HQCC
HEALTHCARE QUALITY CERTIFICATION COMMISSION
4700 W. Lake Avenue
Glenview, IL 60025-1485

February 17, 2012

RE: Martha A Burton, CPHQ

To Whom It May Concern:

Please accept this official letter as verification of Martha A Burton, CPHQ, as a Certified Professional in Healthcare Quality through 12/31/2013 CPHQ # 10222.

Please do not hesitate to contact us should you need any additional information.

Sincerely,

Healthcare Quality Certification Commission

Martha Burton

Company: Delmarva Foundation

Membership

Member ID: 596883

Member Since: 03 Aug 2007

Expires: 31 Aug 2012

Certification Status

You are a PMP in good standing

PMP #: 274433

Earned on: 07 Sep 2005

Renew on: 06 Sep 2012

Maryland Board of Nursing Web Lookup

Maryland Board of Nursing

Licensee Details

Demographic Information

Full Name:	MARTHA ANN BURTON	Home State:	Compact State

No address Information

License Information

Lic #:	R116031	Profession:	Nursing	Type:	REGISTERED NURSE
Status:	Active	Issue Date:	12/10/1992	Expiration Date:	11/28/2012
				Date Renewed:	11/17/2011
Obtained by:	Endorsement US Active	State:			

THE TRUSTEES OF

LONG ISLAND UNIVERSITY

UPON RECOMMENDATION OF THE FACULTY OF

SCHOOL OF EDUCATION

C. W. POST CENTER

CONFER UPON

Karen C. Brusich

THE DEGREE OF

Bachelor of Science

WITH ALL THE RIGHTS, PRIVILEGES, HONORS AND MARKS
OF DISTINCTION EARNED THEREBY
IN WITNESS OF THIS, THE SEAL OF THE UNIVERSITY AND
SIGNATURES OF ITS OFFICERS ARE HERE AFFIXED

MAY TWENTIETH, NINETEEN HUNDRED AND SEVENTY-THREE

Albert Bush-Brown
CHANCELLOR

Robert T. Taylor
PRESIDENT

George E. Bryant
EXECUTIVE DEAN

George A. Gibian
DEAN

*FORMS of CERTIFICATE

Provisional - Valid for five years from effective date

Permanent - Valid for the life of the holder unless annulled for cause

ELIGIBILITY for PERMANENT CERTIFICATE

The holder of a provisional certificate shall be eligible for a permanent certificate upon completion of the specific requirements prescribed in the appropriate Regulations of the Commissioner of Education and shall be responsible for becoming familiar with the requirements.

The University of the State of New York

This certificate, valid for service in the public schools, is granted to the person named below who has satisfied the requirements prescribed by the State Education Department.

The State Education Department

Public School Teacher Certificate

DUPLICATE

KAREN C CHOUINARD

[redacted]

Certification area: NURSERY, KINDERGARTEN & GRADES 1-6

* Form: PERMANENT
Effective date: 09/01/78

Certificate number: 114440414
Control number: 111959852

Given under the authority of the State Education Department

Vincent C Gazzetta
Director, Division of Teacher Education and Certification

(OVER)

Commissioner of Education

G9387

66200

READ INSTRUCTIONS ON REVERSE SIDE

CUT OFF THIS STRIP

84-9299

MARYLAND STATE DEPARTMENT OF EDUCATION

CERTIFICATE

REFERENCE NUMBER

This is to certify that KAREN B CHOUINARD 50 114-44-0414

VALID PERIOD		HIGHEST DEGREE	TYPE OF CERTIFICATE	AREA OR FIELD IN WHICH CERTIFICATED
FROM	TO			
7/01/1986	7/01/1996	BACHELOR'S	ADVANCED PROFESSIONAL	ELEMENTARY GRADES 1-6 AND MIDDLE SCH (S)

is hereby issued the certificate indicated herein, on the basis of having met the legal requirements in the STATE OF MARYLAND for such a certificate.

STATE SUPT. OF SCHOOLS MARYLAND 1865

Given at Baltimore, Maryland, by

STATE SUPERINTENDENT OF SCHOOLS

Virginia Polytechnic Institute
and
State University

The Board of Visitors of the Virginia Polytechnic Institute and State University has conferred upon

Daniel Ward Edris

upon the recommendation of the Faculty, the degree of

Bachelor of Science

Major - Statistics

with all the rights, privileges and honors pertaining thereto. In testimony whereof, the undersigned, by authority vested in them, have hereunto affixed their signatures and the seal of the University at Blacksburg, Virginia this eighth day of May, nineteen hundred and ninety-three.

C C Garrigus Jr.
Rector

VIRGINIA POLYTECHNIC INSTITUTE

James D McComas
President

Salisbury State University

The Faculty of Salisbury State University

with the approbation of the Board of Regents hereby admit

Kimberly Ann Haddaway

to the degree of

Bachelor of Arts

with all the rights, honors, and privileges thereto appertaining.
Given under the seal of Salisbury State University, Salisbury, Maryland
this month of December, nineteen hundred and ninety-nine.

Chairperson of the Board of Regents
of the University System of Maryland

SALISBURY STATE UNIVERSITY MARYLAND

President of the University

The University of Florida

has conferred on

Jeffrey T. Jennings

the degree of

Applied Physiology and Kinesiology

with all the rights and privileges thereunto appertaining.
In Witness Whereof, this diploma, duly signed, has been issued
and the seal of the University affixed.

Issued by the Board of Trustees upon the recommendation of the faculty of

The College of Arts and Sciences

at Gainesville, on May 12th, 1992.

Andrew Gavin
President

Michael Andrs
Secretary

Veronica Miller
Chairman, Board of Trustees

Dr. E. W. Hauss
Dean

HQCB

HQCB is pleased to enclose your CPHQ card. Your support is essential to the growth and progress of the Healthcare Quality Certification Board. If the information below is incorrect, please note changes and return to: **HQCB Executive Office, P.O. Box 19604, Lenexa, KS 66285.**

Healthcare Quality Certification Board
of the National Association for Healthcare Quality
P.O. Box 19604 • Lenexa, KS 66285
(913) 895-4609 • Fax (913) 895-4652
Toll Free 1-800-346-4722

HQCB
HEALTHCARE QUALITY CERTIFICATION BOARD
WORLD CLASS. CERTIFIED. PROFESSIONAL.

CPHQ ID#: 12313 **Expires:** 12/31/2012

Jody A. Jobeck, CPHQ

[redacted]

RECERTIFIED
THROUGH
DECEMBER 31,
2012

Remove this validation sticker and place it on your permanent certificate.

HQCB

THANK YOU FOR YOUR ONGOING COMMITMENT TO THE CPHQ PROCESS.

Perforated at your left is your CPHQ card which includes your personal CPHQ number. This card is to be used to verify your CPHQ designation and status.

THIS IS TO CERTIFY THAT

Jody A Jobeck

HAS BEEN FORMALLY EVALUATED FOR DEMONSTRATED EXPERIENCE, KNOWLEDGE AND SKILLS TO LEAD AND DIRECT PROJECT TEAMS AND IS HEREBY BESTOWED THE GLOBAL CREDENTIAL

Project Management Professional

IN TESTIMONY WHEREOF, WE HAVE SUBSCRIBED OUR SIGNATURES UNDER THE SEAL OF THE INSTITUTE.

Eugene Bounds - Chair, Board of Directors

Gregory Balestrero - Chief Executive Officer and President

PMP® Number **1377203**

PMP® Original Grant Date **14 December 2010**

PMP® Expiration Date **13 December 2013**

MEDICAID LEARNING CENTER

CERTIFIES THAT

Jody Jobeck

HAS SUCCESSFULLY COMPLETED THE TWENTY-FIVE (25) HOUR

MLC MEDICAID BASICS MODULE

AND HAS FORMALLY DEMONSTRATED A COMPREHENSIVE UNDERSTANDING OF THE MLC MEDICAID BODY OF KNOWLEDGE, AND ATTAINED THE STATUS OF

MLC CERTIFIED MEDICAID PROFESSIONAL (MCMP-I)

CERTIFICATION NUMBER: 7111 CERTIFICATION DATE: October 21, 2010

EDUCATION EVERY TWO YEARS IS REQUIRED FOR MAINTENANCE OF THE CERTIFICATION.

Marie Schwartz Day

MARIE SCHWARTZ DAY, MCMP II
MANAGING DIRECTOR

WWW.MEDICAIDLEARNING.COM · 100 MIDDLE STREET, PO BOX 1100, PORTLAND, ME 04104-1100 · (207) 541-2299

University of Phoenix

Upon the recommendation of the Faculty,
University of Phoenix does hereby confer upon

Jody A Jobeck

The Degree of

Master of Business Administration
Health Care Management

with all the rights, honors and privileges thereunto appertaining.

In witness whereof, the seal of the University and the signatures as authorized by the Board of Directors, University of Phoenix, are hereunto affixed, this thirty-first day of August, in the year two thousand three.

UNIVERSITY OF PHOENIX

Chairman, Board of Directors

President

James Madison University

Jody Anne Jones

having completed satisfactorily the requirements of this institution for the degree of

Bachelor of Science

Cum Laude

is by the authority of the law of the Commonwealth of Virginia hereby awarded that Degree with all the Honors, Rights and Privileges thereto appertaining.

Maryland Board of Nursing

Licensee Details

Demographic Information

Full Name:	JOYCE JONES	Home State:	Compact State

License Information

Lic #:	R090067	Profession:	Nursing	Type:	REGISTERED NURSE
Status:	Active	Issue Date:	8/26/1985	Expiration Date:	3/28/2013
Date Renewed:	1/13/2012				
Obtained by:	Exam	State:			

Education Information

School:	WOR-WIC COMM COLLEGE-AD		
Profession:	Nursing	DIPLOMA	
Specialty:			
Type:	RN		
School:			
Profession:	Nursing	DIPLOMA	
Specialty:			
Type:	RN		

Employment Information

No Employment Information

License CSR Information

No License CSR Information

CheckList Information

No CheckList Information

Public Orders

No Related Documents

We're continuing to enhance the new myPMI. Click the Latest Features button to read more about gre additions, and stay tuned for monthly improvements. Feel free to tell us what you think by clicking or Provide your feedback button.

Latest Features

Joyce Jones

Hide for now

Edit Photo

Title: Add your Title
Company: Delmarva Foundation
Email: jjones@dfmc.org
Update my profile

Membership

Member ID: 620497
Member Since: 16 Jul 2005
Membership Expired: 31 Jul 2011
Renew my Membership now
Membership Benefits

Certification Status

PDUs

You are a PMP in good standing

PMP #: 243680

Earned on: 01 Aug 2005

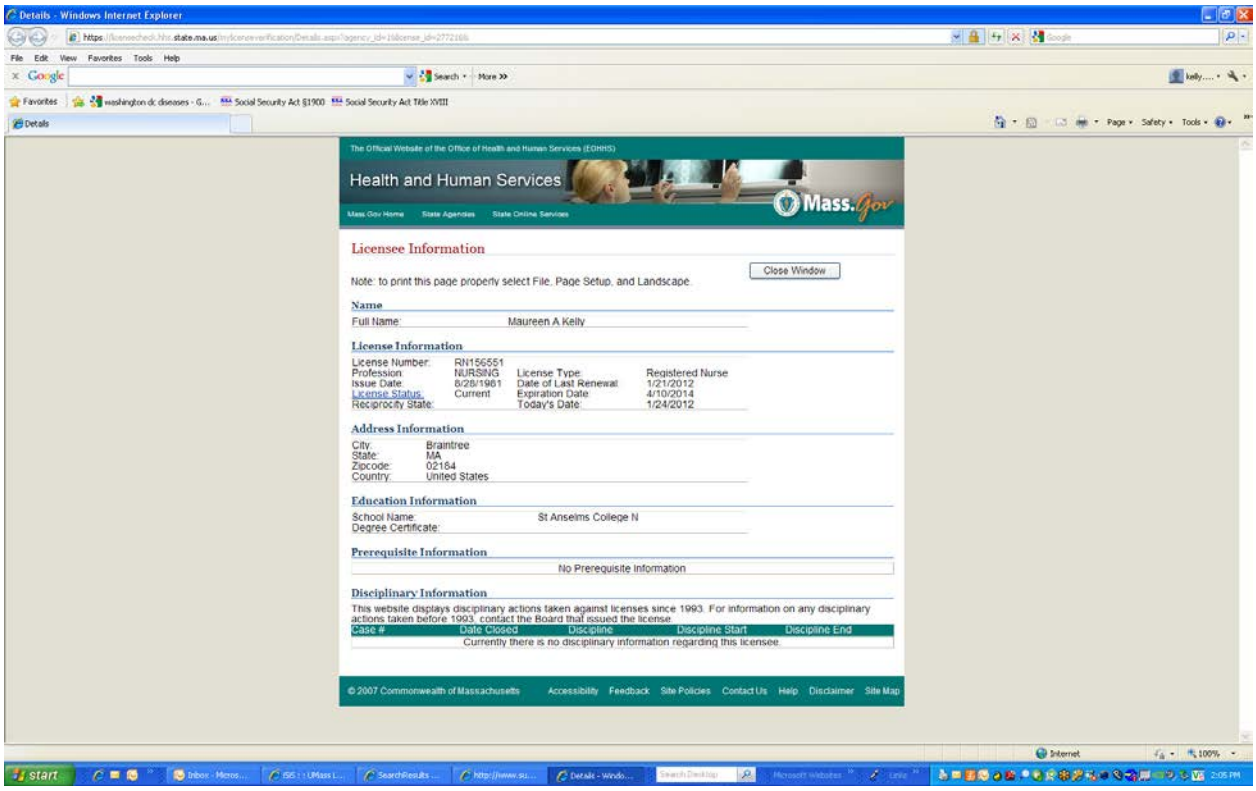
Renew on: 31 Jul 2012

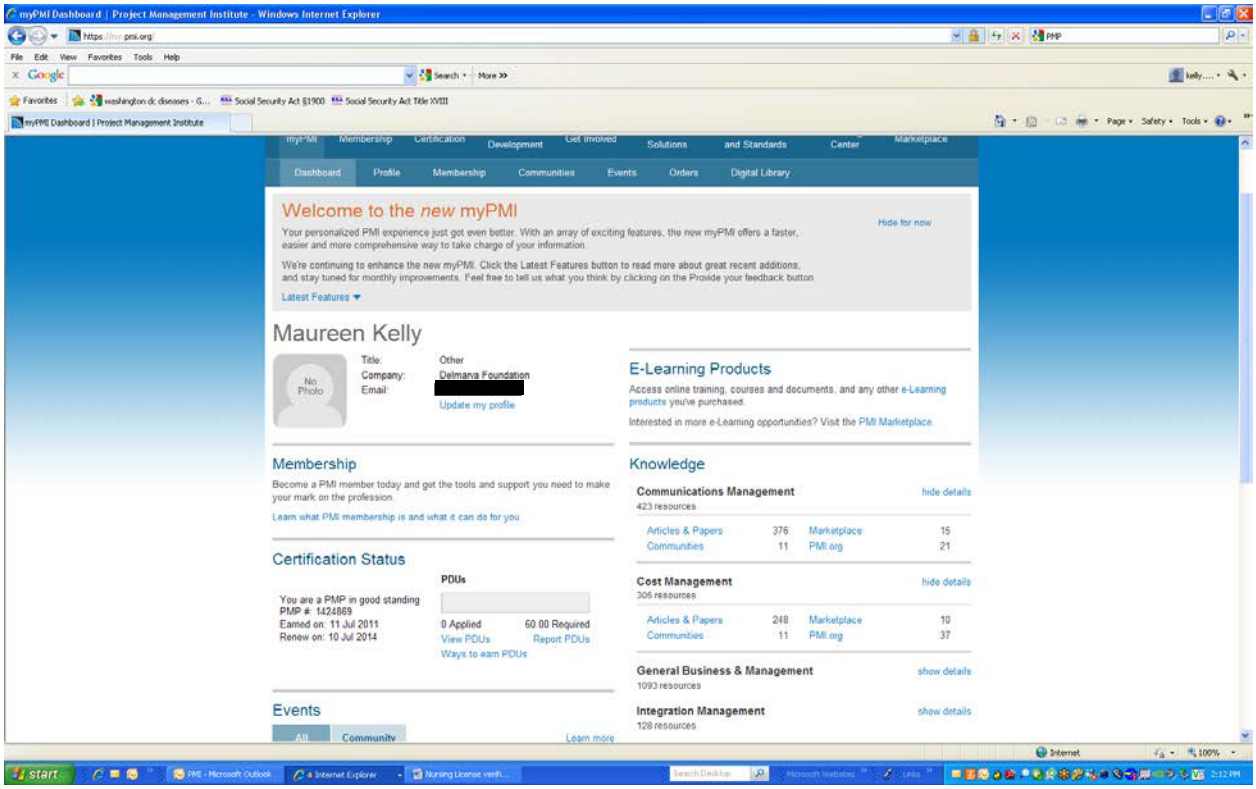
30.00 Applied 60.00 Required
View PDUs Report PDUs
Ways to earn PDUs

Events

Learn more

- All
- Community


Details - Windows Internet Explorer
The Official Website of the Office of Health and Human Services (EOHHS)
Health and Human Services
Mass.Gov
Licensee Information
Close Window
Note: to print this page properly select File, Page Setup, and Landscape.
Name
Full Name: Maureen A Kelly
License Information
License Number: RN156551
Profession: NURSING
Issue Date: 8/28/1981
License Status: Current
Reciprocity State:
License Type: Registered Nurse
Date of Last Renewal: 1/21/2012
Expiration Date: 4/10/2014
Today's Date: 1/24/2012
Address Information
City: Braintree
State: MA
Zipcode: 02184
Country: United States
Education Information
School Name: St Anselms College N
Degree Certificate:
Prerequisite Information
No Prerequisite Information
Disciplinary Information
This website displays disciplinary actions taken against licenses since 1993. For information on any disciplinary actions taken before 1993, contact the Board that issued the license.
Case # Date Closed Discipline Discipline Start Discipline End
Currently there is no disciplinary information regarding this licensee.
© 2007 Commonwealth of Massachusetts Accessibility Feedback Site Policies Contact Us Help Disclaimer Site Map


myPMI Dashboard | Project Management Institute - Windows Internet Explorer
Dashboard Profile Membership Communities Events Orders Digital Library
Welcome to the new myPMI
Your personalized PMI experience just got even better. With an array of exciting features, the new myPMI offers a faster, easier and more comprehensive way to take charge of your information.
We're continuing to enhance the new myPMI. Click the Latest Features button to read more about great recent additions, and stay tuned for monthly improvements. Feel free to tell us what you think by clicking on the Provide your feedback button
Hide for now
Latest Features
Maureen Kelly
No Photo
Title: Other
Company: Delmarva Foundation
Email: [redacted]
Update my profile
E-Learning Products
Access online training, courses and documents, and any other e-Learning products you've purchased.
Interested in more e-Learning opportunities? Visit the PMI Marketplace.
Membership
Become a PMI member today and get the tools and support you need to make your mark on the profession.
Learn what PMI membership is and what it can do for you.
Knowledge
Communications Management hide details
423 resources
Articles & Papers 376 Marketplace 15
Communities 11 PMI.org 21
Cost Management hide details
306 resources
Articles & Papers 248 Marketplace 10
Communities 11 PMI.org 37
General Business & Management show details
1093 resources
Integration Management show details
128 resources
Certification Status
PDUs
You are a PMP in good standing
PMP #: 1424869
Earned on: 11 Jul 2011
Renew on: 10 Jul 2014
0 Applied 60.00 Required
View PDUs Report PDUs
Ways to earn PDUs
Events
All Community
Learn more

ID NO: 0125592
NAME: Kelly, Maureen A

SUFFOLK UNIVERSITY
BOSTON, MASSACHUSETTS 02114
ACADEMIC RECORD

Printed on 01/31/12
Page: 1 OF 1

ISSUED TO: Ms. Maureen A. Kelly
[redacted]

PROGRAM: Graduate
ENTRY DATE: 84/FA
D.O.B: April 10
MAJOR: Public Admin
MINOR:

COURSE NO.	TITLE	GR	E	HP	COURSE NO.	TITLE	GR	E	HP

[redacted]

SAINT ANSELM COLLEGE
1889

ST. ANSELM'S COLLEGE
Manchester, New Hampshire

Transcript of the Record of ..... Maureen Kelly .....

Address ..... 14 Grove St., Boston, Ma. 02114 .....

Entered ..... September 6, 1977 ..... Graduated ..... May 17, 1981, B.S.N. .....

Withdrew .....

[redacted]

Arizona State University

Greeting to all to whom these Letters shall come
The Arizona Board of Regents
by virtue of the authority vested in it by law and
on recommendation of the University Faculty does hereby confer on

Marci Ann Kramer

who has satisfactorily completed the Studies prescribed therefor
the Degree of

Master of Health Services Administration

with all the Rights, Privileges and Honors thereunto appertaining
In Witness whereof the Seal of the University is hereto affixed

Done at Tempe, Arizona, this tenth day of May,
one thousand nine hundred and ninety-one.

Governor of Arizona

President of the Board

ARIZONA STATE UNIVERSITY · 1885 ·

President of the University

Registrar of the University

HQCB

HQCB is pleased to enclose your CPHQ card. Your support is essential to the growth and progress of the Healthcare Quality Certification Board. If the information below is incorrect, please note changes and return to: **HQCB Executive Office, P.O. Box 19604, Lenexa, KS 66285**.

Healthcare Quality Certification Board
of the National Association for Healthcare Quality
P.O. Box 19604 • Lenexa, KS 66285
(913) 599-4173 • Fax: (913) 599-5340
Toll Free 1-800-346-4722

HQCB

CPHQ ID#: 12421 **Expires:**12/31/2008

Marci A. Kramer, CPHQ

[redacted]

HQCB

THANK YOU FOR YOUR ONGOING COMMITMENT TO THE CPHQ PROCESS.

Perforated at your left is your CPHQ card which includes your personal CPHQ number. This card is to be used to verify your CPHQ designation and status.

MEDICAID LEARNING CENTER

CERTIFIES THAT

Marci Kramer

HAS SUCCESSFULLY COMPLETED THE TWENTY-FIVE (25) HOUR

MLC MEDICAID BASICS MODULE

AND HAS FORMALLY DEMONSTRATED A COMPREHENSIVE UNDERSTANDING OF THE MLC MEDICAID BODY OF KNOWLEDGE, AND ATTAINED THE STATUS OF

MLC CERTIFIED MEDICAID PROFESSIONAL (MCMP-I)

CERTIFICATION NUMBER: 7129 CERTIFICATION DATE: December 27, 2010

EDUCATION EVERY TWO YEARS IS REQUIRED FOR MAINTENANCE OF THE CERTIFICATION.

Marie Schwartz, Dr.

MARIE SCHWARTZ-DM, MCMP-II
MANAGING DIRECTOR

WWW.MEDICAIDLEARNING.COM · 100 MIDDLE STREET, PO BOX 1100, PORTLAND, ME 04104-1100 · (207) 541-2299

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

Marci Kramer

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2011	10/31/2013
DATE CERTIFIED	EXPIRATION DATE

Commonwealth of Virginia

State Board for Community Colleges

J. Sargeant Reynolds Community College

This is to Certify that

John R. McDonald, Jr.

is awarded the

Career Studies Certificate

with a major in

Computer Programmer

together with all of the rights and privileges appertaining thereto:

Given this 12th day of May, Two thousand and one

College President

Chancellor, Virginia Community Colleges

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

is pleased to announce

Laura Poynor

passed the HEDIS® Auditor Examination,
fulfilled all the necessary requirements to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

11/01/2011	10/31/2013
DATE CERTIFIED	EXPIRATION DATE

Project Management Institute

THIS IS TO CERTIFY THAT

Laura Poynor

HAS BEEN FORMALLY EVALUATED FOR DEMONSTRATED EXPERIENCE, KNOWLEDGE AND SKILLS TO LEAD AND DIRECT PROJECT TEAMS AND IS HEREBY BESTOWED THE GLOBAL CREDENTIAL

Project Management Professional

IN TESTIMONY WHEREOF, WE HAVE SUBSCRIBED OUR SIGNATURES UNDER THE SEAL OF THE INSTITUTE.

Beth Partleton · Chair, Board of Directors

Mark A. Langley · President and Chief Executive Officer

PROJECT MANAGEMENT INSTITUTE CORPORATE SEAL 1969 PENNSYLVANIA

PMP® Number **1452831**

PMP® Original Grant Date **26 August 2011**

PMP® Expiration Date **25 August 2014**

PMI Project Management Institute

St. Mary's University
of
San Antonio, Texas

Laura K. Poynor

having successfully completed the Course of Study as prescribed
by the Faculty and Board of Trustees is awarded the degree of

Master of Business Administration

with all the rights and privileges appertaining to that Degree.
In testimony thereof, the undersigned have subscribed
their names and affixed the Seal of the University.
Done this the ninth day of August, Nineteen hundred ninety-one.

Edward B. Kelley
Chairman, Board of Trustees

John Moder, Jr.
President

ST. MARY'S UNIVERSITY OF SAN ANTONIO
1852

Charles L. Cotrell
Academic Vice-President

Ronald D. Merrell
Dean

MEDICAID LEARNING CENTER

CERTIFIES THAT

Laura Poynor

HAS SUCCESSFULLY COMPLETED THE TWENTY-FIVE (25) HOUR

MLC MEDICAID BASICS MODULE

AND HAS FORMALLY DEMONSTRATED A COMPREHENSIVE UNDERSTANDING OF THE MLC MEDICAID BODY OF KNOWLEDGE, AND ATTAINED THE STATUS OF

MLC CERTIFIED MEDICAID PROFESSIONAL (MCMP-I)

CERTIFICATION NUMBER: 7073 CERTIFICATION DATE: September 28, 2010

EDUCATION EVERY TWO YEARS IS REQUIRED FOR MAINTENANCE OF THE CERTIFICATION.

Marie Schwartz-Day

MARIE SCHWARTZ-DAY, MCMP-II
MANAGING DIRECTOR

Maryland Board of Physicians Practitioner Profile System

This data was extracted on 02/27/2012

Zale, Jeffrey Marc

License and Education

License No.:	D32018
Accepts Medicaid:	No
Graduated:	1975
License Status:	**Active**
Date License Issued:	03/04/1985
License Expiration:	09/30/2013

Graduated from: NEW YORK MED COLL

Primary Practice Setting

Public Address

[redacted]

Postgraduate Training Program

Postgraduate Training Program	Concentration
• St. Joseph Hospital Health Care Center - Syracuse, Ny.	Family Medicine

Specialty Board Certification
by ABMS/AOA - as reported by licensee

- Family Medicine

Self-Designated Practice Area

- Family Practice [General]

Maryland Hospital Privilege Information

- Saint Agnes Healthcare

Known Disciplinary Actions by any state medical board (within the past 10 years)

Summary: No actions reported during the last ten year period.

Download all Maryland Disciplinary Actions

None

Pending Charges

None

Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)

Malpractice Judgments and Arbitration Awards (within the past 10 years)

None Reported

Malpractice Settlements
(If there are 3 or more settlements of $150,000 or greater within the past 5 years)

None Reported

Convictions for any crime involving moral turpitude

None reported by the courts

Glossary of Terms

Notice to Credential Verification Professionals

Return to Practitioners Profile Search

Marci Kramer, MHSA, CPHQ, CHCA

Project Manager / Certified HEDIS Compliance Auditor

Education

Master of Health Services Administration, Arizona State University, 1991

Bachelor of Social Science, Magna Cum Laude, Pennsylvania State University, 1986
Major: Behavioral Science

Experience

1994-present Delmarva Foundation for Medical Care, Inc., Easton, MD.

Project Director -- Provides oversight of the daily operations of the WV External Quality Review (EQR) contract. Team leader for on-site systems performance reviews (SPR). Assisted in the development and implementation of an electronic data collection tool which streamlined the on-site systems review data collection and reporting process. Developed and implemented standards to assess compliance with Code of Federal Regulations (CFR) requirements for EQR in the areas of quality, grievance systems, and enrollee rights. Conducts HEDIS compliance audits. Assists in the analysis and presentation of performance measurement data. Assesses and provides feedback to states and MCOs on performance improvement projects (PIPs). Develops formats and compiles reports for presentation to the states.

Director of Managed Care Systems -- Assumed overall responsibility for design and management of EQR systems, including, Maryland, the District of Columbia, Delaware and Ohio. Provided technical assistance for all other EQR contracts. Implemented policies and procedures to streamline review processes. Assisted team in developing and implementing sampling specifications. Developed, implemented, and monitored quality improvement studies. Developed and implemented the Quality Management System (QMS) that was used in several states to conduct on-site systems performance reviews of Medicaid MCOs. Smoothly transitioned from peer review to data collection models for focused reviews to enhance reporting capabilities. Provided technical assistance and policy recommendations to states based on results of EQR studies and current trends. Project coordinator for the Medicare +Choice Managed Care Organization (M+CQRO) HCFA national project whose purpose is to monitor the M+C MCOs adherence to the quality improvement project requirements.

Managed Care Manager -- Manager for Maryland and the District of Columbia Medicaid Managed Care External Quality Review. Led the day-to-day quality assurance activities for managed care evaluation and assessment including operational assessment and medical record review activities. Responsible for the analysis and reporting of findings. Oversaw the development of reporting format and compile results for evaluation reports. Served as the project manager for the Maryland Medicaid HMO pediatric asthma quality improvement study project and for the External Quality Review Organization (EQRO) contract for the Vermont Managed Care Program.

Health Analyst - Project manager for the Ambulatory Care Quality Improvement Project (ACQIP)—a three state quality improvement project which focuses on improving the processes of care for Medicare beneficiaries in the outpatient setting. Responsible for the trending and pattern analysis of data for Medicaid and PRO contracts, developing project methodologies, data abstraction tools, and educational materials for quality improvement projects. Complete data analysis of the HMO medical record findings.

1992-1994 Early Intervention Program, DE Health and Social Services, New Castle, DE

Project Manager-- Managed the daily operations of this inter-agency demonstration project in Kent and Sussex Counties which achieved its goal of demonstrating the implementation of a comprehensive inter-agency early intervention system for infants and toddlers with physical disabilities and/or developmental delays. Coordinated the implementation of the Integrated Services Information System (ISIS) for the project staff in Kent and Sussex Counties Assisted in the development of policies and procedures. Exceeded goal of the number of children to be evaluated and served by 29 percent.

1991-1992 Chandler Regional Hospital, Chandler, AZ

Administrative Resident-- Completed a rotation through all departments of this 120 bed acute care facility. Attended all medical staff meetings. In conjunction with Management Engineering, developed and implemented a staffing management program which provided managers with tools to monitor staffing levels and productivity. Completed a cardiology product line profitability analysis determining the need to contract for mobile catheterization laboratory services.

1988-1991 Apache Junction Nursing Center, Apache Junction, AZ

Social Services Consultant/Director -- As a consultant (1/90 to 1/91), trained director of this 120 bed long term care facility. Provided weekly consultation and quality assurance reviews of the department. As the director (7/88 to 12/89), completed psycho social assessments, discharge planning, and community referrals for clients. Designed monthly newsletter and directed all volunteer activities. Consistently scored 95 percent or above on all quality assurance reviews.

1986-1988 York Terrace Nursing Center, Pottsville, PA

Admissions/Social Service Director -- Maintained a 95-100 percent occupancy rate in this 80 bed long term care facility by enhancing marketing activities. Completed all pre-admission screening, psycho social assessments, and discharge planning. Responsible for accessing community services to meet residents' needs. Received scores of 92 percent or above on all corporate quality assurance reviews.

Jody A. Jobeck, MBA, CPHQ

Education

MBA, Healthcare Management, University of Phoenix, 2003

BS, Health Sciences/Healthcare Administration, James Madison University, 1996

Experience

2004-present Delmarva Foundation for Medical Care, Inc., Easton, MD

Quality Improvement Coordinator II – Performs on multiple expert teams across a variety of managed care contracts; manages the performance improvement project (PIP) team and completes validations on PIPs; conducts system performance reviews; participates in performance measure validation activities; assists in process improvement activities to streamline work processes; and participates in report writing for contract deliverables.

Managed Delmarva's Medicare Advantage Quality Review Organization (MAQRO) contract (2005-2008) – Participated in the design, development, and implementation of reporting and review tools for Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIP) projects; developed and revised instructional and reviewer guides; developed trackers and reporting templates; completed QIP and CCIP project reviews; and served as a point of contact with the Centers for Medicare and Medicaid Services (CMS).

1999-2004 University of New Mexico Hospital, Albuquerque, NM

Infection Control Practitioner (2003-2004) – Conducted surveillance and data collection on nosocomial and surgical site infections; investigated and educated regarding infection outbreaks, clusters, and exposures; reviewed the daily census and microbiology reports and followed-up as necessary; coordinated, analyzed, and presented data on Infection Control; assisted with The Joint Commission accreditation; acted as a liaison between hospital departments, county and state public health departments, and the Centers for Disease Control.

Quality Coordinator (1999-2003) – Responsible for the management of quality programs and projects for hospital, clinic, and medical staff areas; completed data collection (including chart reviews), analyses, and report writing; researched, prepared, and presented reports to quality and medical staff; and assisted with multiple accreditations, including The Joint Commission.

1996-1998 Reimbursement Technologies, Inc—Blue Bell, PA

Enrollment Supervisor (1999) – Responsible for overseeing the day-to-day operations of the physician enrollment department for approximately 75 emergency department contracts; maintained high levels of written and oral communication with internal departments, external clients, and managed care organizations; monitored and ensured efficiency of enrollment team and production; created and analyzed monthly held A/R reports.

Management Reporting Associate (1998) – Generated, updated, and edited monthly emergency department contract reports distributed to regional medical directors and vice presidents. Performed financial and patient volume analyses for approximately 30 clients.

Enrollment Specialist (1996-1998) – Processed and completed enrollment applications for physicians enrolling in managed care and other third-party payers; resolved enrollment issues involving delayed billing and provider enrollment; created and maintained tracking logs and reports.

Certifications and Training

Medicaid Training, 2010

Certified Professional in Healthcare Quality (CPHQ), 2006-current

Delmarva Leadership and Quality Institute, 2005

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) Member, 2004

National Surgical Infection Prevention (SIP) Collaborative Participant, Day-to-Day Leader, 2002-2003

Albuquerque Quality Network Member, 2000-2003

Quality New Mexico Examiner Training (Baldrige), 2000

Team Leadership Training, 2000

Laura K. Poynor, MBA, CHCA

Education

Masters in Business Administration, St. Mary's University, San Antonio, TX

BBA in Management/ Marketing, University of Texas at San Antonio, San Antonio, TX

Experience

2002–Present Delmarva Foundation for Medical Care, Inc., Easton, MD

Project Manager, Performance Measurement (Present) – Responsible for leading and coordinating performance measure validation team activities across EQR contracts. Interact with audit team members and managed care organizations (MCO) throughout audit or validation process. Oversee audit subcontractor activities, monitor production and timeliness of preliminary and final audit reports. Provide oversight of production of MCO-specific and statewide reports. Coordinates all analytic activities related to reporting and use of performance measure data. Serve as in-house and client contact for information on HEDIS, CAHPS, performance measure development, and benchmarking.

Senior Health Analyst (2002-2008) Designed data strategies for quality improvement and focused investigation studies. Involved substantially in study research designs and methodology, literature reviews, sample criteria selection, statistical/data analysis and report preparation. Seven years experience with analyzing HEDIS and performance measures. Contributed to data interpretation, drafting and editing of reports for clients. Developed quality indicators through data and statistical analysis using SAS and other software. Organized and presented study findings in clear and concise formats.

2001 - 2002 Harte-Hanks CRM Marketing Analytics, Boston, MA

Senior Database Marketing Analyst – Planned, managed, and delivered analytical marketing solutions to clients in the health insurance, financial services, retail and pharmaceutical industries. Analyzed client marketing programs for performance, cost effectiveness and feasibility. Produced final client documentation and presented key findings and recommendations. Consulted and advised clients on a regular basis regarding marketing database programs and strategies. Performed sophisticated ad-hoc analyses such as marketing opportunity analysis, univariate and multivariate profiling, and market basket analysis. Created customized reporting packages based on each client's needs. Mentored team members on SAS and other analytical tools and solutions

1998 - 2000 Blue Cross Blue Shield of Florida, Orlando, FL

Senior Health Care Data Analyst/ Programmer (1999-2000) - Developed programs, databases, application software and tools for internal and external customers. Conducted analysis in the areas of provider networking, demographic analysis, claims utilization and financial impact studies. Performed statistical analysis and data modeling as needed. Completed programming and analysis of a major cardiology utilization study. Established analytical processes to support new risk-sharing financial arrangement with a major health care provider network. Generated quarterly models for appropriate funding for Provider Incentive Plans and risk sharing arrangements. Conducted data conversion and programming for ad-hoc reports to support management in their decision making process

Business Analyst (1998 - 1999) - Analyzed variances in monthly and quarterly financial statements for assigned products for geographic unit. Generated SAS reports for end-users as

needed. Researched various data resources for financial analysis. Implemented SAS programs to analyze individual insurance products. Programmed and provided analysis for an old outstanding financial settlement for a large provider network. Maintained monthly reports for internal and external users. Researched capitation issues.

1997 - 1998 Westgate Resorts/ Central Florida Investments, Orlando, FL

Market Research Analyst – Planned, implemented, and analyzed marketing initiatives for the specialty marketing division. Worked with outside vendors for timely processing of mailings. Consulted with internal clients on their marketing, lead generation and research needs. Conducted primary and secondary research to develop effective marketing/ communication strategies. Refined and managed some internal mail and telemarketing lists.

1982 - 1997 United Services Automobile Association (USAA), San Antonio, TX

Market Research Analyst/ Programmer (USAA Life Insurance Company, 1991- 1997) – Participated on a five-person consulting team, which conducted planning and development of marketing programs for a variety of financial management and insurance products. Developed criteria and provided system direction for direct and indirect mail programs and alternative distribution channels. Identified and evaluated new marketing opportunities within a 10 million member database. Programmed and analyzed marketing campaigns for effectiveness and profitability, presented results and recommendations to all levels of management. Team facilitator and lead analyst for an 18-month project to develop a campaign addressing the financial needs of women. Participated in the development and analysis of focus group scripts, phone surveys, mailing questionnaires and copy tests. Produced annual master mailing plans for multiple product lines. Initiated several innovative mailings which became prototypes for other programs. Received frequent positive feedback from management and internal customers.

Direct Mail Specialist (USAA Life Insurance Company, 1990 - 1991) – Created initial procedures and documentation for new position. Worked with all areas of marketing to ensure timeliness of mailings. Solved system and production problems. Assisted director with research and presentation needs. Coordinated selection criteria programs for direct mailings. Initiated new criteria program for utilizing billing statements for marketing opportunities.

Mutual Fund Service Representative (USAA Investment Mgt. Company, 1986 - 1990) – Provided professional service and analysis for mutual fund customers. Held NASD Series 6 and 63 licenses.

After-Hours Policy Service Representative (USAA Property and Casualty, 1983 - 1986)

After-Hours Unit Clerk (USAA Property and Casualty, 1982 - 1983)

Certifications and Training

Certified HEDIS Compliance Auditor (Since 2008)

NCQA HEDIS Update and Best Practices Seminar (October 2009)

CMS Medicaid 2010 Training

External Quality Review (EQR) Quarterly Update

January 1 – March 31, 2011

EQR Task	Activity
Systems Performance Review (SPR)	• On-site SPR audit for Carelink (3/23-24/11)
Performance Improvement Project (PIP) Validation	• Revised PIP language in MCO contract for Lewin (1/11/11) • Emergency Department Collaborative PIP discussion during the EQR orientation (2/17/11) • Provided Lewin with an Emergency Department Collaborative PIP summary for inclusion in their Annual Report (3/8/11)
Performance Measure Validation (PMV)	• On-site PMV HEDIS audit for The Health Plan (2/24-25/11) • On-site PMV HEDIS audit for Carelink (3/8-9/11)
Other	• Meeting with BMS re: contract extension (1/6/11) • Prepared EQR Orientation Manual for CY 2010 review activities • Held EQR Orientation (2/17/11) via GoToMeeting • Program Update Meeting with BMS and Lewin (2/23/11 and 3/23/11)
Planning for next quarter	• On-site SPR audit for UniCare (4/5-6/11) • On-site SPR audit for The Health Plan (4/27-28/11) • PIPs will be discussed during the on-site SPR audits • On-site PMV HEDIS audit for UniCare (4/26/11)

External Quality Review (EQR) Quarterly Update

April 1-June 30, 2011

EQR Task	Activity
Systems Performance Review (SPR)	• On-site SPR audit for UniCare (4/5-6/11) • On-site SPR audit for The Health Plan (4/27-28/11)
Performance Improvement Project (PIP) Validation	• Discuss PIPs with THP during on-site SPR • Begin PIP validation for all PIPs • Begin drafting MCO specific PIP Reports
Performance Measure Validation (PMV)	• On-site PMV HEDIS audit for UniCare (4/26/11) • Continual communication with MCOs to complete HEDIS audit • Received and submitted all MCO's audit review results to NCQA by deadline of June 15, 2011
Other	• Program Update Meeting with Lewin and BMS (4/27/11) • Project Director attended Task Force Meeting (5/26/11). Prepared and presented information on HEDIS measurement • Worked with Mike Madalena regarding HEDIS measures and calculations for the CHIPRA Tri-State Grant
Planning for next quarter	• Prepare and submit draft PIP reports • Prepare and submit draft SPR reports • HEDIS Final Audit Reports to NCQA by 6/15/11

External Quality Review (EQR) Quarterly Update

July 1-September 30, 2011

EQR Task	Activity
Systems Performance Review (SPR)	• All three MCO draft SPR reports submitted to BMS and Lewin • Received feedback from Lewin and made revisions to draft reports
Performance Improvement Project (PIP) Validation	• All three MCO draft PIP reports submitted to BMS and Lewin for feedback
Performance Measure Validation (PMV)	• Begin drafting of individual MCO draft reports for PMV • Determined additional HEDIS 2012 measures to collect –selected additional measures that require pharmacy data
Other	• Monthly Program Update Meeting with Lewin and BMS (7/27/11 and • 8/30/11Project Director attended Task Force Meeting (9/21/11). Provided HEDIS update • Continued work/consulting with Mike Madalena regarding HEDIS measures and calculations for the CHIPRA Tri-State Grant • Provided feedback to WV HII on the Final Behavioral Health Work Groups Report
Planning for next quarter	• Await feedback from BMS and Lewin on draft PIP reports • Finalize SPR reports and distribute to BMS and the MCOs • Finalize and submit draft PMV reports • Compile list of HEDIS 2012measures to be collected and distribute to the MCOs • Finalize and submit draft Annual Technical Report

External Quality Review (EQR) Quarterly Update

October 1, 2011 through December 31, 2011

EQR Task	Activity
Systems Performance Review (SPR)	• SPR Reports delivered to BMS and MCOs.
Performance Improvement Project (PIP) Validation	• PIP Report revisions made and forwarded to Lewin. • Received second round of edits from Lewin. • Made second set of revisions. • Report revisions made and forwarded to Lewin for final feedback • Awaiting final feedback on revisions.
Performance Measure Validation (PMV)	• PMV Reports drafted and submitted to BMS and Lewin for feedback. • Received feedback from Lewin. • Currently updating reports with HEDIS 2011benchmarks. • Distributed HEDIS 2012 Measure list to MCOs, BMS and Lewin. • Changes/Additions: o Measures requiring pharmacy data were added to list from last year. o Plans are allowed to rotate Cervical Cancer Screening measure.
Other	• Monthly Program Update Meetings with Lewin and BMS in October and November. • Continued work/consulting with Mike Madalena regarding HEDIS measures and calculations for the CHIPRA Tri-State Grant. • Provided raw data for CHIPRA/HEDIS measures to Mike Madalena and Lewin. • Began work on populating CHIPRA CARTS form with data from HEDIS measure results from CY 2008-CY 2010.
Planning for next quarter	• Await final feedback from BMS and Lewin on PIP report edits. • Finalize and submit PMV reports to BMS and MCOs • Finalize and submit draft Annual Technical Report to BMS in January 2012.

