



Department of Financial Regulation

Rule H-2009-03
Evaluation of the 2013
Managed Care Organization Data
Filings

**Prepared for the Insurance Division of the
Department of Financial Regulation by
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PART I: REPORT OVERVIEW

1.1 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 receive 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) MCO Access to Providers/Services
- 2) MCO Member Satisfaction, UR Determinations and Grievances
- 3) MCO Quality Measures Performance
- 4) MCO Over-Time Quality Measures Performance
- 5) Department Recommendations

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 four appendices included with this report. Appendix A and Appendix B contain graphs displaying performance over time; Appendix C contains additional measure data reported by the managed care organizations; and Appendix D contains technical documentation.

1.1.1 Access to Services

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 been an assess issue for some time. Access to bariatric surgeons is another area which is below standard for most MCOs.

1.1.2 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.

1.1.3 Quality Performance

The report includes a list of MCO opportunities to improve clinical 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. **Because there is significant opportunity for improvement among the measures identified as “Recommendations for All MCOs,” the Department recommends that MCOs select at least one measure from these to include as a joint improvement project for 2014 in their annual QI Improvement Work Plans, due to the Department by March 31, 2014.**

1.1.4 Preauthorization Requests and Grievances

MCOs are completing requests for prior authorization decisions in a timely manner. Grievances remain relatively rare, ranging from six grievances per 1000 members (BCBSVT) to zero grievances per 1000 members (PrimariLink). When examining the rate at which grievances are overturned in the member’s favor, BCBSVT and The Vermont Health Plan (TVHP) have rates that are substantially higher than the other MCOs for physical health grievances. Similarly, BCBSVT, TVHP and Magellan Behavioral Health, Inc. (MBH) have rates that are substantially higher than the other MCOs for mental health and substance abuse grievances.

1.1.5 Improvement Opportunities

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 requirements for timeliness of mental health and substance abuse grievances.

1.2 Vermont MCOs, Enrollment and Market Share

1.2.1 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 these regulations was required to submit a comprehensive set of performance indicators, and other information specified by the Department, on or before July 15, 2013.

In 2012, there were ten entities required to submit data as part of these requirements. The majority of this information includes clinical performance measures for calendar year 2012 and member survey data field in the spring of 2013.

Insurance Entity	Abbreviations in Report	
	HMO 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	NA

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 HMOs w/o PPOs are compared only to each other.

In addition to the MCOs, there were three entities that manage mental health and substance abuse services for Vermont’s MCOs. 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	MBH	BCBSVT & TVHP
PrimariLink	PrimariLink	MVP

For the sixth consecutive year, CIGNA submitted HEDIS[®] and CAHPS[®] data for both its managed network products and its PPO products. For the fourth year, Blue Cross Blue Shield of Vermont submitted data for its BCBSVT PPO, and MVP submitted data for its PPO product. In 2011 the membership of MVP’s HMO plan dropped below meaningful reporting thresholds and stayed there in 2012. Based on discussion and approval by the Department, MVP did not report HEDIS[®] or CAHPS[®] data for this product.

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

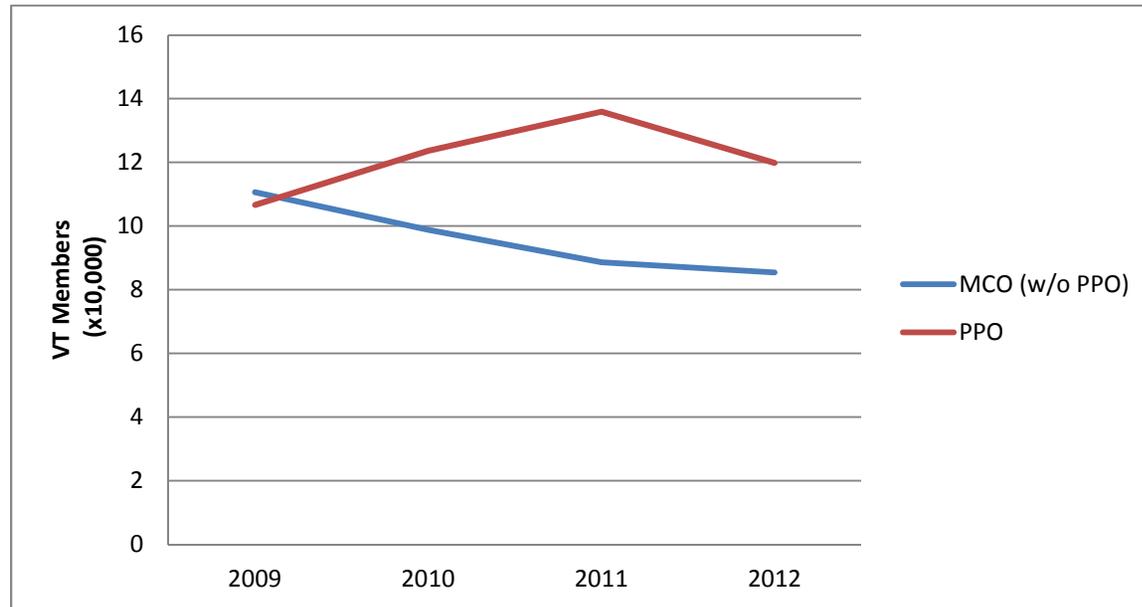
- 1) HEDIS[®] clinical effectiveness measures,
- 2) member satisfaction and experience of care measures, and
- 3) Department-specified Rule H-2009-03 measures.

Occasionally data from multiple categories are presented together to display all data related to a key category.

1.2.2 Enrollment Statistics and Market Share

Enrollment statewide is down for the first time in four years. Enrollment differs greatly between insurance entities, ranging from 26,504 members (MVP) to over 78,184 (BCBSVT combined). TVHP continues to be the only entity to exhibit growth in non-PPO products from 2009 to 2012. BCBSVT's total proportion of MCO w/o PPO products has risen from 65% in 2009 to 94% in 2012. Market share among MCOs has been fairly consistent in the PPO market.

Enrollment Trends, 2009 – 2012										
	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%



For the fourth year, enrollment appears to be shifting from POS/HMO products into PPO/EPO products. This trend is most notable for CIGNA and MVP products. MVP's HMO membership continues to be below the threshold for reporting HEDIS[®] and CAHPS[®] results. Statewide, PPO products have increased 12% from 2009 to 2012.

1.3 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, and 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.

1.3.1 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 HMO/POS 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 HMO/POS products.

Cigna Behavioral Health, Inc. (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 and graphs 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 whether 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, 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:

- neonatology
- urology
- chiropractic
- bariatric surgeons

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.

We did not include charts showing statewide results for the following providers because at least 90% of all MCO members have access within the required 30-minute travel time:

- 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

Similarly, no charts showing statewide results are included for the following providers because at least 90% of all MCO members have access within the required 60-minute travel time:

- chiropractors
- urology
- pharmacies
- intermediate mental health providers (this includes acute residential treatment, partial hospitalization programs and intensive outpatient programs)
- intermediate chemical dependency providers (this includes acute residential treatment, partial hospitalization programs and intensive outpatient programs)
- mental health providers at inpatient facilities (access within specific counties is shown when access falls below the 90% standard)

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

1.3.2 Percentage of Members Statewide with Access to Outpatient Mental Health Services by Provider Type

Rule H-2009-03 requires that at least 90% of each MCO’s members have access to outpatient mental health services within 30 minutes of travel time. Statewide access levels by provider type are reported in the table below.

Percentage of Members Statewide with Access to Outpatient Mental Health Services by Provider Type, 2013				
	Psychiatrists	Psychologists	All Master’s Level Providers	All Ambulatory Mental Health Providers ¹
BCBSVT	92%	97%	100%	100%
CBH	100%	98%	100%	100%
MBH	92%	97%	100%	100%
MVP PPO	100%	100%	100%	100%
TVHP	93%	98%	100%	100%
BCBSVT PPO	91%	97%	100%	100%

¹ Ambulatory mental health providers include individual clinicians and mental health clinics.

1.3.3 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, 2013					
	Psychiatrists	Psychologists		Psychiatrists	Psychologists
Essex County			Orange County		
BCBSVT	43% ●	62% ●	BCBSVT	65% ●	100%
BCBSVT PPO	53% ●	68% ●	BCBSVT PPO	65% ●	100%
CBH	100%	98%	CBH	100%	100%
MBH	43% ●	62% ●	MBH	65% ●	100%
MVP	91%	97%	MVP	100%	100%
TVHP	57% ●	59% ●	TVHP	75% ●	100%
Franklin County			Orleans County		
BCBSVT	76% ●	96%	BCBSVT	20% ●	33% ●
BCBSVT PPO	73% ●	95%	BCBSVT PPO	22% ●	34% ●
CBH	99%	97%	CBH	100%	29% ●
MBH	76% ●	96%	MBH	20% ●	33% ●
MVP	98%	99%	MVP	100%	100%
TVHP	71% ●	97%	TVHP	23% ●	36% ●
Grand Isle County			Windsor County		
BCBSVT	92%	100%	BCBSVT	70% ●	100%
BCBSVT PPO	93%	100%	BCBSVT PPO	65% ●	100%
CBH	100%	100%	CBH	100%	100%
MBH	92%	100%	MBH	70% ●	100%
MVP	100%	100%	MVP	100%	100%
TVHP	92%	100%	TVHP	69% ●	100%

1.3.4 Access to Neonatal Care in Bennington, Essex, and Orleans Counties

Access to neonatologists within 90 minutes statewide ranges between 95% and 100%, which exceeds the 90% standard. However, in Bennington and Essex Counties, only CIGNA meets the standard. TVHP is just below the standard in Orleans County.

Percentage of Members with Access to Neonatal Care Statewide and in Selected Counties, 2013				
	Statewide ²	Bennington County	Essex County	Orleans County
BCBSVT	98%	46% 	48% 	90%
BCBSVT PPO	95%	44% 	52% 	90%
CIGNA	100%	100%	82% 	100%
MVP PPO	96%	38% 	60% 	93%
TVHP	98%	65% 	66% 	89% 

² The actual statewide percentage is slightly below 100% and has been rounded up to 100%.

