



Rule H-2009-03

2014 Performance Evaluation Report of Managed Care Organization's Data Filings

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PART I: EXECUTIVE SUMMARY

The purpose of this report is primarily to assess compliance with Vermont's Rule H-2009-03 quality requirements of the care and services that Vermonters received as members of the four major managed health insurers in Vermont for HMO, POS, and PPO products. In doing so, the report chronicles and compares standardized annual clinical and administrative performance measures against accepted national and regional benchmarks and multi-year performance trends of Vermont's health care plans (known as Managed Care Organizations (MCOs)). This report also identifies areas of performance that fall short of reaching a benchmark and may provide an opportunity for improvement. Key performance domains included in this report include:

- 1) MCOs Overview, Enrollment, Market Share, and Access to Providers/Services
- 2) Member Satisfaction, UR Decisions, and Grievances
- 3) MCO Performance on Quality Measures
- 4) Analyses of MCO Performance Over-Time
- 5) Department Recommendations to Improve MCO Quality

The report uses symbols to denote the results of statistical tests comparing MCO performance against two different benchmarks. For the most part, the benchmarks represent national and New England regional averages calculated by the National Committee for Quality Assurance (NCQA). Although not every MCO in the United States submits data to NCQA, most do. Therefore, NCQA's national and regional averages provide reasonable and generally accepted points of comparison. The Department performs additional statistical significance testing for performance measures, measure subsets, as well as longitudinal analyses.

The body of the report includes only those measures with results that are of special note either because they represent important opportunities for improvement or because they indicate noteworthy superior performance. There are two appendices included with this report. Appendix A contains additional measure data reported by the managed care organizations and Appendix B contains technical documentation.

1.1 MCO Overview, Enrollment, Market Share, and Access to Providers/Services

Access to Providers/Services; Travel Time Standards and Waiting Time Standards: The MCOs are providing adequate geographic access for most services for most members. Consistent with previous reports, the primary area for improving member access to services is in the area of mental health professionals, i.e., psychiatrists and inpatient chemical dependency services. Of particular note, there is a need for improved access to mental health professionals in the Northeast Kingdom, which has had an access issue for some time. Access to kidney transplant and vascular surgery services is another area which is below standard for most MCOs in Essex and Orleans counties.

Provider Satisfaction: The results of provider satisfaction surveys revealed that the majority of Vermont providers who responded to the survey “agreed” or “strongly agreed” in being satisfied with BlueCross BlueShield of Vermont, Inc. (BCBSVT) and MVP Health Care (MVP), while less than half of the providers who responded were satisfied with Cigna Health and Life Insurance Company (CIGNA). For every provider satisfaction question, either BCBSVT or MVP had the highest score. For the first time, all MCOs were compliant with the requirement to use the Department-approved provider satisfaction survey questions and the Department-approved scale. For more information see: [Part II: MCO Overview, Enrollment, Market Share, and Access to Providers/Services](#)

1.2 Member Satisfaction, UR Decisions and Grievances

MCOs are completing requests for prior authorization decisions in a timely manner. Grievances remain relatively rare, ranging from four grievances per 1000 members (TVHP) to less than one grievance per 1000 members (MBH). When examining the rate at which grievances are overturned in the member’s favor, TVHP’s overall rate was slightly higher than the other MCOs for physical health grievances, while MVP had the fewest number of grievances and the lowest percentage of grievances overturned. For more information see: [Part III: Member Satisfaction, UR Decisions, and Grievances](#)

1.3 MCO Performance on Quality Measures

The report includes a list of MCO opportunities to improve outcomes. However, the Department has focused its recommendations for improvement on a set of measures that apply to all MCOs, where the average performance level did not meet 50% and/or did not meet the New England regional average. These recommendations are included in the Recommendations section of the report. For more information see: [Part IV: MCO Performance on Quality Measures](#)

1.4 Analyses of MCO Performance Over-Time

Comparisons of baseline and current year MCO quality measures are used to determine how effectively plans are improving over-time. For the current reporting year, a majority of measures reported by MCOs showed either statistically significant improvement, no statistically significant change, or past and current measures were already reported as being high performing. In total there were seven measures that showed a statistically significant decrease in over-time performance. High variability in the number of over-time performance measures that were reportable for each plan was found. For more information see: [Part V: Analyses of MCO Performance Over-Time](#)

1.5 Department Recommendations to Improve MCO Quality

All of the MCOs, except BCBSVT and MVP, have at least one improvement opportunity related to the timeliness with which they complete grievance requests. Only BCBSVT’s PPO and PrimariLink, mental health delegate for MVP, met the timeframe requirements for mental health and substance abuse grievances. For more information see: [Part VI: Department Recommendations to Improve MCO Quality](#)

PART II: MCO OVERVIEW, ENROLLMENT, MARKET SHARE, AND ACCESS TO PROVIDERS/SERVICES

2.1 Vermont MCOs Overview

Vermont Rule H-2009-03 and statutes (18 V.S.A. § 9414 and 8 V.S.A. §§ 15, 4089a, 4089b and 4724) hold MCOs to consumer protection and quality requirements. Each MCO subject to intensive review under these regulations was required to submit a comprehensive set of performance indicators, and other information specified by the Department, on or before July 15, 2014.

In 2014, there were eight MCOs required to submit data as part of these requirements. The majority of this information includes clinical performance measures for calendar year 2013 and member survey data field in the spring of 2014.

The types of measures required under Rule H-2009-03 are categorized into three categories:

- 1) HEDIS® clinical effectiveness measures,
- 2) Member satisfaction and experience of care measures, and
- 3) Department-specified Rule H-2009-03 measures.

Occasionally data from multiple categories are presented together to display all data related to a key category. Below is a table displaying the different managed care organizations that were required to submit data and their abbreviations used throughout the report.

Insurance Entity	Abbreviations in Report	
	MCO (w/o PPO)	PPO
Blue Cross Blue Shield of Vermont	BCBSVT	BCBSVT PPO
Cigna Health and Life Insurance Company	CIGNA	CIGNA PPO
MVP Health Care	MVP	MVP PPO
The Vermont Health Plan	TVHP	N/A

Rates reported by Preferred Provider Organizations (PPOs) tend to be lower than those reported by other managed care products (e.g., HMOs, POS). In order to improve comparisons, MCOs are divided into one of two types:

1. All Lines of Business minus PPOs (referred to as “MCO (w/o PPO)” in this report)
2. PPO

In this report, PPO products are only compared with other PPOs, while the MCOs w/o PPOs are compared only to each other.

In addition to the health plans, there were four organizations that manage mental health and substance abuse services for Vermonter's. They were required to submit a subset of measures.

Managed Mental Health Organization	Abbreviation in Report	Insurer
Cigna Behavioral Health	CBH	CIGNA
Magellan Behavioral Health ¹	MBH	BCBSVT & TVHP
PrimariLink	PrimariLink	MVP
Vermont Collaborative Care ²	VCC	BCBSVT & TVHP

CIGNA submitted HEDIS[®] and CAHPS[®] data for both its managed physical health and mental health network products, which included its PPO products. Blue Cross Blue Shield of Vermont submitted data for its BCBSVT HMO, Point of Service (POS) and PPO products; MVP submitted data only for its PPO products. In 2011 the membership of MVP's HMO plan dropped below meaningful reporting thresholds and stayed there in 2013. Based on discussion and approval by the Department, MVP did not report HEDIS[®] or CAHPS[®] data for this product. BCBSVT and TVHP filed data for both Magellan Behavioral Health and Vermont Collaborative Care because of a transition in 2014 of their MBHO contractor.

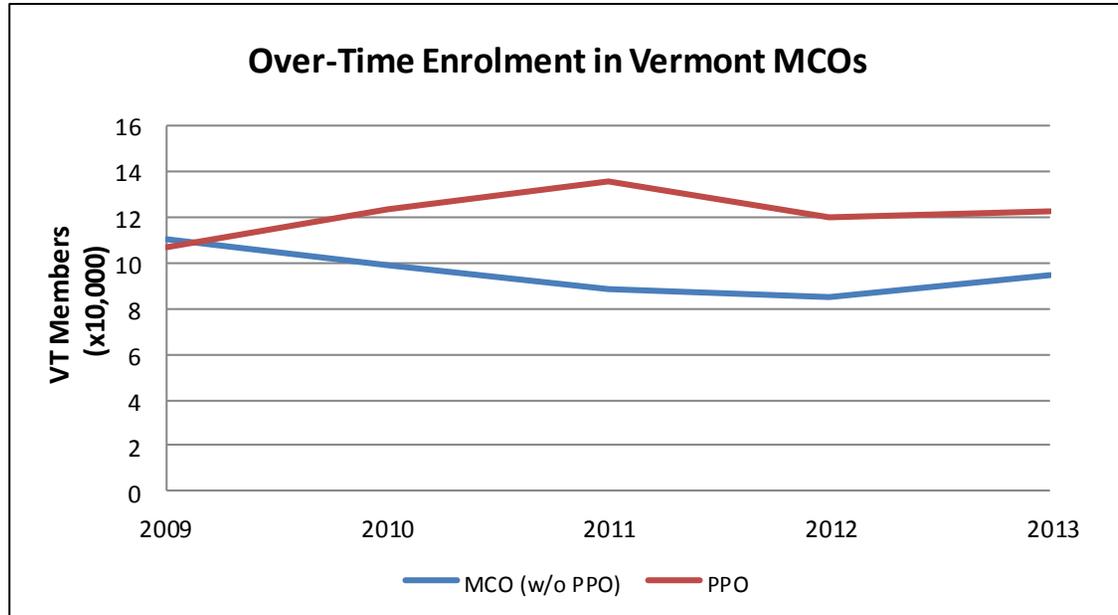
¹ Managed mental health and substance abuse services for BCBSVT and TVHP until June 30, 2013.

² Began managing mental health and substance abuse services for BCBSVT and TVHP on July 1, 2013.

2.2 Enrollment Statistics and Market Share

Enrollment differs greatly between insurance entities, ranging from 23,563 members (MVP combined) to over 91,721 (BCBSVT combined). For the current reporting year, total membership in non-PPO plans increased by 9,310 members, while membership in PPO plans increased by 3,319. The 29% increase in membership by the BCBS HMO represented the largest increase in membership by any plan.

Enrollment Trends, 2009 – 2013										
	BCBSVT	CIGNA	MVP	TVHP	MCO w/o PPO Total	BCBSVT PPO	CIGNA PPO	MVP PPO	Total PPO	All MCO Total
2009										
Members	42,648	23,536	14,701	29,772	110,657	27,145	61,432	18,089	106,666	217,323
Market Share	20%	11%	7%	14%	51%	12%	28%	8%	49%	100%
2010										
Members	41,244	20,410	5,150	32,038	98,842	26,818	69,015	27,803	123,636	222,478
Market Share	19%	9%	2%	14%	44%	12%	31%	12%	56%	100%
Growth 2009-2010	-3%	-13%	-65%	8%	-11%	-1%	12%	54%	16%	2%
2011										
Members	41,937	4,626	3,171	38,945	88,679	27,857	81,000	27,107	135,964	234,643
Market Share	18%	2%	1%	17%	38%	12%	35%	12%	58%	100%
Growth 2009-2011	-2%	-80%	-78%	31%	-20%	3%	32%	50%	27%	8%
2012										
Members	41,404	4,387	523	39,680	85,471	36,780	57,039	25,981	119,800	205,271
Market Share	20%	2%	0.25%	19%	42%	18%	28%	13%	58%	100%
Growth 2009-2012	-3%	-81%	-96%	33%	-22%	35%	-7%	44%	12%	-5%
2013										
Members	53,367	3,577	587	37,250	94,781	38,354	61,789	22,976	123,119	217,899
Market Share	24%	2%	0.27%	17%	43%	18%	28%	11%	57%	100%
Year-Over Change	29%	-18%	12%	-6%	11%	4%	8%	-12%	3%	6%
Growth 2009-2013	25%	-85%	-96%	25%	-14%	41%	1%	27%	15%	0%



The 2014 reporting year was the first time in the past five reporting years that membership has increased for both HMO and MCO (w/o PPO) products. The largest increase in this category was for the BCBS HMO, which experienced a 29% increase in 2013 enrollment.

2.3 Access to Providers/Services; Travel Time Standards and Waiting Time Standards

Access to services is an important consideration for health plan members. Managed care organizations are responsible for ensuring that sufficient numbers and types of contracted providers are available to provide health care services for members without unreasonable delay. This requirement must be met in all service areas in which the MCO has members. In addition, the Rule requires that MCOs meet requirements for travel time standards and waiting time standards so that, under normal circumstances, members are able to obtain services from either their residence or place of business within the required driving and appointment waiting timeframes.

