National Medicaid Average is from HEDIS Quality Compass 2015 (MY 2014) is used only for Performance Withhold Program.
^Measure not collected or denominator too small (less than 30 observations) to calculate a reliable rate.

For MY 2015, The Health Plan and UniCare compared favorably to the NMA for five of eight measures. CoventryCares compared favorably to the NMA for 4 measures and WVFH compared favorably to one measure.

The Health Plan compared favorably to the NMA for the following measures:

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

UniCare compared favorably to the NMA for the following measures:

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

CoventryCares compared favorably to the NMA for the following measures:

- Medication Management for People with Asthma - Total 75% Compliance
- Immunizations for Adolescents - Combination 1
- Adult BMI Assessment
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

WVFH compared favorably to the NMA for *Annual Monitoring for Patients on Persistent Medications - Total.*

All MCOs compared unfavorably to the NMA for *Medical Assistance with Smoking and Tobacco Use Cessation, Advising Smokers to Quit.*

In the following sections, performance measures are presented which assess Quality, Access, and Timeliness. The star rating system in Table 6 is utilized through the discussion to compare the MHT Weighted Averages (MHT-WA) to the 2016 HEDIS (MY 2015) National Medicaid Percentiles (NMPs). Ratings can be from one star indicating the MHT-WA was equal to the 25th NMP or less to five stars where the MHT-WA is greater than the 90th NMP. *The star rating system is only applicable to HEDIS measures as national benchmarks are available.*

Table 13. Star Ratings for Performance Measure Tables.

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

Quality Performance Measures

Five HEDIS indicators from the PMV activities assess the quality of care provided by the MHT MCOs. The HEDIS 2014 (MY 2013) through HEDIS 2016 (MY 2015) MHT Weighted Averages (MHT-WAs) are provided in the table below with the National Medicaid Percentile (NMP) comparisons.

Table 14. Quality Performance Measures.

Measure Name and Goal	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015*
Immunizations for Adolescents - Combination 1	80.7	82.5	83.6	★★★★
Medication Management for People With Asthma - Total, Compliance 75%+	33.9	35.8	32.8	★★★
Adult BMI Assessment	66.9	78.8	89.2	★★★
Annual Monitoring for Patients on Persistent Medications - Total	^	84.1	84.2	★
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	74.4	73.6	71.7	★

***Star ratings are based on the HEDIS 2016 (MY 2015) Quality Compass. Refer to Table 13 for details.**

The MHT performed well for three out of five quality performance measures. The MHT-WA exceeded the 75th NMP for *Immunizations for Adolescents-Combination 1* and improved each year between MY 2013 and MY 2015. *Medication Management for People With Asthma-Total Compliance 75%* exceeded the 50th NMP but did not

improve each year b between MY 2013 and MY 2015. The MHT-WA for the Adult BMI Assessment exceeded the 50th NMP and improved each year between MY 2013 and MY 2015. The MHT-WA for *Annual Monitoring for Patients on Persistent Medications* did not exceed the 25th NMP and the MHT-WA was consistent between MY2014 and MY 2015. An opportunity for improvement was identified for *Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers To Quit* where the MHT-WA did not exceed the 25th NMP and rates declined each year between MY 2103 and MY 2015.

Access Performance Measures

Four measures were used to assess MHT performance for accessibility of health care services:

- Prenatal and Postpartum Care - Postpartum Care
- Percentage of Eligibles That Received Preventive Dental Services
- Dental Sealants for 6-9-Year-Old Children at Elevated Risk
- Annual Percentage of Asthma Patients 2 Through 20 with One or More Asthma-Related Emergency Room Visits

Table 15 provides the MHT-WA for three years and a comparison to national benchmarks for each measure.

Table 15. Access Performance Measure Results.

Measure Name	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015*
Prenatal and Postpartum Care - Postpartum Care	62.7	59.1	58.5	★★
Percentage of Eligibles That Received Preventive Dental Services	^	27.1**	32.8**	46.0+
Dental Sealants for 6-9 Year Old Children at Elevated Risk	^	^	1.6	^
Annual Percentage of Asthma Patients 2-20 Years Old with One or More Asthma-Related Emergency Room Visits (lower score is better)	^	8.1**	8.8**	^

***Star ratings are based on the HEDIS 2015 (MY 2014) Quality Compass. Refer to Table 13 for details.**
****Indicates the MHT-WA is a simple average for the indicated measure.**
+ National Medicaid Average from the HHS Report FFY 2015.
^ Measure not collected or no national benchmark available.

The MHT-WA for *Prenatal and Postpartum Care- Postpartum Care* fell below the 50th NMP and declined between MY 2013 and MY 2015. The MHT-WA for *Percentage of Eligibles That Received Preventive Dental Services* improved between MY 2014 and MY 2015 but compared unfavorably to the National Medicaid Average. The MHT-

WA for *Annual Percentage of Asthma Patients 2-20 Years Old with One or More Asthma-Related Emergency Room Visits* did not improve between MY 2014 and MY 2015.

For access measures, an opportunity for improvement was identified for *Prenatal and Postpartum Care-Postpartum Care* where the MHT-WA was below the national benchmark and declined over the three year period between MY 2013 and MY 2015. National benchmarks are not available for *Dental Sealants for 6-9 Year Old Children at Elevated Risk* and *Annual Percentage of Asthma Patients 2-20 Years Old with One or More Asthma-Related Emergency Room Visits.*

Timeliness Performance Measures

Six measures validated for MY 2015 were selected to assess performance for timeliness of care. The measures include:

- Adolescent Well-Care Visits
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate

Table 16 provides the MHT-WAs for three years and comparison to national benchmarks.

Table 16. HEDIS Performance Measures for Timeliness.

Measure Name	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015*
Adolescent Well-Care Visits	43.6	45.7	46.9	★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	70.0	72.6	73.6	★★★
PQI 01: Diabetes Short-Term Complications Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	^	14.6**	8.03	^
PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	^	28.1**	12.74	^

Measure Name	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015*
PQI 08: Heart Failure Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	^	0.8**	2.21	^
PQI 15: Asthma in Younger Adults Admission Rate (Observed rate per 100,000 member months) (lower rate is better)	^	7.2**	2.00	^

***Star ratings are based on the HEDIS 2016 (MY 2015) Quality Compass. Refer to Table 13 for details.**
****MHT-WA is a simple average for this measure.**
^Measure not reported or no national benchmark available.

The MHT-WA for *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life* exceeded the 50th NMP and improved each year between MY 2013 and MY 2015. The MHT-WA for *Adolescent Well-Care Visits* improved also between MY 2013 and MY 2015 but did not meet the 50th NMP. The MHT-WA improved between MY 2014 and MY 2015 for three of the four PQI admission rates. *PQI 08: Heart Failure Admission Rate* did not improve between years. No opportunities for improvement were identified for timeliness measures.

Summary of Quality, Access, and Timeliness

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

Summary of Quality

Quality, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2016).

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

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

The MY 2015 SPR compliance rates for the QA standard for all four MHT MCOs are presented in Table 17.

Table 17. MCO SPR Compliance Rates for MY 2015 - Quality Assessment and Performance Improvement

SPR Standard	MY 2015 Compliance Rate			
	CoventryCares	The Health Plan	UniCare	WVFH
Quality Assessment and Performance Improvement	100%	99%	98%	92%

All MCOs performed well in the area of quality. CoventryCares achieved full compliance while The Health Plan, UniCare, and WVFH had compliance rates of 99%, 98%, and 92% respectively.

The MY 2015 SPR demonstrated the following MCO accomplishments related to quality. All four MCOs have:

- Well documented Quality Improvement Program (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- QIPs that state that the ultimate authority of the QAPI Program rests with the MCO's governing body, the Board of Directors.
- Committee descriptions in the QIP documents that include all of the required components including committee responsibilities, a designated chairperson and responsibilities for each committee.
- Quality improvement (QI) and utilization management (UM) committees that met at least quarterly as required.
- Detailed committee meeting minutes that describe actions taken, problem identification, and resolution, as well as coordination and communication among committees.
- Completed their annual QI Program Evaluations; all were all reviewed and approved by the governing body.
- The required number of performance improvement projects (PIPs) in place.
- Participated in the mandatory Diabetes and Pediatric Asthma Emergency Department collaborative PIPs.

- Demonstrated that appropriate staff and committees are involved in the decision making process for Utilization Management (UM) and QI activities.
- UM procedures in place for making authorization decisions.
- UM procedures in place to identify over- and under-utilization.
- Clinical practice guidelines (CPGs) in place, and update them at least every two years.
- CPGs and other industry acceptable criteria (e.g. InterQual and Milliman and Robertson) that are used to make UM decisions (e.g. pre-authorization of procedures).
- Procedures in place to monitor delegated credentialing entities. Delegates are held to the same standards as MCOs as demonstrated by the delegated credentialing audits and monitoring conducted by the MCOs.
- On-site pre-delegation audits are conducted prior to contracting with any delegate.
- Disease management programs in place for enrollees with special health care needs.
- Health education programs in place that are based on enrollee characteristics and needs.
- The appropriate policies and procedures in place to cover and pay for emergency and post-stabilization care services.
- Processes in place to collect the required performance data (HEDIS measures, Adult and Child Core Measures).
- Policies and procedures in place to report valid and reliable performance measures.
- Analyzed data collected in the QI and UM programs and use it for problem identification and resolution (e.g. interventions), and program planning (e.g. selection of areas for focused studies and PIPs).

MCOs have the appropriate structures and processes in place to monitor, evaluate, and improve the quality of services to the MHT enrollees using Performance Improvement Projects (PIPs). The MCOs are required to have three PIPs in place at all times. All MCOs have the required PIPs in place, including two mandatory Collaborative PIPs: Diabetes Collaborative PIP and Reducing Emergency Department (ED) Visits for Members with Asthma Collaborative PIP.

There were two MCO PIP topics related to quality in MY 2015. They are Childhood Immunization Status (CIS) conducted by UniCare and the Diabetes Collaborative (all three MCOs).

In UniCare's Childhood Immunization Status Combination 3 (CIS-3) PIP, the MCO aims to meet or exceed the previous year's NCQA Quality Compass National Medicaid Average for the percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday. For HEDIS 2012 (MY 2011), the National Medicaid Average was 70.64%. The MCO's performance improved from the MY 2012 baseline rate of 62.04% to 68.06% for Remeasurement 3 (MY 2015). UniCare achieved sustained improvement with the third remeasurement period and is required to close this PIP.

The final PIP topic related to quality is the mandated Diabetes Collaborative in which all three MCOs are required to participate. The mandatory indictor for the collaborative project is *Comprehensive Diabetes Care (CDC)-Hemoglobin A1c (HbA1c) Control (<8%)* with the goal to meet or exceed the HEDIS 2014 National Medicaid Average (45.4%) by HEDIS 2016 (MY 2015). All MCOs have selected at least one additional HEDIS indicator for their projects to include *Retinal Eye Exam Performed* (UniCare), and *HbA1c Testing* (CoventryCares, The Health Plan and UniCare) as recommended by Delmarva.

For HEDIS 2012 (MY 2011), the Mountain Health Trust (MHT) Weighted Average (MHT-WA) for the *CDC - HbA1c Control (<8%)* measure was 41.3% compared to the National Medicaid Average (NMA) of 48.0%, resulting in a 6.7 percentage point difference and providing opportunity for improvement. The results for the mandatory indicator, *HbA1c Control <8%*, are found in Table 18.

Table 18. Mandatory Diabetes Collaborative PIP Results

Diabetes Collaborative PIP – Mandatory Indicator Results HbA1c Control < 8%			
CoventryCares			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) NMA by HEDIS 2016 (2015)	41.32%
MY 2014	Remeasurement 1	45.52%	43.27%
MY 2015	Remeasurement 2	45.52%	43.16%
The Health Plan			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) NMA by HEDIS 2016 (2015)	45.34%
MY 2014	Remeasurement 1	45.52%	41.24%
MY 2015	Remeasurement 2	45.52%	39.63%
UniCare			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) NMA by HEDIS 2016 (2015)	28.73%
MY 2014	Remeasurement 1	45.52%	38.19%
MY 2015	Remeasurement 2	45.52%	46.06%
WVFH			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	45.52%	39.58%

UniCare's MY 2015 rate of 46.06% for HbA1c Control < 8% exceeded the project goal of 45.52%. Both CoventryCares's and UniCare's rate for HbA1c Control < 8% improved from the Baseline (MY 2013) to Remeasurement 2 (MY 2015).

Best practices for interventions for the Diabetes Collaborative that were implemented in 2015: CoventryCares produces a Practitioner Report annually to high-volume practices including data about diabetes and other diseases. In addition, Practitioner Gaps in Care Lists were produced and distributed monthly to encourage providers to contact members and get them in for needed services and tests. The Gaps in Care Lists provide member-level detail of missing screenings, tests, and services. The MCO encourages providers to follow-up with enrollees who appear on these lists. Delmarva recommended that the MCO put a mechanism in place to ensure that the providers follow-up to get members with missing services in for an appointment.

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

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

All four MCOs participated in the 2016 Performance Measure Validation (PMV) for MY 2015. The MCOs were required to report sixteen performance measures selected from the Performance Withhold Program, Adult and Child Core Measure Sets, and PIPs. The MCOs proved to have appropriate systems and capabilities to accurately collect, calculate and report all the measures according to specifications. The MCO final rates were designated "Reportable" and approved for submission to BMS.

Five measures from the PMV 2016 (MY 2015) set were used to assess quality provided by the MHT MCOs. They are:

- Immunizations for Adolescents – Combination 1
- Medication Management for People with Asthma – Total Compliance 75% or Greater
- Adult BMI Assessment
- Annual Monitoring for Patients on Persistent Medications – Total
- Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers To Quit

The MHT-WA for *Immunizations for Adolescents* exceeded the 75th NMP. The MHT-WA compared favorably to national percentiles by exceeding the 50th NMP for *Medication Management for People With Asthma* and *Adult BMI Assessment*. The MHT-WA for Immunizations *for Adolescents* and *Adult BMI Assessment* improved over the three year period between MY 2013 and MY 2015. An opportunity for improvement was identified for the *Medical Assistance with Smoking and Tobacco Use Cessation* measure where the MHT-WA was below the 50th NMP and MCO rates did not improve between MY 2013 and MY 2015.

Summary of Access

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

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

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

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

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

CoventryCares met all of the access standards. The Health Plan did not meet the 90% threshold for the Emergency Care and 24/7 access standards, which are the same standards it did not meet in MY 2014. UniCare did not meet the 90% threshold for Routine Primary Care, Initial Prenatal Care Visit, and 24/7 access. There is no data for WVFH as the MCO did not assess compliance for the access and availability standards in 2015 as required.

In 2014, Delmarva noted that the MCOs were not consistently meeting the threshold for the 24/7 access standard. A review of data for the five-year period from 2011-2015 shows that CoventryCares met the standard four times, The Health Plan met the standard one time, and UniCare did not meet this standard in any of the five years reviewed. As in 2014, Delmarva recommends that BMS work with the MCOs to focus on meeting this important access standard.

In regards to PIPs, the MCOs reported indicator rates for Remeasurement 2 (MY 2015) for the mandatory Asthma Emergency Department Collaborative PIP. The mandatory indicator is *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits (ages 2-20)*.

The robust interventions that were in place throughout MY 2015 include Gaps in Care Reports (CoventryCares and UniCare), Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare), and Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare).

The Health Plan's Wellness and Health Promotion Call Center (WH&P) allows for one-on-one personalized contact with member. Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program.

A comprehensive lifestyle program was offered to members with Asthma (WVFH). The program supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies. Member interventions include a comprehensive asthma telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care (for high-risk members). Case management is provided to high-risk members and provider interventions include specific asthma training. The indicator results show that the mandatory indicator rate improved for both CoventryCares and The Health Plan in second remeasurement. UniCare did not achieve improvement for the second remeasurement period. MY 2015 was baseline for WVFH.

Delmarva required all MCOs to close the Emergency Department Collaborative PIP since the indicator is retired from the Child Core Set, there are no current national benchmarks, and the indicator is not supported by HEDIS certified reporting software. Table 19 shows the indicator results for the mandatory Emergency Department Collaborative.

Table 19. MCO Emergency Department Collaborative Results

Emergency Department Collaborative PIP Mandatory Asthma Indicator Results Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits Ages 2 – 20			
CoventryCares			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	8.86%
MY 2014	Remeasurement 1	7.974%	8.67%
MY 2015	Remeasurement 2	7.974%	6.96%
The Health Plan			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	6.58%
MY 2014	Remeasurement 1	Decrease of 1 percentage point per year	7.09%
MY 2015	Remeasurement 2	Decrease of 1 percentage point per year	5.29%
UniCare			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with PIP Collaborative Team	8.29%
MY 2014	Remeasurement 1	7.98%	8.38%
MY 2015	Remeasurement 2	7.98%	10.76%
WVFH			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	1% total decrease	5.29%

For the three MCOs with three years of data, CoventryCares and The Health Plan achieved improvement in the indicator (where a lower rate is better) from the Baseline to Remeasurement 2.

