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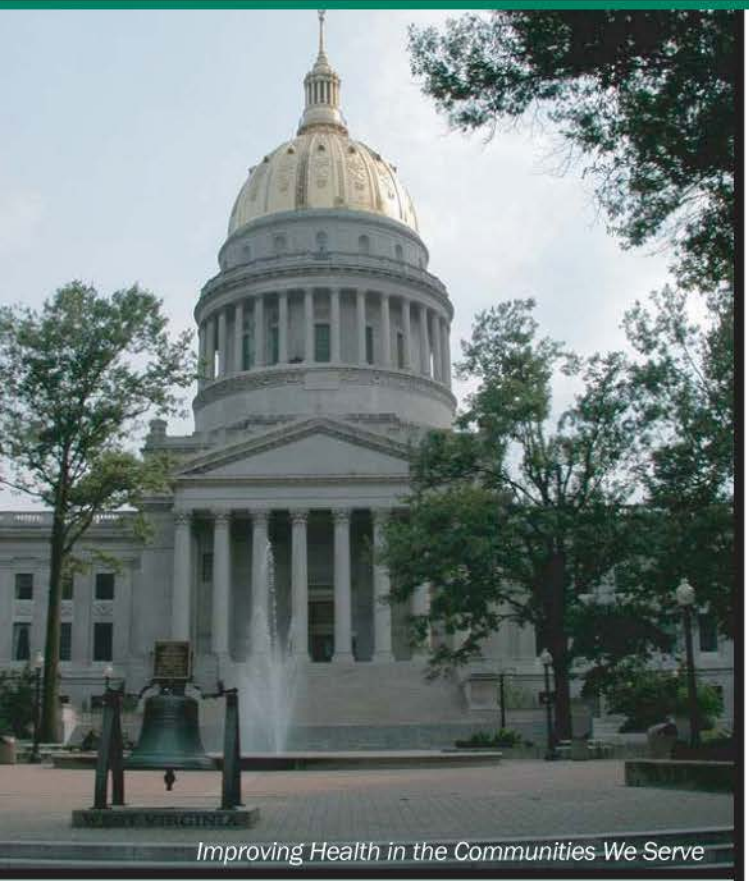

EXTERNAL QUALITY REVIEW ORGANIZATION

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

Annual Technical Report

Final Report

Calendar Year 2011

Submitted by
Delmarva Foundation
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Commonly Used Acronyms in EQRO Reporting

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

Annual Technical Report Executive Summary CY 2011

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). For calendar year (CY) 2011, there were approximately 161,000 members enrolled in the three MHT Managed Care Organizations (MCOs). The three MCOs contracted with BMS to provide care to these enrollees are Carelink Health Plan, Inc. (Carelink), The Health Plan of the Upper Ohio Valley (The Health Plan), and UniCare Health Plan of West Virginia, Inc. (UniCare).

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

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

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

In accordance with 42 C.F.R. §438.364, the EQRO must provide a detailed technical report that describes the manner in which the data from all activities conducted were aggregated and analyzed and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished by MCOs contracting with the State. This Executive Summary describes the SPR, PIP and PMV activities that were conducted for calendar year (CY) 2011 according to the dimensions of quality, access, and timeliness to meet this federal reporting requirement.

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

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its

recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

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

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Summary of Quality

Elements of quality are contained within all standards assessed as part of the Systems Performance Review. Program-wide the MHT MCOs have performed well in meeting the EQR regulatory and contract requirements for the SPR. In the annual CY 2011 review, compliance rates for all three MCOs exceeded the 90% threshold established by BMS for all four standards. The MCOs achieved compliance rates ranging from 94% to 99% on the Quality Assessment and Performance Improvement (QI) Standard. All three MCOs achieved a 100% compliance rating for the Enrollee Rights Standard and compliance rates of 99% to 100% for the Grievance System Standard. MCO performance on the Fraud and Abuse standard ranged from 90% to 100%. 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.

The CY 2011 SPR demonstrated the following MCO accomplishments related to quality. All three MCOs:

- Have well documented Quality Improvement Programs (QIP) plans that describe the organizational structure and include goals, objectives, and a schedule of planned activities (work plan).
- Demonstrated that appropriate staff and committees are involved in the decision making process.
- Have clinical practice guidelines in place, update them at least every two years, and when applicable, use them to make utilization management (UM) decisions (e.g. pre-authorization of procedures).
- Have comprehensive sets of credentialing policies and procedures in place, follow procedures, and complete credentialing and recredentialing according to BMS/MCO contract requirements.

- Have procedures in place to monitor delegated credentialing entities. Delegates are held to same standards as demonstrated by delegated credentialing audits conducted by the MCOs.
- Have overcome challenges in reporting Early and Periodic Screening, Diagnosis and Treatment (EPSDT) data. MCOs worked with BMS' data contractor to implement algorithms to collect required data (e.g. referrals for treatment). Data are now reported to BMS quarterly.

MCOs have the appropriate structures and processes in place to monitor, evaluate, and improve the quality of services to the MHT enrollees using PIPs. The MHT MCOs used the PIP quality improvement process of identifying problems relevant to their population, setting measurement goals, obtaining baseline measurements, and performing interventions aimed at improving performance. MCOs are providing more comprehensive project analyses, which in turn, assist them in identifying barriers and developing more targeted interventions. In general, they are continuing to develop and implement more rigorous interventions. MCOs will continue to focus their efforts on analyzing their data to determine next steps.

There are two MCO PIPs related to quality. One project focuses on childhood obesity and demonstrated improvement during the CY 2011 measurement year. The second PIP is asthma-related. This project is being closed out after two years of remeasurement, as performance is near the Medicaid National 90th percentile for the measure which focuses on members with asthma who were appropriately prescribed medication. While the MCO will continue its effective interventions to ensure continued compliance, it will better serve its membership and identify a new topic where there is a more pronounced opportunity for improvement.

Twelve HEDIS indicators were used to assess quality in the MHT program in the areas of immunizations, screening, and diabetes measures. Nine measures improved between HEDIS 2010 and HEDIS 2012. They are:

- Childhood Immunization Status
  - Combination 1
  - Combination 2
- Immunizations for Adolescents-Combination 1
- Lead Screening for Children
- Controlling High Blood Pressure
- Comprehensive Diabetes are
  - Blood Pressure Control (<140/90),
  - HbA1c Control (<8%),
  - HbA1c Testing, and
  - LDL-C Control (LDL-C <100)

Although the CDC indicators for *Eye Exam* and *LDL-C Screening* indicators did not improve over HEDIS 2010 to HEDIS 2012, both indicators improved from HEDIS 2011 to HEDIS 2012. Only one quality indicator, *Medical Attention for Nephropathy*, did not experience any improvement in either measurement period. Additionally, *Controlling High Blood Pressure* and *Comprehensive Diabetes Care- Blood Pressure Control (<140/90) Controlling High Blood Pressure* exceeded the National Medicaid Average.

Summary of Access

The SPR assesses MCO compliance with ensuring that members have access to the required materials. All three MCOs provide comprehensive member materials. To ensure enrollees have access to services and benefits to which they are entitled, all MCOs' Member Handbooks include the following information:

- A description of covered benefits and services, how to access them, and any other special requirements such as whether or not referrals are required for specialist services
- A statement of enrollee rights
- Customer Service telephone numbers, hours of operation and the MCOs address
- Instructions on how to file complaint, grievances, and appeals and how to access the State Fair Hearing process

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

- 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
- An initial prenatal care visit must be scheduled within 14 days of the date on which the woman is found to be pregnant

One MCO was unable to provide evidence that the BMS/MCO contract-specific appointment access standards were assessed. Two MCOs had compliance rates of ≥93% for all appointment access standards.

The MCO contract also requires qualified medical personnel to be accessible 24 hours each day, seven days a week (24/7), to provide direction to patients in need of urgent or emergency care. All MCOs identified an opportunity for improvement with the 24/7 access standard and have implemented targeted interventions which aim to educate providers and require corrective actions.

The Emergency Department (ED) PIP topic is mandated by BMS and these projects fall in the access category based on barriers identified in the process. For example, limited access to same day appointments

with primary care practitioners and limited after-hours appointments were identified as barriers. All three MCOs reported improvement in at least one of their ED PIP indicators.

Nine HEDIS indicators were selected to measure MCO performance for Access to Care:

- Adults' Access to Preventive/Ambulatory Health Services (20-44 Years, 45-64 Years, Total)
- Children and Adolescents' Access To PCP (12-24 months, 25 months- 6 Years, 7-11 Years, 12-19 Years)
- Prenatal Postpartum Care (Timeliness of Prenatal Care, Postpartum Care)

In the area of access, eight of nine access indicators compared favorably with the National Medicaid Average. *Prenatal and Postpartum Care –Postpartum Care* was only four tenths of one percent below the National Medicaid Average. One indicator, *Prenatal and Postpartum Care - Timeliness of Prenatal Care,* exceeded the National Medicaid 90th Percentile.

Favorable performance on the access measures continues to be a strength for the MHT program. The MHT weighted averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2010 through HEDIS 2012. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population.

Summary of 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. During the SPR on-site review, cases, files, and logs were reviewed to assess the timeliness of MCO activities. Delmarva reviewed cases, files, and logs to assess timeliness of:

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

All initial credentialing applications in the sample were processed according to the MCOs policies and procedures. All provider recredentialing files in the sample were recredentialed within the three-year time requirement as required in the BMS/MCO contract. All delegated credentialing providers are held to the same timeliness standards. All three MCOs complete annual audits of the delegates and no issues were identified with timely completion of credentialing and recredentialing activities.

Complaint, grievance and appeal logs and files were reviewed. The majority of complaints/inquiries are resolved within one day. The BMS/MCO contract requires MCOs to process and provide notice to affected

parties regarding enrollee grievances in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. All cases sampled were resolved and affected parties notified in less than 45 days. None of the cases included a request for an extension.

Each MCO has a Utilization Management (UM) program in place which includes policies and procedures to monitor the timeliness of utilization management decisions. According to the BMS/MCO contract, the MCOs must make authorization decisions and provide notice as expeditiously as required by the enrollee's health condition and within 14 calendar 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 QIP channels at least quarterly.

In addition, the MCOs must provide an expedited authorization for services when the provider indicates that the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The MCO must make the expedited authorization decision and provide notice to the enrollee as expeditiously as the enrollee's health condition requires, and no later than 3 working days after receipt of the request for service. This 3 working day period may be extended up to 14 additional days upon request of the enrollee or provider, or if the MCO justifies to BMS the need for additional information and how the enrollee might benefit from the extension. All MCOs monitor authorization turn-around times for compliance to these standards. These results are usually summarized quarterly and reported through the QIP channels by the UM department. There were no cases on file for expedited authorizations in CY 2011.

For CY 2011, there was one PIP that addressed timeliness. The project focused on Adolescent Well-Care Visits. The project is new and only baseline data was reported. Performance was below the National Medicaid Average and offers an opportunity for improvement. Thus far, project implementation and methodology are on track.

Four HEDIS indicators were selected from the Utilization and Relative Resource Use domain to represent MCO performance in the area of timeliness.

- Adolescent Well-Care Visits
- Frequency of On-going Prenatal Care (≥81%)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life (6 or more visits)

The MHT weighted averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to the National Medicaid Average. The three year trend from HEDIS 2010 to HEDIS 2012 also indicated improving performance for these two measures.

The *Frequency of On-going Prenatal Care (≥81%), Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life and Well-Child Visits in the First 15 Months of Life (6 or more visits)* all improved between HEDIS 2011 and HEDIS 2012. The Adolescent Well-Care Visit measure experienced a decline in performance over the trending period, which indicates an opportunity for improvement.

MHT Program Strengths and Recommendations

Strengths

Systems Performance Review

- The MCOs have performed well for all standards from CY 2009 –CY 2011 achieving above the 90% threshold established by BMS for all four standards (ER, GS, QA, and FA).
- Through CY 2011, MCOs were allowed to use either a CAHPS or CAHPS-like survey. Beginning CY 2012, BMS has mandated MCOs to use the most recent version of the CAHPS survey. Mandating the use of this tool will allow comparison of results among the three MCOs and to national benchmarks.
- Historically, the MCOs have had difficulties collecting certain EPSDT data (tracking of referrals and treatments that result from EPSDT screenings). In CY 2010, BMS established algorithms for the MCOs to use in collecting these data. MCOs now report these measures to BMS quarterly.

Performance Improvement Projects

- In general, MCOs continue to demonstrate improvement in basic project methodology by providing comprehensive project rationales, identifying fitting study questions and indicators, and conducting appropriate data collection procedures.
- MCOs are employing a variety of robust interventions that target enrollees and providers; passive interventions, such as mass mailings, are far less prominent in current PIPs demonstrating MCO growth and understanding of what makes projects successful.

Performance Measure Validation

- All MCOs have experienced staff, established data systems, and well-defined processes to calculate and report HEDIS performance measures.
- All MCOs are on-target to obtain NCQA accreditation by January 2014.
- All MCOs successfully integrated pharmacy data to report respiratory measures including Appropriate Testing for Children with Pharyngitis, Appropriate Treatment for Children with Upper Respiratory Tract Infection, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Use of Appropriate Medications for People with Asthma and Medication Management for People with Asthma.
- All three MCOs used targeted outreach programs in efforts to increase member compliance for recommended services.

Recommendations

Systems Performance Review

The SPR standards were updated to reflect the requirement to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool and methodology. The current MCO contract requires the use of the most current version of CAHPS. The contract language should be more specific to ensure that the MCOs are collecting all of the data that BMS expects. The contract language should require the use of Adult and Child CAHPS as well as supplemental questions to capture such measures as Medical Assistance with Smoking and Tobacco Use Cessation.

Performance Improvement Projects

While project analyses have continued to improve over the years, there is still opportunity for the MCOs to enhance their project analyses. Understanding barriers and causes for performance are critical components of the analysis that assist in effectively planning the next steps of PIP implementation. Requiring MCOs to report their progress on a quarterly basis may facilitate timely project analysis and earlier identification of setbacks or opportunities. More frequent updates would allow the EQRO to provide more timely monitoring and feedback to the MCOs and BMS regarding PIP progress.

Performance Measure Validation

- All three MCOs are encouraged to continue use of tools and methodologies such as modeling and regression to improve their outreach programs to increase member compliance for services included in the HEDIS measures (e.g. immunizations and preventive visits).
- All the MCOs are encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013.
- MCOs should work with BMS and corresponding State agencies to assure they have adequate access to information from the West Virginia Statewide Immunization Information System (WVSIIS). The MCOs should also confer with the West Virginia Health Information Network (WVHIN) whose members are working to establish a statewide health information technology (HIT) system. These additional resources may contribute to data completeness and improved HEDIS rates.

Mountain Health Trust Annual Technical Report CY 2011

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 calendar year (CY) 2011, there were approximately 161,000 members enrolled in MHT Managed Care Organizations (MCOs).

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

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

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

(*West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality*)

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

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

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

The CY 2011 annual technical report findings provide an assessment of the MHT program based on MCO performance, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Where applicable, the findings are compared to the goals and objectives found in the *WV*

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

This report will provide the results of the EQR annual assessment of the SPR, PIP and PMV activities for CY 2011. Following the EQR methodology, the individual MCO findings for the Systems Performance Reviews, Performance Improvement Projects, and Performance Measurement Validation activities are presented. The findings from these activities are then summarized according to quality, access and timeliness as required by the EQR regulations. Conclusions and recommendations are then provided for both the individual MCOs and the MHT program.

The Appendices provide detailed information to support the Annual Technical Report findings. Appendix 1 provides the PIP indicator results for all projects. Appendices 2 through 4 provide information for measures used to assess quality, access, and timeliness in this report. Specifically, Appendix 2 includes HEDIS 2012 MCO Rates, MHT weighted averages, and National Benchmarks; Appendix 3 contains Trending Data: MCO Rates and MHT weighted averages for HEDIS 2010-2012; and Appendix 4 contains Numerators and Denominators for HEDIS 2012 Measures. Appendix 5 provides the MHT Weighted Averages for HEDIS Respiratory Conditions and Smoking Cessation Measures calculated using pharmacy data provided by the fiscal agent and MCO survey data respectively. Appendix 6 contains all measures collected for HEDIS 2010 through 2012 and reported to NCQA. Finally, Appendix 7 contains a summary of the Status of Recommendations from the CY 2010 Review.

EQR Methodology

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

Congruent with the regulations, Delmarva conducts a comprehensive review of the three MHT MCOs and assesses their performance relative to quality of care, timeliness of obtaining needed care and services, and accessibility to those services.

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

- **Quality**, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

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

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Systems Performance Review

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

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

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

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

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

Delmarva uses a three-point scale for scoring: *Met—100%*, *Partially Met—50%*, and *Unmet—0%*. Components for each element are scored. The component scoring is rolled up to the element level, and finally the standard level. Aggregated results are reported by standard. BMS sets the minimum MCO compliance rating. For the CY 2011 SPR, BMS set the compliance threshold at 90 percent for each standard. MCOs not achieving 90 percent were required to develop and implement internal corrective action plans.