2.3.1 Geographic Access

Rule H-2009-03 stipulates travel time requirements to contracted providers from members' residences or places of business. The travel time standards vary by type of health care provider; however, MCOs must ensure that 90% of its members have access to each provider type within the travel time specified in the Rule.

MCOs may submit a combined GeoAccess report for their PPO and MCO (w/o PPO) products if at least 85% of the providers are shared among their different product networks. Cigna submitted combined reports, while BCBSVT submitted separate reports for its PPO and MCO (w/o PPO) products.

CBH and MBH submitted information about member access to mental health and substance abuse services within their provider networks. To avoid duplication, CBH reports mental health and substance abuse service access for Cigna; Cigna does not report any mental health and substance abuse access data. All of the information that was submitted is included in the charts that follow. PrimariLink was not required to report any access data because it does not have its own contracted provider network.

It is important to note that travel time measurements only evaluate the proximity of providers to members' residences. With the exception of access to PCPs, the measures do not address whether a provider who is located within the required distance is accepting new patients, the status of wait times for appointments, or if the provider has the clinical expertise or experience required to meet a specific patient's needs. Therefore, in theory, it is possible for an MCO to have an access score of 100% with only one provider under contract in a particular service area and all of its members living in close proximity to that one provider.

A review of the travel time submissions finds that there are deficiencies in some service areas for some provider services. It should be noted that in some rural counties, particularly in Vermont's Northeast Kingdom (Caledonia, Essex, and Orleans counties), there are relatively few mental health and substance abuse providers and they may exceed the Rule H-2009-03 travel time standard for members in those service areas. This is not a new finding, but one that may require the assistance of other state agencies in partnership with the MCOs to solve.

In addition, each year the Department reviews a different set of medical specialties to determine if MCOs meet the Rule H-2009-03 standard of providing at least 90% of members with access to specialty care within 60 minutes of travel time. During this reporting period, the specialties that were reviewed included the following:

- OB/GYN

- Otolaryngology
- Vascular Surgeons

In the current reporting year, a review of access to Kidney Transplant services within 90 minutes of travel time was also performed.

The tables on the following pages report the areas where MCOs do not meet the access standards for at least 90% of their members on either a statewide or county-specific basis.

When at least one MCO was found to have an opportunity for improvement, the table for access to those services can be found below. The following measures meet or exceed the access standards for all MCOs and do not have a chart displayed in the report.

Services meeting required 30-minute travel time for all MCOs:

- PCPs for adults
- PCPs for children
- Mental health providers in an outpatient or office setting (access within specific counties is shown for psychiatrists and psychologists where access falls below the 90% standard)
- Substance abuse providers in an outpatient or office setting

Services meeting required 60-minute travel time for all MCOs:

- Access to Otolaryngologist
- Access To OB/GYN Services

MCOs that do not meet the travel access requirements under Rule H-2009-03 are marked with a red “⊗” symbol and may represent opportunities for improvement.

2.3.2 Access to Mental Health Providers for Selected Counties

Rule H-2009-03 requires that at least 90% of each MCO's members have access to psychiatrists, psychologists and master's level therapists within 30 minutes of travel time. Access information for selected counties that do not consistently meet the 90% standard for all provider types are reported in the table below.

Percentage of Members within Access to Outpatient Mental Health and Chemical Dependency Providers in Selected Counties					
	Psychiatrists	Psychologists		Psychiatrists	Psychologists
Essex County			Orange County		
BCBSVT	78% ⊗	76% ⊗	BCBSVT	95%	100%
BCBSVT PPO	100%	66% ⊗	BCBSVT PPO	93%	100%
CBH	100%	98%	CBH	100%	100%
MBH	50% ⊗	64% ⊗	MBH	67% ⊗	100%
MVP	76% ⊗	74% ⊗	MVP	100%	100%
TVHP	98% ⊗	73% ⊗	TVHP	75% ⊗	100%
Franklin County			Orleans County		
BCBSVT	98%	97%	BCBSVT	100%	29% ⊗
BCBSVT PPO	99%	98%	BCBSVT PPO	22% ⊗	47% ⊗
CBH	99%	97%	CBH	25% ⊗	25% ⊗
MBH	73% ⊗	96%	MBH	22% ⊗	34% ⊗
MVP	100%	99%	MVP	100%	100%
TVHP	95% ⊗	92%	TVHP	94%	22% ⊗
Grand Isle County			Windsor County		
BCBSVT	100%	100%	BCBSVT	100%	100%
BCBSVT PPO	100%	100%	BCBSVT PPO	100%	100%
CBH	100%	100%	CBH	100%	100%
MBH	92%	100%	MBH	66% ⊗	100%
MVP	100%	100%	MVP	100%	100%
TVHP	100%	100%	TVHP	100%	100%

2.3.3 Access to Kidney Transplants

Rule H-2009-03 requires that at least 90% of each MCO's members have access to Kidney Transplant services within 90 minutes of travel time. Access information for selected counties that do not consistently meet the 90% standard for all provider types are reported in the table below.

Percentage of Members with Access to Kidney Transplants Statewide and for Selected Counties					
County	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Bennington	36% ⊗	32% ⊗	96%	100%	49% ⊗
Essex	53% ⊗	66% ⊗	80% ⊗	29% ⊗	65% ⊗
Windham	99%	100%	100%	81% ⊗	99%
Statewide	97%	98%	100%	90%	98%

2.3.4 Access to Specialties

Rule H-2009-03 requires that at least 90% of each MCO's members have access to the following specialties within 60 minutes of travel time:

- OB/GYN
- Otolaryngology
- Vascular Surgeons

In the current data filing, both OB/GYN and otolaryngology met access standards for selected counties reviewed for all MCOs.

Access standards for vascular surgeons were not met by all MCOs. Rates for MCOs in reviewed counties where less than 90% of members were within 60 minutes of travel time can be found below.

Percentage of Members with Access to Vascular Surgeons for Selected Counties and Statewide					
County	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Essex	31% 	39% 	100%	21% 	49% 
Orleans	78% 	82% 	100%	65% 	71% 
Statewide	99%	99%	100%	97%	98%

2.3.5 Intermediate Chemical Dependency Providers

To meet the geographic access standard for intermediate chemical dependency providers, 90% of members must have access within 60 minutes of travel time. The counties where the 90% standard was not met by all MCOs are shown in the table below. This measure includes acute residential treatment, partial hospitalization programs, and intensive outpatient programs.

Percentage of Members within Access Standards to Intermediate Chemical Dependency Providers for Selected Counties and Statewide						
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Essex County	31% ⊗	39% ⊗	100%	100%	100%	49% ⊗
Orleans County	29% ⊗	45% ⊗	100%	100%	100%	22% ⊗
Rutland	41% ⊗	40% ⊗	100%	100%	100%	37% ⊗
Statewide	92%	90%	100%	100%	100%	88% ⊗

2.3.6 Intermediate Mental Health Providers

To meet the geographic access standard for intermediate mental health providers, 90% of members must have access within 60 minutes of travel time. The counties where the 90% standard was not met by all MCOs are shown in the table below. This measure includes acute residential treatment, partial hospitalization programs, and intensive outpatient programs.

Percentage of Members within Access Standards to Intermediate Mental Health Providers for Selected Counties and Statewide						
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Essex County	89% ⊗	100%	100%	100%	19% ⊗	99%
Orleans County	100%	100%	100%	100%	34% ⊗	99%
Statewide	100%	100%	100%	100%	96%	100%

2.3.7 Percentage of Members with Access to Inpatient Mental Health Facilities for Selected Counties

To meet the geographic access standard for inpatient mental health facilities, 90% of members must have access within 60 minutes of travel time. The counties where the 90% standard was not met by all MCOs are shown in the table below.

Percentage of Members with Access to Inpatient Mental Health Facilities for Selected Counties						
County	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Essex	89% 	100%	100%	35% 	19% 	99%
Orleans	96%	100%	100%	35% 	41% 	97%
Statewide	100%	100%	100%	97%	97%	100%

2.3.8 Percentage of Members with Access to Inpatient Chemical Dependency Facilities - Selected Counties and Statewide

To meet the geographic access standard for an inpatient chemical dependency (CD) facility, 90% of members must have access within 60 minutes of driving time. The counties where the 90% standard was not met by all MCOs are shown in the table below. Given the wide variation across the data reported by the MCOs in the past, the Department researched whether the same methodology and definitions were applied consistently by all MCOs and found that they were not. The Department provided additional clarification this year, including that inpatient chemical dependency facilities include residential facilities.

Percentage of Members within Access Standards to Inpatient Chemical Dependency Facilities for Selected Counties and Statewide						
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Chittenden County	100%	100%	100%	13% ⊗	100%	100%
Essex County	35% ⊗	39% ⊗	100%	45% ⊗	19% ⊗	54% ⊗
Lamoille County	100%	100%	100%	10% ⊗	100%	100%
Orleans County	47% ⊗	56% ⊗	100%	9% ⊗	54% ⊗	38% ⊗
Statewide	98%	99%	100%	60% ⊗	98%	96%

2.3.9 Percentage of Members with Access to Appointments within the Rule H-2009-03 Waiting Time Standards

The access standard for appointment times are shown below:

- 24 hours for urgent care
- 2 weeks for non-emergency, non-urgent care
- 90 days for preventive care, including routine physical examinations

MCOs with performance levels below 90% are identified as having an opportunity for improvement. Since there is no standard for preventive care for mental health, CBH and MBH are designated with “N/A.” It should be noted that MCOs are able to choose how to measure this standard, and the different methods selected by the MCOs are noted in the footnotes.

Percentage of Members with Access to Appointments within the Rule 9-03 Time Standards									
	BCBSVT ²	BCBSVT PPO	CBH ³	CIGNA ⁴	CIGNA PPO	MBH ⁵	MVP ⁶	TVHP	Rule Standard
Urgent Care	90%	96%	28%	94%	99%	100%	100%	91%	90%
Improvement Opportunity			⊗						
Non-Urgent Care	72%	69%	84%	89%	80%	100%	89%	71%	90%
Improvement Opportunity	⊗	⊗	⊗	⊗	⊗		⊗	⊗	
Preventive Care	89%	91%	N/A	65%	61%	N/A	100%	87%	90%
Improvement Opportunity	⊗			⊗	⊗			⊗	

² BCBSVT/BCBSVT PPO/TVHP Members responding to BCBS Custom Questions: 1) “In the last 12 months, when you needed care right away for an acute or sudden illness or injury, how long did it take to get care from your doctor or clinic?” “12 hours or less and 13 to 24 hours”; 2) “How long did it take to get an appointment for a check-up or routine care at your doctor’s office or clinic?” “One week or less and More than one week but less than two weeks”; 3) “How long did it take to get care from your doctor or clinic for your routine preventative exam (for example: a complete physical)?” “Less than one month;” and “At least one month but less than two months” and “At least two months but less than three months.”

³ Members responding “usually/always” to questions of the Experience of Care Survey

⁴ Members responding “usually/always” to questions on the CAHPS® Survey

⁵ MVP reviewed wait time for services based on time from request for authorization of services.

⁶ MVP conducted appointment book audits of all high volume practices.

2.4 Provider Satisfaction

Rule H-2009-03 requires that MCOs conduct an annual survey of their provider network, which includes a set of standardized, Department-approved survey questions. Each MCO uses its own sampling and survey methodology and can expand survey questions beyond those required by the Department. However, the Department-approved survey questions are scored on a five-point scale using the following responses:

- Strongly Agree
- Agree
- Neither Agree or Disagree
- Disagree
- Strongly Disagree

Department-approved survey questions and MCO's provider satisfaction results can be found in Section 1.4.2.

2.4.1 Provider Satisfaction Survey Methods

Survey sampling methods and response rates are summarized below. Overall, sample sizes remain stable or better than historic surveys although response rates continue to be low (six percent to fourteen percent). The best plan response rate, BCBS at fourteen percent, had the most comprehensive survey methodology which included telephone follow-up calls for non-responders.

MCO	Sample Size	Survey Completion	Response Rate	Survey Methodology
Cigna	1,547	90	6%	Mail, Internet
MVP	1,000	81	8%	Mail
BCBS	1,816	249	14%	Mail, Internet, Telephone

While each plan is in compliance with the basic requirements to include standard state questions in their provider satisfaction surveys and to collect responses using a five-point scale, the Department encourages each of the MCOs to seek ways to overcome the barriers to these low response rates.