1.3.5 Access to Bariatric Surgeons

Access to bariatric surgeons within 60 minutes varies widely across plans, from MVP at only 28% to CIGNA at 100%. Cigna is the only plan that meets the 90% standard. MVP has significant access issues. Access is an issue across a range of counties for multiple plans.

Percentage of Members with Access to Bariatric Surgeon Statewide and for Selected Counties, 2013					
County	BCBSVT	BCBSVT PPO	CIGNA	MVP	TVHP
Bennington	5%	4%	100%	69%	4%
Caledonia	27%	27%	100%	16%	28%
Essex	0%	0%	100%	0%	0%
Franklin	96%	94%	100%	0%	97%
Orleans	9%	8%	100%	0%	11%
Rutland	84%	86%	100%	77%	80%
Windham	26%	19%	100%	20%	23%
Statewide	89%	79%	100%	5%	85%

1.3.6 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 driving 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, 2013						
County	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Essex	30%	35%	100%	30%	36%	45%
Orleans	33%	35%	100%	33%	43%	36%

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

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 Statewide and for Selected Counties, 2013						
	BCBSVT	BCBSVT PPO	CBH	MBH	MVP	TVHP
Statewide	60%	69%	100%	60%	99%	66%
Essex County	39%	48%	100%	39%	43%	54%
Lamoille County	11%	10%	100%	11%	100%	11%
Orleans County	8%	8%	100%	8%	51%	10%

1.3.8 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 “NA.” 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, 2013									
	BCBSVT ²	BCBSVT PPO	CBH ³	CIGNA ⁴	CIGNA PPO	MBH ⁵	MVP ⁶	TVHP	Rule Standard
Urgent Care	85%	82%	28%	93%	92%	100%	100%	88%	90%
Improvement Opportunity	●	●	●					●	
Non-Urgent Care	74%	74%	84%	88%	89%	99%	99%	69%	90%
Improvement Opportunity	●	●	●	●	●			●	
Preventive Care	88%	91%	NA	65%	67%	NA	100%	89%	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.

1.4 Provider Satisfaction

Rule H-2009-03 requires that MCOs conduct an annual survey of their provider network. For the 2012 data filing, each MCO used its own sampling and survey methodology, along with including a set of standardized state-approved survey questions, as required. The state-approved survey questions are scored on a five-point scale using the following responses:

1 = Strongly Agree 2 = Agree 3 = Neither Agree or Disagree 4 = Disagree 5 = Strongly Disagree

The standard Department-approved provider survey includes the following questions:

1. Overall, I am satisfied with [MCO].
2. I would recommend [MCO] to other practitioners and to my patients.
3. [MCO's] staff is responsive when I need assistance.
4. [MCO's] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.
5. [MCO] provides adequate support to patients with chronic conditions, or other serious illness.
6. [MCO's] prescription drug formulary is adequate.⁷
7. The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.⁸
8. The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.
9. I have adequate access to [MCO's] Vermont utilization management department (e.g., when coverage for a service has been denied).
10. [MCO's] reimbursement levels are adequate.
11. [MCO's] claims payments are timely.
12. [MCO's] claims processing is accurate.
13. There are an adequate number and breadth of practitioners in [MCO's] network when I need to refer patients for other services.

Based on a review of the survey responses, we have noted the following:

- BCBSVT and TVHP used a mixed mode methodology to reach its providers. This included the use of mail, Internet, and telephone to survey primary care and specialist practices. A total of 375 surveys were completed, 219 primary care physicians and 156 specialists. The overall response rate was 23%.
- CBH sent an electronic survey via email to its mental health and substance abuse practitioners in Vermont and received 132 responses.

⁷ MBHOs are not required to use this question.

⁸ MBHOs are not required to use this question.

- Cigna conducted a satisfaction survey among physicians and practice managers in Vermont during the months of April and May 2013. The survey was conducted using a mix of mail and online approaches. They attempted to reach all practices currently participating in their network. A total of 1,537 individuals were invited to take the survey, but the response rate was only 6%. This year CIGNA used the required questions and required five point scale. To boost response rates, the Department recommends that CIGNA should consider adding a telephonic component to their survey modalities.
- MBH mailed surveys to its Vermont network providers who had at least one authorization for services between January and June 2012. Providers could either mail back or fax back their survey responses. Surveys were mailed to 275 providers and they received 133 responses, or a 48% response rate.
- MVP used a mail survey, sending surveys to 5,129 physicians and health professionals in Vermont, and received 724 responses. This is a 14% response rate. To boost response rates, the Department recommends that MVP should consider adding an Internet and/or telephone component to their survey modalities.
- PrimariLink does not have its own provider network and, as in the past, is not required to submit a provider satisfaction survey.

Based on a review of each MCO's survey methodology, it appears that each plan, with the exception of CIGNA, is in compliance with the requirements to include standard state questions in their provider satisfaction surveys and to collect responses using a five-point scale. In addition, MCOs are required to summarize the results of any corrective actions that they have undertaken during the reporting year to improve provider satisfaction from the previous year's low scoring survey results. The following charts provide an analysis of the provider survey results and improvement activities reported by the MCOs.

1.4.1 Provider Satisfaction Survey Results

The results below are for the “Strongly Agree” and “Agree” categories.

Provider Satisfaction Survey Results, 2012					
Department-Specified Provider Survey Questions	BCBSVT/ BCBSVT PPO/ TVHP	CBH	CIGNA POS & PPO	MBH	MVP
Overall, I am satisfied with [MCO].	87%	44%	43%	70%	74%
I would recommend [MCO] to other practitioners and to my patients.	77% (to colleagues) 76% (to patients)	35%	35%	59%	65%
[MCO’s] staff is responsive when I need assistance.	89%	51%	34%	77%	77%
[MCO’s] quality of communications, such as care management tools, policy bulletins and manuals, is adequate.	77%	49%	24%	56%	70%
[MCO] provides adequate support to patients with chronic conditions, or other serious illness.	52%	28%	27%	37%	52%
[MCO’s] prescription drug formulary is adequate.	53%	NA	28%	NA	38%
The amount of time spent obtaining [MCO] pre-approval for select prescription drugs is appropriate.	40%	NA	23%	NA	28%
The amount of time spent obtaining [MCO] pre-approval for services (other than prescription drugs) for my patients is appropriate.	47%	50%	27%	61%	52%
I have adequate access to [MCO’s] Vermont utilization management department (e.g., when coverage for a service has been denied).	63%	26%	36%	46%	53%
[MCO’s] reimbursement levels are adequate.	57%	15%	30%	15%	40%
[MCO’s] claims payments are timely.	91%	44%	63%	65%	65%
[MCO’s] claims processing is accurate.	87%	53%	47%	72%	66%
There are an adequate number and breadth of practitioners in [MCO’s] network when I need to refer patients for other services.	66%	34%	53%	45%	56%

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

MCO Actions Taken in Response to Prior Year Survey Results, 2012					
Corrective Actions	BCBSVT / BCBSVT PPO / TVHP	CBH	CIGNA POS / PPO	MBH	MVP
Worked to improve survey response rate	X				
Worked to improve resolution of inquiry upon first contact with customer service	X				
Worked to improved provider website			X		X
Streamline drug prior authorization process			X		
Worked to increase staffing for provider telephone				X	
Worked to improve complaints process				X	X
Worked to improve communications with providers					X
Worked to realign the inpatient care management team		X			

1.5 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. The details of the analysis can be found in the technical documentation section included in Appendix D.

In order to determine if an MCO's performance significantly differed from the New England regional or national average in the point-in-time analysis, the Department requires that 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.

The change-over-time analyses only rely on statistical significance (i.e. a "p" value of 0.05 or less) and no practical significance test is applied.

Tables depicting MCO performance for HEDIS[®] measures use the following acronyms:

- **NA** means "***not applicable***" and indicates that the population of members meeting the conditions for this measure is too small to produce a meaningful score (or rate), an MCO has no cases to report, or a significance test or trend analysis cannot be performed because there are no data with which to make the comparison.
- **NR** means "***not required to report***" and indicates that an MCO did not report the measure because it is not required to do so.
- **FTR** means "***failed to report***" and indicates that an MCO was required to report data, but failed to do so.

1.6 Global Performance Rankings - SUPERSCORES

SUPERSCORES have been included in this report in the last four years with the goal of providing a comparative ranking of MCOs by their overall performance of the outcome of selected clinical and survey measures for HMO/POS (subsequently referred to as “HMOs”) products only. This year’s report also includes SUPERSCORES for PPO products.

There are two types of SUPERSCORES. One is based on HEDIS® measures and the other is based on CAHPS® measures. The measures included in the SUPERSCORE calculations are selected from the measures highlighted in this report and focus on effectiveness of care, access to services, and members' survey results of their experience of care and service. The score for each measure is compared to percentiles for that measure developed by the National Committee on Quality Assurance (NCQA) and assigned to the applicable performance category shown in the chart below.

SUPERSCORE RANKING	PERCENTILE	STAR RANKING
Excellent	90th percentile or higher	★★★★
Good	75th through 89th percentile	★★★
Fair	50th through 74th percentile	★★
Poor	Less than the 50th percentile	★

Details about how the measures are derived may be found in Appendix D. *These SUPERSCORE rankings do not include managed mental health organizations.*

1.6.1 Key HEDIS® SUPERSCORE Rankings:

- The scores for HMOs are very close. All plans received two stars.
- CIGNA dropped by one star from last year’s rankings.
- BCBSVT and TVHP have had the same two-stars ranking for the past six years.
- BCBSVT (both HMO & PPO) has the highest score overall, while TVHP has the lowest score.

HMO SUPERSCORE, 2012 HEDIS® Effectiveness of Care Measures			PPO SUPERSCORE, 2012 HEDIS® Effectiveness of Care Measures		
	Score	Ranking		Score	Ranking
BCBSVT	2.38	★★	BCBSVT PPO	2.32	★★
CIGNA	2.00	★★	CIGNA PPO	2.15	★★
TVHP	1.95	★★	MVP PPO	2.05	★★

1.6.2 Key CAHPS® SUPERSCORE Rankings:

- There is more variation in the CAHPS® SUPERSCORES than there is in the HEDIS® SUPERSCORES.
- BCBSVT ranks the highest among the HMOs on CAHPS® scores. .
- BCBSVT PPO & CIGNA PPO are the highest ranked PPOs with three (3) stars each, while MVP PPO has the lowest ranking with only one (1) star.