The robust interventions that were in place in MY 2015 were:

- Gaps in Care Reports (CoventryCares and UniCare).
- Pharmacy Profile Reports which are used to identify asthmatic members with no prescription for a controller medication (UniCare).
- Emergency Department (ED) Usage Lists used to identify asthmatic members who frequently utilize the ED to manage their asthma (CoventryCares and UniCare).
- A Wellness and Health Promotion (WH&P) Call Center at The Health Plan allows for one-on-one personalized contact with members who are identified as having asthma. Phone calls are placed to members by an outbound specialist who completes an initial assessment of the member's health and asthma control and engages them in the MCO's Asthma Wellness program.

- WVFH offered its Gateway to Lifestyle Management (GTLM) program to members with Asthma. GTLM supports the practitioner-patient relationship and plan of care, and emphasizes the prevention of exacerbations and complications by using evidence based guidelines and patient empowerment strategies. Member interventions include a comprehensive asthma telephonic assessment, written self-management plan, and care management which includes assessment of co-morbid conditions, smoking status and gaps in care (for high-risk members). Case management is provided to high-risk members and provider interventions include specific asthma training.

Four performance measures were validated and used to assess MCO performance for Access to Care:

- Prenatal and Postpartum Care (Postpartum Care)
- Percentage of Eligibles That Received Preventive Dental Services
- Percentage of Eligibles That Received Dental Treatment Services
- Annual Percentage of Asthma Patients 2 Through 20 with One or More Asthma-Related Emergency Room Visits

CoventryCares and UniCare's rates decreased for *Prenatal and Postpartum Care- Postpartum Care* between MY 2013 and MY 2015. The rates for the three established MCOs improved between MY 2014 and MY 2015 for *Percentage of Eligibles That Received Preventive Dental Services.* CoventryCares's and The Health Plan's rates for *Annual Percentage of Asthma Patients 2-20 Years Old with One or More Asthma-Related Emergency Room Visits* also improved between MY 2014 and MY 2015.

An opportunity for improvement was identified for *Prenatal and Postpartum Care- Postpartum Care* for all three MCOs as the MHT-WA did not meet the 50th National Medicaid Percentile (NMP) and two MCO rates did not improve between MY 2013 and MY 2015.

Timeliness

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

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

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For MY 2015, Delmarva reviewed cases, files, and logs to assess timeliness of:

- Credentialing and recredentialing of providers,

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

Delmarva sampled 10 credentialing and 10 recredentialing files for each MCO. All initial credentialing applications in the sample were processed according to the MCOs policies and procedures. All provider recredentialing files in the sample were credentialed within the three-year time requirement.

A pre-delegation audit is conducted prior to contracting with any delegate. All delegated credentialing providers are held to the same timeliness standards. The MCOs provided the annual audit reports for all delegated credentialing entities.

For MY 2015, one MCO (The Health Plan) had issues with a delegated entity not responding to requests for information needed to conduct its oversight functions. The Health Plan provided a record of all correspondence with the delegate to demonstrate its attempts at securing the information needed for oversight functions. The breakdown in communication was due to a change in management. After the issue was identified, The Health Plan and the delegate worked together to bring the delegate back into compliance with its delegated credentialing responsibilities.

Delmarva reviewed each MCO's grievance log and selected a sample of 10 formal appeals cases from each MCO for review. In cases where an MCO did not have 10 appeals for MY 2015, all cases were reviewed.

The BMS/MCO contract requires MCOs to process and provide notice to affected parties regarding grievances and appeals in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance or appeal, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. All grievances reviewed were resolved timely.

All sampled appeals cases for 2015 were resolved timely, except two behavioral health cases for UniCare. The timeframe for resolution was extended beyond the timeline for the benefit of the enrollees in both cases. The MCO followed the procedures for notifying the enrollees that the MCO was extending the timeframe; Neither enrollee appealed the decision to extend the timeframe. The end result for both cases was an approval for services requested.

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

Results are compiled at least monthly by all MCOs and reported through the QAPI channels at least quarterly.

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

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported through the QAPI channels by the UM department. There were no cases on file for expedited authorizations in MY 2015.

For MY 2015, there were three PIPs that addressed timeliness. They are CoventryCares's Adolescent Well-Care Visits PIP, The Health Plan's Member Establishment with Primary Care Provider PIP, and WVFH's Prenatal and Postpartum Care PIP.

CoventryCares's Adolescent Well-Care Visits PIP measures the percentage of enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or Obstetrician/Gynecologist during the measurement year. CoventryCares achieved an increase in the indicator rate each year from Baseline (MY 2011) to Remeasurement 3 (MY 2014). The rate increased from 42.13% in the Baseline to 50.47% in Remeasurement 3. CoventryCares realized a decrease from the baseline (42.13%) to Remeasurement 4 (39.86%) and a statistically significant decrease from Remeasurement 3 (50.47%) to Remeasurement 4 (39.86%). Interventions such as face-to-face education of providers about medical record documentation, outreach calls to non-compliant members, provider report cards, and EPSDT reminder systems target identified barriers and the MCO achieved improvement for three out of four 4 remeasurement periods. The MCO should continue with its interventions that have been determined to be effective. The MCO is required to close this project and submit a new proposal to Delmarva.

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

- Disease and case managers conduct targeted calls to members identified as non-compliant to educate them about the need for routine well-visits and assist with appointment scheduling if needed.
- Provider report cards are mailed monthly which contain all members that are non-compliant with the required services. The MCO encourages providers to follow-up with the non-compliant members.

Delmarva recommended that the MCO put a mechanism in place to ensure that providers follow-up with members and attempt to get them up to date with the required services.
- Provider/office staff education, including appropriate medical documentation, was offered when HEDIS medical record reviews were being conducted on-site by the MCO.

The Health Plan's Member Establishment with PCP of Record was implemented in the last quarter of 2015. The MCO aims to improve the *Adolescent Well-Care Visits* (as in CoventryCares's PIP) and the *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life* rates. By encouraging members to establish with their PCP of record, the MCO believed that enrollees will be more likely to obtain routine well exams and preventive services, and may use the ED and walk-in clinics less frequently. Baseline data were provided for this PIP as it was implemented in the second half of 2015. Both indicators showed slight improvement from Baseline to the first remeasurement period. AWC increased from 46.47% to 47.20% and W34 increased from 70.56% to 73.97%. The PIP met requirements and Delmarva recommends it be continued.

Notable interventions from the project include:
- Incentive Program - The MCO provides incentive to members with a qualifying well-visit claim. When a qualifying claim is received, a letter is sent to the member notifying them that they are eligible for incentive and directions are provided on how to claim the incentive.
- The Wellness and Health Promotion (W&HP) Call Center - Members who are identified through claims as not having well exams or other recommended services are called by an outbound call specialist. The call specialist discusses missing services and verifies the member's PCP. When PCPs of record are identified as being wrong, THP changes and updates to the member's correct PCP. For members who may not be established, the outbound specialist is able to help the member get established with a PCP.
- Use of HEDIS Certified Software - In late 2015, THP implemented new HEDIS certified software. The software provides detailed information specific to providers or provider groups to show which members need well exams, as well as other services. Analysts use the software to drill down to the provider level to produce reports that show providers the specific members on their rosters that are missing services.

WVFH submitted their first PIP for Prenatal and Postpartum Care with baseline data in MY 2015. The MCO chose two HEDIS indicators, *Frequency of Ongoing Prenatal Care* measure and *Postpartum Care- Post Partum Care* indicator. The MCO's goal was to meet or exceed the MHT-WA for HEDIS 2014 (MY 2013) by HEDIS 2016 (MY 2015) for both indicators. The MCO's rate of 72.75% for the Frequency of Prenatal Care (≥81%) indicator fell short of the HEDIS 2014 (MY 2013) MHT Weighted Average (MHT-WA) of 74.4%. The Prenatal and Postpartum Care - Postpartum Care measure rate of 51.09% did not meet the HEDIS 2014 MHT-WA goal of 62.7%.

WVFH implemented the following member and provider interventions:

- The Gateway to Lifestyle Management (GTLM) MOM Matters® program which includes a welcome packet to qualified members. The packet includes a welcome letter, education material on pregnancy, depression through pregnancy, smoking cessation and domestic violence.
- Information is also provided on the member reward program including the WVFH Maternity Rewards Program where members receive up to $150 for completing all prenatal and postpartum visits.
- Provider interventions include a $200 incentive for providing postpartum care with in the 21 to 56-day window after delivery.

The following six measures validated for MY 2015 assess performance for Timeliness.

- Adolescent Well-Care Visits
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate

The MHT-WA for *Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life* exceeded the 50th NMP and improved each year between MY 2013 and MY 2015. The MHT-WA for *Adolescent Well-Care Visits* also improved between MY 2013 and MY 2015 but did not the 50th NMP. Three of the four PQI admission measures improved between MY 2014 and MY 2015. There were no opportunities for improvement identified for timeliness measures.

MHT MCO Strengths, Requirements, and Recommendations

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

CoventryCares MY 2015 Strengths, Requirements, and Recommendations	
Systems Performance Review	
Enrollee Rights	**Strengths** ➢ Member materials are at or below the required 6th reading level as assessed using the Flesch-Kincaid metric. ➢ The MCO has a strong outreach program. ➢ Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. ➢ Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. ➢ The Member Handbook, a Provider Directory search, and other important enrollee materials and tools are available on The Health Plan's website for members to access 24/7.
	Requirements and Recommendations ➢ There are no requirements or recommendations as the MCO achieved 100% compliance on this standard.
Grievance Systems	**Strengths** ➢ The Medicaid Appeals policy from 2014 was updated and revised in 2015. It is now named the Member Appeals Policy and includes all of the required components for the Grievance System standard. ➢ CoventryCares has a well-documented grievance system which includes the Member Appeals Policy and the General Complaints Policy. ➢ The policies and procedures are in place and are followed; all complaint, grievance, and appeal resolutions were documented and easy to follow from registration through completion/resolution. ➢ All seven member appeals cases for 2015 were reviewed. The documentation was complete and timely in all cases. ➢ The Notice of Action (NOA) letter sent to enrollees includes all required elements. ➢ All NOAs sent to enrollees include an attachment which notifies enrollees of their right to and process for filing a grievance, appeal, and State Fair Hearing. ➢ All grievance and appeals files reviewed on-site contained the appropriate documentation, including an acknowledgment letter. All files reviewed were resolved within the appropriate time frame. ➢ The entire grievance log was submitted to Delmarva to review. All grievances were documented and resolved timely.
	Requirements and Recommendations ➢ There are no requirements or recommendations as the MCO achieved 100% compliance on this standard.
Quality Assessment and Performance Improvement	**Strengths** ➢ For Utilization Management decisions, CoventryCares exceeded the inter-rater reliability (IRR) goal of 85% (degree of agreement) for application of clinical screening criteria by its Preauthorization Nurses, Concurrent Review Nurses, Case Managers and Physicians. The physical health IRR rate was 96% and the behavioral health IRR rate was 93%. ➢ All credentialing and recredentialing records sampled for the review period were completed timely. ➢ Delegated oversight policies and procedures are in place and followed. The MCO provided the annual audit results for all delegated entities. ➢ Utilization Management monitors over and under-utilization of services to ensure

CoventryCares MY 2015 Strengths, Requirements, and Recommendations	
	enrollees have appropriate access to services. ➢ The MCO is participating in the mandatory Pediatric Asthma Emergency Department and Diabetes Collaboratives. ➢ At the local level, CoventryCares reviews and updates (as needed) clinical practice guidelines (CPGs) every year. Examples of some CPGs reviewed and approved in 2015 include Preventive Guidelines – Adults, Preventive Guidelines – Children, Childhood Immunizations, Diabetes, Coronary Artery Disease, and Asthma. ➢ Behavioral health (BH) was carved into the MCO benefit plans in July 2015. CoventryCares adopted several BH CPGs such as Attention Deficit Hyperactivity Disorder, Major Depressive Disorder. ➢ Based on opportunities for improvement identified in Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, the MCO develops action items and implements interventions to address deficiencies. ➢ Disease and case management programs are in place. An electronic review of cases on-site demonstrated appropriate interventions and outreach efforts are in place. ➢ CoventryCares met all standards for member satisfaction. Their annual CAHPS analysis identify barriers includes a comprehensive plan of action. Survey results were shared with providers through a Faxblast in November 2015. ➢ CoventryCares successfully reported all required performance measures by contractual deadlines. ➢ The Health Education plan is comprehensive and includes many community outreach initiatives such as a backpack program for back to school and a mobile food pantry. ➢ Several sources are reviewed to assess provider availability and access. Sources include geo-access reports, secret shopper reports, member and provider demographics, CAHPS survey results, and member complaints.
	Requirements and Recommendations ➢ There are no requirements or recommendations as the MCO achieved 100% compliance on this standard.
Fraud and Abuse	**Strengths** ➢ CoventryCares's Medicaid Compliance Fraud, Waste, and Abuse Plan integrates Aetna policies and with those for the local MCO. ➢ The Medicaid Program Manager attends both the quarterly internal CoventryCares and Aetna Corporate Compliance Meetings. This provides a link between the local MCO and the Corporate entity. ➢ Committee meeting minutes for 2015 document appropriate activities at both the local and corporate levels. ➢ Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse. ➢ Verisk Health Anti-Fraud software is used to detect fraud during claims processing. In addition, the SIU also uses other software packages such as FraudFinder, Nucleus, and STARSSentinel to detect fraud, waste, and abuse both prospectively and retrospectively. ➢ Aetna (Corporate) provides a comprehensive employee training program on compliance and ethics. Employees must complete training when they are first hired and an annual basis after. Attendance and completion of mandatory training is recorded and tracked to ensure employee compliance with training requirements.
	Recommendations ➢ There are no requirements or recommendations as the MCO achieved 100% compliance on this standard.

<table>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td rowspan="2">Adolescent Well-Care Visits</td><td>Strengths
➢ Interventions target both members and providers.
➢ Interventions include provider and member incentives.</td></tr>
<tr><td>Recommendations
➢ PIP met requirements.
➢ Data and analysis is comprehensive.
➢ The MCO realized improvement year over year from baseline (MY 2011) through remeasurement 3 (MY 2014).
➢ The MCO realized a decrease from the baseline rate of 42.13% to Remeasurement 4 (39.86%) in MY 2015 and a statistically significant decrease from MY 2014 (50.47%) to MY 2015 (39.86%).
➢ The MCO is required to close this PIP.
➢ It is recommended that the MCO keep interventions in place that have been determined to be effective.
➢ The MCO must develop and submit a new PIP project proposal to replace this PIP.</td></tr>
<tr><td rowspan="2">Emergency Department Collaborative</td><td>Strengths
➢ MCO used the Collaborative PIP template and instructions.
➢ Clearly defined study population and indicators.
➢ Clearly defined study design and data analysis plan.
➢ Targeted face-to-face member interventions.</td></tr>
<tr><td>Recommendations
➢ PIP met requirements.
➢ Interventions are expected to improve indicator performance.
➢ All MCOs are required to close this PIP due to the retirement of the Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People with Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. The MCO is encouraged to keep interventions in place that have been determined to be effective.</td></tr>
<tr><td rowspan="2">Diabetes Collaborative</td><td>Strengths
➢ Both performance measures are HEDIS indicators.
➢ The Gaps in Care Lists that are sent to providers are great sources of information for providers.
➢ Several new interventions were implemented in (late) MY 2015. Two of these interventions provide one-to-one contact with members.</td></tr>
<tr><td>Recommendations
➢ PIP met requirements.
➢ The MCO sends providers lists of non-compliant members (Gaps in Care Lists) in hopes that they provide follow-up to get members into care. As noted above, the MCO should put a mechanism in place to monitor or require follow-up as part of the intervention.</td></tr>
<tr><th colspan="2">Performance Measure Validation</th></tr>
<tr><td colspan="2">Strengths
➢ Good coordination between the regional plan and the national quality team for performance measures.
➢ Full utilization of HEDIS certified software for reporting all required performance measures for validation.
➢ The MCO successfully implemented ICD-10 codes by the October 1, 2015 deadline.
➢ The MCO effectively oversaw the carve-in of behavioral health benefit that went into effect July 1, 2015.
➢ The MCO was successfully managed Medicaid Expansion enrollment that occurred from July through December 2015.</td></tr>
</table>

CoventryCares MY 2015 Strengths, Requirements, and Recommendations
Requirements ➢ Be fully prepared to provide a complete and updated ISCA for next reporting period. ➢ Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for performance measures selected for validation and those that are essential for the measures used in the Withhold Program. Missing or incorrect data elements may lead to a measure receiving an audit designation of "Not Report." ➢ The MCO is required to be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV cycle. ➢ Be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017. **Recommendation** ➢ Consider developing incentives specifically for measures selected for the Withhold Program.