2.4.2 Provider Satisfaction Survey Results

Standardized, Department-approved survey questions and response rates are found below. Rates are reported as the percent of respondents who “Strongly Agree” or “Agree” with the survey question.

Department-approved Standardized Provider Survey Questions		Cigna	MVP	BCBS
1	Overall, I am satisfied with [MCO].	46%	73%	91%
2	I would recommend [MCO] to other practitioners and to my patients.	33%	64%	79% ⁷
3	[MCO’s] staff is responsive when I need assistance.	50%	71%	93%
4	[MCO’s] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.	40%	72%	71%
5	[MCO] provides adequate support to patients with chronic conditions, or other serious illness.	26%	58%	57%
6	[MCO’s] prescription drug formulary is adequate.	25%	28%	53%
7	The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.	17%	21%	43%
8	The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.	27%	47%	61%
9	I have adequate access to [MCO’s] Vermont utilization management department (e.g., when coverage for a service has been denied).	26%	56%	76%
10	[MCO’s] reimbursement levels are adequate.	27%	31%	65%
11	[MCO’s] claims payments are timely.	47%	68%	96%
12	[MCO’s] claims processing is accurate.	40%	72%	89%
13	There are an adequate number and breadth of practitioners in [MCO’s] network when I need to refer patients for other services.	32%	51%	59%

⁷ BCBS reported survey item three in two parts: one rate for practitioners and one rate for patients. Responses were appropriately weighted and reported as a single value.

2.4.3 MCO Actions Taken in Response to Last Year's Provider Survey Results

MCOs are required to summarize the results of any corrective actions that they have undertaken during the reporting year to improve provider satisfaction. A variety of improvement activities were undertaken by MCOs and a brief summary of such activities can be found below. The table represents several targeted improvement themes.

Improvement Activity	Cigna	MVP	BCBS
Improve adequacy of utilization and care management tools and processes	X		X
Improve drug pre-approval turnaround time		X	
Improve claim payment timeliness	X	X	
Resolve inquiries upon first contact with customer service representative			X
Improve adequacy of reimbursement levels			X

PART III: MEMBER SATISFACTION, UR DECISIONS, AND GRIEVANCES

3.1 Methodology for Evaluating MCO Performance

The following analysis evaluates various data submitted to the Department by the MCOs. This includes HEDIS[®], CAHPS[®], and Department-specified Rule H-2009-03 measures, with the exception of geographic access data and appointment wait time data, which were presented in the previous section. Department-specified Rule H-2009-03 measures were developed by the Department in cooperation with the MCOs. These measures are not found in a national measurement set such as HEDIS[®].

The HEDIS[®] and CAHPS[®] data were subject to two different types of statistical analyses: point-in-time analysis and trend analysis; whereas the Department-specified Rule H-2009-03 measures were evaluated against performance levels and not subject to any statistical tests. Measure rates are not reported when the sample size is less than thirty. The details of the analysis can be found in the technical documentation section included in Appendix B.

In order for an MCO's performance to be evaluated for significance, the sample size must be greater than or equal to one hundred. The threshold of one hundred for significance testing was selected to ensure enough "statistical power" exists to detect a difference. When sample sizes are very small, it is possible to not find a significant difference when, in fact, a difference exists but can only be detected with a larger sample.⁸ For a measure to be considered significant, the Department requires two separate criteria be met. The first is statistical significance (i.e. a p -value of 0.05 or less) and the second is practical significance test (i.e. a difference of at least four percentage points between the MCO's performance and the relevant standard). The combination of these tests is designed to identify true differences that readers would find important. For change-over-time analyses, only statistical significance (i.e. a p -value of 0.05 or less) and no practical significance test is applied.

Summary of rate reporting and significance testing by measure sample size

Measure Sample	Measure Rate Reporting	Point-In-Time / Over-Time Testing
<30	NO	NO
<100	YES	NO
≥100	YES	YES

⁸ Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*. Routledge Academic.

3.1.1 Table Key

The following symbols and acronyms are used to communicate MCO performance for Part III and Part IV:

Symbol/ Acronym	Interpretation	Definition
★	High Performer	Plan rate is greater than or equal to the 95 th percentile benchmark
▲	Better	Point-In-Time: means that the MCO's point-in-time score is better than the national or regional average by a statistically and practically significant amount. Over-Time: means that there is a statistical significant improvement when comparing the MCO's current and historic score.
○	Similar	Point-In-Time: means that there is no significant difference between the MCO's point-in-time score and the national or regional average. Over-Time: means that there is no statistical significant difference when comparing the MCO's current and historic score.
▼	Worse	Point-In-Time: means that the MCO's performance is worse than the national or regional average by a statistically and practically significant amount. Over-Time: means that there is a statistical significant decrease when comparing the MCO's current and historic score.
N/A	Not Applicable	Significance testing is not applicable when the sample size in the reporting year is less than one hundred or when historical data is missing
⊗	Opportunity For Improvement	Point-In-Time: MCOs are considered to have an opportunity for improvement when either significance testing is below the national/regional average OR the rate is less than fifty percent.
N/R	Not Reported	Rates are not reported when sample sizes are less than 30.

3.2 Members' Experience of Care - CAHPS® Survey

This section of the report covers a range of measures that quantify members' experiences with their MCO or PPO. The topics covered in this section include the following:

- members' experiences with their health plan and provider network as measured by the CAHPS® survey
- the percentage of utilization review decisions that fell below the Rule H-2009-03 timeliness standard
- the percentage of member complaints and grievances that were upheld or overturned, and were decided within the required timeframes

Taken together, these different types of measures provide a picture of members' experiences with their health plan.

In order to gauge how satisfied members are with the services they receive from their health plans, and with the health care providers in their networks, Rule H-2009-03 required BCBSVT, BCBSVT PPO, CIGNA, CIGNA PPO, MVP PPO, and TVHP to report the results of a member experience of care and service survey for their adult commercial population. This section of the report provides the survey results for selected measures by reporting the percentage of members who were satisfied with the performance of their HMO or PPO.

Change over time is also examined to identify whether performance has improved, stayed the same, or declined. Change over time is measured by determining if there are statistically significant changes in performance between the baseline measurement year (2012) and the most recent measurement year (2014).

Details about the survey, including response rates and respondent characteristics, may be found in Appendix A.

3.2.1 Rate Your Overall Health Plan Experience

This measure reports members' overall satisfaction with their HMO or PPO and is commonly seen as the key gauge of how satisfied members are with their specific MCO. These rates represent the percentage of members responding with a rating of 8, 9, or 10 to the question, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"

Rate Your Overall Health Plan Experience									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	84%	80%	56%			66%	67%	51%	
Compared to National Average	▲	▲	▼	68%		▲	○	▼	60%
Compared to Regional Average	▲	▲	▼	70%		▲	▲	▼	70%
Improvement Opportunity			⊗					⊗	
Change Over Time 2012-2014	○	▲	○			▲	○	○	

3.2.2 Call Answering

This is not a CAHPS® survey question, but rather a HEDIS® measure that uses administrative data. This measure is included in this section of the report because it relates to a member’s experience with an MCO’s customer service staff.

Call Answer Timeliness

This measure reports the percentage of calls answered by a live person within 30 seconds. A higher percentage is better.

Call Answer Timeliness										
		BCBSVT ⁹	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Call Answer Timeliness	Plan Rate	45%	77%	45%			45%	81%	75%	
	Compared to National Average	▼	○	▼	78%		▼	▲	▼	79%
	Compared to Regional Average	▼	▲	▼	71%		▼	▲	▼	78%
	Improvement Opportunity	⊗		⊗			⊗		⊗	
	Change Over Time 2012-2014	○	▲	▲			▲	▲	▼	

⁹ In the past two years, BCBSVT and TVHP reported adopting a “concierge model” for customer service that attempts to provide complete and accurate information to members on first contact as means of achieving higher member satisfaction. However, this approach results in much longer wait times and falls substantially below national or regional averages.

3.2.3 Customer Service: Composite and Individual Measures

Composite Measure

NCQA combines the rates from two CAHPS® questions to create a Customer Service Composite measure that includes:

How often did Customer Service staff treat you with courtesy or respect?

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often did your health plan’s customer service staff treat you with courtesy and respect?”

How often did your health plan’s Customer Service give you the information or help you needed?

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often did your health plan’s customer service give you the information or help you needed?”

Customer Service: Composite and Individual Measures									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	94%	94%	87%		88%	80%	86%	
	Compared to National Average	▲	N/R	○	88%	○	N/R	N/R	86%
	Compared to Regional Average	○	N/R	○	90%	○	N/R	N/R	86%
	Change Over Time 2012-2014	○	N/R	○		○	N/R	N/R	
How often did Customer Service staff treat you with courtesy or respect?	Plan Rate	98%	98%	97%		96%	91%	90%	
	Compared to National Average	○	N/R	○	95%	○	N/R	N/R	94%
	Compared to Regional Average	○	N/R	○	96%	○	N/R	N/R	94%
	Change Over Time 2012-2014	○	N/R	○		○	N/R	N/R	
How often did your health plan’s Customer Service give you the information or help you needed?	Plan Rate	90%	89%	77%		78%	70%	77%	
	Compared to National Average	▲	N/R	○	82%	○	N/R	N/R	78%
	Compared to Regional Average	○	N/R	▼	84%	○	N/R	N/R	78%
	Improvement Opportunity			⊗					
	Change Over Time 2012-2014	○	N/R	▼		○	N/R	N/R	

3.2.4 Claims Processing: Composite and Individual Measures

Composite Measure

NCQA measures both the timeliness and the accuracy of the HMO's and PPO's claims payment function in this composite. Poor handling of claims can be costly to the member and to health care providers both in terms of dollars and time spent on follow-up and resolution.

Claims Processing is Timely

This measure reports, of the members who have submitted a claim in the last 12 months, the percentage that reported "usually" or "always" to the question, "In the last 12 months, how often did your health plan handle your claims quickly?"

Claims are Processed Correctly

This measure reports, of the members who have submitted a claim in the last 12 months, the percentage that reported "usually" or "always" to the question, "In the last 12 months, how often did your health plan handle your claims correctly?"

Claims Processing Composite										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	95%	94%	91%			90%	89%	89%	
	Compared to National Average	▲	○	○	89%		○	N/R	○	88%
	Compared to Regional Average	▲	○	○	91%		○	N/R	○	86%
	Change Over Time 2012-2014	○	○	○			○	N/R	○	
Claims Processing is Timely	Plan Rate	97%	94%	91%			89%	86%	88%	
	Compared to National Average	▲	▲	○	88%		○	N/R	○	87%
	Compared to Regional Average	▲	○	○	90%		○	N/R	○	85%
	Change Over Time 2012-2014	▲	○	○			○	N/R	○	
Claims are Processed Correctly	Plan Rate	94%	95%	91%			91%	92%	91%	
	Compared to National Average	○	○	○	91%		○	N/R	○	90%
	Compared to Regional Average	○	○	○	92%		○	N/R	○	89%
	Change Over Time 2012-2014	○	○	○			○	N/R	○	

3.2.5 Getting Needed Care: Composite and Individual Measures

Composite

NCQA combines the rates from the two CAHPS® questions shown below to create a “Getting Needed Care” composite measure:

Getting to See A Specialist

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often was it easy to get appointments with specialists?”

Easy to Get the Care, Tests or Treatment You Needed

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?”

Getting Needed Care									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	87%	94%	88%		89%	88%	91%	
	Compared to National Average	○	★	○	88%	○	○	★	88%
	Compared to Regional Average	○	○	○	90%	○	○	○	89%
	Change Over Time 2012-2014	○	○	○		▲	○	▲	
Getting to See A Specialist	Plan Rate	83%	93%	86%		87%	82%	89%	
	Compared to National Average	○	★	○	85%	○	○	○	85%
	Compared to Regional Average	○	▲	○	87%	○	○	○	85%
	Change Over Time 2012-2014	○	○	○		▲	○	▲	
Easy to Get the Care, Tests or Treatment You Needed	Plan Rate	92%	95%	90%		93%	95%	93%	
	Compared to National Average	○	▲	○	91%	○	○	○	92%
	Compared to Regional Average	○	○	○	93%	○	○	○	92%
	Change Over Time 2012-2014	○	○	○		▲	○	▲	

3.2.6 Plan Information on Costs: Composite and Individual Measures

Composite

NCQA combines the percentage of members who responded “usually” or “always” to the questions listed below to create a “Plan Information on Costs” composite.

Able to Find Out How Much to Pay for a Health Care Service or Equipment

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?”

Able to Find Out How Much to Pay for Prescription Medications

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?”