HMO SUPERSCORE, 2013 CAHPS® Experience of Care Measures			PPO SUPERSCORE, 2013 CAHPS® Experience of Care Measures		
	Score	Ranking		Score	Ranking
BCBSVT	3.22	★★★	BCBSVT PPO	2.56	★★★
CIGNA	1.78	★★	CIGNA PPO	2.67	★★★
TVHP	1.89	★★	MVP PPO	1.44	★

PART II: MEMBER SATISFACTION, UR DECISIONS AND GRIEVANCES

This section of the report discusses quality improvement recommendations for managed care organizations. There are two criteria that are used to identify improvement opportunities for HEDIS[®] and CAHPS[®] measures: 1) the HMO's⁹ or PPO's rate is statistically and practically¹⁰ significantly worse than 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 improvements are identified in the following tables using the criteria described above and are identified with a “stop sign.”

When reviewing the tables, symbols have the following meaning:

- ▲ = Means that the HMO's or PPO's score **is better than** the national or New England regional average.
- ◎ = Means that there is **no significant difference** between the HMO's or PPO's score and the national or New England regional average.
- ▼ = Means that the HMO's or PPO's point-in-time score **is worse than** the national or New England regional average by a statistically and practically significant amount; therefore, the difference cannot be explained by chance alone.
- ◆ = Means that either: 1) the HMO's or PPO's point-in-time score **is below** the better of the national or New England regional average by a statistically and practically significant amount, or 2) all rates (HMO or PPO, regional and national) are **below 50%**. Either of these conditions indicates an opportunity where the HMO or PPO can improve its performance.

⁹ As noted above in this report the term HMO encompasses HMO, HMO/POS and POS.

¹⁰ Practical significance is defined as the MCO'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.

2.1 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, CIGNA, CIGNA PPO, MVP PPO, TVHP, and BCBSVT PPO 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 HMO or PPO performance.

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 (2011) and the most recent measurement year (2013).

Details about the survey, including response rates and respondent characteristics, may be found in Appendix C. Appendix A includes charts detailing relevant measures over time.

2.1.1 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 managed care organization. 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, 2013									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	82%	73%	53%			52%	68%	51%	
Compared to National Average	▲	▲	▼	65%		▼	▲	▼	58%
Compared to Regional Average	▲	⊙	▼	70%		▼	▲	▼	57%
Improvement Opportunity			⬮			⬮		⬮	
Change Over Time 2011-2013	⊙	▲	⊙			⊙	▲	⊙	

2.1.2 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, 2012										
		BCBSVT ¹¹	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Call Answer Timeliness	Plan Rate	29%	74%	29%			29%	76%	91%	
	Compared to National Average	▼	▼	▼	79%		▼	⊙	▲	78%
	Compared to Regional Average	▼	⊙	▼	72%		▼	⊙	▲	75%
	Improvement Opportunity	⬮	⬮	⬮			⬮			
	Change Over Time 2010-2012	▼	▲	▼			▼	▼	▲	

A chart showing performance over time may be found in Appendix A.

¹¹ In the past two years, BCBSVT and TVHP reported adopting a “concierge model” for customer service that focuses on providing complete and accurate information on the first call as means of achieving higher member satisfaction. However, this approach results in much longer wait times, which have fallen substantially below national or regional averages.

2.1.3 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, 2013									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	94%	85%	92%		91%	85%	84%	
	Compared to National Average	▲	◎	◎	88%	▲	◎	◎	86%
	Compared to Regional Average	◎	▼	◎	91%	▲	◎	◎	86%
	Improvement Opportunity		●						
	Change Over Time 2011-2013	◎	◎	▲		◎	◎	◎	
How often did Customer Service staff treat you with courtesy or respect?	Plan Rate	98%	92%	98%		96%	94%	90%	
	Compared to National Average	◎	◎	◎	95%	◎	◎	◎	93%
	Compared to Regional Average	◎	◎	◎	96%	◎	◎	◎	93%
	Change Over Time 2011-2013	◎	◎	◎		◎	◎	◎	
	How often did your health plan’s Customer Service give you the information or help you needed?	Plan Rate	89%	78%	86%		86%	76%	77%
Compared to National Average		◎	◎	◎	82%	▲	◎	◎	79%
Compared to Regional Average		◎	◎	◎	85%	▲	◎	◎	78%
Change Over Time 2011-2013		◎	◎	▲		▲	◎	◎	

2.1.4 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, 2013									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	96%	92%	94%		94%	92%	89%	
	Compared to National Average	▲	⊙	▲	89%	▲	▲	⊙	88%
	Compared to Regional Average	▲	⊙	⊙	91%	▲	▲	⊙	86%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	
Claims Processing is Timely	Plan Rate	95%	90%	92%		91%	89%	88%	
	Compared to National Average	▲	⊙	⊙	88%	▲	⊙	⊙	86%
	Compared to Regional Average	▲	⊙	⊙	90%	▲	⊙	⊙	85%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	
Claims are Processed Correctly	Plan Rate	97%	93%	96%		96%	96%	90%	
	Compared to National Average	▲	⊙	▲	90%	▲	▲	⊙	90%
	Compared to Regional Average	▲	⊙	▲	92%	▲	▲	⊙	87%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	▲	⊙	

2.1.5 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, 2013									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	89%	90%	88%		89%	94%	90%	
	Compared to National Average	⊙	⊙	⊙	87%	⊙	▲	⊙	88%
	Compared to Regional Average	⊙	⊙	⊙	89%	⊙	▲	⊙	89%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	▲	⊙	
Getting to See A Specialist	Plan Rate	86%	86%	85%		86%	92%	88%	
	Compared to National Average	⊙	⊙	⊙	85%	⊙	▲	⊙	85%
	Compared to Regional Average	⊙	⊙	⊙	87%	⊙	▲	⊙	87%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	▲	⊙	
Easy to Get the Care, Tests or Treatment You Needed	Plan Rate	93%	93%	91%		92%	96%	93%	
	Compared to National Average	⊙	⊙	⊙	90%	⊙	⊙	⊙	92%
	Compared to Regional Average	⊙	⊙	⊙	92%	⊙	▲	⊙	92%
	Change Over Time 2011-2013	⊙	⊙	⊙		▲	▲	⊙	

2.1.6 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, 2013										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	73%	60%	66%			62%	61%	57%	
	Compared to National Average	▲	⊙	⊙	66%		⊙	⊙	⊙	61%
	Compared to Regional Average	⊙	▼	⊙	70%		⊙	⊙	⊙	62%
	Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	
Able to find out how much to pay for a health care service or equipment?	Plan Rate	78%	53%	68%			57%	60%	55%	
	Compared to National Average	▲	▼	⊙	64%		⊙	⊙	⊙	58%
	Compared to Regional Average	▲	▼	⊙	69%		⊙	⊙	⊙	62%
	Improvement Opportunity		●							
	Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	
Able to find out how much to pay for prescription medications?	Plan Rate	68%	67%	63%			67%	62%	59%	
	Compared to National Average	⊙	⊙	⊙	67%		⊙	⊙	⊙	64%
	Compared to Regional Average	⊙	⊙	⊙	69%		⊙	⊙	⊙	64%
	Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	

2.1.7 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, 2013										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	88%	90%	85%			90%	92%	87%	
	Compared to National Average	⊙	⊙	⊙	86%		⊙	▲	⊙	86%
	Compared to Regional Average	⊙	⊙	⊙	89%		⊙	⊙	⊙	88%
	Change Over Time 2011-2013	▼	⊙	▼			⊙	⊙	⊙	
Getting Care Quickly When You Needed Care Right Away	Plan Rate	89%	92%	84%			93%	93%	88%	
	Compared to National Average	⊙	⊙	⊙	88%		⊙	⊙	⊙	89%
	Compared to Regional Average	⊙	⊙	▼	91%		⊙	⊙	⊙	91%
	Improvement Opportunity			●						
	Change Over Time 2011-2013	⊙	⊙	▼			⊙	⊙	⊙	
Getting Routine Care As Soon As Wanted	Plan Rate	86%	87%	85%			87%	92%	85%	
	Compared to National Average	⊙	⊙	⊙	84%		⊙	▲	⊙	84%
	Compared to Regional Average	⊙	⊙	⊙	87%		⊙	▲	⊙	86%
	Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	

2.1.8 How Often Did Your Personal Doctor Seem Informed about the Care You Got from Other Health Providers?

This measure reports the percentage of members who responded “definitely yes” and “usually yes” to the CAHPS® question, “In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?”

How Often Did Your Personal Doctor Seem Informed about the Care You Got from Other Health Providers?, 2013									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	85%	86%	84%			84%	87%	81%	
Compared to National Average	⊙	⊙	⊙	80%		⊙	⊙	▲	79%
Compared to Regional Average	⊙	⊙	⊙	82%		⊙	⊙	⊙	82%
Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	

2.1.9 How Well Doctors Communicate: Composite and Individual Measures

Composite

To create this composite, NCQA combines members’ satisfaction levels from the four CAHPS® questions shown below.

How Often Doctors Listen Carefully

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 personal physician listen carefully to you?”

How Often Doctors Explain Things in an Understandable Way

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 personal doctor explain things in a way that was easy to understand?”

How Often Doctors Show 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 personal doctor show respect for what you had to say?”

How Often Doctors Spend Enough Time with Their Patients

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 personal doctor spend enough time with you?”

How Well Doctors Communicate, 2013										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO Average)		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite Measure	Plan Rate	96%	96%	94%			96%	96%	95%	
	Compared to National Average	⊙	⊙	⊙	94%		⊙	⊙	⊙	95%
	Compared to Regional Average	⊙	⊙	⊙	95%		⊙	⊙	⊙	95%
	Change Over Time 2011-2013	⊙	⊙	⊙			⊙	⊙	⊙	

Table continued below.