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EXTERNAL QUALITY REVIEW ORGANIZATION

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

Annual Technical Report for Calendar Year 2010

Calendar Year 2010

Submitted by
Delmarva Foundation
February 2012

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Mountain Health Trust Annual Technical Report CY 2010

Background and Purpose

The Bureau for Medical Services (BMS) operates West Virginia's Medicaid Managed Care Program, Mountain Health Trust (MHT). Initiated in 1996, conceptually the program was based on each Medicaid beneficiary having a medical home—a primary care provider knowing an enrollee's medical history and managing appropriate treatment and preventive services. BMS is responsible for assuring that all MHT beneficiaries receive comprehensive, high quality healthcare services. For calendar year (CY) 2010, there were approximately 162,000 members enrolled in MHT Managed Care Organizations (MCOs).

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

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

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

(*West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality*, revised April 14, 2010)

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

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

The CY 2010 annual technical report findings provide an assessment of the MHT program based on MCO performance, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Where applicable, the findings are compared to the goals and objectives found in the *WV*

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

This report will provide the results of the EQR annual assessment of the SPR, PIP and PMV activities for CY 2010. Following the EQR methodology, the individual MCO findings for the Systems Performance Reviews, Performance Improvement Projects, and Performance Measurement Validation activities are presented. The findings from these activities are then summarized according to quality, access and timeliness as required by the EQR protocols. Conclusions and recommendations are then provided for both the individual MCOs and the MHT program.

EQR Methodology

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

For purposes of assessment, Delmarva adopted the following definitions:

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

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any

disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care" *(Envisioning the National Health Care Quality Report, 2001).*

Systems Performance Review

SPRs are designed to assess MCO compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of healthcare services provided to MHT beneficiaries. Delmarva conducts these reviews in accordance with the CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs).* To determine MCO compliance, Delmarva obtains information from document reviews and interviews with MCO staff. Combined, these methods of data collection provide an accurate depiction of an organization's compliance with regulatory provisions.

Key Delmarva SPR Activities

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

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

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

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

Delmarva uses a three-point scale for scoring: *Met—100%*, *Partially Met—50%*, and *Unmet—0%*. Components for each element are scored. The component scoring is rolled up to the element level, and finally the standard level. Aggregated results are reported by standard. BMS sets the minimum MCO compliance rating. For the CY 2010 SPR, BMS set the compliance threshold at 90 percent for each standard. MCOs not achieving 90 percent were required to develop and implement internal corrective action plans.

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

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

Performance Improvement Project Validation

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

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

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

Performance Measure Validation

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

information systems, procedures, and algorithms used to calculate the performance measures. Delmarva conducts all PMV activities in accordance with the CMS protocol, *Validating Performance Measures*.

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

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

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

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

MHT MCO Findings

Systems Performance Review

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

Table 1. MCO SPR Compliance Rates for CY 2010

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

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

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

Carelink Health Plan, Inc.

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

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

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

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

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

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

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

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

The Health Plan of the Upper Ohio Valley

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

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

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

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

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

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

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

Trending of results shows that the:

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

UniCare Health Plan, Inc.

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

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

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

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

Trending of results shows that the:

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

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

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

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

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

Performance Improvement Project Validation

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

Carelink Health Plan, Inc.

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

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

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

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

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

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

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

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

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

*Goal setting based on previous annual performance

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

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

The Health Plan

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

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

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

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

PIP Summary: Childhood Obesity	
Rationale	• West Virginia is currently ranked third in the nation for obesity. While childhood obesity is difficult to measure within The Health Plan (many physicians are not coding for obesity or documenting body mass index (BMI) within the medical record), it is impacting children of all ages, spanning from 1 year to 17 years of age. Discussions with plan physicians and school wellness teams reinforce the prevalence of childhood obesity and identify it as one of the top health issues.
Indicators and goals	• Members with evidence of BMI documentation (2-17 years of age), Goal: 5% annual increase • Members with evidence of nutritional counseling (2-17 years of age), Goal: 5% annual increase • Members with evidence of physical activity counseling (2-17 years of age), Goal: 5% annual increase
Strengths	• Comprehensive project rationale • In addition to targeting providers with interventions, The Health Plan is also targeting members of the plan, community, and school systems
Barriers	• Provider and member knowledge deficit regarding the purpose and importance of obesity screenings • Provider noncompliance with weight monitoring • Provider knowledge deficit regarding obesity-related educational materials and assistance available through the MCO
Interventions	• One-on-one discussion with physician/appropriate office staff regarding the provider education packet which includes BMI chart, BMI percentile graph worksheets, and Childhood Obesity Program information. Over 200 offices were visited during 2010 • Practitioner Procedural Manual was updated to include all information named above. Additionally, this information is on the provider website • Community-based health fairs included BMI screenings; counseling was provided and included encouragement to discuss results with PCPs

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

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

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

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

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

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

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

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

UniCare Health Plan, Inc.

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

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

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

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

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

PIP Summary: Reducing Inappropriate Emergency Room Utilization (Baseline)	
Rationale	• The emergency department utilization project is mandated by BMS. UniCare notes that 30% of emergency room visits are avoidable and West Virginia experiences 30% more utilization than the national average. In an effort to reduce ER utilization, the MCO states, "The study aims to cement the medical home relationship between patients and families and their primary care providers."
Indicators and Goals	• The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Al Attar) in Princeton/Bluefield community, using total ER visits over total unique member count, Goal: Achieve a 10% reduction in ER Visits

PIP Summary: Reducing Inappropriate Emergency Room Utilization (Baseline)	
	• The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Peters) in Princeton/Bluefield community, using total ER visits over total unique member count, Goal: Achieve a 10% reduction in ER Visits
Strengths	• Commendable indicator goal: 10% reduction in ER services
Barriers	• Lack of member awareness regarding the proper use of ER, associated costs, loss of continuity of care
Interventions	• Intervention analysis is not applicable for the baseline review

PIP Results			
Indicator 1: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Al Attar) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline		88%
Indicator 2: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Peters) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline		96%

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

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

Results for all PIP indicators are included in Appendix 2.

Performance Measure Validation

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

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

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

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

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

WV Mountain Health Trust Program State Strategy Objectives and Targets

The *West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality* (WV MHT State Strategy) includes objectives and targets for selected measures. This plan was updated in April 2010 with plans to update it again in 2012. The objectives, targets, and results for the objectives are found in Table 5.

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

Objective	Target (over the next two years)	Baseline (CY 2008)	CY 2009	CY 2010
Promote Child Preventive Health	Demonstrate improvement of five percentage points in the number of members two years of age compliant with an immunization 4:3:1:2:3:1:1* *(HEDIS Childhood Immunization Status-Combination 2 measure)*	70.4%	62.2%	63.5%
Promote Child Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (80.3%) for the percent of members age three to six years who received one or more well-child visits with a primary care practitioner. *(HEDIS Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life)*	75.7%	72.4%	65.5%
Ensure Child Access to Primary Care Practitioners	Strive to meet the 2008 HEDIS 75th percentile (91.6%) for the number of children ages seven to 11 years who had a visit with a primary care practitioner. *(HEDIS Child and Adolescents' Access to Primary Care Practitioners (PCP) age 7-11 Years)*	86.2%	92.6%	92.6%
Promote Adult Access to Preventive Health	Strive to meet the 2008 HEDIS 90th percentile (88.4%) for the percentage of adults age 20-44 years who had an ambulatory or preventive visit. *(HEDIS Adults Access to Preventive/Ambulatory Health Services measure)*	84.0%	88.4%	87.4%
Encourage Appropriate Postpartum Care	Strive to meet the 2008 HEDIS 75th percentile (68.5%) for the percentage of women who had a postpartum visit on or between 21 and 56 days of delivery. *(HEDIS Prenatal and Post Partum Care measure)*	65.3%	67.8%	63.4%

Objective	Target (over the next two years)	Baseline◘ (CY 2008)	CY◘ 2009	CY◘ 2010
Ensure Comprehensive Chronic Care	Strive to meet the 2008 HEDIS 75th percentile (63.3%) for the number of members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90). *(HEDIS Controlling High Blood Pressure measure)*	58.2%	63.0%	61.0%

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

Of the six measures, the targets were achieved for:

- Ensuring Child Access to Primary Care Practitioners (HEDIS Children and Adolescents' Access to Primary Care Practitioners for Children Age 7-11 Years measure)
- Promoting Adult Access to Preventive Health (HEDIS Adults' Access to Preventive/Ambulatory Health Services for Adults Age 20-44 Years measure)
- Ensuring Comprehensive Chronic Care (HEDIS Controlling High Blood Pressure measure)

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

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

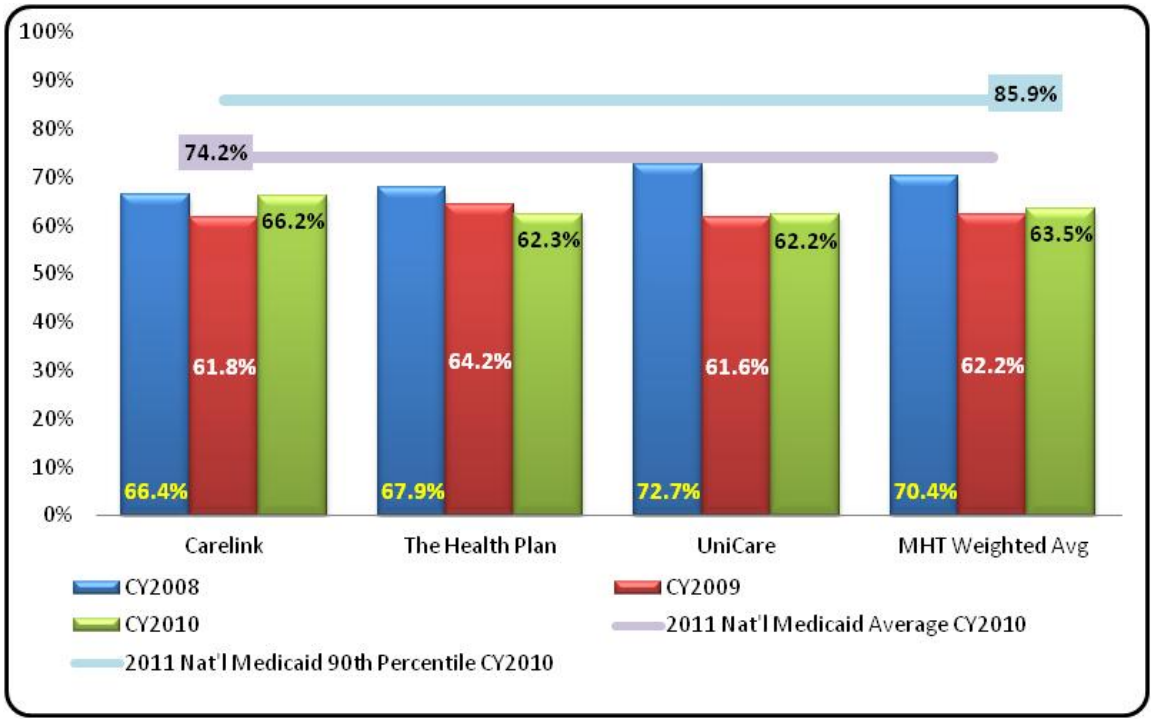
Quality

Childhood Immunization Status-Combination 2 (CIS 2)

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

- 4 Diphtheria, tetanus and acellular pertussis (DTaP),
- 3 polio (IPV),
- 1 Measles, mumps, and rubella (MMR),
- 3 H influenza type B (HiB),
- 3 Hepatitis B (Hep B), and
- 1 Chicken pox (VZV).

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



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

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

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

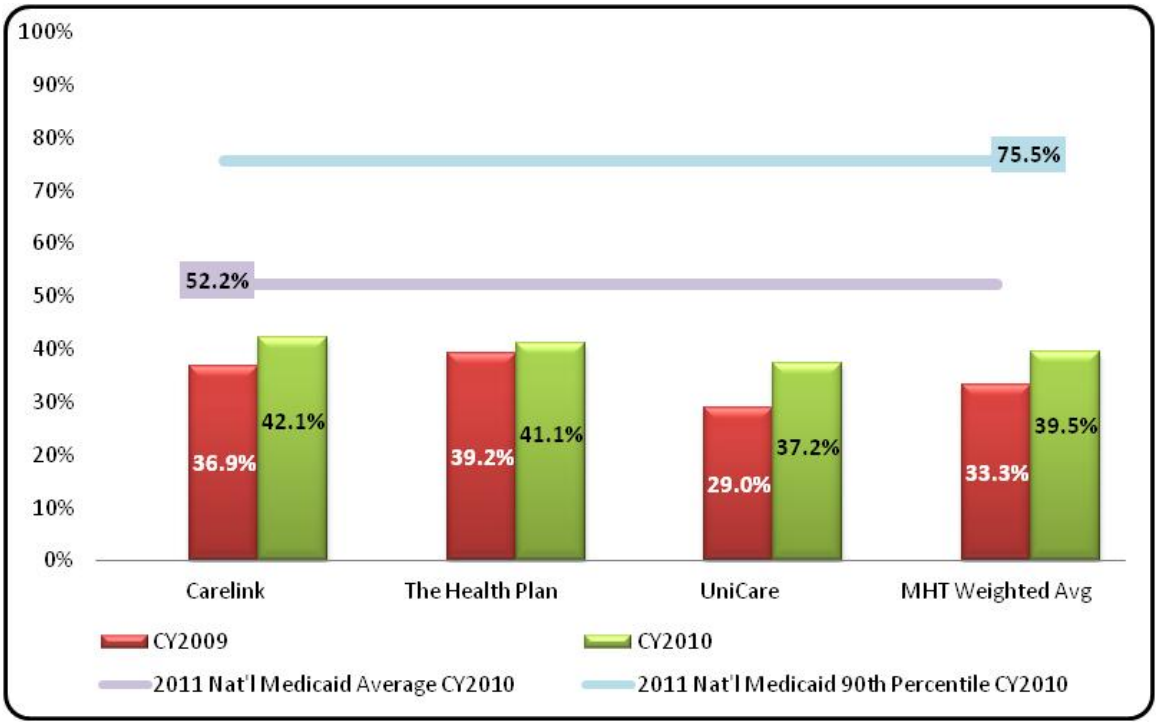
One reason that the Childhood Immunization measure may not meet the benchmark is the lack of MCO access to the West Virginia Statewide Immunization Information System (WVIIS). The WVIIS can be used as a supplemental database for this measure but the MCOs have been challenged in obtaining reasonable access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

Immunizations for Adolescents – Combination 1(IMA)

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

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

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



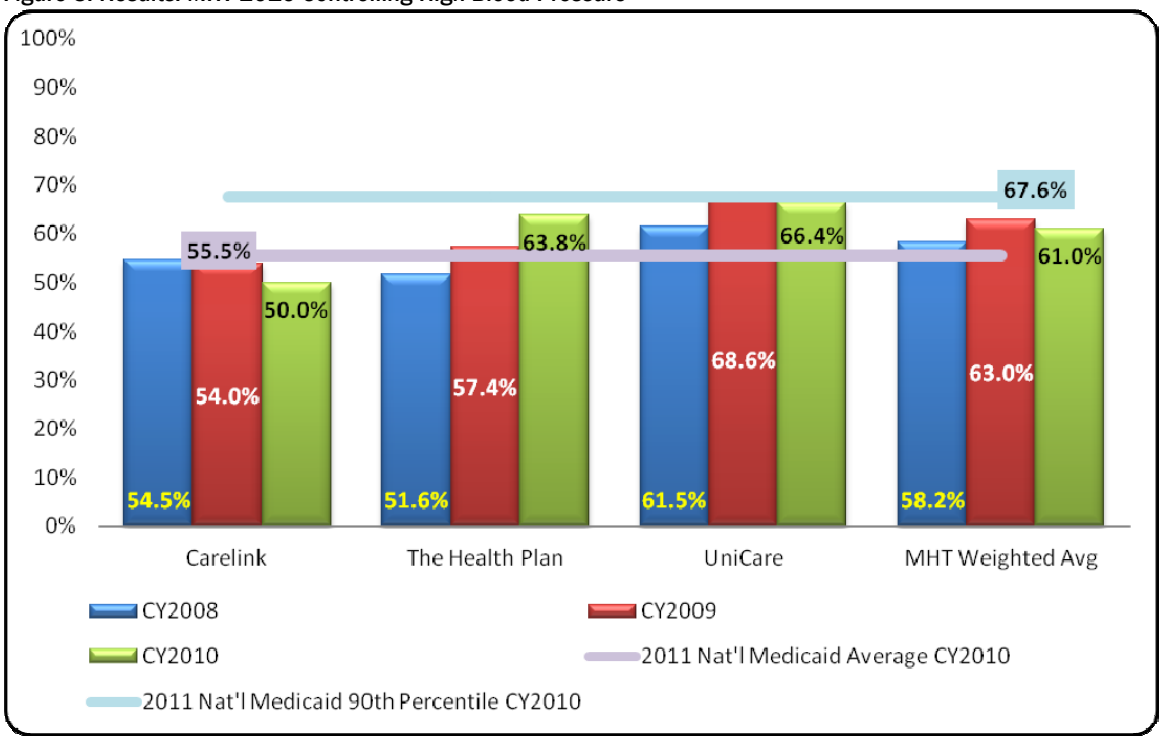
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

Controlling High Blood Pressure (CBP)

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

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



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

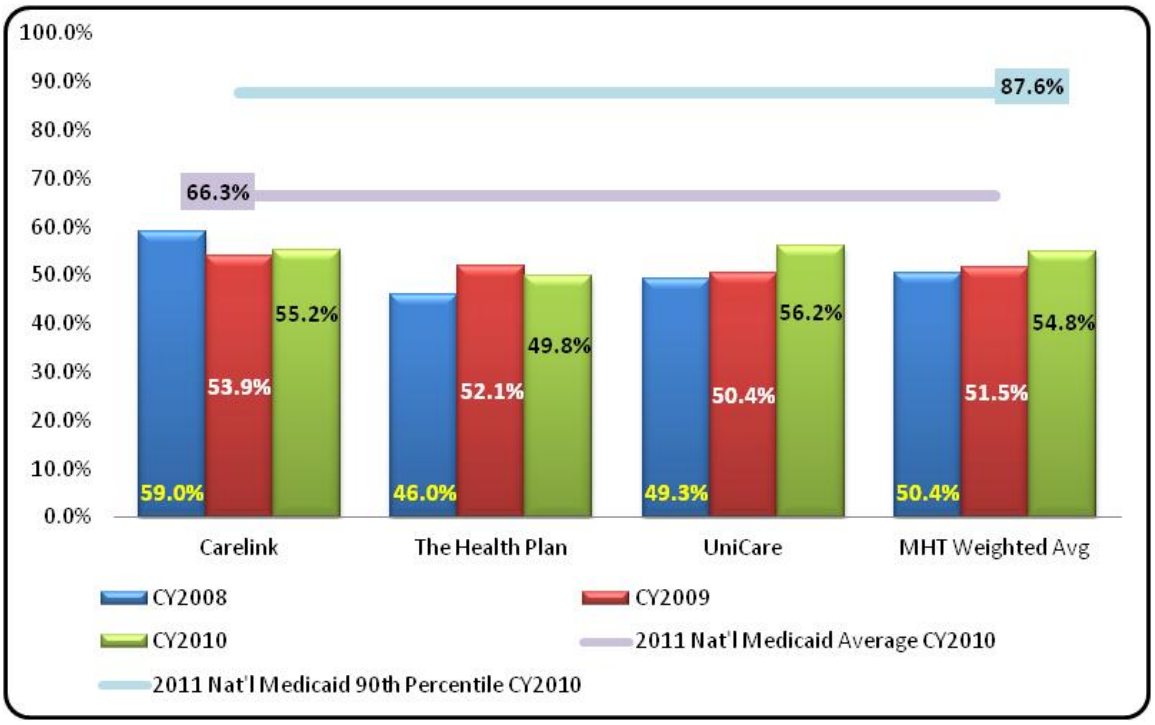
Figure 3 presents the results for *Controlling High Blood Pressure*. In CY 2010, MCO performance rates ranged from 50.0% to 66.4%. UniCare was the top performer in all three measurement years. THP, UniCare, and the MHT Weighted Average exceeded the National Medicaid Average of 55.5% with UniCare only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

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

Lead Screening in Children (LSC)

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

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



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

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

Comprehensive Diabetes Care (CDC)

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

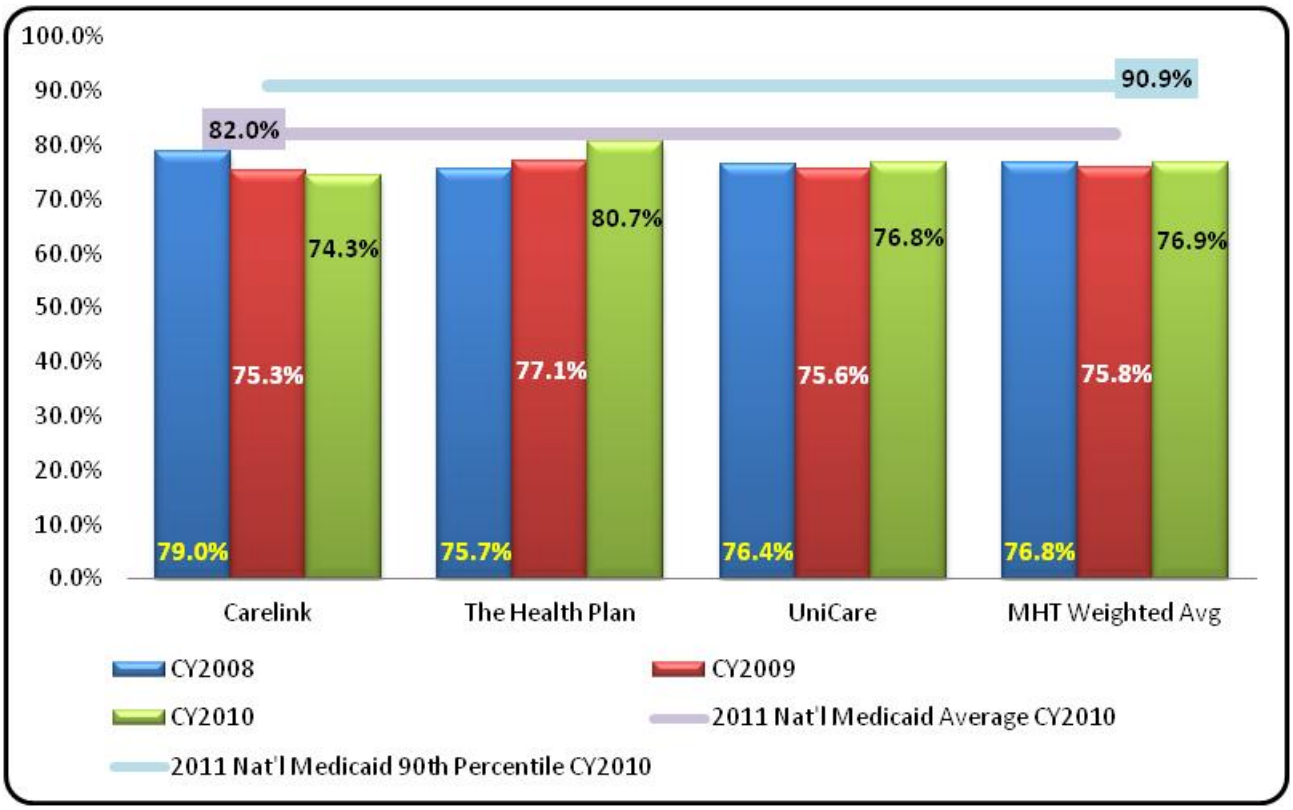
- Hemoglobin A1c (HbA1c testing)
- HbA1c poor control (>9.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for Nephropathy
- BP control (<140/90 mm Hg)

The results of selected CDC indicators are presented separately below.

CDC - Hemoglobin A1c (HbA1c) Testing

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

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



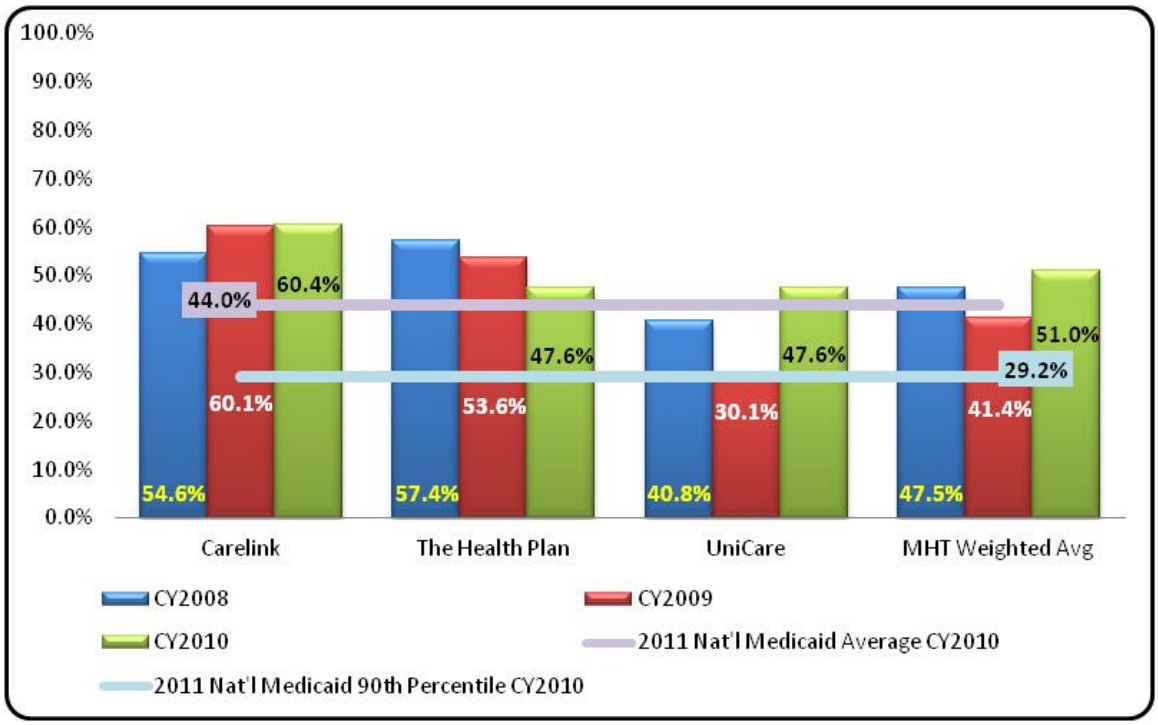
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

CDC- HbA1c Poor Control (>9.0%)

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

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



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

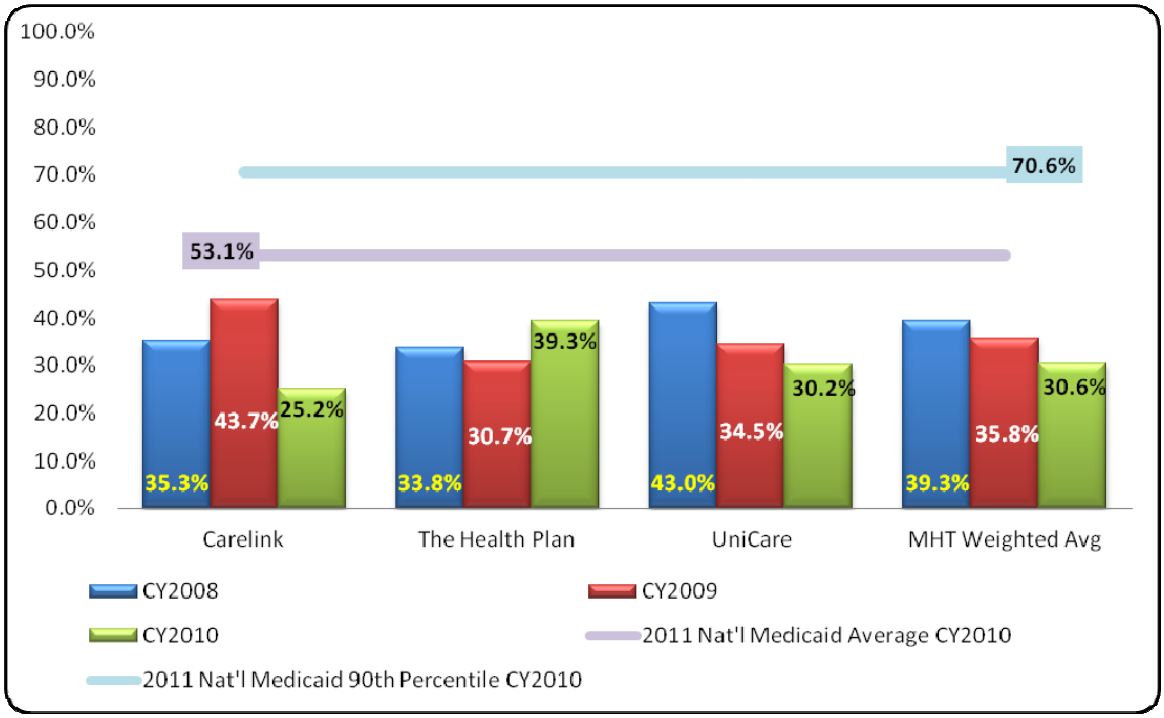
▪A lower rate indicates better performance

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

CDC- Eye Exam (retinal) Performed

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

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



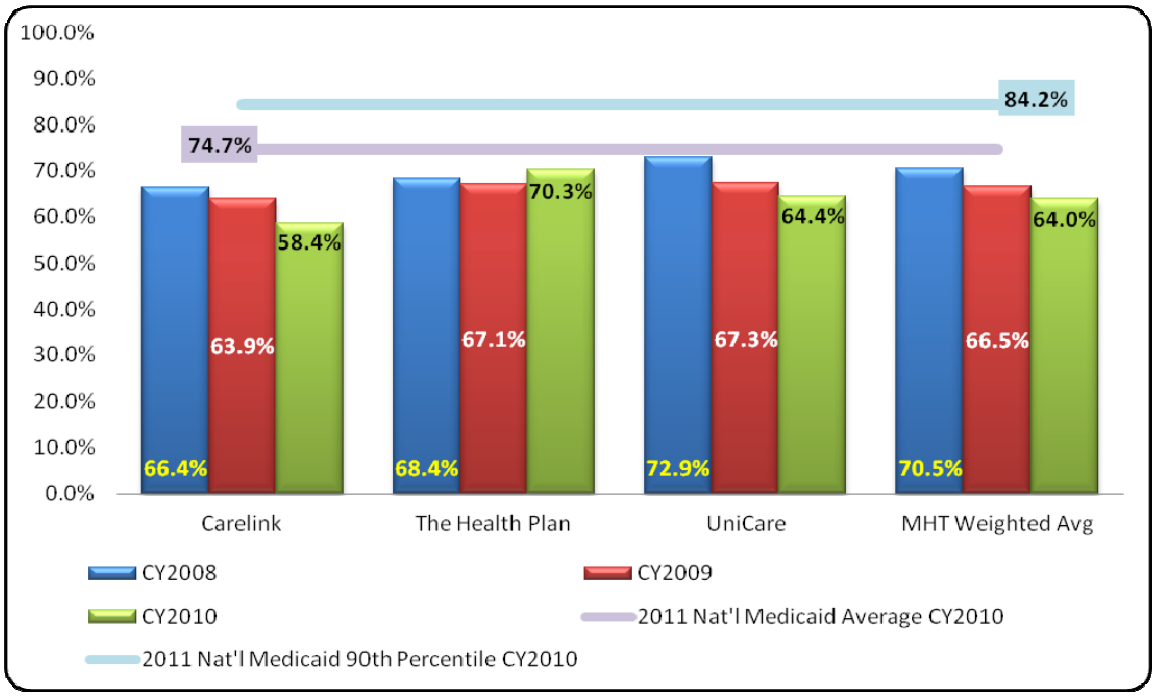
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

CDC- LDL-C Screening

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

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



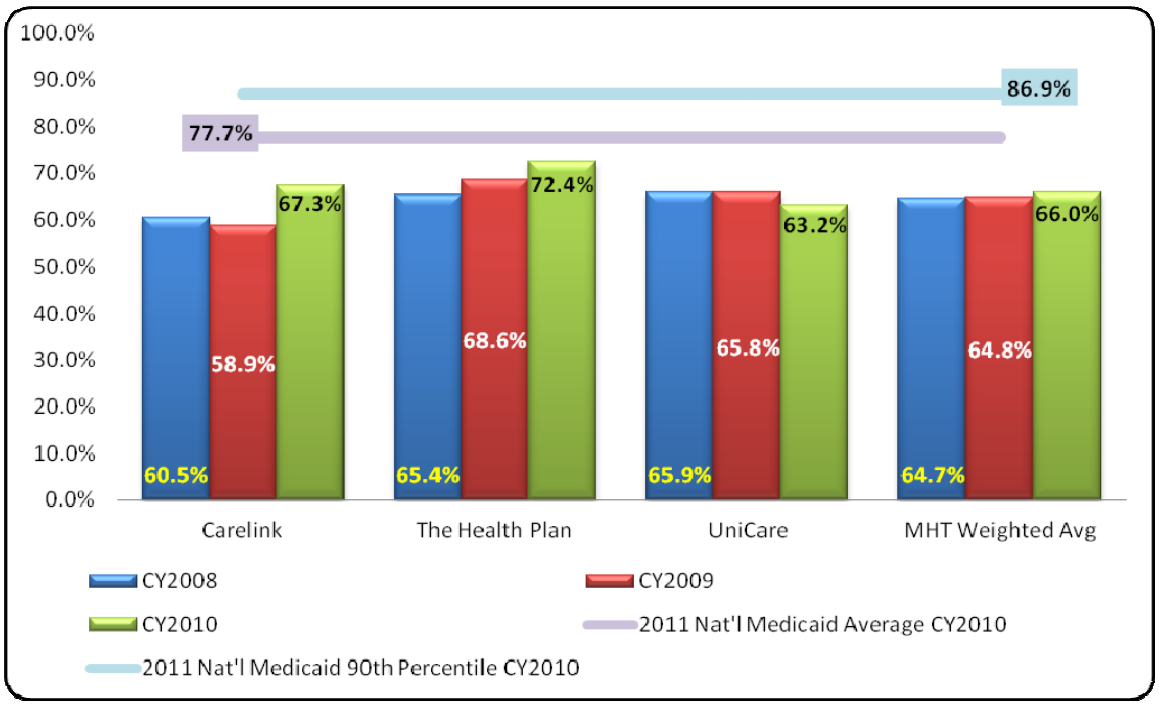
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

CDC - Medical Attention for Nephropathy

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

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



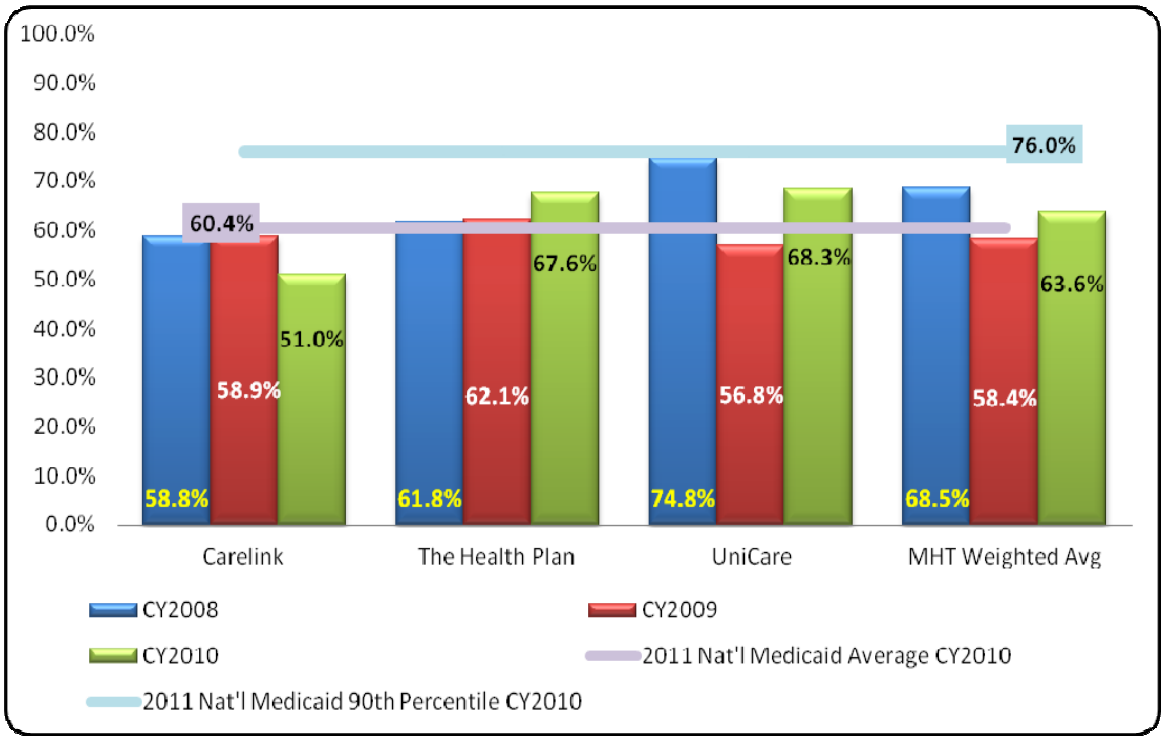
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

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

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

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



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

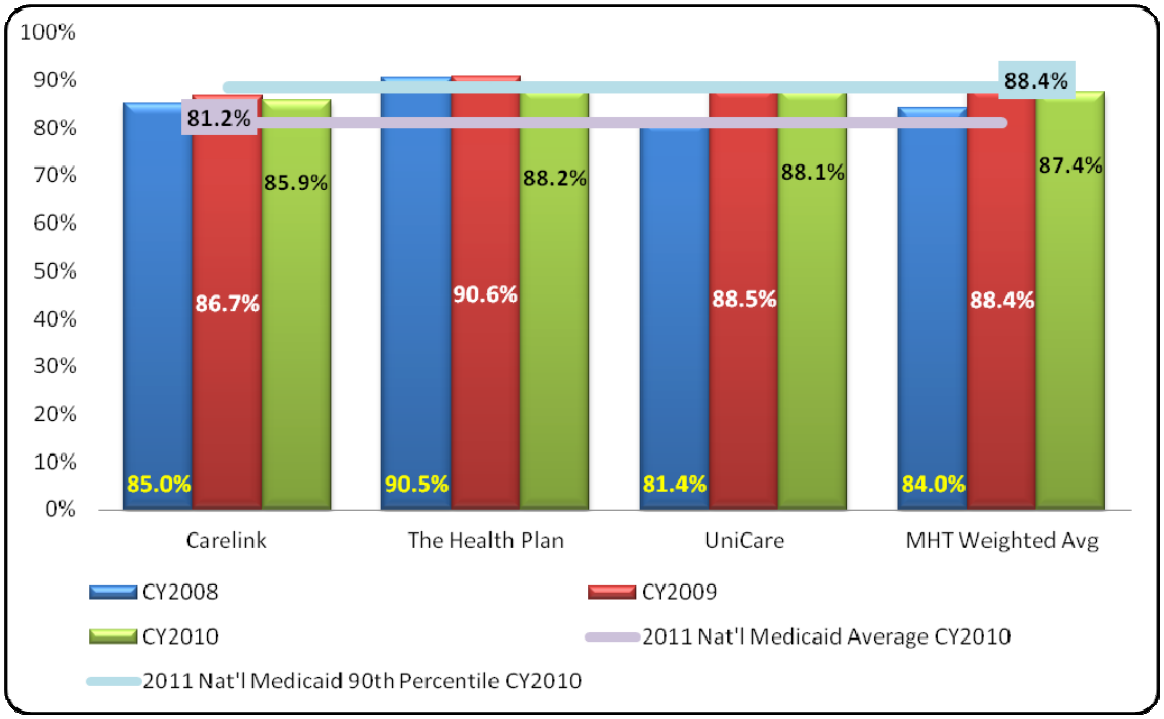
Figure 10 presents the results for *CDC - Blood Pressure (BP) Control (<140/90 mm Hg)*. In CY 2010, individual MCO performance rates ranged from 51.0% to 68.3%. UniCare was the top performer in CY 2008 and CY 2010 while The Health Plan was the top performer in CY 2009. Both The Health Plan and UniCare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

Access

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

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

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



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

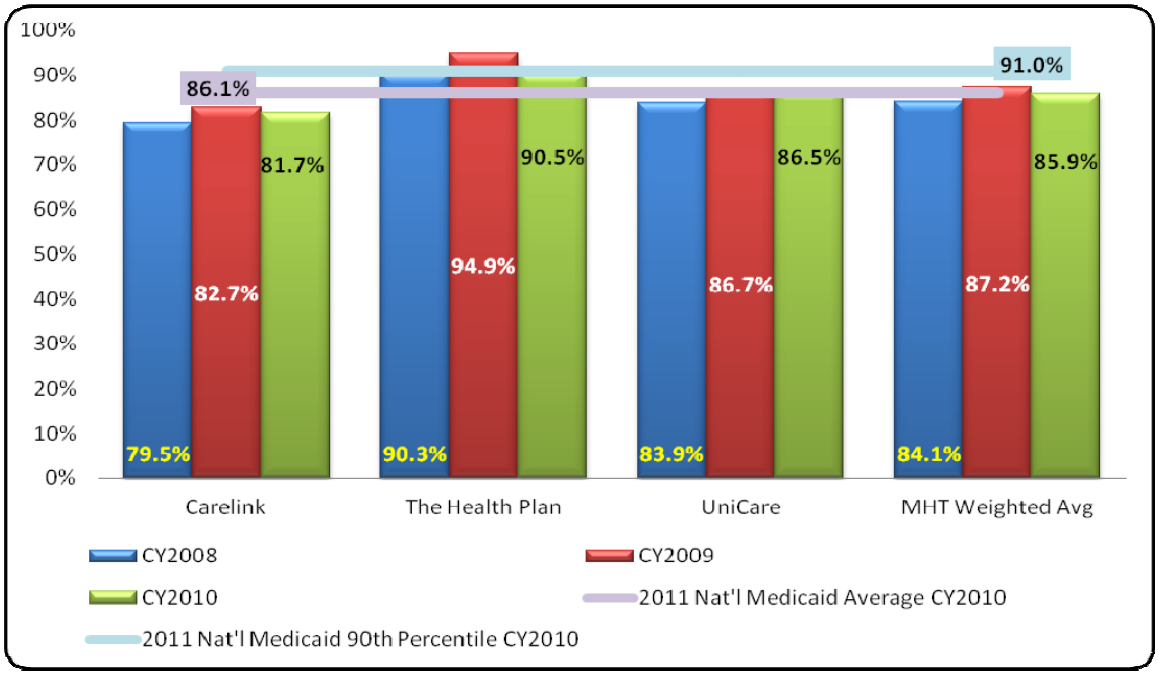
Figure 11 presents the results for *Adults' Access to Preventive/Ambulatory Health Services (AAP) 20-44 Years*. In CY 2010, individual MCO rates ranged from 85.9% to 88.2% and were above the National Medicaid Average of 81.2%. The Health Plan and UniCare fell just short of the National Medicaid 90th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