Plan Information on Costs									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	72%	62%	59%		62%	61%	61%	
	Compared to National Average	○	N/R	○	65%	○	N/R	N/R	60%
	Compared to Regional Average	○	N/R	○	68%	○	N/R	N/R	61%
	Change Over Time 2012-2014	○	N/R	○		○	N/R	N/R	
Able to find out how much to pay for a health care service or equipment?	Plan Rate	73%	60%	63%		60%	55%	64%	
	Compared to National Average	▲	N/R	○	64%	○	N/R	N/R	58%
	Compared to Regional Average	○	N/R	○	68%	○	N/R	N/R	60%
	Change Over Time 2012-2014	○	N/R	○		○	N/R	N/R	
Able to find out how much to pay for prescription medications?	Plan Rate	71%	64%	56%		64%	67%	59%	
	Compared to National Average	○	N/R	▼	66%	○	N/R	N/R	62%
	Compared to Regional Average	○	N/R	▼	69%	○	N/R	N/R	63%
	Improvement Opportunity			⊗					
	Change Over Time 2012-2014	○	N/R	○		○	N/R	N/R	

3.2.7 Getting Care Quickly: Composite and Individual Measures

Composite

NCQA combines the rates from the two CAHPS® questions shown below to create a “Getting Care Quickly” composite measure.

Getting Care Quickly When You Need Care Right Away

This measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?”

Getting Routine Care As Soon as Wanted

The measure reports the percentage of members who responded “usually” or “always” to the CAHPS® question, “In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor’s office or clinic as soon as you thought you needed?”

Getting Care Quickly										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	90%	93%	88%			88%	95%	93%	
	Compared to National Average	○	○	○	87%		○	★	○	87%
	Compared to Regional Average	○	○	○	90%		○	▲	○	88%
	Change Over Time 2012-2014	○	○	○			○	○	○	
Getting Care Quickly When You Needed Care Right Away	Plan Rate	92%	94%	89%			89%	99%	96%	
	Compared to National Average	○	○	○	89%		○	N/R	N/R	89%
	Compared to Regional Average	○	○	○	92%		○	N/R	N/R	90%
	Change Over Time 2012-2014	○	○	○			○	N/R	N/R	
Getting Routine Care As Soon As Wanted	Plan Rate	86%	92%	85%			84%	91%	85%	
	Compared to National Average	○	▲	○	84%		○	★	○	84%
	Compared to Regional Average	○	○	○	88%		○	★	○	86%
	Change Over Time 2012-2014	○	○	▼			○	○	○	

3.3 Utilization Review Decisions

Rule H-2009-03 requires that MCOs make utilization review (UR) decisions within the following specified timeframes:

- concurrent reviews within 24 hours
 - Received greater than 24 hours prior
 - Received less than 24 hours prior
- urgent, pre-service review (including all mental health and substance abuse services and prescription drugs) within 48 hours of receipt of request
- non-urgent, pre-service review within 2 business days of receipt of request
- post-service review within 30 days of receipt of request

MCOs with performance levels below 90% are identified as having an opportunity for improvement because the percentage rate fell below the required standard. Improvement opportunities are noted using a red ⊗ symbol on the same line next to the reported percentage rate.

Percentage of UR Decisions Meeting Rule H-2009-03 Decision-Making Timeframes									
	BCBSVT	BCBSVT PPO	CBH	CIGNA	MBH ¹⁰	MVP	Primari-Link	TVHP	VCC ¹¹
Concurrent Reviews: Received > 24 Hours Prior									
≤ 24 hours	100%	53% ⊗	N/R	N/R	98%	94%	100%	54% ⊗	71% ⊗
Concurrent Reviews: Received < 24 Hours Prior									
≤ 24 hours	74% ⊗	80% ⊗	100%	67% ⊗	N/R	96%	N/R	76% ⊗	97%
Urgent Pre-Service Reviews									
≤ 48 hours or with an extension	100%	100%	100%	80% ⊗	100%	80% ⊗	100%	100%	88% ⊗
Non-Urgent Pre-Service Reviews									
≤ 2 days or with an extension	97%	78% ⊗	100%	98%	100%	88% ⊗	100%	85% ⊗	67% ⊗
Post-Service Reviews									
≤ 30 days or with an extension	98%	87% ⊗	100%	100%	100%	100%	100%	100%	100%

¹⁰ MBH data collection period: 1/1/2013-6/30/2013

¹¹ VCC data collection period: 7/1/2013-12/31/2013

3.4 Member Grievances

Rule H-2009-03 requires MCOs to submit data about member grievances, including:

- grievances per 1,000 members
- number and percentage of members that filed more than one grievance
- number and percentage of grievances that were overturned in a member’s favor
- number and percentage of grievances that were resolved within Rule-specified timeframes

3.4.1 All Grievance Types per 1,000 Members

For the most recent reporting period (January 2013 – December 2013), grievances per 1,000 members varied widely among the MCOs.

Grievances per 1,000 Members									
	BCBSVT	BCBSVT PPO	CBH	CIGNA	MBH	MVP	Primari-Link	TVHP	VCC ¹²
Physical Health	1.95	1.22	N/R	4.48	N/R	0.87	N/R	3.16	N/R
Mental Health & Substance Abuse	0.36	0.48	2.24	0	0.68	0.04	0.04	0.35	0.08
Pharmacy	0.36	0.50	N/R	0.13	N/R	0.15	N/R	0.40	N/R
Total Grievances	2.76	2.56	2.24	4.61	0.76	1.66	0.04	4.31	N/R

¹² Mental health grievance information for VCC was included in the data submissions from BCBSVT and TVHP.

3.4.2 Members with More Than One Grievance

Annually, MCOs report the number of members who have filed more than one grievance. Because the absolute number of members filing grievances is small, and the number filing more than one grievance is even smaller, there are large variations in the reported percentage rates. One should be careful when drawing conclusions; small numbers may reduce the reliability of the results.

Percent of Members Who Filed More than One Grievance									
	BCBSVT	BCBSVT PPO	CBH	CIGNA	MBH	MVP	Primari-Link	TVHP	VCC
Physical Health	0%	2%	N/R	5%	N/R	0%	N/R	5%	N/R
Mental Health & Substance Abuse	13%	8%	9%	N/R	12%	0%	0%	9%	0%
Pharmacy	0%	4%	N/R	0%	N/R	13%	N/R	0%	N/R
Total Percent of Members Filing Multiple Grievances¹³	13%	13%	9%	5%	12%	13%	0%	15%	0%

¹³ The total percentage reflects the total number of members who submitted multiple grievances to each MCO rounded to a whole percentage, not a rounded total percentage of the individual measures.

3.4.3 Percentage of Physical Health Grievances Overturned in Member's Favor

The data submitted by the MCOs include information on the number of physical health grievances that were filed during the reporting period, and the number of grievances overturned in the member's favor. Using these data, percentages are calculated that convey the results of grievance determinations.

Physical Health Grievances Overturned in Member's Favor					
	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Total Number of Grievances Resolved	122	57	140	26	120
Number of Grievances Resolved at 1st Level	104	48	133	23	108
Percent of 1st Level Grievances Resolved in Member's Favor	49%	33%	35%	26%	53%
Number of Grievances Resolved at 2nd Level	18	9	7	3	12
Percent of 2nd Level Grievances Resolved in Member's Favor	22%	22%	29%	0%	50%
Total Percentage of Grievances Resolved in Member's Favor	45%	32%	35%	23%	52%

3.4.4 Percentage of Mental Health and Substance Abuse Grievances Overturned in Member's Favor

The data submitted by the MCOs include information on the number of mental health and substance abuse grievances filed and the number overturned in the member's favor.

Percentage of Mental Health and Substance Abuse Grievances Overturned in Member's Favor								
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	Primari-link	TVHP	VCC
Total Number of Grievances Resolved	25	23	24	53	1	1	13	6
Number of Grievances Resolved at 1st Level	20	22	20	53	1	1	12	6
Percent of 1st Level Grievances Resolved in Member's Favor	55%	45%	40%	53%	100%	100%	58%	67%
Number of Grievances Resolved at 2nd Level	5	1	4	N/R	N/R	N/R	1	N/R
Percent of 2nd Level Grievances Resolved in Member's Favor	20%	100%	0%	N/R	N/R	N/R	100%	N/R
Total Percentage of Grievances Resolved in Member's Favor	48%	48%	33%	N/R	100%	100%	62%	N/R

3.4.5 Percentage of Pharmacy Grievances Overturned in Member's Favor

The data submitted by the MCOs include information on the number of pharmacy grievances filed and the number overturned in the member's favor. Using these data, percentages are calculated that convey the results of grievance determinations.

Pharmacy Grievances Overturned in Member's Favor					
	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Total Number of Grievances Resolved	20	22	4	4	14
Number of Grievances Resolved at 1st Level	19	13	4	4	13
Percent of 1st Level Reviews Resolved in Member's Favor	53%	59%	100%	25%	54%
Number of Grievances Resolved at Voluntary 2nd Level Review	1	N/R	N/R	N/R	1
Percent of Voluntary 2nd Level Reviews Resolved in Member's Favor	100%	N/R	N/R	N/R	0%
Total Percentage of Grievances Resolved in Member's Favor	55%	59%	100%	25%	50%

3.4.6 Timeliness in Making Review Decisions Relating to Physical Health Grievances, Pharmacy Grievances and Grievances Unrelated to an Adverse Benefit Decision

Rule H-2009-03 requires that grievance decisions about physical health services be made within the following timeframes for both Level 1 and voluntary Level 2 grievances:

- physical health service denials requiring concurrent review within 24 hours
- physical health pre-service denials requiring urgent review within 72 hours
- physical health pre-service denials not requiring urgent review within 30 days
- physical health post-service denials within 60 days
- pharmacy pre-service denials requiring urgent review within 72 hours
- pharmacy pre-service denials not requiring urgent review within 30 days
- pharmacy health post-service denials within 60 days
- grievances unrelated to an adverse benefit decision within 60 days

The tables on the following page display the percentage of grievance decisions made within the appropriate timeframes or that exceeded the timeframe, but for which a time extension was justified. MCOs with performance levels below 90% are identified as having opportunities for improvement. Improvement opportunities are noted on the same line with the reported rates with a red ⊗ symbol.

Percentage of Grievances for Physical Health, Prescription Drugs, and Those Unrelated to an Adverse Benefit Decision in Compliance with Rule H-2009-03 Timeframes by Type of Grievance					
	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Level 1 Grievances					
Physical Health, Concurrent	N/R	N/R	0%⊗	N/R	N/R
Physical Health, Urgent Pre-Service	100%	100%	50%⊗	100%	100%
Physical Health, Non-Urgent Pre-Service	100%	100%	88%⊗	100%	100%
Physical Health, Post-Service	100%	100%	96%	100%	100%
Pharmacy, Pre-Service, Urgent Pre-Service	94%	94%	100%	100%	100%
Pharmacy, Pre-Service, Non-Urgent Pre-Service	N/R	N/R	N/R	100%	N/R
Pharmacy, Post-Service	100%	100%	N/R	N/R	N/R
Grievances Unrelated to an Adverse Benefit Decision	100%	100%	N/R	100%	100%
Voluntary Level 2 Grievances					
Physical Health, Concurrent	N/R	N/R	N/R	N/R	N/R
Physical Health, Urgent Pre-Service	N/R	N/R	N/R	100%	100%
Physical Health, Non-Urgent Pre-Service	100%	100%	100%	N/R	100%
Physical Health, Post-Service	100%	100%	100%	100%	100%
Pharmacy, Urgent Pre-Service	100%	N/R	N/R	N/R	100%
Pharmacy, Non-Urgent Pre-Service	N/R	N/R	N/R	N/R	N/R
Pharmacy, Post-Service	N/R	N/R	N/R	N/R	N/R
Grievances Unrelated to an Adverse Benefit Decision	N/R	N/R	N/R	N/R	N/R

3.4.7 Timeliness in Making Mental Health and Substance Abuse Grievance Review Decisions

Rule H-2009-03 requires that 90% of mental health and substance abuse grievance decisions be made within the following timeframes for both Level 1 and voluntary Level 2 grievances:

- mental health and substance abuse service denials requiring concurrent review within 24 hours
- mental health and substance abuse pre-service denials requiring urgent review within 72 hours
- mental health and substance abuse pre-service denials not requiring urgent review within 30 days
- mental health and substance abuse post-service denials within 60 days

MCOs with performance levels below 90% are identified as having opportunities for improvement. Improvement opportunities are noted on the same line with the reported rates with a red ⊗ symbol.