How Well Doctors Communicate, 2013

		BCBSVT	CIGNA	TVHP	MCO (w/o PPO Average)	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
How Often Doctors Listen Carefully	Plan Rate	95%	96%	92%		95%	96%	95%	
	Compared to National Average	⊙	⊙	⊙	94%	⊙	⊙	⊙	95%
	Compared to Regional Average	⊙	⊙	⊙	95%	⊙	⊙	⊙	95%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	
How Often Doctors Explain Things in an Understandable Way	Plan Rate	97%	98%	96%		96%	97%	98%	
	Compared to National Average	⊙	⊙	⊙	95%	⊙	⊙	⊙	96%
	Compared to Regional Average	⊙	⊙	⊙	96%	⊙	⊙	⊙	97%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	
How Often Doctors Show Respect	Plan Rate	97%	97%	96%		97%	97%	95%	
	Compared to National Average	⊙	⊙	⊙	96%	⊙	⊙	⊙	96%
	Compared to Regional Average	⊙	⊙	⊙	96%	⊙	⊙	⊙	96%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	
How Often Doctors Spend Enough Time with Their Patients	Plan Rate	94%	94%	94%		94%	93%	93%	
	Compared to National Average	⊙	⊙	⊙	92%	⊙	⊙	⊙	93%
	Compared to Regional Average	⊙	⊙	⊙	93%	⊙	⊙	⊙	93%
	Change Over Time 2011-2013	⊙	⊙	⊙		⊙	⊙	⊙	

2.2 Utilization Review Decisions

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

- concurrent review within 24 hours
- urgent, pre-service review (including all mental health and substance abuse services and prescription drugs) within 72 hours
- non-urgent, pre-service review within 15 days
- post-service review within 30 days

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 “stop sign” on the same line next to the reported percentage rate.

Percentage of UR Decisions Meeting Rule H-2009-03 Decision-Making Timeframes, 2012									
	BCBSVT	BCBSVT PPO	CBH	CIGNA	MBH	MVP PPO	Primari-Link	TVHP	Rule Standard
Concurrent Reviews									
½ 1 day	93%	93%	100%	60% 	100%	92%	100%	90%	90%
Urgent Pre-Service Reviews									
½ 72 hours or with an extension	93%	92%	100%	82% 	100%	100%	83% 	90%	90%
Non-Urgent Pre-Service Reviews									
½ 15 days or with an extension	98%	92%	93%	98%	100%	100%	100%	100%	90%
Post-Service Reviews									
½ 30 days or with an extension	98%	100%	80% 	100%	100%	97%	100%	95%	90%

2.3 Member Grievances

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

- grievances per 1000 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

2.3.1 Grievances per 1000 Members

For the most recent reporting period (January 2012 – December 2012), grievances per 1000 members varied widely among the MCOs and PPOs.

Grievances per 1000 Members, January 2012 – December 2012								
	BCBSVT	BCBSVT PPO	CBH¹²	CIGNA¹³	MBH	MVP PPO	PrimariLink	TVHP
January 2011 – December 2011	5.46	3.84	2.45	4.08	1.31	1.84	0	3.98

2.3.2 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, January 2012 – December 2012								
	BCBSVT	BCBSVT PPO	CBH¹⁴	CIGNA¹⁵	MBH	MVP PPO	PrimariLink	TVHP
January 2011 – December 2011	6%	6%	6%	10%	10%	0%	0	4%

¹² Results are for Network/Network POS, PPO/OAP (Open Access Plus), Employer Products.

¹³ Results are for Network/Network POS and PPO combined.

¹⁴ Results are for Network/Network POS, PPO/OAP (Open Access Plus), Employer Products.

¹⁵ Results are for Network/Network POS and PPO combined.

2.3.3 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, January 2012 – December 2012					
	BCBSVT	BCBSVT PPO	CIGNA ¹⁶	MVP PPO	TVHP
Total Number of Grievances Resolved	147	66	109	34	134
Number of Grievances Resolved at 1st Level	129	64	98	29	116
Percent of 1st Level Grievances Resolved in Member's Favor	45%	34%	31%	28%	41%
Number of Grievances Resolved at 2nd Level	18	2	11	5	18
Percent of 2nd Level Grievances Resolved in Member's Favor	41%	50%	0%	0%	44%
Total Percentage of Grievances Resolved in Member's Favor	44%	35%	28%	24%	41%

2.3.4 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, January 2012 – December 2012						
	BCBSVT	BCBSVT PPO	CBH ¹⁷	MBH ¹⁸	Primari-Link ¹⁹	TVHP
Total Number of Grievances Resolved	66	62	17	136	0	25
Number of Grievances Resolved at 1st Level	37	62	10	136	0	25
Percent of 1st Level Grievances Resolved in Member's Favor	59%	61%	20%	63%	NA	28%
Number of Grievances Resolved at 2nd Level	3	0	7	0	0	0
Percent of 2nd Level Grievances Resolved in Member's Favor	100%	NA	14%	NA	NA	NA
Total Percentage of Grievances Resolved in Member's Favor	61%	61%	18%	63%	NA	28%

¹⁶ Results are for Network/Network POS and PPO/OAP (Open Access Plus).

¹⁷ Results are for Network/Network POS, PPO/OAP (Open Access Plus), Employer Products.

¹⁸ MBH does not conduct 2nd level reviews. Rather, they are handled by BCBSVT.

¹⁹ PrimariLink does not conduct 2nd level reviews.

2.3.5 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, January 2012 – December 2012					
	BCBSVT	BCBSVT PPO	CIGNA ²⁰	MVP PPO	TVHP
Total Number of Grievances Resolved	10	21	2	2	17
Number of Grievances Resolved at 1st Level	10	6	0	1	9
Percent of 1st Level Reviews Resolved in Member's Favor	100%	29%	0%	50%	53%
Number of Grievances Resolved at Voluntary 2nd Level Review	0	0	0	0	1
Percent of Voluntary 2nd Level Reviews Resolved in Member's Favor	NA	NA	NA	NA	100%
Total Percentage of Grievances Resolved in Member's Favor	91%	29%	0%	50%	59%

²⁰ Results are for Network/Network POS and PPO combined.

2.3.6 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 below 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.

**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, January 2012 – December 2012²¹**

	BCBSVT	BCBSVT PPO	CIGNA	MVP PPO	TVHP
LEVEL 1 GRIEVANCES					
Physical Health, Concurrent	NA	NA	NA	NA	NA
Physical Health, Urgent Pre-Service	100%	75% ●	43% ●	100%	100%
Physical Health, Non-Urgent Pre-Service	100%	100%	88% ●	100%	96%
Physical Health, Post-Service	99%	100%	89% ●	100%	100%
Pharmacy, Pre-Service, Urgent Pre-Service	100%	100%	NA	100%	100%
Pharmacy, Pre-Service, Non-Urgent Pre-Service	NA	NA	100%	100%	NA
Pharmacy, Post-Service	100%	NA	NA	NA	100%
Grievances Unrelated to an Adverse Benefit Decision	100%	100%	NA	100%	100%
VOLUNTARY LEVEL 2 GRIEVANCES					
Physical Health, Concurrent	NA	NA	NA	NA	NA
Physical Health, Urgent Pre-Service	100%	NA	100%	100%	50% ●
Physical Health, Non-Urgent Pre-Service	100%	NA	100%	100%	100%
Physical Health, Post-Service	100%	100%	100%	100%	93%
Pharmacy, Urgent Pre-Service	NA	NA	NA	NA	0% ●
Pharmacy, Non-Urgent Pre-Service	NA	NA	NA	NA	NA
Pharmacy, Post-Service	NA	NA	NA	NA	NA
Grievances Unrelated to an Adverse Benefit Decision	NA	NA	NA	NA	NA

²¹ Grievances resolved within the appropriate timeframe, or with a justified extension, have been counted as meeting the Rule H-2009-03 standard.

2.3.7 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

Timeliness in Making Mental Health and Substance Abuse Grievance Review Decisions, January 2012 – December 2012						
	BCBSVT	BCBSVT PPO	CBH	MBH	PrimariLink	TVHP
LEVEL 1 GRIEVANCES						
Concurrent	67% 	100%	100%	88% 	NA	NA
Urgent Pre-Service	100%	100%	NA	100%	NA	100%
Non-Urgent Pre-Service	91%	100%	0% 	95%	NA	89% 
Post-Service	100%	100%	100%	100%	NA	100%
VOLUNTARY LEVEL 2 GRIEVANCES						
Concurrent	100%	NA	100%	NA	NA	NA
Urgent Pre Service	50% 	NA	NA	NA	NA	NA
Non-Urgent Pre-Service	NA	NA	NA	NA	NA	NA
Post-service	NA	NA	100%	NA	NA	100%

2.3.8 Grievances Unrelated to an Adverse Benefit Decision: Percent Distribution and Number per 1000 Members

Rule H-2009-03 requires MCOs to report grievances that are unrelated to an adverse benefit determination, such as those involving health plan quality. These grievances generally include the following factors:

- provider performance and office management
- plan administration
- access to health care services

Grievances Unrelated to an Adverse Benefit Decision: Number and Percent per 1000 Members, January 2012 – December 2012								
	BCBSVT	BCBSVT PPO	CBH	CIGNA	MBH	MVP PPO	Primari-Link	TVHP
QUALITY OF CARE ISSUES								
Number of Grievances	10	11	1	16	3	5	0	16
Percent of Grievances	71%	61%	17%	100%	27%	23%	0%	84%
PLAN ADMINISTRATION								
Number of Grievances	2	5	4	0	7	17	0	1
Percent of Grievances	14%	28%	67%	0%	64%	77%	0%	5%
ACCESS TO HEALTH CARE								
Number of Grievances	2	2	1	0	1	0	0	2
Percent of Grievances	14%	11%	17%	0%	9%	0%	0%	11%
Total Number of Grievances	14	18	6	16	11	22	0	19
Number of Grievances per 1000 Members	0.33	0.41	0.64	0.51	0.10	0.76	0.00	0.47

PART III: ANNUAL 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.”

3.1 Prevention and Screening

3.1.1 Immunizations for Adolescents: Composite and Individual Measures

Composite: This measure provides a snapshot of the average of the combination of three rates.

Combination: This measure reports the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

Meningococcal: This measure reports the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine by their 13th birthday.

Tdap/TD: This measure reports the percentage of adolescents 13 years of age who had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), or one tetanus, diphtheria toxoids vaccine (Td), by their 13th birthday.