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

Performance Improvement Project Validation

PIPs are designed to provide a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or administrative processes. These improvements can enhance the quality of, access to, or timeliness of services provided to Medicaid beneficiaries, leading to improved health outcomes. According to BMS requirements, MCOs must achieve meaningful improvement in two focus areas during the PIP remeasurement phase.

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

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

Performance Measure Validation

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

In an effort to uniformly measure MCO quality of care, BMS requires MCOs to report nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS®) measures.[1] Since its introduction in the early 1990's, HEDIS has become the gold standard in managed care performance measurement and is used by the majority of MCOs nationally. The NCQA maintains and directs the HEDIS program.

The HEDIS 2012 measure set includes 80 performance measures across five domains of care. The domains include: Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information. BMS requires the submission of all Medicaid HEDIS measures with the exception of measures that are based on carve out services such as behavioral health, pharmacy, and dental.

In accordance with 42 C.F.R. §438.364, the Annual Technical Report must describe the manner in which the data from all activities conducted were aggregated and analyzed and the way in which conclusions were drawn as to the timeliness, quality, and access to the care furnished by MCOs. Therefore, this report focuses only on

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

those measures that are representative of quality, access, and timeliness. The entire set of measures reported by the MCOs can be found in Appendix 2 of this report.

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

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

Validated measures support and promote accountability in managed care. Measures must be calculated according to specifications outlined in NCQA's *HEDIS 2012, Volume 2: Technical Specifications.* Supporting information for all measures reported by the MCOs (e.g. numerators, denominators, trending information, and benchmarks) is found in Appendices 2-4. Although pharmacy is a carved out service, the MCOs have successfully utilized the data from the fiscal agent to calculate the HEDIS respiratory measures which are included in Appendix 5 along with the Smoking Cessation measures collected from survey data. All the HEDIS measures collected by the MCOs and reported to NCQA are found in Appendix 6.

MHT MCO Findings

Systems Performance Review

The CY 2011 SPR compliance rates for all three MHT MCOs are presented in Table 1.

Table 1. MCO SPR Compliance Rates for CY 2011

SPR Standard	CY 2011 Compliance Rate		
	Carelink	The Health Plan	UniCare
Enrollee Rights (ER)	100%	100%	100%
Grievance Systems (GS)	100%	99%	100%
Quality Assessment and Performance Improvement (QA)	94%	99%	98%
Fraud and Abuse (FA)	98%	90%	100%

Program-wide the MHT program has performed well in meeting the EQR regulatory and contract requirements for the operational assessment. Compliance rates for all MCOs exceeded the 90% threshold established by BMS. All MCOs achieved a 100% compliance rating for the Enrollee Rights Standard and compliance rates of 99% to 100% for the Grievance System Standard in CY 2011. These high performance rates demonstrate the MCOs' and BMS' commitment to meeting the structural and operational standards that are demonstrative of a high-quality program for the MHT enrollees. Individual MCO trending results and analysis follow in Tables 2-4.

Carelink Health Plan, Inc.

Carelink's SPR results for CY 2009-CY 2011 are presented in Table 2.

Table 2. Carelink SPR Results (CY 2009 – CY 2011)

Standard	Carelink Compliance Rate		
	CY 2009	CY 2010	CY 2011
Enrollee Rights	99%	100%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	98%	99%	94%
Fraud and Abuse	N/A	100%	98%

Carelink performed well for the CY 2011 review, achieving compliance rates ranging from 94% to 100%. Trending of results shows that the:

- ER Standard maintained a 100% compliance rate for the last two review years.
- GS Standard achieved a 100% compliance rate over the past three years.
- QA Standard compliance rate declined from the prior two review periods.
- FA standard decreased slightly because the Member Handbook was revised and did not provide enrollees with information on how to report suspected fraud, waste, and abuse.

In CY 2011 Carelink achieved SPR compliance ratings of 94% or greater, exceeding the 90% threshold. Both the **Enrollee Rights** and **Grievance Systems** standards achieved a 100% compliance rate. The **Fraud and Abuse** compliance rate was 98%. The only issue identified during the on-site review was that the Member Handbook does not notify enrollees how to report suspected fraud, waste, and abuse. Carelink plans on including this information in the next revision of its Member Handbook.

For **Quality Assessment and Performance Improvement (QA)** several opportunities for improvement were identified during the CY 2011 review of Carelink's Quality Improvement Program (QIP) documents including the QI Program Description, QI Work Plan, and committee meeting minutes. Oversight of the (QIP) was not sufficient. Specifically, the Board of Directors (BOD) did not meet in 2011 and therefore did not approve critical program documents (QIP description and work plan), review program activities, or provide feedback on QIP efforts. Committees met less frequently than required per program requirements and meeting minutes did not document clear lines of communications between the various committees and the BOD. Measureable goals and objectives were absent from the QIP which makes evaluation of program success difficult. The Quality and Utilization Management Annual Evaluation Report, which provides evidence of program effectiveness, was not completed until June 2012, more than half-way through the next year. Untimely completion of this evaluation does not allow the MCO to use the most recent data and analysis to plan the next year's activities. Carelink was also unable to provide evidence that appointment

access standards were evaluated. Finally, the results of their 24/7 access to PCP survey results yielded a 72% compliance rate as a result of answering services not connecting to a healthcare professional and no answer at the number on file.

Although the **QA** standard exceeded the 90% threshold, quality is a key component to a successful program. Therefore, Delmarva requested a Corrective Action Plan (CAP) from Carelink to address the quality oversight and documentation deficiencies identified during the CY 2011 review. Carelink responded with a thorough CAP that addressed all of the QI program oversight issues which was approved by Delmarva. A quarterly update on CAP progress was submitted by Carelink in October 2012 and Delmarva determined that adequate progress has been made. Carelink will continue to provide quarterly updates on its CAP which will be reviewed by Delmarva to ensure that the MCO continues to follow through with the proposed actions. The CAP will be closed when the MCO meets the expectations of the standards regarding QIP oversight.

The Health Plan of the Upper Ohio Valley

The Health Plan of the Upper Ohio Valley's SPR results for CY 2009-CY 2011 are presented in Table 3.

Table 3. The Health Plan of the Upper Ohio Valley SPR Results (CY 2009 – CY 2011)

Standard	The Health Plan Compliance Rate		
	CY 2009	CY 2010	CY 2011
Enrollee Rights	99%	100%	100%
Grievance Systems	99%	100%	99%
Quality Assessment and Performance Improvement	100%	99%	99%
Fraud and Abuse	N/A	96%	90%

The Health Plan performed well for the CY 2011 review achieving rates from 90% to 100%. Trending of results shows that the:

- ER standard maintained a 100% compliance rate for the past two years.
- The GS and QA standards remain relatively constant achieving respectable compliance rates of 99% to 100% in the three review periods.
- The FA standard decreased from CY 2010 to CY 2011.

The CY 2011 results show that The Health Plan achieved SPR compliance ratings of 90% or greater, meeting the BMS performance requirement of 90% compliance. The Health Plan achieved a 100% compliance rate for the **Enrollee Rights** standard. A 99% compliance rate was achieved for the **Grievance Systems** standard with only one opportunity for improvement identified; the MCO did not notify enrollees that they would provide assistance in completing forms during the grievance process in the Member Handbook. For **Quality Assessment and Performance Improvement**, The Health Plan achieved a 99% compliance rate. As in CY

2010, there is an opportunity to improve its after-hours accessibility for providers to meet the 24/7 access standard. BMS requires MCOs to query both the List of Excluded Individuals/Entities (LEIE) and Excluded Parties List System (EPLS) databases during credentialing and recredentialing. The Health Plan queries the LEIE, but not the EPLS database. In addition, Quality Management Program documents were approved out of sequence; the governing body approved documents prior to being reviewed by the Executive Management Team in CY 2010 and CY 2011. Lastly, The Health Plan achieved a 90% compliance rating for the **Fraud and Abuse** standard which meets BMS' performance requirement. In CY 2010, The Health Plan enhanced program practices, developed process flowcharts, and implemented procedures for internal monitoring and auditing. The CY 2011 review revealed that not all policies and procedures have been fully implemented. Employee education efforts must be properly maintained and documentation of internal monitoring must be produced. The MCO must implement the proposed process to verify whether services billed and/or reimbursed were actually furnished. The proposed process entails send a sample of explanation of benefits (EOBs) to enrollees, have them verify whether or not the services were actually received, and report this information back to The Health Plan.

UniCare Health Plan, Inc.

UniCare's results for CY 2009-CY 2011 are presented in Table 4.

Table 4. UniCare SPR Results (CY 2009 – CY 2011)

Standard	UniCare Compliance Rates		
	CY 2009	CY 2010	CY 2011
Enrollee Rights	88%	100%	100%
Grievance Systems	100%	100%	100%
Quality Assessment and Performance Improvement	97%	98%	98%
Fraud and Abuse	N/A	100%	100%

UniCare performed well for the CY 2011 review, achieving compliance rates ranging from 98% to 100%. UniCare's SPR results remained constant for the Grievance System standard at 100%.

Trending of results shows that the:

- ER Standard compliance rate improved significantly from the CY 2009 SPR. The CY 2010 and CY 2011 review demonstrate full compliance for this standard.
- GS Standard has maintained its 100% compliance rate for the last three review periods.
- The QA Standard compliance rate has remained relatively consistent, demonstrating a slight improvement from 97% in CY 2009 to 98% in CY 2010 and CY 2011.
- Grievance Systems Standard has maintained its 100% compliance rate for the last three review periods.

UniCare achieved compliance ratings of 98% and greater, far exceeding the 90% threshold established by BMS. UniCare achieved a 100% compliance rating for the **Enrollee Rights**, **Grievance Systems** and **Fraud and Abuse** standards. A compliance rate of 98% for **Quality Assessment and Performance Improvement** was achieved. Primary care providers (PCPs) are required to be accessible 24 hours a day, 7 days a week. UniCare's after-hours survey yielded a 66% compliance rate with the major issue identified as incorrect messages on PCP answering machines. UniCare also sets more stringent standards for other access standards and has not met their internal goals (e.g. UniCare sets the standard for initial prenatal appointment at 7 days while the MCO contract allows 14 days). Delmarva has recommended that the MCO measure its compliance with the standards in the BMS/MCO contract in addition to its internal standards.

Performance Improvement Project Validation

According to the BMS/MCO contract, MCOs must have at least 2 PIPs in place. In addition to the BMS mandated Emergency Department (ED) PIP, the MHT MCOs have been working on a variety of PIP topics including adolescent well-care visits, childhood obesity, and asthma. PIP validation summaries, findings and recommendations are provided below.

Carelink Health Plan, Inc.

Adolescent Well-Care Visits

This is the first year for Carelink's Adolescent Well-Care Visit PIP which aims to improve the Adolescent Well-Care Visit rate. The baseline indicator rate is 42.13% and Carelink will continue to strive to achieve the HEDIS 90th percentile, which is 64.3% for HEDIS 2012.

PIP Summary: Improving Adolescent Well-Care Visits Rates	
Rationale	• Approximately 26% of Carelink's membership is made up of adolescents 12-21 years of age. Baseline performance of the Adolescent Well-Care Visits measure provides an opportunity for improvement. The CY 2011 performance rate of 42.13% is below the NCQA Quality Compass Medicaid 50th Percentile and the National Average.
Indicators and Goals	• Adolescent Well-Care Visits — the percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year, Goal: National HEDIS Medicaid 90th Percentile
Strengths	• Identification of a stretch goal: achieve the NCQA Quality Compass 90th percentile • Comprehensive baseline analysis, including thorough analysis of noncompliant members
Barriers	• Not all members have a true medical home-members are not using their PCPs as they should • Male members are less likely than females to seek comprehensive well visits; high school students are less likely than middle school students to seek these visits • Providers tend to have incomplete documentation and are missing opportunities to capture well-care visit criteria during other appointments, such as sick visits

PIP Summary: Improving Adolescent Well-Care Visits Rates	
Interventions	• The CY 2011 report was a baseline/proposal submission. Interventions are not assessed during the first year of implementation. They will be assessed after the next annual submission.
Compliance with Previous Recommendations	• This is the first year of project implementation; there were no previous recommendations

PIP Results			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
CY 2011	Baseline	NCQA 90th Percentile	42.13%

Findings. Carelink's project was a proposal submission with baseline data. The MCO is on course with project implementation and methodology. Carelink is currently in the process of implementing its first year interventions which address identified barriers. The MCO has identified a long-term performance target of the NCQA Quality Compass 90th percentile.

Recommendations. Carelink should continue with implementing planned interventions and report remeasurement 1 results during the next annual submission.

Emergency Department Utilization

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

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

This is the first year that Carelink is reporting data for the Partners in Health Network indicator.

PIP Summary: Decreasing Emergency Department Utilization	
Rationale	• The emergency department utilization PIP topic is mandated by BMS. Carelink noted, "It has been observed that one-third or more of all ED visits are classified by the triage nurse as non-emergent. There is also evidence which supports the finding that Medicaid members utilize emergency services more than their privately insured counterparts." • Carelink has experienced a significant increase in growth: 29,568 (12/31/07) to 53,421 (12/31/09). With this membership growth, the MCO has experienced an increase in ED utilization claims. Ten of the counties serviced are considered very rural. Within these rural areas, generally, there are few primary care providers (PCPs) and health clinics. Interestingly, it was determined that only 16% of Carelink's members are 20-44 years of age; however, this age group accounted for 31% of all ED visits. One of Carelink's project measures is specifically targeting this age group and tracking their ED utilization.
• Indicators and Goals	• ED Visits/1000 Member Months (MM) for Medicaid Members (20-44 years of age), Goal: Reduce ED visits by 2.5 visits/1000 MM • ED Visits/1000 MM for Medicaid Members (all ages), Goal: Reduce ED visits by 2.5 visits/1000 MM • ED Visits/1000 MM for Partners In Health Network Medicaid Members (20-44 years of age), Goal: Reduce ED visits by 2.5 visits/1000 MM
• Strengths	• Strong interventions in place promoting medical homes and continuity of care
• Barriers	• Limited access to same day appointments/provider availability (including after hours) • Members lack established medical homes as they are not using their PCPs as they should (e.g. poor communication with PCPs) • Heavy marketing to the public regarding 24/7 availability of ED and fast track services
• Interventions	• Extended clinic hours to enhance availability • Collaboration with Partners in Health Network (PIHN) which aims to engage members in appropriate care and to decrease inappropriate ED utilization. PIHN promotes medical homes. • Monthly ED reports are run to identify members with at least 3 ED visits within the last 6 months. Member contact is then made for educational purposes and to assist members in finding providers, including dentists when appropriate. The case manager works with the member to seek care in a preventive manner that avoids the ED.
• Compliance with Previous Recommendations	• Recommendations were made to improve the project's quantitative analysis. Carelink provided a more comprehensive analysis. Comparisons were made to previous measurements. Statistical testing was completed. Project success and intervention effectiveness were discussed. However, specific numeric comparisons to project goals were not provided and the recommendation to do so remains.

PIP Results			
Indicator 1: ED Visits (Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline		146.45 Visits/1000 MM
CY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	151.37 Visits/1000 MM
CY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	147.10 Visits/1000 MM
CY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	146.00 Visits/1000 MM
Indicator 2: ED Visits (Medicaid Members, All Ages) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline	Reduce ER Visits by 2.5 Visits/1000 MM	74.66 Visits/1000 MM
CY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	81.70 Visits/1000 MM
CY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	74.65 Visits/1000 MM
CY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	78.18 Visits/1000 MM
Indicator 3: ED Visits (PIHN Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		136.56 Visits/1000 MM
CY 2011	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	131.36 Visits/1000 MM

Findings. Carelink continues to meet project methodology requirements. Interventions are appropriate and expected to improve performance; they focus on the promotion of medical homes through Carelink's PIHN initiative. Additionally, case management activities are in place to target and help manage high ED utilizers. While no improvement was noted in reducing ED services for all ages, marginal improvement was achieved for the targeted 20-44 age group.

To support and measure the effectiveness of the PIHN initiative, Carelink introduced a new indicator in CY 2011 that measures the ED visits of members touched by the PIHN intervention. With this new supplemental indicator, Carelink saw a more substantial improvement in the targeted 20-44 year age group; there was a reduction of 5.2 visits/1000 MM. While it is too early to assess sustained improvement, the remeasurement data provided demonstrates the effectiveness of the intervention.

Recommendations. While an improvement in qualitative analysis was noted with Carelink's CY 2011 project submission, as demonstrated with the discussion related to intervention effectiveness and outline of planned initiatives, there is still opportunity to enhance the quantitative analysis and provide comparisons to indicator goals. The MCO is advised to continue PIP efforts to reduce ED utilization and promote member medical homes.

The Health Plan

Childhood Obesity

This project goal is to increase the percent of members with evidence of Body Mass Index (BMI) documentation, nutritional counseling, and physical activity counseling for children 2-17 years of age by 5% annually.