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

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

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

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



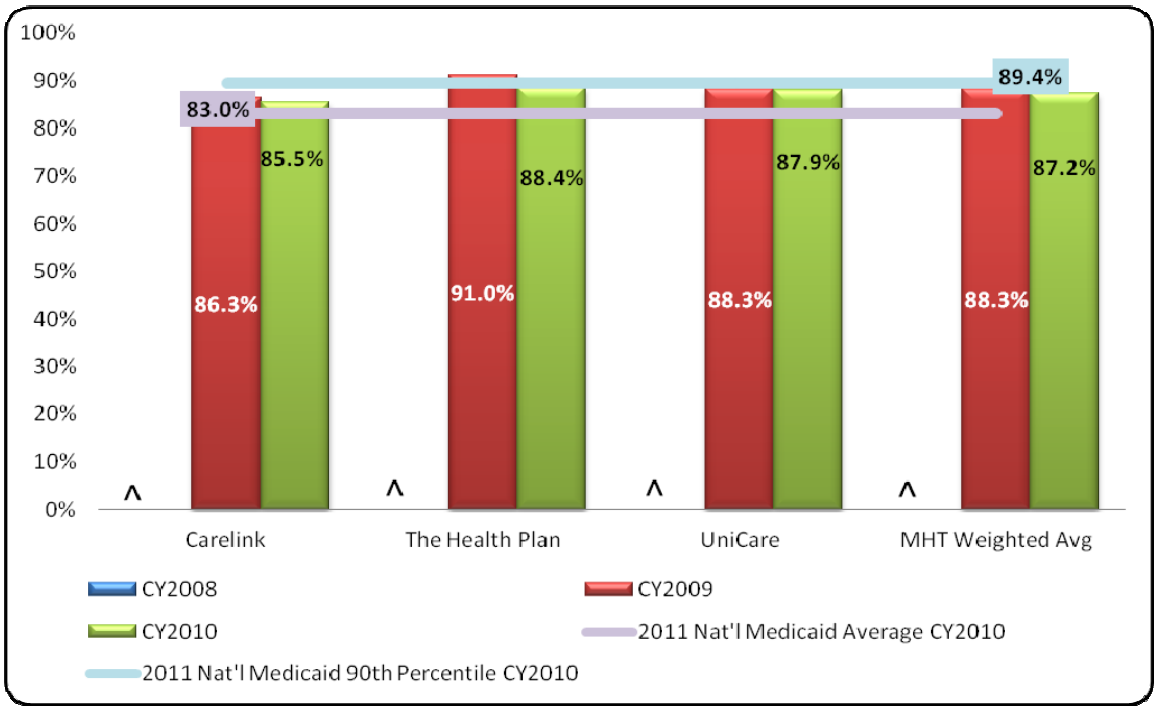
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

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

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

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



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

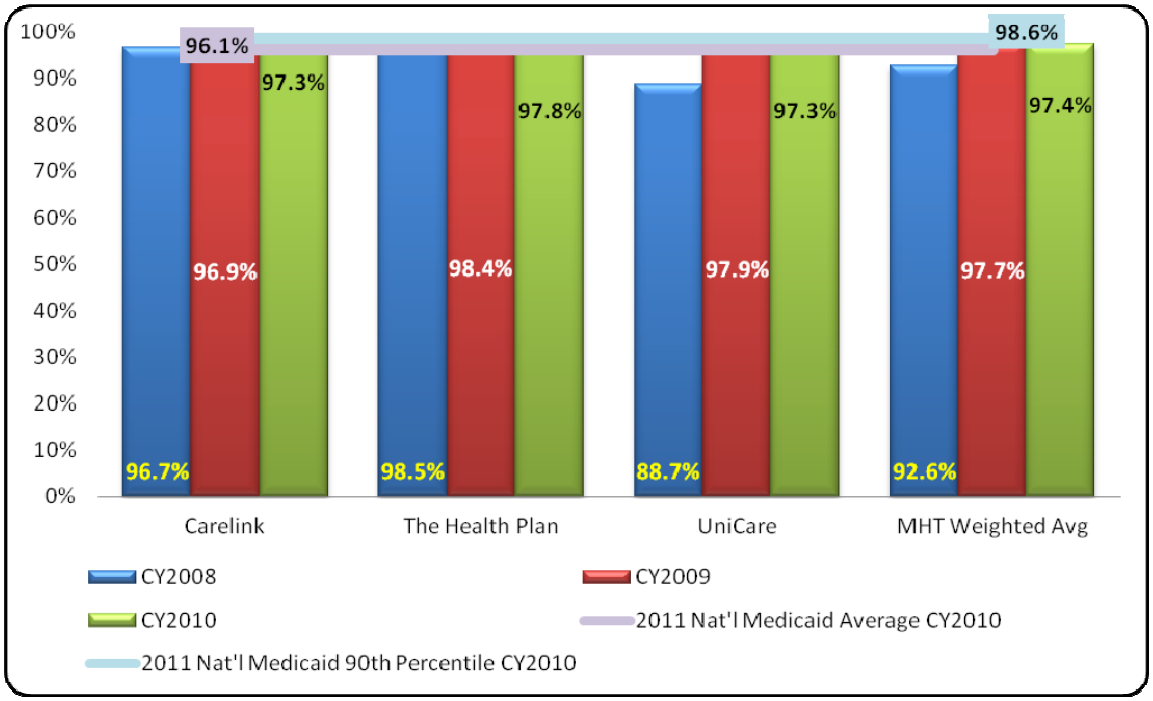
^ Measure not collected

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

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

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

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



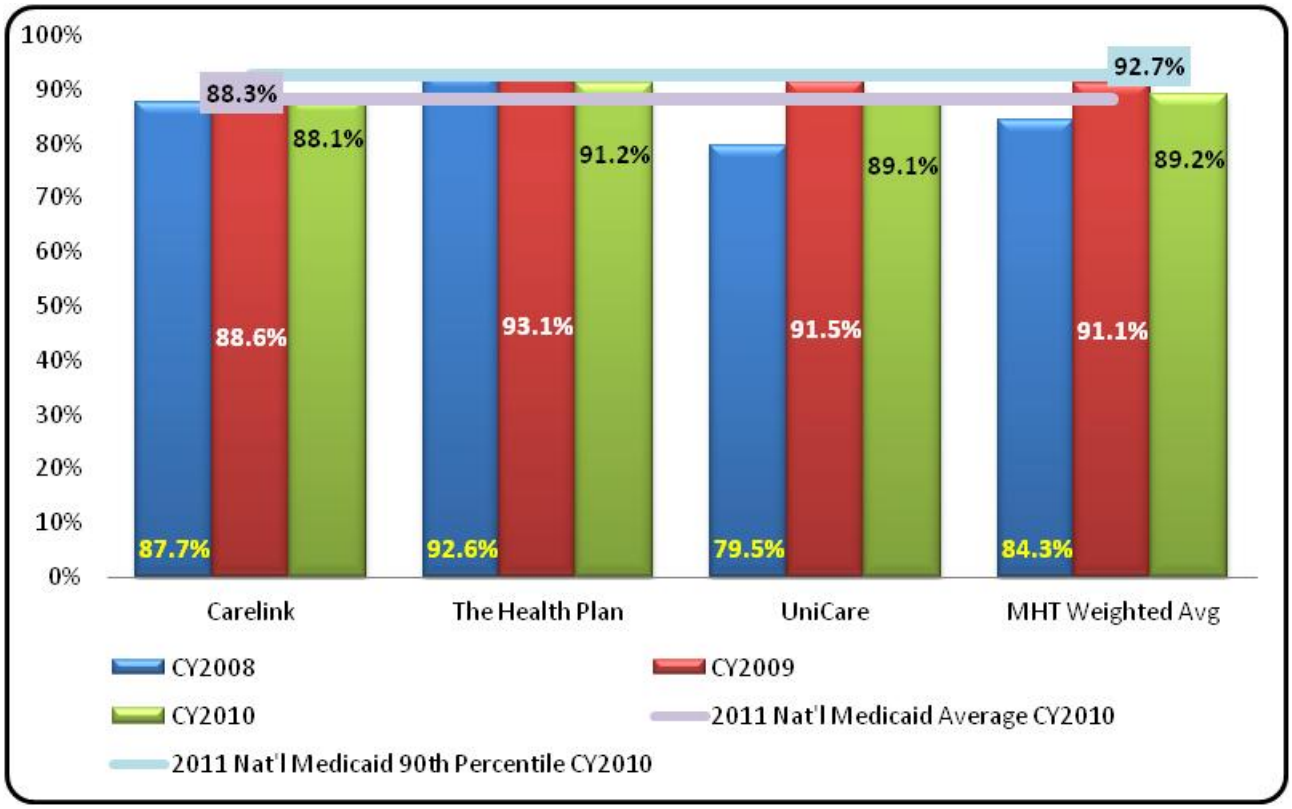
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

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

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

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



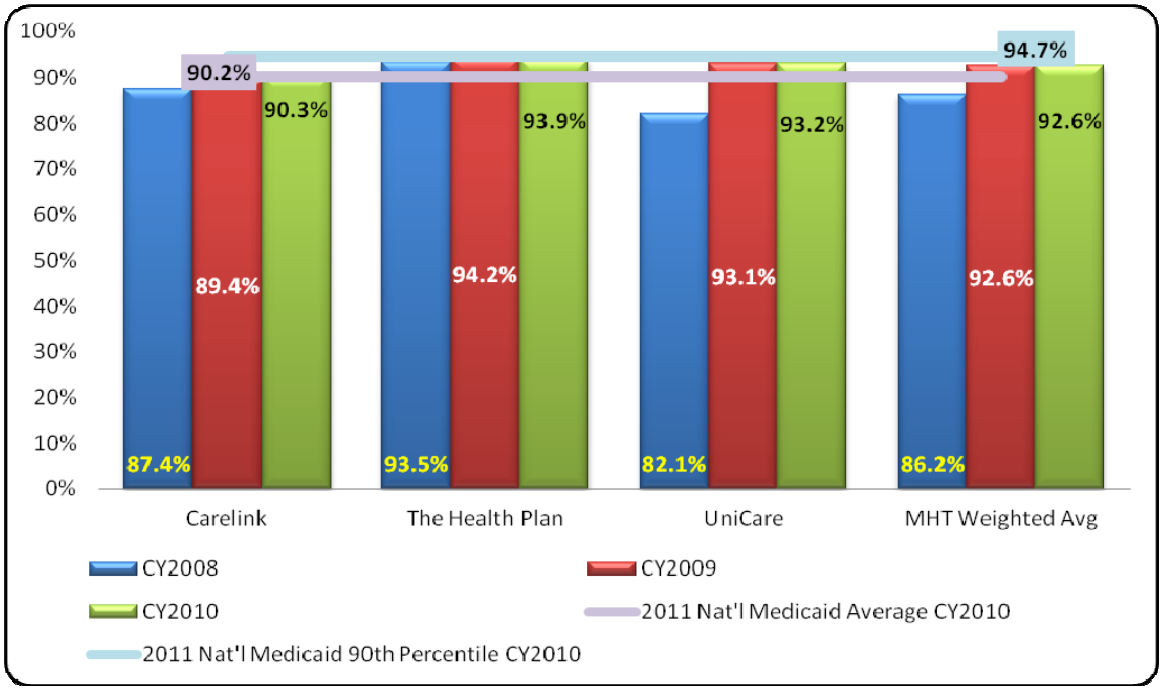
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

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

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

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



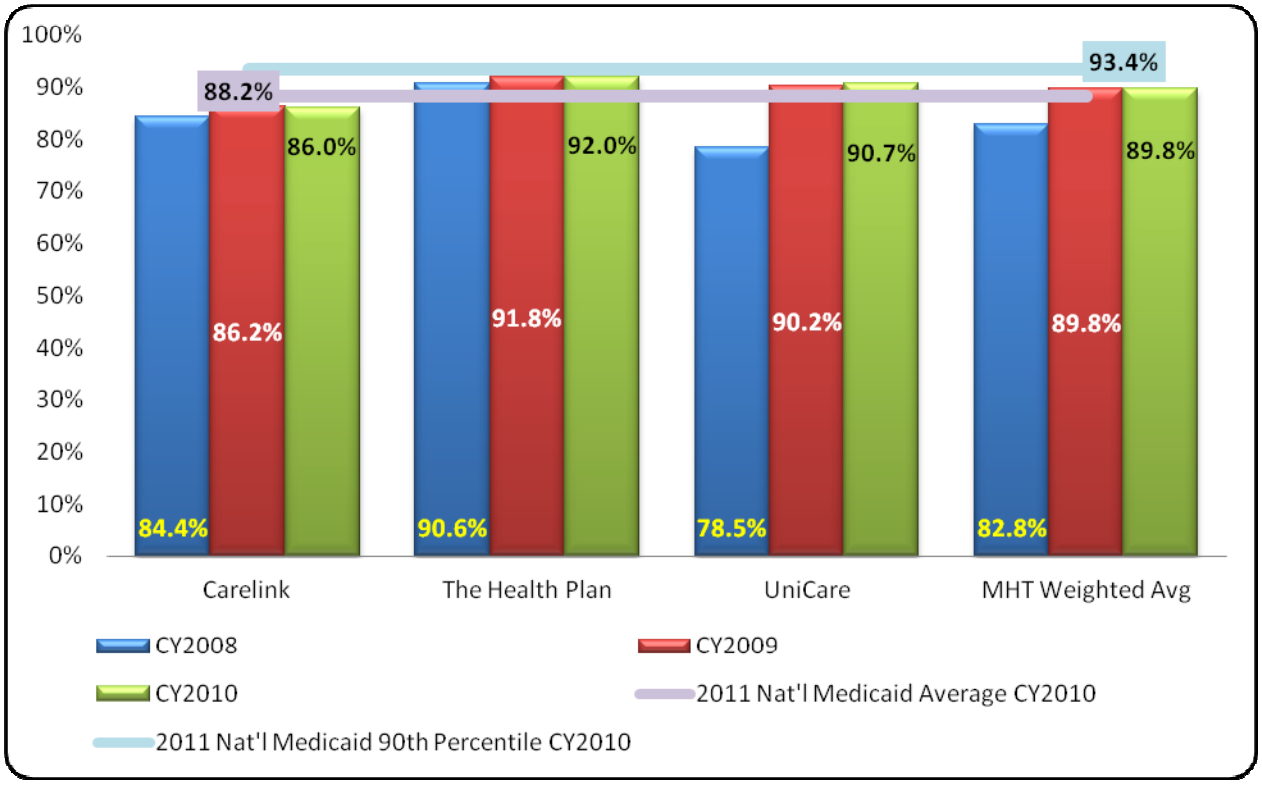
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

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

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

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



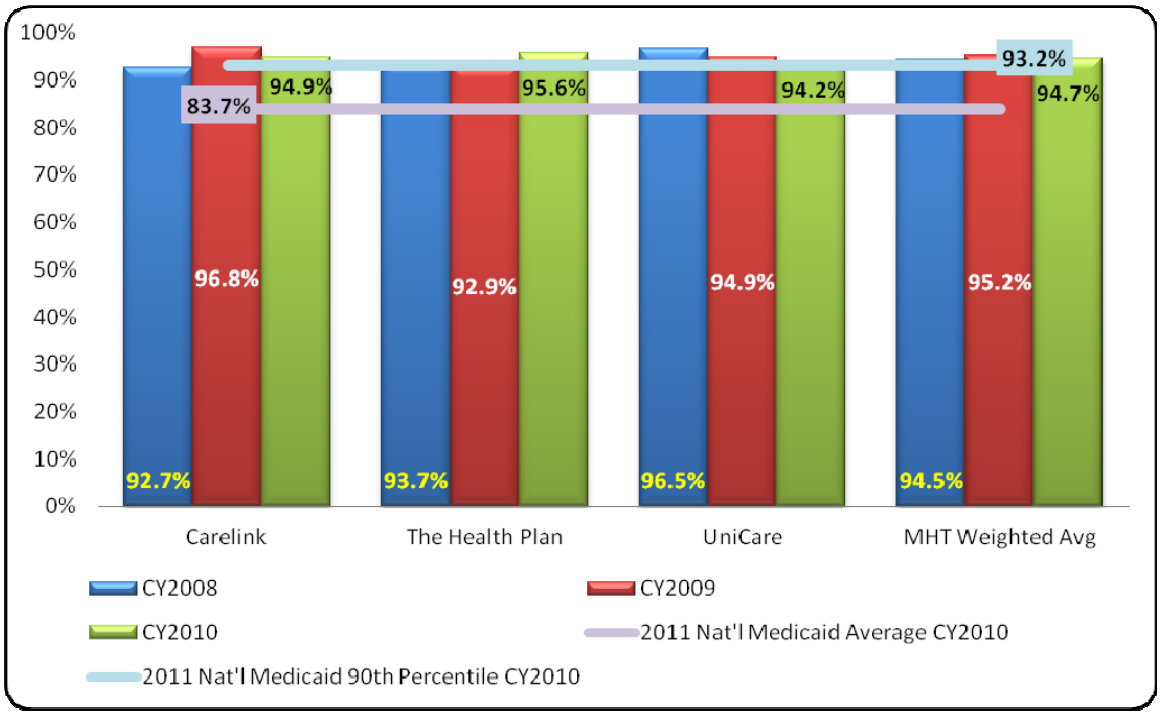
* HEDIS percentile and mean rates are from NCQA Quality Compass 2011

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

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

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

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



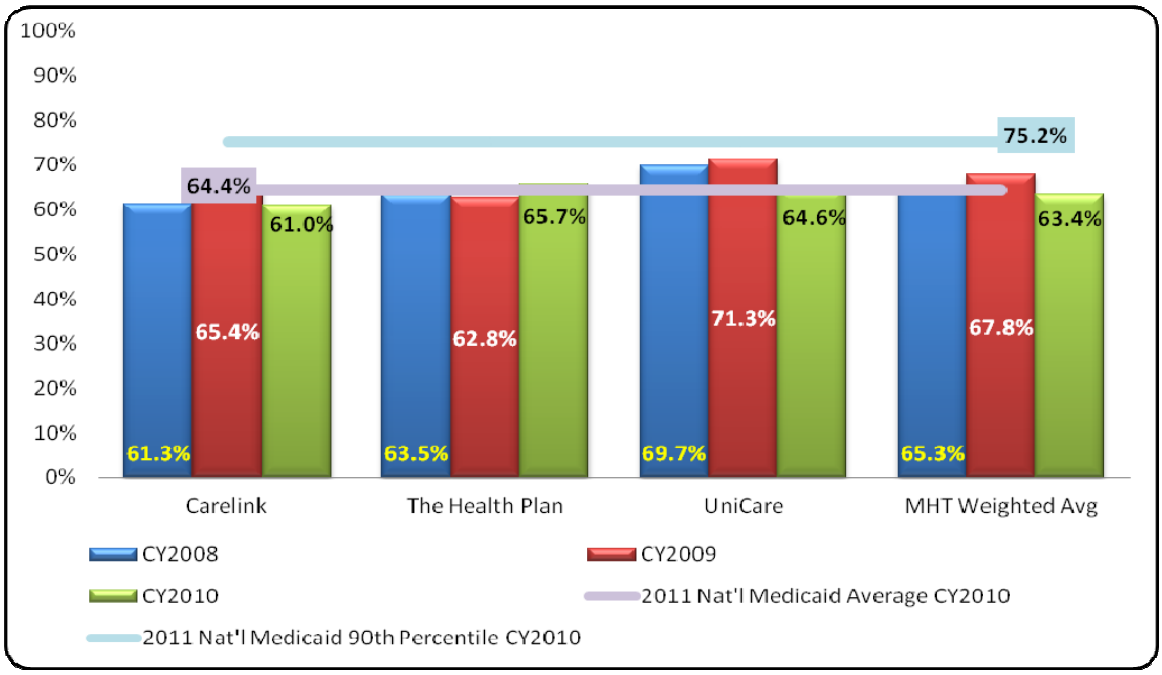
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

Prenatal and Post Partum Care (PPC)-Postpartum Care

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

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



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

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

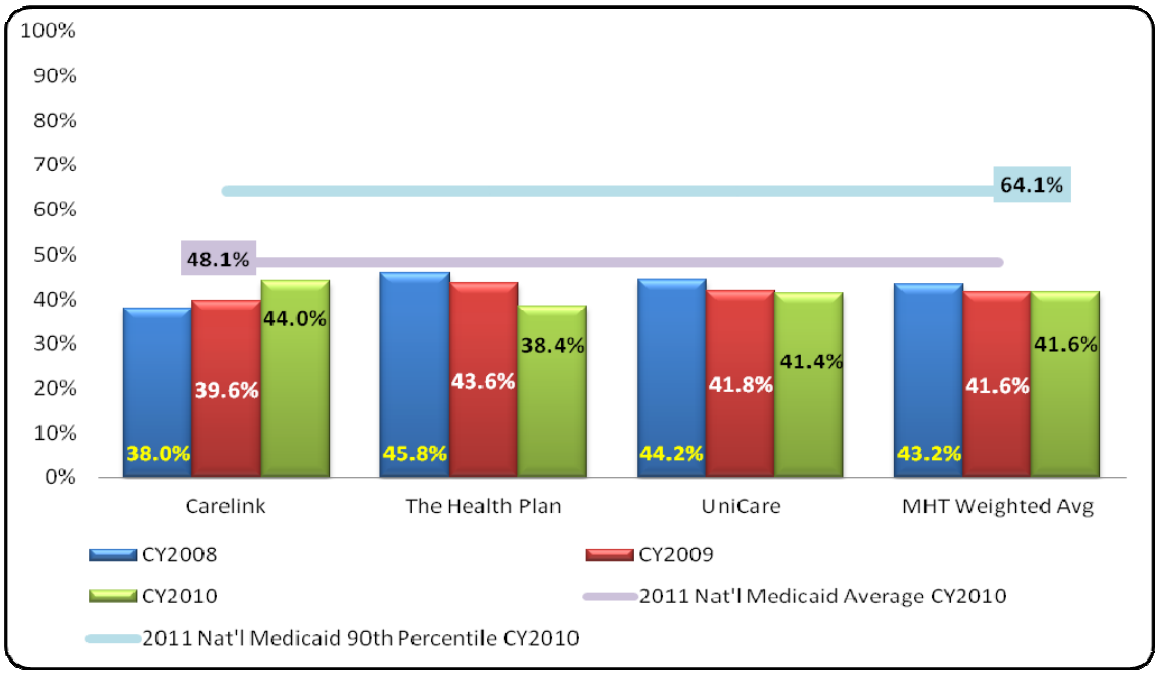
The State Strategy for Assessing and Improving Managed Care Quality sets a goal of 68.5% for this measure. The MHT Weighted Average of 63.4% is below this benchmark indicating unfavorable performance.

Timeliness

Adolescent Well- Care Visits (AWC)

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

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



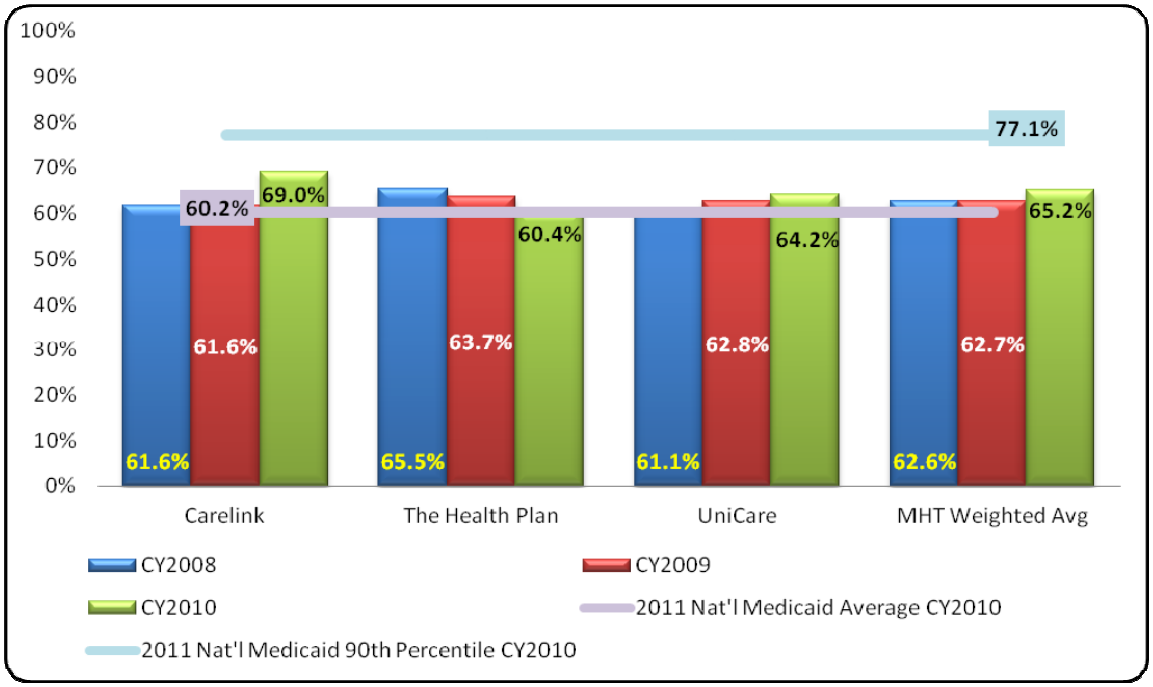
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

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

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

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



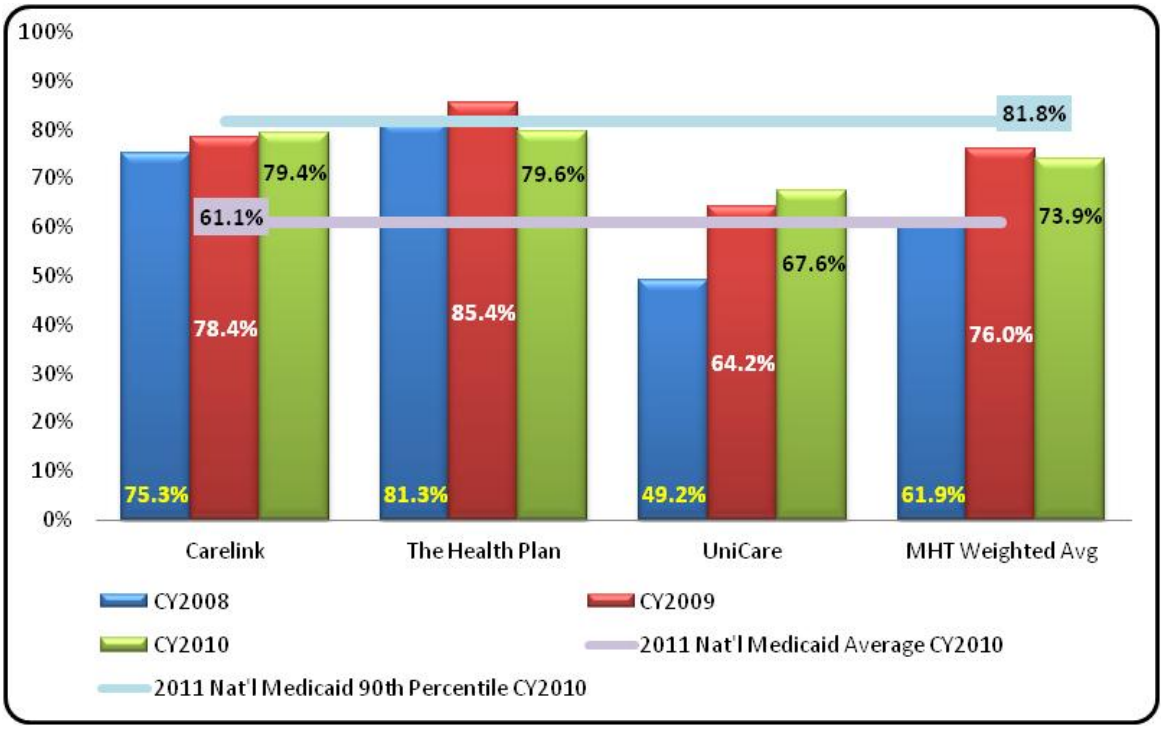
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

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

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

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



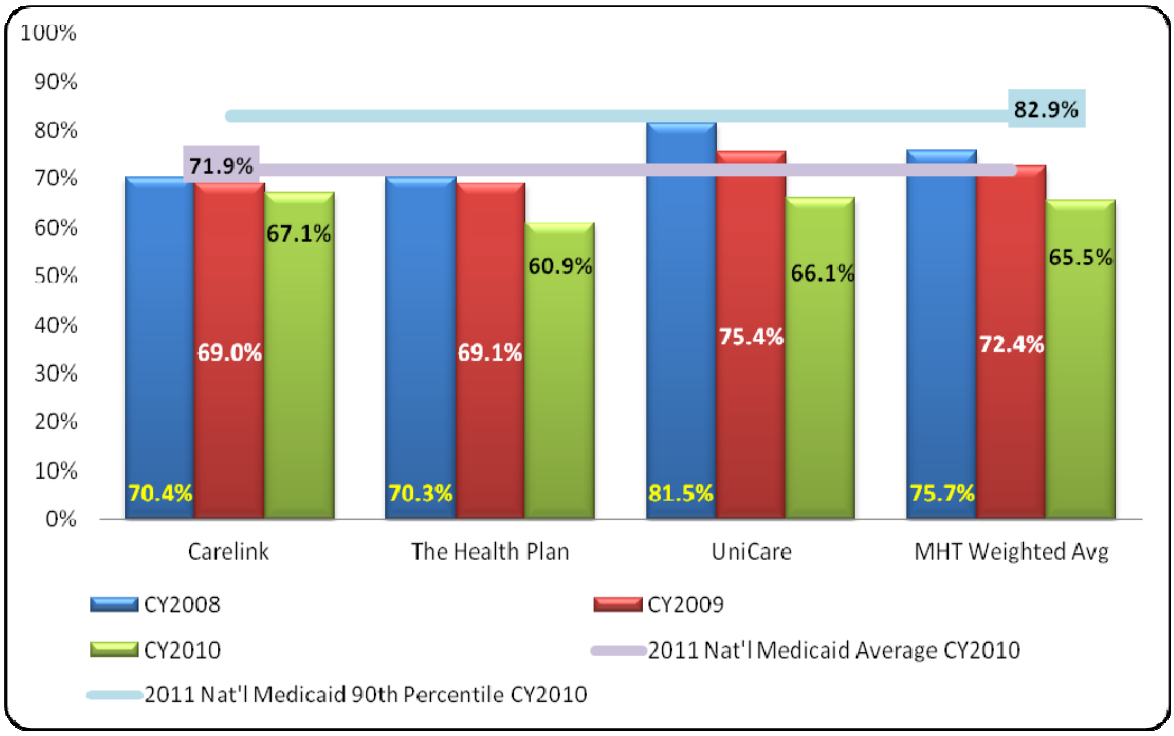
*** HEDIS percentile and mean rates are from NCQA Quality Compass 2011**

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

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

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

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



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

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

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

Summary of Quality, Access, and Timeliness

Quality

PIP

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

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

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

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

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

PMV

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

SPR

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

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

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

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

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

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

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

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

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

Access

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

PIP

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

PMV

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

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

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

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

SPR

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

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

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

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

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

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

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

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

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

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

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

Timeliness

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

PIP

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

PMV

The four measures used to assess timeliness of services are:

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

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

SPR

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

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

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

All three MCOs were able to demonstrate:

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

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

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

MHT MCO Strengths and Recommendations

Carelink Strengths and Recommendations

Strengths

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

Recommendations

- The MCO should enhance its data analysis for the Emergency Department Utilization PIP. A more concentrated, refined analysis (including assessment of diagnoses) should provide opportunity for targeted interventions.
- Carelink meets the West Virginia MCO program access requirements, but it is recommended that the MCO recruit additional specialists to meet its internal standards.
- Tracking and referrals and results of treatments resulting from EPSDT visit have been problematic for Carelink. The MCOs are now required to provide this information to BMS quarterly. It recommended that Carelink adopt the methodology provided by the data contractor to report the EPSDT measures.
- Due to issues and challenges identified in obtaining data from the West Virginia Statewide Immunization Information System (WVSIIS), Carelink was unable to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011. It is recommended that the MCOs work with BMS and the WVIIS to obtain reasonable access to the data.

- While Carelink exhibited a well-coordinated HEDIS reporting process, efficiencies may be gained by equipping nurse reviewers with portable technology such as laptops for medical record abstraction.

The Health Plan Strengths and Recommendations

Strengths

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

Recommendations

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

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

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

UniCare Strengths and Recommendations

Strengths

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

Recommendations

- UniCare should include an assessment of performance in its qualitative analysis for the Asthma PIP.
- A barrier analysis should be completed for PIPs prior to intervention implementation. Barrier identification assists in the process of selecting the most appropriate interventions.
- Although UniCare is compliant with the West Virginia MCO program access requirements, it is recommended the MCO should recruit additional specialists to meet its internal standards.
- UniCare's monitoring of its internal access standard of scheduling prenatal care appointments within 7 days and non-urgent/sick appointments within 72 hours resulted in compliance rates of 67% and 63%, respectively. In order to meet its internal standards, UniCare should focus efforts on improving timely access to providers for non-urgent/sick and prenatal care visits.
- Due to issues and challenges identified in obtaining data from the WVSIIS, the MCO was unable to utilize administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011. It is recommended that the MCOs work with BMS and the WVIIS to obtain reasonable access to the data.
- The organization created two separate hybrid samples for Childhood Immunization Status and Lead Screening in Children, with one reduced and the other not reduced. The audit team recommended that UniCare combine samples for these measures, which will reduce the burden on the MCO.

MHT Program Strengths and Recommendations

Strengths

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

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

Table7. MCO SPR Compliance Rates for CY 2010

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

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

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

Recommendations

The MCOs are committed to quality performance evidenced by their results on the Systems Performance Review with compliance rates greater than 90%. However, collecting certain EPSDT data, tracking of referrals and treatments that result from EPSDT screenings, continue to be problematic for some of the MCOs. In CY 2010, BMS established algorithms and reporting templates for reporting these indicators. These data are now collected and submitted to BMS on a quarterly basis. It is recommended that the rates submitted be monitored for reasonability early in the process to detect any issues with the algorithms.

As in the CY 2009 review, the performance measure validation process uncovered an issue with the MCOs gaining reasonable access to the West Virginia Statewide Immunization Information System (WVSIIS). State law requires all providers to report all immunizations they administer to children under age 18 to the WVSIIS within two weeks. These data are important in collecting accurate rates for the Childhood Immunization Status and Immunizations for Adolescents measures. It is recommended that BMS lead the effort to bring the MCOs, the Division of Immunization Services, and the Vaccines for Children program together to share best practices, to explore joint outreach and to develop messaging opportunities. In addition, it is recommended this collaborative identify a consistent method for the MCOs to access this important data source.

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Appendix 1 - Trending Tables

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2 - PIP Results

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

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

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

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

Indicator 3: Persistent asthmatics who had physician management			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		83.54%
CY 2010	Remeasurement 1	5% annual increase	83.01%
Indicator 4: Persistent asthmatics who had an inpatient visit (with respiratory specific diagnosis)—visits per 1000			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		57.61 k/month
Indicator 5: Persistent asthmatics who had an emergency room encounter (with respiratory specific diagnosis)—visits per 1000			
Time Period	Measurement	Goal	Rate or Results
CY 2010	Baseline		11.69 k/month
Childhood Obesity			
Indicator 1: Members with evidence of BMI documentation			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		1.45%
CY 2010	Remeasurement 1	5% increase	1.12%
Indicator 2: Members with evidence of nutritional counseling			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.94%
CY 2010	Remeasurement 1	5% increase	0.54%
Indicator 3: Members with evidence of physical activity counseling			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		0.78%
CY 2010	Remeasurement 1	5% increase	0.45%
Emergency Department Utilization Diversion			
Indicator 1: Emergency Room visits per 1000 members (ages 0-5 years) with respiratory diagnosis			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		438.27 visits/1000
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	370.72 visits/1000
Indicator 2: Emergency Room visits per 1000 members (age 20 and older) with diagnosis of back pain			
Time Period	Measurement	Goal	Rate or Results
4/1/2009 – 3/31/2010	Baseline		114.97 visits/1000
4/1/2010 – 3/31/2011	Remeasurement 1	5% annual reduction	115.51 visits/1000

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

Improving Asthma Control			
Indicator 1: Persistent asthmatics (5-50 years of age) who were appropriately prescribed medication			
Time Period	Measurement	Goal	Rate or Results
CY 2009	Baseline		95.07%
CY 2010	Remeasurement 1	95.07%	93.84%
Reducing Inappropriate Emergency Department Utilization			
Indicator 1: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Al Attar) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline		88%
Indicator 2: The rate of emergency room visits per 1000 Medicaid members from a participating primary care practice (Peters) in Princeton/Bluefield community, using total ER visits over total unique member count			
Time Period	Measurement	Goal	Rate or Results
10/1/2009 – 9/30/2010	Baseline		96%

Performance Improvement Project

PIP Assessment: Improving Compliance with Childhood Immunizations

Improving Compliance with Childhood Immunizations—Combo 3					
Measurement Period	1/1/2010 -12/31/2010				
Reporting Cycle		Proposal Only			
		Proposal With Baseline Data			
		Remeasurement			
	X	Final			
		Resubmission with Additions/Corrections			
		Other			
PIP Findings					
Validation Step		Met	Partially Met	Unmet	Not Applicable
1. Study Topic and Project Rationale		X			
2. Study Question		X			
3. Study Indicator(s)		X			
4. Study Population		X			
5. Sampling		X			
6. Data Collection Methodology		X			
7. Interventions		X			
8. Data Analysis		X			
9. Assessment of Real Improvement		X			
10. Sustained Improvement		X			
Final PIP Assessment					
X	PIP Meets Requirements				
	PIP Meets Requirements with Recommendations				
	PIP requires revisions; resubmission required				
	PIP does not meet requirements				
	Other				
PIP Recommendations					
	Continue PIP				
X	Close PIP				
	Delmarva Recommends:				

PIP Summary: Improving Compliance with Childhood Immunizations

Rationale

- Carelink's population is predominately children, with almost 83% of members under 19 years of age. The federal government has established a goal that requires 90 percent of all children 19 to 35 months of age be fully immunized. State-level data for West Virginia indicates that the immunization gap for children ages 19 to 35 months without all immunizations is 31% as compared to 23% nationally, ranking the state with the 5th largest gap. Carelink HEDIS Childhood Immunization rates remain below the national Medicaid HEDIS averages.

Strengths

- Demonstrated sustained improvement and statistically significant improvement over baseline
- Enhanced qualitative analysis

Significant Barriers/Issues Experienced

- Member knowledge deficit (understanding the importance/impact of vaccinations)
- Transportation
- Continued access problems with the WV Immunization Registry (delays and technical feed issues)
- Note: Many children have been vaccinated, but have received the vaccines outside of the HEDIS technical specifications (several days past their second birthday).

Most Notable Interventions

- Utilization of a WV immunization module to better track children not current with immunizations (developed by Cabin Creek Health Systems), this has been ongoing
- Outreach by the Carelink Medicaid Outreach Team—made 45 visits during CY 2010 to community events, schools, and health fairs to provide education on immunizations
- Implemented A480 to the MCO's Navigator Tracking System, involving customer service, case management, and outreach departments. Outreach is made to non-compliant members.

Conclusions and Recommendations

- PIP met requirements.
- Based on feedback from the prior review, Carelink improved its qualitative analysis. A more comprehensive assessment was provided.
- The MCO was able to achieve sustained improvement and had a statistically significant improvement over baseline.
- Carelink should close PIP after 4 remeasurements.
- Identify a new PIP topic based on MCO data analysis and opportunity for improvement. Provide the project rationale, study question, and indicator(s) for review and approval prior to the next annual PIP submission.

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

PIP Validation: Improving Compliance with Childhood Immunizations in Carelink Medicaid Children

Step 1 - Study Topic and Project Rationale
This step is met.

1.1 Was the topic selected by the State Agency or identified through data collection and analysis of enrollee needs, care, and services?
This component is met.

Carelink's population is predominately children, with almost 83% of members under 19 years of age. The federal government has established a goal that requires 90 percent of all children 19 to 35 months of age be fully immunized. State-level data for West Virginia indicates that the immunization gap for children ages 19 to 35 months without all immunizations is 31% as compared to 23% nationally, ranking the state with the 5th largest gap. Carelink HEDIS Childhood Immunization rates remain below the national Medicaid HEDIS averages.

1.2 Does the selected topic address key aspects of enrollee care or services, clinical or non-clinical in nature?
This component is met.

Carelink selected a clinical topic that addresses key aspects of enrollee care.

Step 2 - Study Question
This step is met.

2.1 Is there a clear study question that supports the project?
This component is met.

Carelink's problem statement is defined in 1.1. Carelink childhood immunization rates are below the national Medicaid HEDIS averages. The following study question was inferred: Will implementation of various interventions promoting immunizations increase Carelink's childhood immunization rate?

Step 3 - Study Indicator(s)
This step is met.

3.1 Does the study use meaningful, clearly defined, measurable indicators?
This component is met.

Carelink selected the HEDIS Combo 3 measure that includes the percentage of eligible children two years of age in the measurement year who have had 4 DTaP, 3 IPV, 1 MMR, 3HiB, 3 Hepatitis B, 1 VZV, and 4 pneumococcal conjugate vaccinations.

HEDIS measures are objective, clearly defined, and measurable. The use of a HEDIS measure meets the intent of this component.

3.2 Do the indicators measure change in health or functional status, processes of care, or enrollee satisfaction?
This component is met.

The HEDIS indicator is an appropriate preventive health care measure and is a proxy measure for process of care and health status.

3.3 Were reasonable, long-term project goals (performance targets) identified for each study indicator?
This component is met.

Carelink appears to have appropriately identified the national Medicaid HEDIS average as the long-term project goal for the indicator.

Step 4 - Study Population
This step is met.

4.1 Are all individuals clearly defined for whom the study questions and indicators are relevant?
This component is met.

HEDIS specifications were used to clearly identify all individuals to whom the study question and indicator applies.

Step 5 - Sampling
This step is met.

5.1 Does the sampling technique consider and specify the true or estimated frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable?
This component is met.

Carelink followed HEDIS sampling methodology. This methodology meets requirements for this validation component.

5.2 Were valid sampling techniques employed that protect against bias?
This component is met.

Carelink followed HEDIS sampling methodology. This methodology meets requirements for this validation component.

5.3 Does the sample contain a sufficient number of enrollees?
This component is met.

Carelink followed HEDIS sampling methodology. This methodology meets requirements for this validation component.

Step 6 - Data Collection Methodology
This step is met.

6.1 Are sources for data collection clearly specified?
This component is met.

Carelink's study design clearly specified the data to be collected as hybrid (medical/treatment records and administrative) along with supplemental record data from the WV Immunization Registry as approved by the MCO's certified HEDIS auditor.

6.2 Is there a systematic method of collecting valid and reliable data that represents the entire study population?
This component is met.

HEDIS methodology adequately specifies a systematic method for collecting valid and reliable data related to the study population. The use of the HEDIS methodology meets the intent of this component.

6.3 Was the data collection and analysis frequency specified?
This component is met.

Carelink specified annual data collection and analysis.

Step 7 - Interventions

This step is met.

7.1 Were interventions implemented that address identified barriers?

This component is met.

Carelink identified several barriers:

- Member knowledge deficit (understanding the importance/impact of vaccinations)
- Transportation
- Continued access problems with the WV Immunization Registry
- Note: Many children have been vaccinated, but have received the vaccines outside of the HEDIS technical specifications.

Interventions largely addressed the member knowledge deficit barrier. Some of the more robust interventions include:

- Utilization of a WV immunization module to better track children not current with immunizations (developed by Cabin Creek Health Systems), this has been ongoing
- Outreach by the Carelink Medicaid Outreach Team—made 45 visits during CY 2010 to community events, schools, and health fairs to provide education on immunizations
- Implemented A480 to the MCO's Navigator Tracking System, involving customer service, case management, and outreach departments. Outreach is made to non-compliant members.