Immunizations for Adolescents: Composite and Individual Measures, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	67%	36%	69%			66%	61%	66%	
	Compared to National Average	⊙	▼	⊙	70%		⊙	⊙	⊙	61%
	Compared to Regional Average	▼	▼	⊙	73%		⊙	▼	⊙	70%
	Change Over Time 2010-2012	▲	⊙	▲			▲	NA	▲	
	Improvement Opportunity		●							
Combination	Plan Rate	56%	27%	59%			57%	50%	56%	
	Compared to National Average	▼	▼	⊙	64%		⊙	⊙	⊙	54%
	Compared to Regional Average	▼	▼	▼	67%		⊙	▼	▼	64%
	Change Over Time 2011-2012	▲	⊙	▲			▲	NA	▲	
	Improvement Opportunity	●	●	●				●	●	
Meningococcal	Plan Rate	57%	33%	62%			59%	53%	57%	
	Compared to National Average	▼	▼	⊙	66%		⊙	▼	⊙	57%

Immunizations for Adolescents: Composite and Individual Measures, 2012									
	Compared to Regional Average	▼	▼	▼	70%	⊙	▼	⊙	69%
	Change Over Time 2010-2012	▲	▲	▲		▲	NA	▲	
	Improvement Opportunity	⬮	⬮	⬮			⬮	⬮	
Tdap/TD	Plan Rate	87%	47%	86%		81%	79%	83%	
	Compared to National Average	▲	▼	▲	79%	▲	▲	▲	70%
	Compared to Regional Average	▲	▼	⊙	82%	⊙	⊙	▲	76%
	Change Over Time 2011-2012	▲	⊙	▲		⊙	NA	▲	
	Improvement Opportunity		⬮						

3.1.2 Breast Cancer Screening

This measure reports the percentage of women between 42 and 69 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.

Breast Cancer Screening, 2012								
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	77%	77%	73%		70%	71%	70%	
Compared to National Average	▲	▲	⊙	70%	⊙	▲	⊙	67%
Compared to Regional Average	⊙	⊙	▼	78%	▼	⊙	▼	74%
Improvement Opportunity			⬮		⬮		⬮	
Change Over Time 2010-2012	▼	⊙	⊙		⊙	▼	⊙	

3.1.3 Cervical Cancer Screening

This measure reports the percentage of women between the ages of 21 and 64 who received one or more Pap tests to screen for cervical cancer during the measurement period. Early detection and treatment of cervical cancer can significantly increase a woman's chances of survival.

Cervical Cancer Screening, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	76%	74%	74%			72%	71%	71%	
Compared to National Average	⊙	⊙	⊙	76%		⊙	⊙	⊙	74%
Compared to Regional Average	⊙	▼	▼	79%		▼	▼	▼	78%
Improvement Opportunity		⬮	⬮			⬮	⬮	⬮	
Change Over Time 2010-2012	▼	▼	▼			▼	▼	▼	

3.1.4 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 2011. Chlamydia screening is an important public health strategy to control a common sexually transmitted disease.

Chlamydia Screening in Women, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Total	Plan Rate	46%	42%	39%			44%	50%	40%	
	Compared to National Average	⊙	⊙	▼	45%		⊙	▲	⊙	42%
	Compared to Regional Average	▼	▼	▼	52%		▼	⊙	▼	54%
	Improvement Opportunity	●	●	●			●	●	●	
	Change Over Time 2010-2012	▲	⊙	▼			⊙	▲	⊙	
16 – 20 years of age	Plan Rate	41%	39%	34%			41%	49%	34%	
	Compared to National Average	⊙	⊙	▼	41%		⊙	▲	⊙	39%
	Compared to Regional Average	▼	⊙	▼	47%		▼	⊙	▼	50%
	Improvement Opportunity	●	●	●			●	●	●	
	Change Over Time 2010-2012	▲	⊙	⊙			⊙	▲	⊙	
21 – 24 years of age	Plan Rate	50%	44%	45%			46%	52%	45%	
	Compared to National Average	⊙	⊙	▼	49%		⊙	▲	⊙	46%
	Compared to Regional Average	▼	▼	▼	57%		▼	▼	▼	58%
	Improvement Opportunity	●	●	●			●	●	●	
	Change Over Time 2010-2012	⊙	⊙	⊙			⊙	⊙	⊙	

3.1.5 Prenatal and Postpartum Care

Composite: This measure combines the performance of the two measures below, Timeliness of Prenatal Care and Postpartum Care.

Timeliness of Prenatal Care: This measure is the percentage of deliveries of live births that received a prenatal care visit in the first trimester or within 42 days of enrollment.

Postpartum Care: This measure is the percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.

Prenatal and Postpartum Care, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	91%	63%	88%			89%	NA	90%	
	Compared to National Average	▲	▼	⊙	85%		▲	NA	▲	75%
	Compared to Regional Average	⊙	▼	⊙	87%		▲	NA	▲	76%
	Improvement Opportunity		●							
	Change Over Time 2010-2012	⊙	▼	⊙			⊙	NA	▲	
Prenatal Care	Plan Rate	95%	75%	93%			94%	74%	95%	
	Compared to National Average	▲	▼	⊙	90%		▲	▼	▲	81%
	Compared to Regional Average	▲	▼	⊙	90%		▲	▼	▲	82%
	Improvement Opportunity		●					●		
	Change Over Time 2010-2012	⊙	▼	⊙			⊙	⊙	▲	
Postpartum Care	Plan Rate	86%	50%	83%			83%	NA	84%	
	Compared to National Average	▲	▼	⊙	80%		▲	NA	▲	70%
	Compared to Regional Average	⊙	▼	⊙	84%		▲	NA	▲	70%
	Improvement Opportunity		●							
	Change Over Time 2010-2012	⊙	▼	⊙			⊙	NA	▲	

3.2 Respiratory Conditions Measures

3.2.1 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 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.

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.

Care for Children with Respiratory Infections , 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	90%	87%	88%			86%	89%	90%	
	Compared to National Average	▲	◎	▲	82%		◎	▲	▲	81%
	Compared to Regional Average	◎	◎	◎	91%		▼	◎	◎	91%
	Improvement Opportunity						●			
	Change Over Time 2010-2012	◎	◎	◎			◎	◎	◎	
Appropriate Testing of Children with Pharyngitis	Plan Rate	88%	76%	84%			80%	87%	89%	
	Compared to National Average	▲	◎	◎	80%		◎	▲	▲	79%
	Compared to Regional Average	◎	▼	▼	89%		▼	◎	◎	90%
	Improvement Opportunity		●	●			●			
	Change Over Time 2010-2012	◎	◎	◎			▼	◎	◎	
Appropriate Treatment for Children with Upper Respiratory Infection	Plan Rate	92%	98%	92%			90%	92%	91%	
	Compared to National Average	▲	▲	▲	84%		▲	▲	▲	82%
	Compared to Regional Average	◎	▲	◎	92%		◎	◎	◎	92%
	Change Over Time 2010-2012	◎	◎	◎			◎	◎	▼	

3.2.2 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	20%	29%	19%			20%	18%	21%	
Compared to National Average	▼	⊙	▼	25%		⊙	⊙	⊙	21%
Compared to Regional Average	▼	⊙	▼	26%		⊙	▼	⊙	25%
Improvement Opportunity	●		●				●		
Change Over Time 2010-2012	⊙	⊙	⊙			⊙	⊙	⊙	

3.2.3 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	42%	NA	43%			44%	41%	36%	
Compared to National Average	⊙	NA	⊙	44%		⊙	⊙	⊙	42%
Compared to Regional Average	⊙	NA	⊙	45%		⊙	⊙	⊙	45%
Improvement Opportunity	●		●			●	●	●	
Change Over Time 2010-2012	⊙	NA	⊙			⊙	⊙	NA	

3.2.4 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, 2012									
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Total	Plan Rate	95%	94%	93%		92%	90%	87%	
	Compared to National Average	⊙	⊙	⊙	91%	⊙	⊙	⊙	91%
	Compared to Regional Average	⊙	⊙	⊙	92%	⊙	⊙	▼	91%
	Improvement Opportunity							●	
Ages 5 – 11 years	Plan Rate	98%	NA	95%		NA	NA	NA	
	Compared to National Average	⊙	NA	⊙	96%	NA	NA	NA	96%
	Compared to Regional Average	⊙	NA	⊙	96%	NA	NA	NA	97%
Ages 12 – 18 years	Plan Rate	93%	NA	95%		NA	NA	NA	
	Compared to National Average	⊙	NA	⊙	92%	NA	NA	NA	92%
	Compared to Regional Average	⊙	NA	⊙	93%	NA	NA	NA	92%
Ages 19 - 50 years	Plan Rate	95%	NA	93%		89%	88%	83%	
	Compared to National Average	▲	NA	⊙	88%	⊙	⊙	⊙	87%
	Compared to Regional Average	▲	NA	⊙	88%	⊙	⊙	⊙	88%
Ages 51 – 64 years	Plan Rate	95%	NA	91%		92%	93%	87%	
	Compared to National Average	⊙	NA	⊙	92%	⊙	⊙	⊙	92%
	Compared to Regional Average	⊙	NA	⊙	93%	⊙	⊙	⊙	92%

3.3 Musculoskeletal Conditions

3.3.1 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	89%	NA	92%			92%	89%	90%	
Compared to National Average	⊙	NA	⊙	88%		⊙	⊙	⊙	87%
Compared to Regional Average	⊙	NA	⊙	90%		⊙	⊙	⊙	88%
Change Over Time 2010-2012	⊙	NA	⊙			⊙	⊙	⊙	

3.3.2 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	86%	73%	86%			85%	84%	85%	
Compared to National Average	▲	⊙	▲	75%		▲	▲	▲	74%
Compared Regional Average	▲	⊙	▲	78%		▲	▲	▲	77%
Change Over Time 2010-2012	⊙	▼	⊙			⊙	⊙	⊙	

3.4 Behavioral Health (Mental Health and Substance Abuse)

3.4.1 Anti-Depressant Medication Management Composite

This composite assesses the overall performance level of each MCO with regard to anti-depressant medication management during the acute and continuation phases of treatment.

3.4.1.1 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.