PIP Summary: Childhood Obesity	
Rationale	• West Virginia has consistently ranked as one of the most obese states, and at the time of project implementation, it ranked third in the nation. While childhood obesity is difficult to measure within The Health Plan (many physicians are not coding for obesity or documenting body mass index (BMI) within the medical record), it is impacting children of all ages, spanning from 1 year to 17 years of age. Discussions with plan physicians and school wellness teams reinforce the prevalence of childhood obesity and identify it as one of the top health issues.
Indicators and goals	• Members with evidence of BMI documentation (2-17 years of age), Goal: 5% annual increase • Members with evidence of nutritional counseling (2-17 years of age), Goal: 5% annual increase • Members with evidence of physical activity counseling (2-17 years of age), Goal: 5% annual increase
Strengths	• Comprehensive project rationale • Improvement in qualitative analysis, including documentation of barriers to improve performance • In addition to targeting providers with interventions, as the PIP's indicators focus on provider responsibilities/actions, The Health Plan is also targeting members of the plan, community, and school systems as it relates to the obesity epidemic
Barriers	• Providers are not coding for BMI (as there is no financial incentive for them) • Provider and member knowledge deficits regarding the purpose and importance of obesity screenings • Provider noncompliance with weight monitoring • Provider knowledge deficit regarding obesity-related educational materials and assistance available through the MCO • Members are unaware of obesity risks and interventions
Interventions	• One-on-one discussion with physician/appropriate office staff regarding a provider education packet which includes BMI chart, BMI percentile graph worksheets, and Childhood Obesity Program information • Distribution of a provider newsletter that addressed poor performance of BMI assessments and documentation • Development and availability of web-based educational modules pertaining to weight control and physical activity for schools • Distribution of grant money for eight WV schools to implement health and wellness programs which largely focused on nutrition and physical activity • Development and distribution of a children's cookbook and healthy snack program
Compliance with Previous Recommendations	• Recommendations were made to assess barriers annually and to document them within the analysis. The Health Plan identified and included barriers, such as providers not coding for BMI-related services, in the project analysis.

PIP Summary: Childhood Obesity	
	• The MCO was also advised to enhance its quantitative analysis by providing comparisons to goals/benchmarks. The Health Plan did indeed provide a more comprehensive analysis and described improvement in performance and noted that goals were met; however, it did not provide specific quantitative comparisons. This recommendation remains in place.

PIP Results			
Indicator 1: Members with evidence of BMI documentation (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		1.45%
CY 2010	Remeasurement 1	5% annual increase	1.12%
CY 2011	Remeasurement 2	5% annual increase	1.36%
Indicator 2: Members with evidence of nutritional counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.94%
CY 2010	Remeasurement 1	5% annual increase	0.54%
CY 2011	Remeasurement 2	5% annual increase	1.22%
Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.78%
CY 2010	Remeasurement 1	5% annual increase	0.45%
CY 2011	Remeasurement 2	5% annual increase	1.12%

Findings. The MCO continues to be challenged with the fact that providers are not documenting BMI or coding obesity-related services. This has significantly impacted the administrative results that are based on claims data. The Health Plan continues to target providers and provide education and encourage appropriate coding, as well as reach out to children in the community and in local schools to provide them with education and tools that promote healthy eating and physical fitness. During this last measurement period, the MCO documented improvement in its project indicators; however, overall performance remains poor despite system-level interventions and best efforts. The Health Plan is now considering providing a financial incentive to providers who appropriately document BMI.

Recommendations. While The Health Plan did provide an improved qualitative analysis which assessed barriers and identified opportunities for improvement, there is still a recommendation in place to enhance the quantitative analysis and provide precise comparisons to previous measurements, as well as goals. The Health Plan is encouraged to continue its multifaceted interventions and target providers in an effort to improve their coding of BMI and obesity-related services.

ED Utilization Diversion

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

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

PIP Summary: Emergency Department Utilization Diversion	
Rationale	• Emergency Department Utilization is a mandated project topic. **Respiratory** • The Health Plan claims analysis identified throat/respiratory complaints as a top ED diagnosis in the 0-5 age group. The MCO notes that children with upper respiratory illnesses are better handled by primary care providers (PCPs) and can often be treated at home with over-the-counter remedies. Providing caregivers with the knowledge of how to treat such conditions at home should result in fewer ED visits. **Back Pain** • For back pain, The Health Plan states that there appears to be a progression from initial acute back pain to the development of drug seeking behavior in the ED. Targeting these members presenting with back pain at the time of their initial visit and redirecting them to appropriate services for treatment should result in fewer ED visits and reduce drug seeking behavior.
Indicators and Goals	**Respiratory** • Emergency Department visits per 1000 member months (MM) ages 0-5 years with respiratory diagnosis, Goal: 5% annual reduction **Back Pain** • Emergency Department visits per 1000 MM (age 20 and older) with diagnosis of back pain, Goal: 5% annual reduction
Strengths	• Improved data analysis • Significant improvement in indicator 2, ED Visits with a Diagnosis of Back Pain
Barriers	**Respiratory** • Caregivers not feeling equipped to care for a sick child • Caregivers are unaware of after-hours alternatives for scheduling appointments **Back Pain** • Providers are not following guidelines for treatment of new diagnosis of low back pain • Members are not sure how they can treat back pain
Interventions	**Respiratory** • Educational, outreach phone calls to caregivers of members 0-5 with ER diagnosis of upper respiratory condition • In addition to the above named intervention, a follow up letter and a book, What To Do When Your Child is Sick, are mailed to these members **Back Pain** • Adopted Guidelines for the Management of Acute Low Back Pain • Utilization of a pain assessment tool in the ER, which includes low back pain questions • Outreach phone calls (by nurses) to members identified with acute back pain—either ED or PCP office—to educate members regarding back pain and treatment. • Implementation of a pain management contract with patients which identifies their responsibility with their pain management regime

PIP Summary: Emergency Department Utilization Diversion	
Compliance with Previous Recommendations	• Recommendations were made to The Health Plan to provide a more comprehensive qualitative analysis, by including barriers and perceived causes for performance. The MCO responded and enhanced its analysis by describing barriers, such as report errors which delayed outreach. Data analysis was comprehensive and planned activities were identified.

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

Findings. The Health Plan is fully compliant with its project implementation and methodology, and improvement has been achieved. There was evidence of marked improvement in the Emergency Department Visits for Back Pain Diagnosis indicator—falling from a rate of 115 visits/1000 MM to 69 visits/1000 MM. Sustained improvement was noted in the ED Visits for Children with Respiratory Diagnosis indicator—each remeasurement performed better than baseline; visits per 1000 MM dropped from 438 to 398. Improvements appear to be the direct result of member and provider targeted interventions.

Recommendations. The Health Plan should continue with implementation of multifaceted interventions and further enhance its analysis by identifying its project goals more precisely and comparing performance to these goals.

UniCare Health Plan, Inc.

Improving Asthma Control

With the Improving Asthma Control PIP, UniCare aims to improve the percentage of enrollees with persistent asthma that are appropriately prescribed medication while striving to meet the National Medicaid HEDIS 90th percentile. UniCare's CY 2011 rate is 91.02% while the 90th percentile is 93.19%.

PIP Summary: Improving Asthma Control	
Rationale	• UniCare's topic was selected through data collection and analysis. Prevalence data shows approximately 16% of West Virginians who qualify as low socioeconomic status (SES) reported that they currently have asthma. This represents twice that of those who do not qualify as low SES that reported having asthma.
Indicators and Goals	• Persistent asthmatics (5-64 years of age) who were appropriately prescribed medication, Goal: National HEDIS Medicaid 90th percentile
Strengths	• Comprehensive project rationale • Multifaceted interventions were implemented
Barriers	• Members are unaware of how to treat asthma warning signs and flare-ups • Providers not adhering to clinical practice guidelines • Providers not knowing when members go to the ER • Not having a pharmacy benefit through the plan (which would enable the MCO to monitor medication compliance and intervene accordingly)
Interventions	• Outreach to newly enrolled members to orient and educate them about various programs and screen for asthma, among other conditions. For 2011, 81 members were referred to the asthma program based on these calls. • Healthy Habits Count for Asthma disease management program reaches out to members and in 2011 there were 2,192 newly identified members with asthma • Mailed cards and made telephone calls to members to remind them of preventive services
Compliance with Previous Recommendations	• Recommendations were made to UniCare to provide a more comprehensive qualitative analysis. The MCO responded and documented barriers, provided an assessment of performance, and identified activities planned for the future.

PIP Results			
Indicator 1: Persistent asthmatics (5-64 years of age*) who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		95.07%
CY 2010	Remeasurement 1	95.07%	93.84%
CY 2011	Remeasurement 2	93.19%	91.02%*

* HEDIS 2012 technical specifications were modified; the age range expanded from 5-50 to 5-64 years of age

Findings. While UniCare has an organized, methodical PIP and has implemented a variety of multi-faceted interventions, including an asthma disease management program, performance has steadily declined for the PIP. However, it should be noted that performance remains near the National Medicaid HEDIS 90th Percentile for the Appropriate Use of Asthma Medication performance measure. UniCare concludes that one possible reason for not improving performance is due to an unsuccessful implementation of provider outreach. There were confidentiality requirements that prevented them from providing physicians with their member specific data related to asthma. This issue has since been resolved and UniCare is able to report data and information in a confidential manner.

HEDIS technical specifications were modified for the PIP's performance measure; in spite of this, the expanded age range did not negatively impact remeasurements or comparability.

Recommendations. Based on the maturity of this project and the fact that UniCare performs near the National Medicaid HEDIS 90th percentile, the MCO is advised to close this project. There are more significant opportunities for improvement using PIPs in other areas. Although the PIP is being closed, the effective interventions will be continued by UniCare to ensure that it continues to perform well on this measure.

Reducing Inappropriate ED Utilization

UniCare aims to reduce the rate of ED visits per 1000 Medicaid Members from two primary care practices in the Princeton/Bloomfield community. Practice 1's visit rate declined from 876 to 398 per 1000 Medicaid Members and Practice 2's rate declined from 965 to 397 per 1000 Medicaid Members with goals of 788 and 868 visits per 1000 Medicaid members respectively.

PIP Summary: Reducing Inappropriate Emergency Department Utilization	
Rationale	• The emergency department utilization project is mandated. UniCare notes that 30% of emergency room visits are avoidable and West Virginia experiences 30% more utilization than the national average. In an effort to reduce ED utilization, the MCO states, "The study aims to cement the medical home relationship between patients and families and their primary care providers." • UniCare is targeting the Bluefield Community for this PIP and is working with two primary care practices. With interventions targeting members of these practices, UniCare aims to reduce their ED utilization
Indicators and Goals	• The rate of ED visits per 1000 Medicaid members from a participating primary care practice in Princeton/Bluefield community, using total ED visits over total unique member count, Goal: Achieve a 10% reduction in ED Visits • The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice in Princeton/Bluefield community, using total ED visits over total unique member count, Goal: Achieve a 10% reduction in ED Visits
Strengths	• UniCare completed a comprehensive analysis, which should be used as a model
Barriers	• Member knowledge deficit regarding proper use of emergency department and lack of continuity of care with a PCP
Interventions	• Distribution of educational brochures and posters "Are you in the Right Place?" to participating clinics; follow up visits have been made to ensure materials are displayed and being distributed to members • Follow-up telephone contact and in-person visits with practices to answer questions regarding study
Compliance with Previous Recommendations	• Recommendations were made to UniCare to provide a more robust qualitative analysis. The MCO complied and described its barriers, the constructive feedback that it received from stakeholders, and other challenges the MCO faces with this project.

PIP Results			
Indicator 1: The rate of emergency department visits per 1000 Medicaid members from a participating primary care practice (practice 1) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	88% or 876 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	788 visits per 1000 members	40% or 398 visits per 1000 members
Indicator 2: The rate of emergency department visits per 1000 Medicaid members from a participating primary care practice (practice 2) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	96% or 965 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	868 visits per 1000 members	40% or 397 visits per 1000 members

Findings. UniCare's ED utilization PIP was developed based on an insightful project rationale and a carefully coordinated plan with the two participating primary care practices in the Princeton/Bluefield Community. The project aims to reduce ED utilization within these two practices; however, passive interventions are not engaging members and the MCO has faced challenges regarding its data. The baseline data year appears to have been impacted by high utilization related to the H1N1 flu. Subsequently, UniCare has noted difficulty analyzing PCP based utilization data without a PCP lock-in procedure.

UniCare has also received feedback from the targeted primary care practices and its Community Advisory Committee regarding the direction of the project which included expressed concerns regarding passive interventions. The educational materials, including a poster displayed in the participating clinics, have not been effective in initiating conversations about the most appropriate setting to receive care. The MCO had been hopeful that the poster would be more effective as a conversation stimulator as it included a local celebrity questioning members about receiving the right care in the right place.

Recommendations. UniCare is strongly encouraged to develop new, more robust interventions to sustain the project or possibly reconsider the direction of the PIP and define a new aim with new indicators. Confronting inappropriate ED utilization, as a whole, can be overwhelming. UniCare may find that it can better serve its membership and more effectively target inappropriate ED utilization by concentrating on a more narrowly defined population. For example, UniCare may wish to review its ED utilization and diagnoses data and identify a couple of diagnoses to target. Examples include chronic conditions with high ED utilization, such as diabetes. This provides an opportunity to identify very specific barriers and develop interventions that will more effectively address those barriers.

Performance Measure Validation

HEDIS measures are categorized and reported in five domains that gage specific areas of care and service. The measures reported by the MHT MCOs related to quality, access, and timeliness for this report are found in the following three HEDIS domains:

- Effectiveness of Care
- Access/Availability of Care, and
- Utilization and Relative Resources Use

Measures in the Experience of Care and Health Plan Descriptive Information domains are not used in this report as they do not directly relate to the quality, access, and timeliness of care dimensions evaluated in this report.

For this section of the report the MHT Weighted Averages for selected measures are compared to the National Medicaid Averages and 90th percentiles for benchmarking purposes. MCO HEDIS measures and indicators rates, including trended rates are found in the Appendices.

WV Mountain Health Trust Program State Strategy Objectives and Targets

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

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

Objective	Target (over the next two years)	Baseline (CY 2008)	CY 2009	CY 2010	CY 2011
Promote Child Preventive Health	Demonstrate improvement of five percentage points in the number of members two years of age compliant with an immunization 4:3:1:2:3:1:1* (HEDIS Childhood Immunization Status (CIS)-Combination 2 measure)	70.4%	62.2%	63.5%	68.3%
Promote Child Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (80.3%) for the percent of members, age three to six years, who received one or more well-child visits with a primary care practitioner. (HEDIS Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life)	75.7%	72.4%	65.5%	67.3%
Ensure Child Access to Primary Care Practitioners	Strive to meet the 2008 HEDIS 75th percentile (91.6%) for the number of children ages seven to 11 years who had a visit with a primary care practitioner. (HEDIS Child and Adolescents' Access to Primary Care Practitioners (PCP) age 7-11 Years)	86.2%	92.6%	92.6%	92.9%

Objective	Target (over the next two years)	Baseline◘ (CY 2008)	CY◘ 2009	CY◘ 2010	CY◘ 2011
Promote Adult Access to Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (88.4%) for the percentage of adults, age 20-44 years, who had an ambulatory or preventive visit. (HEDIS Adults Access to Preventive/Ambulatory Health Services measure)	84.0%	88.4%	87.4%	86.9%
Encourage Appropriate Postpartum Care	Strive to meet the 2008 HEDIS 75th percentile (68.5%) for the percentage of women who had a postpartum visit on or between 21 and 56 days of delivery. (HEDIS Prenatal and Post Partum Care measure)	65.3%	67.8%	63.4%	63.7%
Ensure Comprehensive Chronic Care	Strive to meet the 2008 HEDIS 75th percentile (63.3%) for the number of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90). (HEDIS Controlling High Blood Pressure measure)	58.2%	63.0%	61.0%	68.8%

* Four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza Type B (HiB); three hepatitis B (HepB), and one chicken pox (VZV).
◘ The rates displayed are WV MHT Weighted Averages for the three MCOs.

The Quality Strategy targets were achieved for the following measures.

- Ensuring Child Access to Primary Care Practitioners (HEDIS Children and Adolescents' Access to Primary Care Practitioners for Children Age 7-11 Years measure)
- Ensuring Comprehensive Chronic Care (HEDIS Controlling High Blood Pressure measure)

All of the selected measures increased from the CY 2010 to CY 2011 measurement period except for the *Adult Access to Preventive/Ambulatory Health Services for Ages 20-44 Years* measure. However, compared to HEDIS 2012, the most recent benchmark available, this measure outperformed the 75th percentile of 85.4%. HEDIS measures collected, including those in Table 5, are presented in the Quality, Access, and Timeliness sections that follow.

Quality Performance Measures

Twelve measures that gage immunizations, screenings, and diabetes care were selected from the HEDIS Effectiveness of Care Domain to assess the quality of care provided by the MHT MCOs. For the ease of reading, the five immunizations and screening measures are displayed in separate tables from the seven diabetes measures. The HEDIS 2010 through HEDIS 2012 MHT Weighted Averages for the immunization and screening measures are provided in Table 6 below with the National benchmarks.