Timeliness in Making Mental Health and Substance Abuse Grievance Review Decisions								
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	Primari-link	TVHP	VCC
Level 1								
Concurrent	80% ⊗	67% ⊗	54% ⊗	82% ⊗	N/R	N/R	100%	N/R
Urgent Pre-Service	100%	100%	N/R	100%	N/R	N/R	100%	100%
Non-Urgent Pre-Service	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Post-Service	100%	100%	100%	100%	100%	N/R	100%	100%
Level 2								
Concurrent	100%	100%	N/R	N/R	N/R	N/R	100%	N/R
Urgent Pre Service	100%	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Non-Urgent Pre-Service	100%	N/R	N/R	N/R	N/R	N/R	N/R	N/R
Post-service	100%	N/R	N/R	N/R	N/R	N/R	N/R	N/R

PART IV: MCO PERFORMANCE ON QUALITY MEASURES

This section of the report provides comparative data for 2013 HEDIS® Effectiveness of Care measures. The Healthcare Effectiveness of Data and Information Set (HEDIS®) is one of the most widely used set of health care performance measures in the United States. The measures below have been grouped using the same categories of clinical conditions provided in the “2013 HEDIS® Technical Specifications for Health Plans.”

4.1 Prevention and Screening

4.1.1 Childhood Immunization Status: Combination 2¹⁴

Combination: Combination Two of childhood immunization status evaluates the percentage of children two years of age who had each of the following vaccines: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), and one chicken pox (VZV).

Childhood Immunization Status: Combination 2										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Combination	Plan Rate	79%	89%	77%			74%	83%	44%	
	Compared to National Average	○	N/A	○	79%		○	▲	▼	67%
	Compared to Regional Average	○	N/A	○	82%		○	▲	▼	76%
	Improvement Opportunity								⊗	
	Change Over Time 2011-2013	○	N/A	○			○	▲	▲	

¹⁴ <http://www.ncqa.org/portals/0/Childhood%20Immunization%20Status.pdf>

4.1.2 Breast Cancer Screening

This measure reports the percentage of women between 42 and 74 years of age who had a mammogram during the last two years. Early detection and treatment of breast cancer can significantly increase a woman's chances of survival. Change over time is not reported due to changes in sample selection.

Breast Cancer Screening									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	81%	79%	78%			73%	71%	75%	
Compared to National Average	▲	▲	▲	74%		▲	▲	▲	69%
Compared to Regional Average	○	○	▼	81%		▼	▼	▼	77%
Improvement Opportunity			⊗			⊗	⊗	⊗	

4.1.3 Colorectal Cancer Screening

This measure reports the percentage of adults ages 50-75 who receive an appropriate screening for colorectal cancer.

Colorectal Cancer Screening									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	72%	73%	67%			58%	70%	47%	
Compared to National Average	▲	▲	○	63%		○	★	▼	57%
Compared to Regional Average	○	○	○	72%		▼	▲	▼	65%
Improvement Opportunity						⊗		⊗	
Change Over Time 2011-2013	○	▲	○			○	▲	▲	

4.1.4 Chlamydia Screening in Women

This measure reports the total percentage of sexually active women between 16 and 24 years of age who received at least one test for chlamydia during the reported year of measurement. Chlamydia screening is an important public health strategy to control a common sexually transmitted disease.

Chlamydia Screening in Women									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Total	Plan Rate	48%	48%	45%		46%	50%	45%	
	Compared to National Average	○	N/A	○	46%	▲	▲	○	42%
	Compared to Regional Average	▼	N/A	▼	54%	▼	▼	▼	56%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	N/A	N/A	N/A		N/A	N/A	N/A	
16 – 20 years of age	Plan Rate	44%	39%	39%		42%	47%	40%	
	Compared to National Average	○	N/A	○	41%	○	▲	○	38%
	Compared to Regional Average	▼	N/A	▼	50%	▼	▼	▼	53%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	N/A	○		N/A	N/A	N/A	
21 – 24 years of age	Plan Rate	51%	44%	52%		50%	54%	50%	
	Compared to National Average	○	N/A	○	50%	○	▲	○	46%
	Compared to Regional Average	▼	N/A	▼	58%	▼	▼	▼	59%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	N/A	N/A	N/A		N/A	N/A	N/A	

4.2 Respiratory Conditions Measures

4.2.1 Care for Children with Respiratory Infections - Composite

This composite measure combines performance on the two measures detailed below to create a Care for Children composite.

Appropriate Testing of Children with Pharyngitis

This measure reports the percentage of children between 2 and 18 years of age who were diagnosed with a sore throat and who were prescribed an antibiotic and received a strep test. By giving a strep test, the doctor is verifying that bacteria, not a virus, caused the infection and that prescribing an antibiotic is the appropriate treatment. Unnecessary use of antibiotics is of great concern because it can lead to the growth of dangerous bacteria that cannot easily be controlled by antibiotics.

Appropriate Treatment for Children with Upper Respiratory Infection

This measure reports the percentage of children between the ages of 3 months and 18 years of age who were diagnosed with an upper respiratory infection and were not given an antibiotic prescription until at least three days after the initial doctor's visit. If an infection is from a virus, a child will be feeling better within 3 days and will not need an antibiotic. Unnecessary use of antibiotics is of great concern because it can lead to the growth of dangerous bacteria that cannot easily be controlled by antibiotics.

For details see the following page.

Care for Children with Respiratory Infections										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	89%	96%	90%			87%	91%	90%	
	Compared to National Average	▲	N/A	▲	83%		▲	▲	▲	81%
	Compared to Regional Average	○	N/A	○	91%		▼	○	○	91%
	Improvement Opportunity						⊗			
	Change Over Time 2011-2013	○	N/A	○			○	○	○	
Appropriate Testing of Children with Pharyngitis	Plan Rate	87%	97%	90%			84%	89%	89%	
	Compared to National Average	▲	N/A	▲	81%		○	▲	▲	78%
	Compared to Regional Average	○	N/A	○	90%		▼	○	○	90%
	Improvement Opportunity						⊗			
	Change Over Time 2011-2013	○	N/A	○			○	○	○	
Appropriate Treatment for Children with Upper Respiratory Infection	Plan Rate	92%	95%	91%			92%	92%	90%	
	Compared to National Average	▲	N/A	▲	85%		▲	▲	▲	83%
	Compared to Regional Average	○	N/A	○	92%		○	○	○	93%
	Change Over Time 2011-2013	○	N/A	○			○	○	○	

4.2.2 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measure is the percentage of members 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription. A higher rate represents better performance. Unnecessary use of antibiotics is of great concern because it can lead to the growth of dangerous bacteria that cannot easily be controlled by antibiotics.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	27%	28%	25%			23%	22%	23%	
Compared to National Average	○	N/A	○	26%		○	○	○	24%
Compared to Regional Average	▼	N/A	▼	31%		▼	▼	▼	29%
Improvement Opportunity	⊗		⊗			⊗	⊗	⊗	
Change Over Time 2011-2013	▲	N/A	▲			○	○	○	

4.2.3 Use of Spirometry Testing in the Assessment and Diagnosis of COPD

This measure reports the percentage of members 40 years of age and older with a new diagnosis of or newly active chronic obstructive pulmonary disease (COPD) who received appropriate spirometry testing to confirm the diagnosis.

Use of Spirometry Testing in the Assessment and Diagnosis of COPD									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	40%	N/R	36%			26%	37%	54%	
Compared to National Average	N/A	N/R	N/A	42%		N/A	○	N/A	41%
Compared to Regional Average	N/A	N/R	N/A	42%		N/A	▼	N/A	46%
Improvement Opportunity							⊗		
Change Over Time 2011-2013	N/A	N/R	N/A			N/A	○	N/A	

4.2.4 Use of Appropriate Medications for People with Asthma

This measure reports the percentage of members between five and 64 years of age who were identified as having persistent asthma and who were prescribed medications that are considered appropriate for long-term control of asthma. If used properly, medications are able to minimize the symptoms of asthma for most patients.

Use of Appropriate Medications for People with Asthma									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Total	Plan Rate	94%	94%	92%		92%	90%	89%	
	Compared to National Average	○	N/A	○	92%	○	○	○	91%
	Compared to Regional Average	○	N/A	○	92%	○	○	○	91%
Ages 5 – 11 years	Plan Rate	100%	N/R	N/R		N/R	N/R	N/R	
	Compared to National Average	N/A	N/R	N/R	96%	N/R	N/R	N/R	96%
	Compared to Regional Average	N/A	N/R	N/R	96%	N/R	N/R	N/R	97%
Ages 12 – 18 years	Plan Rate	93%	N/R	97%		N/R	N/R	N/R	
	Compared to National Average	N/A	N/R	N/A	92%	N/R	N/R	N/R	93%
	Compared to Regional Average	N/A	N/R	N/A	93%	N/R	N/R	N/R	93%
Ages 19 - 50 years	Plan Rate	91%	N/R	90%		92%	89%	91%	
	Compared to National Average	○	N/R	○	89%	○	○	N/A	87%
	Compared to Regional Average	○	N/R	○	89%	○	○	N/A	88%
Ages 51 – 64 years	Plan Rate	95%	N/R	93%		92%	88%	84%	
	Compared to National Average	○	N/R	○	93%	○	N/A	N/A	92%
	Compared to Regional Average	○	N/R	○	93%	○	N/A	N/A	92%

4.3 Musculoskeletal Conditions

4.3.1 Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis

This measure assesses whether patients diagnosed with rheumatoid arthritis have had at least one outpatient prescription dispensed for a disease modifying anti-rheumatic drug which can slow bone erosions, improve functional status and improve quality of life.

Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis								
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	88%	N/R	91%		92%	98%	92%	
Compared to National Average	N/A	N/R	N/A	88%	N/A	N/A	N/A	87%
Compared to Regional Average	N/A	N/R	N/A	90%	N/A	N/A	N/A	89%
Change Over Time 2011-2013	N/A	N/R	N/A		N/A	N/A	N/A	

4.3.2 Use of Imaging Studies for Low Back Pain

This measure assesses whether imaging studies (e.g., x-rays, MRIs, CT scans) are overused in evaluating patients with acute low back pain. In interpreting this measure, a higher score is better and indicates that imaging studies were being used more appropriately.

Use of Imaging Studies for Low Back Pain								
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	87%	87%	85%		87%	86%	86%	
Compared to National Average	★	N/A	▲	75%	★	★	★	74%
Compared Regional Average	★	N/A	★	78%	★	▲	▲	77%
Change Over Time 2011-2013	○	N/A	○		○	○	○	

4.4 Behavioral Health (Mental Health and Substance Abuse)

4.4.1 Anti-Depressant Medication Management

4.4.1.1 Anti-Depressant Medication Management: Effective Acute Phase Treatment

This measure reports the percentage of adults newly diagnosed with depression who were treated with anti-depressant medication and remained on an anti-depressant drug during the entire 12-week acute treatment phase.

4.4.1.2 Anti-Depressant Medication Management: Effective Continuation Phase Treatment

This measure reports the percentage of adults diagnosed with a new episode of depression who were treated with anti-depressant medication and who remained on an anti-depressant drug for at least six months.

Antidepressant Medication Management									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Effective Acute Phase Treatment	Plan Rate	76%	73%	78%		73%	68%	68%	
	Compared to National Average	▲	N/A	★	64%	▲	○	○	64%
	Compared to Regional Average	▲	N/A	★	66%	▲	○	○	68%
	Change Over Time 2011-2013	▼	N/A	○		○	○	○	
Effective Continuation Phase Treatment	Plan Rate	60%	53%	60%		59%	41%	54%	
	Compared to National Average	★	N/A	★	47%	▲	○	○	49%
	Compared to Regional Average	▲	N/A	▲	49%	▲	○	○	53%
	Change Over Time 2011-2013	▼	N/A	○		○	▼	○	

4.4.2 Follow-Up After Hospitalization for Mental Illness

4.4.2.1 Follow-Up Within 7 Days

This measure reports the percentage of members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and within seven days of discharge were seen by a mental health provider either on an ambulatory basis or in an intermediate treatment facility.

Follow-Up After Hospitalization for Mental Illness										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Within 7 Days	Plan Rate	63%	N/R	50%			67%	69%	N/R	
	Compared to National Average	N/A	N/R	N/A	55%		N/A	N/A	N/R	50%
	Compared to Regional Average	N/A	N/R	N/A	63%		N/A	N/A	N/R	64%
	Change Over Time 2011-2013	N/A	N/R	N/A			N/A	N/A	N/R	

4.4.3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

This Initiation of treatment is defined either as an alcohol and other drug (AOD) inpatient admission, or two outpatient AOD treatments within 14 days of an initial diagnosis. Continuation of treatment (engagement) means having two additional AOD treatments within 30 days. Continuation of treatment can improve outcomes for individuals with AOD disorders.