The Health Plan MY 2015 Strengths, Requirements, and Recommendations	
Systems Performance Review	
Enrollee Rights	**Strengths** ➢ Member materials are at or below the required 6th reading level as assessed using the Flesch-Kincaid metric. ➢ The MCO has a strong outreach program which is used to provide orientation, enroll members in case and disease management programs, and help members access services they need (e.g. help arrange transportation). ➢ Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. The Member Handbook was updated mid-year to include the Behavioral Health benefits to which members are entitled. ➢ Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. ➢ The Member Handbook, a Provider Directory search, and other important enrollee materials and tools are available on The Health Plan's website for members to access 24/7.
	Requirements and Recommendations ➢ In its Exit Letter to all MCOs, Delmarva provided a general requirement for all MCOs to review and revise as necessary, any policies, procedures and member materials (e.g. Member Handbook) that contain information on the appeals process. Any practitioner is able to file an appeal on behalf of a member, not just doctors as stated in several documents. In all documents that refer to the appeals process, the MCO must review and assess whether or not the appropriate language regarding providers and practitioners is used consistently and appropriately. Because all of the MCOs are required to be NCQA accredited, Delmarva Foundation is requiring use of the term 'provider' to refer to such entities as hospitals, clinics etc. The term 'practitioner' is to be used to refer to doctors, PCPs, physician assistants or any person providing direct services to enrollees. As the MCO's documents come up for review/revision, the MCO must make these changes.

<table>
<tr><th colspan="2">The Health Plan MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td rowspan="2">Grievance Systems</td><td>Strengths
➢ Complaint, grievance and appeals procedures are well established and interviews with staff confirm they are followed.
➢ The Medicaid chapter of the Practitioner Procedural Manual and Behavioral Health Practitioner Provider Manual provides information for providers to file grievances and appeals.
➢ The Member Handbook provides an overview of procedures enrollees should use to file grievances, appeals, and to access a State Fair Hearing. (As above, the MCO must review the Grievance and Appeals section to ensure the correct use of “provider” and “practitioner.”)
➢ Complaints, grievances, and appeals are monitored for timeliness of completion.
➢ All 2015 grievance and appeal case files reviewed on-site were completed in a timely manner.
➢ Timeliness of completion of appeals, grievances, and complaints is monitored and reported through the Continuous Quality Improvement Committee, to the Executive Management Committee, which reports directly to the Board of Directors.
➢ Thorough documentation is maintained in appeal files in the MCO’s electronic proprietary HEART system to support all decisions.
➢ All member grievance cases for 2015 were reviewed. All were completed timely and files included all required documentation.</td></tr>
<tr><td>Requirement
➢ Any provider is able to file an appeal on behalf of a member. In all documents pertaining to appeals, especially in the Appeals Policies and Member Handbook, the MCO must review and assess whether or not the appropriate language regarding providers, practitioners, and doctors, etc. is used consistently and appropriately. Because all of the MCOs are required to be NCQA accredited, Delmarva Foundation is requiring use of the term ‘provider’ to refer to such entities as hospitals, clinics etc. The term ‘practitioner’ is to be used to refer to doctors, PCPs, physician assistants or any person providing direct services to enrollees. As the MCO’s documents come up for review/revision, the MCO can make these recommended changes.</td></tr>
</table>

<table>
<tr><th colspan="2">The Health Plan MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td rowspan="2">Quality Assessment and Performance Improvement</td><td>Strengths
➢ The Quality Management (QM) and Utilization Management (UM) program documents are comprehensive and describe the major activities, goals, and objectives.
➢ There are separate work plans for QM, UM, and Behavioral Health (BH).
➢ Disease and case management programs are in place. An electronic review of cases on-site demonstrated appropriate interventions and outreach efforts are in place.
➢ The Health Plan successfully manages, tracks, and monitors its EPSDT-eligible enrollees via HEART, a proprietary electronic program.
➢ The MCO Performance Improvement Project (PIP) topics and indicators are relevant and appropriate.
➢ The MCO participates in the mandatory Diabetes and Pediatric Asthma Emergency Department (ED) PIPs. The third PIP was implemented in 2014 and focuses on children establishing a relationship with the PCP to improve the well-child visit rate. The MCO faced challenges with this PIP, but has implemented several interventions to address these challenges.
➢ Lines of authority and communication among the QM and UM committees are well documented. Meeting minutes document the information flow among these committees and up to the Executive Management Team (EMT). The MCO was able to successfully implement reporting of BH activities into its QM committee structure.
➢ There is documentation in QM and QIC committee meeting minutes to demonstrate EMT and BOD involvement (feedback and recommendations etc.) in the various QM and UM activities.
➢ The Medical Director is the Chairperson for the Credentialing Committee, Medical Directors Oversight Committee (MDOC), Physician Advisory Committee (PAC), and the Quality Improvement Committee (QIC).
➢ Medical Director involvement is evident in all quality-related activities and documented in these various committee meeting minutes.
➢ Provider participation is apparent throughout quality programs and initiatives as documented in the QIC and PAC meeting minutes.
➢ All credentialing and recredentialing records sampled for the review period were completed timely.
➢ The MCO appropriately reviews and updates clinical practice guidelines (CPGs) at least every two years, and more frequently if warranted.
➢ The Health Plan has a comprehensive health education plan and targets its members and community needs.</td></tr>
<tr><td>Recommendations and Requirements
➢ QM Program Description - The Quality Management Program description does not specifically designate the President and CEO as the senior executive responsible for the QM Program, although it states that the EMT can act on his behalf. It is recommended that the Quality Management Program Description explicitly state that the President and CEO is the senior executive responsible for the QM Program.
➢ EPDST - It is recommended that the MCO update policy ME-7-MHT Health Check to include the ICD-10 codes which came into use in 2015.
➢ Access and Availability - The MCO must be prepared to analyze and report behavioral health provider access and availability as required by the BMS Contract.
➢ Access and Availability - The MCO is encouraged to work with BMS and the other MHT MCOs to standardize measurement for the 24/7 access standard.</td></tr>
<tr><td>Fraud and Abuse</td><td>Strengths
➢ Use of the STARSSentinel software has improved the MCOs ability to identify potential</td></tr>
</table>

The Health Plan MY 2015 Strengths, Requirements, and Recommendations	
	areas of fraud and abuse. It is being utilized to systematically identify potential fraud and abuse for further investigation. ➢ The Special Investigative Unit increased staff for data analysis and case review. ➢ Required staff education on compliance, fraud, waste, and abuse was conducted in 2015. Electronic confirmation of training is maintained in the Compliance Department. ➢ Staff educational materials include all required information. ➢ Specific steps have been identified and are used to investigate potential fraud and abuse offenses, as well as follow-up steps when an offense has been confirmed. ➢ The Compliance Committee meets regularly. Meeting minutes document its activities.
	Requirements and Recommendations ➢ A general recommendation was made to all MCOs to encourage them to continue efforts to work with the MFCU and the other MCOs to collaborate on cases that affect entire MHT and share best practices.
Performance Improvement Projects	
Member Establishment with PCP of Record	**Strengths** ➢ Both indicators are HEDIS measures. ➢ The WH&P call center is a well-established mechanism to identify members that are in need of services. ➢ Interventions target both members and providers. ➢ Interventions include one-to-one contact with members and face-to-face contact with providers.
	Recommendations ➢ PIP meets requirements. ➢ Continue with this PIP.
Emergency Department Collaborative	**Strengths** ➢ The MCO's Wellness and Health Promotion (W&HP) Call Center provides one-on-one personalized contact with members who are identified as asthmatic using HEDIS indicators as a guide for identifying members with asthma and high ER users. ➢ The MCO began using the HEDIS software to drill down to the provider and member level to produce reports to show providers members with asthma who are missing services.
	Recommendations ➢ PIP meets requirements. ➢ Interventions are expected to improve indicator performance. ➢ Continue with those interventions that have been determined to be successful in impacting the indicators. ➢ Close PIP. All MCOs are required to close this PIP due to the retirement of the Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. The MCO is encouraged to keep interventions in place that have been determined to be effective.
Diabetes Collaborative	**Strengths** ➢ Comprehensive project rationale. ➢ The performance measures are HEDIS measures. ➢ Interventions target members and providers.

<table>
<tr><th colspan="2">The Health Plan MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td></td><td>Recommendations
➢ PIP submission met requirements.
➢ Continue with targeted member and provider specific interventions.
➢ The MCO began using HEDIS certified software. This software provides detailed information specific to providers or provider groups to show which members with diabetes need treatment or services. Analysts use the software to drill down to the provider level to produce reports that show providers the specific members on their rosters that are missing services. It is recommended that the MCO have a mechanism in place to ensure that providers follow-up with members identified who have gaps in care.</td></tr>
<tr><th colspan="2">Performance Measure Validation</th></tr>
<tr><td colspan="2">Strengths
➢ Utilizing certified HEDIS software for the first time for HEDIS 2016.
➢ The team of programmers and quality analysts are very experienced and work well with each other.
➢ The MCO successfully implemented ICD-10 codes by the October 1, 2015 deadline.
➢ Provided comprehensive pre-site visit documentation and source code for non-HEDIS measures.
➢ The MCO effectively oversaw the carve-in of behavioral health benefit that went into effect July 1, 2015.
➢ The MCO was successfully managed Medicaid Expansion enrollment that occurred from July through December 2015.</td></tr>
<tr><td colspan="2">Requirements
➢ Be fully prepared to provide a complete and updated ISCA for next reporting period.
➢ Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for PMV measures and those that are essential for the measures used in the Withhold Program. Missing or incorrect data elements may lead to a measure receiving an audit designation of “Not Report.”
➢ The MCO is required to be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV cycle.
➢ Be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017.

Recommendation
➢ The MCO should also consider utilizing its HEDIS software for Adult and Child Core measures where appropriate.</td></tr>
</table>

<table>
<tr><th colspan="2">UniCare MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><th colspan="2">Systems Performance Review</th></tr>
<tr><td rowspan="2">Enrollee Rights</td><td>Strengths
➢ Member materials are comprehensive and provide enrollees with information on their benefits and how to access them.
➢ Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format.
➢ The Member Handbook and Provider Directory are available on UniCare's website for members to access 24/7.
➢ The MCO provides oral interpretation for any language to enrollees free-of-charge as required.
➢ Member materials are assessed to ensure a reading level of 6th grade or below using the Flesch-Kincaid metric.
➢ All required enrollee rights and responsibilities are provided in the Member Handbook and in the Members' Rights Policy.
➢ The Member Handbook provides all of the required information to ensure enrollees have access to information on how to access services to which they are entitled.
➢ Behavioral health benefits were made available to enrollees in July 2015. The Member Handbook was revised to ensure that it contained the appropriate information on behavioral health services and how members can access these services.
➢ The Member Handbook details how members can file grievances, appeals, and access the State Fair Hearing process.</td></tr>
<tr><td>Requirements and Recommendations
➢ Several policies reviewed on-site in 2016 were last reviewed in October of 2013. It is recommended that the MCO review all policies and procedures at least bi-annually.</td></tr>
<tr><td rowspan="2">Grievance Systems</td><td>Strengths
➢ UniCare has well-developed grievance policies and procedures that meet all requirements.
➢ Appeals and grievance files contain all the required components.
➢ The Notices of Action (NOA) letters are comprehensive and include all of the required elements.
➢ NOAs inform enrollees how to file an appeal, outline the appeal process, and explain enrollee rights during the appeal process.
➢ Appeals are resolved in an expeditious manner. All case files reviewed were resolved within the 30 day timeframe requirement.</td></tr>
<tr><td>Requirement
➢ Any provider is able to file an appeal on behalf of a member, not just a doctor. In all documents pertaining to appeals and grievances, the MCO must review and assess whether or not the appropriate language regarding providers, practitioners, and doctors, etc. is used consistently and appropriately. As above, because all of the MCOs are required to be NCQA accredited, Delmarva Foundation is requiring use of the term 'provider' to refer to such entities as hospitals, clinics etc. The term 'practitioner' is to be used to refer to doctors, PCPs, physician assistants or any person providing direct services to enrollees. As the MCO's documents come up for review/revision, the MCO can make these recommended changes.</td></tr>
</table>

<table>
<tr><th colspan="2">UniCare MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td rowspan="2">Quality Assessment and Performance Improvement</td><td>Strengths
➢ The MCO achieved a Commendable Accreditation Status from NCQA which was effective through August 2015.
➢ The MCO appropriately coordinates services for enrollees with special health care needs.
➢ UniCare consistently applies review criteria for authorization decisions.
➢ Interrater reliability is conducted routinely to ensure consistent application of review criteria by clinical staff.
➢ A credentialing and recredentialing file review demonstrates that UniCare meets timeliness requirements. No deficiencies were noted in the files that were audited on-site.
➢ The delegated credentialing policies and procedures are comprehensive. All delegated entities received an annual audit; no corrective action plans (CAPs) were required as a result of the 2015 audits.
➢ Clinical practice guidelines and criteria are in place and appropriately used to make authorization decisions.
➢ UniCare maintains a quality and health information system that collects, analyzes, integrates, and reports data. All required HEDIS® measures were reported to NCQA and BMS.
➢ All required Adult and Child Core Measures were reported for 2015.
➢ UniCare has a comprehensive Health Education Plan and appropriately reaches out to members in an effort to engage them in health education related programs.
➢ The MCO participates in the mandatory Diabetes and Pediatric Asthma Emergency Department Collaborative PIPs.
➢ Collaboration between quality-related committees and sub-committees is clear and documented in meeting minutes/reports.</td></tr>
<tr><td>Requirements
➢ Requirement: Access and Availability – UniCare must achieve at least a 90% compliance rating for each type of appointment to ensure that members have timely access to care and services. The MCO's provider access survey found that providers met the threshold for Urgent Care (94%), but did not meet the standards for After Hours (24/7) Access to Primary Care Providers (85%), Prenatal Appointment Within 14 Days (80%), and Routine Appointment (85%).
➢ Requirement: Credentialing and Recredentialing – The MCO must ensure that all required databases are queried on a monthly basis.
➢ Requirement: Utilization Management – Any provider is able to file an appeal on behalf of a member following a denial. In all documents pertaining to grievances, appeals, authorizations, and preauthorizations, the MCO must review and assess whether or not the appropriate language regarding providers, practitioners, and doctors, etc. is used consistently and appropriately. As above, because all of the MCOs are required to be NCQA accredited, Delmarva Foundation is requiring use of the term 'provider' to refer to such entities as hospitals, clinics etc. The term 'practitioner' is to be used to refer to doctors, PCPs, physician assistants or any person providing direct services to enrollees. As the MCO's documents come up for review/revision, the MCO can make these recommended changes.
➢ Recommendation: Access and Availability – The MCO is encouraged to work with BMS and the other MHT MCOs to standardize measurement for the 24/7 access standard. BMS and Delmarva will be in touch with the MCOs in this effort.
➢ Recommendation – It is recommended that the Quality Management Program Description addresses the Adult and Child Core Measures that are required to be submitted to BMS on an annual basis.</td></tr>
</table>

<table>
<tr><th colspan="2">UniCare MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td rowspan="2">Fraud and Abuse</td><td>Strengths
➢ UniCare has a comprehensive set of policies and procedures that address fraud, waste and abuse.
➢ The Standards for Ethical Business Conduct provides employees with the company's expectations for ethical behavior as well as their responsibilities for reporting suspected fraud, waste and abuse.
➢ Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse.
➢ UniCare provides a comprehensive employee training program on compliance/ethics. In this training, employees are educated on how to identify and report any suspicious activity.
➢ Documentation of successful completion of mandatory training is electronically maintained for each employee.
➢ UniCare uses its experience both locally (WV) and nationally to detect fraud, waste and abuse. Any "schemes" identified in one region of the country are investigated in all their markets.</td></tr>
<tr><td>Requirements and Recommendations
➢ There are no MCO specific recommendations or requirements as the MCO achieved full compliance on this standard.</td></tr>
</table>

<table>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td rowspan="2">Childhood Immunization Status Combination 3</td><td>Strengths
➢ The performance measure is a HEDIS measure.
➢ Interventions address many of the barriers identified, target and provide one-to-one contact with providers and enrollees.
➢ Provider and member incentive programs have been implemented.</td></tr>
<tr><td>Recommendations
➢ PIP meets requirements.
➢ The QACI provider incentive program was fully implemented in 2015. This will provide face-to-face contact with providers and addresses follow-up from the Gap in Care reports distributed by the MCO.
➢ Close PIP. The MCO must close this PIP at the end of 2016 as sustained improvement has been achieved.
➢ The MCO should continue all interventions that have been determined to be successful after this project is closed.
➢ UniCare must select a new project topic and submit a project proposal to Delmarva to replace this PIP.</td></tr>
<tr><td>Emergency Department Collaborative</td><td>Strengths
➢ Interventions directly target the members with asthma and their providers.
➢ Interventions target identified barriers and provide one-to-one contact to members and providers.
➢ Interventions are multi-faceted using outreach, case management, disease management, provider profiling and reporting.
➢ Two of the three indicators are HEDIS indicators.</td></tr>
</table>