Table 6. Quality Performance Measures - Immunizations and Screenings

Measure Name	MHT Weighted Average HEDIS 2010 %	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Childhood Immunization Status - Combination 2	62.2	63.5	68.3	74.5	84.2
Childhood Immunization Status – Combination 3	55.2	57.1	62.4	70.7	82.4
Immunizations for Adolescents - Combination 1	33.3	39.5	45.0	60.4	80.9
Lead Screening in Children	51.5	54.8	55.1	67.7	86.6
Controlling High Blood Pressure	63.0	61.0	64.7	56.8	69.1

The *Controlling High Blood Pressure* measure exceeded the National Medicaid Average, and all five indicators improved between HEDIS 2010 and HEDIS 2012.

The three year trend for all three immunization measures shows continuous improvement for each year between HEDIS 2010 through HEDIS 2012. The *Immunizations For Adolescents-Combination 1* measure achieved the greatest improvement over the three year period with an increase of 11.7 percentage points. This indicator also achieved the greatest improvement with a 5.5 percentage point increase from HEDIS 2011 to HEDIS 2012.

The improvement in the immunization measures is most likely the result of the MCOs' continuing outreach efforts to have members bring their immunizations up-to-date, obtaining data from the WV Statewide Immunization Information System (WVSIIS), and more focused attempts at securing immunization information from medical records.

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

Table 7. Quality Performance Measures- Comprehensive Diabetes Care *

Measure Name	MHT Weighted Average HEDIS 2010 %	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	58.4	63.5	68.8	60.8	75.4
Comprehensive Diabetes Care - Eye Exams	35.8	30.6	32.8	53.2	69.7
Comprehensive Diabetes Care - HbA1c Control (<8%)	38.7	40.1	41.3	48.0	59.4
Comprehensive Diabetes Care - HbA1c Testing	75.8	76.9	76.8	82.4	91.1
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	25.1	24.7	27.7	35.2	46.4
Comprehensive Diabetes Care - LDL-C Screening	66.5	64.0	64.2	74.9	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	64.8	66.0	63.1	77.8	86.9

* It should be noted that the total eligible population for the Comprehensive Diabetes Care indicators is small with an eligible population of 812 out of approximately 161,000 enrollees.

Rates for four indicators in the Comprehensive Diabetes Care measure improved between HEDIS 2010 and HEDIS 2012. They are

- Blood Pressure Control (<140/90),
- HbA1c Control (<8%),
- HbA1c Testing, and
- LDL-C Control (LDL-C <100)

CDC- Blood Pressure Control (<140/90) exceeded the National Medicaid Average. This indicator achieved the greatest increase of all indicators in this set with a 10.4 percentage point increase over the three year period.

Overall, in the area of quality, the MHT Weighted Average improved for 9 out of the 12 immunization, screening and comprehensive diabetes care indicators between HEDIS 2010 and HEDIS 2012. The *Immunizations For Adolescents-Combination 1* measure achieved the greatest improvement with an increase of

11.7 percentage points between HEDIS 2010 and HEDIS 2012. This improvement is most likely the result of the MCOs' continuing outreach efforts to have members bring their immunizations up-to-date, obtaining data from the WV Statewide Immunization Information System (WVSIIS), and more focused attempts at securing immunization information from medical records.

The HEDIS 2012 MHT Weighted Averages for two indicators compared favorably to national benchmarks; *Controlling High Blood Pressure* and *Comprehensive Diabetes Care -Blood Pressure Control (<140/90)* exceeded the National Medicaid Average.

Access Performance Measures

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

Table 8. Access Performance Measures

Measure Name	MHT Weighted Average HEDIS 2010 %	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	88.5	88.1	86.9	79.9	88.5
Adults' Access to Preventive/Ambulatory Health Services (45-64)	86.7	86.5	87.0	85.9	91.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	88.3	87.9	86.9	81.8	89.3
Children and Adolescents' Access To PCP (12-19 Yrs)	90.2	90.7	90.4	87.9	93.0
Children and Adolescents' Access To PCP (12-24 Months)	97.9	97.3	97.4	96.1	98.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	91.5	89.1	91.0	88.2	92.6
Children and Adolescents' Access To PCP (7-11 Yrs)	93.1	93.2	92.9	89.5	94.5
Prenatal and Postpartum Care - Postpartum Care	71.3	64.6	63.7	64.1	74.5
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.9	94.2	93.4	82.7	93.3

MHT continues to perform well in providing access to care for its members with all measures comparing favorably with national benchmarks. Eight out of nine measures exceeded the National Medicaid Average. *Prenatal and Postpartum Care –Postpartum Care* was within four tenths of a percentage point in meeting the National Medicaid Average.

The *Prenatal and Postpartum Care - Timeliness of Prenatal Care* measure performed best. This measure exceeded the National Medicaid Average by 10.7 percentage points and also exceeded the National Medicaid 90th Percentile of 93.3%.

Favorable performance on the access measures continues to be a strength for the MHT program. The MHT Weighted Averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2010 through HEDIS 2012. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population.

Timeliness Performance Measures

Table 9 contains the four performance measures for the HEDIS Utilization and Relative Resources Use domain that were selected to represent MHT performance for timeliness of care.

Table 9. Timeliness Performance Measures

Measure Name	MHT Weighted Average HEDIS 2010 %	MHT Weighted Average HEDIS 2011 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Adolescent Well-Care Visits	42.1	41.6	38.7	49.7	64.3
Frequency of Ongoing Prenatal Care (≥81%)	72.8	73.9	77.1	60.9	82.8
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	72.4	65.5	67.3	71.9	82.9
Well-Child Visits in the First 15 Months of Life (6 or more visits)	62.7	65.2	68.6	61.7	77.3

The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to the National Medicaid Average. The three year trend from HEDIS 2010 to HEDIS 2012 also indicated improving performance for these two measures. The MHT Weighted Averages for *Adolescent Well-Care Visits* and *Well-Child in the 3rd, 4th, 5th, and 6th Years of Life* suggest opportunities for improvement.

Summary of Quality, Access, and Timeliness

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

Quality

Quality, as stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO)… increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" (Centers for Medicare & Medicaid Services [CMS], Final Rule: External Quality Review, 2003).

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

All three MCOs performed well for the QA standard. Carelink, The Health Plan and UniCare achieved compliance rates of 94%, 98%, and 99% respectively.

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

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

The ultimate authority of the QAPI program rests with each MCO's governing body.

All MCOs have clinical practice guidelines in place and update them at least every two years. When applicable, clinical practice guidelines are used to make utilization management (UM) decisions such as pre-authorizing treatments and procedures.

The MCOs have comprehensive sets of credentialing policies and procedures in place. A review of 10 initial credentialing and 10 recredentialing files per MCO provided evidence that the MCOs completed the credentialing and recredentialing activities within the required time frames and according to their policies and procedures. In CY 2011, the credentialing procedures and provider files were also reviewed to determine if the MCOs were querying the List of Excluded Individuals or Entities (LEIE) and Excluded Parties List System (EPLS) databases as recommended by the Centers for Medicare and Medicaid Services (CMS). All MCOs query the LEIE, and all MCOs except for The Health Plan query the EPLS database. The Health Plan is aware of this requirement and is taking steps to implement this step into its policies and procedures.

All three MCOs have procedures in place to monitor delegated credentialing entities. Annual compliance audits for each delegated entity were presented for review and demonstrated appropriate oversight of the delegates and their activities.

A key component of successful QAPI programs is involvement of appropriate staff and committees in the decision making process. The Health Plan and UniCare completed an annual QI program evaluation which was reviewed and approved by the Board of Directors (BOD). Committee meeting minutes were kept and demonstrated acceptable meeting frequency, involvement of appropriate persons in the process (e.g. nurses, medical director, and physician consultants), communication among the committees, routine reporting to and oversight of the BOD.

In CY 2011 Carelink's QAPI program did not meet several requirements. The BOD did not provide adequate oversight (the BOD did not meet in CY 2011), committee meetings were not held at least quarterly, and meeting minutes did not demonstrate communication among the various committees. Although Carelink exceeded the 94% threshold for the QA standard, BMS required the MCO to complete an internal corrective action plan to address these QI program issues. Carelink provided an acceptable CAP which Delmarva monitoring on a quarterly basis to ensure that the MCO addresses the issues and is compliant for the CY 2012 review.

In previous years, the MCOs had challenges collecting certain EPSDT data, specifically tracking referrals and results of treatments. Collaboration with the data contractor resulted in the use of several algorithms which now enables all MCOs to collect and report the data as required. These data are now successfully being submitted to BMS on a quarterly basis.

The MHT MCOs used the PIP quality improvement process of identifying problems relevant to their population, setting measurement goals, obtaining baseline measurements, and performing interventions aimed at improving performance. As a whole, MCOs are providing more comprehensive project analyses, which in turn, assist them in identifying barriers and developing more targeted interventions. In general, they are continuing to develop and implement more rigorous interventions. MCOs should continue to focus their efforts on analyzing their data to determine next steps. Data and project analysis is one of the most critical PIP steps as it requires the MCO to look back and identify successes and opportunities and facilitates process improvement.

The PIP topics are largely clinical in nature and The Health Plan's Childhood Obesity PIP and UniCare's Asthma PIP focus on quality-related issues. The Health Plan's Childhood Obesity PIP focuses on improving the rates of members with evidence of: BMI documentation, nutritional counseling, and physical activity counseling. During this reporting period, the MCO submitted its second remeasurement data. When data was compared to the first remeasurement period, there was noted improvement for each indicator; however, improvement was marginal. The Health Plan continues to struggle with getting providers to code their BMI and obesity-related assessments. The MCO is considering offering provider reimbursement for documentation of BMI.

UniCare's Asthma PIP which assessed the percentage of persistent asthmatics who were appropriately prescribed medication is being closed after two years of remeasurement. While performance slightly declined, it is noteworthy to report that performance is near the NCQA Quality Compass 90th percentile and UniCare's population is better served by the MCO developing a new PIP that offers more opportunity for improvement.

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

All five of the immunization and screening measures improved between HEDIS 2010 and HEDIS 2012. They are:

- Childhood Immunization Status
  - Combination 1
  - Combination 2
- Immunizations for Adolescents-Combination 1
- Lead Screening for Children
- Controlling High Blood Pressure

Immunizations for Adolescents-Combination 1 achieved the greatest improvement over the three year period increasing 11.7 percentage points from 33.3% in HEDIS 2010 to 45.0% in HEDIS 2012. Additionally, the *Controlling High Blood Pressure* measure rate of 64.7% exceeded the National Medicaid Average of 56.8%.

Rates for four of the seven indicators in the Comprehensive Diabetes Care (CDC) measure improved between HEDIS 2010 and HEDIS 2012. They are:

- Blood Pressure Control (<140/90),
- HbA1c Control (<8%),
- HbA1c Testing, and
- LDL-C Control (LDL-C <100)

Although the CDC indicators for *Eye Exam* and *LDL-C Screening* indicators did not improve over HEDIS 2010 to HEDIS 2012, both indicators improved from HEDIS 2011 to HEDIS 2012. Only one indicator in the, *Medical Attention for Nephropathy*, did not experience any improvement in either measurement period. Overall in the area of quality, the MHT Weighted Average improved for 9 out of 12 indicators between HEDIS 2010 and HEDIS 2012. *Immunizations For Adolescents-Combination 1* achieved the greatest improvement with an increase of 11.7 percentage points between HEDIS 2010 and HEDIS 2012. The HEDIS 2012 MHT Weighted Averages for two indicators compared favorably to national benchmarks. Controlling High Blood Pressure and *Comprehensive Diabetes Care- Blood Pressure Control (<140/90) Controlling High Blood Pressure* exceeded the National Medicaid Average.

Access

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

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

Access standards are found throughout the Enrollee Rights, Grievances, and QA standards. The MCOs performed well for standards and elements related to access. All MCOs provided comprehensive member materials. Telephone numbers to access Member/Customer service lines are provided in member handbooks. Member handbooks describe the covered services, how to access those services, and any other special requirements such as whether or not referrals are required for specialist services.

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

- Emergency cases must be seen immediately or referred to an emergency facility;
- Urgent cases must be seen within 48 hours;
- Routine cases other than clinical preventive services must be seen within 21 days (exceptions are permitted at specific times when PCP capacity is temporarily limited);
- An initial prenatal care visit must be scheduled within 14 days of the date on which the woman is found to be pregnant

Carelink was unable to provide evidence that the MCO contract-specific appointment access standards were assessed. Both The Health Plan and UniCare assessed these appointment access standards. The Health Plan had compliance rates of greater than 96% for all appointment access standards. UniCare achieved compliance rates of ≥93% on the emergency, urgent and routine cases. However, UniCare's prenatal appointment access standard is much more stringent than that in the BMS/MCO contract at 7 days. Their performance on this internal access standard was 63%. Delmarva has recommended that UniCare measure appointment access standards as written in the BMS/MCO contract so that the MCO can be assessed for compliance to the BMS/MCO contract standards.

The MCO contract requires qualified medical personnel to be accessible 24 hours each day, seven days a week (24/7), to provide direction to patients in need of urgent or emergency care. Such medical personnel include, but are not limited to, physicians, physicians on call, licensed practical nurses, and registered nurses.

All MCOs identified an opportunity for improvement with the 24/7 access standard. Carelink's assessment of 24/7 access for PCPs yielded a 72% compliance rate. The major issues identified were answering services not connecting to a health care professional and no answer at the number on file. The Health Plan's After-Hours Accessibility survey yielded a 64.4% compliance rate with returning calls within one hour. The Health Plan followed up with interventions, including individualized letters requiring corrective action. Further, the offices are scheduled for follow-up survey calls to reevaluate compliance. Noncompliance is noted in each respective provider's file which will be reviewed during recredentialing. UniCare's 24/7 PCP access survey yielded a 66% compliance rate with the major issues identified as incorrect answering machine messages and non-compliance with instructions for non-emergency care. In prior years, UniCare only notified noncompliant providers via mail. They now contacted them in person or by telephone and review the standards. Non-compliant providers are re-surveyed and corrective actions are put into place for providers who remain non-compliant after being re-surveyed.

The Emergency Department Utilization-related PIPs fall under the category of access due to accessibility barriers identified in the process. For example, limited access to same day appointments with primary care practitioners was noted. Additionally, after hours appointments are very limited.

Carelink's PIP, which focuses on utilization for all of its members, was able to improve performance in the 20-44 year member age range. In particular, it was able to demonstrate the effectiveness of its Partners in Health Network (PIHN) initiative, which focuses on the promotion of medical homes. This indicator that assesses ED utilization of members reached by the PIHN initiative demonstrated a reduction of 5.2 visits per 1000/MM.

The Health Plan's ED PIP focuses on children with respiratory diagnoses and adults with back pain. While improvement was reported for both measures, significant improvement was noted in the Emergency Room Visits for Back Pain Diagnosis indicator—falling from a rate of 115 visits/1000 MM to 69 visits/1000 MM. Improvements appear to be the direct result of member and provider targeted interventions.

UniCare's ED PIP targets two primary care practices in an effort to reduce utilization. Remeasurement results noted an improvement; however, the data seems to be impacted by the H1N1 influenza. UniCare will be restructuring and/or reorganizing its PIP focus and aim in an effort to produce valid and reliable improvement.

Nine HEDIS indicators were selected to measure MCO performance for Access to Care:

- Adults' Access to Preventive/Ambulatory Health Services (20-44 Years, 45-64 Years, Total)
- Children and Adolescents' Access To PCP (12-24 months, 25 months- 6 Years, 7-11 Years, 12-19 Years)
- Prenatal Postpartum Care (Timeliness of Prenatal Care, Postpartum Care)

In the area of access, eight of nine access indicators compared favorably with the National Medicaid Average. *Prenatal and Postpartum Care –Postpartum Care* was only four tenths of one percent below the National Medicaid Average. One indicator, *Prenatal and Postpartum Care - Timeliness of Prenatal Care,* exceeded the National Medicaid 90th Percentile.

Favorable performance on the access measures continues to be a strength for the MHT program. The MHT Weighted Averages for all access performance measures have remained high compared to national benchmarks over the three year period from HEDIS 2010 through HEDIS 2012. This is especially important as these measures primarily target children and pregnant women, who represent the majority of the MHT enrolled population.

Timeliness

Timeliness, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" (*2013 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

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

Timeliness is an important factor for evaluating MCO performance because organizations must have procedures in place to make decisions timely in order not to disrupt or delay the provision of care or services to their members. The SPR standards in place evaluate timeliness as it relates to both the provision of services and timely access to customer services. These standards are found throughout the Enrollee Rights (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QA) standards.

During the SPR on-site review, cases, files, and logs are reviewed to assess the timeliness of MCO activities. For CY 2011, Delmarva reviewed cases, files, and logs to assess timeliness of:

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

Delmarva sampled 10 credentialing and 10 recredentialing files for each MCO. All initial credentialing applications in the sample were processed according to the MCOs policies and procedures. All provider recredentialing files in the sample were recredentialed within the three-year time requirement as required in the BMS/MCO contract. All delegated credentialing providers are held to the same timeliness standards. All three MCOs complete annual audits of the delegates and no issues were identified with timely completion of credentialing and recredentialing activities.

