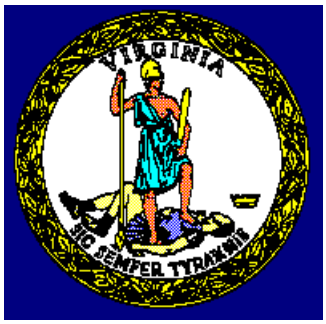


Commonwealth of Virginia
Department of Medical Assistance Services

2019 External Quality Review Technical Report—Commonwealth Coordinated Care Plus

January 1, 2019–December 31, 2019

April 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Overview of 2019 External Quality Review

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care plans to "provide for an annual external independent review conducted by a qualified independent entity of the quality and timeliness of, and access to, the items and services for which the organization is responsible under the contract." According to the 42nd Code of Federal Regulations (CFR) §438.350, states with capitated Medicaid managed care delivery systems and that contract with managed care entities (MCEs) are required to arrange for the provision of an annual external quality review (EQR) for each Medicaid managed care contractor.

The external quality review organization (EQRO) must annually provide an assessment of each MCE's performance related to the quality and timeliness of, and access to care and services provided by each MCE and produce the results in an annual EQR technical report (42 CFR §438.364). The annual technical report must also describe how data from activities were collected and, in accordance with the CFR, were aggregated and analyzed. To meet this requirement, the Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform an EQR of the Virginia managed care organizations (MCOs) and produce this EQR technical report.

DMAS contracted with HSAG to conduct EQR activities and produce this technical report covering review activities completed during the period of January 1, 2019, through December 31, 2019. HSAG used the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services' (CMS') December 2018 update of its External Quality Review Toolkit for States when preparing this report.[1-1]

The annual EQR technical report includes a review of members' access to care and the quality of services received by members of Title XIX, Medicaid, and Title XXI, Children's Health Insurance Program (CHIP). The report focuses on three mandatory EQR activities, which were federally required during state fiscal year (SFY) 2019. In addition to the mandatory activities, HSAG performed a set of optional activities at the request of DMAS. Those activities are detailed in Sections 4 through 8 of this report.

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvement and a comparison of the MCOs that operate in the Virginia Medicaid managed care program.

[1-1] The Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR) Protocols, December 2018. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: June 27, 2019.

DMAS, in partnership with CMS, is responsible for administration of the Commonwealth Coordinated Care Plus (CCC Plus) program. As of August 1, 2017, DMAS contracted with six MCOs to deliver services under the new CCC Plus program. The CCC Plus program began in Tidewater on August 1, 2017; it operates statewide across six regions of the Commonwealth (Table 1-1). Contracted MCOs included Aetna Better Health of Virginia (Aetna); HealthKeepers, Inc. (HealthKeepers); Magellan Complete Care of Virginia (Magellan); Optima Family Care (Optima); UnitedHealthcare of the Mid-Atlantic, Inc. (United); and Virginia Premier Health Plan, Inc. (VA Premier).

The CCC Plus program is an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports (LTSS). The CCC Plus program, which includes individuals with disabilities and older adults, comprises 25 percent of Virginia's Medicaid enrollment and represents 69 percent of its expenditures during 2018.[1-2] The MCOs in the CCC Plus program delivered services to approximately 244,548 CCC Plus members with complex needs across the Commonwealth of Virginia as of July 2019.[1-3] Participation in the program is mandatory for eligible populations and includes individuals ages 65 and over, adults and children with disabilities, dual and non-dual individuals receiving LTSS (facility- and community-based), and developmentally disabled waiver participants for non-waiver services.

Managed Care Organizations

Table 1-1—Managed Care Organization Profiles

MCO	MCO Profile	MCO NCQA Accreditation Status
Aetna	Aetna is the Medicaid/ Family Access to Medical Insurance Security (FAMIS) Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited
HealthKeepers	HealthKeepers is a Virginia health maintenance organization (HMO) affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate healthcare company, headquartered in Indianapolis, Indiana.	Commendable
Magellan	Magellan is a Medicaid/FAMIS Plus program offered by Magellan Health, Inc., conducting business in Virginia since 1972, headquartered in Scottsdale, AZ.	Interim
Optima	Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara, Optima is a not-for-profit healthcare organization serving Virginia and	Commendable

[1-2] Virginia Department of Medical Assistance Services. 2019 Medicaid at a Glance. Available at: http://www.dmas.virginia.gov/files/links/221/2019%20MAG%20Draft%20(01.07.2019).pdf. Accessed on: Jan 15, 2019.
[1-3] Virginia Department of Medical Assistance Services. CCC Plus M4 Demographic Population Report, July 2019.