7.2 Are interventions system-level and reasonably expected to improve outcomes?

This component is met.

Interventions are expected to improve the childhood immunization rate.

Step 8 - Data Analysis

This step is met.

8.1 Was an analysis of findings conducted according to the data analysis plan?

This component is met.

Carelink conducted an analysis of findings according to its plan.

8.2 Are numerical results and findings presented accurately and clearly?

This component is met.

Numerical results are clearly and accurately stated.

8.3 Is the analysis comprehensive and both quantitative and qualitative in nature?
This component is met.

Carelink provided a comprehensive analysis, both quantitative and qualitative in nature. Included were comparisons to previous measurements, statistical testing, and intervention effectiveness. Additionally, barriers were noted along with planned interventions.

The MCO improved its quantitative analysis by including comparisons to baseline and the indicator goal, which were omitted in the previous year's project submission.

8.4 Did the analysis include an interpretation of project success and identify planned follow-up activities?
This component is met.

The analysis included an interpretation of the project's success. Remeasurement 4 compared to remeasurement 3 demonstrated a very slight statistically significant improvement. Remeasurement 4 compared to baseline demonstrated a much more statistically significant improvement.

Specific interventions, such as the outreach department's member education, were named as contributing to improvement. Planned interventions were identified and include tracking noncompliant members on a monthly basis and providing more focus on provider knowledge of vaccines.

Step 9 - Assessment of Real Improvement
This step is met.

9.1 Was the same methodology repeated for remeasurement to ensure comparability?
This component is met.

Carelink repeated the same methodology for remeasurement.

9.2 Was there any documented quantitative improvement in processes or outcomes of care?
This component is met.

Carelink noted a 6.5 percentage point increase when comparing remeasurement 4 to remeasurement 3. When comparing remeasurement 4 to baseline, there was a 15.9 percentage point increase.

9.3 Does the reported improvement have face validity? Does the improvement appear to have been the result of the planned intervention (as opposed to an unrelated occurrence)?
This component is met.

Reported improvement appears to be the result of interventions initiated.

Step 10 - Sustained Improvement
This step is met.

10.1 Was sustained improvement demonstrated through repeated remeasurements over comparable time periods?
This component is met.

Carelink sustained improvement over baseline with all four remeasurements.

WV Fraud and Abuse Detection Standards

Contract Reference	Standard	Element	Component	Element/Component Description
Fraud and Abuse Detection				
Section 8.1	FA	1		The MCO must have in place internal controls, policies, and procedures to prevent and detect fraud and abuse. The MCO must have a formal fraud and abuse plan with clear goals, assignments, measurements, and milestones. The MCO's fraud and abuse plan must include the following elements:
Section 8.1	FA	1	a	Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards;
Section 8.1	FA	1	b	The designation of a compliance officer and a compliance committee that are accountable to senior management;
Section 8.1	FA	1	c	Effective training and education for the compliance officer and the organization's employees;
Section 8.1	FA	1	d	Effective lines of communication between the compliance officer and the organization's employees;
Section 8.1	FA	1	e	Enforcement of standards through well-publicized disciplinary guidelines;

Contract Reference	Standard	Element	Component	Element/Component Description
Section 8.1	FA	1	f	Provision of internal monitoring and auditing; and
Section 8.1	FA	1	g	Provision for prompt response to detected offenses, and for development of corrective action initiatives.
Section 8.1	FA	2		The Fraud and Abuse plan must include procedures for:
Section 8.1	FA	2	a	Conducting regular reviews and audits of operations to guard against fraud and abuse;
Section 8.1	FA	2	b	Verifying whether services reimbursed were actually furnished to members, as required in 42 CFR 455.1;
Section 8.1	FA	2	C	Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;
Section 8.1	FA	2	d	Educating employees, network providers, and beneficiaries about fraud and abuse and how to report it;
Section 8.1	FA	2	e	Effectively organizing resources to respond to complaints of fraud and abuse;
Section 8.1	FA	2	f	Establishing procedures to process fraud and abuse complaints by the MCO;

Contract Reference	Standard	Element	Component	Element/Component Description
Section 8.1	FA	2	g	Establishing procedures for reporting information to BMS; and
Section 8.1	FA	2	h	Developing procedures to monitor service patterns of providers, subcontractors, and beneficiaries.
Section 8.1	FA	3		The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include identifying provider fraud and abuse by reviewing for:
Section 8.1	FA	3	a	A lack of referrals;
Section 8.1	FA	3	b	Improper coding (upcoding and unbundling);
Section 8.1	FA	3	c	Billing for services never rendered; or
	FA	3	d	Inflating bills for services and/or goods provided.
Section 8.1	FA	4		The MCO must monitor provider fraud for underutilization of services and beneficiary/provider fraud for overutilization of services. Monitoring should include identifying beneficiary fraud by reviewing:
Section 8.1	FA	4	a	Access to services;
Section 8.1	FA	4	b	Inappropriate emergency care; or.

Contract Reference	Standard	Element	Component	Element/Component Description
Section 8.1	FA	4	c	Card-sharing
Section 8.1	FA	5		The MCO must take part in coordination activities within the state to maximize resources for fraud and abuse issues. The MCO must meet regularly with BMS, the MFCU and the EQRO to discuss plans of action, and attend fraud and abuse training sessions as scheduled by the state.
Section 8.1	FA	6		The MCO must submit a report to BMS by the 15th of each month regarding any suspected fraud and abuse cases identified during the prior calendar month. The report must include the following for each instance that warrants investigation: ➢ Name/ID number; ➢ Source of complaint; ➢ Type of provider; ➢ Nature of complaint; ➢ Approximate dollars involved; and ➢ Legal and administrative disposition of case. (If the MCO does not identify any suspected cases of fraud and abuse during the prior month, the MCO must submit the report stating that it did not identify any suspected cases of fraud and abuse for that period.)
Section 8.1	FA	7		The MCO must promptly comply with requests from BMS or the MFCU for access to and copies of any records, computerized data, or information kept by MCO providers to which BMS is authorized to have access.
Section 8.1	FA	8		Pursuant to Section 6032 of the Deficit Reduction Act of 2005, any entity who receives or makes Title XIX (Medicaid) payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

Delmarva Foundation

March 6, 2012

West Virginia Department of Health and Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

Attn: Donna D. Smith, Senior Buyer

Subj: Request for Proposal MED 12009, External Quality Review Organization

Dear Ms. Smith:

Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation) is pleased to provide our technical and cost proposals in response to the above referenced solicitation and all issued amendments.

Our knowledge and experience in External Quality Review, and long-standing relationship with the Bureau for Medical Services (BMS) uniquely qualifies us to support the resultant EQRO contract.

We have assembled a proven and successful team to provide the sophisticated skills and knowledge necessary for performing all of the tasks addressed in the EQRO RFP's statement of work. Our proposed subcontractor, MetaStar, is familiar to BMS and is a recognized expert.

A copy of Delmarva Foundations' Certificate of Liability Insurance is provided as Attachment 1.
Attachment 2 presents a copy of Delmarva Foundation's certificate to do business in the state of West Virginia. While we do have a current West Virginia contract, we do not have any West Virginia residents as part of our employee base nor do we have a physical location in West Virginia; therefore, the requirement for Unemployment Compensation coverage and Worker's Compensation coverage is not applicable. However, should we hire West Virginia residents on this or any other contract held with the state, we would certainly make all necessary arrangements to comply with such coverage. A copy of Delmarva Foundation's MED Purchasing Affidavit is included as Attachment 3. In accordance with Sections 2.5.4 and 5.3 of the RFP, Statements are provided as Attachment 4 and 5 by Delmarva and its Subcontractor of their independence from the State Medicaid Agency and the MCOs or PIHPs that they will review.

Should you require additional information, please contact Ms. Julie Tyler, Sr. Vice President at 410-822-0697 or via email at tylerj@dfmc.org. You may also contact me directly at 410-770-3829 or via email at jacksonth@dfmc.org.

Thank you for the opportunity to present our proposal to you and your colleagues and we look forward to continuing our relationship with BMS.

Sincerely,

Thomas R. Jackson
Chief Executive Officer
Delmarva Foundation for Medical Care, Inc.

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

External Quality Review Organization

Request for Proposal MED-12009

Volume I—Technical Proposal

By: Delmarva Foundation for Medical Care, Inc.
9240 Centreville Road
Easton, MD 21601-7098

POC: Julie Tyler
Sr. Vice President
Phone: 410-822-0697
Fax: 410-822-7971
Email: tylerj@dfmc.org

Signature: Thomas R Jackson

Thomas Jackson
Chief Executive Officer

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Named Insured: Quality Health Strategi
Insured City: Easton

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 02/16/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies)must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

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E-MAIL ADDRESS: certificates@willis.com

INSURER(S)AFFORDING COVERAGE	NAIC #
INSURER A: Continental Casualty Company	20443-200
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

Quality Health Strategies, Inc.
Delmarva Foundation
9240 Centreville Road
Easton, MD 21601

COVERAGES **CERTIFICATE NUMBER: 17430901** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN. THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADD'L INSRD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY	Y		2047956671	3/31/2011	3/31/2012	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurence)	$ 100,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$
	POLICY PRO-JECT X LOC							$
A	AUTOMOBILE LIABILITY			2047956718	3/31/2011	3/31/2012	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	ANY AUTO						BODILY INJURY(Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY(Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
	X Hired Physical Damage / X $100 Comp/ $1000 Coll							$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N	N/A		2064585401	3/31/2011	3/31/2012	X WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?						E.L. EACH ACCIDENT	$ 1,000,000
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach Acord 101, Additonal Remarks Schedule, if more space is required)

Certificate Holder is named as an Additional Insured in regards to the General Liability, as required by written contract.

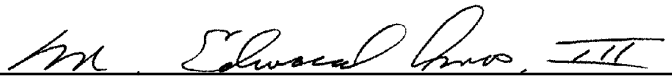
CERTIFICATE HOLDER

The State of West Virginia
(Bureau for Medical Services)
WV Department of Health and Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



Coll:3637828 Tpl:1405486 Cert:17430901

State of West Virginia

Certificate

I, Natalie E. Tennant, Secretary of State of the State of West Virginia, hereby certify that

DELMARVA FOUNDATION FOR MEDICAL CARE, INC.

a corporation formed under the laws of Maryland filed an application to be registered as a foreign corporation authorizing it to transact business in West Virginia. The application was found to conform to law and a "Certificate of Authority" was issued by the West Virginia Secretary of State on November 04, 1996.

I further certify that the corporation has not been revoked by the State of West Virginia nor has a Certificate of Withdrawal been issued to the corporation by the West Virginia Secretary of State.

Accordingly, I hereby issue this

CERTIFICATE OF AUTHORIZATION

Validation ID:8WV3R_JKWDD

Given under my hand and the Great Seal of the State of West Virginia on this day of January 25, 2012

Natalie E Tennant

Secretary of State

RFQ No. MED 12009

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Delmarva Foundation for Medical Care, Inc.

Authorized Signature: Thomas A. Taylor Date: 3-5-12

State of Maryland

County of Talbot, to-wit:

Taken, subscribed, and sworn to before me this 5th day of March, 2012

My Commission expires June 19, 2015.

AFFIX SEAL HERE **NOTORY PUBLIC** Joan M. Toms

Independence Statement

Delmarva Foundation for Medical Care, Inc. ("Contractor") hereby acknowledges the definition provided by the State of West Virginia Bureau of Medical Services for independence of an external quality review organization ("EQRO"). Specifically, the State of West Virginia identified in Sections **2.5.4** and **5.3** of the EQRO RFP (Number MED12009) the following qualifications:

2.5 Mandatory Requirements

2.5.4 Vendor must comply with all Federal regulations. Vendor must meet the competence and independence requirements as specified in 42 CFR §438.354

5.3 **Conflict of Interest:** Vendor affirms that neither it nor its representatives have any interest nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Bureau.

The language quoted above appears on pages 7 and 13 of the RFP

42 C.F.R. §438.354 Qualifications of external quality review organizations provides as follows with regard to independence:

. . .

(c) ***Independence.*** The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review. To qualify as "independent"—

(1) A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and

(2) A State agency, department, university, or other State entity must be governed by a Board or similar body the majority of whose members are not government employees.

(3) An EQRO may not—

(i) Review a particular MCO or PIHP if either the EQRO or the MCO or PIHP exerts control over the other (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through—

(A) Stock ownership;

(B) Stock options and convertible debentures;

(C) Voting trusts;

(D) Common management, including interlocking management; and

(E) Contractual relationships.

(ii) Deliver any health care services to Medicaid recipients;

(iii) Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or PIHP services, except for the related activities specified in §438.358; or

(iv) Have a present, or known future, direct or indirect financial relationship with an MCO or PIHP that it will review as an EQRO.

Contractor certifies that it is independent, as defined above, from the State of West Virginia Medicaid agency and from the MCOs and PIHPs subject to review under the EQRO program, except to the extent identified below. Contractor will provide in the space below information explaining in detail any current ownership, business, contracting, subcontracting, or other relationship(s) that may result in or be perceived as a conflict of interest. (Attach an additional sheet if necessary.)

N/A

Contractor agrees that upon release of an updated Solicitation or amendments to the RFP by the State of West Virginia Contractor will review any updated definition of independence and will confirm the extent of its continued compliance with such updated definition. Contractor further agrees, in the event of any change to Contractor's status as represented herein, Subcontractor will immediately notify the State of West Virginia Bureau of Medical Services and work with BMS to determine the extent of its continued compliance with the applicable independence requirements for this project.

I hereby attest that my response and the information provided on this form are true, complete and accurate as of the date identified below and I understand that this information may be used to verify initial and continuing eligibility to serve on the West Virginia External Quality Review Organization project.

Delmarva Foundation for Medical Care, Inc.
Entity Name

Thomas R. Jackson
Print Name of individual signing

Thomas R Jackson
Signature

17 Feb 2012
Date

Chief Executive Officer
Title

Independence Statement

MetaStar, Inc. ("Subcontractor") hereby acknowledges the definition provided by the State of West Virginia Bureau of Medical Services for independence of an external quality review organization ("EQRO"). Specifically, the State of West Virginia identified in Sections **2.5.4** and **5.3** of the EQRO RFP (Number MED12009) the following qualifications:

2.5 Mandatory Requirements

2.5.4 Vendor must comply with all Federal regulations. Vendor must meet the competence and independence requirements as specified in 42 CFR §438.354

5.3 **Conflict of Interest:** Vendor affirms that neither it nor its representatives have any interest nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Bureau.

The language quoted above appears on pages 7 and 13 of the RFP

42 C.F.R. §438.354 Qualifications of external quality review organizations provides as follows with regard to independence:

. . .

(c) ***Independence.*** The EQRO and its subcontractors are independent from the State Medicaid agency and from the MCOs or PIHPs that they review. To qualify as "independent"—

(1) A State agency, department, university, or other State entity may not have Medicaid purchasing or managed care licensing authority; and

(2) A State agency, department, university, or other State entity must be governed by a Board or similar body the majority of whose members are not government employees.

(3) An EQRO may not—

(i) Review a particular MCO or PIHP if either the EQRO or the MCO or PIHP exerts control over the other (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through—

(A) Stock ownership;

(B) Stock options and convertible debentures;

www.metastar.com

2909 Landmark Place
Madison, WI 53713

608-274-1940
800-362-2320

(C) Voting trusts;

(D) Common management, including interlocking management; and

(E) Contractual relationships.

(ii) Deliver any health care services to Medicaid recipients;

(iii) Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or PIHP services, except for the related activities specified in §438.358; or

(iv) Have a present, or known future, direct or indirect financial relationship with an MCO or PIHP that it will review as an EQRO.

Subcontractor certifies that it is independent, as defined above, from the State of West Virginia Medicaid agency and from the MCOs and PIHPs subject to review under the EQRO program, except to the extent identified below. Subcontractor will provide in the space below information explaining in detail any current ownership, business, contracting, subcontracting, or other relationship(s) that may result in or be perceived as a conflict of interest. (Attach an additional sheet if necessary.)

None

Subcontractor agrees that upon release of an updated Solicitation or amendments to the RFP by the State of West Virginia Subcontractor will review any updated definition of independence and will confirm the extent of its continued compliance with such updated definition. Subcontractor further agrees, in the event of any change to Subcontractor's status as represented herein, Subcontractor will immediately notify the State of West Virginia Bureau of Medical Services and work with BMS to determine the extent of its continued compliance with the applicable independence requirements for this project.

I hereby attest that my response and the information provided on this form are true, complete and accurate as of the date identified below and I understand that this information may be used to verify initial and continuing eligibility to serve on the West Virginia External Quality Review Organization project.

MetaStar, Inc.

Entity Name

Greg E. Simmons

Print Name of individual signing

Signature

February 17, 2012

Date

President & CEO

Title

Request for Quotation

RFQ NUMBER	PAGE
MED12009	1

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	SHIP TO
Delmarva Foundation for Medical Care 9240 Centreville Road Easton, MD 21601	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. TO ANSWER VENDOR QUESTIONS AS PER THE ATTACHED.
2. TO MODIFY THE RFP PER THE ATTACHED.
3. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED12009

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 X
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Thomas R Jackson	410-822-0697	03/05/2012

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Chief Executive Officer	52-1000082	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

RFQ NUMBER	PAGE
MED12009	2

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

ADDRESS CORRESPONDENCE TO ATTENTION OF
DONNA D. SMITH
304-957-0218

VENDOR	SHIP TO
Delmarva Foundation for Medical Care 9240 Centreville Road Easton, MD 21601	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 03/06/12 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

Thomas R Jackson
SIGNATURE

Delmarva Foundation for Medical Care
COMPANY

03/05/2012
DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Thomas R Jackson	410-822-0697	03/05/2012

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Chief Executive Officer	52-1000082	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"

Attachment A: Vendor Response Sheet

Provide a response regarding the following:

1. *Firm and staff qualifications and experience in completing similar projects;*
2. *References*
3. *Copies of any staff certifications or degrees applicable to this project;*
4. *Proposed staffing plan*
5. *Descriptions of past projects completed entailing the location of the project, project manager name and contact information, type of project, and what the project goals and objectives were and how they were me.*

Introduction

Delmarva Foundation provides the West Virginia Bureau for Medical Services (BMS) with specific information demonstrating:

- ✓ Our extensive qualifications and depth of knowledge and breadth of experience in West Virginia and;
- ✓ Delmarva Foundation is the best qualified organization to support the BMS in its efforts to continually improve the quality of care for those served.

Provided in the following narratives is a presentation of Delmarva Foundation's knowledge of and experience working with the West Virginia BMS managed care programs. This includes earlier work providing direct program assistance for the Primary Care Program known as PAAS through the implementation of the managed care program. This is followed by the five (5) requirements referenced and subsequent Sections 2.4.1 through 2.4.14 (note 2.4.11 deleted per Addendum 1).

West Virginia Knowledge and Experience

Long before the Patient Protection and Affordable Care Act, (PPACA), the BMS has strived to provide timely, affordable, high quality care to its Medicaid recipients. The shared goal of the primary care case management program, the Physician Assured Access System (PAAS), and the capitated managed care organization (MCO) program, Mountain Health Trust (MHT), has been to stabilize health care spending while improving quality. To demonstrate that the MCOs support timely, affordable and high quality care, BMS is seeking an experienced external quality review organization with the ability to:

- Identify any issues or problems regarding access, quality and utilization;
- Verify MCO compliance with program systems, and clinical requirements as outlined in the MCO contract;
- Identify best practices and with MCOs to improve results;
- Provide BMS with a comprehensive report that can be used as part of Bureau's overall quality strategy; and
- Prepare BMS and the MCOs for full review activities that will take place during the year. Our approach does include an on-site orientation meeting with the MCOs and BMS.

As West Virginia's External Quality Review Organization (EQRO), Delmarva Foundation has successfully collaborated with BMS to provide timely, accurate, and actionable evaluations and

recommendations for MHT. During this collaboration, we have accurately evaluated the MCOs' compliance with operational standards, performance improvement projects (PIPs), and validated performance measures such as:

- Implementing 42 CFR requirements for MCOs
- Updating the annual compliance review (ACR) to include fraud and abuse detection standards to keep pace with the PPACA and CMS focus on this issue
- Helping all MCOs exceed the 90% threshold for compliance in quality assurance and performance improvement, grievance systems, enrollee rights, and fraud and abuse detection standards
- Evaluating and making recommendations for PIPs in the areas of childhood immunizations and obesity, and treatment results for asthma, diabetes, and high blood pressure
- Developing the framework for the first statewide MCO collaborative which focuses on Emergency Department Use
- Recommending that MCOs, BMS, and the Immunization Registry collaborate to share information to benefit all parties and care recipients.

Since 1997, Delmarva Foundation has helped BMS through the transition from PAAS to the managed care program. As it has in the past, Delmarva Foundation's tools and processes will help provide the accurate information and actionable recommendations to support future initiatives and projects.

Delmarva Foundation will continue its long-time commitment to support the WV Department of Health and Human Services, Bureau for Medical Services in its efforts to achieve quality and affordability of health care. Delmarva Foundation has employed a cooperative and collaborative approach to providing high quality, timely, and cost-effective services to the Department. Our ongoing goal is to help BMS meet its goals in this challenging economic environment. Our proven methods, tools, and processes, as well as our expertise with West Virginia's projects and population, make us uniquely qualified to meet these goals.

Here's what Medicaid directors in other states have said about Delmarva Foundation's contract work:

“Delmarva Foundation’s team has exceeded our expectations. We are fortunate to partner with an organization that understands the complexity of our state Medicaid program and is able to tailor the required tasks and reporting to meet the needs of the program and our participating MCOs.”

“Delmarva Foundation has done an outstanding job of partnering with the Department to successfully manage program implementation. We appreciate Delmarva’s staff flexibility and commitment to the Department’s goals.”

1. Firm and Staff Qualifications and Experience in Completing Similar Projects

A. Delmarva Foundation Qualifications and Experience

Delmarva Foundation is a non-profit organization established in 1973 as a Professional Standards Review Organization. Over the years, the company has grown in size and in mission. Delmarva Foundation is designated by Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) for the State of Maryland and performs External Quality Review (EQR) and other services to Medicaid agencies in a number of jurisdictions across the United States. The organization has continued to build upon its core strength to develop into a well-recognized leader in Quality Assurance (QA) and Quality Improvement (QI). Products and services include QA and Quality Management (QM) contracts that address all healthcare provider sectors and home and community based waiver support providers. In addition to the QIO and current EQR Contracts, Delmarva Foundation holds current contracts including Medicaid Developmental Disability QA/QM, Utilization Review, QI, and Patient Safety QI Programs.

Delmarva Foundation is divided into several distinct business units, representing major client groups, products, support functions and technical expertise. The company's diverse and extensive contract portfolio is organized around three core teams:

- ***The Performance Assessment and Validation (PAV) Team*** engages stakeholders in assuring appropriate and necessary services are provided, while assisting them in ongoing program and policy development.

- ***The QIO Team*** is dedicated to transforming health systems consistent with the aims of the Medicare Quality Improvement Organization program.

- ***The Quality Safety and Innovations Team*** provides service to contracts in pursuit of patient safety and innovative approaches to quality for non-CMS federal agencies.

Delmarva Foundation's more than 23 years of experience serving Medicaid programs brings to the contract an in-depth familiarity of Medicaid requirements, benefits, state and national data systems, and management processes, including delivery of care and regulatory requirements. This broad-based experience and collaboration, in addition to our years of experience as an EQRO, gives us a solid understanding of the wide variety of state approaches to managed care. Our approach emphasizes knowledge, presence, and flexibility.

Delmarva Foundation's state EQR experience includes West Virginia, Maryland, Virginia, the District of Columbia, North Dakota, and California. Table 1-1 summarizes the Delmarva Foundation team's experience serving contracts of similar scope to the tasks identified in West Virginia's Request for Proposal for External Quality Review (EQR) services.

Table 1-1. Delmarva Foundation's Experience in Completing Similar Projects

Contract References Relevant EQR Experience	WV EQRO 1998 – Present	MD EQRO 1997 – Present	VA EQRO 2001-2006 & 2009 – Present	DC EQRO 2004 - Present	ND EQRO 2011 - Present	CA EQRO 2003-2008
Validate PIPS	√	√	√	√	√	√
Validate Performance Measures	√	√	√	√	√	√
Conduct Annual Compliance Review	√	√	√	√	√	
Monitor Medicare and Private Standards	√	√	√	√		
Review Activities Unique to the Program	√	√	√	√	√	
Identification and Application of Best Practices	√	√	√	√		

B. Staff Qualifications and Experience in Completing Similar Projects

Our proposed work team includes Delmarva Foundation staff and subcontractors who are dedicated to the success of this contract. Together, our proposed EQR Team is providing the essential level of support and dedication to ensure that all of BMS' goals are met for this resultant contract. In all aspects of our staffing approach, we ensure that:

- individuals have appropriate skills, experience, and credentials
- individuals fully understand and endorse the program goals
- each contract activity and task is adequately staffed and supported.

2. References

References for projects that are similar in scope are provided in Section 2.4.14. We believe that our references will validate our ability to deliver high quality services that best meet the individual client's needs.

3. Copies of Any Staff Certifications or Degrees Applicable to This Project

Table 1-2 provides the proposed EQR staff for this project, and includes a synopsis of their respective certifications and degrees applicable to this project.

Copies of staff certifications and degrees are located in the Appendix to Volume 1.

Table 1-2. EQR Team Certifications and Degrees

Proposed Staff	Certifications and Degrees	Title
Marci Kramer,	MHSA, CHCA, CPHQ, MCMP-I	Project Director (Project Manager)
Jody Jobeck,	MBA, CPHQ, PMP, MCMP-I	Project Manger II
Julie Tyler,	RN, CPHQ	Sr. VP of PAV
Maureen Kelly,	MPA, BSN, RN, CPHQ, PMP, MCMP-I	VP Managed Care
Laura Poynor,	MBA, CHCA, PMP, MCMP-I	Health Analyst
Dan Edris	BS	Director of Data Management
John McDonald	BS	Database Analyst
Karen Chouinard	BA	Jr. Analyst
Kimberly Haddaway	BA	Administrative Assistant

Descriptions of the professional certifications and degrees held by project staff are described in Table 1-3.

Table 1-3. Description of Delmarva Staff Professional Certifications

Certification	Description/Relevance to EQR Activities
PMP	The Project Management Professional (PMP) ® credential is the most important industry-recognized certification for project managers. Globally recognized and demanded, the PMP® demonstrates that the PMP has the experience, education and competency to successfully lead and direct projects. Project management professional certification which provides definition of the project, definition of the effort, execution of the project, monitoring and controlling of the project tasks and subtasks in the most efficient manner. Using project management methodologies allows the project manager to manage the entire scope of the EQRO project and provide deliverables in a timely manner.
CHCA	The National Committee for Quality Assurance (NCQA) has developed a precise, standardized methodology for verifying the integrity of HEDIS® collection and calculation processes - the NCQA HEDIS® Compliance Audit. This is a two-part program consisting of an overall information systems capabilities assessment (IS standards) followed by an evaluation of the MCO's ability to comply with HEDIS® specifications (HD standards). NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans. CHCAs can use the same methodology to validate state- or CCO-developed indicators, provide technical assistance, or make recommendations for improving specifications for measures.
CPHQ	The CPHQ credential signifies professional and academic achievement by individuals in the field of healthcare quality management. The comprehensive body of knowledge includes quality management, quality improvement, case/care/disease/utilization management, and risk management at all employment levels and in all healthcare Certified Professionals in Health Care Quality who are knowledgeable in health care quality principles and able to provide technical assistance to both BMS and the MCOs in achieving full compliance with the BBA and state contract standards by identifying strengths and opportunities for improvement across the three domains of quality, timeliness and access.
MCMP-I	MCMP-I designation is earned by an individual who has successfully completed 25 hours and the courseware of the 18 modules in Medicaid

Certification	Description/Relevance to EQR Activities
	topics. Expertise must be demonstrated in areas such as health information technology, Medicaid information technology architecture and health care reform.

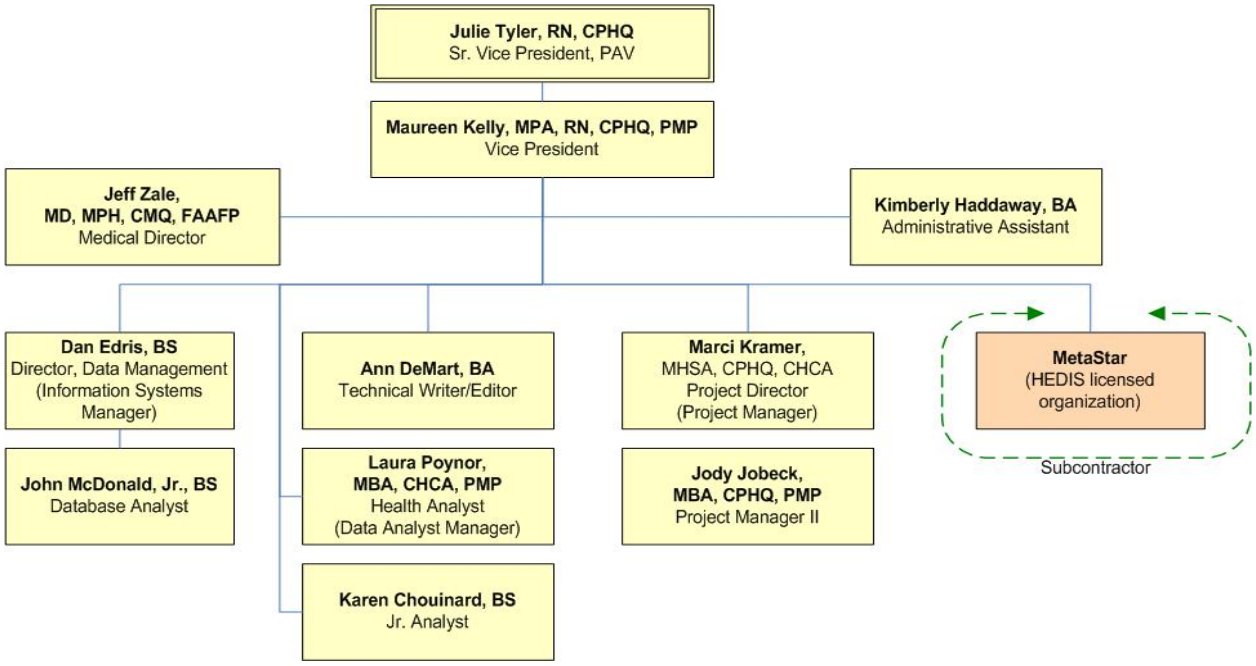
1. Proposed Staffing Plan

Delmarva Foundation's proposed EQR team is composed of employees and subcontractors who, working in concert with BMS, will provide the highest level of support to achieve this contract's goals. Our approach to staffing the SOW activities ensures that Delmarva Foundation has the right individuals with the appropriate skills, experience, and credentials to achieve the contract goals and work plan deliverables. Table 1-4 identifies the proposed EQR project by labor category and FTE for the base year.

Table 1-4. Staffing Plan

Base Year FTE	Labor Category	Years of EQRO Experience	Staff Name
Key Staff			
0.60	Project Director (Project Manager)	10	Marci Kramer, MHSA, CPHQ, CHCA, MCMP
0.54	Project Manager II	7	Jody Jobeck, MBA, CPHQ,PMP, MCMP
0.19	Health Analyst	10	Laura Poynor, MBA,CHCA,PMP, MCMP
Other Staff			
0.004	Medical Director	5	Jeff Zale, MD, MPH, CMQ, FAAFP
0.01	Director of Data Management	10	Dan Edris, BA
0.07	Database Analyst	7	John McDonald, BS
0.09	Jr. Analyst	5	Karen Chouinard, BS
0.15	VP Managed Care	3	Maureen Kelly, MPA, RN, CPHQ, PMP, MCMP
0.004	Senior Vice President of PAV	10	Julie Tyler, RN, CPHQ
0.14	Administrative Assistant	7	Kimberly Haddaway, BA
0.11	Technical Writer/Editor	1	Ann DeMart, BA
Subcontractors			
0.18	Metastar, Inc	10	Pat Martin

Figure 1-1. Organizational Chart



Introduction to Key Staff

Our skilled workforce includes employees with relevant, successful experience with current clients and who are capable of providing the same level of support and dedication to meeting your needs. Brief summaries of relevant experience for our proposed key personnel, as well as essential staff involved in ongoing operations, are presented below. Resumes for proposed key personnel are presented in the Appendix.

Marci Kramer, MHSA, CPHQ, CHCA
Project Manager/Certified HEDIS® Compliance Auditor

Ms. Kramer leads MCO systems performance reviews (SPRs), also known as compliance reviews, which evaluate structural and operational standards. As a Certified HEDIS® Compliance Auditor (CHCA), she leads the Performance Measure Validation (PMV) Team, using National Committee for Quality Assurance (NCQA) HEDIS® specifications and CMS protocols. Ms. Kramer also has direct oversight of the PIP validation activities, as she has extensive PIP review experience. She was the original Project Manager for the Medicare Advantage Quality Review Organization (MAQRO) CMS special project. Working with three other Quality Improvement Organizations, Ms. Kramer participated in the development of performance improvement project (PIP) review tools, PIP scoring methodology, reviewer instructional manuals, and training materials for Medicare Advantage staff. In her role as Project Manager, Ms. Kramer led the Delmarva Foundation PIP review team, consisting of physicians, health analysts and nurses, in conducting reviews of PIPs and providing feedback to the plans and CMS Regional Offices.

Additionally, she is the primary writer of Annual Technical Reports (ATRs), which requires synthesizing results of all contract activities (SPR, PMV, and PIP) in the categories of quality, access, and timeliness. She provides direction and technical assistance to BMS in areas such as program evaluation and measure development.

During her tenure (17+ years) with Delmarva Foundation, as a Project Director, she assumed the overall responsibility for design and management of EQR systems for clients including the states of Maryland, Delaware, Ohio, and the District of Columbia and developed and implemented a Quality Management System (QMS) that was used in several states to conduct on-site SPRs.

Ms. Kramer's educational credentials include a Master of Health Services Administration, Arizona State University, 1991 and a Bachelor of Social Science, Magna Cum Laude, Pennsylvania State University, 1986.

Jody Jobeck, MBA, CPHQ, PMP

Ms. Jobeck is a valued member of multiple expert teams consisting of physicians, nurses, analysts, and scientists across a variety of Delmarva Foundation's managed care contracts. Her expertise in PIPs has been essential to the successful management of the PIP Team and validation process. She has conducted PIP training sessions and has reviewed PIPs for VA, WV, CA, MD, and DC Medicaid programs. She has also conducted compliance reviews in multiple states and has been involved with all aspects of the review process. Additionally, Ms. Jobeck participates in report writing for all EQR activities, including ATRs.

Prior to joining Delmarva Foundation in 2004, Ms. Jobeck was responsible for the management of quality programs and projects for the University of New Mexico Hospital. Additionally, she assisted in accreditation processes, including the Joint Commission.

Ms. Jobeck's educational credentials include a Master of Business Administration, University of Phoenix, 2003 and a Bachelor of Science, James Madison University, 1996.

Laura Poynor, MBA, CHCA, PMP

Ms. Poynor is a CHCA with more than eight years of experience analyzing HEDIS® performance measures. Her depth of knowledge and expertise has made her Delmarva Foundation's client contact for information on HEDIS®, Consumer Assessment of Healthcare Providers and Systems (CAHPS), performance measure development, and benchmarking. In her role as Health Analyst, Ms. Poynor led the teams and coordinated PMV efforts and analysis for ATRs for West Virginia, Virginia, Ohio, California, and the District of Columbia. She has maintained oversight of 32 independent HEDIS® audits by two vendors. She has also completed the analysis for Focus Clinical Studies (FCS) for Ohio, Michigan, California, Virginia, and West Virginia.

She has designed data strategies for quality improvement and focused investigation studies and has been extensively involved in study research designs, including methodology, literature review, and sample criteria selection. She has completed statistical/data analysis, report preparation, and developed quality indicators through data and statistical analysis using SAS and other tools.

Ms. Poynor earned a MBA from St. Mary's University in San Antonio, Texas, and a BBA in Management/Marketing from University of Texas in San Antonio.

2. Descriptions of Past Projects Completed

Descriptions of Past Projects, Including Location, Project Manager Name, Contact Information, Type of Project, Project Goals and Objectives and how They were Met

Delmarva Foundation has more than 23 years of experience with Medicaid programs, including requirements, benefits, state and national data systems, and management processes. This broad-based experience and collaboration, in addition to our years of experience as an EQRO, brings a solid understanding of the wide variety of state approaches to managed care. Our approach emphasizes knowledge, presence, and flexibility.

Each of these projects descriptions includes the location of the project, project manager name and contact information, type of project, and how the goal and objectives were met.

Project Title: District of Columbia External Quality Review Organization

Project Manager Name: Maureen Kelly, MPA, RN, CPHQ, PMP

Contact Information:
Yolonda Williams
899 North Capitol Street NE
Suite 600
Washington, DC 20001
202-724-4282

Notable Successes: **District of Columbia External Quality Review Organization**	
The contract was modified using DF expertise to develop a managed care data repository.	• ***Developed measure specifications in support of the District's two quality collaboratives Improving Perinatal Care and Chronic Care Conditions***

Scope and Complexity: As the EQRO for the District of Columbia, Delmarva Foundation validates the collaborative performance measures produced by the District's two MCOs and one PIHP utilizing a methodology consistent with the CMS protocol for validation of performance measures. As part of the audit activity, Delmarva Foundation conducted a

complete information systems assessment at each participating MCO during the first contract year.

Delmarva Foundation evaluated the outcomes of MCOs' PIP activities and conducted intensive compliance reviews of each MCO annually. We developed MCO specific and District-wide reports for each contract task, as well as an Annual EQRO Technical Report. The technical report consists of qualitative and quantitative analysis and comparison of MCO performance to other participating MCOs against the District average and national benchmarks.

EQR Mandated and Optional Tasks Performed:

- Conducted quality review of Healthy Families MCOs: annual review with site visits that focus on quality assurance and performance improvement programs, complaints and grievances, member rights, and outreach to enrollees.
- Validated the MCOs' reported collaborative measures.
- Validated Healthy Families MCOs' required PIPs.
- Developed Annual Technical Report with aggregated rates for the performance measures.

Project Title: State of Maryland Department of Health and Mental Hygiene External Quality Review of Managed Care Organizations

Project Manager Name:
Dana Pate, MA, MCMP

Contact Information:
Nadine Smith, Deputy Director
201 West Preston Street
Baltimore, MD 21201
410-767-3567

Notable Successes-- State of Maryland Department of Health and Mental Hygiene External Quality Review of Managed Care Organizations	
Delmarva Foundation provides innovative products to assist enrollees in selecting an MCO that best meets their	• ***Developed an innovative HealthChoice MCO report card to assist consumers in selecting an MCO. The report card includes a variety of quality metrics including access, communication with health care providers, and management of chronic disease*** • ***Delivered annual compliance review reports one month early due to advancements in technology of review tools***

Scope and Complexity: As Maryland's EQRO, Delmarva Foundation monitors and reports on the quality of care provided by Medicaid Managed Care Organizations (MCOs) in Maryland. Delmarva Foundation has served as Maryland's EQRO since 1997.

Delmarva Foundation performs an intensive on-site two-day compliance audit (systems review) annually for each of the seven MCOs to monitor plan compliance with provider agreements and state laws and regulations. Delmarva Foundation's review team assess the MCO's structures, processes, and outcomes related to medical record-keeping practices, credentialing program,

outreach efforts, utilization management, quality assurance and improvement, and fraud and abuse program and activities.

Delmarva Foundation prepares monthly progress reports, orientation manuals, system performance review standards, and preliminary and final MCO systems performance review reports for each MCO annually. Delmarva Foundation also submits statewide systems performance review executive summaries and validates performance measures used for the state's value-based purchasing incentive program. We issue preliminary and final value-based purchasing reports. In addition, Delmarva Foundation conducts PIP validations, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews, encounter data validation, and case reviews for medical necessity. Delmarva Foundation also produces the annual HealthChoice consumer report card.

EQR Mandated and Optional Tasks Performed:

- Conduct Quality review of HealthChoice MCOs: annual review with site visits that focus on quality assurance and performance improvement programs, complaints and grievances, member rights, outreach to enrollees, and fraud and abuse programs and activities.
- Validated the Department Health and Mental Hygiene's value-based purchasing measures.
- Validated and monitored HealthChoice MCOs' required PIPs.
- Created Consumer report card on HealthChoice MCOs (annual).
- Performed Focused studies including data collection and analysis of well-child services provided through Maryland's HealthChoice program. Delmarva Foundation also provides technical assistance to the program for sampling and criteria development.

Project Title: North Dakota CHIP External Quality Review Organization

Project Manager Name: Jody Jobeck

***Notable Successes* -- North Dakota CHIP External**	
In less than 4 months Delmarva completed a readiness review for the MCO preparing it for its first external quality review.	• ***Completed analysis and report compilation with delivery of report almost 1 month ahead of schedule maximizing the MCO's preparation***

Contact Information:
Jodi Hulm* (*Ms. Hulm is on leave, in her absence Mr. Erik Elkins will provide reference information that she has provided)
600 East Boulevard Ave, Department 325
Bismarck, ND 58505-0250
701-328-2246 (Ms. Hulm) 701-328-2246 (Mr. Elkins)

Scope and Complexity: As the EQRO for North Dakota's CHIP program, Delmarva Foundation validates performance improvement projects and CHIP performance measures. Additionally, Delmarva Foundation completes a compliance review. Results of all activities are compiled into

an annual technical report which assesses the quality, access, and timeliness of health care provided to children enrolled in the program. Within the first few months of contract implementation, Delmarva Foundation completed a readiness review to prepare the CHIP MCO for its first annual external quality review.

EQR Mandated and Optional Tasks Performed:

- Performance improvement project validation
- Performance measure validation
- Compliance review
- Annual Technical Report of findings

Project Title: Virginia External Quality Review Services

Project Manager Name: Martha Burton

Contact Information:
Carol L. Stanley, MS, CPHQ
600 East Broad Street, Suite 1300
Richmond, VA 23219
804-371-7980

NOTABLE SUCCESSES: Virginia External Quality Review Services	
• ***Initiated and developed the first VA MCO quality collaborative that evolved into quarterly quality meetings. MCOs now share best practices with other MCOs and stakeholders annually.***	• ***Completed the first focused clinical study that integrated birth and immunization registry data to produce reports on Birth Outcomes and Child Health***

Scope and Complexity: Delmarva Foundation served as the EQRO for the Commonwealth of Virginia from 2001 through 2006 and has been the current EQRO since 2009. In support of this contract, Delmarva Foundation provides measurable information that can be easily understood and reported with ongoing re-measurement activities to evaluate quality, access, and timeliness with regard to specific populations and indicators.

Contract objectives include performing external quality reviews of five MCOs, validating HEDIS® performance measures, conducting clinical focus studies, validating PIPs conducted by MCOs, administering a CAHPS survey, and providing technical assistance to the Commonwealth in meeting regulatory compliance. Study topics have included pediatric asthma, immunizations, prenatal care, well-child care, and 24/7 coverage by primary care providers. Delmarva Foundation also assists the Commonwealth by presenting information for the state's Medicaid Advisory Committee, providing on-site education to new Commonwealth staff, and providing technical assistance to MCOs on the requirements of the BBA managed care regulations and EQR standards.