Complaint, grievance and appeal logs were reviewed. Delmarva selected a sample of 10 formal appeals cases for each MCO. In cases where an MCO did not have 10 appeals for CY 2011, all cases were reviewed. The BMS/MCO contract requires MCOs to process and provide notice to affected parties regarding enrollee grievances in a reasonable length of time not to exceed 45 days from the day the MCO receives the grievance, unless the enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of

the enrollee. All cases sampled were resolved and affected parties notified in less than 45 days. None of the cases included a request for an extension.

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

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

All authorization decisions are monitored for timeliness. Turn-around time is measured and documented. These results are usually summarized quarterly and reported through the QAPI channels by the UM department. There were no cases on file for expedited authorizations in CY 2011.

For CY 2011, there was one PIP that addressed timeliness. Carelink has developed an Adolescent Well-Care Visits project. Baseline performance is below the National Medicaid Average and offers an opportunity for improvement. Thus far, Carelink is on track with its project implementation and methodology. It is in the process of implementing its first year interventions which address identified barriers.

Four HEDIS indicators were selected to represent MCO performance in the area of timeliness.

- Adolescent Well-Care Visits
- Frequency of On-going Prenatal Care (≥81%)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the First 15 Months of Life (6 or more visits)

The MHT Weighted Averages for *Frequency of Ongoing Prenatal Care (≥ 81%)* and *Well-Child Visits in the First 15 Months of Life (6 or more visits)* compared favorably to the National Medicaid Average. The three year trend from HEDIS 2010 to HEDIS 2012 also indicated improving performance for these two measures.

The *Frequency of On-going Prenatal Care (≥81%), Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life and Well-Child Visits in the First 15 Months of Life (6 or more visits)* all improved between HEDIS 2011 and HEDIS 2012. The Adolescent Well-Care Visit measure has experienced a decline in performance over the trending period and indicates an opportunity for improvement.

MHT MCO Strengths and Recommendations

Carelink Strengths and Recommendations

Systems Performance Review

Carelink: CY 2011 SPR Strengths and Recommendations	
Enrollee Rights	**Strengths** • Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. • Enrollee Rights and Responsibilities are comprehensive and included in the Member Handbook. • The Member Handbook and Provider Directory are available on Carelink's website for members to access 24/7. This provides enrollees with another method to access member materials.
	Recommendations • Changes to member benefits, policies etc. must be communicated to members within 30 days. The Member Handbook states that members will be notified, but does not state how they will be notified. It is recommended that the Member Handbook state how members will be informed of any changes in benefits.
Grievance Systems	**Strengths** • Carelink has a well-documented grievance system. Policies and procedures are in place and are followed. • The Notice of Action statement includes all required elements including enrollee rights during the grievance/appeals process. • All grievance/appeals files reviewed contained adequate documentation and were resolved within the required timeframes.
	Recommendations • The Member Handbook notes Carelink's liability when a denial of delivered services is reversed, but the appeal-related policies do not. It is recommended that Carelink include this language in its appeal-related policies (Medicaid Pre and Post Service Appeal and Medicaid Urgent Appeal policies). This recommendation was made in CY 2010. The policies were reviewed and approved in 2011, but this revision was not made. Therefore, this recommendation is made again for CY 2011.
Quality Assessment and Performance Improvement	**Strengths** • Carelink achieved an average inter-rater reliability score of 94% for application of clinical screening criteria. • Credentialing and recredentialing policies and procedures are comprehensive. All 20 files reviewed were complete and timely. • Carelink has well-established policies and procedures in place to identify persons in need of case management and/or disease management. • Utilization Management monitors over and under-utilization of services to ensure enrollees have appropriate access to services. • Supplemental data was captured for multiple HEDIS measures to enhance indicator performance rates for targeted measures (e.g. BMI; Well-Child Visits for Adolescents childhood immunizations, prenatal visits, and postpartum visits). • Carelink reviews and updates clinical practice guidelines as appropriate and no less than every two years. • Based on opportunities for improvement identified in CAHPS survey results, the MCO develops action plans and implements interventions to address areas of concern. • Carelink has a comprehensive Health Education Plan in place.

Carelink: CY 2011 SPR Strengths and Recommendations	
	Recommendations • Ensure that the various quality committees are meeting at least as frequently as required in QI program documents. Minutes must document the quality related activities (findings, recommendations, actions taken), and information must be communicated through the appropriate channels/departments. Documentation must be in place to ensure that communication is timely and ultimately reaches the governing body. • Increase governing body meeting frequency to allow for an increase in guidance, and oversight of QI related activities. Minutes must demonstrate that the governing body routinely receives and reviews written reports from the QAPI program. • Complete the annual quality evaluation, work plans and QAPI program description in a timely manner. Ensure that these documents are also reviewed and approved by the governing body in a reasonable timeframe. • Identify specific*, measurable* goals/objectives in the Quality and Utilization Management Work Plans. • The 24/7 PCP access survey yielded a 72.2% compliance rate. Carelink should provide evidence of follow-up for non-compliant PCPs and documentation of any other efforts employed to improve the overall survey compliance rate. • Assess compliance with contractual appointment access standards. It is recommended that the MCO conduct a survey to determine compliance rather than attempting to use CAHPS survey results and complaint data which do not address the specific access standards for the different appointment types (prenatal, urgent care, routine etc). • Carelink must provide evidence of corrective action for providers that are non-compliant with the 24/7 PCP access standard and appointment access standards. • Carelink must identify measureable goals and objectives for the activities identified in their work plans. It is difficult to measure success without such measures.
Fraud and Abuse	**Strengths** • Carelink restructured its fraud, waste, and abuse (FWA) program in CY 2010 to include a Program Integrity Plan specifically focusing on Medicaid. • A Compliance Committee was implemented in CY 2010 and was fully functioning in CY 2011. Committee meeting minutes document appropriate activities. • Carelink benefits from the FWA efforts at the corporate level. Coordination of efforts between the corporate and local levels is documented in meeting minutes. • Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse. • Carelink provides a comprehensive employee training program on compliance/ethics. Employee attendance and completion of mandatory training is recorded and tracked to ensure employee compliance with training requirements.
	Recommendations • The Carelink Member Handbook does not include information on how enrollees can report suspected fraud, waste, and abuse. Carelink must include this information in the Member Handbook.

Performance Improvement Projects

Carelink's CY 2011 PIP Strengths and Recommendations	
Improving Adolescent Well-Care Visits	**Strengths** • Identification of a stretch goal: achieve the NCQA Quality Compass 90th percentile. • Comprehensive baseline analysis, including thorough analysis of noncompliant members.
	Recommendations • Continue implementation of planned interventions.
Decreasing Emergency Department Utilization	**Strengths** • Strong interventions in place promoting member medical home and continuity of care.
	Recommendations • Enhance quantitative analysis and provide comparisons to indicator goals.

Performance Measure Validation

Carelink's CY 2011 PMV Strengths and Recommendations
Strengths • The MCO is maintaining a proactive project timeline for ICD-10 readiness, which includes comprehensive staff trainings in ICD-10 coding, and a project goal to be fully ICD-10 compliant by Fall of 2013. • The MCO maintains and uses case management and HEDIS Navigator software applications to log and manage issues and to document calls. The MCO implemented automated notifications for Member Services representatives to flag and discuss services that members may need based on HEDIS measure requirements. • There is a work group in place for master data management and metadata registry management. Carelink maintains formal data governance policies, including approved vendor lists and endorsed methodologies for software development. Another work group is in place to assure IT processes and systems align and support Carelink's core goals and strategic direction. • The MCO successfully integrated pharmacy data provided by the fiscal agent to the MCOs to generate a separate HEDIS report on pharmacy benefit dependent measures, including Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with Upper Respiratory Tract Infection (URI), Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM) and Medication Management for People With Asthma (MMA). Carelink of West Virginia, Inc. successfully reported all required measures to BMS for HEDIS 2012. • Production of HEDIS reports was a well-coordinated and shared responsibility between Coventry corporate and Carelink of West Virginia, Inc. local staff. Corporate staff maintained responsibility for transaction systems, data integration, HEDIS report production, while local health plan staff coordinated medical record retrieval, abstraction, and data entry. These arrangements enabled the organization to recognize efficiencies through centralization at the corporate level and through market familiarity at the local level.
Recommendations • The audit team supported the MCO's intention to apply scientific methodology, including pilot tests and use of control groups, to HEDIS improvement initiatives. Carelink should design improvement initiatives so that changes from baseline can be assessed both clinically and statistically. • Investigate the feasibility of obtaining laptops for nurse reviewers to enable them to conduct abstractions directly into Hybrid Reporter without the use of paper tools. • Update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013.

The Health Plan Strengths and Recommendations

Systems Performance Review

The Health Plan's CY 2011 SPR Strengths and Recommendations	
Enrollee Rights	**Strengths** • Member materials, including the Member Handbook, provide enrollees with information on how to access benefits and services. • Enrollee Rights and Responsibilities are comprehensive and provided in an easily understood format. • The Member Handbook and a Provider Directory search are available on The Health Plan's website for members to access 24/7.
	Recommendations • Clearly state in the Member Handbook that the enrollee has the options to have benefits continue during the time the enrollee requests a State Fair Hearing. This information is provided in the notice of action (NOA) letter sent to the enrollee, but it would be helpful to have this information in the Member Handbook. • The Health Plan informs enrollees regarding the time frames for filing a grievance/appeal via the Member Handbook. It is recommended that this information be included in the appeals/grievances information on the MCO's website.
Grievance Systems	**Strengths** • Complaint, grievance, and appeals policies are in place and are followed. • The Practitioner Procedural Manual provides information for providers to file grievances and appeals. • The Member Handbook outlines the procedures for enrollees to file complaints, grievances, and appeals. • Complaints, grievances, and appeals are monitored for timeliness of completion • All grievance and appeal case files reviewed on-site in CY 2011 were completed in a timely manner. • Thorough documentation is maintained in appeal files to support the MCO's decisions.
	Recommendations • The MCO must give enrollees any reasonable assistance in completing forms. This provision was inadvertently removed from the Member Handbook in the CY 2011 revision. (The MCO has already addressed this concern.)

The Health Plan's CY 2011 SPR Strengths and Recommendations	
Quality Assessment and Performance Improvement	**Strengths** • The Quality Management and Utilization Management program documents are comprehensive and describe the major activities, goals, and objectives. • Disease and case management programs are in place. A review of cases on-site demonstrated appropriate interventions and outreach efforts are in place. • The Health Plan successfully manages, tracks, and monitors its EPSDT-eligible enrollees via a homegrown program. • Performance improvement project topics and indicators are relevant and appropriate. • Collaboration between quality-related committees and sub-committees is clear and documented in meeting minutes/reports. • Medical Director involvement is evident and documented in meeting minutes. • Provider participation is apparent throughout quality programs and initiatives. • All credentialing and recredentialing records sampled for the review period were completed timely. • The Health Plan demonstrated timely access to PCP appointments. It met standards and improved timely access compared to CY 2010; each domain of care was assessed as being ≥96% compliant. • The MCO appropriately reviews and updates clinical practice guidelines, as required. • The Health Plan has a comprehensive health education plan and targets numerous, relevant wellness initiatives.
	Recommendations • Continue efforts to improve compliance with the 24/7 PCP access standard. The compliance rate for returning calls within one hour decreased from CY 2010 to CY 2011. • As part of its credentialing and recredentialing procedures, the MCO must query the Excluded Provider List System (EPLS) database. • Ensure that the Quality Management program documents are approved by committees and the governing body in the correct sequence. In the past two review periods, the Board of Directors approved the program documents prior to approval of the Executive Management Team. • Include the minimum compliance requirement (90%) for physician interrater reliability in its Physician Interrater Review Policy. As written, the policy applies only to case managers and nurses. • Enhance the authorization decision extension timeframe portion of the Timeliness of Utilization Management and Behavioral Health Decision Policy. Language should be added to include: If the MCO determines that an extension is necessary to gather additional information, the MCO must justify, upon request, to the State that this extension is in the enrollee's best interest. • Revise the Case Management policy and include more specific language to describe the specific monitoring processes and measures that are used; the current policy is vague and does not describe specific processes and measures.
Fraud and Abuse	**Strengths** • To enhance program practices, flowcharts were developed to document procedures for internal monitoring and auditing. • Specific steps have been identified that are used to investigate potential fraud and abuse offenses, as well as follow-up steps when an offense has been confirmed. • A Compliance Committee was developed and implemented. Meeting minutes document its activities.
	Recommendations • Implement a process to record and track employee completion of annual compliance

The Health Plan's CY 2011 SPR Strengths and Recommendations	
	training requirements. Attendance logs are maintained for sessions, but not recorded for each individual employee upon successful completion. • Provide results/documentation of internal monitoring and auditing efforts as described in policies and procedures. • The Health Plan has developed a process to verify that services provided were actually received. The MCO should implement this process as planned.

Performance Improvement Projects

The Health Plan's CY 2011 PIP Strengths and Recommendations	
Childhood Obesity	**Strengths** • Comprehensive project rationale. • Improvement in qualitative analysis, including documentation of barriers to improve performance. • In addition to targeting providers with interventions, as the PIP's indicators focus on provider responsibilities/actions, The Health Plan is also targeting members of the plan, community, and school systems as it relates to the obesity epidemic.
	Recommendations • Enhance quantitative analysis and provide precise comparisons to previous measurements, as well as goals.
Decreasing Emergency Department Utilization	**Strengths** • Improved data analysis. • Significant improvement in indicator 2 (emergency room visits with back pain).
	Recommendations • Make comparisons to specific numeric project goals.

Performance Measure Validation

The Health Plan's CY 2011 PMV Strengths and Recommendations
Strengths • The Health Plan met HIPAA 5010 compliance in 2011. Furthermore, both of the organization's transaction systems, Minisoft and HEART, are already ICD-10 compliant and able to conduct dual processing of ICD-9 and ICD-10 coded claims. • The Health Plan maintains a birth file database that is populated by a nurse case manager who receives pregnancy notifications from claims or directly from providers. The hospital contacts the MCO regarding date of delivery, which is recorded in database with data on gestational age and diagnoses. The MCO reconciles data with claims, but the database has higher priority than claims as it has been proven to be most accurate. Claims for which there were no case management records are verified before counting towards maternity measures. • The MCO successfully integrated pharmacy data provided by the fiscal agent to the MCOs to generate a separate HEDIS report on pharmacy benefit dependent measures, including Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with Upper Respiratory Tract Infection (URI), Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM) and Medication Management for People With Asthma (MMA). Carelink of West Virginia, Inc. successfully reported all required measures to BMS for HEDIS 2012. • The Health Plan effectively maintained supplemental lab data from a number of participating network hospitals to supplement its administrative data for HEDIS reporting.
Recommendations • The audit team recommended that the organization pursue opportunities to obtain BMI and blood pressure results from participating hospitals and provider groups to supplement additional measures and indicators and reduce medical record review burden. • The Health Plan is encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013.

UniCare Strengths and Recommendations

Systems Performance Review

UniCare: CY 2011 SPR Strengths and Recommendations	
Enrollee Rights	**Strengths** • Member materials are comprehensive and provide enrollees with information on their benefits and how to access them. • Enrollee Rights and Responsibilities are comprehensive and provided in the Member Handbook. • The Member Handbook and Provider Directory (search) are available on UniCare's website for members to access 24/7.
	Recommendations • This standard received a 100% compliance rating. There are no recommendations for improvement.
Grievance Systems	**Strengths** • UniCare has well-developed grievance policies and procedures that meet all requirements. • Appeals and grievance files contain all the required components. • The Notices of Action (NOA) letters are comprehensive. NOAs inform enrollees how to file an appeal, outline the appeal process, and explain enrollee rights during the appeal process. • Appeals are resolved in an expeditious manner. All cases files reviewed were resolved within the 30 day timeframe requirement.
	Recommendations • This standard received a 100% compliance rating. There are no recommendations for improvement.
Quality Assessment and Performance Improvement	**Strengths** • UniCare completes a comprehensive annual membership analysis in an effort to align quality improvement efforts with members' needs. • UniCare made significant improvement in reducing the number of closed panel PCPs over the course of 2011. • The MCO appropriately coordinates services for enrollees with special health care needs. • UniCare consistently applies review criteria for authorization decisions. • A credentialing and recredentialing file review demonstrates that UniCare meets timeliness requirements. No deficiencies were noted in the files that were audited. • Practice guidelines are reviewed and updated as required. • UniCare maintains a quality and health information system that collects, analyzes, integrates, and reports data. Information is communicated to applicable communities and stakeholders. UniCare provides follow up and corrective actions for areas requiring intervention. • The MCO informs providers of quality-related initiatives and requires provider participation in quality improvement activities. • UniCare has a comprehensive Health Education Plan and appropriately reaches out to members in an effort to engage them in the health education related programs. • Clinical practice guidelines are in place and appropriately used to make authorization decisions. • Performance improvement project topics and indicators are relevant and appropriate. • Collaboration between quality-related committees and sub-committees is clear and documented in meeting minutes/reports.