<table>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td></td><td>Recommendations
➢ Interventions are expected to improve outcomes.
➢ PIP meets requirements.
➢ Continue with those interventions that have been determined to be successful in impacting the indicators.
➢ Close PIP. All MCOs are required to close this PIP due to the retirement of the Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. The MCO is encouraged to keep interventions in place that have been determined to be effective.</td></tr>
<tr><td rowspan="2">Diabetes Collaborative</td><td>Strengths
➢ The performance measures are HEDIS indicators.
➢ Interventions target both members and providers.
➢ All three project indicators improved from MY 2014 to MY 2015 and from Baseline to MY 2015.</td></tr>
<tr><td>Recommendations
➢ PIP meets requirements.
➢ Continue PIP.</td></tr>
<tr><th colspan="2">Performance Measure Validation</th></tr>
<tr><td colspan="2">Strengths
➢ Fully utilized its NCQA-certified software for reporting performance measures.
➢ Provided comprehensive pre-site visit documentation.
➢ UniCare’s medical record review and supplemental training data is comprehensive.
➢ Reporting staff is experienced with HEDIS and other performance measures.
➢ The MCO successfully implemented ICD-10 codes by the October 1, 2015 deadline.
➢ The MCO effectively oversaw the carve-in of behavioral health benefit that went into effect July 1, 2015.
➢ The MCO was successfully managed Medicaid Expansion enrollment that occurred from July through December 2015.</td></tr>
<tr><td colspan="2">Requirements
➢ Be fully prepared to provide a complete and updated ISCA for next reporting period.
➢ Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for performance measures selected for validation and those that are essential for the measures used in the Withhold Program. Missing or incorrect data elements may lead to a measure receiving an audit designation of “Not Report.”
➢ Be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV cycle.
➢ Be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017.
Recommendations
➢ Continue to evaluate the use of supplemental data in measures in the Withhold Program.
➢ Continue to explore new data sources and incentive programs for measures in the Withhold Program.</td></tr>
</table>

<table>
<tr><th colspan="2">WVFH MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><th colspan="2">Systems Performance Review</th></tr>
<tr><td rowspan="2">Enrollee Rights</td><td>Strengths
➢ Member materials are at or below the required 6th reading level as assessed using the Flesch-Kincaid metric.
➢ Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services.
➢ The Member Handbook, a Provider Directory search, and other important enrollee materials and tools are available on WVFH's website for members to access 24/7.</td></tr>
<tr><td>Requirements
➢ The Your Rights and Responsibilities section of the WVFH Member Handbook states that members have the right to, "know that we, your doctors, and your other providers cannot treat you in a different way because of your age, sex, race, national origin, language needs, or degree of illness of health condition." This enrollee right must be updated to include religion, mental or physical disability, sexual orientation, genetic information, and source of payment.
➢ The MCO did not have an Advance Directives policy in place for 2015. The policy provided dated January 2016 must be implemented.
➢ The MCO must develop and implement a policy on the appropriate treatment of minors.

Recommendation
➢ Recommendation: The Procedures for Obtaining Printed Materials in Alternate Formats Policy (FI-027-ALL) should be reviewed and/or revised as necessary; this policy was last reviewed on 8/31/2012.</td></tr>
<tr><td rowspan="2">Grievance Systems</td><td>Strengths
➢ The member appeals cases sampled for 2015 were reviewed; documentation was complete and timely in all cases.
➢ All NOAs sent to enrollees include an attachment which notifies enrollees of their right to and the process for filing a grievance, appeal, and State Fair Hearing.
➢ All grievance and appeals files reviewed on-site contained the appropriate documentation, including an acknowledgment letter. All files reviewed were resolved within the appropriate time frame.</td></tr>
<tr><td>Requirements
➢ The MCO must include the required content of the notices of action (NOAs) in the appropriate policies and procedures (e.g. date completed, reason for action, right to file an appeal).
➢ The WVFH Formal and Informal Appeals Policy only includes four of the six conditions under which enrollees can request continuation of benefits. The two conditions that must be added to the NOA are that benefits can continue if (1) the services are being appealed were ordered by an authorized provider and (2) the enrollee or provider is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment.
➢ The WVFH Formal and Informal Appeals Policy must allow the member's representative, or the legal representative of a deceased enrollee's estate to act as parties of the appeal. The present policy only includes members as parties to the appeal process.</td></tr>
</table>

<table>
<tr><th colspan="2">WVFH MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td rowspan="2">Quality Assessment and Performance Improvement</td><td>Strengths
➢ All credentialing and recredentialing records sampled for the review period were organized and completed timely.
➢ The MCO is participating in the mandatory Pediatric Asthma Emergency Department and Diabetes Collaboratives.
➢ At the local level reviews and updates (as needed) clinical practice guidelines (CPGs) every year. Examples of some CPGs reviewed and approved in 2015 include Preventive Guidelines-Adults, Preventive Guidelines – Children, Childhood Immunizations, Diabetes, Coronary Artery Disease, and Asthma.
➢ Behavioral health (BH) was carved into the MCO benefit plans in July 2015. The MCO delegates BH to Beacon Health Strategies and monitors this provider on a quarterly basis.
➢ Several BH CPGs such as Attention Deficit Hyperactivity Disorder, Major Depressive Disorder were adopted by Beacon and through the WVFH Quality Improvement Committee.</td></tr>
<tr><td>Requirements
➢ The MCO must assess provider compliance with all standards at least annually and document the results.
➢ WVFH has a threshold of 80% for these standards. The minimum compliance rate for BMS is 90%; policies and procedures must be updated to reflect this requirement access and availability standards.
➢ WVFH's Member Handbook must allow Ob/Gyn specialists to be PCPs for female enrollees.
➢ Gateway Timeframes and Procedures for Standard and Expedited Requests Notifications Policy provided for review must address the requirement that the notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered service must be mailed at least 10 days prior to the action.
➢ The MCO must demonstrate that members and potential members know how to request guidelines.
➢ The Credentialing/Recredentialing of Practitioners Desktop Procedure must include high volume specialists in the list of providers requiring an on-site review. There must be evidence that the on-site reviews are conducted per the requirements.
➢ The Credentialing/Recredentialing of Practitioners Desktop Procedure must include the Dental Anesthesiologist requirements for WV.
➢ The MCO must include all the reasons the MCO may not request disenrollment in the Disenrollment Processing Procedure.
➢ The Gateway Disenrollment Processing Policy must include all the reasons the MCO may not request disenrollment.
➢ The MCO must share survey findings with providers (e.g. CAHPS, HEDIS).
➢ Medical record reviews must be conducted and documented as outlined in the Medical Record Review Policy.</td></tr>
<tr><td>Fraud and Abuse</td><td>Strengths
➢ Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse.
➢ Highmark provides a comprehensive employee training program on compliance and ethics. Employees must complete training when they are first hired and an annual basis after. Attendance and completion of mandatory training is recorded and tracked to ensure employee compliance with training requirements.</td></tr>
</table>

<table>
<tr><th colspan="2">WVFH MY 2015
Strengths, Requirements, and Recommendations</th></tr>
<tr><td></td><td>Requirements
➢ The FWA and Compliance Plan does not refer to WVFH and it does not describe the relationship among the entities conducting the Fraud Waste and Abuse (FWA) and compliance activities for WVFH. The FWA Compliance plan must describe the relationship among the entities conducting the FWA and compliance activities to WVFH. This must include the reporting structure.</td></tr>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td rowspan="2">Prenatal and Postpartum Care Project</td><td>Strengths
➢ The two indicators, Frequency of Ongoing Prenatal Care (FPC) and Prenatal and Postpartum Care - Postpartum Care (PPC) are HEDIS indicators.</td></tr>
<tr><td>Recommendations
➢ PIP meets requirements.
➢ Continue PIP.
➢ The MCO is required to include all of the elements of the recently implemented (July 1, 2016) mandatory Postpartum Care Visit and Behavioral Health Risk Assessment (BHRA) Collaborative PIP. The mandatory collaborative indicator is Prenatal and Postpartum Care-Postpartum Care (PPC), and is a part of the MCO's current project. The MCO will need to add the BHRA measure and incorporate all of the collaborative interventions selected for this PIP.
➢ The MCO is encouraged to keep the Frequency of Prenatal Care (≥81%) indicator in this project.</td></tr>
<tr><td rowspan="2">Emergency Department Collaborative</td><td>Strengths
➢ Clearly defined study population and indicators.
➢ Clearly defined study design and data analysis plan.
➢ Targeted face-to-face member and provider interventions.</td></tr>
<tr><td>Recommendations
➢ PIP meets requirements.
➢ Interventions are expected to improve indicator performance.
➢ Continue with those interventions that have been determined to be successful in impacting the indicators.
➢ Close PIP. All MCOs are required to close this PIP due to the retirement of the Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. The MCO is encouraged to keep interventions in place that have been determined to be effective.</td></tr>
<tr><td rowspan="2">Diabetes Collaborative</td><td>Strength
➢ Both performance measures are HEDIS indicators.
➢ Member interventions include incentives for key diabetes measures HbA1c Testing and Retinal Eye Exam.</td></tr>
<tr><td>Recommendations
➢ PIP meets requirements.
➢ Continue PIP.
➢ The MCO proposed developing a quarterly Provider Dashboard Report that would provide practices with member gaps in care. This was not implemented. It is recommended that the MCO consider implementing a robust provider-focused intervention in its place.</td></tr>
</table>

Performance Measure Validation

Strengths

- Received "Accredited" status by NCQA in 2015.
- Fully utilized its NCQA-certified software for reporting HEDIS and Core measures.
- Provided comprehensive pre-site visit documentation.
- WVFH's medical record review and supplemental training data - are comprehensive.
- Reporting staff is experienced with HEDIS and other performance measures.
- The MCO is ready for ICD-10 implementation.
- The MCO effectively oversaw the carve-in of behavioral health benefit that went into effect July 1, 2015.
- The MCO was successfully managed Medicaid Expansion enrollment that occurred from July through December 2015.

Requirements

- Be fully prepared to provide a complete and updated ISCA for next reporting period.
- Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for performance measures selected for validation and those that are essential for measures used in the Withhold Program. Missing or incorrect data elements may lead to a measure receiving an audit designation of "Not Report."
- Be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV cycle.
- Be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017.

Recommendation

- Continue to explore new incentives and supplemental data sources for measures in the Withhold Program.

MHT Program Strengths, Requirements, and Recommendations

MHT Program Strengths, Requirements and Recommendations for MY 2015*	
Systems Performance Review	**Strengths** ➢ The MCOs achieved rates of 98% to 100% for the Enrollee Rights Standard. ➢ The MCOs achieved rates of 92% to 100% for the Grievance System Standard. ➢ The MCOs achieved rates of 98% to 100% for the Fraud and Abuse Standard. ➢ The MCOs achieved rates of 92% to 100% for the Quality Assessment and Performance Improvement Standard. ➢ Three of four MCOs achieved full compliance for the Grievance System standard. ➢ Three of four MCOs achieved full compliance for the Fraud and Abuse standard. ➢ As required, the MCOs completed internal Corrective Action Plans (CAPs) to address any areas that were not fully compliant. All CAPs addressed the non-compliant areas and provided interventions to address the deficiencies. CAP progress reports are submitted quarterly to Delmarva for monitoring of progress toward addressing deficiencies.
	Recommendation ➢ The MCOs must focus efforts on consistently meeting the 24/7 access standard. Over the last four trend years, the MCOs have not consistently met this standard. Each MCO measures the compliance to this standard differently and therefore the results are not comparable across MCOs. It is recommended that BMS develop a methodology for the MCOs to use to measure 24/7 access so that the results can be comparable.
Performance Improvement Projects	**Strengths** ➢ All MCOs understand the major components of PIPs. All MCO projects have (1) relevant study topics, (2) clear study questions, (3) meaningful and well-defined indicators, (4) well-defined study populations, (5) use appropriate and valid sampling methods, (6) data collection methods that provide for the collection of valid and reliable data, (7) interventions that are reasonable and address barriers, and (8) reported the study findings accurately and clearly. ➢ All MCOs continued the mandatory Diabetes and Emergency Department PIPs. ➢ CoventryCares and UniCare achieved improvement in the mandatory Diabetes PIP indicator, HbA1c<8%. ➢ CoventryCares and The Health Plan achieved improvement in the mandatory Pediatric ED Use PIP, Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Department Visits Ages 2-20. ➢ The MCOs all have some type of Gaps in Care Reports and Provider Profiles that they are using to identify members in need of care or services for the mandatory PIPs. ➢ WVFH submitted and received approval to implement the two mandatory PIPs (Pediatric Emergency Department Use and the Diabetes Collaborative) and its Prenatal and Postpartum Care PIP. ➢ WVFH submitted baseline data for all three PIPs. ➢ The Health Plan achieved improvement for both indicators in its Member Establishment with PCP PIP. ➢ UniCare achieved Sustained Improvement for its Childhood Immunization Status – Combination 3 PIP.
	Requirement ➢ All MCOs are required to close Emergency Department Collaborative PIP due to the retirement of the mandatory Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) measure (used by three MCOs) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to

MHT Program Strengths, Requirements and Recommendations for MY 2015*	
	gage performance. All the MCOs are encouraged to keep interventions in place that have been determined to be effective. **Recommendation** ➢ The Quality Unit of BMS is the recipient of an Adult Quality Measures Grant through the Centers for Medicare and Medicaid Services (CMS). The Grant has a project in place to improve the post-partum care visit rate. The MCOs are required to implement the new Postpartum Care Visit (PPC) Visit and Behavioral Health Risk Assessment (BRHA) PIP. The MCO will collaborate with the Quality Unit to enhance the State's efforts to improve the rates for prenatal Behavioral Health Risk Assessments and Postpartum Care Visits.
Performance Measure Validation	**Strengths** ➢ All four MCOs have established data systems and processes to calculate and report performance measures. ➢ The MCOs successfully reported all HEDIS behavioral health measures required for HEDIS 2016. ➢ All MCOs use HEDIS certified software. ➢ All MCOs were timely in submitting performance measures to BMS for HEDIS, CAHPS, PMV, and the Adult and Child Core Sets. ➢ The MHT-WA for the Percentage of Eligibles That Received Preventive Dental Services improved between MY 2014 and MY 2015. ➢ The MHT-WA exceeded the 75th NMP for Immunizations for Adolescents. ➢ The MHT-WA exceeded the 50th NMP for Medication Management for People With Asthma. ➢ The MHT-WA exceeded the 50th NMP for Adult BMI Assessment.
	Requirements **The MCOs:** ➢ Must be fully prepared to provide a complete and updated ISCA for next reporting period. ➢ Fully validate the PMV Rate Reporting Worksheet prior to submitting the final product to Delmarva. The MCO is required to provide all requested data elements for performance measures selected for validation and those that are essential for the measures used in the Withhold Program. ➢ Be prepared to report the modified Behavioral Health Risk Assessment measure during the next PMV review. ➢ Must be prepared for an increase in membership with the enrollment of the SSI population scheduled for January 1, 2017. ➢ CoventryCares and UniCare must address the Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit measure. The MHT-WA was below the 25th NMP and MCO rates declined between MY 2013 and MY 2015. ➢ CoventryCares must address the Adolescent Well-Care Visit measure where the MCO rate did not improve between MY 2013 and MY 2015 and the MHT-WA did not exceed the 50th NMP. ➢ All MCOs must address the *Prenatal and Postpartum Care - Postpartum Care* measure MHT-WA did not meet the 50th National Medicaid Percentile (NMP) and the MCO rates did not improve between MY 2013 and MY 2015.

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Centers for Medicare and Medicaid Services (CMS). (2012). *External Quality Review (EQR) Protocols*. Retrieved December 30, 2016, from https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

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Appendix 1 - PIP Results

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

Adolescent Well-Care Visits PIP Results			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
MY 2011	Baseline	Not Applicable	42.13%
MY 2012	Remeasurement 1	5 percentage point increase over prior year's rate	46.58%
MY 2013	Remeasurement 2	5 percentage point increase over prior year's rate	47.20%
MY 2014	Remeasurement 3	5 percentage point increase over prior year's rate	50.47%
MY 2015	Remeasurement 4	5 percentage point increase over prior year's rate	39.86%
Emergency Department Collaborative PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with the PIP Collaborative Team	8.86%
MY 2014	Remeasurement 1	7.974%	8.67%
MY 2015	Remeasurement 2	7.974%	6.96%
Indicator 2: Medication Management for People with Asthma – 75% Total			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	43.38%	31.12%
Diabetes Collaborative PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1C Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	41.32%
MY 2014	Remeasurement 1	45.52%	43.27%
MY 2015	Remeasurement 2	45.52%	43.16%
Indicator 2: Comprehensive Diabetes Care – HbA1c Testing			
Time Period	Measurement	Goal	Rate or Results
MY 2014	Remeasurement 1	83.81%	76.40%
MY 2015	Remeasurement 2	83.81%	77.36%

Table A1-2. The Health Plan Performance Improvement Project (PIP) Results.