EQR Mandated and Optional Tasks Performed:

- Performed clinical focus studies for Medicaid recipients enrolled in managed care plans, primary case management programs, fee-for-service programs, and the SCHIP program. Clinical study topics are prenatal care and birth outcomes, pediatric asthma management, immunizations, well-child care, and access to primary care providers.
- Conducted CAHPS surveys to capture information specific to managed care and FFS delivery systems.
- Performed operational standards review of MCOs: annual review with site visits in alternating years that focus on quality assurance and performance improvement programs, complaints and grievances, and member rights. Standards are updated annually and a
- Validated MCOs' required performance measures and required PIPs.
- Evaluated pre-PACE program provider.
- Performed Annual evaluation and summary technical report of activities to meet CMS requirements.

Project Title: West Virginia External Quality Review Organization

Project Manager Name: Marci Kramer

Contact Information:
Brandy Pierce, Director of Managed Care and Procurement Services,
Bureau for Medical Services,
350 Capitol Street,
Room 251
Charleston, WV 23501
304-356-4912

Notable Successes: **West Virginia External Quality Review Organization**	
Delmarva Foundation assists BMS in developing and implementing processes to evaluate and improve the quality of care to enrollees.	• ***Designed and implemented WV's first operational systems standards to assess MCO compliance with regulations and contract provisions.*** • ***Assisted in developing the process to identify, investigate, and report "sentinel events."Monitoring and trending of patterns resulted in systemic and sustained changes.*** • ***Developed the framework and assisted MCOs in implementing the first MHT MCO collaborative, which focuses on Emergency Department use.***

Scope and Complexity: As the EQRO for the West Virginia's Medicaid managed care program, Delmarva Foundation designed and implemented the state's first managed care quality improvement program.

Under contract with the West Virginia Department of Health & Human Resources (WVDHHR), Delmarva Foundation conducts focused studies and compliance assessments of managed care plans. In addition, Delmarva Foundation performs on-site administrative reviews and applies West Virginia specific standards to evaluate MCO organizational functions.

Delmarva Foundation produces annual reports on West Virginia's managed care organizations.

Delmarva Foundation has designed and conducted 18 focused clinical studies in the past 3 years that target identified areas for improvement in health outcomes. The most recent clinical studies include immunizations, prenatal care, access to care for children with special health care needs (CSHCN), obesity (status and attitudes), appropriate treatment for respiratory conditions, and utilization of emergency room services. Delmarva Foundation also validated the HEDIS® performance measures and the PIPs selected by the state.

Delmarva Foundation was re-awarded the West Virginia EQRO contract in April 2008. The current contract includes compliance reviews of three MCOs, validation of MCO reported HEDIS® measures, evaluation of PIPs, and development of appropriate performance measures for special needs populations enrolled in managed care. Optional activities to be undertaken at the direction of the state include evaluation of home and community based services, readiness reviews and annual assessment of PACE, and development of pay-for-performance strategies.

EQR Mandated and Optional Tasks Performed:

- Conducted Quality review of MCOs: annual review with site visits every year that focus on quality assurance and performance improvement programs, complaints and grievances, and member rights.
- Validated Mountain Health Trust MCOs' required performance measures.
- Validated Mountain Health Trust MCOs' required PIPs.
- Conducted Clinical focus studies for Medicaid recipients enrolled in managed care plans. Clinical studies include immunizations, prenatal care and birth outcomes, access to care for CSHCN, obesity (status and attitudes), appropriate treatment for respiratory conditions, and utilization of emergency room services. The CSHCN and obesity studies were designed and conducted using telephonic interviews with parents/guardians and providers to gather qualitative data.
- Performed Quarterly assessments of MCOs' Quality Improvement Plans.
- Performed Quarterly on-site review of MCOs' sentinel events cases and reporting processes.
- Provided Technical assistance and education in root cause analysis to MCOs.

Project Approach and Methodology

The project goals and objectives are to provide services that satisfy federal requirements for the mandatory activities related to EQR and results specified in 42 CFR Part 438 Subpart E-External Quality Review. Table 1-5 outlines the project goals, and how each goal will be addressed, and where the goal is addressed in this proposal.

Table 1-5. Addressing Project Goals and Objectives

Project Goal	How Project Goal is Addressed	Location Within the Proposal
Identify any issues or problems regarding access, quality, and utilization	These issues are identified while conducting the three major activities of the contract-annual compliance review (ACR), performance measure validation (PMV), and validation of performance improvement projects (PIPs). Results will be documented in	Identification of issues: Task 2.4.2 Validation of PIPs Task 2.4.3 PMV Task 2.4.4 Conducting the ACR Reporting of issues: Task 2.4.8 Detailed Annual

Project Goal	How Project Goal is Addressed	Location Within the Proposal
	the Annual Plan Specific, Comparative, and Detailed Technical Reports.	Technical Report Task 2.4.9 Annual Plan-Specific Reports Task 2.4.10 Annual Comparative Report
Verify MCO compliance with program systems and clinical requirements as outlined in the MCO contract	MCO compliance is assessed and verified through the on-site annual compliance review. Each MCO is evaluated against the set of standards developed by Delmarva Foundation and approved by BMS.	Task 2.4.4 Conducting the ACR
Identify "Best Practices" and work with MCOs to improve results	Best practices are identified and documented while conducting the three major activities of the contract-the ACR, PMV, and validating PIPs. Results will be documented in the Annual Plan Specific, Comparative, and Detailed Technical Reports.	Identification of issues: Task 2.4.2 Validation of PIPs Task 2.4.3 PMV Task 2.4.4Conducting the ACR Reporting of issues: Task 2.4.8 Detailed Annual Technical Report Task 2.4.9 Annual Plan-Specific Reports Task 2.4.10 Annual Comparative Report
Provide BMS with a comprehensive report that can be used as part of the Bureau's overall quality strategy	The Detailed Annual Technical Report contains and the summary analysis of all EQR activities performed during a calendar year. Final formats will be agreed upon by BMS. Delmarva Foundation's current Annual Technical Report includes an analysis of MCO and MHT performance on measures contained in the Bureau's Quality Strategy.	Task 2.4.8 Detailed Technical Report
Prepare BMS and the MCOs for all review activities that will take place during the year.	An annual orientation is provided to the MCOs and BMS staff in Charleston, WV. Delmarva prepares and distributes and orientation manual to describe each major activity and project timelines.	Task 2.4.4 Conducting the ACR

Section 2.4.1: Vendor should propose an organized, integrated plan to evaluate the quality of MCOs participating in the West Virginia MHT program. The work plan should specifically address how the Vendor conducts all EQR activities and reporting requirements in the most efficient way for both State and MCO staff. The work plan should establish time estimates for each significant segment of work that demonstrates the Vendor's ability to comply with expected timeframes in Section 2.5.5 of this RFP.

Vendor Response:

As the current contractor, Delmarva Foundation will provide BMS continuity of EQR and related services. This partnership began in 1997, and over the last 15 years Delmarva Foundation has collaborated with BMS and its stakeholders to evaluate and improve the quality, access, and timeliness of care provided to Medicaid recipients.

Delmarva Foundation's proposed Integrated Work Plan outlined in this section will help us to effectively manage the EQR activities for each of the MCOs participating in the West Virginia MHT program. The Integrated Work Plan (draft Work Plan) includes (1) a high-level time estimates for each significant segment of work: Validating Performance Improvement Projects (PIPs); Performance Measure Validation (PMV); and Conducting the Annual Compliance Review (ACR) and (2) a Proposed Detailed Timeline that includes all major activities and other tasks, including monitoring regulations, reviewing activities unique to the MHT program, administrative tasks, and training and technical assistance. **All draft timelines will be provided to BMS within 30 calendar days from the date of the contract award and must be approved by BMS prior to beginning EQR activities.**

The Integrated Work Plan includes a variety of performance monitoring, management, and communication techniques. Our continuous evaluation and improvement of tools and processes result in efficient methods and compact timelines that enable faster reporting and more time for adequate review and input from BMS.

We will provide training and technical assistance to the Department of Health and Human Resources (DHHR) and the Bureau for Medical Services (BMS) staff and their contractors participating in this project during the duration of this contract. Quarterly written status reports will be provided to BMS within 15 calendar days after the close of each quarter. Quarterly progress reports will include a status update in accordance with the approved work plan and identify any potential barriers or risks that need to be addressed and plans to mitigate these risks. Examples of quarterly progress reports can be found in the Appendix.

After a thorough review of the contract tasks and meeting with BMS, the project manager will develop a work plan in consultation with essential staff for the new contract. Delmarva Foundation utilizes Microsoft® Project to develop a detailed annual work plan. Delmarva Foundation will create a new time-staged plan that meets the deliverable deadlines defined by the State. The work plan will be saved to a secure web based portal, which can be directly accessed by the State's contract manager. Key features Delmarva Foundation's work plan include:

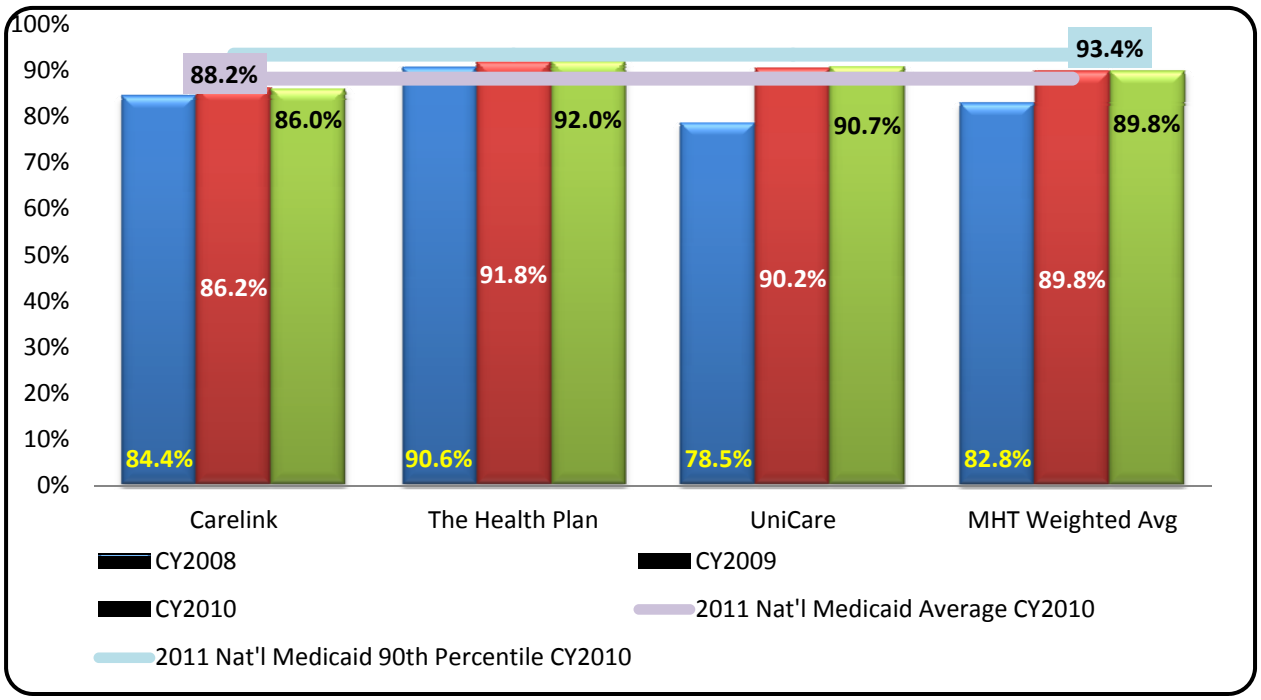
- Data management and analysis techniques
- Methods for meeting the deliverables, ranging from meetings with BMS contract manager to MCO training sessions
- Timeframes from task launch to final reports, including start and end dates

The high-level time estimates for each significant segment of work, including Validating Performance Improvement Projects (PIPs), Performance Measure Validation (PMV), and Conducting the Annual Compliance Review (ACR), are described below. The proposed schedule for deliverables associated with each task is presented with each of the three significant activities.

Validating and Reviewing PIPs

Delmarva Foundation has 14 years of experience in reviewing, monitoring, and validating PIPs for the MHT MCOs. Our tools and processes have facilitated the evaluation process, and our actionable recommendations have measurably helped the MCOs in their goal to achieve and sustain improvement in the specific projects. In the past five years, Delmarva Foundation evaluated and made recommendations for improvement for MHT PIPs related to improving compliance with childhood immunizations, controlling high blood pressure, providing lead screening for children, assessment of weight and nutritional counseling for children, and access to primary care physicians, among many other projects. Figure 1-2 provides an example of sustained improvement for Children and Adolescent Access to Primary Care Practitioners Ages 12-19 Years.

Figure 1-2. 2010 Children and Adolescents' Access to Primary Care Practitioners–12-19 Years



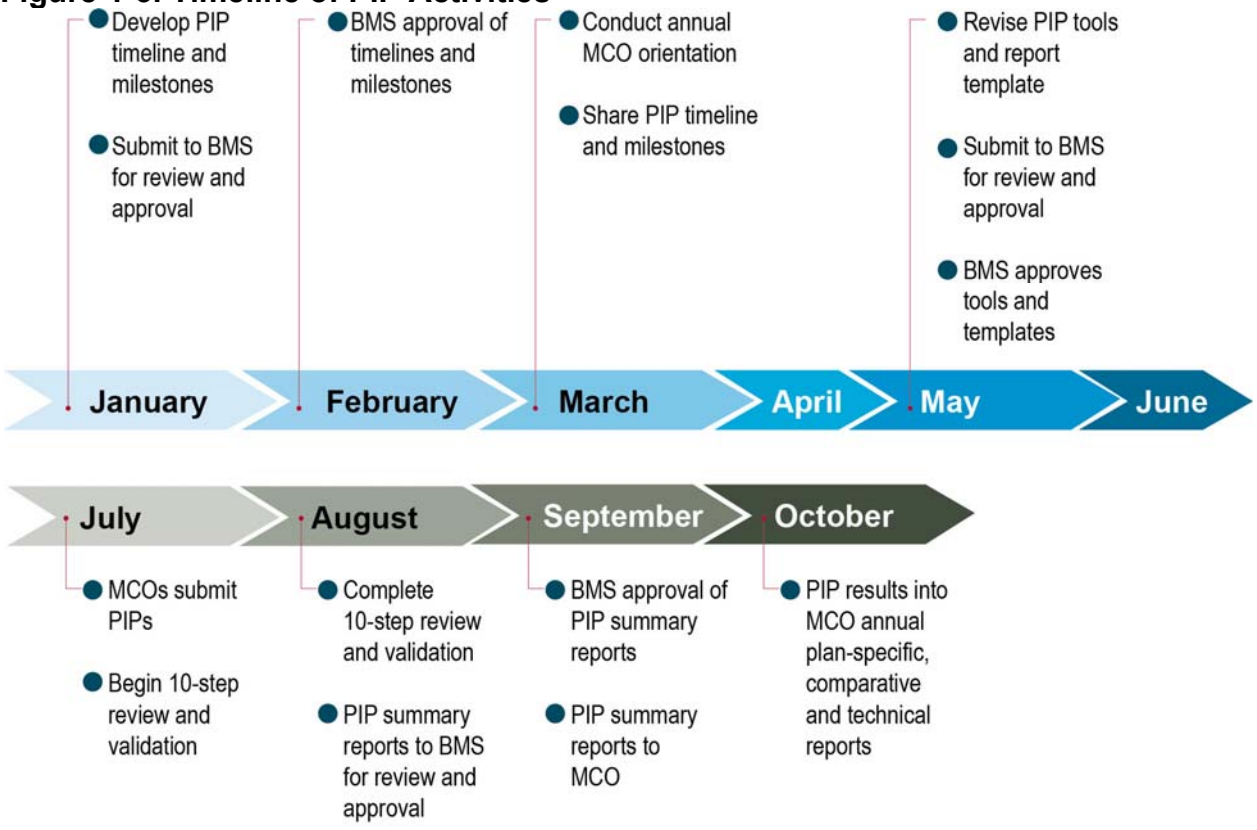
Delmarva Foundation will continue to conduct the PIP reviews and validations according to approved protocols and PIP timeline. In accordance with 42 CFR §438.358(b)(1), our PIP review methodology is based upon the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.* We will collaborate with the MCOs and develop a timeline for all PIP-related activities and will review and validate two PIPs annually for each MCO. Findings will be included in the Detailed Technical Report, Annual Plan-Specific Report, and the Annual MCO Comparative Report planned for delivery in December. Best practices will be highlighted and recommendations on how to best translate these best practices to other MCOs in order that all MCOs benefit which will, ultimately impact the quality of care received by MHT beneficiaries.

In order to provide timely feedback on PIP submissions, a PIP Summary Report will be provided to each MCO in September. The PIP summary includes the rationale for the project, strengths, weaknesses, best practices/interventions, barriers, and recommendations. By providing the PIP Summary Report three months prior to the final reports, the MCO has additional time to address any issues that have been identified.

Delmarva Foundation will provide progress reports on the PIP validation task in the Quarterly Progress Reports submitted to BMS within 15 days of the close of each quarter. In addition, a status update will be provided to the BMS and The Lewin Group during monthly update conference calls. It is possible that issues with the potential to negatively impact the PIP process will be identified throughout the year. These issues will be brought to BMS' attention immediately via telephone. A plan for resolution will be developed in collaboration with BMS, the MCO, and Delmarva Foundation.

Delmarva Foundation's Project Manager will work with BMS staff to finalize a work plan and timeline for the PIP activities. Figure 1-3 depicts the PIP activities timeline in the proposed work plan.

Figure 1-3. Timeline of PIP Activities



Deliverables

Annually, Delmarva Foundation will review, monitor and validate two PIPs per MCO. Delmarva Foundation will provide BMS with a quarterly status update in the Quarterly Written Status

report due to BMS within 15 calendar days of the close of each quarter. Upon receipt of PIPs, on or before the contractual due date of July 15, Delmarva Foundation will conduct the PIP reviews and validations according to approved protocols and PIP timeline. Findings will be included in the Annual Technical Report, Annual Plan Specific Reports, and Annual MCO Comparative Report.

All reports will be submitted using approved templates. Delmarva Foundation will collaborate with BMS staff on the format and content of all PIP reports. Draft reports, using approved templates, will be submitted to BMS for review and approval. Final reports will be delivered according to the schedule presented in Table 1-6.

Table 1-6. PIP Report Deliverable Schedule

Deliverable	Submission Date
Approval of Final Work Plan by BMS	Annually
PIP Validation Protocol	May
PIP Activity Timeline	May
Report Templates	May
PIP Validations Completed	August
PIP Summary Report	September
Draft PIP Findings Reported in Annual Plan-Specific Reports, Comparative Report, and Detailed Technical Report to BMS for Review and Approval	November
Final Reports Delivered to BMS and MCOs	December

Performance Measure Validation

Delmarva Foundation will validate performance measures as required by 42 CFR §438.358(b)(2). The Performance Measure Validation (PMV) activities are in compliance with the requirements set forth in 42 CFR §438.240(b)(2). The HEDIS Compliance Audit™ methodology is compliant with the Centers for Medicare and Medicaid protocol, *Validating Performance Measures, A Protocol for use in Conducting Medicaid External Quality Review Activities, May 1, 2002*. As a NCQA licensed HEDIS® Audit organization, MetaStar, Inc. will conduct all audit activities. Delmarva Foundation will manage this task to ensure that contract deliverables are completed accurately and timely.

PMV performance findings are included as examples of the quality and strength of Delmarva Foundation's analysis. CY 2010 results indicate that the MHT Weighted Average *and* all MCOs outperformed the national Medicaid Average for the following measures of access:

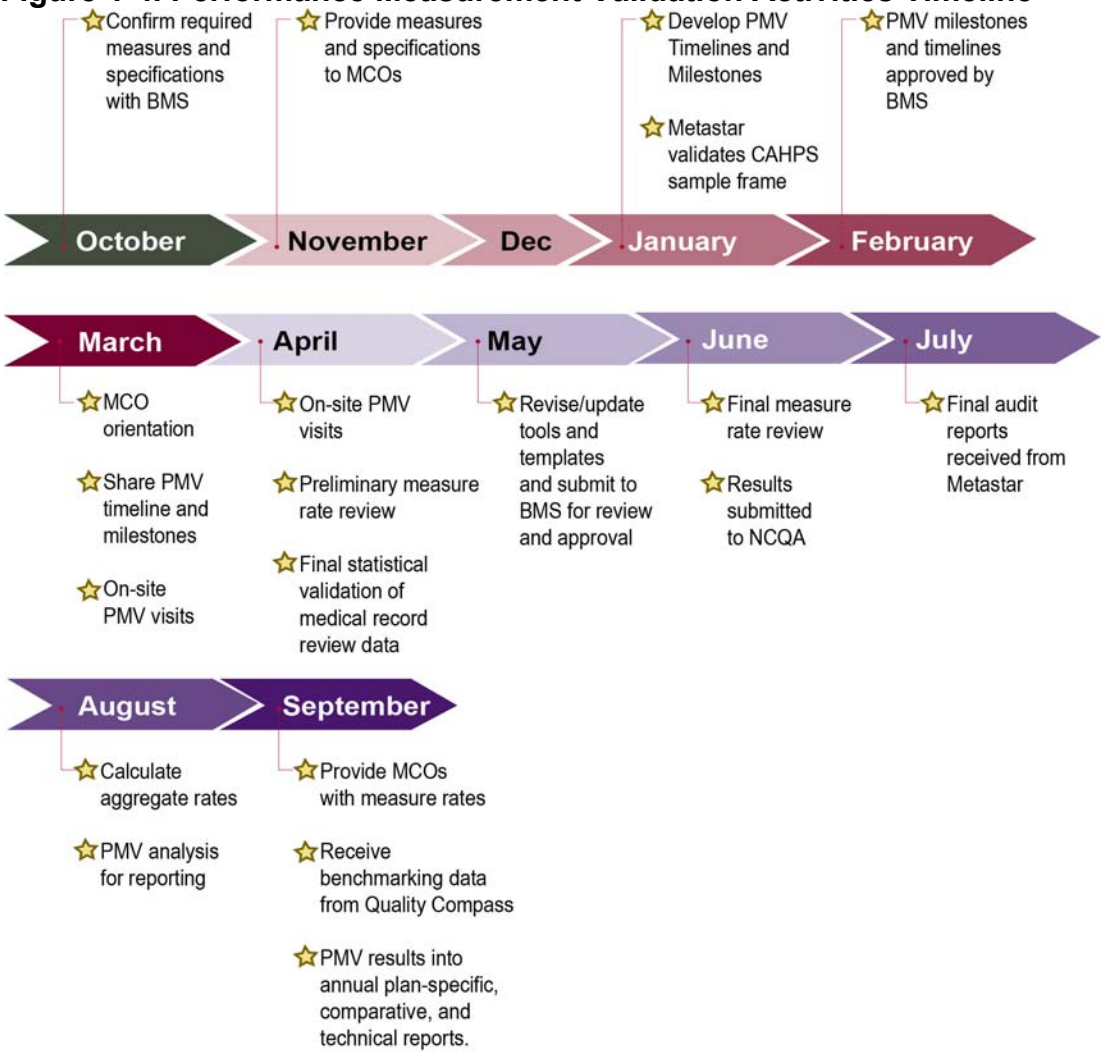
- Adults' Access to Preventive/Ambulatory Health Services ages 20-44 Years
- Adults' Access to Preventive/Ambulatory Health Services-Total
- Children and Adolescents' Access to Primary Care Practitioners 12-24 Months
- Children and Adolescents' Access to Primary Care Practitioners 25 Months-6 Years
- Children and Adolescents' Access to Primary Care Practitioners 7-11 Years
- Children and Adolescents' Access to Primary Care Practitioners 12-19 Years

- Prenatal and Post Partum Care-Timeliness of Prenatal Care

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

As we have in previous contract years, Delmarva Foundation will submit an annual work plan consistent with the CMS protocols and the HEDIS Compliance Audit™ timelines for all performance measure validation activities to BMS. Delmarva Foundation's Project Manager will work with BMS to create a work plan and timeline for the performance measure review activities. Figure 1-4 depicts the flow of the performance measure validation activities in the proposed work plan.

Figure 1-4. Performance Measurement Validation Activities Timeline



Delmarva Foundation and Metastar, Inc.'s Certified HEDIS® Compliance Auditors (CHCAs) coordinate efforts throughout the project to ensure that the final reports are submitted in November of the year following the reporting period.

Delmarva Foundation will provide updates on the performance measurement validation task in the Quarterly Progress Reports to BMS. Verbal reports will be provided monthly during the Monthly Update Call with BMS and The Lewin Group.

Deliverables
Delmarva Foundation will collaborate with BMS on the format and content of all deliverables. Final reports will be delivered to BMS by November of the year following the reporting period. In order to provide timely feedback to the MCOs, we will provide each MCO with their HEDIS® measure rates soon after we receive them from Metastar, Inc. Historically the MCOs have had to wait for their HEDIS® measure rates until they received their final PMV reports. By providing timely feedback on the measure results, the MCOs can begin their own internal data analysis approximately three months earlier than in the past. The final report will be delivered to BMS by November of the year following the reporting period. We will conduct the PMV activities according to approved protocols and PMV timeline. Findings will be included in the Annual Technical Report, Annual Plan Specific Reports, and Annual MCO Comparative Report. All reports will be submitted using approved templates. A schedule of the PMV deliverables is included as Table 1-7.

Table 1-7. PMV Deliverables Schedule

Deliverable	Submission Date
Approval of Final Work Plan by the BMS	Annually
Individual MCO Rates Provided to MCOs and BMS	September
Draft PMV Findings Reported in Annual Plan-Specific Reports, Comparative Report and Detailed Technical Report for Review and Approval	November
Final Reports Distributed to BMS and MCOs	December

The PMV report will include an executive summary and detail each MCO's performance for each measure. Delmarva Foundation will update the current report template with input from the BMS to include revised measures, methods, and background information.

Annual Compliance Review–(ACR)
In accordance with 42 CFR §438.358(b)(3), our ACR is based upon the CMS protocol, *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* In addition to using the standards derived from the CFR (Enrollee Rights, Grievance Systems, and Quality Assessment and Performance Improvement), we also include standards based on BMS's contract with the MHT MCOs. For example, we have added elements on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and the Fraud and Abuse.

ACRs 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 enrollees. This assessment provides BMS with an accurate and objective portrait of each MCO's capabilities which can be used to promote accountability and improve important aspects of organizational achievement. Delmarva Foundation will conduct an annual compliance review at each MHT MCO. The review protocol and timeline will be approved by BMS prior to each annual review.

Delmarva Foundation has extensive experience in conducting all activities related to compliance audits. BMS can continue to have confidence in the assessment results. We consistently use the same scoring methodology allowing for MCO comparisons, as well as trending over time. We have used procedures and standardized, electronic tools that have provided valid and reliable assessments in an efficient manner.

Delmarva Foundation has performed annual assessments of MCO operational infrastructure and the quality, access and timeliness of services provided to MHT enrollees with standards developed from the CFR, relevant state regulations, and MCO contractual requirements. Standards are updated each year, as needed and approved by BMS prior to conducting the ACR. In CY 2010, Delmarva Foundation's review revealed that all MCOs exceeded the BMS-established a performance threshold of 90% compliance for the four standard areas of review. Table 1-8 provides the MCO compliance rates by year by standard area of review.

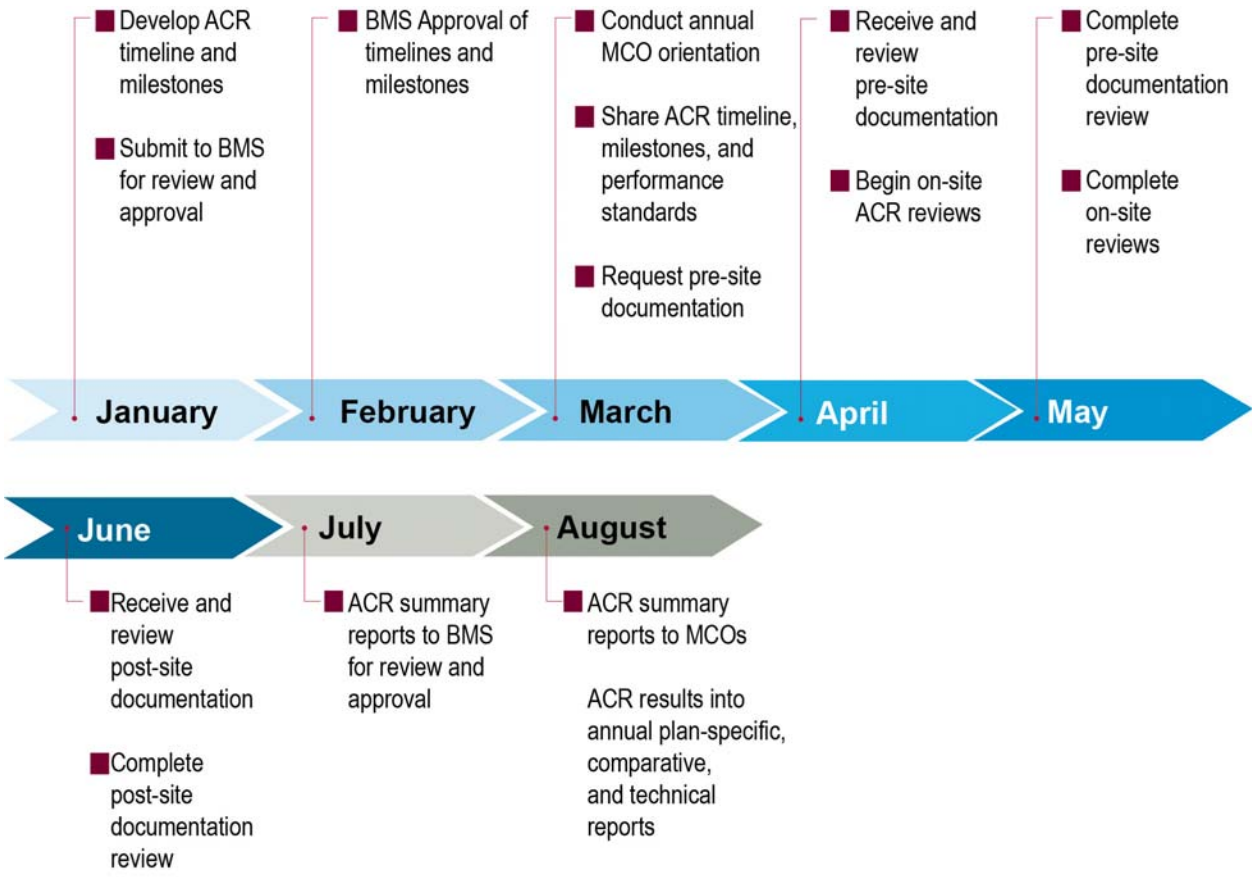
Table 1-8. MCO Compliance Rates for CY 2010 by Standard Area of Review

Standard	CY 2010 Compliance Rate		
Enrollee Rights (ER)	100%	100%	100%
Grievance Systems (GS)	100%	100%	100%
Quality Assessment and Performance Improvement (QA)	99%	99%	98%
Fraud and Abuse (FA)*	100%	96%	100%

*CY 2010 is the first year for compliance reporting on the fraud and abuse standard.

Delmarva Foundation's Project Manager will work with BMS to create a work plan and timeline for the Annual Compliance Review activities. Figure 1-5 defines the ACR activities as outlined in the work plan.

Figure 1-5. ACR Activity Timeline



Deliverables

Delmarva Foundation will provide MCO Specific ACR Summary Reports to BMS by August of each contract year. The purpose of the ACR Summary Report is to provide the MCOs with timely feedback. The results of the ACR activity are reported in the Annual Plan Specific Reports, MCO Comparative Reports and Detailed Technical Report which, because of timing of activities, are delivered later in the year.

In order to provide timely feedback to the MCOs on their performance, Delmarva Foundation will provide each MCO with an ACR Summary Report. This report will include findings related to the performance standards (e.g. Enrollee Rights, Grievances and Appeal). This summary will display compliance with, and hold MCOs accountable for, operational standards that impact quality, timeliness, and accessibility of healthcare services provided to MHT enrollees. The Summary Report will include a request for Corrective Action Plans in areas where the MCO does not meet the performance targets established by BMS. Draft reports, using approved templates, will be submitted to BMS for review and approval. We will construct the final ACR Summary Reports from templates approved by BMS. The schedule for ACR-related deliverables is presented in Table 1-9.

Table 1-9. ACR-Related Deliverables

Deliverable	Submission Date
Approval of Final Work Plan by BMS	**Annually**
Criteria/standards and guidelines	**January**
ACR protocol detailing audit activities	**January**
ACR timeline	**January**
Report templates for approval	**May**
ACR Summary Reports	**August**
Draft Findings in the Annual Plan-Specific Report, Comparative Report and Detailed Technical Report to BMS for Review and Approval	**November**
Final Reports to BMS and MCOs	**December**

The second portion of the Integrated Work Plan is the Proposed Detailed Timeline. This timeline includes all major activities and other tasks in this proposal to include monitoring regulations, reviewing activities unique to the MHT program, administrative tasks and training and technical assistance. **This draft timeline will be provided to BMS within 30 calendar days from the date of the contract award and must be approved by BMS prior to beginning EQR activities.**

In this detailed timeline, included as Table 1-10., we assume a start date of 4/1/12 so as not to interrupt services to BMS. Several tasks for the calendar year 2011 review have already been completed and are noted as such in the Work Plan.

Table1-10. Proposed Detailed Timeline

High Level Deliverables & Services	Start Date	End Date	Staff Title
Validate Project Improvement Projects			
• Develop PIP Timeline and Milestone Dates	2012-Ready for Approval 1/1/13 1/1/14 1/1/15	2012-Ready for Approval 1/31/13 1/31/14 1/31/15	• Project Director (Project Manager) • Project Manager • Admin. Assistant • Database Analyst • Director of Data Management • Medical Director • Technical Writer/Editor
• PIP Milestones Approved by BMS	2/1/12 2/1/13 2/1/14 2/1/15	2/28/12 2/28/13 2/28/14 2/28/15	
• Conduct Annual Orientation and Update for BMS and MCOs-share PIP Timeline	3/26/12 3/1/13	3/26/12 3/31/13	

High Level Deliverables & Services	Start Date	End Date	Staff Title
with MCOs	3/1/14 3/1/15	3/31/14 3/31/15	
• Revise/Update PIP Tools and Report Templates and Submit to BMS for Review and Approval	5/1/12 5/1/13 5/1/14 5/1/15	5/7/12 5/7/13 5/7/14 5/7/15	
• BMS Approves Tools and Report Templates	5/8/12 5/8/13 5/8/14 5/8/15	5/14/12 5/14/13 5/14/14 5/14/15	
• Receive PIP Submissions from MCOs	7/15/12 7/15/13 7/15/14 7/15/15	7/15/12 7/15/13 7/15/14 7/15/15	
• Complete 10 Step Review and Validation	7/16/12 7/16/13 7/16/14 7/16/15	7/31/12 7/31/13 7/31/14 7/31/15	
• PIP Validations Completed and Summary Reports Prepared	8/1/12 8/1/13 8/1/14 8/1/15	8/15/12 8/15/13 8/15/14 8/15/15	
• PIP Summary Reports Submitted to BMS for Review and Approval	8/15/12 8/15/13 8/15/14 8/15/15	9/1/12 9/1/13 9/1/14 9/1/15	

High Level Deliverables & Services	Start Date	End Date	Staff Title
• Process Individual MCO Final PIP Results - Incorporate Results into the Annual Plan Specific Reports , MCO Comparative Report and Annual Technical Report	9/1/12 9/1/13 9/1/14 9/1/15	9/31/12 9/31/13 9/31/14 9/31/15	
• PIP Summary Reports Distributed to BMS and MCOs	9/1/12 9/1/13 9/1/14 9/1/15	9/31/12 9/31/13 9/31/14 9/31/15	
Validate Performance Measures			
• Approval of Final Work Plan by BMS	Annually	Annually	• Project Director (Project Manager) • Sr. Health Analyst • Jr. Analyst • Admin. Assistant • Subcontractor-Metastar, Inc. • Technical Writer/Editor
• Confirm Required Measures and Specifications with BMS	Completed 10/11/12 10/1/12 10/1/13 10/1/14	Completed 10/11/12 10/31/12 10/31/13 10/31/14	
• Provide Required Measures and Specifications to MCOs	11/1/12 11/1/13 11/1/14 11/1/15	11/31/12 11/31/13 11/31/14 11/31/15	
• Develop PMV Timeline and Milestones and	2012-Ready for Approval 1/1/13 1/1/14 1/1/15	2012-Ready for Approval 1/31/13 1/31/14 1/31/15	
• Metastar Validates CAHPS® Sample Frame	1/15/12 1/15/13 1/15/14 1/15/15	2/28/12 2/28/13 2/28/14 2/28/15	
• Auditors Receive and Review HEDIS® Roadmap	2/1/12	2/28/12	

High Level Deliverables & Services	Start Date	End Date	Staff Title
	2/1/13 2/1/14 2/1/15	2/28/13 2/28/14 2/28/15	
• PMV Milestones Approved by BMS	2/1/12 2/1/13 2/1/14 2/1/15	2/28/12 2/28/13 2/28/14 2/28/15	
• Auditors Receive Software Vendor's Final Certification Reports	3/1/12 3/1/13 3/1/14 3/1/15	3/1/12 3/1/13 3/1/14 3/1/15	
• Auditor Selects a Core Set of Measures (for non-certified code)	3/1/12 3/1/13 3/1/14 3/1/15	3/15/12 3/15/13 3/15/14 3/15/15	
• On-Site Visits Completed	3/1/12 3/1/13 3/1/14 3/1/15	4/30/12 4/30/13 4/30/14 4/30/15	
• Preliminary Measure Rate Review	4/15/12 4/15/13 4/15/14 4/15/15	5/15/12 5/15/13 5/15/14 5/15/15	
• Final Statistical Validation of Medical Record Review	4/15/12 4/15/13 4/15/14 4/15/15	5/15/12 5/15/13 5/15/14 5/15/15	

High Level Deliverables & Services	Start Date	End Date	Staff Title
• Revise/Update PMV Tools and Report Templates and Submit to BMS for Review and Approval	5/1/12 5/1/13 5/1/14 5/1/15	5/15/12 5/15/13 5/15/14 5/15/15	
• Final Rate Review Completed and Auditor Locks Results	6/1/12 6/1/13 6/1/14 6/1/15	6/8/12 6/8/13 6/8/14 6/8/15	
• Validated Results Submitted to NCQA	6/15/12 6/15/13 6/15/14 6/15/15	6/15/12 6/15/13 6/15/14 6/15/15	
• Final Audit Reports from Metastar, Inc. to NCQA and Delmarva Foundation	6/15/12 6/15/13 6/15/14 6/15/14	7/16/12 7/16/13 7/16/14 7/16/15	
• Begin PMV analysis and Calculate MHT Averages	8/1/12 8/1/13 8/1/14 8/1/15	8/31/12 8/31/13 8/31/14 8/31/15	
• Provide MCOs and BMS with Measure Rates	9/1/12 9/1/13 9/1/14 9/1/15	9/15/12 9/15/13 9/15/14 9/15/15	
• Benchmark Data Received from Quality Compass	9/15/12 9/15/13 9/15/14	9/30/12 9/30/13 9/30/14 9/30/15	

High Level Deliverables & Services	Start Date	End Date	Staff Title
	9/15/15		
• Process Individual MCO Final PMV Results - Incorporate Results into the Annual Plan Specific Reports , MCO • Comparative Report and Annual Technical Report	9/15/12 9/15/13 9/15/14 9/15/15	10/31/12 10/31/13 10/31/14 10/31/15	
Conduct Annual Compliance Review			
• Revise/ Update Performance Standards, Tools , and Templates and submit to BMS for Approval	1/1/12 1/1/13 1/1/14 1/1/15	1/31/12 1/31/13 1/31/14 1/31/15	• Project Director (Project Manager) • Project Manager • Admin. Assistant • VP Operations • Database Analyst • Director of Data Management • Technical Writer/Editor
• ACR Timelines and Milestones Approved by BMS	2/1/12 2/1/13 2/1/14 2/1/15	2/28/12 2/28/13 2/28/14 2/28/15	
• Conduct Annual Orientation and Update for BMS and MCOs-Request Pre-Site Documentation	3/1/12 3/1/13 3/1/14 3/1/15	3/26/12 3/31/13 3/31/14 3/31/15	
• Receive Pre-Site Documentation	4/1/12 3/1/13 3/1/14 3/1/15	4/30/12 4/1/13 4/1/14 4/1/15	

High Level Deliverables & Services	Start Date	End Date	Staff Title
• Evaluate Pre-Site Documentation and Enter Results into Database	5/1/12 4/1/13 4/1/14 4/1/15	5/31/12 4/30/13 4/30/14 4/30/15	
• Conduct On-Site Reviews	5/1/12 4/1/13 4/1/14 4/1/15	5/30/13 5/30/13 5/30/14 5/30/15	
• Receive and Evaluate Post On-site Information	5/30/12 4/30/13 4/30/14 4/30/15	7/15/12 6/15/13 6/15/14 6/15/15	
• Complete Review of Pre-site and Post-site Documentation and Data Entry of Results	5/30/12 4/30/13 4/30/14 4/30/15	7/15/12 7/15/13 7/15/14 7/15/15	
• Summary Reports for MCOs Prepared and submitted to BMS for Review and Approval	7/15/12 7/15/13 7/15/14 7/15/15	8/15/12 8/15/13 8/15/14 8/15/15	
• Summary Reports Distributed to MCOs	8/15/12 8/15/13 8/15/14 8/15/15	8/31/12 8/31/13 8/31/14 8/31/15	

High Level Deliverables & Services	Start Date	End Date	Staff Title
• Process Individual MCO Final Annual Compliance Review Results - Incorporate Results into the Annual Plan Specific Reports , MCO Comparative Report and Annual Technical Report	8/15/12 8/15/13 8/15/14 8/14/15	9/15/12 9/15/13 9/15/14 9/15/15	
Monitor Regulations			
• Monitor Medicare and Private Standards such as URAC and NCQA	1/1/12 1/1/13 1/1/14 1/1/15	11/31/12 12/31/13 12/31/14 12/31/15	• Project Director (Project Manager) • Sr. VP
• Revise/Update Report Templates and Submit to BMS for Review and Approval	5/1/12 5/1/13 5/1/14 5/1/15	5/7/12 5/7/13 5/7/14 5/7/15	• Project Director (Project Manager) • Project Manager • Sr. Health Analyst • Jr. Analyst • Admin. Assistant • Technical Writer/Editor
• BMS Approval of Reporting Templates	6/1/12 6/1/13 6/1/14 6/1/15	6/30/12 6/30/13 6/30/14 6/30/15	
• Process Individual MCO Final Annual Compliance Review Results - Incorporate Results into the Annual Plan Specific Reports, MCO Comparative Report and Annual Technical Report	8/15/12 8/15/13 8/15/14 8/14/15	9/15/12 9/15/13 9/15/14 9/15/15	
• Process Individual MCO Final PIP Results - Incorporate Results into the Annual Plan Specific Reports , MCO Comparative Report and Annual Technical Report	9/1/12 9/1/13 9/1/14 9/1/15	9/31/12 9/31/13 9/31/14 9/31/15	
• Process Individual MCO Final PMV Results - Incorporate Results into the	10/1/12 10/1/13	10/31/12 10/31/13 10/31/14	

High Level Deliverables & Services	Start Date	End Date	Staff Title
Annual Plan Specific Reports , MCO Comparative Report and Annual Technical Report	10/1/14 10/1/15	10/31/15	
• Complete Executive Summaries and Analysis According to Quality Access and Timeliness • Compile Draft Reports	9/15/12 9/15/13 9/15/14 9/1515	11/15/12 11/15/13 11/15/14 11/15/15	
• Draft Reports to BMS	11/15/12 11/15/13 11/15/14 11/15/15	11/15/12 11/15/13 11/15/14 11/15/15	
• Review and Approval of Draft Reports	12/15/12 12/15/13 12/15/14 12/15/15	12/15/12 12/15/13 12/15/14 12/15/15	
• Final Reports Delivered to BMS and MCOs	12/15/12 12/15/13 12/15/14 12/15/15	12/15/12 12/15/13 12/15/14 12/15/15	
Review MCO Activities Unique to the MHT Program			
• Unique Activity Identified	TBD	TBD	• Project Director (Project Manager) • Project Manager • Sr. Health Analyst • Jr. Analyst • Admin. Assistant • VP Operations • Sr. VP • Database Analyst Director of Data
• Develop Standards and Criteria for Review	TBD	TBD	
• Incorporate Review Activities into Annual Compliance Review	TBD	TBD	
Administrative Tasks			
• Quarterly Status Reports to BMS	1/15/12 4/15/12	1/15/12 4/15/12	• Project Director (Project Manager)

High Level Deliverables & Services	Start Date	End Date	Staff Title
	7/15/1210/15/12	7/15/12 10/15/12	
• Quarterly Task Force Meetings	Quarterly 2012 Quarterly 2013 Quarterly 2014 Quarterly 2015		• Project Director (Project Manager)
Training and Technical Assistance			
• Technical Assistance	Ongoing	Ongoing	• Project Director (Project Manager) • Project Manager • Sr. Health Analyst • VP Operations • Other as needed

Communication

A key component of contract management is effectively communicating with all customers, providers/partners, stakeholders, staff, and subcontractors. Effective communications are strategic, clear and concise, and delivered through appropriate channels. They allow for real-time assessment of customer satisfaction.