Initiation and Engagement of Alcohol and Other Drug Treatment									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Initiation of Alcohol and Other Drug Dependence Treatment	Plan Rate	38%	N/R	29%		31%	38%	36%	
	Compared to National Average	○	N/R	▼	38%	▼	○	○	41%
	Compared to Regional Average	○	N/R	▼	40%	▼	○	○	42%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	N/R	▼		○	○	○	
Engagement of Alcohol and Other Drug Dependence Treatment	Plan Rate	22%	N/R	16%		15%	21%	13%	
	Compared to National Average	▲	N/R	▼	14%	○	○	○	15%
	Compared to Regional Average	▲	N/R	▼	17%	○	○	▼	18%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	N/R	▼		▼	○	○	

4.5 Medication Management

4.5.1 Annual Monitoring for Patients on Persistent Medications

Combined Rate

This measure reports the percentage of members 18 years of age and older who received at least a 180-day supply of outpatient medication therapy for selected conditions and had at least one therapeutic monitoring of the medication during the year.¹⁵ Regular monitoring and follow-up is recommended for patients who take these medications to assess continued effectiveness and side-effects, and to adjust dosages accordingly.

Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme Inhibitors (ACE) or Angiotensin Receptor Blockers (ARB)

This measure reports the percentage of members receiving at least one six-month supply of ACE or ARB medications (drugs to treat high blood pressure) who were monitored by a doctor at least once in the measurement year.

Annual Monitoring for Patients on Persistent Medications: Anticonvulsants

This measure reports the percentage of members receiving at least one six-month supply of anticonvulsants (drugs used to control seizures) who were monitored by a doctor at least once during the measurement year.

Annual Monitoring for Patients on Persistent Medications: Diuretics

This measure reports the percentage of members receiving at least one six-month supply of diuretics (drugs used to control excess fluid in the body that can lead to high blood pressure or heart failure) who were monitored by a doctor at least once during the measurement year.

For details, see the table on the following page.

¹⁵ Data for Annual Monitoring for Patients on Digoxin is not displayed separately because none of the MCOs had a denominator that met the reporting threshold. Performance for this measure is, however, incorporated into the composite.

Annual Monitoring for Patients on Persistent Medications

		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Combined Rate	Plan Rate	79%	83%	79%		79%	79%	78%	
	Compared to National Average	▼	○	▼	83%	○	○	▼	80%
	Compared to Regional Average	▼	○	▼	83%	▼	▼	▼	81%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	○	○		○	▲	○	
Angiotensin Converting Enzyme Inhibitors (ACE) or Angiotensin Receptor Blockers (ARB)	Plan Rate	79%	84%	80%		79%	79%	78%	
	Compared to National Average	▼	○	▼	83%	○	○	▼	80%
	Compared to Regional Average	▼	○	▼	84%	▼	▼	▼	82%
	Improvement Opportunity	⊗		⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	○	○		○	○	○	
Anticonvulsants	Plan Rate	55%	N/R	63%		58%	60%	77%	
	Compared to National Average	○	N/R	N/A	59%	N/A	N/A	N/A	56%
	Compared to Regional Average	▼	N/R	N/A	63%	N/A	N/A	N/A	62%
	Improvement Opportunity	⊗							
	Change Over Time 2011-2013	○	N/R	N/A		N/A	N/A	N/A	
Diuretics	Plan Rate	80%	83%	80%		80%	80%	78%	
	Compared to National Average	▼	○	▼	83%	○	○	○	80%
	Compared to Regional Average	▼	○	▼	84%	▼	○	▼	81%
	Improvement Opportunity	⊗		⊗		⊗		⊗	
	Change Over Time 2011-2013	○	○	○		○	▲	○	

4.6 Hypertension Measures

4.6.1 Cholesterol Management for Patients with Cardiovascular Conditions

These measures reports the percentage of members ages 18-75 who were discharged alive for a heart attack (Acute Myocardial Infarction), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) during the previous year or patients who had a diagnosis of ischemic vascular disease (IVD) during both during the current measurement year and during the previous measurement year who had:

4.6.1.1 Cholesterol Management for Patient with Cardiovascular Conditions: LDL-C Screening

This measure is the percent of members with the above cardiovascular conditions who had their LDC-C values tested during the measurement year.

4.6.1.2 Cholesterol Management for Patient with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)

This measure reports the percentage of members who received and LDL-C test during the measurement year and were deemed to be compliant based on a test measurement of <100 mg/dL.

Cholesterol Management for Patients with Cardiovascular Conditions										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
LDL-C Screening	Plan Rate	84%	92%	87%			82%	82%	83%	
	Compared to National Average	○	N/A	○	87%		○	○	○	83%
	Compared to Regional Average	▼	N/A	○	89%		○	▼	○	86%
	Improvement Opportunity	⊗						⊗		
	Change Over Time 2011-2013	○	N/A	○			○	▲	○	
LDL-C Control (<100 mg/dL)	Plan Rate	67%	60%	64%			59%	58%	38%	
	Compared to National Average	▲	N/A	▲	58%		▲	▲	▼	50%
	Compared to Regional Average	○	N/A	○	66%		○	▼	▼	64%
	Improvement Opportunity							⊗	⊗	
	Change Over Time 2011-2013	▲	N/A	▲			○		▲	

4.7 Diabetes Care Measures

Care for Patients with Type 1 or Type 2 diabetes requires many different tests and screenings to be performed by healthcare professionals to ensure that a patient's health is maintained through careful management of their chronic condition. The measures below, reported on the next page, reflect a few of the important tests that should be performed annually for diabetic patients.

4.7.1.1 Diabetic Management: LDL-C Screening

This measure reports the percentage of members age 18-75 diagnosed with diabetes either type 1 or type 2 who received at least one LDL-C test during the measurement year.

4.7.1.2 Diabetic Management: Diabetic Eye Exam

This measure reports the percentage of members diagnosed with diabetes either type 1 or type 2 who were screened for diabetic retinal disease by an eye care professional (optometrist or ophthalmologist) in the past year.

4.7.1.3 Diabetic Management: HbA1c Testing

This measure reports the percentage of eligible members diagnosed with diabetes either type 1 or type 2 who received an HbA1c test during the measurement year.

4.7.1.4 Diabetic Management: Monitoring for Diabetic Nephropathy

This measure reports the percentage of eligible members diagnosed with diabetes either type 1 or type 2 who received a nephropathy screening test during the measurement year.

Diabetic Management Measures									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
LDL-C Screening	Plan Rate	81%	79%	83%		80%	83%	76%	
	Compared to National Average	▼	○	○	85%	○	○	▼	81%
	Compared to Regional Average	▼	▼	▼	87%	▼	▼	▼	85%
	Improvement Opportunity	⊗	⊗	⊗		⊗	⊗	⊗	
	Change Over Time 2011-2013	○	○	○		○	▲	○	
Diabetic Eye Exam	Plan Rate	78%	70%	82%		61%	66%	49%	
	Compared to National Average	▲	▲	▲	56%	▲	★	○	47%
	Compared to Regional Average	○	○	○	71%	○	▲	▼	60%
	Improvement Opportunity							⊗	
	Change Over Time 2011-2013	○	▲	○		○	▲	▲	
HbA1c Testing	Plan Rate	95%	91%	94%		95%	93%	91%	
	Compared to National Average	▲	○	▲	90%	▲	▲	▲	87%
	Compared to Regional Average	○	○	○	93%	▲	▲	○	91%
	Change Over Time 2011-2013	○	○	○		▲	▲	○	
Monitoring for Diabetic Nephropathy	Plan Rate	83%	85%	88%		86%	85%	83%	
	Compared to National Average	○	○	○	84%	▲	▲	▲	79%
	Compared to Regional Average	▼	○	○	87%	○	▲	○	83%
	Improvement Opportunity	⊗							
	Change Over Time 2011-2013	○	○	○		○	▲	▲	

4.8 Measures Collected Through the CAHPS® Health Plan Survey

4.8.1 Flu Shot for Adults Ages 18-64

This measure reports the percentage of members ages 18-64 who were vaccinated for influenza during the measurement year. This is the first year of reporting this measure with an expanded age range so an over time measurement was not conducted.

Flu Shots for Adults 18 – 64 Years of Age									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	60%	60%	47%			47%	55%	48%	
Compared to National Average	▲	▲	○	50%		○	○	○	48%
Compared to Regional Average	○	○	▼	56%		▼	○	▼	55%
Improvement Opportunity			⊗			⊗		⊗	

4.8.2 Medical Assistance with Smoking and Tobacco Use Cessation: Advising to Quit

This measure reports the percentage of people who reported that they were advised by their doctor to quit using tobacco, discussed with their doctor medication to help them to quit, and discussed strategies other than medication to help them to quit.

Medical Assistance with Smoking and Tobacco Use Cessation: Advising to Quit										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Advising to Quit	Plan Rate	76%	N/R	72%			78%	N/R	70%	
	Compared to National Average	N/A	N/R	○	77%		★	N/R	N/A	71%
	Compared to Regional Average	N/A	N/R	▼	84%		N/A	N/A	N/A	*16
	Improvement Opportunity			⊗						
	Change Over Time 2011-2013	N/A	N/R	○			○	N/R	N/A	

¹⁶ NCQA does not report the regional average of the Medical Assistance with Smoking and Tobacco Use Cessation: Advising to Quit measure for New England PPOs.

4.9 Utilization Measures

4.9.1 Well-Child and Adolescent Visit Composite

This composite provides a snapshot of MCO performance on the following measures:

- Well-Child Visits in the First 15 Months of Life (6 or More Visits)
- Well-Child Visits 3-6 Years of Age
- Adolescent Well-Care Visits

Well-Child And Adolescent Visits Composite									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	89%	66%	84%			82%	69%	68%	
Compared to National Average	▲	N/A	▲	62%		★	▲	▲	58%
Compared to Regional Average	○	N/A	○	77%		○	○	○	78%
Change Over Time 2011-2013	▲	N/A	○			○	▼	▲	

4.9.2 Well-Child Visits in the First 15 Months of Life (6 or More Visits)

This measure reports the percentage of children who received at least six well-child visits within the first 15 months of life. Having regular well-child check-ups is one of the best ways to achieve early detection of physical, developmental, behavioral and emotional problems.

Well-Child Visits in the First 15 Months of Life									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	93%	N/R	88%			84%	92%	88%	
Compared to National Average	★	N/R	▲	79%		○	★	N/A	77%
Compared to Regional Average	▲	N/R	○	87%		○	▲	N/A	88%
Change Over Time 2011-2013	▲	N/R	○			○	○	N/A	

4.9.3 Well-Child Visits 3-6 Years of Age

This measure reports the percentage of children between 3 and 6 years of age who received one or more well-child visits with a primary care physician during the measurement year. Well-child visits during the pre-school and early school years are important for the early detection of physical, developmental, behavioral and emotional problems.

Well-Child Visits 3-6 Years of Age									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	86%	69%	82%			80%	79%	80%	
Compared to National Average	▲	○	▲	74%		▲	▲	▲	70%
Compared to Regional Average	▼	▼	▼	87%		▼	▼	▼	87%
Improvement Opportunity	⊗	⊗	⊗			⊗	⊗	⊗	
Change Over Time 2011-2013	○	▼	○			○	▼	○	

4.9.4 Adolescent Well-Care Visits

This measure reports the percentage of enrolled members between 12 and 21 years of age who had at least one comprehensive well-care visit during the measurement year. Adolescents benefit from annual preventive health care visits that address the changing physical, emotional and social aspects of their health.

Adolescent Well-Care Visits									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	52%	47%	50%			48%	49%	49%	
Compared to National Average	▲	▼	▲	45%		▲	▲	▲	41%
Compared to Regional Average	▼	▼	▼	63%		▼	▼	▼	64%
Improvement Opportunity	⊗	⊗	⊗			⊗	⊗	⊗	
Change Over Time 2011-2013	▲	○	○			○	▼	▲	

4.9.5 Plan All-Cause Readmission Rates

In order to measure coordination and continuity of care, the Department elected to use the HEDIS® measure: Plan All-Cause Readmissions. This measure counts the number of acute inpatient hospital stays for patients 18 and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, and compares actual readmissions to the predicted probability of an acute readmission. This measure is calculated by dividing the observed rate by the Average Adjusted Probability (i.e., the expected rate). In interpreting this measure, a lower rate is better.