MCO	MCO Profile	MCO NCQA Accreditation Status
	northeastern North Carolina, headquartered in Norfolk, Virginia.	
United	United is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, MN. United provides Medicaid managed care and nationally serves more than 6.6 million low-income and medically fragile people, including Dual-Eligible Special Needs Plans (D-SNPs) across 30 states plus Washington, DC.	In Process
VA Premier	VA Premier is a local, not-for-profit MCO owned by the Virginia Commonwealth University (VCU) Medical Center, headquartered in Richmond, Virginia.	Accredited

Mandatory Activities

In accordance with 42 CFR §438.364, and in compliance with CMS' EQR Protocols and the External Quality Review Toolkit for States, this report includes the following information for each activity conducted:

- Describes how data from mandatory and optional EQR activities were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each MCO's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the MCOs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the MCOs, including recommendations for each individual MCO and recommendations for DMAS to target the Virginia Quality Strategy to improve the quality of care provided by the DMAS managed care program as a whole.
- Contains methodological and comparative information for all MCOs.
- Assesses the degree to which each MCO has addressed the recommendations for quality improvement made by the EQRO during the 2018 EQR.

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality and timeliness of, and access to care provided by the MCOs, HSAG assigned each of the EQR activities to one or more of three domains. Assignment to these domains is depicted in Table 1-2.

Table 1-2—EQR and DMAS Activities and Domains

Activity	Quality	Access	Timeliness
NCQA HEDIS Compliance Audit™	✓	✓	
PMV	✓	✓	✓
Consumer Decision Support Tool	✓		
PIP Validation	✓	✓	✓
Compliance Reviews	✓	✓	✓
CAHPS	✓	✓	✓
Focused Studies	✓	✓	✓

Aggregating and Analyzing Statewide Data

For each MCO, HSAG analyzed the results obtained from each EQR mandatory activity as well as those obtained from optional activities. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and the overall statewide CCC Plus program. For a detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in Sections 4 through 9 of this report.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of the domains of quality of, access to, and timeliness of care and services.

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-4]

[1-4] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."[1-5]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-6] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care. In the final 2016 Federal Managed Care Regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and at 42 CFR §438.68(b), requiring states to develop both time and distance standards for network adequacy.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from calendar year (CY) 2019 to assess the performance of Medicaid MCOs in providing quality, timely, and accessible healthcare services to Virginia CCC Plus Medicaid members. For each activity, HSAG provides the following summary of its overall key findings and conclusions based on each MCO's performance. For activity-specific findings, strengths, and recommendations for the activities conducted, refer to Sections 4 through 8.

Compliance Monitoring

DMAS conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2019, HSAG did not conduct MCO compliance review activities for the CCC Plus program. During 2019, DMAS monitored the MCOs' implementation of federal and State requirements and corrective action plans from prior years' compliance reviews.

[1-5] Ibid.
[1-6] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

Performance Measure Validation (PMV)

HSAG validated the performance measures (PMs) identified by DMAS to evaluate their accuracy as reported by, or on behalf of, the Medicare-Medicaid plans (MMPs) (during 2018, transitioned from MMPs to MCOs). DMAS annually selects a set of PMs to evaluate the quality of care and services delivered by its contracted MCOs to CCC Plus members. PMV determines the extent to which the MCOs followed specifications established by DMAS for its PMs when calculating the PM rates.

HSAG conducted validation of the PM rates following the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[1-7] Compliance Audit™ timeline, from January 2019 through July 2019. The final PM validation results generally reflected the measurement period of January 1, 2018, through December 31, 2018. HSAG provided final PMV reports to the MCOs and DMAS in November 2019.[1-8]

Per the three-way contract among CMS, DMAS, and the MCOs, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit. Each MCO contracted with an NCQA-licensed organization (LO) to conduct the HEDIS audit. HSAG reviewed the MCOs' final audit reports (FARs), information systems (IS) compliance tools, and Interactive Data Submission System (IDSS) files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key CCC Plus Medicaid measures for HEDIS 2019.

HSAG's PMV activities included validation of the following measures:

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*
- *Follow-Up After Emergency Department Visit for Mental Illness*
- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions Rate (PQI05-AD)*
- *Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*
- *Heart Failure Admissions Rate (PQI08-AD)*

HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate) for assistance with the validation of the PMs above. Using the validation methodology and protocols described in Appendix A, HSAG determined validation results for each PM. The CMS PMV protocol identifies two possible validation designations for PMs: Report (R)—measure data were compliant with DMAS specifications,

[1-7] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

[1-8] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 22, 2019.

and the data were valid as reported; or Not Reported (NR)—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 1-3.