The project manager serves as the point of contact for BMS. All contract communications regarding the contract will be initiated by the project manager. The project manager is responsible for managing the work plan and routinely communicating with BMS regarding the status of tasks and subtasks. Project management scheduling software, Microsoft® Project, is used to track the status of all EQR tasks.

To manage the project tasks successfully, the project manager convenes a weekly project team meeting to review the work plan and the status of tasks and subtasks. This internal meeting provides an opportunity for the project manager to discuss barriers to task completion, identify solutions, and request additional internal resources, and so forth. Additionally, on a monthly basis, the Delmarva Foundation project team participates in the monthly update calls hosted by The Lewin Group. This meeting agenda includes a monthly review of project and contract deliverables, updates from BMS, Delmarva Foundation and The Lewin Group on any issues that may impact our work. The project manager is responsible for overseeing communications throughout the project life cycle and updating the project work plan as needed.

The project manager will also attend all MCO quarterly task force meetings in person as hosted by BMS. Historically, Delmarva Foundation has presented on topics of interest to the members of this group. Quarterly Progress Reports will continue to be provided to BMS by the 15th calendar day following the close of each quarter.

Delmarva Foundation will employ a variety of communication techniques—both formal and informal—demonstrating our commitment to the highest levels of customer service and transparency. The variety of communication channels available between the Department and Delmarva Foundation are outlined in Table 1-11.

Table 1-11. Communication Channels

Communication Channel	Description
BMS' Secure Web-Based Portal Site	BMS already has a landing page for all EQR tasks, deliverables, links to key quality and utilization sites, benchmark data and reports. This site is intended as a communication pathway for deliverables in production, as well as a repository for all accepted deliverables and quarterly status reports.
Quarterly Task Force Meetings	A more formal communication channel, the Quarterly Task Force Meetings are essential for fostering collegial and collaborative relationships for stakeholders. BMS sets the agenda with presentations and discussions on topics relevant to the MHT program.
Quarterly Status Reports	Quarterly status reports are provided to BMS and include information on the quarter's EQR activities, status of deliverables, issues related to project management and the work plan, and planning for the next quarter's EQR activities.
Teleconferences and Email	The Project Manager will be immediately available Monday through Friday 8:00 am and 5:00 pm Eastern Standard Time. This informal communication pathway provides BMS and the MCOs with the assurance of ongoing technical support, provides answers to questions promptly, and is a mechanism to identify potential issues of concern in order to resolve the problem promptly.

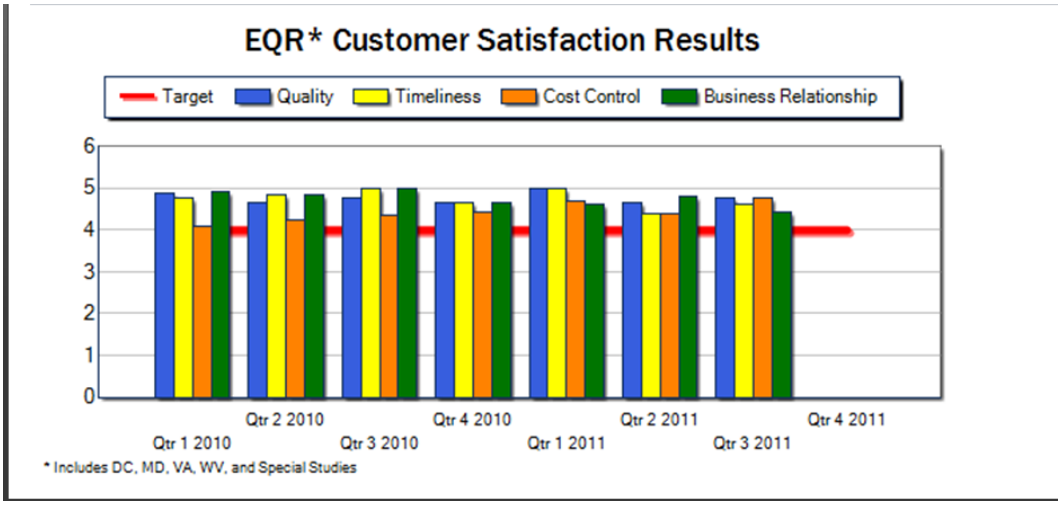
Project Management Methodology and Techniques

Clearly defined tasks, resources, and deliverables are essential for successful project and time management. Delmarva Foundation's project manager will manage the work plan and routinely communicate with BMS on the status of tasks and subtasks, using Microsoft® Project to report the status of all EQR tasks to BMS on a quarterly basis. As a monitoring tool, the work plan allows the project manager to take early action and redirect resources if the schedule starts to slip. Moreover, it is a constant guardrail supporting the team's efforts in staying focused on the project priorities.

Quality Management System

Integral to our project approach and our management plan is our Quality Management System. Delmarva Foundation utilizes its corporate Quality Management System (QMS), to help meet specific contract requirements and to ensure customer satisfaction. We encourage all of our customers to complete our quarterly customer satisfaction summary. Results are summarized and analyzed to identify opportunities for improvement. Based on a scale of 1 being very dissatisfied and 5 being very satisfied, our EQR team continues to receive highly and very highly satisfaction scores from its EQR clients as noted in Figure 1-6.

Figure 1-6. EQRO Quarterly Customer Satisfaction Results



Delmarva Foundation's QMS incorporates a secure, web-based system for project management, activity tracking, and performance measurement that blends detailed input and information with multi-level process measures, document libraries, and advanced reporting capabilities. The QMS delivers:

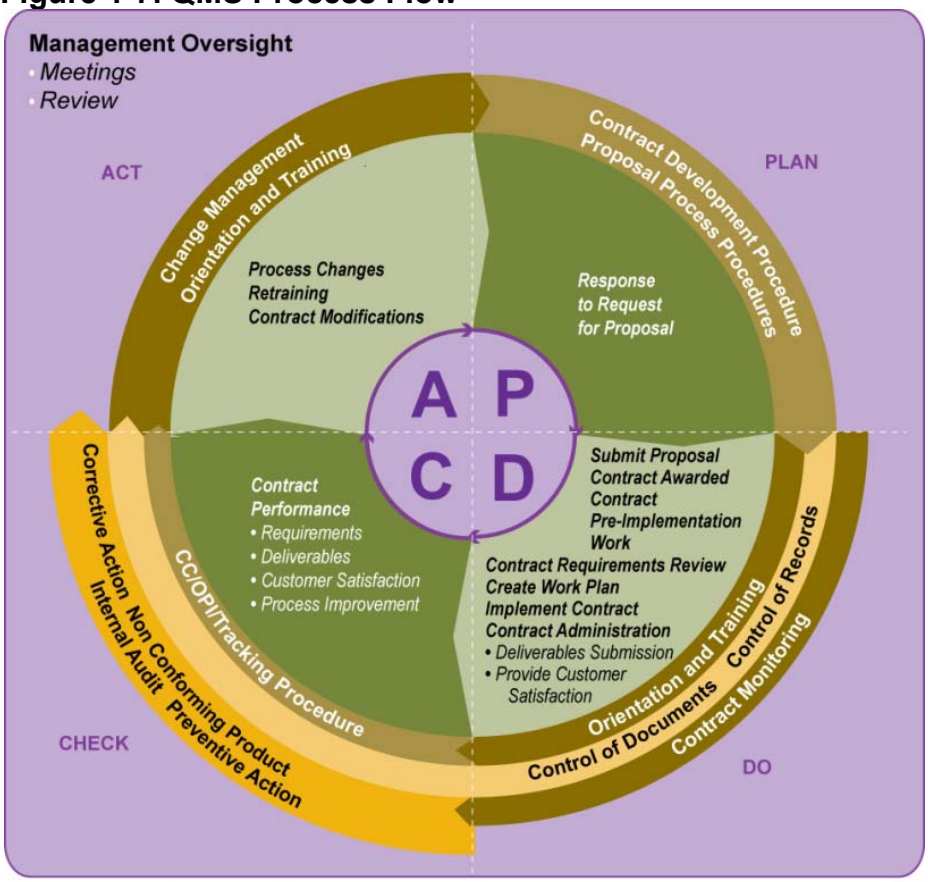
- Totally integrated performance management system that measures the overall contract performance, including all tasks and subtasks
- Customer satisfaction metrics and reporting
- Tracking and advanced notification of compliance with contract requirements ensuring timely, accurate, and complete reports and deliverables

As an ISO certified organization, Delmarva Foundation uses a process-driven approach to effectively manage EQR activities (Delmarva Foundation achieved ISO certification in July 2011). This process includes:

- A standardized methodology using the Plan-Do-Check-Act (PDCA) approach
- Measurement and monitoring to assure achievement of requirements
- Transparency and consistency in work processes and outputs
- Continuous improvement that fosters quality and improves efficiency

The process begins with the business proposal, contract award, and pre-implementation activities, which lead into full implementation. Figure 1-7. shows the integration of operations, procedures, and the PDCA approach.

Figure 1-7. QMS Process Flow



Through our QMS, we continually and concurrently monitor, evaluate, refine and improve performance, ensure integrity, and foster innovations in both contract-specific and internal processes. Some of the specific process measures applicable to this contract include communication/status reports, and timeliness of contract deliverables.

Project Management Plan and Control Mechanisms

Although the QMS is designed to prevent risks, on rare occasions there may be an error identified. Delmarva Foundation's QMS helps identify potential errors to mitigate their impact. Delmarva Foundation will notify BMS of any event, incident or error that would compromise the external quality review. Taking it one step further, in the event there are errors, Delmarva uses Root Cause Analysis to drill down to the foundation issue so that it can be properly corrected and eliminate the error from occurring again.

The project manager also uses QMS processes to measure performance, a proactive strategy that controls the process to ensure timely deliverables and milestones. Should a schedule appear to be in jeopardy, the project manager will direct the project team to:

- Implement risk analysis and identify/adopt risk mitigation strategies
- Identify the cause of the problem
- Determine potential impact and propose solutions

- Brief corporate management so they may coordinate with BMS' management and administration team
- Initiate and monitor corrective action
- Document the problem, corrective actions, and results
- Monitor process going forward to ensure corrective actions are effective (improvement sustained)

Should BMS desire any change in the EQR scope or approach, Delmarva Foundation will draw from its experience with MHT to adapt and implement the changes necessary to maximize project success and minimize risk due to our flexible planning system.

Section 2.4.2: The Vendor should propose a plan to validate and review PIPs as required by 42 CFR §438.358(b)(1). The Vendor should propose a plan to validate PIPs required by the State that were underway during the preceding twelve (12) months, to comply with requirements set forth in 42 CFR §438.240(b)(1). The plan should describe how the Vendor assess the study and methodology for conducting the PIPs, verify actual PIP study findings, evaluate overall validity and reliability of study results, and monitor performance indicators after completion of the PIP to ensure sustained improvements.

Vendor Response:

PIP Experience, Purpose, and Background
Delmarva Foundation currently conducts PIP validation for West Virginia, Virginia, Maryland, North Dakota, and the District of Columbia. Further we draw on experience from our national Medicare Advantage Quality Review Organization (MAQRO) contract with CMS. Under the scope of work, we completed hundreds of Quality Improvement Project (QIP) reviews, as well as Chronic Care Improvement Program (CCIP) reviews for Medicare Advantage Organizations across the United States. As one of only three Quality Improvement Organizations serving as a MAQRO, we developed tools and instructional guides for CMS and the Medicare Advantage Organizations (MAOs) across the United States. In addition to reviewing and validating the projects, we provided the MAOs with on-going support and technical assistance during project implementation and reporting.

Significant improvement has been demonstrated in MHT MCO Performance Improvement Projects (PIPs) through ongoing technical assistance by Delmarva Foundation: ***One MCO saw an improvement of more than 16 percentage points for the Comprehensive Diabetes Care Eye Exams indicator based on efforts made in its Diabetes PIP. Another MCO documented in its PIP a 15 percentage point improvement in its Childhood Immunizations rate.*** Delmarva Foundation aided the MCOs in these accomplishments by helping the MCOs better understand their barriers and identify interventions that result in change. These improvements, when sustained, can lead to a healthier MHT population. As West Virginia's EQRO, Delmarva Foundation provides quality, accurate assessments of MCO performance which includes recommendations that drive performance improvement and create healthier communities.

When conducted appropriately, PIPs can be effective, data-driven tools used by MCOs to facilitate process improvement. The resulting positive outcomes can enhance the quality of, access to, or timeliness of services provided to Medicaid beneficiaries.

Delmarva Foundation has had the privilege to continuously serve as the WV EQRO, and as a result, we have developed collaborative relationships with MCO staff. They feel comfortable contacting us at anytime to obtain technical assistance and direction. We are frequently contacted and asked for recommendations on indicator selection and best practices related to interventions. This interaction ensures that MCOs are on the right track before spending unnecessary time and resources on a project.

Delmarva Foundation's experience in West Virginia PIP review exceeds the statutory EQR Protocol requirement for completing annual validations. **We meet with MCO quality improvement staff during the annual compliance reviews and specifically discuss all PIPs in progress**. This provides an opportunity for the MCO to describe its successes and challenges, in detail. Discussions about these projects yield more information than what is submitted in a written report. **These face-to-face meetings allow us to provide specific feedback and recommendations, including additional opportunities for exploration with the aim of improving processes or health-related outcomes of MHT enrollees.** ***An example of a recommendation we provided during one of these face-to-face meetings is as follows:***

One of the MCOs shared its struggle with a pediatric-related project. Pediatricians were not open to changes in practice as demonstrated in the project results. Delmarva Foundation noted that a pediatrician was part of the MCO's quality improvement team for this particular project. Consequently, we strongly encouraged the MCO to take full advantage of this "project champion" and push for provider buy in based on recommendations coming from a peer, rather than MCO quality improvement staff. Providers are often more receptive to change when direction comes from a peer.

Delmarva Foundation will continue, without interruption to BMS or the MCOs, annual PIP review and validation using our internally developed, automated PIP tool that promotes efficiency and ensures accuracy of reported findings. The tool was developed with input from BMS and the MCOs, and is easy to modify as program needs or requirements change. We will validate at least two PIPs annually for each MCO. Currently, MCOs are working on emergency department utilization-related PIPs and other miscellaneous topics that have demonstrated a need for improvement, such as childhood obesity and asthma control. These projects are in the "re-measurement" phase of reporting. Delmarva Foundation has the knowledge and history required for these PIPs and is in the best position to offer technical assistance, and aid the MCOs in their efforts to sustain improved performance.

Delmarva Foundation's work with BMS and the MCOs led to the development and implementation of the emergency department collaborative. Initially our medical director

worked with the MCOs and provided each one a written report that highlighted their respective problem statements, measures, interventions, and recommendations. Subsequent to that, we worked with the MCOs to refine their indicators and associated study populations. While MCOs were in the development phase of the PIP, we held bimonthly conference calls to provide technical assistance. For example, we encouraged MCOs to break down their encounter data, including diagnoses, to identify diseases or conditions where they could most effectively concentrate their efforts. By doing this, the PIPs became more manageable and MCOs were better able to attribute successes to specific interventions. Delmarva Foundation's knowledge, history, and expertise in the MHT MCO program is needed to continue the quality improvement process for this project.

PIP Validation Methodology

Beyond the added value of having face-to-face meetings with the MCOs to discuss PIPs as previously described, we conduct PIP review and validation activities in accordance with 42 CFR §438.358(b)(1). Our PIP review is based upon the CMS protocol, *Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities.* Tables below document an overview of the 10-step approach that our multi-disciplinary PIP Team of quality improvement professionals and analytic staff follow. These 10 steps describe how we assess the MCO's study topics and methodology, verify PIP findings or results, gauge overall validity and reliability of results, and monitor performance through sustained improvement.

Step 1. Study Topic	
The **study topic** selected must be appropriate and relevant to the MCO's population.	Delmarva Foundation reviews the study topic/project rationale and looks for demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.

For new projects, we require MCOs to submit the PIP topic, rationale, and project indicators for review and approval prior to project implementation. Taking this extra step of project approval ensures that the MCO has identified an appropriate study topic and indicator(s) prior to the MCO devoting resources to the PIP. Further, based on our understanding of the nature of the WV population and the intricacies of obtaining certain data, such as immunization registry and pharmacy data, we are able to recommend PIP topics on areas that offer opportunity for evaluation and improvement.

Step 2. Study Question	
The **study question** must be clear, simple, and answerable.	Delmarva Foundation reviews the study question that addresses the topic and relates to the indicators. The study question guides the PIP.

The study question assists to define the aim of the project. It should reference the study population, activity, and expected outcome.

Step 3. Study Indicator(s)	
The **study indicator(s)** must be meaningful, clearly defined, and measurable.	Delmarva Foundation examines each project indicator to ensure appropriateness to the activity. The technical specifications described in the numerators/ denominators must be clearly and accurately defined. Additionally, we ensure that project goals are fitting as they serve to motivate process improvement.

MCOs often use HEDIS® indicators, which are acceptable, and often recommended. When an MCO develops its own indicator(s), we pay careful attention to ensure it is current with clinical standards, practices, and research.

Step 4. Study Population	
The **study population** must reflect all individuals to whom the study questions and indicators are relevant.	Delmarva Foundation examines the study population (targeted population) relevancy, which is provided in the project rationale and indicator statements.

The PIP should describe the individuals for which the topic and indicators are relevant and eligible.

Step 5. Sampling Method	
The **sampling method** must be valid and protect against bias.	Delmarva Foundation assesses the sampling techniques used to provide valid and reliable information. When the MCO studies the entire population, this step is not necessary. MCOs primarily use administrative data and skip this step.

If sampling is used to identify select members of the study, proper sampling techniques are required and must be documented. A review of the sample size and technique provides insight for this step. Delmarva Foundation and other stakeholders must have confidence in the results being reported; we require a 95% confidence level.

Step 6. Data Collection	
The **data collection procedures** must use a systematic method of collecting valid and reliable data.	Delmarva Foundation reviews the project data sources and collection methodologies, to ensure the entire study population is appropriately captured.

The PIP must clearly identify the data sources and methods of collecting data. The project is only meaningful if data collection is both valid and reliable. Largely, MCOs report administrative data (claims/encounter data).

Step 7. Improvement Strategies	
The **improvement strategies**, or interventions, must be reasonable and address barriers on a system-level.	Delmarva Foundation assesses each intervention to ensure that barriers are addressed. Interventions are expected to be multi-faceted and induce permanent change. Passive interventions, such as mass mailings, have minimal impact, and are generally seen as ineffective.

This is often the most challenging and resource-intensive element of the PIP for MCOs. However, it is also the most critical. Without effective interventions that drive changes in procedures or operation, PIPs will flounder and it will be a struggle to improve performance. EQRO recommendations are essential for this step. ***Delmarva Foundation was commended by an MHT MCO for providing actionable recommendations related to interventions that resulted in improvement.*** We understand that MCOs are constrained by limited resources, and we take that into consideration before making formal recommendations. We often remind the MCOs to perform an annual barrier analysis to identify any changes, including new barriers, and to implement very targeted and focused interventions based on the analysis findings. We have made recommendations to MCOs to complete provider profiling. This method of outreach is generally viewed as an effective means to gain provider attention by providing their performance rates compared to that of their peers'.

Step 8. Study Findings	
The **study findings**, or results, must be accurately and clearly stated.	Delmarva Foundation examines the project results, including the data analysis. There must be a comprehensive quantitative and qualitative analysis for each project indicator.

Study findings must be accurately and clearly stated, and include quantitative as well as qualitative analysis. Quantitative analysis should include current performance compared to the baseline and the previous measurement, and assess performance against indicator goals, as well as benchmarks. Statistical significance should also be identified. The qualitative analysis should focus more on the project's success and identify successful and unsuccessful interventions. The barrier analysis should be comprehensive and identify opportunities. **We often encourage MCOs to spend more time on this step, as it is imperative for them to understand their current performance and how they achieved it. Most importantly, an MCO needs to identify future opportunities and its next steps. Our experience indicates that MCOs that complete these steps are more successful in achieving and sustaining improvement.**

Step 9. Real Improvement	
Project results must demonstrate **real improvement**.	Delmarva Foundation assesses performance improvement and ensures the same methodology is repeated. Improvement should be linked to interventions, as opposed to an unrelated occurrence. Results of statistical testing are reviewed.

Not only are MCOs expected to report improvement, but the improvement must have face validity. In other words, Delmarva Foundation assesses whether the improvement correlates to intervention activities or is a result of random occurrences. Improved performance results from strong, system-level interventions. We stress this in our feedback and recommendations to the MCO. Additionally, results must be based on the same data collection methodologies and specifications as the previous year's results in order to ensure comparability.

Step 10. Sustained Improvement	
Sustained improvement must be demonstrated through repeated measurements.	Delmarva Foundation assesses this step after the second re-measurement has been reported. Results are compared to baseline to confirm consistent and sustained improvement.

PIPs should demonstrate sustained improvement. At this time, best practices and lessons learned should be spread to other performance improvement initiatives. ***For the 2011 PIP review, Delmarva Foundation assessed this final step in four PIPs. In three of the four PIPs, the MCOs were able to sustain improvement in their projects which speaks to the positive outcomes and impact on the MHT Medicaid beneficiaries. Our recommendations pressed MCOs to initiate more robust interventions that aided in this sustained improvement.***

Long after PIPs are "closed" performance is still monitored through performance measure validation activities. The performance measure results are reported annually and Delmarva Foundation also provides trending data and comparisons with benchmarks, including the MHT weighted average, the HEDIS® Medicaid Average, and the HEDIS® Medicaid 90th Percentile.

PIP Scoring
Delmarva Foundation's PIP validation form contains a series of questions corresponding to each of the steps referenced above. Each question, and ultimately each step, is assessed as "Met," "Partially Met," or "Unmet." Assessments for each step include comments and where appropriate, reasonable and actionable recommendations.

At the conclusion of a PIP review, the project is scored as "PIP meets requirements," "meets requirements with recommendations," "requires revisions; resubmission required," or "does not meet requirements." Historically, this system has worked well to meet the needs of BMS and the MCOs. Alternatively, if BMS chooses, Delmarva Foundation can numerically score the project submissions. Validation scoring of 90-100% yields "high confidence;" 75-89% yields "confidence;" 60-74% yields "low confidence;" and 0-59% yields results that are "not credible."

In addition to providing final results, validations also include a project summary that includes:

- Strengths
- Barriers
- Most notable interventions
- Actionable recommendations

An example of performance improvement based on direct technical assistance from Delmarva Foundation is as follows:

Delmarva Foundation recommended increasing the frequency of data collection and analysis for an MCO's Asthma PIP. By increasing the measurement frequency from annually to quarterly, it enabled the MCO to identify performance changes and attribute the changes to specific interventions. The MCO recognized successful interventions more quickly, and decreased asthma-related emergency department visits by 29% from 605 per 1000 members to 428 per 1000 members.

Section 2.4.3: The Vendor should propose a plan to validate performance measures as required by 42 CFR §438.358(b)(2). The Vendor should propose a plan to validate MCO performance measures reported (as required by the State) or MCO performance measure calculated by the State during the preceding twelve (12) months to comply with requirements set forth in 42 CFR §438.240(b)(2). The plan should describe how the Vendor develops an understanding of State requirements, prepare the MCOs for onsite activities, conduct an assessment or reviewing the results of a prior assessment of the MCOs' information systems, review and assess the MCOs' procedures for collecting and integrating data, evaluate MCO processes to produce performance measures, evaluate the MCOs' processes for State reporting, produce required reports for the State, and conduct any necessary follow-up with the MCOs.

Vendor Response:

Delmarva Foundation will validate performance measures submitted by the three MHT MCOs to BMS for accuracy and reliability.

To give purchasers, state agencies, and consumer's confidence in the accuracy of a health care organization's HEDIS® data, the NCQA developed the HEDIS® Compliance Audit™. The HEDIS® audit assesses an organization's information systems characteristics and capabilities, and compliance with HEDIS® specifications for individual measures. The HEDIS® Compliance Audit ™ methodology is compliant with the Centers for Medicare and Medicaid protocol, *Validating Performance Measures, A Protocol for use in Conducting Medicaid External Quality Review Activities, May 1, 2002*.

As a National Committee for Quality Assurance (NCQA) HEDIS® Licensed Organization (LO), MetaStar, Inc. will conduct all performance measure validation audit activities and Delmarva Foundation will manage this task to ensure that contract deliverables are completed accurately and timely. **Since 2006, Delmarva Foundation and our audit partner, MetaStar, Inc., have assured reliable performance measure rates were reported to BMS. MetaStar, Inc. has HEDIS® experience auditing 77 plans in over twenty-six states, and has previously partnered with Delmarva Foundation in California and DC.**

MetaStar, Inc. will conduct all parts of the HEDIS® audit. They will provide the lead auditor and technical staff to conduct off-site source code review and medical record review. Their staff for the project will include the Audit Practice Lead, Lead Auditor, source code reviewers and nurse reviewers. Delmarva Foundation's CHCAs will serve as secondary auditors.

The audit team will conduct all audit and validation activities as prescribed by NCQA's *HEDIS® Compliance Audit™: Standards, Policies and Procedures*. The audit process is divided into three phases:

- audit preparation or pre-site phase,
- on-site visit, and
- post-site and reporting activities.

During the three audit phases, auditors focus on a number of performance areas—including information practices and control procedures, sampling methods, data integrity, and analytic file production, algorithmic compliance with measurement specifications, reporting, and documentation.

The pre-site activities are critical to ensure that all participants in the process are informed of their roles and responsibilities during the process. The critical activities are found in Table 1-12.

Table 1-12. Pre-Site Visit Activities

1.	Determine and confirm measures and specifications to be audited
2.	Review any prior audit data as provided

3.	Discuss any key area(s) of concern identified by the auditors or MCO staff
4.	Assign a lead auditor
5.	Provide the HEDIS® Roadmap for completion
6.	Select audit dates
7.	Certify **Consumer Assessment of Healthcare Providers and Systems** (CAHPS®) sample frames (as required)
8.	Review completed HEDIS® Roadmap
9.	Finalize composition of audit team
10.	Request source code for measures outside of any NCQA-Certified Software
11.	Develop agenda for on-site audit
12.	Review vendor operations and processes
13.	Conduct pre-site visit conference call to discuss outstanding issues

Determining Measures and Specifications for Audit

The audit team's first task is to determine and confirm the measures and specifications to be audited. This will be done in conjunction with BMS, taking into consideration the state's priorities and areas of concern. Historically, Delmarva Foundation has validated over 30 HEDIS® measures for BMS annually. The following is a partial list of those measures:

- Adult Body Mass Index (BMI) Assessment
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- Cholesterol Management
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- Adults' Access to Preventive/Ambulatory Health Services
- Children's and Adolescents' Access to Primary Care Practitioners
- Prenatal and Postpartum Care
- Call Answer Timeliness
- Call Abandonment
- Frequency of Ongoing Prenatal Care
- Well-Child Visits
- Adolescent Well-Care Visits

- Board Certification

Because we understand BMS' priorities, Delmarva Foundation can recommend a subset of the HEDIS® measures for validation. As a recent example, Delmarva Foundation worked with BMS to assure MCOs received the necessary pharmacy data to calculate the "Appropriate Use of Medications for People with Asthma." A special request had to be coordinated with the pharmacy contractor, Molina. All three plans were successful in providing reliable rates for the asthma measure. Building on that success, Delmarva Foundation has requested that the MCOs calculate more respiratory measures using pharmacy data for the upcoming HEDIS® season.

Validation of the HEDIS® measures will assure BMS that the selected measures are reliable and accurate. Once the measures have been selected, the audit team will send an introductory letter to each MCO outlining the measures, timelines, and procedures for the HEDIS® reporting period.

HEDIS® Roadmap
Another key audit activity is completion of the HEDIS® Roadmap by the MCO staff. The HEDIS® Roadmap is a standardized, comprehensive instrument designed by NCQA to collect information from the MCO on its structure, information collection, and processing (e.g., claims/encounter processing, medical record review processes, membership data processes, provider data processes) and HEDIS® reporting procedures (e.g., measure programming, determinations, reporting functions). Accurate, and timely completion of this document will help the auditors focus their questions and document review during the on-site audit. The HEDIS® Roadmap is submitted to MetaStar, Inc. by each MCO four to six weeks prior to the on-site visit, allowing the audit team ample time to review and formulate questions for the on-site review.

Synthesizing Pre-Site Information
Communication with the MCOs during the pre-site period is essential. Ongoing dialogue between the auditors and the MCO staff to review documentation provided in the HEDIS® Roadmap prepares the audit team for the on-site visit, and helps the organization prepare for both medical record review and measure production. Key activities of the Roadmap review are:

- Review provider mapping into the certified software product
- Examine chase logic for medical record review and offer suggestions
- Examine receipt of data from vendors (e.g., lab data) and impact on measures
- Review and mapping supplemental databases
- Review mapping of benefit designations to members
- Review and approve supplemental databases for use in producing measures
- Prepare questions for on-site review based on review of all information provided by MCO

The final pre-site activity occurs approximately two weeks prior to the on-site visit. The audit team will conduct a conference call with the MCOs to review the on-site agenda, resolve any

outstanding issues, ensure the availability of staff and requested documentation, and to answer any questions the MCO or Delmarva Foundation and MetaStar, Inc. may have prior to the on-site audit.

On-Site Activities

On-site activities focus on collecting additional information to assess each MCO's compliance with NCQA's Information Systems (IS) standards and HEDIS® Measure Determination (HD) standards. The IS standards are used to assess how the MCOs collect, store, analyze, and report their data, while the HD standards are used to assess their adherence to the HEDIS® technical specifications. These standards are the foundation upon which the CHCAs will base the MCOs' ability to report HEDIS® data accurately and reliably.

IS Standards Capabilities Assessment

The IS assessment determines what effects the IS practices have on the HEDIS® reporting process. The audit evaluates the overall effectiveness of the organization's management information systems and also focuses on the impact the organization's IS has on accurately reporting HEDIS® results. The auditor determines whether the organization's automated systems, information management practices, and data control procedures ensure that all information required for HEDIS® reporting is adequately captured, translated, stored, analyzed, and reported. We will assess seven major IS standards capabilities, presented in Table 1-13, each MCO.

Table 1-13. IS Standards

Standard	Description	Evaluates
1.0	Medical Services Data	Coding methods and data capture, transfer, and entry
2.0	Enrollment Data	Data capture, transfer, and entry
3.0	Practitioner Data	Data capture, transfer, and entry
4.0	Medical Record Review Processes	Training, sampling, abstraction, and oversight
5.0	Supplemental Data	Capture, transfer, and entry
6.0	Member Call Center Data	Capture, transfer, and entry
7.0	Data Integration	Accurate HEDIS® reporting and control procedures that support HEDIS® reporting integrity

The methodology for assessing IS compliance consists of the following:

- Interviews with key organization representatives responsible for operations or departments supplying data used in HEDIS® reporting.
- Review of documentation relevant to the information system domains and, as needed, view a demonstration of specific procedures.
- Analysis of documentation describing the operation of computer systems and computerized files via text, code, and flow charts.
- Observation of operations which include those areas that use the information system resources while preparing data for the HEDIS® report.
- Verification that file contents are accurate.

- Review oversight actions by the organization for all data received and transmitted.
- Confirmation of data integration from the medical record review data abstraction process.

HD Standards

The purpose of the HEDIS® measure determination audit component is to assess whether the processes used to produce each HEDIS® measure are compliant with individual HEDIS® measure specifications and the measures are "reportable." The five standards and a description of each are presented in Table 1-14.

Table 1-14. HD Standards

Standard	Description	Evaluates
1.0	Denominator Identification	Processes for correctly categorizing member and service events into member subgroups
2.0	Sampling	Sampling selections, sample sizes, and procedures for correcting faulty samples
3.0	Numerator Identification	Whether claims, encounter, membership, practitioner, and vendor data are analyzed properly for numerator qualification
4.0	Algorithmic Compliance	Whether rate calculations are arithmetically correct and precise, administrative and medical record data are incorporated correctly, and rates are accurately entered into data submission tool
5.0	Outsourced or Delegated HEDIS® Reporting Function	Coordination of software vendor activities, monitoring of software vendors, and whether vendors meet all applicable HEDIS® Compliance Audit standards

To assess these areas, the auditors may:

- Review the computer programs, identify numerators, and calculate rates
- Run programs against test data where the outcome is predetermined
- Examine files pertaining to specific measures
- Evaluate medical record review tools, training, and processes
- Determine accuracy of continuous enrollment criteria by measure

Closing Conference

At the conclusion of the on-site visit, the audit team will conduct a closing conference, providing the MCO with an issue log of items that need to be addressed prior to reporting the final rates. (e.g., areas requiring follow-up action, potential problems noted, measures in jeopardy of being non-reportable based on findings).

Post -Site Activities to Validate HEDIS® Performance Measures

The post-site activities commence with the audit team collating its findings. Within 10 working days of the on-site visit, the team prepares an initial report for the MCO that:

- Details any outstanding issues
- Lists any materials/documentation not yet received
- Assesses whether specific data requirements are met for each measure tested

- Lists all problem areas that require follow-up action before the Final Audit Report (FAR) is issued
- Identifies potential problems with measure rate integrity
- Notes any measures which, based on current findings to that point, would not be reportable should no further action be taken to correct identified deficiencies

The audit team works closely with each MCO during this process, providing technical assistance as needed. It will coordinate and document corrective actions and reporting according to the HEDIS® Compliance Audit™ methodology and may include additional questions about an organization's software, programming, manual processing, data input and output, and the effect of significant events (e.g., system conversion).

Validation of Source Code
Source code validation is the manual or automated process of examining original programming to verify that source code programming is accurate, complete, and complies with measure specifications. For MCOs such as Carelink and Unicare, which use certified HEDIS® software, the auditor will evaluate the vendor's Certification Report and determine the need for further manual source code review. The auditor may review source code on-site or off-site.

Validation of Medical Record Data
An additional off-site audit component is validating medical records. This Medical Record Review (MRR) validation is performed if the hybrid methodology is used by the MCO for any of the applicable HEDIS® measures. A nurse reviewer (RN) reviews completed charts in which a numerator positive event was found in order to verify the accuracy of the organization's findings. Depending on the organization's scheduling of MRR, the auditors may conduct the medical record review during the on-site visit**.** Historically, the three MHT MCOs have succeeded in meeting their Inner Rater Reliability (IRR) rate of 95% or higher.

Final Validation of Measures and Reporting
Auditors will review and validate the performance measures in the organization's Interactive Data Submission System (IDSS) file submit HEDIS® results to NCQA and an excel workbook designed by Delmarva Foundation for reporting to BMS. The audit team prepares the Final Audit Report (FAR) or validation report as required. In addition to the FAR, a statewide MCO aggregate report will also be created that includes the following components:

- MCO specific rates for each measure
- Statewide aggregate rates for each measure
- HEDIS® benchmarking data when available
- Trending data and analysis
- Comparative analysis
- Strengths
- Conclusions and recommendations

All individual and statewide MCO reports will be reviewed and approved by BMS prior to releasing the final reports. The MHT MCOs have realized sustained improvement for two measures over the past few years; namely; *Immunization for Adolescents* and *Child and Adolescents' Access to Primary Care Practitioners (PCP) age 7-11 measures.*

Section 2.4.4: The Vendor should propose a plan to conduct an annual compliance review as required by 42 CFR §438.358(b)(3) and determine the MCOs' compliance with the standards established by the State to comply with the requirements of 42 West Virginia Department of Health and Human Resources The Bureau for Medical Services BMS Request for Proposal MED120096 CFR §438.204(g), as well as other components of the MHT MCO contract. The plan should address how the Vendor identifies areas to review, in accordance with Federal and State requirements, obtain background information, review documents, conduct interviews, collect any other necessary information, analyze and compile findings, and report results to the Bureau.

Vendor Response:

ACR Purpose, Background, and Experience
Delmarva Foundation completed the MHT MCOs' first Annual Compliance Review (ACR) in 2006. The ACR assesses MCO adherence with structural and operational standards, which may impact the quality, timeliness, or accessibility of healthcare services provided to enrollees. Over the years, the MHT MCO compliance with standards and contract requirements has improved significantly.

Delmarva Foundation consistently provides very specific feedback and recommendations on how MCOs can make improvements and achieve compliance. Consequently, the MCOs have taken advantage of our technical assistance and recommendations. In one instance, an MCO improved from 82% compliance to 100% compliance in the Enrollee Rights Standard.
Delmarva Foundation had identified specific deficiencies in the Member Handbook that was provided to enrollees. Further, the distribution of enrollee material was not completed according to regulation timeframes. Following our recommendations, the MCO made modifications to its handbook and revised policies relating to distribution. These actions resulted in improved compliance.

This improved compliance ultimately impacts the MHT beneficiaries, as the review assesses enrollees' rights to make sure that they are not only appropriate, but enrollees are made aware of them and the protections they offer, including grievance and appeal rights. Further, the review assesses quality standards to ensure appropriateness and compliance.

Delmarva Foundation has worked with BMS and added additional areas of focus that are important to the State, including the Fraud and Abuse standards. This standard was introduced two years ago as part of the ACR. For the first year, we did not officially report scores on this standard; instead we focused on providing a significant amount of technical assistance to bring the MCOs into compliance. In the second review period, (their first year of reporting

compliance rates) the MCOs had implemented our recommendations and achieved performance scores of 96% and higher. ***This demonstrates our ability to collaboratively work with BMS and the MCOs to develop standards, provide technical assistance to MCOs, and monitor MCO practices in an efficient and effective manner*, and achieve impressive results.**

ACR Methodology

In accordance with 42 CFR §438.358(b)(3), our ACR is based upon the CMS protocol, *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* In addition to using the standards derived from the CFR (Enrollee Rights, Grievance Systems, and Quality Assessment and Performance Improvement), we also include standards based on BMS's contract with the MHT MCOs. For example, we have added an element on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and on Fraud and Abuse standard.

Delmarva Foundation's approach to the ACR includes working with BMS and its subcontractor, The Lewin Group, to obtain any new background information and to determine if any additional standards or elements need to be added to the ACR. Existing standards have been pulled directly from the CFR and the MHT MCO contract. We also review each MCO's previous year's assessment and make note of any corrective actions that need additional follow-up. Our electronic ACR tool tracks this information, including subsequent follow up and monitoring. Further, we examine any other areas that are of concern that are uncovered throughout the course of the year. An example of this stems from a concern BMS raised regarding advance directives and new information that was being distributed by one of the MCOs to its members. ***Delmarva Foundation provided technical assistance to BMS when this advance directive issue first arose by reviewing the contents of the advance directive letter to ensure compliance with the advance directive regulations.***

Pre-site Phase
Delmarva Foundation provides the MCOs with the review standards during its annual orientation. At that time, the MCOs are informed of when they need to post their electronic documents (written plans, policies, and procedures) into our secure web-based tool. Additionally, we ask the MCOs to complete a questionnaire that collects background information and any changes that may have occurred at the MCO during the course of the year that would be helpful to know in preparation for the ACR. Delmarva Foundation then begins the document review.

The MHT MCOs are accustomed to and pleased with the opportunity to electronically post their documents for review, which eliminates the need for them to copy and mail volumes of documents to us (efficient and cost-effective). To further reduce burden to the MCOs, we provide them with a list of documents we reviewed the previous year in which we found evidence of compliance. Effective management of this process allows us to complete the majority of the document review prior to going on-site, and consequently, allows reviewers

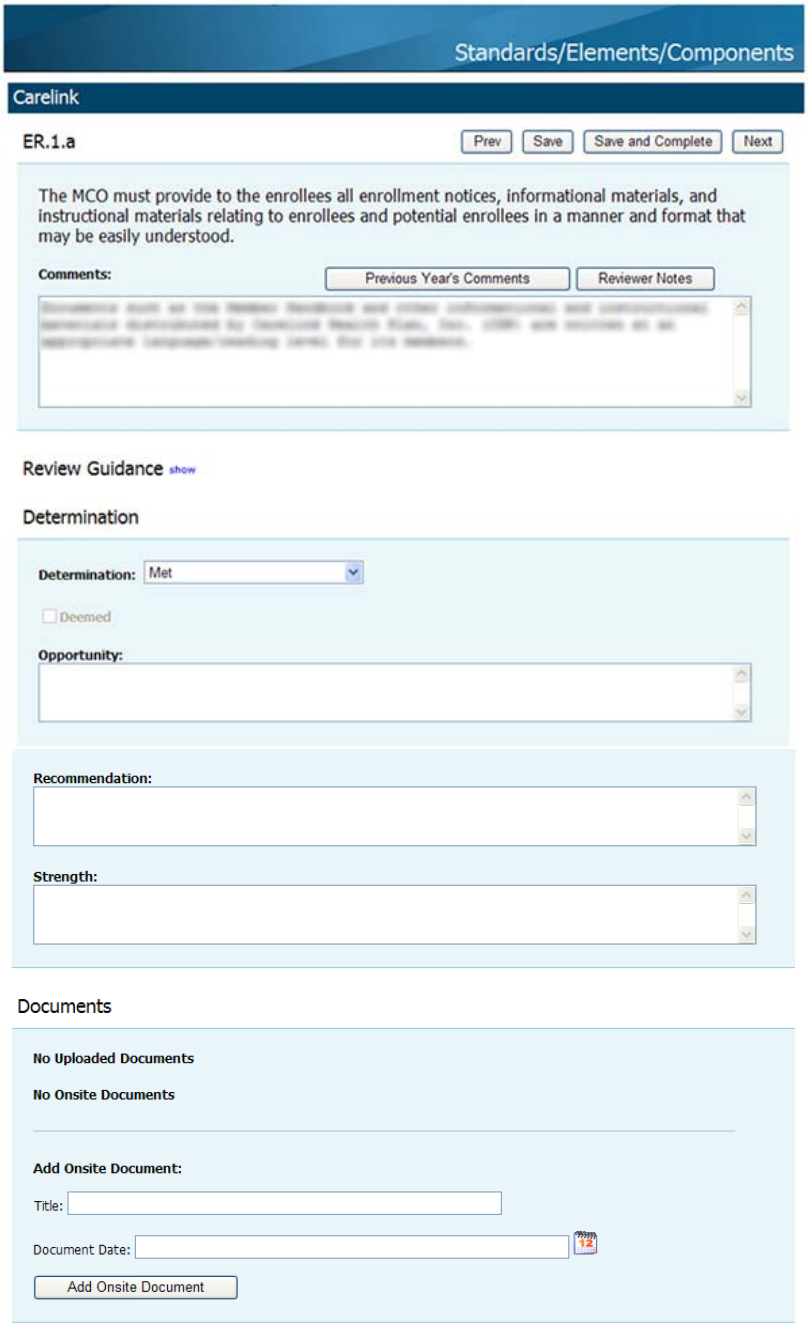
more time to focus on interview questions and any areas of concern when we meet with MCO staff.