Member Establishment with PCP of Record PIP Results			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
MY 2014	Baseline	5 percentage point increase annually	46.47%
MY 2015	Remeasurement 1	5 percentage point increase annually	47.20%
Indicator 2: Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life			
Time Period	Measurement	Goal	Rate or Results
MY 2014	Baseline	5 percentage point increase annually	70.56%
MY 2015	Remeasurement 1	5 percentage point increase annually	73.97%
Emergency Department Collaborative PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Department Visits (ages 2-20)			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined by the PIP Collaborative Team	6.58%
MY 2014	Remeasurement 1	Decrease of 1 percentage point per year	7.09%
MY 2015	Remeasurement 2	Decrease of 1 percentage point per year	5.29%
Indicator 2: Asthma Medication Ratio			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	5 percentage point increase over prior year's rate	83.67%
MY 2014	Remeasurement 1	5 percentage point increase over prior year's rate	71.84%
MY 2015	Remeasurement 2	5 percentage point increase over prior year's rate	62.90%
Diabetes Collaborative PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	45.34%
MY 2014	Remeasurement 1	46%	41.24%
MY 2015	Remeasurement 2	46%	39.63%
Indicator 2: Comprehensive Diabetes Care – HbA1c Testing			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	100%	73.91%
MY 2014	Remeasurement 1	100%	78.87%
MY 2015	Remeasurement 2	100%	81.11%

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

Childhood Immunizations Combination 3 PIP Results			
Indicator 1: The percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV); 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 hepatitis B (Hep B); 1 chicken pox (VZV); and 4 pneumococcal conjugate (PCV) vaccines by their second birthday.			
Time Period	Measurement	Goal	Rate or Result
MY 2012	Baseline	70.64%	62.04%
MY 2013	Remeasurement 1	72.08%	63.43%
MY 2014	Remeasurement 2	70.85%	67.13%
MY 2015	Remeasurement 3	70.41% (NCQA National Average)	68.06%
Emergency Department Collaborative PIP Results			
Indicator 1: Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits.			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	To be determined with the PIP Collaborative Team	8.29%
MY 2014	Remeasurement 1	7.98%	8.38%
MY 2015	Remeasurement 2	7.98%	10.76%
Indicator 2: (ASM) The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	TBD upon release of NCQA's Quality Compass	76.61%
MY 2014	Remeasurement 1	65.48%	90.85%
MY 2015	Remeasurement 2	65.48%	91.10%
Indicator 3: (MMA)The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during at least 75% of the treatment period.			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	TBD upon release of NCQA's Quality Compass	42.39%
MY 2014	Remeasurement 1	31.11%	38.53%
MY 2015	Remeasurement 2	30.34%	32.58%
Diabetes Collaborative PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	28.73%
MY 2014	Remeasurement 1	45.52%	38.19%
MY 2015	Remeasurement 2	45.52%	46.06%

Indicator 2: Comprehensive Diabetes Care – HbA1c Testing			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	80.18%
MY 2014	Remeasurement 1	83.81%	81.71%
MY 2015	Remeasurement 2	83.81%	83.80%
Indicator 3: Comprehensive Diabetes Care – Eye (Retinal) Exam Performed			
Time Period	Measurement	Goal	Rate or Results
MY 2013	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) National Medicaid Average by HEDIS 2016 (MY 2015)	25.84%
MY 2014	Remeasurement 1	53.53%	25.93%
MY 2015	Remeasurement 2	53.53%	27.31%

Table A1-4. West Virginia Family Health Performance Improvement Project (PIP) Results

PIP Results			
Indicator 1: Frequency of Ongoing Prenatal Care ≥ 81%			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) MHT Weighted Average of 74.4% by HEDIS 2016 (MY 2015)	72.75%
Indicator 2: Prenatal and Postpartum Care – Postpartum Care			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) MHT Weighted Average of 62.7% by HEDIS 2016 (MY 2015)	51.09%
PIP Results			
Indicator 1: Annual Percentage of Asthma Patients with one or More Asthma-Related Emergency Department Visits (ages 2-20).			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To be determined with the PIP Collaborative Team	8.15%
Indicator 2: Medication Management for People With Asthma (MMA) The percentage of members 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during at least 75% of the treatment period.			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	Meet or exceed the HEDIS 2014 (MY 2013) MHT Weighted Average of 36.9% by HEDIS 2016 (MY 2015)	N/A (denominator too small to report a reliable rate)
PIP Results			
Indicator 1: Comprehensive Diabetes Care – HbA1c Control (<8%)			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) MHT WA of 36.1% by HEDIS 2016 (MY 2015)	39.58%
Indicator 2: Comprehensive Diabetes Care – HbA1c Testing			
Time Period	Measurement	Goal	Rate or Results
MY 2015	Baseline	To meet or exceed the HEDIS 2014 (MY 2013) National Medicaid 90th Percentile of 91.7% by HEDIS 2016 (MY 2015)	85.42%

Appendix 2 – PMV Results

For 2016 PMV (MY 2015), the MCOs were required to report twelve HEDIS and non-HEDIS measures. All MCO rates received an audit designation of **Reportable**. Table A2-1 provides the MCO rate, the MHT weighted average or simple average, and a comparison to national benchmarks. The star ratings pertain to the first twelve HEDIS measures.

Star Ratings for HEDIS Measures.

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

Table A2-1. PMV 2015 (MY 2014) and National Benchmarks.

Measure Name	Coventry Cares MY 2015 %	The Health Plan MY 2015 %	UniCare MY 2015 %	WVFH MY 2015 %	MHT-WA** MY 2015 %	MHT-WA* Compared to NMPs MY 2015 %
Adolescent Well-Care Visits	39.9%	47.2%	51.9%	49.9%	46.9%	★★
Prenatal and Postpartum Care – Postpartum Care	59.4%	63.0%	57.1%	51.1%	58.5%	★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	72.1%	74.0%	74.9%	62.5%	73.6%	★★★
Immunizations for Adolescents – Combination 1	83.9%	81.3%	84.3%	^	83.2%	★★★★
Medication Management for People With Asthma – Total, Compliance 75%+	31.1%	37.0%	32.6%	^	32.8%	★★★

Measure Name	Coventry Cares MY 2015 %	The Health Plan MY 2015 %	UniCare MY 2015 %	WVFH MY 2015 %	MHT-WA** MY 2015 %	MHT-WA* Compared to NMPs MY 2015 %
Adult BMI Assessment (ABA)	90.6%	83.0%	90.3%	^	89.2%	★★★
Annual Monitoring for Patients on Persistent Medications – Total (MPM)	82.4%	84.5%	84.8%	93.2%	84.2%	★
Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers To Quit (MSC)	67.7%	75.0%	69.1%	74.8%	71.7%	★
Mental Health Utilization – Total Any Service (MPT)	10.8%	7.5%	9.9%	4.8%	9.7%	★★
Mental Health Utilization – Total Inpatient (MPT) *	0.46%	0.37%	0.42%	0.39%	0.43%	★
Mental Health Utilization* – Total Intensive Outpatient or Partial Hospitalization (MPT) *	0.01%	0.17%	0.01%	0.04%	0.03%	★
Mental Health Utilization – Total Outpatient and ED (MPT) *	10.7%	7.3%	9.8%	4.5%	9.5%	★★
Percentage of Eligibles That Received Preventive Dental Services	43.0%	39.0%	24.6%	9.0%	32.8%	46.0^{+}
Dental Sealants for 6-9 Year Old Children at Elevated Risk	0.0%	7.0%	0.0%	33.0%	1.6%	^
Annual Percentage of Asthma Patients 2-20 Years Old with One or More Asthma-Related Emergency Room Visits (lower score is better)	7. 7%	5.3%	10.8%	8.2%	8.8%	^

Measure Name	Coventry Cares MY 2015 %	The Health Plan MY 2015 %	UniCare MY 2015 %	WVFH MY 2015 %	MHT-WA** MY 2015 %	MHT-WA* Compared to NMPs MY 2015 %
PQI 01: Diabetes Short-Term Complications Admission Rate (Observed rate per 100,000 member months, lower score is better)	6.9%	10.4%	11.2%	1.9%	8.0%	^
PQI 05: Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (Observed rate per 100,000 member months, lower score is better)	19.3%	6.9%	22.1%	1.0%	12.7%	^
PQI 08: Heart Failure Admission Rate (Observed rate per 100,000 member months, lower score is better)	4.0%	0.4%	1.6%	1.9%	2.2%	^
PQI 15: Asthma in Younger Adults Admission Rate (Observed rate per 100,000 member months, lower score is better)	1.7%	3.2%	2.1%	0.9%	2.0%	^

*The Mental Health Utilization Measure indicator rates are provided for informational purposes only. These measures were calculated using only 6 months of data and therefore should not be used for any analyses.
**Indicates the MHT-WA is a simple average for the indicated measure.
+ Medicaid average is from the HHS Report FFY 2015.
^ Denominator too small (less than 30 observations) to calculate a reliable rate or national benchmark not available.

Appendix 3 – HEDIS Measures Collected and Reported to NCQA

These tables provide information for all measures collected and reported for HEDIS 2014 (MY 2013) through HEDIS 2016 (MY 2015) by HEDIS domains. Individual MCO rates for three years, the MHT Weighted Average (MHT-WA) for three years, and a comparison of MHT-WA (MY 2015) to the most current National Medicaid Percentiles (NMP) are provide for each measure.

Star Ratings for HEDIS Measures.

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

Table A3-1 Effectiveness of Care Domain Measures.

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	^	^	62.5	^	^	71.4	^	^	30.0	100.0	^	^	50.0	★
Adult BMI Assessment	71.5	85.0	90.6	67.9	72.0	83.0	63.1	75.7	90.3	^	66.9	78.8	89.2	★★★
Annual Monitoring for Patients on Persistent Medications - ACE or ARB	^	80.0	82.6	^	85.5	83.3	^	85.2	84.5	92.2	^	83.3	83.9	★
Annual Monitoring for Patients on Persistent Medications - Digoxin	^	^	75.0	^	^	100.0	^	^	100.0	^	^	^	85.7	★★★★★
Annual Monitoring for Patients on Persistent Medications - Diuretics	^	84.2	82.4	^	82.5	86.1	^	86.7	85.2	94.9	^	85.3	84.6	★
Annual Monitoring for Patients on Persistent Medications - Total	^	81.8	82.4	^	84.2	84.5	^	85.8	84.8	93.2	^	84.1	84.2	★
Antidepressant Medication Management - Effective Acute Phase Treatment	^	45.5	48.8	^	45.0	46.1	^	53.0	48.3	46.7	^	49.2	48.0	★
Antidepressant Medication Management - Effective Continuation Phase Treatment	^	31.0	30.2	^	29.0	34.0	^	35.5	28.4	26.7	^	33.0	30.1	★
Appropriate Testing for Children With Pharyngitis	^	66.8	70.7	^	67.3	69.4	^	64.8	68.0	63.3	^	65.8	69.0	★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Appropriate Treatment for Children With Upper Respiratory Infection	^	66.4	68.6	^	79.1	76.8	^	64.7	67.9	70.0	^	67.2	69.4	★
Asthma Medication Ratio (5-11)	^	79.5	79.2	^	82.3	74.7	^	79.7	82.0	^	^	80.0	79.9	★★★★
Asthma Medication Ratio (12-18)	^	63.9	58.4	^	69.1	59.5	^	66.5	72.3	^	^	66.1	66.0	★★★★
Asthma Medication Ratio (19-50)	^	48.3	45.2	^	44.7	39.0	^	49.6	54.0	^	^	48.3	47.8	★★
Asthma Medication Ratio (51-64)	^	^	33.3	^	^	66.7	^	^	50.0	^	^	^	50.0	★★
Asthma Medication Ratio (Total)	^	69.2	66.8	^	71.8	62.9	^	71.1	74.4	^	^	70.6	69.9	★★★★
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	^	14.1	10.6	^	13.7	19.3	^	17.4	15.1	20.0	^	15.5	14.3	★
Breast Cancer Screening	50.0	38.3	44.9	^	60.6	58.8	46.7	37.3	40.0	^	48.1	42.8	45.4	★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	^	^	100.0	^	^	^	^	^	^	^	^	^	100.0	★★★★★
Cervical Cancer Screening	55.2	53.2	52.3	57.3	55.2	52.6	61.5	58.6	53.4	32.4	58.5	56.0	52.0	★★
Childhood Immunization Status - Combo 2	72.0	69.6	75.9	75.7	74.7	72.5	67.4	72.5	71.3	33.3	70.4	71.7	73.3	★★
Childhood Immunization Status - Combo 3	67.4	66.3	71.9	72.5	69.3	70.3	63.4	67.1	68.1	33.3	66.3	67.1	70.0	★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Childhood Immunization Status - Combo 4	65.0	65.3	69.8	70.1	67.9	68.1	60.9	65.5	65.7	33.3	63.8	65.8	67.8	★★
Childhood Immunization Status - Combo 5	52.8	47.6	59.7	56.9	53.8	57.9	52.1	55.1	54.2	33.3	53.1	52.0	57.0	★★
Childhood Immunization Status - Combo 6	36.7	37.0	38.0	38.7	36.7	32.6	35.2	35.4	34.0	33.3	36.3	36.3	35.4	★★
Childhood Immunization Status - Combo 7	51.3	47.4	58.5	56.7	53.0	57.4	50.7	54.2	53.7	33.3	51.8	51.3	56.2	★★
Childhood Immunization Status - Combo 8	36.0	36.6	37.7	38.4	36.5	32.1	33.8	35.0	33.3	33.3	35.3	35.8	34.9	★★
Childhood Immunization Status - Combo 9	30.4	27.4	34.0	33.1	32.4	30.4	30.3	30.8	28.9	33.3	30.8	29.7	31.2	★★
Childhood Immunization Status - Combo 10	29.9	27.4	33.7	33.1	32.1	30.2	29.4	30.3	28.5	33.3	30.2	29.4	30.9	★★
Chlamydia Screening in Women (Lower Age Stratification)	39.2	35.1	38.6	36.4	38.0	34.6	36.5	34.7	35.9	30.8	37.4	35.4	36.5	★
Chlamydia Screening in Women (Upper Age Stratification)	53.2	46.0	52.3	53.0	46.7	43.8	50.5	46.7	48.5	38.0	52.0	46.4	48.6	★
Chlamydia Screening in Women - Total	43.9	39.1	43.1	40.4	40.8	37.7	40.2	38.5	39.8	34.6	41.6	39.1	40.5	★
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	64.3	58.2	58.7	69.6	68.6	64.4	54.1	61.1	65.3	43.8	60.4	61.1	61.9	★★★
Comprehensive Diabetes Care - Eye Exams	32.3	34.0	34.2	32.9	30.4	27.4	25.8	25.9	27.3	25.0	29.4	29.8	29.9	★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	29.8	31.7	^	^	^	^	^	^	^	29.3	29.8	31.7	29.3	★★
Comprehensive Diabetes Care - HbA1c Control (<8%)	41.3	43.3	43.2	45.3	41.2	39.6	28.7	38.2	46.1	39.6	36.1	40.7	43.6	★★
Comprehensive Diabetes Care - HbA1c Testing	72.9	76.4	77.4	73.9	78.9	81.1	80.2	81.7	83.8	85.4	76.4	79.2	80.9	★
Comprehensive Diabetes Care - Medical Attention for Nephropathy	55.3	67.1	82.1	57.8	69.1	85.2	64.1	67.6	88.0	89.6	59.7	67.6	85.3	★
Comprehensive Diabetes Care - Poor HbA1c Control (>9.0%) A lower is Better	48.7	47.8	48.1	46.6	46.9	50.7	64.1	51.9	46.5	56.3	55.5	49.5	48.2	★★
Controlling High Blood Pressure	56.0	55.6	53.8	67.0	56.4	61.0	40.1	50.6	55.2	33.3	49.5	53.4	54.8	★★
Diabetes Monitoring for People With Diabetes and Schizophrenia	^	^	^	^	^	50.0	^	^	100.0	^	^	^	50.0	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	^	88.1	77.5	^	^	74.1	^	79.8	76.2	64.7	^	82.7	75.9	★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	^	^	71.4	^	^	77.8	^	69.7	58.8	^	^	69.7	64.6	★
FU Care for Children Prescribed ADHD Medication - Initiation Phase	^	41.9	41.9	^	44.2	39.7	^	35.6	37.5	^	^	37.4	39.4	★
FU Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase	^	40.5	50.0	^	49.6	44.6	^	34.7	46.1	^	^	36.2	47.2	★★
FU After Hospitalization For Mental Illness - 7 days	^	^	31.0	^	^	21.5	^	^	^	18.9	^	^	27.3	★
FU After Hospitalization For Mental Illness - 30 days	^	^	60.4	^	^	38.9	^	^	^	24.3	^	^	51.3	★
Human Papillomavirus Vaccine for Female Adolescents	23.6	18.4	21.2	26.8	23.4	23.1	13.2	25.3	22.2	16.7	19.0	22.6	22.0	★★
Immunizations for Adolescents - Combination 1	83.4	84.3	83.9	83.2	84.4	81.3	78.0	80.5	84.3	75.0	80.7	82.5	83.6	★★★★
Lead Screening in Children	59.4	53.1	56.4	51.6	49.6	51.8	56.0	53.4	59.0	33.3	56.6	52.7	56.8	★★
Medication Management for People With Asthma: Medication Compliance 50% (5-11)	^	58.2	60.4	^	63.6	58.8	^	66.4	58.8	^	^	63.3	59.4	^