BCBSVT, Cigna, and MVP PPOs all reported ratios below both the National and Regional Averages. The Cigna POS plan meets the National and Regional averages, while the BCBSVT HMO and TVHP plans are higher than the national averages.

All-Cause Readmission Rates			
MCO (w/o PPO)		PPO	
BCBSVT	0.82	BCBSVT	0.68
CIGNA	0.79	CIGNA	0.74
TVHP	0.89	MVP	0.66
National Average	0.79	National Average	0.76
Regional Average	0.79	Regional Average	0.77

4.10 Blueprint for Health Measures

To meet the requirements of Section 6.6 (B) 6 of Rule H-2009-03, MCOs must submit data on specific measures that assess provider adoption and MCO support for Vermont's *Blueprint for Health*. The three Blueprint measures appear in succession below:

4.10.1 Percentage of Contracted Primary Care Providers (PCPs) Receiving Enhanced Payment to Support Medical Home Operations:

The numerator for this measure is the number of contracted PCPs receiving enhanced payments to support medical home operations. The denominator for this measure is the total number of contracted PCPs in the network.

Percentage of Contracted Primary Care Providers (PCPs) Receiving Enhanced Payment to Support Medical Home Operations			
MCO	Number of contracted PCPs receiving enhanced payment	Total number of contracted PCPs	Percentage of contracted PCPs receiving enhanced payment
BCBSVT/TVHP/BCBSVT PPO¹⁷ (PCPs and associated mid-level providers)	686	1273	54%
CIGNA¹⁸	320	841	38%
MVP HMO & PPO (PCPs and associated mid-level providers)	690	882	78%

4.10.2 Per Member Per Month (PMPM) Value of Enhanced Practice Payments to Support Medical Home Operations

MCOs reported the total PMPM value of the enhanced practice payments they are making to support medical home operations for the Blueprint. The total PMPM value is calculated as the total enhanced practice payments over the total member months.

Per Member Per Month (PMPM) Value of Enhanced Practice Payments to Support Medical Home Operations	
MCO	PMPM value of enhanced practice payments to support medical home operations
BCBSVT / TVHP / BCBSVT PPO¹⁹	\$3.27
CIGNA²⁰	\$1.96
MVP HMO & PPO²¹	\$2.04

¹⁷ Calculated on a cumulative basis as of YTD May 2012

¹⁸ Calculated on an annual basis, includes PPO/OAP (Open Access Plus)/Network/Network POS

¹⁹ Includes PCPs as well as Mid-Levels measured on a cumulative basis as of YTD May 2012

²⁰ Includes PPO/OAP(Open Access Plus) /Network/Network POS

²¹ Calculated on an annual basis

4.10.3 Names and the Percentage of Vermont Health Service Areas (VHSAs) Where the MCOs/PPOs Are Making Payments to Support Community Health Teams in Accordance with Vermont Blueprint-Defined Payment Terms

Names and the Percentage of Vermont Hospital Service Areas (VHSAs) Where the MCO is Making Payments to Support Community Health Teams in Accordance with Vermont Blueprint-Defined Payment Terms			
Name of Health Service Area	BCBSVT / TVHP / BCBSVT PPO	CIGNA ²²	MVP HMO & PPO
Barre	Y	Y	Y
Bennington	Y	Y	Y
Brattleboro	Y	Y	Y
Burlington	Y	Y	Y
Middlebury	Y	Y	Y
Morrisville	Y	Y	Y
Newport	Y	Y	Y
Randolph	Y	Y	Y
Rutland	Y	Y	Y
Springfield	Y	Y	Y
St. Albans	Y	Y	Y
St. Johnsbury	Y	Y	Y
Upper Valley (Bradford)	Y	Y	Y
Windsor	Y	Y	Y
Percentage of VHSAs where the MCO is making payments to support Community Health Teams in accordance with Vermont Blueprint-defined payment terms			
	100%	100%	100%

²² Includes PPO/OAP/Network/Network POS

PART V: ANALYSES OF MCO PERFORMANCE OVER-TIME

This section reports summary data on HMO and PPO performance over time by totaling the number of measures for which each plan has demonstrated improvement, has had no change, and/or reported a decline in performance. For this analysis the Department has utilized the CAHPS® data for 2012–2014 and HEDIS® data for 2011–2013.

5.1 Methodology for Evaluating MCO Performance Over-Time

Baseline and current year quality measures are compared to determine how effectively plans are improving historic quality measures.

For a measure to be included in the evaluation of an MCO’s performance over time the following criteria had to be met:

- An over-time comparison of the measure must be possible due to consistent measurement between the current and baseline year;
- The sample size for the current year must be ≥ 100 ; and
- Measurements must have rates below 90% in the baseline year because of difficulty improving beyond 90%. MCO measures with a baseline rate higher than 90% are marked as “High Performing.”

5.1.2 Key for Evaluating MCO Performance Over-Time

Symbol/ Acronym	Interpretation	Definition
★	High Performer	If the MCO’s rate is above 90% in the base year, it is included in the high performing category, as it is difficult for an HMO’s or PPO’s rate to improve beyond 90%.
▲	Better	Over-Time: means that there is a statistical significant difference when comparing the MCO’s current and historic score.
○	Similar	Over-Time: means that there is no statistical significant difference when comparing the MCO’s current and historic score.
▼	Worse	Over-Time: means that there is no statistical significant difference when comparing the MCO’s current and historic score.
N/R	Not Reportable	The HMO, POS, or PPO must have had a reportable rate in the baseline reporting year and in the current reporting year for a measure to be considered in the analysis.

5.2 Members' Experience of Care Over-Time Summary

Our analysis showed the following change-over-time results for the CAHPS® survey measures:

- Significant variation existed between plans on the number of measures that met reporting criteria. Blue Cross Blue Shield and TVHP plans had the most reportable measures with eleven, while the Cigna PPO had the fewest reportable measures with only four.
- TVHP had two measures that showed a significant reduction in performance and was the only plan that had reportable measures that showed a significant reduction in performance.

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
How often did Customer Service staff treat you with courtesy or respect?	★	N/R	★	★	N/R	N/R
How often did your health plan's Customer Service give you the information or help you needed?	○	N/R	▼	○	N/R	N/R
Claims Processing is Timely	★	★	★	★	N/R	○
Claims are Processed Correctly	★	★	★	★	N/R	★
Getting to See A Specialist	○	★	○	○	N/R	N/R
Easy to Get the Care, Tests or Treatment You Needed	★	★	★	★	★	★
Getting Care Quickly When You Needed Care Right Away	★	★	○	★	★	★
Getting Routine Care As Soon As Wanted	○	★	▼	○	★	○
Able to Find Out How Much to Pay for a Health Care Service or Equipment	○	N/R	○	○	N/R	N/R
Able to Find Out How Much to Pay for Prescription Medications	○	N/R	○	○	N/R	N/R
Rating of Overall Health Plan Experience	○	▲	○	▲	○	○
Count: High Performer or Significant Improvement in Performance	5	7	4	6	3	3
Count: No Change	6	0	5	5	1	3
Count: Significant Reduction in Performance	0	0	2	0	0	0

5.3 Acute Care Over-Time Summary

A summary review of change-over-time performance for the HEDIS® Acute Care measures shows the following:

- There were no plans that had a significant over-time performance reduction for acute care measures.
- All plans, with the exception of the Cigna POS, had data that met measurement criteria for reporting.
- No plans had data that was reportable on the Follow-Up after Hospitalization for Mental Illness: 7 days.

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Appropriate Testing of Children with Pharyngitis	○	N/R	★	○	○	○
Appropriate Treatment for Children with Upper Respiratory Infection	★	N/R	★	★	★	★
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	▲	N/R	▲	○	○	○
Use of Imaging Studies for Low Back Pain	○	N/R	○	○	○	○
Follow-Up After Hospitalization for Mental Illness: 7 Days	N/R	N/R	N/R	N/R	N/R	N/R
Initiation of Alcohol and Other Drug Dependence Treatment	○	N/R	○	○	○	○
Engagement of Alcohol and Other Drug Dependence Treatment	○	N/R	○	○	○	○
Count: High Performer or Significant Improvement in Performance	2	0	3	1	1	1
Count: No Change	4	0	3	5	5	5
Count: Significant Reduction in Performance	0	0	0	0	0	0

5.4 Preventive Care Over-Time Summary

A summary review of the change-over-time for the HEDIS® Preventive Care measures shows the following:

- BCBS PPO and TVHP had the most reportable Preventive Care Over-Time measures with seven, while the Cigna POS reported the fewest measures with three.
- Cigna POS had the only reportable measure that had a significant reduction in performance.
- A majority of reportable measures showed no change when compared to the baseline reporting period.

Measures	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Breast Cancer Screening	▲	○	▲	▲	○	▲
Chlamydia Screening in Women 16-20 Years of Age	○	N/R	○	○	○	○
Medical Assistance with Smoking and Tobacco Use Cessation: Composite and Individual Measures	N/R	N/R	○	○	N/R	N/R
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	★	N/R	○	○	★	N/R
Well-Child Visits 3-6 Years of Age	▲	▼	○	○	○	○
Adolescent Well-Care Visits	▲	○	▲	▲	▲	○
Childhood Immunization: Combination 2	○	N/R	○	○	▲	▲
Count: High Performer or Significant Improvement in Performance	4	0	2	2	3	2
Count: No Change	2	2	5	5	3	3
Count: Significant Reduction in Performance	0	1	0	0	0	0

5.5 Chronic Care Over-Time Summary

A summary review of the change-over-time for the HEDIS® Chronic Care measures shows the following:

- MVP PPO reported the only measure that showed statistically significant improvement from the baseline year.
- Cigna PPO had the most reportable measures (five reported) while the Cigna POS had the fewest (two reported).

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	N/R	N/R	N/R	N/R	○	N/R
Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme Inhibitors (ACE) or Angiotensin Receptor Blockers (ARB)	○	○	○	○	○	○
Annual Monitoring for Patients on Persistent Medications: Diuretics	○	○	○	○	○	▲
Anti-Depressant Medication Management: Effective Acute Phase Treatment	○	N/R	○	▼	○	○
Anti-Depressant Medication Management: Effective Continuation Phase Treatment	▼	N/R	○	○	▼	○
Count: High Performer or Significant Improvement in Performance	0	0	0	0	0	1
Count: No Change	3	2	4	3	4	3
Count: Significant Reduction in Performance	1	0	0	1	1	0

NOTE: "Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis," "Annual Monitoring for Patients on Persistent Medications: Digoxin" and "Annual Monitoring for Patients on Persistent Medications: Anticonvulsants" not reported since all MCOs had sample sizes less than 100.

PART VI: DEPARTMENT RECOMMENDATIONS TO IMPROVE MCO QUALITY

This section of the report discusses quality improvement recommendations for MCOs. There are two criteria that were used to identify improvement opportunities for HEDIS[®] and CAHPS[®] measures: 1) the HMO's or PPO's rate is statistically and practically²³ significantly below the better of the national or regional average, or 2) both the HMO's or PPO's rate and the better of the national or regional average are below 50%. For most Department-specified Rule H-2009-03 measures, MCOs are expected to achieve a 90% performance level.

Opportunities for improvement were identified in the previously presented tables using the criteria described above and were denoted with a “⊗” symbol. These opportunities are listed below and identify those that are shared by all plans and those that are specific to each MCO or PPO.

6.1 Improvement Opportunities for All MCOs

6.1.1 Hybrid Measures

While Vermont MCOs demonstrate satisfactory performance on many measures, there is always room for improvement. A recurring limitation of the Department's ability to adequately and comparatively assess MCO performance is due to the lack of adequate data for some measures. Several measures require a combination of data collected administratively (i.e. data from claims) and data gathered through chart review. In cases where MCOs do not collect chart review data and rely solely on administrative data, the results are, in most cases, not meaningful.

In those situations where the data were collected differently than specified, the Department cannot determine whether or not there is a difference in performance between MCOs for annual measure performance. Similarly, this also limits the Department's ability to determine meaningful measures of performance over-time.

Collecting data from chart review is more costly and disruptive to providers than data collected administratively. Nonetheless, the measures provide information that may inform health care policy and improve the quality of care to MCO members in Vermont. In consideration of these issues the Department now requires (beginning with the July 2014 data filing) that the submission of HEDIS[®] hybrid-specified measures for Rule H-2009-03 must be consistent with the HEDIS[®] hybrid-specified measures included on NCQA's “scored measures” list for the relevant reporting year. MCOs, regardless of accreditation status, will be required to submit data for its managed health plan products (HMO, PPO, POS, EPO, etc.) using the hybrid collection methodology for any “scored” HEDIS[®] hybrid-specified measure. .