UniCare: CY 2011 SPR Strengths and Recommendations	
	Recommendations • Increase the internal minimum compliance rating for medical record documentation standards from 80% to 90%. The current standard is too low. • The timeliness of scheduling appointments appears to be an ongoing issue, specifically with non-urgent /sick and prenatal appointments. UniCare's internal prenatal appointment standard of 7 days is much more stringent than the contractual standard of 14 days. It is recommended that the MCO assess its compliance rate with the contractual standard in addition to its internal standard. UniCare should also conduct a barrier analysis and develop methods to effectively address this issue. • Access to PCPs 24/7 also appears to be an ongoing issue For the noncompliant PCPs the most common issue was non-compliance with instructions for non-emergency care on answering machine messages. UniCare notifies noncompliant providers via mail, telephone, or in person. Corrective actions are required in some cases. UniCare should increase its provider education efforts in this area to improve compliance with this BMS/MCO contractual standard. • UniCare notifies enrollees that preventive health screenings (pap smears and mammograms) are available. However, the eligible ages are not clearly stated. UniCare should clearly document the age requirements for such screenings. This can be communicated in the Member Handbook and enrollee newsletter. • UniCare provides coverage of colorectal cancer screening, as referenced in its Well Woman Reminder Program Policy. However, it is not evident that this screening is addressed in the member handbook or the annual newsletter. UniCare must clearly communicate the availability of this screening to members. This can be communicated in the Member Handbook and enrollee newsletter.
Fraud and Abuse	**Strengths** • UniCare has a comprehensive set of policies and procedures that address fraud, waste and abuse • The Standards for Ethical Business Conduct provides employees with the company's expectations for ethical behavior as well as their responsibilities for reporting suspected fraud, waste and abuse. • Appropriate compliance officers/personnel and systems are in place to detect, report, monitor, and eliminate fraud and abuse. • UniCare provides a comprehensive employee training program on compliance/ethics. In this training, employees are educated on how to identify and report any suspicious activity. • Documentation of successful completion of mandatory training is maintained for each employee. • UniCare uses its experience both locally (WV) and nationally to detect fraud, waste and abuse. Any "schemes" identified in one region of the country are investigated in all their markets.
	Recommendations • UniCare continues to achieve a 100% compliance rating for Fraud and Abuse. There are no recommendations for improvement.

Performance Improvement Projects

UniCare's CY 2011 PIP Strengths and Recommendations	
Improving Asthma Control	**Strengths** • Comprehensive project rationale. • Multifaceted interventions.
	Recommendations • Mature project with performance near the NCQA Quality Compass 90th percentile—close project and identify a new PIP topic requiring improvement.
Decreasing Emergency Department Utilization	**Strengths** • Comprehensive project analysis.
	Recommendations • Develop new, more robust interventions to sustain project or reconsider the direction of the PIP and define a new aim with new indicators that target ED utilization.

Performance Measure Validation

UniCare's CY 2011 PMV Strengths and Recommendations
• Strengths • UniCare Health Plan of West Virginia, Inc. is maintaining a proactive project timeline for ICD-10 readiness, including end-to-end testing starting in 2013, and ongoing staff trainings in ICD-10 coding methodologies. • The organization continued to successfully migrate disparate data sources and processes to its enterprise data warehouse (EDW). In 2011, laboratory results were integrated to the EDW, and the organization is scheduled to migrate both Vision Service Plan and WV pharmacy data to EDW in 2012. • The MCO successfully integrated pharmacy data provided by the fiscal agent to the MCOs to generate a separate HEDIS report on pharmacy benefit dependent measures, including Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with Upper Respiratory Tract Infection (URI), Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM) and Medication Management for People With Asthma (MMA). Carelink of West Virginia, Inc. successfully reported all required measures to BMS for HEDSI 2012. • UniCare Health Plan of West Virginia, Inc. was able to enhance reporting of member language data by combining demographic data with data available from member services on non-English language preferences. The Lead Auditor recommended that the organization should complete migration to HIPAA 834 format to improve capture of any available language data from the state. • Production of the MCO's HEDIS reports was a well-coordinated and shared responsibility between WellPoint corporate and UniCare Health Plan of West Virginia, Inc. local staff. Corporate staff maintained responsibility for transaction systems, data integration, HEDIS report production, while local health plan staff coordinated medical record retrieval, abstraction, and data entry. These arrangements enabled the organization to recognize efficiencies through centralization at the corporate level and through market familiarity at the local level.
Recommendations • The audit team supported the organization's intention to apply scientific methodology, such as using pilot tests and control groups, to HEDIS improvement initiatives. Especially promising are new programs that are tied to, member incentive structures that increase as the member's compliance increases. • UniCare is encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013.

MHT Program Strengths and Recommendations

MHT Program Strengths and Recommendations	
Systems Performance Review	**Strengths** • The MCOs have performed well for all standards from CY 2009 –CY 2011 achieving above the 90% threshold established by BMS for all four standards (ER, GS, QA, and FA). • Through CY 2011, MCOs were allowed to use either a CAHPS or CAHPS-like survey. Beginning CY 2012, BMS has mandated MCOs to use the most recent version of the CAHPS survey. Mandating the use of this tool will allow comparison of results among the three MCOs and to national benchmarks. • Historically, the MCOs have had difficulties collecting certain EPSDT data (tracking of referrals and treatments that result from EPSDT screenings). In CY 2010, BMS established algorithms for the MCOs to use in collecting these data. MCOs now report these measures to BMS quarterly.
	Recommendations • The Systems Performance Review standards will be updated to reflect the requirement to use the CAHPS tool and methodology for CY 2012. The current MCO contract requires the use of the most current version of CAHPS. The contract language should be more specific to ensure that the MCOs are collecting all of the data that BMS expects. The contract language should require the use of Adult and Child CAHPS as well as supplemental questions to capture such measures as Medical Assistance with Smoking and Tobacco Use Cessation.
Performance Improvement Projects	**Strengths** • In general, MCOs continue to demonstrate improvement in basic project methodology by providing comprehensive project rationales, identifying fitting study questions and indicators, and conducting appropriate data collection procedures. • MCOs are employing a variety of robust interventions that target enrollees and providers; passive interventions, such as mass mailings, are far less prominent in current PIPs demonstrating MCO growth and understanding of what makes projects successful.
	Recommendations • While project analyses have continued to improve over the years, there is still opportunity for the MCOs to enhance their project analyses. Understanding barriers and causes for performance are critical components of the analysis that assist in effectively planning the next steps of PIP implementation. Requiring MCOs to report their progress on a quarterly basis may facilitate timely project analysis and earlier identification of setbacks or opportunities. More frequent updates would allow the EQRO to provide more timely monitoring and feedback to the MCOs and BMS regarding PIP progress.

MHT Program Strengths and Recommendations	
Performance Measure Validation	**Strengths** • All three MCOs have experienced staff, established data systems, and well-defined processes to calculate and report HEDIS performance measures. • All MCOs are on-target to obtain NCQA accreditation by January 2014. • The MCOs all successfully integrated pharmacy data provided by the fiscal agent to report respiratory measures to the State including Appropriate Testing for Children with Pharyngitis (CWP), Appropriate Treatment for Children with Upper Respiratory Tract Infection (URI), Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB), Use of Appropriate Medications for People With Asthma (ASM) and Medication Management for People With Asthma (MMA). All the MCOs successfully reported all required measures to BMS for HEDIS 2012. • All three MCOs used targeted outreach programs in efforts to increase member compliance for recommended services.
	Recommendations • All three MCOs are encouraged to continue use of tools and methodologies such as modeling and regression to further hone their outreach programs to increase member compliance for services included in the HEDIS measures (e.g. immunizations and preventive visits). • All the MCOs are encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. • MCOs should work with BMS and corresponding State agencies to assure they have adequate access to information from the West Virginia Immunization Registry (WVIMS). The MCOs should also confer with the West Virginia Health Information Network (WVHIN) whose members are working to establish a statewide health information technology (HIT) system. These additional resources may contribute to data completeness and improved HEDIS rates.

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Appendix 1- PIP Results

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

PIP Results-Adolescent Well-Care Visits			
Indicator 1: Adolescent Well-Care Visits			
Time Period	Measurement	Goal	Rate or Results
CY 2011	Baseline	NCQA 90th Percentile	42.13%

PIP Results-Emergency Department			
Indicator 1: ED Visits (Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline		146.45 Visits/1000 MM
CY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	151.37 Visits/1000 MM
CY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	147.10 Visits/1000 MM
CY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	146.00 Visits/1000 MM
Indicator 2: ED Visits (Medicaid Members, All Ages) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2008	Baseline	Reduce ER Visits by 2.5 Visits/1000 MM	74.66 Visits/1000 MM
CY 2009	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	81.70 Visits/1000 MM
CY 2010	Remeasurement 2	Reduce ER Visits by 2.5 Visits/1000 MM	74.65 Visits/1000 MM
CY 2011	Remeasurement 3	Reduce ER Visits by 2.5 Visits/1000 MM	78.18 Visits/1000 MM
Indicator 3: ED Visits (PIHN Medicaid Members, Ages 20-44) reported per 1000 MM			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		136.56 Visits/1000 MM
CY 2011	Remeasurement 1	Reduce ER Visits by 2.5 Visits/1000 MM	131.36 Visits/1000 MM

Table A1-2. The Health Plan of the Upper Ohio Valley Performance Improvement Project (PIP) Results.

PIP Results- Obesity			
Indicator 1: Members with evidence of BMI documentation (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		1.45%
CY 2010	Remeasurement 1	5% annual increase	1.12%
CY 2011	Remeasurement 2	5% annual increase	1.36%
Indicator 2: Members with evidence of nutritional counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.94%
CY 2010	Remeasurement 1	5% annual increase	0.54%
CY 2011	Remeasurement 2	5% annual increase	1.22%

Indicator 3: Members with evidence of physical activity counseling (2-17 years of age)			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.78%
CY 2010	Remeasurement 1	5% annual increase	0.45%
CY 2011	Remeasurement 2	5% annual increase	1.12%
PIP Results-Emergency Department			
Indicator 1: Emergency Room visits per 1000 member months (ages 0-5 years) with respiratory diagnosis			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		438.27 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	398.95 visits/1000 MM
Indicator 2: Emergency Room visits per 1000 member months (age 20 and older) with diagnosis of back pain			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		114.97 visits/1000 MM
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000 MM
4/1/2011 – 3/31/2012	Remeasurement 2	5% annual reduction	68.76 visits/1000 MM

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

PIP Results-Asthma			
Indicator 1: Persistent asthmatics (5-64 years of age*) who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		95.07%
CY 2010	Remeasurement 1	95.07%	93.84%
CY 2011	Remeasurement 2	93.19%	91.02%*
PIP Results- Emergency Department			
Indicator 1: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Al Attar) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	88% or 876 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	788 visits per 1000 members	40% or 398 visits per 1000 members
Indicator 2: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Peters) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline	NA	96% or 965 visits per 1000 members
10/1/2010 – 9/30/2011	Remeasurement 1	868 visits per 1000 members	40% or 397 visits per 1000 members

* HEDIS 2012 technical specifications were modified; the age range expanded from 5-50 to 5-64 years of age

Appendix 2 – HEDIS 2012 MCO Rates, MHT Weighted Average, and National Benchmarks

Tables A2-1through A2-4 below provide a comparison of the MCO Rates, MHT Weighted Average, and National Medicaid Benchmarks for HEDIS 2012 (MY 2011).

Table A2-1. Quality Measures

Measure Name	Carelink HEDIS 2012 %	The Health Plan HEDIS 2012 %	UniCare HEDIS 2012 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Childhood Immunization Status - Combo 2	67.1	70.6	68.6	68.3	74.5	84.2
Childhood Immunization Status - Combo 3	62.5	63.8	62.0	62.4	70.7	82.4
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	61.8	74.5	71.2	68.8	60.8	75.4
Comprehensive Diabetes Care - Eye Exams	34.9	34.5	31.0	32.8	53.2	69.7
Comprehensive Diabetes Care - HbA1c Control (<8%)	36.5	47.6	42.1	41.3	48.0	59.4
Comprehensive Diabetes Care - HbA1c Testing	75.1	77.9	77.5	76.8	82.4	91.1
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	23.2	28.3	30.2	27.7	35.2	46.4
Comprehensive Diabetes Care - LDL-C Screening	61.8	67.6	64.6	64.2	74.9	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	67.6	66.2	59.3	63.1	77.8	86.9
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	54.8	40.0	47.6	48.5	43.2	29.0
Controlling High Blood Pressure	56.9	77.9	67.4	64.7	56.8	69.1
Immunizations for Adolescents - Combination 1	49.8	45.5	41.9	45.0	60.4	80.9
Lead Screening in Children	53.6	54.5	56.5	55.1	67.7	86.6

Table A2-2 Access Measures

Measure Name	Carelink HEDIS 2012 %	The Health Plan HEDIS 2012 %	UniCare HEDIS 2012 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	84.6	89.4	87.6	86.9	79.9	88.5
Adults' Access to Preventive/Ambulatory Health Services (45-64)	87.6	89.2	85.9	87.0	85.9	91.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	84.9	89.4	87.5	86.9	81.8	89.3
Children and Adolescents' Access To PCP (12-19 Yrs)	87.5	91.6	91.7	90.4	87.9	93.0
Children and Adolescents' Access To PCP (12-24 Months)	97.2	98.2	97.3	97.4	96.1	98.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	89.6	91.8	91.6	91.0	88.2	92.6
Children and Adolescents' Access To PCP (7-11 Yrs)	90.6	92.9	94.3	92.9	89.5	94.5
Prenatal and Postpartum Care - Postpartum Care	60.7	66.4	65.0	63.7	64.1	74.5
Prenatal and Postpartum Care - Timeliness of Prenatal Care	94.0	93.7	92.9	93.4	82.7	93.3

Table A2-3. Timeliness Measures

Measure Name	Carelink HEDIS 2012 %	The Health Plan HEDIS 2012 %	UniCare HEDIS 2012 %	MHT Weighted Average HEDIS 2012 %	National Medicaid Average HEDIS 2012 %	National Medicaid 90th Percentile HEDIS 2012 %
Adolescent Well-Care Visits	42.1	41.4	35.5	38.7	49.7	64.3
Frequency of Ongoing Prenatal Care (≥ 81%)	83.1	83.2	70.9	77.1	60.9	82.8
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	67.6	63.9	68.2	67.3	71.9	82.9
Well-Child Visits in the first 15 Months of Life (6 or more visits)	71.1	64.9	67.6	68.6	61.7	77.3

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

Tables A3-1 through A3-3 provide the MCO Rates and MHT Weighted Averages for the three-year period from HEDIS 2010 through HEDIS 2012.

Table A3-1 Quality Measures

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %
Childhood Immunization Status - Combo 2	61.8	66.2	67.1	64.2	62.3	70.6	61.6	62.2	68.6	62.2	63.5	68.3
Childhood Immunization Status - Combo 3	54.4	60.9	62.5	56.7	56.0	63.8	55.0	55.1	62.0	55.2	57.1	62.4
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	58.9	51.0	61.8	62.1	67.6	74.5	56.9	68.3	71.2	58.4	63.5	68.8
Comprehensive Diabetes Care - Eye Exams	43.7	25.3	34.9	30.7	39.3	34.5	34.5	30.2	31.0	35.8	30.6	32.8
Comprehensive Diabetes Care - HbA1c Control (<8%)	32.9	29.7	36.5	43.6	44.8	47.6	39.3	43.5	42.1	38.7	40.1	41.3
Comprehensive Diabetes Care - HbA1c Testing	75.3	74.3	75.1	77.1	80.7	77.9	75.6	76.8	77.5	75.8	76.9	76.8
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	17.7	17.3	23.2	26.4	28.3	28.3	27.4	27.0	30.2	25.1	24.7	27.7
Comprehensive Diabetes Care - LDL-C Screening	63.9	58.4	61.8	67.1	70.3	67.6	67.3	64.4	64.6	66.5	64.0	64.2
Comprehensive Diabetes Care - Medical Attention for Nephropathy	58.9	67.3	67.6	68.6	72.4	66.2	65.8	63.2	59.3	64.8	66.0	63.1
Controlling High Blood Pressure	54.0	50.0	56.9	57.4	63.8	77.9	68.6	66.4	67.4	63.0	61.0	64.7
Immunizations for Adolescents - Combination 1	36.9	42.1	49.8	39.2	41.1	45.5	29.0	37.2	41.9	33.3	39.5	45.0
Lead Screening in Children	53.9	55.2	53.6	52.1	49.8	54.5	50.4	56.2	56.5	51.5	54.8	55.1

Table A3-2 Access Measures

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %
Adults' Access to Preventive/Ambulatory Health Services (20-44)	86.7	85.9	84.6	90.6	88.2	89.4	88.5	88.1	87.6	88.4	87.4	86.9
Adults' Access to Preventive/Ambulatory Health Services (45-64)	82.8	81.7	87.6	94.9	90.6	89.2	86.7	86.5	85.9	87.2	85.9	87.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	86.3	85.5	84.9	91.0	88.4	89.4	88.3	87.9	87.5	88.3	87.2	86.9
Children and Adolescents' Access To PCP (12-19 Yrs)	86.2	86.0	87.5	91.8	92.0	91.6	90.2	90.7	91.7	89.7	89.8	90.4
Children and Adolescents' Access To PCP (12-24 Months)	96.9	97.3	97.2	98.5	97.8	98.2	97.9	97.3	97.3	97.7	97.4	97.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	88.6	88.1	89.6	93.1	91.2	91.8	91.5	89.1	91.6	91.1	89.2	91.0
Children and Adolescents' Access To PCP (7-11 Yrs)	89.4	90.3	90.6	94.3	93.9	92.9	93.1	93.2	94.3	92.6	92.6	92.9
Prenatal and Postpartum Care - Postpartum Care	65.4	61.0	60.7	62.8	65.7	66.4	71.3	64.6	65.0	67.8	63.4	63.7
Prenatal and Postpartum Care - Timeliness of Prenatal Care	96.8	94.9	94.0	92.9	95.6	93.7	94.9	94.2	92.9	95.2	94.5	93.4

Table A3-3 Timeliness Measures

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average		
	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %	HEDIS 2010 %	HEDIS 2011 %	HEDIS 2012 %
Adolescent Well-Care Visits	39.6	44.0	42.1	43.6	38.4	41.4	41.9	41.4	35.5	42.1	41.6	38.7
Frequency of Ongoing Prenatal Care (≥ 81%)	78.4	79.4	83.1	85.4	79.6	83.2	64.2	67.6	70.9	72.8	73.9	77.1
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	69.0	67.1	67.6	69.1	60.9	63.9	75.4	66.1	68.2	72.4	65.5	67.3
Well-Child Visits in the first 15 Months of Life (6 or more visits)	61.6	69.0	71.1	63.7	60.4	64.9	62.8	64.2	67.6	62.7	65.2	68.6

Appendix 4-1 WV HEDIS 2012 Rates, Numerators, Denominators, and Eligible Populations

Tables A4-1a through A4-3c provides all the data collection method (administrative or hybrid), numerators, denominators, and eligible populations used to calculate the MCO Rates and MHT Weighted Averages for the three-year period from HEDIS 2010 through HEDIS 2012.