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Medication Management for People With Asthma: Medication Compliance 50% (12-18)	^	55.3	55.4	^	56.3	60.9	^	59.4	57.2	^	^	57.6	57.2	^
Medication Management for People With Asthma: Medication Compliance 50% (19-50)	^	65.2	58.8	^	^	53.5	^	71.1	63.6	^	^	68.5	60.0	^
Medication Management for People With Asthma: Medication Compliance 50% (51-64)	^	^	50.0	^	^	100.0	^	^	50.0	^	^	^	66.7	^
Medication Management for People With Asthma: Medication Compliance 50% (Total)	^	58.0	58.5	^	60.6	59.3	^	64.1	58.5	^	^	61.5	58.6	^
Medication Management for People With Asthma: Medication Compliance 75% (5-11)	^	29.9	31.2	^	37.2	39.2	^	40.4	34.4	^	^	36.4	33.9	★★
Medication Management for People With Asthma: Medication Compliance 75% (12-18)	^	32.9	28.7	^	31.3	33.6	^	34.5	28.7	^	^	33.5	29.4	★★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Medication Management for People With Asthma: Medication Compliance 75% (19-50)	^	40.9	37.7	^	^	37.2	^	47.0	40.2	^	^	44.3	38.7	★★★
Medication Management for People With Asthma: Medication Compliance 75% (51-64)	^	^	50.0	^	^	66.7	^	^	50.0	^	^	^	55.6	★★★
Medication Management for People With Asthma: Medication Compliance 75% (Total)	^	32.3	31.1	^	33.8	37.0	^	38.5	32.6	^	^	35.8	32.8	★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics (1-5)	^	^	20.0	^	^	50.0	^	^	20.0	^	^	^	25.0	★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics (6-11)	^	11.6	17.0	^	20.4	17.0	^	12.8	20.2	11.1	^	13.7	18.5	★
Metabolic Monitoring for Children and Adolescents on Antipsychotics (12-17)	^	16.8	19.4	^	24.2	30.4	^	18.0	20.5	^	^	18.9	22.3	★
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total)	^	14.0	18.3	^	22.5	25.6	^	15.5	20.4	7.7	^	16.3	20.6	★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) A lower score is better	7.9	5.5	3.8	9.5	7.0	4.9	10.2	6.6	4.7	5.4	9.3	6.3	4.4	★
Persistence of Beta-Blocker Treatment after a Heart Attack	^	^	66.7	^	^	60.0	^	^	100.0	100.0	^	^	75.0	★★
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	^	71.4	80.8	^	^	82.2	^	88.6	81.2	79.0	^	67.4	80.9	★★
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	^	74.3	84.6	^	^	65.6	^	81.8	68.4	72.8	^	65.3	73.0	★★★
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (21-75 years Male)	^	^	77.8	^	^	20.0	^	^	66.7	^	^	^	62.1	^
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (40-75 years Female)	^	^	76.9	^	^	66.7	^	^	64.3	^	^	^	69.5	^
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)	^	^	77.3	^	^	50.0	^	^	65.5	^	^	^	66.2	^

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence (21-75 years Male)	^	^	42.9	^	^	100.0	^	^	80.0	^	^	^	66.7	^
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence (40-75 years Female)	^	^	70.0	^	^	16.7	^	^	44.4	^	^	^	48.0	^
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence (Total)	^	^	58.8	^	^	28.6	^	^	63.2	^	^	^	55.8	^
Statin Therapy for Patients With Diabetes - Received Statin Therapy	^	^	54.6	^	^	46.9	^	^	55.6	^	^	^	53.8	^
Statin Therapy for Patients With Diabetes - Statin Adherence	^	^	48.3	^	^	65.2	^	^	53.3	^	^	^	53.2	^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-5)	^	^	^	^	^	^	^	^	^	^	^	^	^	^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (6-11)	^	^	37.0	^	^	100.0	^	^	^	^	^	^	37.9	★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)	^	^	44.8	^	^	33.3	^	^	^	^	^	^	41.2	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)	^	^	41.1	^	^	50.0	^	^	^	^	^	^	39.7	★
Use of Imaging Studies for Low Back Pain	65.5	65.6	64.2	71.7	61.5	66.8	65.5	68.2	66.2	69.4	66.4	66.2	65.7	★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (1-5)	^	^	^	^	^	^	^	^	^	^	^	^	^	^
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (6-11)	^	^	^	^	^	^	^	0.8	0.9	^	^	0.8	0.5	★★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (12-17)	^	0.8	1.3	^	1.9	5.3	^	0.4	^	^	^	0.8	1.5	★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Total)	^	0.4	0.7	^	1.1	3.1	^	0.6	0.4	^	^	0.6	1.0	★★★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (3-11 years)	54.7	49.7	63.0	38.7	56.1	59.4	40.3	49.7	61.3	46.6	45.2	50.6	61.5	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (12-17 years)	51.9	50.0	58.9	39.5	57.1	56.4	43.5	55.1	68.5	51.6	45.8	53.6	62.7	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	53.8	49.8	61.6	38.9	56.5	58.4	41.3	51.4	63.4	48.9	45.4	51.6	61.8	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (3-11 years)	55.0	53.9	56.8	48.8	62.0	56.5	37.6	50.7	62.3	51.1	45.6	53.6	59.2	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (12-17 years)	47.4	44.7	58.9	45.2	47.9	50.0	33.6	39.9	53.9	50.5	40.3	43.0	54.9	★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	52.6	51.4	57.6	47.7	57.2	54.3	36.4	47.1	59.7	50.9	43.9	50.3	57.9	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (3-11 years)	35.3	43.2	42.9	22.7	35.8	40.6	24.1	39.0	46.0	46.1	27.9	40.1	44.0	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (12-17 years)	38.8	46.5	53.6	37.9	35.7	44.3	33.6	39.9	51.5	49.0	36.1	41.6	51.0	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	35.8	44.1	46.7	27.3	35.8	41.9	27.0	39.3	47.7	47.5	30.2	40.6	46.4	★★

+HEDIS percentiles are from NCQA Quality Compass 2016 (MY 2015).
^ Indicates that denominator was too small to report a rate or that a comparative benchmark is not available.

Table A3-2 Access/ Availability of Care Domain Measures.

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Adults' Access to Preventive/Ambulatory Health Services (20-44)	84.2	82.6	82.7	86.8	83.7	84.0	85.7	84.8	84.2	79.6	85.3	83.8	83.4	★★★
Adults' Access to Preventive/Ambulatory Health Services (45-64)	83.6	84.0	83.1	89.4	88.7	87.7	85.8	85.5	85.4	80.0	85.5	85.4	84.7	★★
Adults' Access to Preventive/Ambulatory Health Services (65+)	^	^	^	^	^	^	^	^	^	^	^	^	^	^
Adults' Access to Preventive/Ambulatory Health Services (Total)	84.1	82.8	82.7	87.0	84.2	84.4	85.7	84.8	84.3	79.6	85.3	83.9	83.5	★★★
Annual Dental Visit (2-3 Yrs.)	^	31.9	33.5	^	36.2	32.0	^	15.9	26.0	27.8	^	23.7	29.9	★★
Annual Dental Visit (4-6 Yrs.)	^	61.3	68.6	^	60.8	67.6	^	34.2	55.3	55.2	^	47.3	62.2	★★★
Annual Dental Visit (7-10 Yrs.)	^	62.9	67.1	^	61.9	64.7	^	35.6	55.9	58.0	^	48.2	61.2	★★
Annual Dental Visit (11-14 Yrs.)	^	60.3	62.7	^	56.4	59.3	^	35.0	53.3	57.1	^	46.6	57.6	★★
Annual Dental Visit (15-18 Yrs.)	^	51.9	55.6	^	50.0	54.9	^	30.5	47.2	48.3	^	40.5	51.4	★★★
Annual Dental Visit (19-21 Yrs.)	^	36.2	41.4	^	41.1	43.7	^	18.4	31.5	41.1	^	27.2	37.8	★★★
Annual Dental Visit (Total)	^	54.8	59.0	^	55.8	57.3	^	31.3	49.4	51.4	^	42.5	54.1	★★★
Children and Adolescents' Access To PCP (12-24 Months)	97.7	97.4	97.9	98.0	96.4	97.0	97.2	93.5	97.9	96.7	97.5	95.5	97.7	★★★★
Children and Adolescents' Access To PCP (25 Months-6 Yrs.)	92.5	92.8	92.1	89.9	89.4	89.4	90.7	86.1	89.5	81.6	91.3	89.1	90.4	★★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2015 %
	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2013 %	MY 2014 %	MY 2015 %	MY 2015 %				
Children and Adolescents' Access To PCP (7-11 Yrs.)	94.4	94.8	94.6	92.4	91.4	91.0	93.9	93.5	90.3	^	93.8	93.6	91.9	★★★
Children and Adolescents' Access To PCP (12-19 Yrs.)	93.5	94.0	93.8	91.7	90.4	90.2	92.6	92.2	89.0	^	92.7	92.5	90.8	★★★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (13-17 Yrs)	^	^	7.8	^	^	50.0	^	^	^	^	^	^	9.0	★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement (18+ Yrs.)	^	^	26.8	^	^	16.6	^	^	^	8.2	^	^	22.7	★★★★★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Engagement Total	^	^	25.3	^	^	17.0	^	^	^	8.1	^	^	21.9	★★★★★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (13-17 Yrs.)	^	^	35.9	^	^	50.0	^	^	^	100.0	^	^	37.3	★★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation (18+ Yrs.)	^	^	43.7	^	^	44.0	^	^	^	25.9	^	^	41.3	★★★
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation Total	^	^	43.1	^	^	44.1	^	^	^	26.4	^	^	41.1	★★★
Postpartum Care - Postpartum Care	60.6	55.0	59.4	62.8	61.6	63.0	64.9	61.7	57.1	51.1	62.7	59.1	58.5	★★
Prenatal and Postpartum Care - Timeliness of Prenatal Care Prenatal and	92.7	89.8	93.6	93.2	96.4	89.5	92.5	89.1	86.5	85.9	92.7	90.7	89.4	★★★★

+HEDIS percentiles are from NCQA Quality Compass 2016 (MY 2015).
^ Indicates measure not collected or benchmark not available.

Table A3-3 Utilization and Risk Adjusted Utilization Domain Measures.

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2014 %
	MY 2012 %	MY 2013 %	MY 2014 %	MY 2012 %	MY 2013 %	MY 2014 %	MY 2012 %	MY 2013 %	MY 2014 %	MY 2015 %				
Adolescent Well-Care Visits	47.2	50.5	39.9	43.1	46.5	47.2	41.2	41.9	51.9	49.9	43.6	45.7	46.9	★★
Frequency of Ongoing Prenatal Care (<21%)	3.8	3.6	3.1	2.7	0.5	3.7	7.8	3.6	6.5	8.3	5.2	3.0	5.0	★★
Frequency of Ongoing Prenatal Care (21-40%)	3.0	3.9	1.4	1.5	1.0	5.1	4.7	2.0	2.1	3.4	3.4	2.6	2.5	★
Frequency of Ongoing Prenatal Care (41-60%)	7.0	11.4	4.3	1.5	1.5	5.1	7.3	2.8	8.2	5.6	6.1	5.9	6.1	★★
Frequency of Ongoing Prenatal Care (61-80%)	10.1	11.6	14.3	3.9	6.8	9.3	14.9	9.9	11.9	10.0	10.9	10.0	12.1	★
Frequency of Ongoing Prenatal Care (>= 81%)	76.1	69.5	76.9	90.5	90.3	76.9	65.3	81.7	71.3	72.8	74.4	78.6	74.4	★★★★
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	73.7	77.8	72.1	71.3	70.6	74.0	66.9	69.0	74.9	62.5	70.0	72.6	73.6	★★
Well-Child Visits in the first 15 Months of Life (0 visits)	0.3	2.3	0.7	1.4	2.5	1.1	1.6	2.1	1.7	^	1.1	2.2	1.2	★★
Well-Child Visits in the first 15 Months of Life (1 visit)	2.3	1.8	1.0	1.2	1.1	1.5	2.6	0.8	2.0	^	2.3	1.2	1.5	★★★
Well-Child Visits in the first 15 Months of Life (2 visits)	2.6	4.1	1.7	3.6	2.7	2.6	3.1	3.9	4.9	^	3.0	3.8	3.3	★★★
Well-Child Visits in the first 15 Months of Life (3 visits)	6.1	6.7	5.1	5.1	4.5	4.6	3.9	5.5	6.1	7.1	4.9	5.8	5.5	★★

Measure	CoventryCares			The Health Plan			UniCare			WVFH	MHT-WA MY 2013 %	MHT-WA MY 2014 %	MHT-WA MY 2015 %	MHT-WA Compared to NMPs MY 2014 %
	MY 2012 %	MY 2013 %	MY 2014 %	MY 2012 %	MY 2013 %	MY 2014 %	MY 2012 %	MY 2013 %	MY 2014 %	MY 2015 %				
Well-Child Visits in the first 15 Months of Life (4 visits)	8.2	7.2	7.8	5.7	8.9	9.1	6.8	6.0	8.6	21.4	7.1	6.9	8.4	★★
Well-Child Visits in the first 15 Months of Life (5 visits)	15.2	18.6	17.1	14.0	14.5	18.4	14.1	19.0	14.2	21.4	14.5	18.1	16.1	★★★
Well-Child Visits in the first 15 Months of Life (6 or more visits)	65.2	59.3	66.6	69.1	65.8	62.7	68.0	62.9	62.5	50.0	67.1	61.9	64.1	★★★

+HEDIS percentiles are from NCQA Quality Compass 2016 (MY 2015).

Appendix 4 – CAHPS Survey Measure Results

The MHT MCOs conducted the HEDIS 2016 Consumer Assessment of the Health Providers and Systems (CAHPS) survey to meet NCQA accreditation standards and their contractual requirements with BMS. Different summary measures are used to report survey results including averages, composites and ratings. Individual MCO rates for three years (MY 2013-2015), the MHT Average (MA) for three years, and a comparison of MA (MY 2015) to the most current National Medicaid Percentiles (NMP) for CAHPS 2016 (MY 2015) are provide for each measure in Table A4-1.

Star Ratings for Adult and Child CAHPS Measures.

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

Table A4-1. Adult and Child CAHPS Measure Results.

Measure	Coventry Cares MY 2013 %	Coventry Cares MY 2014 %	Coventry Cares MY 2015 %	The Health Plan MY 2013 %	The Health Plan MY 2014 %	The Health Plan MY 2015 %	UniCare MY 2013 %	UniCare MY 2014 %	UniCare MY 2015 %	WVFH MY 2015 %	MA MY 2013 %	MA MY 2014 %	MA MY 2015 %	MA Compared to NMPs MY 2015 %
Adult Survey														
Customer Service Composite	88.7	^	^	92.6	86.5	^	^	92.2	^	^	90.7	89.4	^	^
Getting Needed Care Composite	80.5	77.7	78.4%	85.7	77.9	81.4	83.7	72.2	81.8	80.4	83.3	75.9	80.5	★★
Getting Care Quickly Composite	80.9	82.6	83.4	84.0	83.5	79.4	85.0	83.7	84.3	85.9	83.3	83.2	83.2	★★★
How Well Doctors Communicate Composite	88.0	92.4	90.6	90.6	91.2	91.7	90.0	89.6	92.7	93.4	89.5	91.1	92.1	★★★
Shared Decision Making Composite*	55.2	83.0	80.5	55.2	83.0	85.1	55.8	85.0	82.7	81.5	55.4	83.6	82.4	★★★★
Health Promotion and Education Composite	68.3	73.8	69.3	65.0	67.3	69.3	70.5	68.6	68.4	73.5	67.9	69.9	70.1	★★
Coordination of Care Composite	72.0	^	^	73.0	78.2	^	75.5	83.1	75.4	86.7	73.5	80.7	81.0	★★
Rating of Health Plan	65.2	59.9	66.3	78.6	73.0	73.1	70.3	66.4	68.7	71.7	71.4	66.4	70.0	★
Rating of All Health Care	65.4	68.3	66.8	71.2	68.7	70.8	69.0	62.5	69.1	67.5	68.5	66.5	68.6	★
Rating of Personal Doctor	75.4	72.7	77.3	78.2	76.3	77.1	80.4	77.5	80.9	84.6	78.0	75.5	80.0	★★
Rating of Specialist Seen Most Often	73.5	^	75.3	79.4	71.1	^	^	73.0	76.1	81.5	76.5	72.0	77.6	★