3.4.1.2 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, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	75%	69%	71%			73%	64%	63%	
	Compared to National Average	▲	⊙	▲	61%		▲	⊙	⊙	61%
	Compared to Regional Average	▲	⊙	⊙	66%		▲	⊙	⊙	65%
	Change Over Time 2010-2012	⊙	⊙	▲			▲	⊙	⊙	
Effective Acute Phase Treatment	Plan Rate	81%	74%	79%			82%	72%	71%	
	Compared to National Average	▲	⊙	▲	69%		▲	⊙	⊙	69%
	Compared to Regional Average	▲	⊙	▲	73%		▲	⊙	⊙	72%
	Change Over Time 2010-2012	⊙	⊙	▲			⊙	⊙	⊙	
Effective Continuation Phase Treatment	Plan Rate	69%	62%	62%			64%	57%	56%	
	Compared to National Average	▲	⊙	▲	54%		▲	⊙	⊙	53%
	Compared to Regional Average	▲	⊙	⊙	58%		▲	⊙	⊙	58%
	Change Over Time 2010-2012	⊙	⊙	▲			▲	⊙	⊙	

3.4.2 Follow-Up After Hospitalization for Mental Illness

3.4.2.1 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 7 days of discharge were seen by a mental health provider either on an ambulatory basis or in an intermediate treatment facility.

3.4.2.2 Within 30 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 30 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, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Within 7 Days	Plan Rate	72%	NA	79%			73%	64%	64%	
	Compared to National Average	▲	NA	▲	58%		▲	⊙	⊙	53%
	Compared to Regional Average	⊙	NA	⊙	71%		⊙	⊙	⊙	68%
	Change Over Time 2010-2012	⊙	NA	▲			⊙	⊙	⊙	
Within 30 Days	Plan Rate	92%	NA	94%			78%	77%	81%	
	Compared to National Average	▲	NA	▲	76%		⊙	⊙	⊙	72%
	Compared to Regional Average	⊙	NA	⊙	86%		⊙	⊙	⊙	83%
	Change Over Time 2010-2012	⊙	NA	▲			⊙	⊙	⊙	

3.4.3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

This measure looks at the combined percentages of adolescents and adults diagnosed with alcohol or other drug dependency who start alcohol or other drug dependency (AOD) treatment and continue with treatment for at least 30 days. Initiation of treatment is defined either as an 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, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	27%	NA	25%			27%	27%	24%	
	Compared to National Average	⊙	NA	⊙	26%		⊙	⊙	⊙	28%
	Compared to Regional Average	⊙	NA	⊙	29%		⊙	⊙	▼	30%
	Improvement Opportunity	⬮		⬮			⬮	⬮	⬮	
	Change Over Time 2010-2012	▼	NA	▼			⊙	⊙	⊙	
Initiation of Alcohol and Other Drug Dependence Treatment	Plan Rate	34%	NA	33%			35%	36%	34%	
	Compared to National Average	▼	NA	▼	39%		▼	▼	▼	41%
	Compared to Regional Average	▼	NA	▼	42%		▼	▼	▼	42%
	Improvement Opportunity	⬮		⬮			⬮	⬮	⬮	
	Change Over Time 2010-2012	▼	NA	▼			▼	⊙	⊙	
Engagement of Alcohol and Other Drug Dependence Treatment	Plan Rate	19%	NA	18%			20%	18%	14%	
	Compared to National Average	▲	NA	▲	13%		▲	⊙	⊙	15%
	Compared to Regional Average	⊙	NA	⊙	17%		⊙	⊙	⊙	18%
	Improvement Opportunity	⬮		⬮			⬮	⬮	⬮	
	Change Over Time 2010-2012	▼	NA	▼			⊙	⊙	▼	

3.4.4 Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase

This measure assesses the percentage of children ages 6 through 12 years who were prescribed and dispensed an ADHD prescription drug and who had one follow-up visit within 30 days of the initial prescription fill date.

Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase, 2012								
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	42%	NA	NA		NA	49%	NA	
Compared to National Average	⊙	NA	NA	39%	NA	⊙	NA	38%
Compared to Regional Average	⊙	NA	NA	46%	NA	⊙	NA	48%
Improvement Opportunity	⬮				⬮			
Change Over Time 2010-2012	⊙	NA	NA		NA	⊙	NA	

3.5 Medication Management

3.5.1 Annual Monitoring for Patients on Persistent Medications Composite

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.²² 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.

3.5.1.1 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.

3.5.1.2 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.

3.5.1.3 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.

²² 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, 2012

		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average	BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	78%	81%	78%		77%	77%	75%	
	Compared to National Average	⊙	⊙	⊙	82%	⊙	⊙	⊙	78%
	Compared to Regional Average	▼	⊙	▼	83%	⊙	⊙	▼	80%
	Improvement Opportunity	●		●				●	
	Change Over Time 2010-2012	⊙	⊙	⊙		⊙	⊙	▼	
Angiotensin Converting Enzyme Inhibitors (ACE) or Angiotensin Receptor Blockers (ARB)	Plan Rate	79%	82%	79%		78%	78%	76%	
	Compared to National Average	▼	⊙	▼	83%	⊙	⊙	⊙	79%
	Compared to Regional Average	▼	⊙	▼	84%	⊙	⊙	▼	80%
	Improvement Opportunity	●		●				●	
	Change Over Time 2010-2012	⊙	⊙	⊙		⊙	⊙	⊙	
Anticonvulsants	Plan Rate	61%	NA	63%		61%	59%	68%	
	Compared to National Average	⊙	NA	⊙	59%	⊙	⊙	⊙	56%
	Compared to Regional Average	⊙	NA	⊙	63%	⊙	⊙	⊙	62%
	Improvement Opportunity								
	Change Over Time 2009-2011	⊙	NA	⊙		⊙	⊙	⊙	
Diuretics	Plan Rate	79%	79%	79%		77%	78%	74%	
	Compared to National Average	⊙	⊙	⊙	82%	⊙	⊙	▼	79%
	Compared to Regional Average	▼	⊙	▼	83%	⊙	⊙	▼	80%
	Improvement Opportunity	●		●				●	
	Change Over Time 2010-2012	⊙	⊙	⊙		⊙	⊙	▼	

3.6 Hypertension Measures

3.6.1 Controlling High Blood Pressure

This measure assesses the percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90).

Controlling High Blood Pressure, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Controlling High Blood Pressure	Plan Rate	70%	67%	62%			61%	62%	67%	
	Compared to National Average	▲	⊙	⊙	63%		⊙	⊙	▲	57%
	Compared to Regional Average	⊙	⊙	▼	68%		⊙	⊙	⊙	63%
	Improvement Opportunity			●						
	Change Over Time 2010-2012	NA	NA	NA			▲	NA	NA	

3.7 Measures Collected Through the CAHPS® Health Plan Survey

3.7.1 Flu Shot for Adults Ages 50-64

This measure is a two-year rolling average of the percentage of adults between the ages of 50 and 64 who received flu shots. Flu shots can reduce the severity of flu symptoms and prevent deaths.

Flu Shots for Adults 50 – 64 Years of Age, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	61%	64%	56%			54%	60%	48%	
Compared to National Average	▲	▲	⊙	55%		⊙	▲	▼	54%
Compared to Regional Average	⊙	⊙	⊙	60%		▼	⊙	▼	59%
Improvement Opportunity						●		●	
Change Over Time 2010-2012	▲	⊙	▲			⊙	▲	⊙	

3.7.2 Medical Assistance with Smoking and Tobacco Use Cessation

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. A composite measure, which is a summary of the three component measures, is also reported.

Medical Assistance with Smoking and Tobacco Use Cessation: Composite and Individual Measures, 2012										
		BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Composite	Plan Rate	64%	70%	58%			57%	NA	54%	
	Compared to National Average	NA	NA	⊙	60%		NA	NA	NA	51%
	Compared to Regional Average	NA	NA	▼	68%		NA	NA	NR	NR²³
	Improvement Opportunity			●						
	Change Over Time 2010-2012	NA	NA	⊙			⊙	NA	NA	
Advising to Quit	Plan Rate	84%	87%	76%			70%	NA	66%	
	Compared to National Average	NA	NA	⊙	78%		NA	NA	52%	71%
	Compared to Regional Average	NA	NA	▼	83%		NA	NA	NR	NR
	Improvement Opportunity			●						
	Change Over Time 2010-2012	NA	NA	⊙			⊙	NA	NA	
Discussing Medications	Plan Rate	52%	63%	53%			53%	NA	52%	
	Compared to National Average	NA	NA	⊙	53%		NA	NA	NA	45%
	Compared to Regional Average	NA	NA	▼	64%		NA	NA	NR	NR
	Improvement Opportunity			●			●			
	Change Over Time 2010-2012	NA	NA	⊙			⊙	NA	NA	
Discussing Strategies	Plan Rate	56%	59%	44%			49%	NA	45%	
	Compared to National Average	NA	NA	⊙	48%		NA	NA	NA	37%
	Compared to Regional Average	NA	NA	▼	57%		NA	NA	NR	NR
	Improvement Opportunity			●					●	
	Change Over Time 2010-2012	NA	NA	⊙			⊙	NA	NA	

²³ Note: there are NCQA no regional averages for these measures.

3.8 Utilization Measures

3.8.1 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	86%	81%	81%			89%	85%	78%	
Compared to National Average	▲	▲	▲	65%		▲	▲	▲	62%
Compared to Regional Average	▲	⊙ ²⁴	▲	78%		▲	▲	⊙	79%
Change Over Time 2010-2012	⊙	⊙	⊙			▲	▲	▲	

3.8.2 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	91%	85%	84%			89%	89%	80%	
Compared to National Average	▲	⊙	▲	78%		▲	▲	⊙	76%
Compared to Regional Average	▲	⊙	⊙	86%		⊙	⊙	▼	88%
Improvement Opportunity								●	
Change Over Time 2010-2012	⊙	⊙	⊙			▲	▲	▲	

²⁴ CIGNA's rate was not statistically significantly different from the regional average because of its small denominator size.