Table A4-1a Quality Measures HEDIS 2012 (Measurement Year 2011)

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

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

Table A4-1b Access Measures HEDIS 2012 (Measurement Year 2011)

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

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

Table A4-1c Timeliness Measures HEDIS 2012 (Measurement Year 2011)

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

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

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

Column Definitions:

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

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

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

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

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

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

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

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

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

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

Appendix 4-2-WV HEDIS 2011 Rates, Numerators, Denominators, and Eligible Populations

Table A4-2a Quality Measures

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

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

Table A4-2b Access Measures

Measure Name	Carelink Health Plan, Inc					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2010) %
	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	2798	0	85.9	3,258	A	1601	0	88.2	1,815	A	4279	0	88.1	4,858	9,931	8,679	87.4
Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	241	0	81.7	295	A	182	0	90.6	201	A	442	0	86.5	511	1,007	865	85.9
Adults' Access to Preventive/Ambulatory Health Services (Total)	A	3039	0	85.5	3,553	A	1783	0	88.4	2,016	A	4721	0	87.9	5,369	10,938	9,539	87.2
Children and Adolescents' Access To PCP (12-19 Yrs)	A	4567	0	86.0	5,308	A	4170	0	92.0	4,532	A	9677	0	90.7	10,673	20,513	18,415	89.8
Children and Adolescents' Access To PCP (12-24 Months)	A	3089	0	97.3	3,176	A	1199	0	97.8	1,226	A	3987	0	97.3	4,098	8,500	8,277	97.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	A	8285	0	88.1	9,408	A	5173	0	91.2	5,673	A	14714	0	89.1	16,514	31,595	28,176	89.2
Children and Adolescents' Access To PCP (7-11 Yrs)	A	3992	0	90.3	4,420	A	3793	0	93.9	4,040	A	8612	0	93.2	9,242	17,702	16,398	92.6
Prenatal and Postpartum Care - Postpartum Care	H	263	431	61.0	3,552	H	270	411	65.7	1,347	H	221	342	64.6	4,372	9,271	5,876	63.4
Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	409	431	94.9	3,552	H	393	411	95.6	411	H	322	342	94.2	4,372	8,335	7,882	94.5

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

Table 4-2c Timeliness Measures

Measure Name	Carelink					The Health Plan					UniCare					MHT Total Eligible Population	MHT Weighted Average Numerator	MHT Weighted Average (MY2010) %
	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP	CM	Num	Denom	HEDIS 2011 %	EP			
Adolescent Well-Care Visits	H	190	432	44.0	8,989	A	2204	0	38.4	5,746	H	170	411	41.4	14,818	29,553	12,296	41.6
Frequency of Ongoing Prenatal Care (≥ 81%)	H	342	431	79.4	3,552	H	327	411	79.6	1,347	A	2958	0	67.6	4,374	9,273	6,849	73.9
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	290	432	67.1	7,352	A	2837	0	60.9	4,659	H	207	313	66.1	13,335	25,346	16,585	65.5
Well-Child Visits in the first 15 Months of Life (6 or more visits)	H	298	432	69.0	2,117	A	619	0	60.4	1,025	H	249	388	64.2	3,038	6,180	4,030	65.2

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

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

Column Definitions:

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

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

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

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

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

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

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

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

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

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

Appendix 4- 3 WV HEDIS 2010 Rates, Numerators, Denominators and Eligible Populations

Table A4-3a Quality Measures HEDIS 2010

Measure Name	Carelink Health Plan, Inc					The Health Plan					UniCare					MHT Weighted Average Denominator	MHT Weighted Average Numerator	MHT Weighted Average (MY2009) %
	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP			
Childhood Immunization Status - Combo 2	H	267	432	61.8	1,471	H	264	411	64.2	1,355	H	253	411	61.6	3,636	6,462	4,019	62.2
Childhood Immunization Status - Combo 3	H	235	432	54.4	1,471	H	233	411	56.7	1,355	H	226	411	55.0	3,636	6,462	3,568	55.2
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H	93	158	58.9	160	H	87	140	62.1	145	H	191	336	56.9	419	724	423	58.4
Comprehensive Diabetes Care - Eye Exams	H	69	158	43.7	160	H	43	140	30.7	145	H	116	336	34.5	419	724	259	35.8
Comprehensive Diabetes Care - HbA1c Control (<8%)	H	52	158	32.9	160	H	61	140	43.6	145	H	132	336	39.3	419	724	281	38.7
Comprehensive Diabetes Care - HbA1c Testing	H	119	158	75.3	160	H	108	140	77.1	145	H	254	336	75.6	419	724	549	75.8
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	H	28	158	17.7	160	H	37	140	26.4	145	H	92	336	27.4	419	724	181	25.1
Comprehensive Diabetes Care - LDL-C Screening	H	101	158	63.9	160	H	94	140	67.1	145	H	226	336	67.3	419	724	482	66.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	93	158	58.9	160	H	96	140	68.6	145	H	221	336	65.8	419	724	469	64.8
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	H	95	158	60.1	160	H	75	140	53.6	145	H	101	336	30.1	419	724	300	41.4
Controlling High Blood Pressure	H	136	252	54.0	281	H	74	129	57.4	152	H	282	411	68.6	597	1,030	649	63.0
Immunizations for Adolescents - Combination 1	H	159	431	36.9	952	H	161	411	39.2	859	H	119	411	29.0	1,979	3,790	1,262	33.3
Lead Screening in Children	H	233	432	53.9	1,471	H	214	411	52.1	1,335	H	207	411	50.4	3,636	6,442	3,321	51.5

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

Table A4-3b Access Measures

Measure Name	Carelink Health Plan, Inc					The Health Plan					UniCare					MHT Weighted Average Denominator	MHT Weighted Average Numerator	MHT Weighted Average (MY2009) %
	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP			
Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	2049	0	86.7	2,364	A	1590	0	90.6	1,755	A	3894	0	88.5	4,400	8,519	7,534	88.4
Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	211	0	82.8	255	A	166	0	94.9	175	A	378	0	86.7	436	866	755	87.2
Adults' Access to Preventive/Ambulatory Health Services (Total)	A	2260	0	86.3	2,619	A	1756	0	91.0	1,930	A	4272	0	88.3	4,836	9,385	8,287	88.3
Children and Adolescents' Access To PCP (12-19 Yrs)	A	3546	0	86.2	4,114	A	4253	0	91.8	4,631	A	9313	0	90.2	10,321	19,066	17,107	89.7
Children and Adolescents' Access To PCP (12-24 Months)	A	2259	0	96.9	2,331	A	1330	0	98.5	1,351	A	3897	0	97.9	3,981	7,663	7,487	97.7
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	A	6231	0	88.6	7,032	A	5534	0	93.1	5,944	A	13699	0	91.5	14,974	27,950	25,465	91.1
Children and Adolescents' Access To PCP (7-11 Yrs)	A	3073	0	89.4	3,439	A	3868	0	94.3	4,104	A	8128	0	93.1	8,728	16,271	15,070	92.6
Prenatal and Postpartum Care - Postpartum Care	H	282	431	65.4	3,131	H	250	411	62.8	1,507	H	311	411	71.3	4,239	8,877	6,016	67.8
Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	417	431	96.8	3,131	H	382	411	92.9	1,507	H	390	411	94.9	4,239	8,877	8,454	95.2

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

Table 4-3c Timeliness Measures

Measure Name	Carelink Health Plan, Inc					The Health Plan					UniCare					MHT Weighted Average Denominator	MHT Weighted Average Numerator	MHT Weighted Average (MY2009) %
	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP	CM	Num	Denom	HEDIS 2010 %	EP			
Adolescent Well-Care Visits	H	171	432	39.6	2,364	A	2521	0	43.6	5,780	H	172	411	41.9	13,900	22,044	9,280	42.1
Frequency of Ongoing Prenatal Care (≥ 81%)	H	338	431	78.4	3,131	H	351	411	85.4	1,507	A	2723	0	64.2	4,239	8,877	6,463	72.8
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	298	432	69.0	5,625	A	3307	0	69.1	4,788	H	310	411	75.4	11,917	22,330	16,175	72.4
Well-Child Visits in the first 15 Months of Life (6 or more visits)	H	265	411	61.6	1,198	A	711	0	63.7	1,117	H	258	411	62.8	3,059	5,374	3,371	62.7

CM=collection methodology (H/A), Num=numerator, Denom=denominator EP=Eligible population

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

Column Definitions:

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

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

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

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

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

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

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

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

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

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

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

For HEDIS 2012, MHT MCOs were asked to calculate rates for seven additional HEDIS measures. They are:

- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Pharmacotherapy Management of COPD Exacerbation
- Use of Appropriate Medications for People With Asthma
- Medication Management for People With Asthma, Compliance 75%
- Medical Assistance with Smoking and Tobacco Use Cessation

These measures were collected and solely reported to BMS and not to NCQA for two reasons. First, six of the measures require the use of pharmacy data and the pharmacy benefit is currently provided by the state. Since the benefit is carved out from the MCOs, their access to pharmacy data is limited. Secondly, the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure is a component of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. During CY 2011 MHT MCOs had the option of using CAHPS or a CAHPS-like survey. Two of the three MCOs fielded a CAHPS survey in 2011, and therefore this measure will not be comparable across all MCOs.

BMS worked with the State's Pharmacy Third Party Administrator (TPA) and the three MCOs to provide each one with pharmacy data file of their beneficiaries. All three MCOs were able to calculate reportable rates according to measure specifications.

Table. A5-1 State Requested Measures Using Pharmacy Data

Measure	MHT Weighted Average
Appropriate Testing for Children With Pharyngitis	57.5%
Appropriate Treatment for Children With Upper Respiratory Infection	62.9%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	15.2%
Pharmacotherapy Management of COPD Exacerbation- Systemic corticosteroid	62.2%
Pharmacotherapy Management of COPD Exacerbation- Bronchodilator	73.3%
Use of Appropriate Medications for People With Asthma –Ages 5-11 Years	92.0%

Measure	MHT Weighted Average
Use of Appropriate Medications for People With Asthma—Ages 12-18 Years	83.6%
Use of Appropriate Medications for People With Asthma – Ages 19-50 Years	72.0%
Use of Appropriate Medications for People With Asthma – Ages 51-64 Years	80.0%
Use of Appropriate Medications for People With Asthma – Total	87.7%
Medication Management for People With Asthma-Ages 5-11 Years, Compliance 75%	39.3%
Medication Management for People With Asthma-Ages 12-18 Years, Compliance 75%	32.8%
Medication Management for People With Asthma-Ages 19-50 Years, Compliance 75%	38.9%
Medication Management for People With Asthma-Ages 51-64 Years, Compliance 75%	75.0%
Medication Management for People With Asthma – Total, Compliance 75%	36.9%

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

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

Indicator	MHT Average
Advising Smokers and Tobacco Users to Quit	75.34%
Discussing Cessation Medications	45.82%
Discussing Cessation Strategies	39.11%

Appendix 6 –HEDIS Measures Collected and Reported to NCQA (HEDIS 2010-HEDIS 2012)

Table Appendix 6-1 provides information for all measures collected and reported for HEDIS 2010 through HEDIS 2012 (CY 2009-CY 2011) by HEDIS domains. Individual MCO rates for three years, the MHT Weighted Average for three years, the most current National Medicaid Average, and the most current National Medicaid 90th Percentile are provide for each measure.

Appendix 6-1. Effectiveness of Care Domain Measures

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average (MY 2009) - %	MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	National Medicaid Average HEDIS 2012 - %	National Medicaid 90th Percentile HEDIS 2012 - %
	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %					
Adult BMI Assessment	39.7	45.4	46.6	6.2	10.3	47.7	31.1	41.4	49.6	28.0	36.6	48.4	52.6	77.4
Breast Cancer Screening	28.4	31.2	40.4	51.4	51.1	44.1	47.0	45.9	40.0	43.9	43.6	40.9	50.4	62.8
Cervical Cancer Screening	56.8	58.8	63.9	67.5	64.7	62.3	70.1	70.4	70.4	64.7	65.7	66.9	66.6	78.5
Childhood Immunization Status - Combo 2	61.8	66.2	67.1	64.2	62.3	70.6	61.6	62.2	68.6	62.2	63.5	68.3	74.5	84.2
Childhood Immunization Status - Combo 3	54.4	60.9	62.5	56.7	56.0	63.8	55.0	55.1	62.0	55.2	57.1	62.4	70.7	82.4
Chlamydia Screening in Women - Total	51.0	40.7	43.2	35.5	43.2	33.7	37.4	36.6	37.3	40.4	39.1	38.9	57.7	68.8
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	^	50.0	^	^	14.3	^	^	42.9	^	^	39.2	^	42.1	55.6
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	^	100.0	^	^	^	^	^	57.1	^	^	^	^	82.0	88.8
Comprehensive Diabetes Care - Blood Pressure Control (<140/80)	25.3	30.2	34.9	27.1	44.1	42.1	33.9	42.9	44.7	30.7	39.7	41.2	39.4	53.0
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	58.9	51.0	61.8	62.1	67.6	74.5	56.9	68.3	71.2	58.4	63.5	68.8	60.8	75.4
Comprehensive Diabetes Care - Eye Exams	43.7	25.3	34.9	30.7	39.3	34.5	34.5	30.2	31.0	35.8	30.6	32.8	53.2	69.7

Comprehensive Diabetes Care - HbA1c Control (<7% for a selected population)	25.9	21.0	26.9	32.8	33.3	^	31.9	30.8	^	30.8	28.8	26.9	35.4	44.0
Comprehensive Diabetes Care - HbA1c Control (<8%)	32.9	29.7	36.5	43.6	44.8	47.6	39.3	43.5	42.1	38.7	40.1	41.3	48.0	59.4
Comprehensive Diabetes Care - HbA1c Testing	75.3	74.3	75.1	77.1	80.7	77.9	75.6	76.8	77.5	75.8	76.9	76.8	82.4	91.1
Comprehensive Diabetes Care - LDL-C Control (LDL-C<100 mg/dL)	17.7	17.3	23.2	26.4	28.3	28.3	27.4	27.0	30.2	25.1	24.7	27.7	35.2	46.4
Comprehensive Diabetes Care - LDL-C Screening	63.9	58.4	61.8	67.1	70.3	67.6	67.3	64.4	64.6	66.5	64.0	64.2	74.9	83.5
Comprehensive Diabetes Care - Medical Attention for Nephropathy	58.9	67.3	67.6	68.6	72.4	66.2	65.8	63.2	59.3	64.8	66.0	63.1	77.8	86.9
Comprehensive Diabetes Care - Poor HbA1c Control >9% (lower rate is better)	60.1	60.4	54.8	53.6	47.6	40.0	30.1	47.6	47.6	41.4	51.0	48.5	43.2	29.0
Controlling High Blood Pressure	54.0	50.0	56.9	57.4	63.8	77.9	68.6	66.4	67.4	63.0	61.0	64.7	56.8	69.1
Immunizations for Adolescents - Combination 1	36.9	42.1	49.8	39.2	41.1	45.5	29.0	37.2	41.9	33.3	39.5	45.0	60.4	80.9
Lead Screening in Children	53.9	55.2	53.6	52.1	49.8	54.5	50.4	56.2	56.5	51.5	54.8	55.1	67.7	86.6
Use of Imaging Studies for Low Back Pain	66.5	67.3	67.1	72.8	65.6	69.2	71.4	71.9	69.7	70.2	69.3	68.8	75.8	82.0
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile	9.0	24.3	22.7	1.5	1.1	1.4	21.4	14.1	21.4	13.9	14.1	18.1	46.1	77.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	40.3	44.4	45.4	0.9	0.5	1.2	40.6	34.6	32.4	31.7	30.0	30.5	50.1	77.6
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	22.7	40.5	39.8	0.8	0.5	1.1	27.3	19.5	16.3	20.2	21.2	20.4	40.7	64.9