Measure	Coventry Cares MY 2013 %	Coventry Cares MY 2014 %	Coventry Cares MY 2015 %	The Health Plan MY 2013 %	The Health Plan MY 2014 %	The Health Plan MY 2015 %	UniCare MY 2013 %	UniCare MY 2014 %	UniCare MY 2015 %	WVFH MY 2015 %	MA MY 2013 %	MA MY 2014 %	MA MY 2015 %	MA Compared to NMPs MY 2015 %
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers To Quit	75.0	69.3	67.7	74.6	77.4	75.0	73.6	74.2	69.1	74.8	74.4	73.6	71.7	★
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Medications	39.8	34.3	32.3	49.7	50.4	45.9	36.7	38.1	35.7	45.5	42.1	40.9	39.9	★
Medical Assistance with Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	42.5	34.7	32.0	46.4	51.2	45.5	33.7	33.2	33.4	42.2	40.9	39.7	38.3	★
Flu measure- Had flu shot or spray in the nose since July 1, 201x	32.6	33.5	32.3	30.3	26.7	29.7%	33.6	32.1	27.6	37.6	32.2	30.8	31.8	★
Child Survey- General Population														
Child Survey - General Population: Customer Service Composite	93.8	93.6	89.6	91.0	92.8	94.4	88.2	88.0	88.3	^	91.0	91.5	90.8	★★★★

Measure	Coventry Cares MY 2013 %	Coventry Cares MY 2014 %	Coventry Cares MY 2015 %	The Health Plan MY 2013 %	The Health Plan MY 2014 %	The Health Plan MY 2015 %	UniCare MY 2013 %	UniCare MY 2014 %	UniCare MY 2015 %	WVFH MY 2015 %	MA MY 2013 %	MA MY 2014 %	MA MY 2015 %	MA Compared to NMPs MY 2015 %
Child Survey - General Population: Getting Needed Care Composite	90.3	87.1	89.6	86.2	90.2	89.2	89.6	88.8	87.4	87.5	88.7	88.7	88.4	★★★★
Child Survey - General Population: Getting Care Quickly Composite	95.1	93.4	95.6	94.0	94.9	95.7	94.4	94.1	93.3	95.2	94.5	94.1	94.9	★★★★★
Child Survey - General Population: How Well Doctors Communicate Composite	94.8	94.0	96.5	95.5	95.7	95.8	93.4	95.6	95.1	95.9	94.5	95.1	95.8	★★★★★
Child Survey - General Population: Shared Decision Making Composite*	58.7	82.4	84.0	55.0	78.7	77.8	50.7	78.8	76.3	^	54.8	79.9	79.4	★★★
Health Promotion and Education Composite	71.4	74.3	76.5	70.6	69.5	69.5	71.8	72.1	71.3	78.8	71.3	72.0	74.0	★★★★
Coordination of Care Composite	81.6	80.9	88.2	80.9	78.5	84.3	73.6	82.7	83.2	85.0	78.7	80.7	85.2	★★★
Child Survey - General Population: Rating of Health Plan	87.4	81.5	86.7	87.3	85.0	84.3	84.8	84.7	83.7	77.5	86.5	83.7	83.1	★★

Measure	Coventry Cares MY 2013 %	Coventry Cares MY 2014 %	CoventryCares MY 2015 %	The Health Plan MY 2013 %	The Health Plan MY 2014 %	The Health Plan MY 2015 %	UniCare MY 2013 %	UniCare MY 2014 %	UniCare MY 2015 %	WVFH MY 2015 %	MA MY 2013 %	MA MY 2014 %	MA MY 2015 %	MA Compared to NMPs MY 2015 %
Child Survey - General Population: Rating of All Health Care	89.4	81.6	85.0	87.8	86.2	85.8	83.7	83.8	83.9	86.8	86.9	83.9	85.3	★★
Child Survey - General Population: Rating of Personal Doctor	91.4	87.9	91.2	88.4	87.7	88.6	84.7	87.4	87.6	88.8	88.2	87.7	89.0	★★★
Child Survey - General Population: Rating of Specialist Seen Most Often	86.8	82.7	83.8	78.2	83.1	75.2	91.7	80.3	85.6	^	85.6	82.0	81.5	★

⌘ CAHPS percentiles are from NCQA Quality Compass 2015 (MY 2014)
^ Indicates that denominator was too small to report a rate or that a comparative benchmark is not available
+ Measure specifications changed significantly between MY 2013 and MY 2015 for Share Decision Making Composite in both the Adult and Child Surveys.

Appendix 5 - Status of Recommendations from Measurement Year 2014 Review

Delmarva provided recommendations to all three MCOs based on the results of the 2014 SPR, PIP, and PMV activities with the expectation that they would be addressed. The tables below provide the recommendations made and the actions, if any, that have been undertaken by each of the MCOs in 2014 to address these recommendations. Summaries are presented below by MCO and activity.

Delmarva provided recommendations to all three MCOs based on the results of the 2014 SPR, PIP, and PMV activities with the expectation that they would be addressed. The tables below provide the recommendations made and the actions, if any, that have been undertaken by each of the MCOs in 2015 to address these recommendations. Summaries are presented below by MCO and activity as well as for the Mountain Health Trust Program.

Table A5-1. CoventryCares 2014 Recommendations and 2015 Current Status

CoventryCares 2014 Recommendations and 2015 Current Status	
Systems Performance Review	
Enrollee Rights	**Requirements and Recommendations** ➢ There were no requirements or recommendations as the MCO achieved 100% compliance on this standard in 2014.
	Status ➢ Not applicable.
Grievance Systems	**Requirements and Recommendations** ➢ There were no requirements or recommendations as the MCO achieved 100% compliance on this standard in 2014.
	Status ➢ Not applicable.
Quality Assessment and Performance Improvement	**Requirements and Recommendations** ➢ There were no requirements or recommendations as the MCO achieved 100% compliance on this standard in 2014.
	Status ➢ Not applicable.
Fraud and Abuse	**Requirements and Recommendations** ➢ There were no requirements or recommendations as the MCO achieved 100% compliance on this standard in 2014.
	Status ➢ Not applicable.

<table>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td rowspan="2">Adolescent Well-Care Visits</td><td>Recommendation
➢ Delmarva recommended that the MCO close this project after achieving “sustained improvement” in MY 2014.</td></tr>
<tr><td>Status
➢ The MCO continued the PIP for one more reporting cycle and thus realized a decrease from the Baseline rate of 42.13% to Remeasurement 4 (39.86%) in MY 2015 and a statistically significant decrease from MY 2014 (50.47%) to MY 2015 (39.86%).
➢ The MCO is required to close this PIP and submit a proposal for new PIP project l to replace it.</td></tr>
<tr><td rowspan="2">Emergency Department Collaborative</td><td>Recommendation
➢ For the second year the recommendation was made that the MCO put a mechanism in place to monitor or require follow-up on the Gaps-in-Care lists that the MCO sends to providers.</td></tr>
<tr><td>Status
➢ The MCO did not implement a follow-up mechanism to this intervention.</td></tr>
<tr><td rowspan="2">Diabetes Collaborative</td><td>Recommendation
➢ The MCO sends Gaps in Care Lists in hopes that practitioners provide follow-up and schedule members for an office visit to get the necessary services. While these lists are sent to the practitioners, there is no follow up with the provider to encourage outreach to the member.</td></tr>
<tr><td>Status
➢ In both MY 2013 and MY 2014, it was recommended that the MCO put a mechanism in place to monitor or follow-up to get members into care. The MCO did not address this recommendation and therefore it is made again for MY 2015.PIP met requirements.</td></tr>
<tr><th colspan="2">Performance Measure Validation</th></tr>
<tr><td colspan="2">Requirement
➢ Be fully prepared to report HEDIS behavioral health measures in the next reporting period.
Status
➢ The MCO was successful in reporting selected behavioral health measures.</td></tr>
<tr><td colspan="2">Recommendation
➢ Continue to work with BMS to implement the MOU with Vital Statistics, and identify a process to access data. Once Vital Statistics data becomes available, the MCO should be prepared to report the Adult and Child Core measures that rely on that data.
Status
➢ The MOU expired and there are no current plans to pursue another at this time.</td></tr>
</table>

Table A5-2. The Health Plan 2014 Recommendations and 2015 Current Status

The Health Plan 2014 Recommendations and 2015 Current Status	
Systems Performance Review	
Enrollee Rights	**Requirements and Recommendations** ➢ There were no requirements or recommendations from the 2014 review.
	Status ➢ Not Applicable
Grievance Systems	**Requirements and Recommendations** ➢ Any provider type is able to file an appeal on behalf of a member. In order to maintain a finding of Met in the next annual review, The Health Plan must change "doctor" to "provider" in its grievance and appeals description in all relevant policies, procedures, and the Member Handbook.
	Status ➢ The MCO is revising documents as they are due for review.
Quality Assessment and Performance Improvement	**Requirements and Recommendations** ➢ **Credentialing** – The Health Plan requires each delegate to submit quarterly reports. In addition, the MCO conducts an annual review of each delegate. All reviews were up to date and complete for 2014. One delegated entity, Preferred Care of the Virginia's (PCV) had staff turn-over and did not notify The Health Plan timely. This impacted the MCOs ability to schedule the annual audit for 2015 in a timely manner despite numerous attempts to contact PCV. Delmarva recommends that The Health Plan continue to document all efforts to contact PCV and schedule the annual audit and to receive all required reports for the 2015 review period. ➢ **Member Satisfaction** – The MCO conducted the Child and Adult CAHPS surveys as required but only limited information was shared with providers. The Provider Focus newsletter provided a brief summary of the areas identified for improvement and a phone number that providers can call to receive more details. In order to maintain a review requirement of "Met" for the next review, the MCO must provide more detailed information in the Provider Focus newsletter about the CAHPS findings, such as composite and ratings scores. ➢ **Access and Availability** – The Emergency Care Access and the After-Hours Access Standards did not meet the 90% minimum threshold. In order to achieve full compliance in the next review, the MCO implement corrective actions to achieve a minimum of 90% compliance for both access standards.
	Status ➢ **Credentialing** – The MCO put the provider in question on a corrective action plan and was successful in scheduling and conducting the required delegated oversight audit in 2015. ➢ **Member Satisfaction** – The MCO shared all its 2015 Adult and Child CAHPS survey ratings and composite scores with its providers via the Third Quarter Newsletter. The article also informed providers how to obtain more information. Access and Availability – The MCO implemented its CAP, but both access indicators did not achieve the 90% target again in 2015. The MCO has implemented a new CAP for 2015 and will report progress to Delmarva at least quarterly.

Fraud and Abuse	**Requirements and Recommendations** ➢ There were no requirements or recommendations from the 2014 review. **Status** ➢ Not Applicable
Performance Improvement Projects	
Members Establishment with PCP of Record Project	**Recommendation** ➢ Last year was the first submission and there were no recommendations except to implement the PIP. **Status** ➢ PIP meets requirements. ➢ Continue with this PIP.
Emergency Department Collaborative	**Recommendation** ➢ Continue with targeted member and provider specific interventions. **Status** ➢ The Health Plan continues with those interventions that have been determined to be successful in impacting the indicators.
Diabetes Collaborative	**Recommendation** ➢ The MCO sends letters to providers containing members with missing services, hoping that providers will follow-up with non-compliant members. The MCO should consider implementing a mechanism to ensure providers do some sort of follow-up. This recommendation was made in 2014 and should be addressed by the MCO. **Status** ➢ PIP submission met requirements. ➢ Continue with targeted member and provider specific interventions. ➢ The MCO began using HEDIS certified software. This software provides detailed information specific to providers or provider groups to show which members with diabetes need treatment or services. Analysts use the software to drill down to the provider level to produce reports that show providers the specific members on their rosters that are missing services. It is recommended that the MCO have a mechanism in place to ensure that providers follow-up with members identified who have gaps in care.
Performance Measure Validation	
Requirement ➢ Be fully prepared to report HEDIS behavioral health measures in the next reporting period. **Status** ➢ The MCO was successful in reporting selected behavioral health measures.	
Recommendation ➢ The MCOs must be prepared to report non-HEDIS performance measures to BMS from the CMS Child and Adult Quality Core Measure Sets for MY 2014. **Status** ➢ The MCO successfully reported all Child and Adult Quality Core Set Measures to BMS for MY 2014.	

Table A5-3. UniCare 2014 Recommendations and 2015 Current Status

<table>
<tr><th colspan="2">UniCare
2014 Recommendations and 2015 Current Status</th></tr>
<tr><th colspan="2">Systems Performance Review</th></tr>
<tr><td rowspan="2">Enrollee Rights</td><td>Requirement
➢ There are no recommendations or requirements for 2014 as the MCO achieved full compliance for this standard.</td></tr>
<tr><td>Status
➢ Not applicable</td></tr>
<tr><td rowspan="2">Grievance Systems</td><td>Recommendation
➢ In general, the notice of action letters (NOAs) include the required components. However, the notices state “doctor,” but should state “provider” since all providers are not doctors. In addition, the document “Your Rights Under Mountain Health Trust” should include these same changes. These documents, and any similar documents in use by UniCare must be revised to maintain a finding of “met” in the next annual review.</td></tr>
<tr><td>Status
➢ The MCO is making changes to documents as they come up for review.</td></tr>
<tr><td rowspan="2">Quality Assessment and Performance Improvement</td><td>Requirements
➢ Access and Availability – UniCare must achieve at least a 90% compliance rating for each type of appointment to ensure that members have timely access to care and services. The MCO’s provider access survey found that providers were not meeting the 90% threshold for Urgent Care (88%), After Hours 24/7 Access to Primary Care Providers (69%), Prenatal Appointment within 14 Days (84%), and Routine Appointment (84%).
➢ Credentialing and Recredentialing – Not all providers were brought up to date in 2014 for the on-site recredentialing visits identified as missing in the 2013 review. The MCO must provide documentation that the seven outstanding providers are up to date with a recredentialing on-site visit.
➢ Member Satisfaction – UniCare must share its CAHPS survey findings to its providers. This can be done through provider newsletters, fax blasts, etc.
➢ Utilization Management – As in the Grievance System Requirements section, in general, the notice of action letters (NOAs) include the required components. However, some UM policies and procedures use the term “doctor,” but should state “provider” since all providers are not doctors. These documents, and any similar documents in use by UniCare must be revised as they come up for review and revisions.</td></tr>
<tr><td>Status
➢ Access and Availability – The MCO implemented a CAQI program. The results of the most recent access and availability survey found that providers were not meeting the 90% threshold for Urgent Care (88%), After Hours 24/7 Access to Primary Care Providers (69%), Prenatal Appointment within 14 Days (84%), and Routine Appointment (84%).
➢ Credentialing and Recredentialing – The outstanding on-site visits for recredentialing have been completed.
➢ Member Satisfaction – 2015 CAHPS survey results were presented during the Fourth Quarter 2015 Meetings for the Medical Advisory Committee and the Quality Committee. The survey results were also communicated through the 2015 Fall/Winter Provider Newsletter.
➢ Utilization Management – The MCO is making changes to the documents as they come up for review.</td></tr>
</table>

<table>
<tr><th colspan="2">UniCare
2014 Recommendations and 2015 Current Status</th></tr>
<tr><td rowspan="2">Fraud and Abuse</td><td>Requirements and Recommendations
➢ There are no recommendations or requirements for 2014 as the MCO achieved full compliance for this standard.</td></tr>
<tr><td>Status
➢ Not Applicable</td></tr>
<tr><th colspan="2">Performance Improvement Projects</th></tr>
<tr><td rowspan="2">Childhood Immunization Status Combination 3</td><td>Recommendations
➢ Continue the PIP.</td></tr>
<tr><td>Status
➢ UniCare continued the PIP for one more year and achieved sustained improvement. Close PIP. The MCO must close this PIP at the end of 2016 as sustained improvement has been achieved.
➢ The MCO should continue all interventions that have been determined to be successful after this project is closed.
➢ UniCare must select a new project topic and submit a project proposal to Delmarva to replace this PIP.</td></tr>
<tr><td rowspan="2">Emergency Department Collaborative</td><td>Recommendation
➢ It was recommended that the MCO participate with the PIP Collaborative Team to determine the collaborative indicator goal. The Collaborative decided to have each MCO select its own goal and UniCare selected the goal of 7.98% based on its prior year's performance.</td></tr>
<tr><td>Status
➢ Continue with those interventions that have been determined to be successful in impacting the indicators.
➢ Close PIP. All MCOs are required to close this PIP due to the retirement of the Pediatric Asthma ED Use measure from the Child Core Set and the Use of Appropriate Medication for People With Asthma (ASM) from the HEDIS measure set. The retired measures are no longer supported by HEDIS Certified Software vendors and there are no current national benchmarks to gage performance. The MCO is encouraged to keep interventions in place that have been determined to be effective.</td></tr>
<tr><td rowspan="2">Diabetes Collaborative</td><td>Recommendation
➢ It was recommended that UniCare continue the member incentives and Disease Management Program to try and increase member participation in interventions.</td></tr>
<tr><td>Status
➢ PIP meets requirements.
➢ Continue PIP.
➢ The MCO continued both interventions in MY 2015.</td></tr>
<tr><th colspan="2">Performance Measure Validation</th></tr>
<tr><td colspan="2">Requirement
➢ Be fully prepared to report HEDIS behavioral health measures in the next reporting period.
Status
➢ The MCO was successful in reporting selected behavioral health measures.</td></tr>
</table>

UniCare 2014 Recommendations and 2015 Current Status
Recommendation ➢ Continue to work with BMS to implement the MOU with Vital Statistics, and identify a process to access data. Once Vital Statistics data becomes available, the MCO should be prepared to report the Adult and Child Core measures that rely on that data. **Status** ➢ The MOU expired and there are no current plans to pursue another at this time.