On-site Phase
Delmarva Foundation's two day on-site review begins with an opening conference, describing the purpose of the ACR. Next we delve into document review that provides evidence of compliance such complaints, grievances, utilization, and credentialing records. We conduct interviews with staff, observe processes, review meeting minutes, and follow up on corrective actions. We also dedicate time to discuss PIPs and provide feedback and recommendations on the projects. Lastly, we hold a closing conference (exit interview) where we share preliminary findings with the MCO.

The on-site review allows Delmarva Foundation an opportunity to validate the MCO's compliance with standards that appear to conform based on the policy and procedure documentation review. We accomplish this by interviewing management level and line staff and observing processes. Record review also provides evidence of how the processes work.

During this time, we enter all of our findings into an electronic tool that was specifically designed for the ACR assessment. With this tool we have access to last year's findings and recommendations at the click of a button. This tool provides a significant amount of efficiency in the review process that helps reduce review time while on-site and minimizes any potential business-related interruptions for the MCO. **For these reasons, this electronic ACR tool has been invaluable to our ACR process over the last several years and has promoted efficiencies in the review process.** Further, we recently upgraded this tool, which now allows BMS and the MCOs direct access. MCOs can upload their documents for review directly into the tool. BMS will have the capability to review our findings and track any corrective actions that may result. Figure 1-8 is a screenshot of Delmarva Foundation's ACR tool.

Figure 1-8. Annual Compliance Review Tool Screen Shot



Post-site Visit Phase
Based on preliminary review findings, Delmarva Foundation drafts and submits an exit letter to the MCO with notification of partially met or unmet items. This letter gives the MCO the opportunity to respond and provide any additional information to support compliance with the identified deficiencies. This information, which must be received within 10 days of the letter submission, is then reviewed by Delmarva Foundation and taken into consideration when making final determinations.

Delmarva Foundation reviews all information provided by the MCO before making final assessments. When compliance is achieved, Delmarva Foundation describes the evidence provided and cites the source**. If there is an area not achieving full compliance, Delmarva Foundation provides guidance and recommendations to the MCO on how to meet requirements.**

ACR Scoring

Delmarva Foundation uses a three-point scoring system for analysis and aggregation of MCO ACR results: Met–100%; Partially Met–50%; and Unmet–0%. This scale allows for credit when a requirement is partially met. We assess findings for each component and roll them up to the element level and finally to the standard level.

Currently, MCOs are required to achieve at least 90% compliance for each standard. For standards not meeting the 90% compliance threshold, MCOs are required to complete corrective action plans (CAPs). Delmarva Foundation works with the MCOs and provides guidance and recommendations for corrective actions. Most recently this was demonstrated when we worked with the BMS subcontractor to provide the MCOs with an algorithm to track children's specialty care visits. Previously a few of the MCOs were deficient in the tracking and reporting of this required data, as they were unsure how to accomplish this task. With our next ACR, we will continue to monitor these corrective actions and look for evidence of compliance to ensure the MCOs are meeting their standards.

ACR Reporting

We report ACR findings, which include highlighted strengths and recommendations, to BMS and the MCOs. Upon completion of the ACR task, we distribute an ACR summary report that provides scoring and itemizes elements and components that are not fully met. Specific recommendations will be included in this report. The summary report is intended for distribution to MCOs after the completion of the ACR to allow MCOs ample opportunity to respond to recommendations and make necessary changes in order to achieve full compliance for the next annual review.

Comprehensive ACR findings will be reported in the annual technical report (ATR) that is submitted to BMS and the MCOs. In addition to providing detailed findings, strengths, and recommendations, the ATR will also include trending information.

Section 2.4.5: The Vendor should propose a plan to monitor the Medicare and private standards and processes for review and make recommendations to BMS as to where it may be appropriate to use the Medicare or private review to avoid duplication.

Vendor Response:

Delmarva Foundation provides our state Medicaid customers with options for MCOs that achieve accreditation by a private review organization to avoid duplication of EQR activities. If an MCO has undergone a survey and meets national accreditation guidelines and these comparable accreditation requirements demonstrate compliance with federal standards, the MCO can be considered *deemed* and *exempt from duplication of review* through the EQR process. This option could help BMS and the MCO conserve resources while meeting compliance with both the BBA and state requirements.

BMS has the responsibility to ensure that the quality of health care services provided to the state's Medicaid managed care enrollees is evaluated on a periodic basis. The review of the Medicaid managed care systems has been a primary component of the EQR services provided by Delmarva Foundation. We have conducted hundreds of EQR compliance activities using the Centers for Medicare and Medicaid Services (CMS) standards, including the evaluation of fraud, waste and abuse programs.

As part of our continuing corporate commitment to prepare for business changes, Delmarva Foundation closely monitors evolving managed care legislative and regulations, with specific emphasis on Medicaid and Medicare. We are keenly aware of the need to be current on any state or federal legislation or regulation that may impact our customers and their stakeholders. We maintain communication and monitoring channels to give BMS confidence in receiving the latest updates and interpretations of existing and proposed regulatory changes. We will provide BMS information about changes that may impact Medicaid managed care requirements. Delmarva Foundation has developed a process to provide information to assist BMS in making informed decisions about how changes may impact its current procedures while ensuring compliance with all regulations.

Overview of Mandatory Requirements

The BBA of 1997 became effective in 2002 and served as the comprehensive revision to federal statutes governing all aspects of the Medicaid Managed Care Programs as set forth in the Social Security Act and Title 42 of the Code of Federal Regulations (CFR 438 5 seq). The BBA specified three mandatory EQR activities:

- Validation of performance improvement projects conducted by MCO/PIHP;
- Validation of performance measures produced by MCO/PIHP; and
- An operational system review to evaluate MCO/PIHP compliance with federal Medicaid managed care regulations.

The BBA and the Medicaid managed care regulations for external quality review (42 CFR §438.360) also provided the authority for CMS to develop an optional process for states to use.

In recognition of the comparability between government requirements and private accreditation standards, the CMS "non-duplication" regulation (42 CFR §438.360) gives states the authority to use information obtained from a private accreditation review to demonstrate compliance with the operational review standards.

This mechanism was designed to prevent duplication of mandatory compliance review for certain standards that were surveyed by a national accrediting organization, such as the National Committee for Quality Assurance (NCQA) or URAC, formally known as the Utilization Review Accreditation Commission and determined to meet requirements. If an MCO or PIHP has undergone a survey and meets national accreditation guidelines, certain standards have been found to be comparable or equivalent to the BBA standards. This accreditation can demonstrate compliance with federal requirements to allow states to *deem* private accreditation organization standards as equivalent to state standards. The *deemed* standards would be *exempt from duplication of review* through the EQR process.

Private Accreditation Status

Both NCQA and URAC publish crosswalks that compare their private accreditation standards with the BBA regulations. Over the years, state Medicaid agencies have recognized the value of NCQA or URAC accreditation in whole or in part in their managed care programs. NCQA has had a business objective to increase the number of states that recognize its standards as compliant with the state's regulatory requirements through the process of *deeming.* There are currently forty-one states, including 25 Medicaid programs that recognize or require NCQA accreditation.

Monitoring Process

Delmarva Foundation's integrated business development, corporate communications, and executive leadership form the foundation for soliciting, updating, and distributing current and proposed changes in legislation and regulations impacting our business, our customers, and our stakeholders. Delmarva Foundation participates in local, state, and national organizations that address the services and needs of Medicaid agencies and their enrollee populations. These organizations provide periodic updates of the latest information of policies, changes in regulations, proposed and enacted legislation, court decisions, decisions of professional and accrediting bodies and other relevant information. Examples of participation include the following organizations:

- The National Association of State Medicaid Directors
- The National Association of State Directors of Developmental Disabilities Services
- Reinventing Quality conferences
- Medicaid Managed Care Congress conferences
- National Initiative for Children's Healthcare Quality (NICHQ) Childhood Obesity Action Network
- NCQA Annual HEDIS Compliance Auditor conference

Electronic subscriptions to list serves provide daily updates through the distribution of transmittals, public announcements, changes in regulations and both proposed and enacted

legislation. The following is a list of monitored sources most essential for most current and updated information:

- The Centers for Medicare & Medicaid Services: www.cms.gov/
- The National Commission on Quality Assurance (NCQA): www.ncqa.org; the annual updated NCQA Crosswalk; the NCQA Medicaid Managed Care Toolkit Health Plan Accreditation Standards, *Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight*
- The URAC Guide to Medicaid Managed Care External Quality Review: www.urac.org
- The Electronic Code of Federal Regulations (e-CFR) is a currently updated version of the Code of Federal Regulations (CFR): http://ecfr.gpoaccess.gov/
- The Code of Federal Regulations (CFR)
- National Initiative for Children's Healthcare Quality (NICHQ) Childhood Obesity Action Network
- The most current BMS MCO Managed Care Contract requirements
- Monitoring of proposed and enacted legislation in states with Medicaid customers

Decision Process

Annually, NCQA updates the crosswalk comparing the most recent accreditation survey standards with the BBA regulations. Each standard contains the NCQA survey requirements and whether their evaluation is comparable with the BBA. If a standard is considered equivalent and eligible for *deeming* status, BMS would have the final authority as to whether or not a standard would be considered *deemed* for their specific MCOs. We recommend the following steps to assist BMS in their decision making process:

Step 1. Delmarva Compares Current *Deemable* Standards	
NCQA/BBA Crosswalk BMS MCO Contract Requirements	Delmarva Foundation reviews the most current NCQA Crosswalk and rationale for deeming with the BBA standards along with the current BMS MCO contract requirements to present a comprehensive comparison of data for review with BMS.

Step 1. Delmarva Foundation will provide BMS with the most current NCQA/BBA crosswalk and technical assistance to help BMS decide whether *deeming* for each standard is appropriate for the MHT MCOs.

Step 2. Delmarva Foundation Reviews Comparison with BMS	
The comprehensive comparison is presented to BMS for decision of specific determinations of *deeming.*	The comprehensive comparison provides BMS with a complete overview of both the BBA and NCQA standards and the specific MCO contractual requirements. This gives BMS the information necessary to decide whether the deeming of a specific qualified standard is the most appropriate for BMS'

Step 2. Delmarva Foundation Reviews Comparison with BMS	
	MCOs.

Step 2. Delmarva Foundation will prepare a comprehensive standards document detailing the NCQA standards, its rationale for deeming status side by side with the BBA standards, and the BMS MCO contract requirements. Included will be a discussion of each standard, the rationale, and Delmarva Foundation's recommendation for BMS to consider in determining whether to deem standards.

There may be individual state issues or situations in which, even though a standard may be eligible for deeming, BMS would not consider appropriate for deeming during that review cycle. BMS has the authority to make a final determination based upon individual circumstances in West Virginia.

Step 3. Finalizing Standards (Reviewed and *Deemed*)	
Finalize standards – for review and deeming status	Delmarva Foundation develops the standards for review with each BBA requirement finalized as either reviewed or deemed.

Step 3. Based upon the discussion and BMS decisions, Delmarva Foundation will prepare a draft BBA Standards and BMS contract requirements document that will include all the relevant standards to be reviewed in the next MCO annual compliance review. After approval by BMS, the standards will be finalized with a designation of either deemed or not deemed. Standards are provided to the MCOs during the annual orientation period and available online at the secure web portal in the MCO resource center.
_https://portal2.dfmc.org/SiteDirectory/dfmc/pav/pm/eqr/wv/res/default.aspx

Step 4. MCO Orientation – include *Deeming*	
The Final Standards are presented to MCOs	Delmarva Foundation develops the Final Standards for an in-depth orientation with the MCOs to include rationale for change in process and how compliance will be evaluated for review period.

Step 4. Delmarva Foundation will provide an MCO orientation annually, prior to conducting the annual compliance reviews. The orientation includes background information on why a change in process is allowed and explanations of the deeming status and rationale for the final standards.

Table 1-15. Examples of NCQA Deemed Standard

Example of Deemable Regulations		
BBA Regulation	**NCQA Standard**	**Equivalency**
Regulation 438.236 Practice Guidelines	QI.9 Organization is responsible for ensuring that practitioners are using relevant clinical practice guidelines	Deemable Regulation Equivalency is Met
Each MCO (PIHP) adopts practice guidelines that are based on valid and reliable clinical evidence; that considers the needs of enrollees, are adopted in consultation with contracting health care professionals and are reviewed and updated on a periodic basis.	Organization is accountable for adopting and dissemination clinical practice guidelines relevant to its members for...acute and chronic medical and behavioral health services. Guidelines must be established with a clinical basis, be updated every 2 years and distributed to appropriate practitioners.	Eligible for Deeming

We understand that BMS does not currently require NCQA accreditation for its contracted MCOs. Advance planning is needed before implementing this requirement. National organizations that operate in West Virginia and other locations may already have NCQA accreditation in other states and their process would differ from an MCO seeking accreditation for the first time.

Issues for consideration include any updates or changes in the BBA or state requirements, the time frames required for accreditation and any change in priorities in BMS' quality strategy. There are advantages to using the results of accreditation by private organizations and eliminating duplication of certain activities. As BMS continues it's monitoring and oversight of the health care services provided to state enrollees, it may gain efficiencies without compromise to compliance with advantages for itself and its MCOs.

Advantages of Using Private Organization Standards to meet federal regulations	
Advantages to BMS • National accreditation of quality provides standardized and public documentation of commitment to improvement in enrollee outcomes • Avoids duplication of effort • Serves as incentive for MCOs to obtain accreditation status	Advantages for BMS' MCOs: • Is an incentive to acquire accreditation status • Avoids duplication of effort and resources • Accreditation provides a consistent national quality standard that has documented improvement in patient outcomes

Section 2.4.6: The Vendor should propose a plan to review MCO activities that are unique to the MHT program, such as review of grievance and appeals processes, timelines, and notifications regarding State fair hearing processes and Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach and notices; notify MCOs of the preliminary review findings and request corrective action plans for each area in which the MCO has not demonstrated sufficient compliance; and provide clarification and/or technical assistance to MCOs as necessary to develop and implement corrective action plans.

Vendor Response:

Identifying and Incorporating Activities Unique to the MHT Program into Annual Review
Numerous MCO activities are required by BMS that are unique to the MHT population defined in the BMS MCO contract. Delmarva Foundation reviews this contract to ensure that it understands the MCO requirements. Our collaboration with BMS and The Lewin Group helps us identify areas that should be assessed. Reviewing these requirements by incorporating them into the annual CR, we gain a thorough understanding of MCO processes and their level of compliance.

Grievance and Appeal Process, Timelines, and Notifications Regarding State Fair Hearing Process
The CR includes an entire standard area devoted to Grievance Systems, which includes specific requirements from the MHT MCO contract. As part of the grievance and appeal review, MCOs must make enrollees aware of their rights to file grievances and appeals, including the procedures and timelines, for doing so. MCOs must respond to these grievances and appeals in writing, make decisions, and inform enrollees of the actions within specified timeframes. Some of these timeframes are unique for the MHT MCOs. If enrollees are dissatisfied with the decisions, they are informed about actions they may take, including a state fair hearing. By reviewing MCO policies and procedures as well as actual grievance files, Delmarva Foundation is able to determine MCO compliance with this standard. Results from the last annual review demonstrated 100% compliance for each of the MCOs for the Grievance Systems standard.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Outreach and Notices
Another example of work conducted under the current EQR contract includes several elements devoted to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements in the Annual Compliance Review (ACR). The specific EPSDT elements are described below.

EPSDT Elements of the ACR
Element QA.51. The MCO must have a mechanism to offer periodic health screening programs to enrollees. The screening programs must provide a methodology to evaluate the effectiveness of the program and a follow-up mechanism to provide feedback to primary care providers.
Element QA.52.* MCOs must have written policies and procedures providing the full range of EPSDT services to all eligible children and young adults up to age 21. The MCO procedures must include a description of the process employed for components a-e.

EPSDT Elements of the ACR
Element QA.53.* The MCO must have an established tracking system that provides up-to-date information on compliance with EPSDT service requirements.

*Within each element, there are numerous component requirements (including outreach and notices) that must be met to support compliance.

Other Unique Requirements
Using MCO contract requirements, Delmarva Foundation recently added a set of Fraud and Abuse (FA) standards to the Annual Compliance Review (**refer to the Fraud and Abuse Standards in the Appendix**). The FA standard assesses prevention practices, as well as the monitoring and reporting of fraud and abuse. With Delmarva Foundation's guidance and recommendations for improvement related to internal monitoring and auditing practices and reporting of data, MCOs made significant strides to meet BMS contract requirements.

Notification of Findings and Subsequent Corrective Actions and Technical Assistance
During the exit conference of the on-site phase of ACRs, MCOs are made aware of any deficiencies based on preliminary findings. Following the on-site review, MCOs are provided an exit letter specifically outlining elements or components of the ACR that were partially met or unmet. MCOs have an opportunity to respond and provide additional supporting information that may provide evidence of compliance. Generally MCOs take the opportunity to state how they plan to correct the deficiency.

Currently, if an MCO fails to meet the 90% compliance threshold for a standard, the organization is required to complete a formal internal corrective action plan (CAP). Delmarva Foundation makes BMS aware of the corrective action request and works with BMS to approve the plan. Subsequent to providing a CAP for review and approval, Delmarva Foundation monitors MCO activities related to the corrective action, keeping BMS informed in the quarterly progress reports. Delmarva Foundation works with the MCO to provide needed clarification and technical assistance. Our aim is to make recommendations that, if implemented by the MCO, will bring it into compliance. These activities are formally reported in the annual technical report submitted to BMS.

An example of technical assistance includes Delmarva Foundation's response to one of the MHT MCO requirements related to EPSDT. Two MCOs reported being unable to track referrals made as a result of EPSDT screenings and resultant treatment. We worked in collaboration with the BMS data contractor and developed an algorithm for MCOs to use in order to capture this data. Presently all the MCOs are using the same methodology. This has enabled the MCOs to complete their quarterly reporting to BMS.

Section 2.4.7: The Vendor should address within their proposal how information provided to the Bureau accurately and reliably summarizes the performance of each MCO in each quality management area and identifies areas for corrective action and performance improvement.

Vendor Response:

Delmarva Foundation will provide reliable and accurate MCO performance information through key activities such as PIP, PMV, and the ACR. MCO findings are consistently and accurately summarized in the Annual Technical Report. Each section below highlights examples where Delmarva Foundation recommendations have been implemented.

Summary of MCO Performance
The external quality review activities (PIP validation, PMV, ACRs, and the Annual Technical Report) provide information regarding MCO performance. Delmarva Foundation uses CMS protocols, NCQA HEDIS® audit methodology, and EQR protocols as the foundation for collecting and summarizing MCO performance information. By using standardized protocols, BMS can be confident that each MCO is reviewed in a similar fashion for each activity, improving the validity of results.

PIP Validation
Delmarva Foundation uses the 10-step process to review and validate PIPs in accordance with 42 CFR §438.358(b)(1). Our approach is based on the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities.* Delmarva Foundation's validation results in one of four validation outcomes:

- PIP meets requirements
- PIP meets requirements with recommendations
- PIP requires revisions; resubmission required
- PIP does not meet requirements; corrective action plan required

Delmarva Foundation works with MCOs to develop corrective action plans and provides technical assistance in developing solutions. We offer recommendations that include best practices. **For example for a MCO asthma PIP that aimed to improve outcomes, we recommended the distribution of asthma took kits and direct contact by case management to target individuals requiring intervention to the MCO.**

After BMS approves the corrective action plan, Delmarva Foundation monitors the MCO's corrective actions and reports our findings to BMS. Monitoring continues through subsequent remeasurement periods.

PMV
Delmarva Foundation has validated HEDIS® measures for West Virginia for the past thirteen years. In addition, we have validated performance measures in six other states as part of our other EQR contracts. Because of the depth of our experience, BMS can be confident that the performance measure validation process is well managed through by Delmarva Foundation's Certified HEDIS® Compliance Auditors and our audit partner, MetaStar, Inc. MCO performance measures are validated in accordance with 42 CFR §438.358(b)(2). The HEDIS® Compliance Audit is the widely accepted methodology which follows the CMS Protocol, *Validating Performance Measures, and A Protocol for use in Conducting Medicaid External Quality Review Activities* providing a consistent and standard method of rate calculation and reporting. This

consistency allows reliable and accurate rates to be fairly compared among MCOs as well as with national and regional benchmarks. The validation is conducted in three phases; during each phase of the audit, opportunities for improvement are continuously identified and resolved before the final rates are calculated and their final reporting status determined. If a formal correction action plan is needed during the audit process, the MCO must complete it two weeks before the final rates are calculated.

Upon completion of the validation audit, Delmarva Foundation provides a comprehensive PMV report to each MCO which includes the final rate determination for all performance measures. Each measure will receive one of the following reporting determinations: Reportable: the MCO followed the specifications and calculated a reliable rate for the measure

- Not Reportable: there was a bias in the calculation or the MCO decided or was not required to report the measure
- Not Applicable: the denominator was too small to calculate a reliable rate
- Benefit Not Offered: the MCO did not provide the health benefit needed to calculate the measure

The MCO PMV report compares MCO performance rates to state and national benchmarks. In the past, we have used a three-year rate history to provide BMS with trending information. Although MCO performance data may meet the validation process and be “reportable,” findings such as a decline in performance year over year may also spark an MCO specific corrective action plan. Table 1-16 provides an example of how this type of performance information is reported. Any measure that is required to be reported to BMS, but does not get reported, can serve as a trigger for a corrective action plan.

Table 1-16. MCO Measure Performance Trended over Three Years

Measure	Carelink HEDIS 2009 (CY 2008)	Carelink HEDIS 2010 (CY 2009)	Carelink HEDIS 2011 (CY 2010)	Three Year Trend✦
Children's and Adolescents' Access to Primary Care Practitioners – 12-24 Months	96.7%	96.9%	97.3%	↑
Children's and Adolescents' Access to Primary Care Practitioners – 25 Months-6 Years	87.7%	88.6%	88.1%	↑
Children's and Adolescents' Access to Primary Care Practitioners – 7-11 Years	87.4%	89.4%	90.3%	↑
Children's and Adolescents' Access to Primary Care Practitioners – 12-19 Years	84.4%	86.2%	86.0%	↑

✦**A (↑) indicates a rising trend and a (↓) indicates a falling trend in the Three Year Trend column**

From Table 1-16, the results of three-year trended MCO performance data shows improved performance over time for the listed measures. This is another example of how Delmarva Foundation has worked with BMS to present data in easy-to-understand formats.

Delmarva Foundation has worked with BMS and its MCOs in improving data quality and mining efforts to not only produce more accurate rates, but to also report on additional measures. Three examples of Delmarva Foundation's work in West Virginia are highlighted below.

1. Childhood immunization status (CIS) and immunizations for adolescents (IMA) are two HEDIS® hybrid measures that rely on administrative data, including supplemental databases such as immunization registries, and medical record review to derive rates. When access to data is denied, it may be a reason for these measures to fall below set benchmarks (i.e. Medicaid national average). A barrier to access for the West Virginia Statewide Immunization Information System (WVIIS) was identified during a HEDIS® audit cycle. Because the WVIIS is a rich source of supplemental data for the MCOs, and since the MCOs are likely have data to contribute to the WVIIS, Delmarva Foundation continues to encourage the MCOs to work directly with the Immunization Division to ensure that they have adequate access to the WVIIS for future reporting.

2. In 2011, the MCOs were asked to report a measure that relied on pharmacy data. The "Use of Appropriate Medications for People with Asthma" measure requires pharmacy data for medications to treat asthma. Because pharmacy benefits are "carved out," Delmarva Foundation worked with BMS to assure pharmacy data was delivered to the MCOs in order to calculate the rate. Because the MCOs had access to pharmacy data, each was able to calculate the asthma measure rate.

3. The MCOs were asked to calculate the "Medical Assistance with Smoking and Tobacco Use Cessation CAHPS®" survey measure. This measure was collected using CAHPS® survey data. Two of the MCOs administer the CAHPS® survey and were able to report the rate. The third MCO did not use the CAHPS® survey using an internally developed member survey. These different methodologies, consequently, did not allow for accurate and reliable MCO comparisons. **Delmarva Foundation informed BMS of this methodological inconsistency, which led to a contract change that now requires the CAHPS® survey for all contracted MCOs. This change in methodology and reporting will now yield comparable results across all three MCOs.**

Compliance Reviews

Delmarva Foundation conducts compliance review (ACR) activities in accordance with 42 CFR §438.358(b)(3). Our thorough ACR process is based upon the CMS protocol, *Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* We work collaboratively with BMS and The Lewin Group to identify unique requirements for the MHT MCOs. We develop standards relevant to these unique areas and incorporate them into the ACR which includes not only compliance with federal standards, but also compliance with MHT MCO contract standards. When deficiencies are identified, we provide technical assistance to the MCO by making recommendations for improvement in order for the MCO to achieve compliance.

BMS can be confident in the accuracy of reported results based on Delmarva Foundation's documentation review (policies and procedures must address and comply with standards). In addition to performing an extensive review of documents, while on-site, Delmarva Foundation's team monitors processes, interviews staff, and reviews tracking logs and records that provide evidence of compliance. Corrective action plans are required for review scores that do not meet the 90% threshold established for each standard.

All corrective action plans are reviewed and approved by BMS. Upon approval of the corrective action plan, Delmarva Foundation monitors the plan and provides technical assistance as needed. Recommendations can vary from being a simple policy change to creating a whole new policy and procedure that captures the intent of a specific requirement (as required with the implementation of the fraud and abuse standard). We monitor subsequent corrective actions and reassess activity and performance as needed.

Annual Technical Report

Delmarva Foundation assesses all the information gathered from the three EQR activities: PIPs; PMV; and ACR and compiles the information in one document, the Annual Technical Report (ATR). Since 2006, Delmarva Foundation has provided BMS with thorough ATRs that summarize the MCOs' performance. The ATR highlights the strengths and challenges for each MCO and for the MHT program overall. Historically, information in the ATR has been distilled into smaller components such as the at-a-glance summaries, performance reports, and assorted reports needed by BMS and other stakeholders. The ATR provides information regarding all the MCOs' performance in the arenas of quality, access, and timeliness of care, as well as comprehensive information regarding each MCO's strengths and challenges. The report also includes recommendations, identifies opportunities for improvements, and corrective actions.

To ensure the accuracy of the performance results reported in the ATR, Delmarva Foundation uses internal quality control procedures to verify the accuracy of the information. This process involves at least two team members. Our editing approach, which is completed as a multi-step process, and also requires at least two team members to verify the accurate analysis of findings reported to BMS. Figure 1-9 illustrates the continuous improvement process and how information from the ATR flows back into each key activity for the next review cycle.

Figure 1-9. Continuous Improvement Cycle

Section 2.4.8: The Vendor should propose a plan to develop a detailed technical report that describes the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO. The report includes all elements as required by 42 CFR §438.358 and does not disclose the identity of any individual patient.

Vendor Response:

As the current contractor, Delmarva Foundation has well-established processes in place for collecting and analyzing the data required to complete the Detailed Technical Report (DTR) for BMS. We have conducted the analysis of EQR activities for the MHT program and provided it to BMS in the MHT Annual Technical Report since 2006 (please see the MHT Annual Technical Report for CY 2010 attached in the Appendix). This report includes data from all activities conducted in accordance with 42 CFR §438.358.

The current format and content are consistent with EQR regulations, but are also flexible enough to permit the incorporation of any additional information required by new regulations or requested by BMS. For example, fraud and abuse detection became a hot topic in 2010 with the implementation of enhanced methods of detection under the Patient Protections and Affordable Care Act (PPACA) and feedback from CMS. We worked with BMS to develop and implement a set of Fraud and Abuse (FA) standards. Delmarva Foundation incorporated the new FA standards the same year as they were developed allowing for immediate assessment and feedback to BMS of the standard. We found that MCO did not perform to BMS' minimum performance threshold of 90%. Delmarva Foundation assisted the underperforming MCO in developing appropriate policies, procedures and flowcharts during the next review cycle. In less than one year, the MCO successfully met the performance threshold, thus obviating the need to develop any internal corrective actions.

The DTR summarizes the findings of the annual EQR activities in a format and manner that helps BMS plan, monitor, and evaluate the MHT program. The overall findings of the three mandatory EQR activities, Annual Compliance Review (ACR), Performance Measure Validation (PMV), and Performance Improvement Project (PIP)Validation, currently are, and will continue to be, reported according to the requirements in 42 CFR §438.364 without disclosing the identity of any individual patient. Specifically, the report summarizes how the data are aggregated and analyzed and draws conclusions on the quality, timeliness, and access to the care provided by MCOs. Information from the Technical Report aids in selecting indicators for measurement in the WV MHT State Quality Strategy. Delmarva Foundation provides trended aggregate rates in our detailed reports. BMS uses these aggregate rates to set performance targets in the MHT State Strategy.

The Annual Compliance Review provides compliance rates for each standard that is reviewed (e.g. Enrollee Rights, Grievance Systems, Quality Assurance and Performance Improvement, and Fraud and Abuse Detection). The trending of individual MCO compliance rates allows BMS to monitor each MCOs progress toward achieving full compliance with the standards, while the MHT aggregate rate provides an indicator of overall performance for the MHT program.

CMS developed the *State External Quality Review Tool Kit for State Medicaid Agencies* which provides the recommended content for the EQR technical report. Delmarva Foundation follows these recommendations for the DTR's format and contents, which are outlined in Table 1-17.

Table 1-17. Recommended EQR Reporting Format Template

EQR Technical Component	Section Contents
Executive Summary	EQR Process, major findings, conclusions for timeliness, access and quality of care, recommendations for state and MCOs
Background	History of BMS' managed care programs, summary of quality objectives, performance measures, PIP requirements and targets, and operational systems standards
Description of EQRO Activities	How the annual EQR technical reporting process is used for assessing the state's progress in meeting its overall quality goals and objectives
State Quality Initiatives	Highlight quality initiatives implemented by the state to support MCO efforts to improve the quality of care and service for Medicaid managed care enrollees
MCO Best and Emerging Practices for Improving Quality of Care and Service	Highlight MCO activities that are unique, effective in demonstrating improvements in care or service, or generate high satisfaction survey results
Organizational Assessment and Structure Performance (Annual Compliance Review)	Provide background on assessment process, reference assessment tool in appendices, summarize comparative results for MCOs, highlight best practices identified, identify strengths for MCOs and the state, document major opportunities identified, and reference individual plan findings in the appendices
Performance Measurement Validation	Provide background on the process, reference assessment tool in appendices, summarize comparative results for MCOs, highlight best practices and strengths for the state and individual plans, document major opportunities, and reference individual plan findings in the appendices
Performance Improvement Project Performance	Provide background on the process, reference assessment tool in appendices, summarize comparative results for MCOs highlight best practices and strengths for the state and individual plans,

	document major opportunities, and reference individual plan findings in the appendices
Conclusions and Recommendations for the State	Summary conclusion on data collected for all mandatory activities with regards to quality, timeliness, and access to care across all participating MCOs should be documented (required by 42 CFR §438.364(a)(1)
Conclusions and Recommendations for the MCOs	Specific conclusions (including strengths and weaknesses) and recommendations for each mandatory activity should be documented, and referred to in the next reporting period (required by 42 CFR § 438.364(a)(3) and 42 CFR §438.364(a)(5)

To demonstrate our experience and knowledge of this process, we have provided excerpts from the most recent Mountain Health Trust Annual Technical Report below. The complete MHT Annual Technical Report can be found in the Appendix.

The *West Virginia Mountain Health Trust Program State Strategy for Assessing and Improving Managed Care Quality* (WV MHT State Strategy) includes objectives and targets for selected measures. This plan was updated in April 2010 with plans to update it again in 2012. The objectives, targets, and results for the objectives are found in Table 1-18.

Table 1-18. WV MHT State Strategy Objectives, Targets, and Results

Objective	Target (over the next two years)	Baseline (CY 2008)	CY 2009	CY 2010
Promote Child Preventive Health	Demonstrate improvement of five percentage points in the number of members two years of age compliant with an immunization 4:3:1:2:3:1:1* *(HEDIS® Childhood Immunization Status-Combination 2 measure)* * 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)	70.4%	62.2%	63.5%
Promote Child Preventive Health	Strive to meet the 2008 HEDIS® 90th percentile (80.3%) for the percent of members age three to six years who received one or more well-child visits with a primary care practitioner. *(HEDIS® Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life)*	75.7%	72.4%	65.5%
Ensure Child Access to Primary Care Practitioners	Strive to meet the 2008 HEDIS® 75th percentile (91.6%) for the number of children ages seven to 11 years who had a visit with a primary care practitioner. *(HEDIS® Child and Adolescents' Access to Primary Care Practitioners (PCP) age 7-11 Years)*	86.2%	92.6%	92.6%
Promote Adult Access to Preventive Health	Strive to meet the 2008 HEDIS® 90th percentile (88.4%) for the percentage of adults age 20-44 years who had an ambulatory or preventive visit. *(HEDIS®*	84.0%	88.4%	87.4%

Objective	Target (over the next two years)	Baseline (CY 2008)	CY 2009	CY 2010
	Adults Access to Preventive/Ambulatory Health Services measure)			
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%
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%

The rates displayed are WV MHT Weighted Averages for the three MCOs. The results of the measures in the MHT State Quality Strategy have had mixed results. Of the six measures, targets were achieved for:

- Ensuring Child Access to Primary Care Practitioners (HEDIS® Children and Adolescents' Access to Primary Care Practitioners for Children Age 7-11 Years measure)
- Promoting Adult Access to Preventive Health (HEDIS® Adults' Access to Preventive/Ambulatory Health Services for Adults Age 20-44 Years measure)
- Ensuring Comprehensive Chronic Care (HEDIS® Controlling High Blood Pressure measure)

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

MCO Best and Emerging Practices

Best and emerging practices are collected from all EQR activities and addressed in the DTR. Across Delmarva Foundation's numerous EQRO contracts, we have witnessed best practices and made recommendations to translate these activities to other MCOs. Examples are provided in Table 1-19.

Table 1-19. MHT MCO Identified Opportunities and Action Taken

Opportunity	Actions Resulting in Best Practice
Improve the rate of adolescent enrollees, 12-21 years of age, who had at least one comprehensive well care visit with a primary care provider	• Educational efforts targeting enrollees were made via telephone, in-person, and community health promotion events • Reminder notices were submitted to providers about specific patients due for services
Assist pregnant members in an effort to achieve healthier pregnancies, deliveries, and babies	• Emphasis was placed on early risk assessment by obstetrical nursing support • Personalized, telephonic counseling and support was available 24/7 via toll free access • Implementation of the nation's first free mobile health initiative, *text4baby*
Improve the percentage of enrollees 2-56 years of age who were identified as having persistent asthma and who were appropriately prescribed medication	• Telephonic outreach was made to reach 100% of enrollees admitted with asthma • Case management provided education to enrollees, coordinated care, and provided home visits by a nurse, when required • Promoted collaboration with primary care providers and use of community resources

Organizational Assessment and Structure Performance (Annual Compliance Review)

The ACR results are an essential component of the MHT Annual Technical Report analysis and findings. Below is a typical analysis completed for the ACR. The detailed findings can be found in the MHT Annual Technical Report found in the Appendix. The ACR assesses MCO adherence to structural and operational standards, which may impact the quality, timeliness, or accessibility of healthcare services provided to enrollees. This is the first year that a compliance rating is reported for the FA standard, a baseline of which was completed in CY 2009. Following this review, Delmarva Foundation provided each MCO with a baseline compliance rate and recommendations for improvement if any deficiencies were noted.

For CY 2010, all MCOs met or exceeded the BMS established threshold of 90% compliance for the four standards. Therefore Delmarva Foundation did not request any internal corrective action plans as part of the ACR. Trending of annual compliance rates can also be a useful tool for monitoring compliance with standards. Table 1-20. provides trend data for CY 2008-2010.

Table 1-20. MCO Compliance Rates for Quality Assessment and Performance Improvement (QA) CY 2008-CY 2010

MCO	QA Standard Compliance Rate		
	CY 2008	CY 2009	CY 2010
	97%	98%	99%
	100%	100%	99%
	98%	97%	98%
	98.3%	**98.3%**	**98.7%**

It is clear from reviewing the individual MCO performance rates, that all MCOs have demonstrated a commitment to their quality improvement programs. All MCOs performed exceptionally well for the QA standard, achieving commendable compliance rates ranging from 97% to 100% across the measurement years with the MHT Aggregate Rate performing above 98% in that same period. All MCOs surpassed the 90% performance threshold for all standards each year thus obviating the need for any internal corrective action plans.

Performance Measure Validation

In the PMV section of the DTR, Delmarva Foundation provides comparative results for all MCOs. Results for selected measures are displayed with the MCO and MHT aggregate trended over three years, including national benchmarks such as the NCQA Quality Compass. An example of a measure and results from CY2008-CY2010 is provided in Figure 1-10.

Figure 1-10 presents the results for *CDC - Blood Pressure (BP) Control (<140/90 mm Hg).* In CY 2010, individual MCO performance rates ranged from 51.0% to 68.3%. [redacted] was the top performer in CY 2008 and CY 2010 while [redacted] was the top performer in CY 2009. Both [redacted] Medicaid Average. Overall, the MHT Weighted Average decreased from CY 2008 to CY 2010, but the CY 2010 rate of 63.6% exceeded the Medicaid National Average of 60.4%.

MCO Strengths, Weakness, and Recommendations with Respect to Quality, Access, and Timeliness

As part of the DTR, and consistent with Delmarva Foundations current reporting practices for BMS, we summarize strengths, weaknesses, and recommendations after all EQR activities and categorize them according to quality, access and timeliness as outlined in 42 CFR §438.358. A sampling of some of the recent strengths and actionable recommendations made to the MHT MCOs and BMS is provided in Table 1-21.

Table 1-21. Examples of Strengths, Weaknesses, and Recommendations

Strengths	Weaknesses	Recommendations
The MCOs conducted comprehensive medical record data abstraction training for medical record reviewers. Processes are in place for monitoring the accuracy and reliability of data abstraction and entry.	Due to access issues identified at the West Virginia Statewide Immunization Information System the MCOs were unable to fully utilize all administrative immunization data to supplement the Childhood Immunization Status and Immunizations for Adolescents measures in 2011.	It is recommended that the MCOs work with the WVSIIS to obtain reasonable access to the data to improve the Childhood Immunization and Adolescent Immunization Status measures.
The MCO performed well on the majority of access measures.	An evaluation of provider access yielded poor results for 24/7 access to PCPs for one MCO. Last year's results were similar.	Monitor provider access to the 24/7 standard more often than annually. Evaluate the effectiveness of the interventions and develop new interventions if warranted.
For the 2011 HEDIS® report, BMS required all MCOs to report on the Use of Appropriate Medications for People with Asthma (ASM). The ASM measure required the MCOs to obtain and integrate pharmacy data from the state's fiscal services agent, Molina. All MCOs were able to report the measure successfully.	This is only one measure in the set of Respiratory Conditions measures. A better picture of care can be provided by requiring the MCOs to collect the additional measures in this category.	The process of receiving and processing pharmacy data from Molina was successful. Delmarva Foundation recommends that the remaining Respiratory Conditions measures be added to the required list of measures for HEDIS® 2012. This will provide BMS with more information regarding the processes of care for the MHT enrollees.

Plan for Developing Detailed Annual Technical Report

Delmarva Foundation generates three levels of reports: Individual MCO Annual Reports, an MCO Comparative Report, and the DTR as part of the Annual EQR. Delmarva Foundation's Project Manager controls the work plan and communicates with BMS on the status of tasks and subtasks. We use Microsoft® Project software to schedule all EQR tasks, monitor them for completion, and ensure that we remain on schedule. The DTR requires that all ACR, PIP, and PMV related tasks are completed in a timely manner; the times are listed in Table 1-22.

Table 1-22. Timeline of Tasks Required to Complete the Detailed Technical Report

Month	ACR	PIP Validation	PMV
June	Complete ACR On-site Reviews	Awaiting PIPs from MCOs	PMV data to NCQA (June 15)
July	Develop ACR of DTR, Comparative Report and Annual Plan-Specific Reports	Receive PIPs (July 15) and begin validation	Receive PMV Final Audit Reports
August	ACR Summary Reports to BMS for review and approval	Complete PIP validations Develop ACR Section of DTR, Comparative Report and Annual Plan-Specific Reports	Begin PMV analysis calculate MHT averages
September	Distribute ACR Summary Reports to MCOs Complete ACR Section of DTR, Comparative Report and Annual Plan-Specific Reports	PIP Summary Reports to BMS for review and approval	Benchmarks for PMV analysis become available Develop PMV ACR Section of DTR, Comparative Report and Annual Plan-Specific Reports
October		Distribute PIP Summary Reports to MCOs Complete ACR Section of DTR, Comparative Report and Annual Plan-Specific Report	Complete PMV sections of DTR, Comparative Report and Annual Plan-Specific Reports
November	Preliminary Reports to BMS for Review and Approval		
December	Final Reports Distributed to BMS		

Section 2.4.9: The Vendor should propose a plan to develop annual plan-specific reports that include all elements required by 42 CFR §438.364, including an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients, recommendations for improving the quality of health care services furnished by each MCO based on the evaluation of the EQR activities, an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the Vendor during the previous year's EQR, and assessment of the extent to which corrective actions recommended by the EQR have been implemented and the results of these corrective actions.

Vendor Response:

The 42 CFR §438.364 specifies that the EQRO must prepare a report that describes the manner in which the data from all activities conducted in accordance with EQR protocols are aggregated and analyzed, and conclusions are drawn as to the quality, timeliness, and access to the care furnished by the MCO. Delmarva Foundation will provide BMS and each MCO with an annual MCO-Specific Report to include all of these requirements.

Delmarva Foundation's current reporting process for the BMS includes the development of an individual MCO report for each of the three mandated activities, which creates a total of nine reports. The mandatory activities, ACR, PMV, PIP validation do not follow the same time lines for completion. Therefore, as each activity is completed, Delmarva Foundation produces a report for review and approval by BMS. After BMS approval, reports are distributed to the MCOs and are housed on the respective MCO secure, web-based portal. Timely feedback is important as it allows the MCO an opportunity to address any recommendations prior to the close of the current review period. If the MCO does not get timely feedback it may not be able to address the issue in time to impact or improve the next review cycle's results.