²³ Practical significance is defined as the MCO's or PPO's performance varying by at least four percentage points from the benchmark. The practical significance test is designed to identify differences that a reader would find important, by eliminating statistically significant differences that might be so small that the reader would find them immaterial.

6.1.2 Improvement Opportunities for Specific Measures

The Department has identified several measures in which the performance is notably below 50% or an opportunity exists to improve performance to the higher New England regional average. As a result, the Department has identified these as priorities which MCOs should consider when selecting opportunities for quality improvement. The measures the Department identified last year remain areas which the MCOs should continue to focus their improvement effects, in addition to the measures that have been prioritized for this year. These areas include:

Chlamydia Screening in Women (Ages 16-24)

- For Chlamydia Screening in Women Ages 16-20 and 21-24, the MCO's rates are below regional averages which range between 50% and 59% in the current measurement year. None of the health plans report a total rate for Chlamydia screening higher than 50% thereby representing an opportunity for improvement. Chlamydia is the most common sexually transmitted disease in the US. It causes no symptoms in 75% of infected women, but is easily diagnosed and curable. Improving chlamydia screening for adolescent women has been a goal of the Vermont Youth Health Improvement Initiative.

Avoidance of Antibiotic Use in Adults with Acute Bronchitis

- For Avoidance of Antibiotic Use in Adults with Acute Bronchitis, HMO and PPO national averages are 26% and 24% respectively, with HMO and PPO Regional averages being 31% and 29%. All plans were rated as being statistically significantly below the regional averages and showing no statistical difference from national rates of avoidance of improper antibiotic use. Antibiotics are ineffective against viral illnesses and are not recommended for routine treatment of acute bronchitis. The unnecessary use of antibiotics is a long-term public health concern due to its contribution to antibiotic-resistant infections. In addition to the current low performance, there is no evidence of improvement over time.

Initiation and Engagement of Alcohol and Other Drug Dependence

- Alcohol and other drug dependence is a significant public health problem. Low performance is particularly concerning in Vermont due to the high incidence of binge drinking²⁴ and the increase in drug addiction, the singular topic about which Governor Shumlin addressed the Vermont legislature in his 2014 State of the State message. However, the national and regional rates of Initiation and Engagement of Alcohol and Other Drug Dependence are also low. National and regional initiation rates are below 43% with no MCO reporting initiation rates above 38%. National and regional engagement is below 20%. Even though some MCO's performance exceeds national averages for engagement, the low absolute rates provide ample opportunity for improvement.

Adolescent Well-Care Visits

²⁴ See www.americashealthrankings.org/VT/2012.

- Improving Adolescent Well-Care Visits was a 2012 goal of the Youth Health Improvement Initiative in Vermont. For this measure all of the MCO's rates are between 47% and 52%, falling below regional rates of 63-64 percent. While performing well relative to national averages, both the HMO and PPO plans are statistically significantly below the regional average (for both HMOs and PPOs).

6.1.3 Improve performance levels to at least 50% for the following measures:

- Avoidance of Antibiotic Screening in Adults with Acute Bronchitis
- Chlamydia Screening in Women Ages 16–20 and for the Total Population receiving Screenings
- Engagement of Alcohol and Other Drug Dependence
- Initiation of Alcohol and Other Drug Dependence

6.1.4 Improve performance levels to or above the New England regional average for the following measures:

- Adolescent Well-Care Visits
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Annual Monitoring for Patients on Persistent Medications – Composite Measure
- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Diabetic Management Measures: LDL-C Screening
- Well-Child Visits 3-6 Years of Age

6.2 Improvement Opportunities for Individual MCOs

The Department has identified the following performance measures where improvement opportunities exist for individual MCOs to achieve at least the Rule H-2009-03 standard of 90%, to improve performance to meet or exceed the New England regional average or to exceed a rate of 50%.

6.2.1 Improvement Opportunities for BCBSVT

6.2.1.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-Care Visits
- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Annual Monitoring for Patients on Persistent Medications: ACE/ARBs
- Annual Monitoring for Patients on Persistent Medications: Anticonvulsants
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

- Call Answer Timeliness
- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Diabetic Management Monitoring for Diabetic Nephropathy
- Diabetic Management Screening
- Shared Decision Making Composite
- Well-Child Visits 3-6 Years of Age

6.2.1.2 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Access to Inpatient Chemical Dependence Facilities in Essex and Orleans County
- Access to Inpatient Mental Health Facilities in Essex County
- Access to Intermediate Chemical Dependency Providers in Essex, Orleans, and Rutland Counties
- Access to Intermediate Mental Health Providers in Essex county
- Access to Kidney Transplants Bennington and Essex counties
- Access to Psychiatrists in Essex County
- Access to Psychologist Essex and Orleans County
- Access to Vascular Surgeons in Essex and Orleans counties
- Concurrent Reviews Meeting Decision Making Timeframes for reviews received < 24 hours prior
- Level 1 Mental Health and Substance Abuse Grievance Review Decisions
- Members with access to Non-Urgent Care
- Members with access to Preventative Care

6.2.2 Improvement Opportunities for BCBSVT PPO

6.2.2.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-Care Visits
- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Appropriate Testing for Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Call Answer Timeliness

- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Colorectal Cancer Screening
- Diabetic Management LDL-C Screening
- Diabetic Management Measures: LDL-C Screening
- Health Provider talked with you about reasons you might not want to take a medicine
- Health Provider talked with you about reasons you might want to take a medicine
- Shared Decision Making Composite
- Well-Child Visits 3-6 Years of Age

6.2.2.2 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Access to Inpatient Chemical Dependency Facilities in Essex and Orleans County
- Access to Intermediate Chemical Dependency Providers in Essex, Orleans, and Rutland Counties
- Access to Kidney transplantation in Bennington and Essex Counties
- Access to Psychiatrists in Essex and Orleans Counties
- Access to Psychologists in Essex and Orleans Counties
- Access to Vascular Surgeons in Essex and Orleans Counties
- Concurrent Reviews Meeting Decision Making Timeframes for reviews received < 24 hours prior
- Concurrent Reviews Meeting Decision Making Timeframes for reviews received > 24 hours prior
- Level 1 Mental Health and Substance Abuse Grievance Review Decisions
- Non-Urgent Pre-Service Reviews with less than two days
- Percentage of Members with access to Non-Urgent Care

6.2.3 Improvement Opportunities for CIGNA

6.2.3.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-Care Visits
- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Chlamydia Screening in Women 16-20 years of age

- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Diabetic Management Measures: LDL-C Screening
- Did a doctor or other health provider talk about the reason you might not want to take a medicine
- Shared Decision Making Composite
- Well-Child Visits 3-6 Years of Age

6.2.3.2 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Concurrent Reviews Meeting Decision Making Timeframes for reviews received < 24 hours prior
- Level 1 Concurrent Physical Health Decisions
- Level 1 Non-Urgent Per-Service Physical Health Decisions
- Level 1 Urgent Pre-Service Physical Health Decisions
- Members with Access to Kidney Transplants in Essex County
- Members with Access to Non-Urgent Care
- Members with Access to Preventive Care
- Non-Urgent Pre-Service Reviews with less than two days or with an extension
- Urgent Pre-Service Reviews with less than 48 hours or with an extension

6.2.4 Improvement Opportunities for CIGNA PPO

6.2.4.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-care visits
- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Antidepressant Management – Effective Continuation Phase Treatment
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Cholesterol Management for Patients with Cardiovascular Conditions – LDL-C control (<100 mg/dL)
- Diabetic Management Measures: LDL-C Screening

- Engagement of Alcohol and Other Drug Dependence Treatment
- Initiation of Alcohol and Other Drug Dependence Treatment
- Use of Spirometry Testing in the Assessment and diagnosis of COPD
- Well-Child Visits 3-6 Years of Age

6.2.5 Improvement Opportunities for CIGNA Behavioral Health (CBH)

6.2.5.1 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Access to Psychiatrists in Orleans County
- Access to Psychologists in Orleans County
- Members with access to Non-Urgent Care
- Members with Access to Urgent Care
- Members with access to Urgent Care
- Mental Health and Substance Abuse Level 1 Concurrent Review Grievances
- Mental Health and Substance Abuse Voluntary Level 2 Concurrent Review Grievances

6.2.6 Improvement Opportunities for Magellan Behavioral Health (MBH)

6.2.6.1 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Access to Psychiatrists in Essex, Franklin, Orange, Orleans, and Windsor Counties
- Access to Psychologists in Essex and Orleans Counties
- Level 1 Concurrent Mental Health and Substance Abuse Grievance Review Decisions
- Members with access to Inpatient Chemical Dependency Facilities Statewide, Chittenden, Essex, Lamoille, and Orleans Counties
- Members with access to Inpatient Mental Health facilities in Essex and Orleans Counties
- Pre-Service Non-Urgent Grievance Reviews within Required Timeframes

6.2.7 Improvement Opportunities for MVP Health Care

6.2.7.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-Care Visits
- Adult BMI Assessment

- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Breast Cancer Screening
- Call Answer Timeliness
- Childhood Immunization Status – Combination 2
- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Cholesterol Management LDL-C Control (<100 mg/dL)
- Colorectal Cancer Screening
- Diabetic Management Measures: LDL-C Screening
- Diabetic Management: Diabetic Eye Exam
- Diabetic Management: LDL-C Screening
- Engagement of Alcohol and Other Drug Dependence Treatment
- Medical Assistance with smoking cessation – advising to quit
- Rating of Overall Health Plan Experience
- Well-Child Visits 3-6 Years of Age

6.2.7.2 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Access to Kidney Transplants Essex and Windham County
- Access to Psychiatrists Essex County
- Access to Psychologists Essex County
- Access to Vascular Surgeons in Essex and Orleans Counties
- Members with Access to Inpatient Chemical Dependency Facilities in Essex and Orleans Counties
- Members with Access to Inpatient Mental Health Facilities in Essex and Orleans Counties
- Members with Access to Intermediate Mental Health Providers in Essex and Orleans Counties
- Non-Urgent Pre-Service Reviews ≤ 2 days or with and extension
- State-Wide Member access to Non-Urgent Care appointments
- Urgent Pre-Service Reviews ≤ 48 hours or with and extension

6.2.8 Improvement Opportunities for TVHP

6.2.8.1 Improve performance levels to meet or exceed the regional average for the following measures:

- Adolescent Well-Care Visits
- Annual Monitoring for Patients on Persistent Medications: Combined Rate
- Annual Monitoring for Patients on Persistent Medications: Diuretics
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Call Answer Timeliness
- Chlamydia Screening in Women 16-20 years of age
- Chlamydia Screening in Women 21-24 years of age
- Chlamydia Screening in Women Total
- Diabetic Management Measures: LDL-C Screening
- Engagement of Alcohol and Other Drug Dependence Treatment
- Flu Shot for Ages 18-64 Medical Assistance with Smoking and Tabaco Use Cessation: Advising to Quit
- Initiation of Alcohol and Other Drug Dependence Treatment
- Members able to find out from your health plan required payment for prescription medications.
- Plans Customer service Provided information or help needed
- Rating of Health Plan
- Well-Child Visits 3-6 Years of Age

6.2.8.2 Improve performance levels to at least the 90⁰% standard under Rule H-2009-03 for the following measures:

- Access to Inpatient Chemical Dependency Facilities Statewide and in Essex, Lamoille, and Orleans County
- Access to Kidney Transplants in Bennington and Essex Counties
- Access to Psychiatrists in Essex, Franklin, and Orange Counties
- Access to Psychologists in Essex and Orleans Counties
- Concurrent Reviews Received with more than 24 hours prior and taking less than 24 hours to review
- Concurrent Reviews Received with more than 24 hours prior and taking more than 24 hours to review
- Members with Access to Non-Emergency Care
- Members with Access to Intermediate Chemical Dependency Providers Statewide and in Essex, Orleans, and Rutland Counties
- Members with Access to Preventive Care

- Members with Access to Urgent Care
- Mental Health and Substance Abuse Concurrent Voluntary Level 2 Grievances
- Non-Urgent Pre-Service reviews taking less than two days or with extension

6.2.9 Improvement Opportunities for VCC

6.2.9.1 Improve performance levels to at least the 90% standard under Rule H-2009-03 for the following measures:

- Concurrent Reviews Received with more than 24 hours prior and taking less than 24 hours to review
- Non-Urgent Pre-Service Reviews \leq 2 days or with and extension
- Urgent Pre-Service Reviews \leq 48 hours or with and extension