Table A5-4. MHT Program Recommendations and 2015 Current Status

<table>
<tr><th colspan="2">MHT Program
2014 Recommendations and 2015 Current Status</th></tr>
<tr><td rowspan="2">Systems Performance Review</td><td>Recommendations
➢ The MCOs must focus efforts on consistently meeting the 24/7 access standard. In the last three measurement years, CoventryCares met the threshold two years, The Health Plan met the standard in one year, and UniCare did not meet the standard in any of the three years. BMS should consider an MHT-wide approach to addressing this issue, such as a statewide provider educational initiative.
➢ Continue to require the MCOs to achieve a 100% for each of the four standards (ER, GS, QA, FA). This is the first full review where BMS required the MCOs to achieve 100% compliance for each standard. The MCOs were required to submit an internal improvement plan for each standard, element, and/or component that was not fully met. The value of improvement plans will only be able to be assessed at the time of the next annual audit. It is expected that SPR results will improve based on the MCOs targeting areas for improvement.</td></tr>
<tr><td>Status
➢ One of the MCOs met the 24/7 access standard for MY 2014. It was recommended again that BMS consider an MHT-wide approach to addressing this issue, such as a statewide provider educational initiative. In addition, Delmarva also recommended that BMS develop a method for all MCOs to use to assess the 24/7 standard. All MCOs are using a different methodology, so the results are not comparable among the MCOs.
➢ BMS plans to continue the 100% compliance requirement for the SPR. All three MCOs achieved 100% on the QA, GS, and FA standards for 2014.</td></tr>
<tr><td rowspan="2">Performance Improvement Projects</td><td>Recommendation
➢ The PIP Collaborative Team must meet to determine the collaborative indicator goal for the Emergency Department Collaborative.</td></tr>
<tr><td>Status
➢ The PIP Collaborative Team met to discuss the first year baseline results and select a goal for the mandatory indicator. Each MCO selected its own goal because the individual rates varied and one goal would not fit for all MCOs.</td></tr>
<tr><td rowspan="2">Performance Measure Validation</td><td>Requirements
➢ The MCOs should adhere to the new HEDIS guidelines for reporting numerator events attributed to supplemental data. Supplemental data used to report Withhold Measures may be subject to additional review activities such as primary source validation during the next PMV.
➢ The MCOs should be fully prepared to report behavioral health measures in the next reporting period.
Recommendation
➢ Data Quality – MCOs are encouraged to continue to work with BMS for the implementation of the MOU with Vital Statistics and identify a process to access data. Once Vital Statistics data becomes available, each MCO should be prepared to report the Adult and Child Core measures that rely on that data.</td></tr>
<tr><td>Status
➢ The MCOs were prepared the review of supplemental files used for the Withhold measures. The supplemental data sources were validated by the auditor and approved to be used in the calculations of the measures.
➢ The MCOs were successful in reporting selected behavioral health measures.
➢ The MOU expired and there are no plans to pursue another at this time.</td></tr>
</table>

Appendix 6 – SPR Compliance Ratings Matrix MY 2015

The SPR Compliance Matrix provides a comparison of individual MCO performance on each element within each of the four standards (Enrollee Rights, Grievance Systems, Quality Assessment and Performance Improvement and Fraud and Abuse. An "**M**" indicates that all requirements for the elements were fully met, a "**P**" indicates that the requirements were partially met, a "**U**" indicates the requirements were unmet, and "**N/A**" means the element was not applicable for this review.

Table A6-1. SPR Compliance Ratings Matrix

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
ER - Enrollee Rights and Protections	**100%**	**99%**	**100%**	**98%**
ER.1 - The MCO must provide to the enrollees written information in a manner and format that may be easily understood.	**M**	**M**	**M**	**M**
ER.2 - The MCO must make information on providers available to the enrollees upon enrollment and annually thereafter, and give enrollees reasonable notice of any changes regarding providers.	**M**	**M**	**M**	**M**
ER.3 - The MCO must provide to enrollees information on enrollee rights and responsibilities.	**M**	**M**	**M**	**P**
ER.4 - The MCO inform enrollees about grievance and fair hearing procedures to the enrollee upon enrollment, annually, and at least 30 days prior to any change.	**M**	**M**	**M**	**M**
ER.5 - The MCO must inform enrollees about benefits available to the enrollee upon enrollment, annually, and at least 30 days prior to any change in benefits.	**M**	**M**	**M**	**M**
ER.6 - The MCO must inform enrollees about after-hours and emergency coverage and do so upon enrollment, annually, and at least 30 days prior to any change.	**M**	**M**	**M**	**M**
ER.7 - The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and time frames in a State-developed or State-approved description.	**M**	**M**	**M**	**M**
ER.8 - The MCO must provide information to enrollees regarding advance directives.	**M**	**M**	**M**	**P**
ER.9 - The MCO must provide information to their enrollees regarding physician incentive plans.	**M**	**M**	**M**	**M**
ER.10 - The MCO must ensure that its Medicaid enrollees are not held liable for any debts of the MCO or payments for covered services.	**M**	**M**	**M**	**M**
ER.11 - The MCO may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.	**M**	**M**	**M**	**M**
ER.12 - The MCO must have policies and procedures regarding the appropriate treatment of minors that are in keeping with all state regulations regarding disclosure circumstances.	**M**	**M**	**M**	**P**

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
ER.13 - The MCO must ensure through its provider contracts that providers disclose individually identifiable health information in accordance with the privacy requirements (HIPAA Provisions).	**M**	**M**	**M**	**M**
ER.14 - The MCO shall submit its annual report to BMS by April 1 and make copies of the annual report available at the local Department of Health and Human Resources (DHHR) offices in which it operates.	**M**	**P**	**M**	**M**
GS - Grievance System	**100%**	**100%**	**100%**	**92%**
GS.1 - The MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's Fair Hearing system.	**M**	**M**	**M**	**M**
GS.2 - The MCO's grievance process must be timely.	**M**	**M**	**M**	**M**
GS.3 - The MCO must maintain written requirements regarding the filing of a grievance.	**M**	**M**	**M**	**M**
GS.4 - The MCO must adhere to the State's regulations regarding the content of the notice of action (NOA).	**M**	**M**	**M**	**P**
GS.5 - The MCO must handle grievances and appeals according to regulations.	**M**	**M**	**M**	**P**
GS.6 - The MCO must dispose of each grievance and resolve each appeal, and provide notice as expeditiously as the enrollee's health condition requires, within State-established time frames.	**M**	**M**	**M**	**M**
GS.7 - The MCO must notify any enrollee who has entered a grievance or appeal of the outcome of his or her case.	**M**	**M**	**M**	**P**
GS.8 - The MCO must provide an expedited review process for appeals.	**M**	**M**	**M**	**M**
GS.9 - The MCO must provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.	**M**	**M**	**M**	**M**
GS.10 - The MCO must maintain records of grievances and appeals and must review the information as part of the State's Quality Strategy.	**M**	**M**	**M**	**M**
GS.11 - The MCO must continue to provide benefits to the enrollee while the appeal and the State Fair Hearing are pending.	**M**	**M**	**M**	**M**
GS.12 - The MCO may recover the cost of the services furnished to the enrollee while the appeal is pending if the final resolution of the appeal is adverse to the enrollee.	**M**	**M**	**M**	**M**
GS.13 - The MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, if the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.	**M**	**M**	**M**	**M**

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
GS.14 - The MCO or the State must pay for those services, in accordance with State policy and regulations, if the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.	M	M	M	M
QA - Quality Assessment and Performance Improvement	100%	99%	98%	92%
Access and Availability (AA)				
AA.1 - The MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	M	M	M	M
AA.2 - Each MCO, consistent with the scope of the contracted services, must provide female enrollees with direct access to a women's health specialist, provide for a second opinion, cover out-of-network services they are unable to provide, and must coordinate payment with out-of-network providers.	M	M	M	M
AA.3 - The MCO must furnish services timely.	M	M	P	P
Continuity of Care (CC)				
CC.1 - The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees.	M	M	M	P
CC.2 - The MCO must coordinate services for enrollees with special health care needs.	M	M	M	M
CC.3 - The MCOs must develop a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	M	M	M	M
CC.4 - The MCO must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist.	M	M	M	M
CC.5 - The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	M	M	M	M
CC.6 - The MCO must have mechanisms in place for assigning enrollees into case management according to established criteria.	M	M	M	M
Utilization Management (UM)				
UM.1 - The MCO's written notice of action for termination, suspension, or reduction of previously authorized Medicaid-covered service must be mailed in a timely manner.	M	M	M	P
UM.2 - The MCO must have written procedures in place for processing requests for initial and continuing services.	M	M	M	M
UM.3 - The MCO must notify the requesting provider and give the enrollee written notice of any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.	M	M	M	M

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
UM.4 - The MCO must provide timely authorization decisions.	M	M	M	M
UM.5 - The MCO must not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	M	M	M	M
UM.6 - The MCO must maintain practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	M	M	M	P
UM.7 - The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	M	M	M	M
Emergency Services (ES)				
ES 1. - The MCO must cover and pay for emergency services and post-stabilization care services.	M	M	M	M
Credentialing, Recredentialing and Delegation (CR)				
CR.1 - The MCO must implement written policies and procedures for selection and retention of providers.	M	M	P	M
CR.2 - The MCO's provider selection policies and procedures must not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.	M	M	M	M
CR.3 - The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor.	M	M	M	M
CR.4 - The MCO must request information on the provider from the National Practitioner Data Banks (NPDB) and appropriate state licensing boards.	M	M	M	M
CR.5 - The MCO must perform monthly federal database checks.	M	M	P	M
CR.6 - The MCO must comply with any additional requirements established by the State. Additional credentialing and recredentialing criteria for specialty areas (PCPs, OB/GYN, high-volume specialists, and dental providers) must be applied.	M	M	M	P
CR.7 - The MCO's formal selection and retention criteria may not discriminate.	M	M	M	M
CR.8 - The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor. The following conditions must be met.	M	M	M	M
Enrollment and Disenrollment Policies (ED)				
ED.1 - The MCO must have disenrollment procedures that comply with the enrollment and disenrollment requirements and limitations set forth in the regulations.	M	M	M	P
ED.2 - The disenrollment procedures must address BMS initiated disenrollments.	M	M	M	M

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
ED.3 - The disenrollment procedures must address enrollee-initiated disenrollments. The MCO disenrollment procedures must provide that a recipient may request disenrollment for cause at any time and for any reason.	M	M	M	M
Quality Assessment (QA)				
QA.1 - The MCO must develop and implement written policies for an ongoing QAPI program. The QAPI Program should be designed to achieve, through ongoing measurement and intervention, significant improvement in clinical and nonclinical areas of care that are expected to have a favorable effect on health outcomes and enrollee satisfaction. It must include a review of the entire range of services provided by the MCO.	M	M	M	M
QA.2 - The QA Program/Plan must specify clinical or health services delivery areas to be studied that represent the population served by the MCO in terms of age groups, disease categories, and special risk status.	M	M	M	M
QA.3 - The QA Program/Plan must designate appropriate clinicians and other professionals to monitor and evaluate individual cases where there is a question about care, patterns of care, or service. If the MCO utilizes a multidisciplinary team approach, the QA Program/Plan must direct the team to analyze and address delivery systems issues.	M	M	M	M
QA.4 - The QA Program/Plan must include written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished, or services that should have been furnished were not.	M	M	M	M
QA.5 - The QA Program/Plan must include a written description of the QA committee, composed of qualified staff, namely QA professionals, RNs, and non-technical staff.	M	M	M	M
QA.6 - There must be evidence that participating physicians and other providers are kept informed about the written QA Program/Plan.	M	M	M	M
QA.7 - There must be documentation that the governing body routinely receives and reviews written reports from the QA Program/Plan, describing actions taken, progress in meeting QA objectives, and improvements made.	M	M	M	M
QA.8 - The QA Program/Plan requires that the QA Committee meet on a regular basis (no less than quarterly) to oversee QA activities and to verify that all findings and required actions are being monitored and followed.	M	M	M	M
QA.9 - The QAPI requires that the QA Committee meet on a regular basis, no less than quarterly, and documentation should demonstrate that this occurs.	M	M	M	M

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
QA.10 - The findings, conclusions, recommendations, actions taken, and results of QA activity must be documented and reported to appropriate individuals within the organization and through the established QA channels.	M	M	M	M
QA.11 - The QA Program/Plan must reflect that the results of QA activities are used, coordinated, and linked to other management functions.	M	M	M	M
QA.12 - There must be evidence that results of QA activities are coordinated with other performance monitoring activities, including utilization management, risk management, and complaint management.	M	M	M	M
QA.13 - The MCO must conduct performance improvement projects that achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical and no-clinical care and that are expected to have a favorable effect on health outcomes and enrollee satisfaction.	M	M	M	M
Member Satisfaction (MS)				
MS.1 - The MCO must survey a sample of its adult and child members at least annually.	M	M	M	M
MS.2 - The MCO must conduct the most recent version of the Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey annually.	M	M	M	M
MS.3 - The MCO shall use survey results to identify and investigate areas of enrollee dissatisfaction and outline action steps to follow-up on the survey findings.	M	M	M	M
MS.4 - The MCO must share findings with providers.	M	M	M	P
Medical Records (MR)				
MR.1 - The MCO must have a medical record system in place	M	M	M	M
MR.2 - The MCO must have a record review process to monitor conformance to the Medical Records Standards.	M	M	M	P
Performance Measurement (PM)				
PM.1 - The MCO must submit performance measurement data.	M	M	M	M
PM.2 - The MCO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances, and disenrollments for other than loss of eligibility.	M	M	M	M
Health Education (HE)				
HE.1 - The MCO must provide a continuous program of general health education for disease, injury prevention, and identification without cost to the enrollees.	M	M	M	M

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HE.2 - The MCO must provide for qualified staff to develop and conduct educational programs.	M	M	M	M
HE.3 - There must be evidence that the MCO makes Health Education programs available to the enrollee population and that the MCO periodically reminds and encourages enrollees to use benefits.	M	M	M	M
HE.4 - The MCO must offer periodic health education and screening programs to enrollees that in the opinion of the medical staff would effectively identify conditions indicative of a health problem.	M	M	M	M
HE.5 - The MCO shall instruct each enrollee that receives a screen and shall ensure that each enrollee receives a printed summary of the assessment information to take to his or her PCP.	M	M	N/A	M
HE.6 - The MCO must provide wellness education programs.	M	M	M	M
HE.7 - The MCO must keep a record of all activities it has conducted to satisfy the Health Education requirements.	M	M	M	M
HE.8 - The MCO periodic health screening programs must include evidence of coverage for wellness screens.	M	M	M	M
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)				
EPSDT.1 - MCOs must have written policies and procedures providing the full range of EPSDT services to all eligible children and young adults up to age twenty-one (21).	M	M	M	M
EPSDT.2 - The MCO must have an established tracking system that provides up-to-date information on compliance with EPSDT service requirements.	M	M	N/A	M
FA - Fraud and Abuse	**100%**	**100%**	**100%**	**98%**
FA.1 - The MCO must have in place internal controls, policies, and procedures to prevent and detect fraud and abuse. The MCO must have a formal fraud and abuse plan with clear goals, assignments, measurements, and milestones.	M	M	M	P
FA.2 - The Fraud and Abuse plan must include procedures for conducting regular reviews and audits to guard against fraud and abuse, verifying whether services reimbursed were actually furnished, educating employees, network providers, and enrollees about fraud and abuse and how to report it, effectively organizing resources to respond to complaints of fraud and abuse, establishing procedures for reporting information to BMS, and developing procedures to monitor service patterns.	M	M	M	M

SPR Compliance Ratings Matrix by Element	Coventry Cares	The Health Plan	UniCare	WVFH
FA.3 - The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include identifying provider fraud and abuse by reviewing for a lack of referrals, improper coding, billing for services never rendered, and inflating bills for services and/or goods provided.	M	M	M	M
FA.4 - The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include identifying beneficiary fraud by reviewing access to services, inappropriate emergency care, and card sharing.	M	M	M	M
FA.5 - The MCO must take part in coordination activities within the state to maximize resources for fraud and abuse issues. The MCO must meet regularly with BMS, the Medicaid Fraud Control Unit and the EQRO to discuss plans of action, and attend fraud and abuse training sessions as scheduled by the state.	M	M	M	M
FA.6 - The MCO must submit a report to BMS by the 15th of each month regarding any suspected fraud and abuse cases identified during the prior calendar month.	M	M	M	M
FA.7 - The MCO must promptly comply with requests from BMS or the MFCU for access to and copies of any records, computerized data, or information kept by MCO providers to which BMS is authorized to have access.	M	M	M	M
FA.8 - Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.	M	M	M	M

M=Requirements were fully met. P=Requirements were partially met. U=Requirements were unmet. N/A=Not applicable.