3.8.3 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 PCP 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	83%	82%	81%			81%	79%	80%	
Compared to National Average	▲	▲	▲	73%		▲	▲	▲	70%
Compared to Regional Average	⊙	⊙	▼	86%		▼	▼	▼	86%
Improvement Opportunity			●			●	●	●	
Change Over Time 2010-2012	⊙	⊙	⊙			⊙	▲	▲	

3.8.4 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, 2012									
	BCBSVT	CIGNA	TVHP	MCO (w/o PPO) Average		BCBSVT PPO	CIGNA PPO	MVP PPO	PPO Average
Plan Rate	50%	50%	47%			44%	47%	47%	
Compared to National Average	▲	▲	▲	43%		⊙	▲	▲	40%
Compared to Regional Average	▼	▼	▼	62%		▼	▼	▼	62%
Improvement Opportunity	●	●	●			●	●	●	
Change Over Time 2010-2012	⊙	⊙	▼			⊙	⊙	⊙	

3.8.5 Plan All-Cause Readmission Rates

In order to measure coordination and continuity of care, the Department elected to use a new 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 & TVHP HMOs have ratios that are below both the National and Regional averages. The CIGNA HMO & CIGNA PPO ratio exceeds both the national and regional ratios. MVP’s and BCBSVT PPO's ratios are below both the national and regional ratios.

All-Cause Readmission Rates, 2012			
MCO (w/o PPO)		PPO	
BCBSVT	0.73	BCBSVT	0.71
CIGNA	1.03	CIGNA	0.81
TVHP	0.74	MVP	0.71
National Average	0.88	National Average	0.78
Regional Average	0.79	Regional Average	0.80

3.9 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:

3.9.1 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, 2012			
MCO	Number of contracted PCPs receiving enhanced payment	Total number of contracted PCPs	Percentage of contracted PCPs receiving enhanced payment
BCBSVT/TVHP/BCBSVT PPO²⁵ (PCPs and associated mid-level providers)	622	1224	51%
CIGNA²⁶	305	854	36%
MVP HMO & PPO (PCPs and associated mid-level providers)	557	864	65%

3.9.2 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 PPO²⁷	\$2.04
CIGNA²⁸	\$1.96
MVP HMO & PPO²⁹	\$1.98

²⁵ Calculated on a cumulative basis as of YTD May 2012

²⁶ Calculated on an annual basis, includes PPO/OAP (Open Access Plus)/Network/Network POS

²⁷ Includes PCPs as well as Mid-Levels measured on a cumulative basis as of YTD May 2012

²⁸ Includes PPO/OAP(Open Access Plus) /Network/Network POS

3.9.3 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 ³⁰	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%

²⁹ Calculated on an annual basis

³⁰ Includes PPO/OAP/Network/Network POS

PART IV: SUMMARY ANALYSES OF MCO PERFORMANCE OVER-TIME

For the first time in this report the Department is presenting 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 has reported a decline in performance. For this first analysis the Department has utilized the data presented in this report for 2011–2013 for CAHPS® and 2010–2012 for HEDIS®.

4.1 Members' Experience of Care Over-Time Summary

The CAHPS® data included in the analysis met the following criteria:

- The HMO or PPO must have had a reportable rate in the baseline reporting year (2011) and in the current reporting year (2013).
- The HMO or PPO rates must be below 90% in the baseline reporting year, as it is often difficult to improve a rate beyond 90%.

The following table displays the measures included for each MCO and PPO. Measures marked with a “Y” are included; those marked with a > 90% are excluded because the HMO or PPO had a rate > 90% in the base year.

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Rating of Overall Health Plan Experience	Y	Y	Y	Y	Y	Y
Call Answer Timeliness	FTR	Y	FTR	FTR	Y	Y
How often did Customer Service staff treat you with courtesy or respect?	>90%	>90%	>90%	>90%	Y	Y
How often did your health plan's Customer Service give you the information or help you needed?	Y	Y	Y	Y	Y	Y
Claims Processing is Timely	>90%	Y	>90%	>90%	Y	Y
Claims are Processed Correctly	>90%	>90%	>90%	>90%	Y	>90%
Getting to See A Specialist	Y	Y	Y	Y	Y	Y
Easy to Get the Care, Tests or Treatment You Needed	>90%	>90%	>90%	>90%	>90%	Y
Getting Care Quickly When You Needed Care Right Away	>90%	>90%	Y	Y	>90%	Y
Getting Routine Care As Soon As Wanted	Y	>90%	Y	>90%	>90%	Y
How Often Doctors Listen Carefully	>90%	>90%	>90%	>90%	>90%	>90%
How Often Doctors Explain Things in an Understandable Way	>90%	>90%	>90%	>90%	>90%	>90%
How Often Doctors Show Respect	>90%	>90%	>90%	>90%	>90%	>90%
How Often Doctors Spend Enough Time with Their Patients	>90%	>90%	>90%	>90%	>90%	>90%
How Often Did Your Personal Doctor Seem Informed about the Care You Got from Other Health Providers?	Y	Y	Y	Y	Y	Y
Able to Find Out How Much to Pay for a Health Care Service or Equipment	Y	Y	Y	Y	Y	Y
Able to Find Out How Much to Pay for Prescription Medications	Y	Y	Y	Y	Y	Y

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

- With the exception of MVP PPO, plans had fairly similar range (nine to twelve) of measures for which they were already performing at or above 90% or showed statistically significant improvement for CAHPS[®] measures.
- The MCO and PPO plans have more than half of their CAHPS[®] measures showing no change and the other improving or already greater than 90%.
- There was only CIGNA PPO and TVHP showed a statistically significant decline in performance over time on only one measure.

Change Over Time Performance - CAHPS [®] Experience of Care Measures, 2011-2013						
	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
No. of Measures that Improved or Scored > 90%	9	12	9	10	10	6
No. of Measures with No Change	7	5	6	6	6	11
No. of Measures that Declined	0	0	1	0	1	0

Additional charts that display performance over-time for CAHPS[®] Experience of Care measures are located in the Appendix A.

4.2 Acute Care Over-Time Summary

The HEDIS[®] data included in the analysis met the following criteria:

- The MCO must have had a reportable rate in the base year (2009) and the current year (2012).
- 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%. Unlike in the CAHPS[®] section of the report, the Department has only provided one table and graph because combining the performance categories has minimal impact on the results.

The table below shows which measures were included in the analysis. An “NA” indicates that the MCO did not have a sufficiently large denominator to report the measure.

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Appropriate Testing of Children with Pharyngitis	Y	Y	Y	Y	Y	y
Appropriate Treatment for Children with Upper Respiratory Infection	>90%	>90%	>90%	>90%	>90%	>90%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Y	Y	Y	Y	Y	Y
Use of Imaging Studies for Low Back Pain	Y	Y	Y	Y	Y	Y
Follow-Up After Hospitalization for Mental Illness: 7 Days	Y	NA	Y	Y	Y	NA
Follow-Up After Hospitalization for Mental Illness: 30 Days	Y	NA	Y	Y	Y	NA
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	Y	NA	NA	NA	Y	NA
Initiation of Alcohol and Other Drug Dependence Treatment	Y	NA	Y	Y	Y	Y
Engagement of Alcohol and Other Drug Dependence Treatment	Y	NA	Y	Y	Y	Y

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

- All of the plans had the majority of their acute care measures showing no change.
- All plans had at least one measure already above 90% or showing improvement.
- Several acute care measures showed a decline in performance, ranging from zero to three measures.

HEDIS [®] Acute Care Measures - Change Over Time 2010 – 2012						
	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Number of Measures that Improved or Already Scored >90%	3	1	4	2	1	3
Number of Measures that Stayed the Same	5	2	4	6	8	6
Number of Measures that Declined	2	3	2	2	0	1

Additional charts that display performance over-time for acute care measures are located in the Appendix B.

4.3 Preventive Care Over-Time Summary

The HEDIS® data was gathered from reporting years 2010 through 2012. Only data meeting the following criteria were included in the analysis:

- MCOs must have had a reportable rate in the baseline reporting year (2010) and the current reporting year (2012).
- The rate was calculated in a consistent manner, and where appropriate, the hybrid method was used to calculate the rate. Rates not meeting this criterion are excluded from the analysis and are labeled as “non-credible” using “NC” in the table below.
- If an MCO’s rate is above 90% in the base year, it is included in the high performing category.

The table below shows which measures were included and excluded for each MCO.

Measures	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Breast Cancer Screening	Y	Y	Y	Y	Y	Y
Cervical Cancer Screening	Y	Y	Y	Y	Y	Y
Chlamydia Screening in Women 16-20 Years of Age	Y	Y	Y	Y	Y	Y
Chlamydia Screening in Women 21-24 Years of Age	Y	Y	Y	Y	Y	Y
Flu Shot for Adults Ages 50-64	Y	Y	Y	Y	Y	Y
Medical Assistance with Smoking and Tobacco Use Cessation: Composite and Individual Measures	NA	NA	NA	NA	NA	NA
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	>90	Y	Y	Y	Y	NA
Well-Child Visits 3-6 Years of Age	Y	Y	Y	Y	Y	Y
Adolescent Well-Care Visits	Y	Y	Y	Y	Y	Y
Immunizations for Adolescents: All Measures	Y	Y	Y	Y	NA	Y

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

- BCBSVT and MVP PPO showed improvement or are already meeting the 90% standard on the largest number of measures; six and five respectively (with the immunization for adolescents measure contributing to this performance).
- All MCOs showed improvement on at least one measure. Last year CIGNA showed improvement on the greatest number of measures, and this year they had the largest number of measures staying the same.
- The majority of HEDIS Preventive Care measures stayed the same for all plans.

HEDIS® Preventive Care Measures - Change Over Time 2010 – 2012						
	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Number of Measures that Improved or Already Scored >90%	6	1	4	3	4	5
Number of Measures that Stayed the Same	3	9	5	7	2	5
Number of Measures that Declined	2	1	2	1	2	1

Additional graphs that display performance over-time for preventive care measures are located in the Appendix B.

4.4 Chronic Care Over-Time Summary

The analysis included HEDIS® data that met the following criteria:

- The MCO must have a reportable rate in the base year (2010) and the current year (2012). The “NA” indicates that a rate was not reportable.
- The MCO’s rate was calculated in a consistent manner, and where appropriate the hybrid method was used to calculate a rate. Rates not meeting this standard are indicated by an “NC” in the following table listing the measures and labeled “non-credible” in the summary table below.
- 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%. Unlike in the CAHPS® section of the report, the Department has only provided one table and graph because combining the two performance categories had minimal impact on the results.