Each Annual Plan Specific Report will include results from the ACR, PMV, and PIP validation activities and include:

- MCO strengths and weaknesses with respect to quality, access and timeliness
- Recommendations for improving the quality of health care services furnished by the MCO based on EQR activities
- An assessment of the degree to which each MCO addressed recommendations for quality improvement during the previous year's review
- An assessment of the extent to which corrective action plans from the previous year were implemented and their results

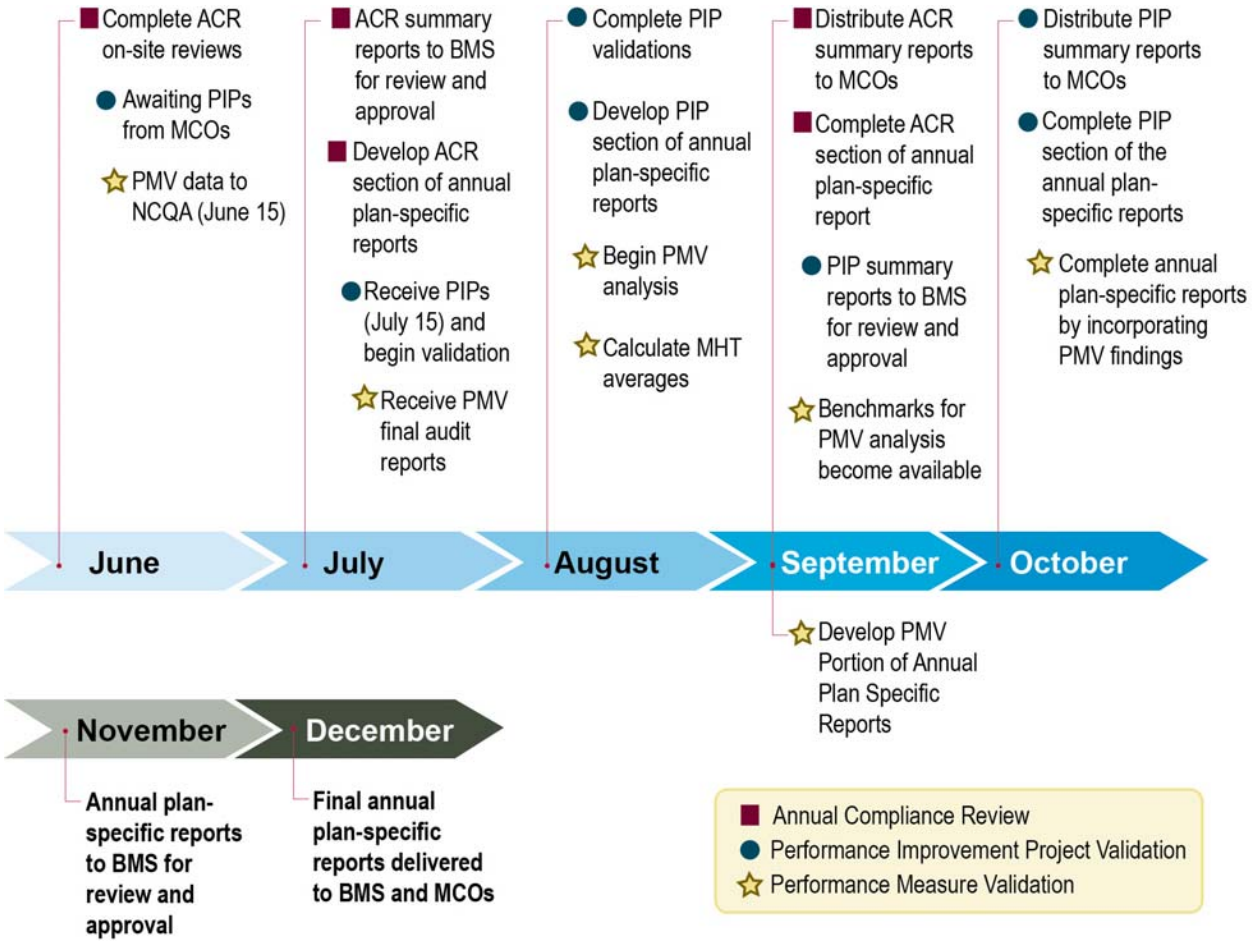
Plan for Management and Development of the Annual Plan Specific Reports

Delmarva Foundation recommends continuing the practice of providing timely feedback to each MCO as an activity is completed. Therefore, we propose providing the MCOs with an ACR Summary Report, a PIP Validation Summary Report, and a PMV Measure Results Report following the completion of each activity. A Sample PIP Summary Report can be found in the Appendix. At the completion of the last mandatory activity (PMV) on the draft Work Plan, Delmarva Foundation will analyze the results of all three activities as to quality, access and

timeliness, producing an Annual Plan Specific Report for each MCO. As a result, the MCOs get timely feedback on each activity prior to the release of the final Annual Plan Specific Report that complies all of the information in one report. Delmarva Foundation will provide actionable recommendations for improving the quality of health care services furnished by the MCO based on the EQR activities. Additionally we will assess the degree to which the MCO addressed recommendations for quality improvement or CAPS during the previous year.

The timeline for the detailed tasks required to complete the ACR, PMV and PIP activities is found in the Integrated Work Plan. This section outlines the timelines and processes that are currently used to synthesize the results of all activities into an Annual Plan Specific Report. The timeline for completion of mandatory activities is shown in Figure 1-11.

Figure 1-11. Timeline for Completion of Mandatory Activities



MCO Strengths, Weakness and Recommendations for Quality, Access, and Timeliness
A summary of each MCO's results for the ACR, PMV, and PIP validation activities will be included in the Annual Plan Specific Report. Results will be provided for each activity and then the MCO's performance will be summarized according to the dimensions of quality, access and

timeliness. Individual MCO results can be found throughout the CY 2010 MHT Annual Technical Report completed by Delmarva Foundation. This report is located in the Appendix.

Assessment of the Degree to Which the MCO addressed Recommendations for QI Made during the Prior Year's Review

We present the assessments within the appropriate section of the report (ACR, PIP, PMV) and consolidate the recommendations made throughout the reporting sections in a separate section of the report for ease of tracking throughout the life of the contract. When the issue is resolved, the outcome will be recorded and the issue will be closed. For each recommendation, details including the activity, deficiency/issue, MCO progress, and outcome will be addressed. Sample findings are provided in Tables 1-23 and 1-24.

Table 1-23. Sample Annual Compliance Review Findings.

Activity	Annual Compliance Review
Description of Deficiency/Issue Identified	Grievance System Component GS 5.e The MCO's Notice of Action (NOA) does not include the procedures for exercising the right to an expedited appeal and a state fair hearing.
Recommendation	Revise the NOA and include language to address expedited appeals and state fair hearings.
MCO Progress	The MCO revised its NOA in November of 2010. The revised NOAs were in use by the end of the year.
Outcome	Component GS 5.e is fully met.

Table 1-24. Sample PIP Review Findings.

Activity	Performance Improvement Project Validation
Description of Deficiency/Issue Identified	ED PIP did not contain a thorough barrier analysis as part of the qualitative analysis. This was also requested at the last annual review.
Recommendation	Complete a thorough barrier analysis for the PIP.
MCO Progress	The MCO did not take the recommendation.
Outcome	Step 8, Data Analysis, of the PIP Validation remains unmet. Failure to complete the barrier analysis for the next submission will result in the need for a Corrective Action Plan.

Assessment of the Extent to which CAPs Recommended by the EQR were Implemented and their Results

Monitoring CAPs is important to ensure that the MCOs address outstanding performance issues. Delmarva Foundation will provide each MCO with the CAP template. This standardized documentation format captures all of the required data elements needed to make the assessment of MCO efforts in correcting identified deficiencies. A sample CAP is found in Table 1-25.

Table 1-25. Sample Corrective Action Plan

Element	4.4 (j) Adherence to the time frames set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in insurance article section 15-112(d).
Planned Interventions	Notification of incomplete provider applications will be furnished to provider applicants within *ten (10) business days* of receipt, with hard-copy documentation maintained in the appropriate master file and provider application activity entered into the provider electronic record in MPC's Credentialing database to ensure the timely management and reporting of the status of provider credentialing applications and contracts in accordance with Insurance Article 15-112(d). Quarterly audits will be conducted where random provider files are and reviewed selected to ensure compliance with prescribed turnaround times for credentialing.
Evaluation Methodology	Weekly Reports and Quarterly Audits
Timeframe	Weekly / Quarterly
Responsible Party	Provider Relations/Credentialing
Outcome	Provider notifications will adhere to the time frames specified in Insurance article Section 15-112(d) and documentation maintained in the provider file and the Credentialing database. MPC's Provider Credentialing Database is used to track credentialing application receipts and turn-around times. This information is included in the quarterly PR KIR, which are furnished to MPC's Service Improvement Committee. Final: Provider Relations Management conducted staff education to ensure that the correct notification and timeframes were followed. Letters of intent to contract/credential are sent to providers within ten (10) business days of receipt of a completed application/contract. Provider file audit findings will be shared with the Service Improvement Committee (SIC) for documentation of the activity.

Delmarva Foundation requests CAPS when an MCO does not meet the minimum performance threshold. For example, the MCOs are required to achieve a 90% minimum performance threshold in each area of the annual CR. If the MCO receives a compliance rating of less than 90%, Delmarva Foundation will issue a request for a CAP. We review completed CAPs prior to the submission of the Annual Plan Specific Reports to BMS and include all CAPs in an appendix of the Annual Plan Specific Reports.

Section 2.4.10: The Vendor should propose a plan to develop a report to include comparative information about all MCOs. Vendor should provide a sample report; final format to be agreed upon by the Vendor and State.

Vendor Response:

Delmarva Foundation has collected and maintained MCO data from the inception of the MHT program in 1996. Historically, Delmarva Foundation has presented in-depth comparative analyses to BMS in the Annual Technical Report. Delmarva Foundation has the processes in place and already collects and analyzes the data needed to complete the MHT Annual Comparative Report. **The MHT Annual Technical Report CY 2010 is provided as a sample report in the Appendix**.

The comparative analysis Delmarva Foundation currently provides in the ATR assists BMS in monitoring MHT and MCO performance. For example, when selecting the measures to be included in the WV MHT State Strategy, we worked with BMS and its subcontractor to determine which measures and what benchmarks would be appropriate to monitor for its population. Measures were selected in the areas of prevention, access, chronic care and postpartum care. The CY 2010 analysis revealed that over the past two years, the Childhood Immunization Status measure decreased both years from the baseline. This was not surprising as our PMV activities identified an issue with the MCOs not having adequate access to the West Virginia Immunization Information System. Our next step is to determine how much this impacts the measure rate.

A comparative analysis for each activity, including the ACR, PMV, and PIP validation will be completed annually. Using performance data, comparisons can be made among the MCOs to assess ***individual plan performance compared to its peers.*** As part of our standard processes, Delmarva Foundation calculates MHT Aggregate Rates where possible. These rates provide BMS with an overall performance rate for the MHT program. The MHT Aggregate Rate allows for comparison of the ***individual MCO performance to the overall MHT Program performance***. Three examples of Delmarva Foundation's comprehensive annual comparative analysis are in the examples below.

Example 1- MCO Annual Compliance Review performance compared to Peers and MHT Aggregate Rate. Table 1-26 provides the CY 2010 Annual Compliance Review rates for all standards

Table 1-26. MCO Annual Compliance Rates by Standard for CY 2010

SPR Standard	CY 2010 Compliance Rate			
Enrollee Rights (ER)	100%	100%	100%	100%
Grievance Systems (GS)	100%	100%	100%	100%

SPR Standard	CY 2010 Compliance Rate			
Quality Assessment and Performance Improvement (QA)	99%	99%	98%	98.7%
Fraud and Abuse (FA)*	100%	96%	100%	98.7%

All MCOs performed exceptionally well in CY 2010, achieving commendable compliance rates ranging from 96% to 100%, with the MHT Aggregate Rate performing above 98%. All the MCOs surpassed the 90% threshold in CY 2010 for the QA standards thus obviating the need for any internal corrective action plans. In CY 2009, [redacted] fell below the 90% threshold for the newly implemented Fraud and Abuse standard. Because it was a baseline review, we did not require a corrective action plan. Delmarva Foundation provided technical assistance to the MCO to assist them in interpreting the regulations, developing appropriate policies, procedures, and work flows. The MCO overhauled its fraud and abuse program and was able to exceed the threshold in CY 2010.

The Fraud and Abuse standard was implemented in CY 2009. The baseline review yielded similar results [redacted]. However, [redacted] performed well below the 90% threshold. Delmarva Foundation provided technical assistance to [redacted] to assist them in developing a meaningful compliance plan and procedures. In CY 2010 [redacted] overhauled its Compliance Program to incorporate which now meets the majority of the FA standards.

The analysis is further defined by using the trend data Delmarva Foundation has maintained since the inception of the MHT program. The use of trend data helps monitor both ***MCO and MHT program progress compared to MHT program goals*** **and objectives** set forth by BMS.

Example 2: Trending of Individual MCO Plan Performance Compared to Peers and MHT Aggregate.

Table 1-27. MCO Compliance Rates for Quality Assessment and Performance Improvement (QA) CY 2008-CY 2010

MCO	QA Standard Compliance Rate		
	CY 2008	CY 2009	CY 2010
[redacted]	97%	98%	99%
	100%	100%	99%
	98%	97%	98%
	98.3%	**98.3%**	**98.7%**

It is clear from the individual MCO performance rates in Table 1-27, that all MCOs have demonstrated a commitment to their quality improvement programs. For example, disease management programs have been put in place for chronic conditions such as diabetes. The impact of these programs can be measured using the HEDIS® data collected during the PMV process. All MCOs performed exceptionally well for the QA standard, achieving commendable compliance rates ranging from 97% to 100% across the measurement years with the MHT

Aggregate Rate performing above 98% in that same period. All MCO's surpassed the 90% performance threshold in CY 2010 for the QA standards thus obviating the need for any internal corrective action plans.

In analyzing performance measures, the analysis is further enhanced with the addition of national benchmarks. Annually, the individual **MCO performance measures and MHT Aggregate Rates are trended and compared to the HEDIS® National Benchmarks**.

Example 3: Figure 1-12 provides the indicator results for *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*.

[redacted] CY 2009 to CY 2010 at 92.6%, and exceeded both the CY 2008 rate of 86.2% and National Medicaid Average of 90.2%. The State Strategy for Assessing and Improving Managed Care Quality goal is 91.6%. The MHT Weighted Average exceeded this goal with a rate of 92.6% in CY 2009 and CY 2010.

All reporting formats will be provided to BMS to review and approve prior to use. The proposed format for the Annual MCO Comparative Report is:

I. Executive Summary

II. Background and Purpose Methodology

III. Annual Compliance Review

IV. Performance Improvement Projects

V. Performance Measure Validation MHT MCO Findings

VI. Annual Compliance Review Comparative Analysis

VII. Performance Measure Validation Comparative Analysis

VIII. Performance Improvement Comparative Analysis

IX. Analysis Summary of Comparative Analysis Findings by Quality, Access and Timeliness Conclusions

IX.1.1. Strengths

IX.1.2. Weaknesses

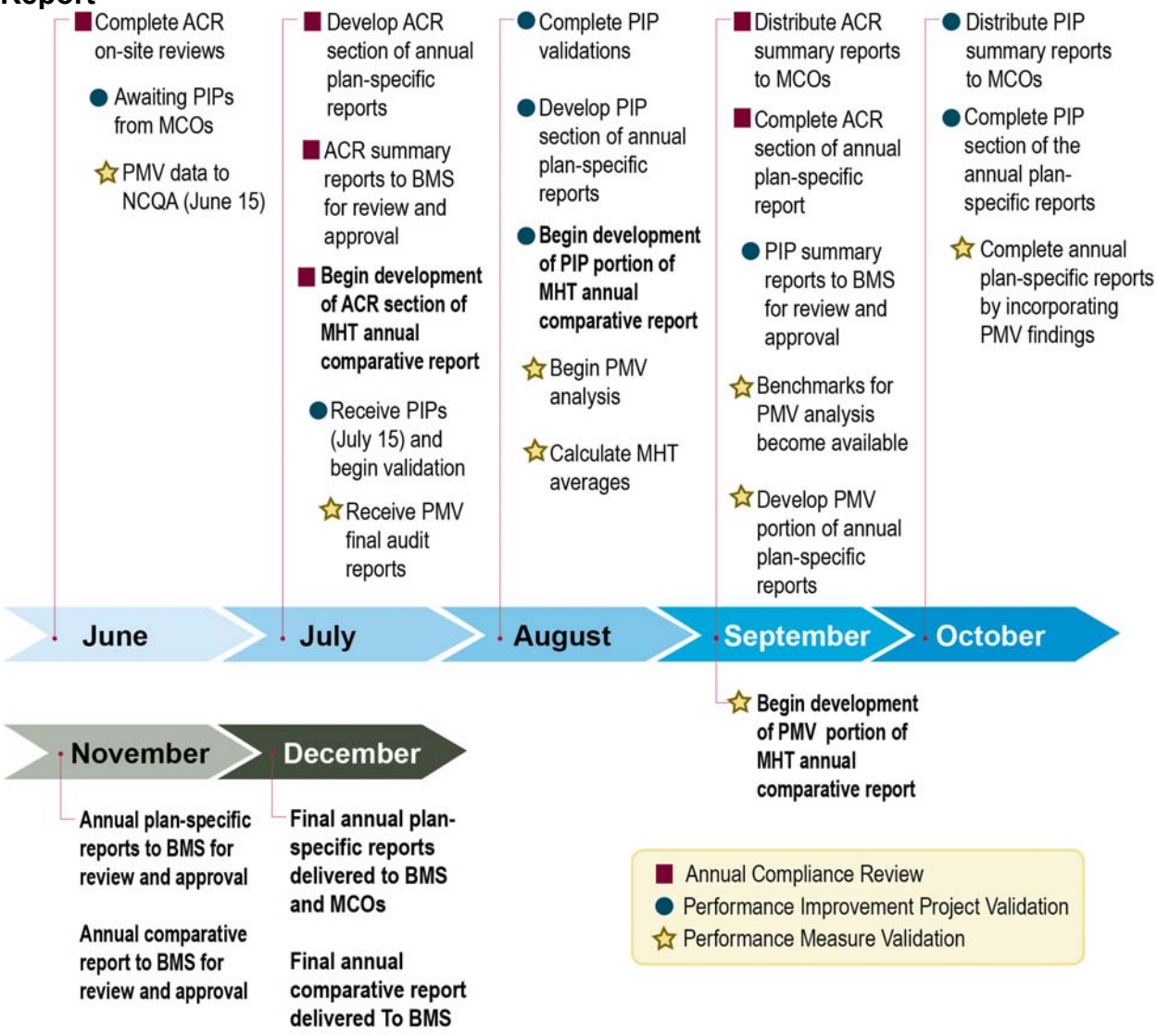
IX.1.3. Recommendations

BMS will review and approve the format of the report prior to development of the ACR. This is a scheduled activity within the Integrated Work Plan.

Plan to Develop Annual MCO Comparative Report

The data, analysis, and findings from the Annual Plan Specific Reports will feed the MHT Annual MCO Comparative Report. Therefore, the development and production of both reports will run parallel on the timeline. The proposed high-level plan for developing the Annual MCO Comparative Report is summarized below. The proposed detailed timeline (Figure 1-13) is contained in the Integrated Work Plan.

Figure 1-13. Timeline for Development and Production of the Annual Comparative Report



Section 2.4.11: Vendor should propose a yearly Operations Plan that addresses compliance with all of the following program requirements: Validating and reviewing PIPs, performance measures and annual compliance reviews. The Operations Plan should include a timeline of events.

Vendor Response: Deleted per Addendum 1.

Section 2.4.12: Vendor should demonstrate their expertise in Federal statutes, regulations, and guidance related to quality assurance and performance measurement including the Patient Protection and Affordable Care Act (PPACA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Vendor Response:

Demonstrate expertise in Federal statutes, regulations and guidance related to quality assurance, performance measurement including the PPACA and CHIPRA 2009.

Delmarva Foundation's mission is to improve health in the communities we serve. To achieve this mission, we must be acutely aware of the ever changing legislative mandates that govern the course of our work. Monitoring regulations and interpreting their impact on our customers is a priority. Delmarva Foundation conducts legislative and regulatory environment scanning on an ongoing basis. Our integrated business development, corporate communication and executive leadership form the foundation for soliciting, updating, and distributing current and proposed changes in legislation that may impact our business, our customers and stakeholders.

Children's Health Insurance Program
Delmarva Foundation has collaborated with BMS, the state's data contractor, and the WV CHIP program to determine which measures in the core set can be reported for the MHT program through the CHIP Annual Report Template System (CARTS). An assessment of the MCO data and the measures resulted in the Delmarva Foundation providing data for the 11 of the 24 core measures.

Chapter 5, Article 16B, of the West Virginia Code established the regulations for the expansion of West Virginia Children's Health Insurance Program (CHIP). The legislature's intent is to "expand access to health services for eligible children and to pay for this coverage by using private, state and federal funds to purchase those services or purchase insurance coverage for those services."

One key component of the Children's Health Insurance Program Reauthorization Act (CHIPRA, Public Law 111-3) passed in early 2009, was to identify an initial set of core measures to be used to voluntarily assess the state of children's health care quality and outcomes for children. The Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) have been working since then to implement specific provisions of the legislation that relate to children's health care quality across and within state CHIP and Medicaid programs and to establish the Pediatric Quality Measures Program (PQMP). The PQMP is charged with improving and strengthening the initial cores set of 24 measures and developing new measures as needed.

As a CHIPRA Demonstration Grantee, West Virginia, Alaska and Oregon formed the Tri-State Children's Health Improvement Consortium (T-CHIC). These three states have similar challenges in that they attempt to provide children's health care in some of the most rural, low-income areas of the United States. The Consortium proposes to demonstrate the unique and combined impact of patient-centered care delivery models and health information technology (HIT) on the quality of children's health care, using the 24 CHIPRA Initial Core Measures Set. To date, WV has recruited 10 pediatric practices representing approximately 83 providers in nine different counties. The 10 providers use Electronic Health Records (HER) in their clinical practices and will

participate in an assessment of the effective use of EHRs, Patient Health Records (PHRs), and the Health Information Exchange (HIE) in improving children's health care outcomes.

All three states in the Consortium have the challenge of providing health care in some of the most rural, low-income areas in the country. During the project, the states hope to quantify racial and ethnic health care disparities where possible, implement strategies under the medical homes model to reduce such disparities, and use the data to develop state-level improvement strategies through Performance Improvement Projects (PIPs). To this end, the T-CHIC proposes to collect the core measure set and a group of measures to assess medical home for children. The T-CHIC will propose the medical home measures to the PQMP for inclusion in a future measurement set.

The Balanced Budget Act of 1997 and Resulting Code of Federal Regulations
The Balanced Budget Act (BBA) of 1997, which became effective in 2002, set the course for overhauling the federal statutes governing all aspects of the Medicaid Managed Care Programs as set forth in the Social Security Act and Title 42 of the Code of Federal Regulations (CFR 438 et seq).

The general rule in 42 CFR §438.360 states that to avoid duplication, "the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare of private accreditation review to provide information otherwise obtained from the mandatory activities." Mandatory activities are defined as performance improvement project (PIP) validation, performance measure validation (PMV), and an assessment of the MCO compliance with operational systems standards (compliance review) review. The BBA and the Medicaid managed care regulations provided the authority for the Centers for Medicare and Medicaid (CMS) to develop an option process for states to use.

In general, if an MCO has undergone a survey, such as once completed by URAC, formerly known as the Utilization Review Accreditation Commission or National Committee for Quality Assurance (NCQA) and meets national accreditation guidelines, certain standards have been found to be comparable or equivalent to the BBA standards. If a NCQA requirement is equivalent to the same BBA standard, then the standard is eligible for exemption from duplicate review by the EQRO. This is known as deeming.

Annually, NCQA publishes a crosswalk document that compares each BBA standard with the standards required for accreditation. The deeming process is currently applicable only to standards for access, structure and operations, and measurement and improvement; they do not apply to grievances.

The Delmarva Foundation has applied the deeming process as the EQRO for the Virginia Medicaid managed care program. All MCOs are required to achieve NCQA accreditation and as such are eligible to have certain standards that are equivalent to the BBA exempt from duplication of review by Delmarva Foundation. In planning for this process, Delmarva Foundation prepared a comprehensive document detailing the NCQA standards their deeming status, the BBA standards and the MCO contract requirements. Information included details of

the standard, the review rationale Delmarva Foundation's recommendation Virginia to consider in determining whether to deem standards. Since there may be issues or situations individual to each state in making this decision, some standards may be eligible for deeming, but were not considered to be deemed during a review cycle. The state Medicaid agency has the authority to make a final determination based upon individual circumstances in their state.

Based upon the discussion and Virginia's decisions, draft BBA standards and state contract requirements were developed for final review and use in the next MCO annual compliance review. After approval by the state, the standards were finalized with a designation of either deemed or not deemed. Standards were provided to the MCOs during the annual orientation and available online at the secure web portal. Delmarva Foundation provided a detailed MCO orientation prior to conducting the annual compliance reviews. The orientation included background information on why a change in process is allowed and explanations of the deeming status and rationale for the final standards.

Delmarva Foundation also conducted a review of the MCO's most recent NCQA accreditation documentation for the deemed standards to validate compliance. Pre-site documentation was submitted for the BBA and contract standards that were not considered to be deemed. An on-site visit was conducted to include review of all BBA standards and contract requirements that were not deemed. The EQR report detailed findings of the reviewed standards and noted those that were not reviewed due to deeming.

NCQA HEDIS®

NCQA's HEDIS® measure set is considered the gold standard in health care performance measurement. The current measure set, HEDIS® 2012, contains 76 measures across five domains of care. The domains are Effectiveness of Care, Access/Availability of Care, Experience of Care, Utilization and Relative Resource Use, and Health Plan Descriptive Information.

As a part of the PMV activities, Delmarva Foundation works with BMS to establish the performance measures to be validated each year. Our HEDIS® audit partner, Metastar, Inc., along with Delmarva Foundation's Certified HEDIS® Compliance Auditors, monitor the updates and changes to the measures and the standard audit methodology. In the most recent audit year, BMS notified the audit team of the Secretary's request that each MCO report the Medication Management for People with Asthma measure. Historically this measure and any other measure requiring pharmacy data, was not collected by the MCOs owing to the pharmacy carve out. As a carve-out service, the MCOs did not have access to the required pharmacy data to construct these measures. Delmarva Foundation worked with the MCOs to determine the pharmacy file requirements needed to construct this measure. This collaborative effort including Delmarva Foundation, the MCOs and Molina, the State's fiscal services agent, resulted in the Molina providing pharmacy data files to each MCO with the required data fields to construct the this measure, successfully.

This collaboration was successful as the three MCOs were able to report this measure to BMS. Because of the MCO success integrating pharmacy data from Molina, Delmarva Foundation

recommended, and BMS agreed, to require the MCOs to collect the additional Respiratory Conditions measures listed below.

- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Conditions
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Medication Management for People with Asthma

Incorporation of these measures into the MHT reporting process will provide BMS with data to assess the quality of treatment and services provided to its enrollees. If the success of incorporating pharmacy data to construct these measures is realized, Delmarva Foundation may recommend adding additional measures in subsequent years to increase BMS' ability to measure key metrics of care.

In another approach to reduce the overall HEDIS® reporting burden and allow allocation of resources to improvement activities, the HEDIS® General Guidelines allow the rotation of select measures on a biennial basis. Measure rotation allows an organization to use the audited and *reportable* hybrid method rate from the prior year's data collection in lieu of collecting the measure for the measurement year. Historically, BMS MHT MCOs were not offered the opportunity to rotate measures. For HEDIS® 2012 (calendar year 2011), eligible measures for rotation are:

- Cervical Cancer Screening
- Controlling High Blood Pressure
- Frequency of Ongoing Prenatal Care
- Prenatal and Post Partum Care
- Weeks of Pregnancy at Time of enrollment

Delmarva Foundation suggested that BMS consider rotation of at least one measure for HEDIS® 2012. The Prenatal and Postpartum Care and Controlling High Blood Pressure measures are part of the current WV MHT Program Strategy and therefore would not be appropriate for rotation. The Cervical Cancer Screening rate has remained relatively stable over the past three measurement periods and therefore was recommended for rotation.

Patient Protection and Affordable Care Act

Enhanced methods of fraud and abuse detection were implemented in September 2010 as a component of the PPACA. In response to the increased focus on fraud and abuse, BMS asked Delmarva Foundation to explore the possibility of assessing the MHT MCOs' efforts in this area. Delmarva Foundation staff reviewed the current PPACA requirements, 42 CFR §438.608 Program Integrity Requirements, and the MHT MCO contractual obligations. A set of Fraud and Abuse (FA) standards were developed by Delmarva Foundation and submitted to BMS for approval. A baseline review was completed for 2010 efforts with two MCOs meeting the required threshold. Delmarva Foundation provided technical assistance to the one plan that did not meet the threshold. Technical assistance included interpreting standards and regulations, drafting policies and flow-charts, and providing feedback on revised policies and procedures.

The MCO embraced the recommendations for improvement and achieved a commendable compliance rate in the first review, avoiding any corrective actions.

Another component of PPACA was the requirement to develop an initial core set of quality measures for Medicaid eligible adults. The initial core set of quality measures was published on December 30, 2010 and sets forth quality measures directed at maternal/reproductive health, overall adult health, complex health care needs, and mental health and substance use. The final notice published in the Federal Register on January 4, 2012 announced the initial core set of health care quality measures for Medicaid-eligible adults, as required by section 2701 of the Affordable Care Act, for voluntary use by state programs administered under title XIX of the Social Security Act, health insurance issuers and managed care entities that enter into contracts with Medicaid, and providers of items and services under these programs. The core set includes 26 measures in the areas of:

- Prevention and Health Promotion (Flu shots for Adults Ages 50-65, Adult BMI Assessment, Breast Cancer Screening)
- Management of Acute Conditions (Follow-up After Hospitalization for Mental Illness, Elective Delivery)
- Management of Chronic Conditions (Annual HIV/AIDS Medical Visit, Controlling High Blood Pressure)
- Family Experiences of Care (Consumer Assessment of Health Plans Survey)
- Care Coordination (Care Transition)
- Availability (Prenatal and Postpartum Care, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment)

Delmarva Foundation collaborated with BMS, the state's data contractor, and the WV CHIP program to determine which measures in the core set can be reported for the MHT program. Delmarva Foundation will continue to provide technical assistance for BMS in implementing, measuring and reporting these data.

Section 2.4.13: Vendor should demonstrate their knowledge of "best practices" in performance improvement and their ability to work with MCOs to improve results.

Vendor Response:

Delmarva Foundation's staff has forged strong working relationships with each of the MHT MCOs. Year after year, we have assisted the MCOs in efforts to improve performance, as demonstrated in all of the activities. For example for PIPs, we have recommended MCOs complete annual barrier analyses, as barriers and circumstances do change over time. New barriers require new interventions, which can significantly impact performance improvement.

Best practices are identified throughout the annual audit activities as we complete the Annual Compliance Review (ACR), validate Performance Measures (PMV), and validate Performance Improvement Projects (PIPs). In addition, each member of the EQR team was re-designated a subject matter expert (SAME) in one or more areas (e.g. health reform, managed care,

performance measure validation, accountable care organizations). Each week the SMEs report any relevant regulations, mandates, or best practices identified to the EQR team for dissemination. Best practices are catalogued and maintained by the EQR team for use across all of our contracts.

A clear example of performance improvement is highlighted in Table 1-28 below and provides results of an Annual Compliance Review assessment. One MHT MCO's ACR results are provided using CY 2006 (first year of review) compared to the most recent review of CY 2010.

Table 1-28. MHT MCO Compliance Review Scores CY 2006 vs. CY 2010

Compliance Review Standard Areas	CY 2006	CY 2010
Enrollee Rights	82%	100%
Grievance Systems	84%	100%
Quality Assessment and Performance Improvement	98%	99%

With all of our review activities, Delmarva Foundation provides reasonable, and actionable recommendations to the MCOs. Rates in the table above provide evidence that when an MCO follows through on the recommendations we provide, such as revisions to policies and procedures, distribution of enrollee materials according to timeframe requirements, data collection and reporting to BMS, etc., an organization can make significant improvement and achieve compliance with standards.

Across our numerous EQRO contracts, we have witnessed best practices and made recommendations to spread activities that have led to other successes. Examples are provided in Table 1-29.

Table 1-29. MHT MCO Identified Opportunities and Action Taken

Opportunity	Actions taken that resulted in best practices
Improve the rate of adolescent enrollees, 12-21 years of age, who had at least one comprehensive well care visit with a primary care provider	• Educational efforts targeting enrollees were made via telephone, in-person, and community health promotion events • Reminder notices were submitted to providers about specific patients due for services
Assist pregnant members in an effort to achieve healthier pregnancies, deliveries, and babies	• early risk assessment by obstetrical nursing support • Personalized, telephonic counseling and support was available 24/7 via toll free access • Implementation of the nation's first free mobile health initiative, *text4baby*
Improve the percentage of enrollees 2-56 years of age who were identified as having persistent asthma and who were appropriately prescribed medication	• Telephonic outreach was made to reach 100% of enrollees admitted with asthma • Case Management provided education to enrollees, coordinated care, and provided home visits by a nurse, when required • Promoted collaboration with primary care providers and use of community resources

In one of Delmarva Foundation's EQR contracts, we hold an annual meeting with the MCOs where each MCO presents their best practices. This allows the MCOs to highlight their achievements and discuss best practices. This sharing of information benefits all of the MCOs and has potential to positively impact more enrollees as lessons learned and best practices are shared. **Delmarva Foundation recommends that the MHT MCOs participate in an annual best practices presentation. This could easily be accomplished and incorporated into the annual MCO EQR orientation agenda.**

Delmarva Foundation's well qualified and credentialed staff maintain current working knowledge of industry standards and promote process improvement in all of the EQR activities. Our subcontractor, MetaStar, Inc., which assists us with the PMV activities, also participates in best practice efforts. For example, when the auditors are on-site completing validation activities, they share best practices that they have learned while auditing other organizations such as utilizing sample size reduction strategies in hybrid measures to minimize the number of medical record chases. In our experience, the MHT MCOs have received this type of information favorably and may assimilate it into their own performance measure reporting processes.

Section 2.4.14: Vendor should provide three (3) references (excluding West Virginia) from similar projects of work performed within the past five (5) years along with a detailed description of the work performed for each reference. Each referenced project should include one (1) or more key staff member from the list of staff proposed for this project. References should include:

- **Names of the staff members who worked on the project;**
- **Time period of the project;**
- **Scheduled and actual completion date;**
- **Organization name, address, and current telephone number; and**
- **Contact name, phone number, and e-mail address of project administrator familiar with the Vendor's performance.**

Vendor Response:

Delmarva Foundation for Medical Care, Inc.	
Contracting Entity	Maryland Department of Health and Mental Hygiene, HealthChoice and Acute Care Administration, Division of HealthChoice Management and Quality Assurance
Type of Contract	Fixed Price
Total Contract Value	$3,593,041
Point of Contact Information (name, address, phone, email)	Nadine Smith, Deputy Director 201 West Preston Street Baltimore, MD 21201 410-767-3567 smithn@dhmh.state.md .us
Description of Work Performed External Quality Review Organization	
Scheduled Completion Date	2016
Actual Completion Date	08/2007 11/2002
Length and Dates of Contract	12/2002-08/2007 12/1997-11/2002
Proposed Key Staff Involved	[redacted]
Work Undertaken Delmarva Foundation monitors and reports on the quality of care provided by Medicaid managed care organizations (MCOs) in Maryland. The comprehensive compliance audit (systems review) is performed annually and it assesses the MCO's adherence to its provider agreement and state regulations and laws. The compliance review includes monitoring MCOs' structures, processes, and outcomes related to, for example, medical record-keeping practices, credentialing program, outreach efforts, and quality assurance and improvement activities. Additional contract activities include the development of the HealthChoice MCO report card for consumers, performance measure validation and a final value-based purchasing report, a report that summarizes MCO performance in relation to the Maryland Healthy Kids program requirements including a review of approximately 3,000 medical records annually, performance improvement project validation, encounter data validation and technical assistance to MCOs regarding quality improvement measures and projects .	
Deliverables Produced	• MCO compliance reviews • Value-based purchasing measure validation • Performance improvement project validation • Consumer report card on MCOs • Focus studies – EPSDT • Encounter Data Validation

Delmarva Foundation for Medical Care, Inc.	
Contracting Entity	State of North Dakota Department of Human Services
Type of Contract	Fixed Price
Total Contract Value	$138,283
Point of Contact Information (name, address, phone)	Jodi Hulm* (*Ms. Hulm is on leave, in her absence Mr. Erik Elkins will provide reference information that she has provided) 600 East Boulevard Ave, Department 325 Bismarck, ND 58505-0250 701-328-2246 (Ms. Hulm) 701-328-2246 (Mr. Elkins)

	jmhulm@nd.gov
Description of Work Performed CHIP External Quality Review Organization	
Scheduled Completion Date	2013
Actual Completion Date	Ongoing
Length and Dates of Contract	07/2011-Present
Proposed Key Staff Involved	[redacted]
Work Undertaken Delmarva Foundation provides external quality review of North Dakota's CHIP program, including conducting performance improvement project validation, performance measure validation, and compliance review according to federal and state regulations. Additional activity includes providing technical assistance to the CHIP MCO.	
Deliverables Produced	• Performance improvement project validation • Performance measure validation • Compliance review • Annual Technical Report

Delmarva Foundation for Medical Care, Inc.	
Contracting Entity	Commonwealth of Virginia – Department of Medical Assistance Services
Type of Contract	Fixed Price
Total Contract Value	$1,276,640
Point of Contact Information (name, address, phone)	Carol L. Stanley, MS, CPHQ 600 East Broad Street, Suite 1300 Richmond, VA 23219 804-371-7980 Carol.Stanley@DMAS.Virginia.Gov
Description of Work Performed External Quality Review Organization	
Scheduled Completion Date	2013
Actual Completion Date	09/2006 Ongoing
Length and Dates of Contract	07/2001-09/2006 02/2009-Present
Proposed Key Staff Involved	[redacted]
Work Undertaken External quality review activities include: Performance Improvement Project Validation, Performance Measure Validation, Operational Systems (compliance) Review in 3rd year, Annual Technical Report, Focused Clinical Study for Birth Outcomes, Focused Clinical Study for Well Child Services (using Hybrid methodology to include Immunizations, Well-Child Visits and Access to Primary Care), and a Consumer Assessment of Health Plans Survey (CAHPS®) for the Fee-for-Service population in 2nd year. Additionally, EQR activities included training for Department of Medical Assistance and managed care organization staff.	
Deliverables Produced	• Clinical focus studies • Operational standards review of MCOs • Performance measure validation • Performance improvement project validation • Annual evaluation and summary technical report

2. RFP Attachment B: Mandatory Specification Checklist

List mandatory specifications contained in Section 2.5:

Section 2.5.1: Must comply with requirements listed in Attachment D.

Vendor Response:
An electronic copy of the technical proposal that omits proprietary language for publishing to the DHHR website is provided as part of this proposal. All data, procedures, programs, work papers and all materials gathered or developed by Delmarva under this contract are the property of the State Medicaid Agency (BMS).

Section 2.5.2: Vendor shall provide a lead point of contact that will be immediately available by telephone and e-mail at a minimum, during business hours of Monday through Friday, 8:00 AM – 5:00 PM Eastern Standard Time (EST).

Vendor Response:
Delmarva Foundation has designated Marci Kramer, MHSA, CPHQ, CHCA as the proposed project manager and lead point of contact. Her qualifications and experience are provided in Attachment A, Section 1. 2. Qualifications and Experience. The project manager will be immediately available by telephone, and email during business hours Monday through Friday, 8:00 am through 5:00 pm EST.

Section 2.5.3: Vendor will provide necessary training and technical assistance to all designated DHHR and BMS staff and their contractors participating in this project during the duration of this contract.

Vendor Response:
Delmarva Foundation will provide the necessary resources for training and technical assistance to the designated DHHR and BMS staff and their contractors participating in this project during the duration of this contract. Training and technical assistance is included as a task in the Organized Integrated Work Plan located in Section 2.4.1. The Yearly Operations plan in Section 2.4.11 of this proposal addresses ongoing training and technical assistance during the project in the introductory paragraph.

Section 2.5.4: Vendor must comply with all Federal regulations. Vendor must meet the competence and independence requirements as specified in 42 CFR §438.354.

Vendor Response:
Delmarva Foundation meets all required competency and Independence Requirements defined in 42 CFR 438.354. These include demonstrated competence in the following:

1. Staff with demonstrated Experience and knowledge of Medicaid:
    a. Recipients, policies, data systems, and processes

   b. Managed Care delivery systems, organizations and financing
2. Quality assessment and improvement methods
3. Research design and methodology including statistical analysis
4. Sufficient physical, technological and financial resources to conduct EQR/EQR-related activities
5. Other clinical and non clinical skills necessary to carry out EQR/EQR-related activities and to oversee the work of any subcontractors
6. Delmarva Foundation and its proposed subcontractor meet the independence requirements. Delmarva Foundation and MetaStar are each independent from BMS and from MHT MCOs, PHIPs that are reviewed under this scope of services. Neither Delmarva Foundation nor MetaStar have any financial or business relationship with any entities reviewed under the scope of services for the External Quality Review Organization for West Virginia Mountain Health Trust Medicaid Managed Care Program.

Section 2.5.5: Vendor must prepare and submit a draft work plan for review and approval by DHHR/BMS within thirty (30) calendar days from the date of contract award. The approved work plan must be submitted to the Bureau for Medical Services, prior to beginning EQR activities.

Vendor Response:
Delmarva Foundation will submit a draft work plan for review and approval by DHHR/BMS within thirty (30) calendar days from the date of contract award prior to beginning the annual EQR activities. A draft work plan including our approach and key features is provided in Attachment A, Section 2.4.1 of the technical proposal.

Section 2.5.6: Vendor's project manager or a designated representative shall attend all quarterly meetings of the MHT Task Force.

Vendor Response:
Delmarva Foundation has designated Marci Kramer, MHSA, CPHA, CHCA as the proposed project manager and lead point of contact. Incorporated into her roles and responsibilities is attendance at all quarterly meetings of the MHT Task Force.

Section 2.5.7: The Vendor will provide quarterly written status reports to Bureau for Medical Services within fifteen (15) calendar days of end of quarter.

Vendor Response:
Delmarva Foundation will submit quarterly written status reports to the BMS within 15 calendar days of the end of the quarter. The report will include a progress report in accordance with the approved work plan and identify any potential barriers or risks that need to be addressed and plans to mitigate these risks. Quarterly reporting is included as an Administrative Task on the Proposed Detailed Timeline included in Attachment A, Section 2.4.1. Sample Quarterly Status Reports are included in the Appendix to this proposal.

Section 2.5.8: The Vendor shall provide additional services to comply with externally driven changes to BMS programs and requirements, including any State or Federal laws, rules, and regulations. Additional Services shall be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work (SOW) and submission of related Cost Estimate.

Vendor Response:
Delmarva Foundation will provide additional services/resources to comply with externally driven changes to BMS programs and requirements, including any State or Federal laws, rules, and regulations. An all-inclusive hourly rate is provided in the cost sheet presented as part of this proposal, but in a separately sealed envelope. These services will be provided upon written approval by BMS of a SOW and submission of related cost estimates by Delmarva Foundation.

I certify that the proposal submitted meets or exceeds all the mandatory specifications of this RFP. Additionally, I agree to provide any additional documentation deemed necessary by the Bureau to demonstrate compliance with said mandatory specifications.

Delmarva Foundation for Medical Care, Inc.
(Company)


(Signature)

Thomas Jackson, Chief Executive Officer
(Representative Name, Title)

(410) 770-3829 ext. 11170
(Contact Phone/Fax Number)

03/05/2012
(Date)

Attachment C: Cost Sheet

In accordance with the RFP requirements, the completed cost sheet which details our start-up costs, yearly operating costs, and additional services costs by contract year is presented in a separate, sealed envelope.

Attachment D: Special Terms and Conditions

If a Vendor's proposal includes proprietary language within the technical proposal, an electronic copy omitting any proprietary language for publishing to the DHHR web-site shall be submitted.

Agree that BMS retains ownership of all data, procedures, programs, workpapers and all materials gathered or developed under the contract with West Virginia.

I certify that I have acknowledged the additional contract provisions contained in Attachment D and that the proposal meets or exceeds all additional requirements as listed.

Delmarva Foundation for Medical Care, Inc.
(Company)


(Signature)

Thomas Jackson, Chief Executive Officer
(Representative Name, Title)

(410) 770-3829 ext. 11170
(Contact Phone/Fax Number)

03/05/2012
(Date)