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2012 (MY 2011)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Table 6-2 Access to Care Domain Measures

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average (MY 2009) - %	MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	National Medicaid Average HEDIS 2012 - %	National Medicaid 90th Percentile HEDIS 2012 - %
	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %					
Adults' Access to Preventive/Ambulatory Health Services (20-44)	86.7	85.9	84.6	90.6	88.2	89.4	88.5	88.1	87.6	88.4	87.4	86.9	79.9	88.5
Adults' Access to Preventive/Ambulatory Health Services (45-64)	82.8	81.7	87.6	94.9	90.6	89.2	86.7	86.5	85.9	87.2	85.9	87.0	85.9	91.0
Adults' Access to Preventive/Ambulatory Health Services (Total)	86.3	85.5	84.9	91.0	88.4	89.4	88.3	87.9	87.5	88.3	87.2	86.9	81.8	89.3
Call Abandonment (lower rate is better)	1.2	1.7	1.9	2.9	1.9	1.9	1.7	4.4	5.3	1.6	2.2	2.5	2.6	1.0
Call Answer Timeliness	84.1	82.8	81.7	92.7	96.7	96.2	83.9	79.3	81.0	85.3	84.1	83.5	83.3	93.6
Children and Adolescents' Access To PCP (12-19 Yrs)	86.2	86.0	87.5	91.8	92.0	91.6	90.2	90.7	91.7	89.7	89.8	90.4	87.9	93.0
Children and Adolescents' Access To PCP (12-24 Months)	96.9	97.3	97.2	98.5	97.8	98.2	97.9	97.3	97.3	97.7	97.4	97.4	96.1	98.4
Children and Adolescents' Access To PCP (25 Months-6 Yrs)	88.6	88.1	89.6	93.1	91.2	91.8	91.5	89.1	91.6	91.1	89.2	91.0	88.2	92.6
Children and Adolescents' Access To PCP (7-11 Yrs)	89.4	90.3	90.6	94.3	93.9	92.9	93.1	93.2	94.3	92.6	92.6	92.9	89.5	94.5
Prenatal and Postpartum Care - Postpartum Care	65.4	61.0	60.7	62.8	65.7	66.4	71.3	64.6	65.0	67.8	63.4	63.7	64.1	74.5
Prenatal and Postpartum Care - Timeliness of Prenatal Care	96.8	94.9	94.0	92.9	95.6	93.7	94.9	94.2	92.9	95.2	94.5	93.4	82.7	93.3

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2012 (MY 2011)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Table 6-3 Utilization and Relative Resource Use Domain

Measure	Carelink Health Plan, Inc			The Health Plan			UniCare			MHT Weighted Average (MY 2009) - %	MHT Weighted Average (MY 2010) - %	MHT Weighted Average (MY 2011) - %	National Medicaid Average HEDIS 2012 - %	National Medicaid 90th Percentile HEDIS 2012 - %
	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %	HEDIS 2010 - %	HEDIS 2011 - %	HEDIS 2012 - %					
Adolescent Well-Care Visits	39.6	44.0	42.1	43.6	38.4	41.4	41.9	41.4	35.5	42.1	41.6	38.7	49.7	64.3
Frequency of Ongoing Prenatal Care (≥ 81%)	78.4	79.4	83.1	85.4	79.6	83.2	64.2	67.6	70.9	72.8	73.9	77.1	60.9	82.8
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	69.0	67.1	67.6	69.1	60.9	63.9	75.4	66.1	68.2	72.4	65.5	67.3	71.9	82.9
Well-Child Visits in the first 15 Months of Life (6 or more visits)	61.6	69.0	71.1	63.7	60.4	64.9	62.8	64.2	67.6	62.7	65.2	68.6	61.7	77.3

(x)==> HEDIS percentile and mean rates are from NCQA Quality Compass 2012 (MY 2011)
(--)==> No comparative benchmarks available
(^)==> Measures not collected or denominator too small to calculate reliable rate

Appendix 7 - Status of Recommendations from the CY 2010 Review

Delmarva provided recommendations to all three MCOs in the 2010 review for the SPR, PIP, and PMV activities with the expectation that they would be addressed. The tables below provide the recommendations made and the actions, if any, that have been undertaken by each of the MCOs in CY 2011 to address recommendations. Summaries are presented below by MCO and activity.

Carelink - SPR

Carelink: CY 2010 SPR Recommendations and CY 2011 Current Status	
Enrollee Rights	**Recommendation** • Inform enrollees via a mailing (such as a newsletter) that member materials (Member Handbook, Provider Directory, Member Rights and Responsibilities, information on benefits, grievances/appeals, etc.) are available on Carelink's website and can be obtained at any time by contacting Customer Service. This informational mailing to enrollees must be completed annually.
	Status • Instead of notifying enrollees of the availability of member materials on the Carelink website, the MCO mailed all materials to members. This meets the intent of the requirements.
Grievance Systems	**Recommendation** • Update appeal-related policies to reflect Carelink's liability when a denial of delivered services is reversed. Appropriate language is included in the Member Handbook.
	Status • Carelink reviewed the appeals related policies but did not make the suggested revisions. Therefore, this recommendation was made again in CY 2011.
Quality Assessment and Performance Improvement	**Recommendations** • Improve (increase) the availability of high volume specialists, including hematologist/oncologist, cardiologist, and dermatologists. • Identify specific*, measurable* goals/objectives in the Quality and Utilization Management Work Plan. • Increase Board of Directors meeting frequency to allow for an increase in guidance and governance for all quality improvement related activities. • In relation to evaluating the effectiveness of the EPSDT Program for children, Carelink must track specialty care visits/diagnoses/treatment based on screening results and provide up-to-date information on initial visits for newborns.
	Status • Carelink met the MHT program access standards in CY 2011 and therefore, the availability of specialists is considered adequate. • Measurable goals/objectives were not included in the Quality and Utilization Management Work Plan. Therefore, this recommendation is made again in CY 2011. • The Board of Directors did not meet at all in CY 2011. Therefore, Delmarva has made the recommendation again in CY 2011 that the governing body meets regularly to provide oversight of the quality improvement efforts. • UniCare now has algorithms supplied by BMS's data contractor for EPSDT reporting. EPSDT reporting is now completed quarterly as required by BMS.

Carelink: CY 2010 SPR Recommendations and CY 2011 Current Status	
Fraud and Abuse	**Recommendations** • Carelink should continue to enhance its Fraud and Abuse Program. **Status** • N/A

Carelink – PIP

Carelink: CY 2010 PIP Recommendations and CY 2011 Current Status	
Improving Adolescent Well-Care Visit rates	• This is the first year of project implementation; there were no previous recommendations
Decreasing ED Utilization	**Recommendation** • Recommendations were made to improve the project's quantitative analysis. **Status** • Carelink provided a more comprehensive analysis. Comparisons were made to previous measurements. Statistical testing was completed. Project success and intervention effectiveness were discussed. However, specific numeric comparisons to project goals were not provided and the recommendation to do so remains.

Carelink -PMV

Carelink: CY 2010 PMV Recommendations and CY 2011 Progress
Recommendations • Due to issues and challenges identified in obtaining data from the West Virginia Statewide Immunization Information System (WVSIIS), Carelink was unable to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011. It is recommended that the MCOs work with BMS and the WVIIS to obtain reasonable access to the data. • While Carelink exhibited a well-coordinated HEDIS reporting process, efficiencies may be gained by equipping nurse reviewers with portable technology such as laptops for medical record abstraction.
Status • The MCO is able to review individual records one at a time on the WSIIS. Any other form of access has yet to be granted by the WVIIS. • Paper abstraction tools are still preferred method. However, current management is considering changing.

The Health Plan - SPR

The Health Plan: CY 2010 SPR Recommendations and CY2011 Status	
Enrollee Rights	**Recommendations** • Inform enrollees via a newsletter that they can access the Member Handbook, Provider Directory, and other pertinent enrollee information via the MCO's website or they can contact the Customer Service Department to obtain information in hardcopy form. Enrollees should be informed of this on an annual basis. • Include the time frame requirements for filing an appeal in the appeals/grievances information on The Health Plan's website. • Clearly state in the Member Handbook that the enrollee has the option to have benefits continue during the time the enrollee files an appeal or requests a State Fair Hearing.

The Health Plan: CY 2010 SPR Recommendations and CY2011 Status	
	Status • Instead of notifying enrollees of the availability of member materials on The Health Plan's website, the MCO mailed all materials to members. This meets the intent of the requirements. • The time frame requirements for filing an appeal were not added to the MCO's website. Therefore, this recommendation is made again for CY 2011. • Member Handbook was updated in CY 2011; information regarding continuation of benefits was not included. This recommendation is made again for CY 2011.
Grievance Systems	**Recommendations** • None
	Status • Not applicable
Quality Assessment and Performance Improvement	**Recommendations** • Improve after hours accessibility specifically in regards to the 24/7 PCP access requirement. • Increase internal inter-rater reliability standards for authorization decisions to 90% (currently it is 80%). • Revise the Timeliness of Utilization Management and Behavioral Health Decisions Policy to include the following requirement: if an extension is requested for an authorization decision, the MCO must justify to the State that the extension is in the enrollee's best interest. • Ensure that credentialing applications are screened and processed according to policy.
	Status • The after-hours accessibility (24/7 access to PCP) compliance rate decreased from 66.7% in CY 2010 to 64.4% in CY 2011. Each non-compliant provider office was assessed to determine reasons for noncompliance, the MCO followed-up with interventions, including individualized letters requiring corrective action, and offices are scheduled for follow-up survey calls to reevaluate compliance. Noncompliance is noted in each respective provider's file which will be reviewed during recredentialing. • The Physician Interrater Review Policy now establishes a 90% compliance rate for inter-rater reliability. As written, the policy applies only to case managers and nurses; it appears as though physicians were inadvertently omitted with the policy revision. Recommendation made in CY 2011 to add the 90% compliance rate for physicians to this policy. • The Timeliness of Utilization Management and Behavioral Health Decisions Policy were not revised. This recommendation was made again in CY 2011. • One provider credentialing record in CY 2010 was not processed according to procedure. Delmarva re-reviewed this provider record to ensure that the issue was taken care of. Documentation in CY 2011 shows that the issue was being addressed by the medical director. If this issue is not resolved at the time of the CY 2012 review, the credentialing standard will not be fully met.
Fraud and Abuse	**Recommendations** • Provide Fraud and Abuse reports to BMS by the 15th of each month, whether or not any cases of suspected fraud and abuse are identified.
	Status • Reports are now submitted to BMS each month, whether or not cases of suspected fraud and abuse are identified.

The Health Plan – PIP

The Health Plan: CY 2010 PIP Recommendations and CY 2011 Progress	
Childhood Obesity	**Recommendations** • Recommendations were made to assess barriers annually and to document them within the analysis. • The MCO was also advised to enhance its quantitative analysis by providing comparisons to goals/benchmarks. **Status** • The Health Plan identified and included barriers, such as providers not coding for BMI-related services, in the project analysis. • The Health Plan did indeed provide a more comprehensive analysis and described improvement in performance and noted that goals were met; however, it did not provide specific quantitative comparisons. This recommendation remains in place.
ED Utilization Diversion	**Recommendations** • Recommendations were made to The Health Plan to provide a more comprehensive qualitative analysis, by including barriers and perceived causes for performance. **Status** • The MCO responded and enhanced its analysis by describing barriers, such as report errors which delayed outreach. Data analysis was comprehensive and planned activities were identified.

The Health Plan – PMV

The Health Plan: CY 2010 PMV Recommendations and CY 2011 Progress
Recommendation: • The Health Plan was the only MCO successful in obtaining access to the WV Immunization Registry for HEDIS 2011, but it was not without challenges. Due to persistent issues and challenges identified in obtaining data from the WVSIIS over the last two years, it is recommended that the MCOs work with BMS and the WVIIS to obtain reasonable access to the data.
Status: • THP continues to work with the State to secure more access to the WVIIS. Currently their access is limited to looking up records on an individual basis.

UniCare - SPR

UniCare: CY 2010 SPR Recommendations and CY 2011Status	
Enrollee Rights	**Recommendation** • Inform enrollees via a newsletter that they can access the Provider Directory by way of the MCO's website or they can contact the Customer Care Center to obtain a hardcopy directory.
	Status • UniCare provided this information in a newsletter in CY 2011 as recommended.
Grievance Systems	**Recommendation** • Ensure acknowledgement letters are submitted to members within five days of receipt of an appeal or grievance.

UniCare: CY 2010 SPR Recommendations and CY 2011Status	
	Status • UniCare audit process and Delmarva annual audit revealed compliance with timely notification of members.
Quality Assessment and Performance Improvement	**Recommendations** • Improve timeliness of appointment scheduling for non-urgent/sick visits and prenatal appointments; improve 24/7 PCP access survey results. • Increase the internal minimum compliance rating for medical record documentation standards from 80% to 90%. The current standard is too low. • Document and inform members of age requirements for periodic health screenings. • Improve the tracking and reporting of EPSDT-related referrals and treatments.
	Status • The telephone access survey was repeated and compliance was still not at the 90% standard. Recommendation made this year for UniCare to conduct a barrier analysis and identify methods to effectively address this issue. • UniCare did not increase the internal minimum compliance rating for medical record documentation standards from 80% to 90%. Delmarva recommends that UniCare increase the standard to 90% in its policy. • UniCare did not document and inform members of age requirements for periodic health screenings. Delmarva makes the same recommendation this year. UniCare must document this or the preventive standards regarding periodic health screenings will not be met in the next review. • UniCare now has algorithms supplied by BMS's data contractor. EPSDT reporting is now completed quarterly as required by BMS.
Fraud and Abuse	**Recommendations** • None
	Actions • Not applicable.

UniCare – PIP

UniCare: CY 2010 PIP Recommendations and CY 2011 Status	
Improving Asthma Control	**Recommendation** • Recommendations were made to UniCare to provide a more comprehensive qualitative analysis. **Status** • The MCO responded and documented barriers, provided an assessment of performance, and identified activities planned for the future.
Reducing Inappropriate ED Utilization	**Recommendation** • Recommendations were made to UniCare to provide a more robust qualitative analysis. **Status** • The MCO complied and described its barriers, the constructive feedback that it received from stakeholders, and other challenges the MCO faces with this project.

UniCare - PMV

UniCare: CY 2010 PMV Recommendations and CY 2011 Progress
Recommendation • The organization created two separate hybrid samples for Childhood Immunization Status and Lead Screening in Children, with one reduced and the other not reduced. The audit team informed the organization that it is permitted to combine samples between these measures, which the organization will consider for HEDIS 2012 reporting. **Status** • The MCO's HEDIS Roadmap indicates this recommendation was successfully applied for HEDIS 2012.

MHT Recommendations

MHT: CY 2010 PMV Recommendations and CY 2011 Progress
Recommendation • The MCOs are committed to quality performance evidenced by their results on the Systems Performance Review with compliance rates greater than 90%. However, collecting certain EPSDT data, tracking of referrals and treatments that result from EPSDT screenings, continue to be problematic for some of the MCOs. In CY 2010, BMS established algorithms and reporting templates for reporting these indicators. These data are now collected and the MCOs are required to submit the data to BMS on a quarterly basis. It is recommended that the rates submitted be monitored for reasonability when there are at least a year's worth of data. **Status** • All MCOs have been reporting the EPSDT data to BMS on a quarterly basis during CY 2011. BMS now has adequate data to assess reasonability of the MCO submissions.
Recommendation • As in the CY 2009 review, the performance measure validation process uncovered an issue with the MCOs gaining reasonable access to the West Virginia Statewide Immunization Information System (WVSIIS). State law requires all providers to report all immunizations they administer to children under age 18 to the WVSIIS within two weeks. These data are important in collecting accurate rates for the Childhood Immunization Status and Immunizations for Adolescents measures. It is recommended that BMS lead the effort to bring the MCOs, the Division of Immunization Services, and the Vaccines for Children program together to share best practices, to explore joint outreach and to develop messaging opportunities. In addition, it is recommended this collaborative identify a consistent method for the MCOs to access this important data source. **Status** • BMS continues its efforts to get MCOs reasonable access to the WVIIS. Although the MCOs continue to query the database one record at a time for their HEDIS data collection, the immunization rates for all measures collected increased from HEDIS 2010 to HEDIS 2012.