The table below shows which measures were included for each MCO.

Measure	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Use of Appropriate Medications for People with Asthma All Ages	NA	NA	NA	NA	NA	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Y	NA	Y	Y	Y	NA
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	Y	NA	Y	Y	Y	NA
Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme Inhibitors (ACE) or Angiotensin Receptor Blockers (ARB)	Y	Y	Y	Y	Y	Y
Annual Monitoring for Patients on Persistent Medications: Anticonvulsants	Y	NA	Y	Y	Y	Y
Annual Monitoring for Patients on Persistent Medications: Diuretics	Y	Y	Y	Y	Y	Y
Anti-Depressant Medication Management: Effective Acute Phase Treatment	Y	NA	Y	Y	Y	Y
Anti-Depressant Medication Management: Effective Continuation Phase Treatment	Y	NA	Y	Y	Y	Y
Controlling High Blood Pressure	NA	NA	NA	Y	NA	NA

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

- Most of the MCOs, except CIGNA & CIGNA PPO, showed statistically significant improvement or high performance on at least one of the chronic care measures.
- The majority of MCOs' measures stayed the same.
- Only MVP PPO had 2 measures that declined in performance.

The Department notes that several of these measures have small denominators, which can result in large swings on an annual basis and can make the change-over-time analysis less reliable

HEDIS [®] Chronic Care Measures - Change Over Time 2010-2012						
	BCBSVT	CIGNA	TVHP	BCBSVT PPO	CIGNA PPO	MVP PPO
Number of Measures that Improved or Scored > 90%	1	0	4	4	0	1
Number of Measures that Stayed the Same	8	6	5	6	9	5
Number of Measures that Declined	0	0	0	0	0	2

Additional graphs that display performance over-time for chronic care measures are located in the Appendix B.

PART V: 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 practically³¹ 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.

5.1 Improvement Opportunities for All MCOs

5.1.1 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. When MCOs do not complete both parts of the data collection and rely solely on administrative data, the results are, in most cases, not meaningful.

In those situations where the data were collected differently, 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.

This has not been an issue in past years, but the Department has recently seen a departure from collecting record review data due in part to cost. While the Department has not mandated hybrid collection of specific measures and is working with MCOs to establish reasonable collection criteria, the Department strongly encourages the use of appropriate collection methodology. The Department is also investigating means to collect hybrid measures in a less invasive manner.

³¹ 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.

5.1.2 Improvement Opportunities for Specific Measures

The Department has identified several measures in which the performance is notably below 50% or the performance could be improved 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 (Both Age Groups 16 – 20 and 21-24)

- For Chlamydia Screening in Women Ages 16-20 and 21-24, with the exception of CIGNA PPO for the 21-24 age group, the MCO's rates are below national and regional averages which range between 39% and 58%. Chlamydia is the most common sexually transmitted disease in the US. It causes no symptoms in 75% of infected women and is curable and easily diagnosed. Improving screening 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, the national and regional averages are in the mid 25% range and the HMOs are below or just at the averages. 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 current poor 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 amount of binge drinking³². National and regional rates of Initiation and Engagement of Alcohol and Other Drug Dependence are low. Initiation rates fall in the 40% range and engagement is below 20%. Even though MCO performance exceeds national averages for engagement, the low absolute rates provide ample opportunity for improvement.

Adolescent Well-Care Visits

- 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 44% and 50%, with little movement since last year. 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) of 62%.

³² See www.americashealthrankings.org/VT/2012.

Immunizations for Adolescents

- Adolescent immunizations are related to the above Adolescent Well-Care Visit measure and may be impacted by similar improvement initiatives. Most Vermont plans (both HMO and PPO) still remain below both the national (57%) and regional (64%) averages for both the Combination Immunization and the Meningococcal Immunization. A few plans (TVHP and the three PPOs) are performing at the national average, but the rate is still relatively low. For Meningococcal immunizations, BCBSVT PPO and MVP PPO demonstrated improvement this past year and are performing at the regional average (69%).

Cervical Cancer Screening

- Early detection and treatment of cervical cancer can significantly increase a woman's chances of survival. While performing about the same as the national average (for both HMOs and PPOs), most plans are statistically significantly below the regional average of 79%. The exception is BCBSVT, which has a rate similar to the regional average.

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

- Chlamydia Screening in Women Ages 16–20 and 21-24
- Avoidance of Antibiotic Screening in Adults with Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Initiation of Alcohol and Other Drug Dependence
- Engagement of Alcohol and Other Drug Dependence
- Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase

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

- Adolescent Well-Care Visits
- Immunizations for Adolescents (Combination and Meningococcal)

5.2 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%, or to improve performance to meet or exceed the New England regional average.

5.2.1 Improvement Opportunities for BCBSVT

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

- Call Answer Timeliness
- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Immunizations for Adolescents: Combination
- Immunizations for Adolescents: Meningococcal
- Annual Monitoring for Patients on Persistent Medications: ACE/ARBs
- Annual Monitoring for Patients on Persistent Medications: Diuretics

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

- Concurrent Reviews Meeting Decision Making Timeframes
- Level I Pharmacy Pre-Service, Urgent Meeting Decision Making Timeframes
- Level II Physical Health, Pre-service Urgent Reviews Meeting Decision Making Timeframes
- Level I Mental Health and Substance Abuse Post-Service Reviews Completed within the Required Timeframe
- Members with Access to Urgent Care
- Members with Access to Non-Emergency Care
- Members with Access to Preventive Care
- Access to Psychiatrists in Essex, Franklin, Orange, Orleans and Windsor Counties
- Access to Psychologists in Essex and Orleans Counties
- Access to NeoNatal Care in Bennington, Essex, and Orleans Counties
- Access to Bariartic Surgeons

5.2.2 Improvement Opportunities for BCBSVT PPO

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

- Rating of Overall Health Plan Experience
- Call Answer Timeliness
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Medications
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Flu Shot for Adults Ages 50-64
- Immunizations for Adolescents: Combination
- Immunizations for Adolescents: Meningococcal
- Appropriate Testing of Children with Pharyngitis
- Well-Child Visits 3-6 Years of Age

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

- Concurrent Reviews Meeting Decision Making Timeframes
- Physical Health, Pre-service Urgent Reviews Meeting Decision Making Timeframes
- Level I Pharmacy Pre-Service, Urgent Reviews Meeting Decision Making Timeframes
- Level I Mental Health and Substance Abuse Pre-Service Non-Urgent Reviews Completed within the Required Timeframe
- Members with Access to Urgent Care
- Members with Access to Non-Emergency Care
- Members with Access to Preventive Care
- Access to Psychiatrists in Essex, Franklin, Orange, Orleans and Windsor Counties
- Access to Psychologists in Essex and Orleans Counties
- Access to NeoNatal Care in Bennington, Essex, and Orleans Counties
- Access to Bariatric Surgeons

5.2.3 Improvement Opportunities for CIGNA

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

- Call Answer Timeliness
- Customer Service Composite
- Able to Find Out How Much to Pay for a Health Care Service or Equipment?

- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Cervical Cancer Screening
- Timeliness for Prenatal Care
- Postpartum Care
- Immunizations for Adolescents: Combination
- Immunizations for Adolescents: Meningococcal
- Immunizations for Adolescents: Tdap/TD
- Appropriate Testing of Children with Pharyngitis

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

- UR Decisions: Concurrent Review <= 1 day, and Urgent Pre-Service Reviews <= 72 hours or with an extension
- Level I Physical Health, Grievance Reviews Meeting Decision Making Timeframes (all)
- Members with Access to Non-Urgent Care
- Members with Access to Preventive Care

5.2.4 Improvement Opportunities for CIGNA PPO

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

- Cervical Cancer Screening
- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Immunizations for Adolescents: Combination
- Immunizations for Adolescents: Meningococcal
- Timeliness for Prenatal Care
- Well-Child Visits 3-6 Years of Age
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

5.2.5 Improvement Opportunities for CIGNA Behavioral Health (CBH)

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

- Members with Access to Urgent Care

5.2.6 Improvement Opportunities for Magellan Behavioral Health (MBH)

5.2.6.1 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
- Pre-Service Non-Urgent Grievance Reviews within Required Timeframes

5.2.7 Improvement Opportunities for MVP Health Care

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

- Rating of Overall Health Plan Experience
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Strategies
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Flu Shot for Adults Ages 50-64
- Well-Child Visits in the First 15 Months of Life (6 or More Visits)
- Well-Child Visits 3-6 Years of Age
- Immunizations for Adolescents: Combination
- Annual Monitoring for Patients on Persistent Medications: ACE/ARB
- Annual Monitoring for Patients on Persistent Medications: Diuretics

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

- Concurrent Reviews Completed Within Decision Making Timeframes
- Access to Neonatal Care in Bennington and Essex Counties
- Access to Bariatric Surgeons

5.2.8 Improvement Opportunities for TVHP

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

- Rating of Overall Health Plan Experience
- Call Answer Timeliness

- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women (Ages 16-20 and 21-24)
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising to Quit
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Medications
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Strategies
- Appropriate Testing of Children with Pharyngitis
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Controlling High Blood Pressure
- Immunizations for Adolescents: Combination
- Immunizations for Adolescents: Meningococcal
- Annual Monitoring for Patients on Persistent Medications: ACE or ARBs
- Annual Monitoring for Patients on Persistent Medications: Diuretics
- Well-Child Visits 3-6 Years of Age

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

- Level II Physical Health, Urgent Pre-Service Grievance Reviews Meeting Decision Making Timeframes
- Level II Pharmacy, Urgent Pre-Service Grievance Reviews Meeting Decision Making Timeframes
- Members with Access to Urgent Care
- Members with Access to Non-Emergency Care
- Members with Access to Preventive Care
- Access to Psychiatrists in Essex, Franklin, Orange, Orleans and Windsor Counties
- Access to Psychologists in Essex and Orleans Counties
- Access to Neonatal Care in Bennington, Essex, and Orleans Counties
- Access to Bariatric Surgeons