Table 1-3—MCO Validation Results

	Performance Measure	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier
1.	*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	R	R	R	R	R	R
2.	*Follow-Up After Emergency Department Visit for Mental Illness*	R	R	R	R	R	R
3.	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	R	R	R	R	R	R
4	*COPD or Asthma in Older Adults Admissions Rate (PQI05-AD)*	R	R	R	R	R	R
5.	*Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*	R	R	R	R	R	R
6	*Heart Failure Admissions Rate (PQI08-AD)*	R	R	R	R	R	R

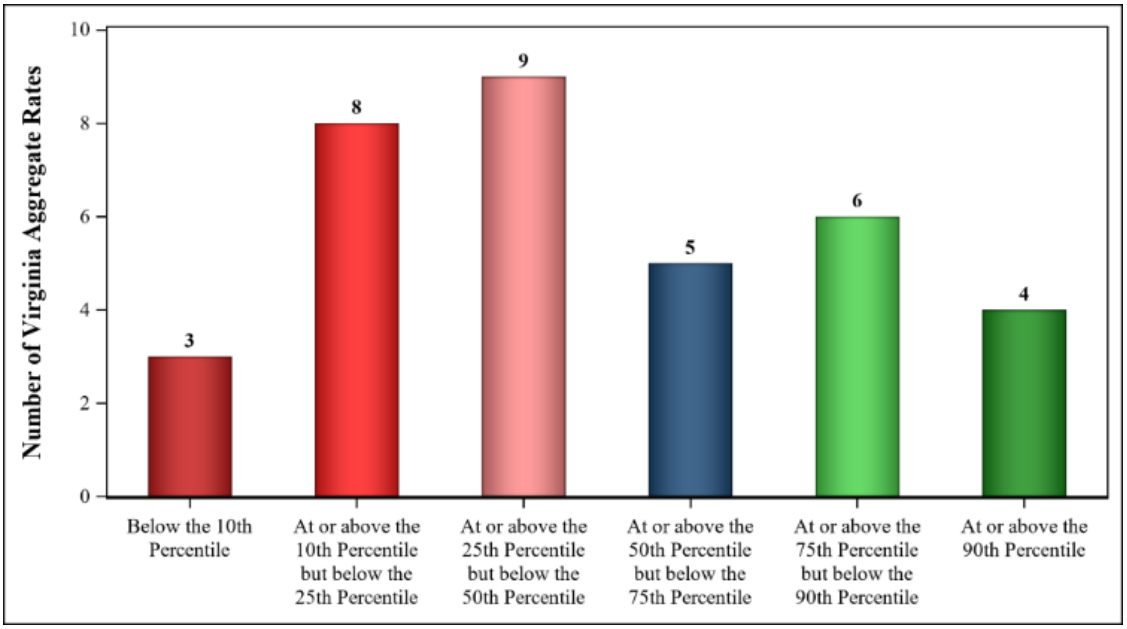
Statewide HEDIS Results

State fiscal year (SFY) 2018 saw a number of major changes and innovations to the Virginia Medicaid program, particularly with managed care. The magnitude of changes, outlined below, to Virginia's Medicaid managed care programs necessitates a break in trending for all reported measures from previous years.

Reporting year 2018 was the first full year of CCC Plus, Virginia's new managed long-term services and supports (MLTSS) program, with the inclusion of new carved-in services and new significant, high-risk populations into managed care. This includes the transition of existing higher acuity Health and Acute Care Program (HAP) and the Aged, Blind, and Disabled (ABD) members from Medallion 3.0 to CCC Plus, effective January 1, 2018, with emphasis on care coordination and continuity of care during the transition. CCC Plus carved in community mental health services, early intervention services, consumer-directed personal care, and third party liability (TPL) members in 2018.

Figure 1-1 shows CCC Plus's aggregated performance on NCQA's HEDIS 2019 (CY 2018 data) performance measure indicators that were comparable to NCQA's Quality Compass®[1-9] national Medicaid HMO percentiles for HEDIS 2018. The aggregate rates represent the average of all six MCOs' measure rates weighted by the eligible population. The bars represent the number of Virginia aggregate rates that fell into each percentile range.

Figure 1-1—HEDIS 2019 CCC Plus Aggregate Results



Overall, the Virginia aggregate rates for HEDIS 2019 indicated opportunities for improvement, as 20 of 35 (57.1 percent) measure rates fell below the 50th percentile, with 11 of these rates (31.4 percent) falling below the 25th percentile. Additionally, three Virginia aggregate rates (*Cervical Cancer Screening*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*) fell below the 10th percentile. Of note, the Virginia aggregate rates for four measures (*Adults' Access to Preventive/Ambulatory Health Services—Total*, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*, and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*) exceeded the 90th percentile.

While there are identified opportunities for improvement from the data, the large-scale changes that occurred in the managed care programs in calendar year 2018 make interpretation of the HEDIS results from this year difficult, and analyses should be interpreted with caution.

[1-9] Quality Compass® is a registered trademark of NCQA.

Consumer Decision Support Tool

The CCC Plus Consumer Decision Support Tool demonstrates how Virginia Medicaid's MCOs compare to one another in key performance areas.

Table 1-4—Consumer Decision Support Tool Results—2019

MCO	Doctors' Communication	Access and Preventive Care	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	★★★	★★★	★★	★★★	★★★
HealthKeepers	★★★	★★★★★	★★★	★★★★★	★★★★★
Magellan	★★★	★	★★★	★	★
Optima	★★★	★★★★★	★★★	★★★★★	★★
United	★★	★★★	★★★	★★★	★★★
VA Premier	★★★★	★★★★	★★★★★	★★★	★★★

For 2019, HealthKeepers demonstrated the strongest performance by achieving the Highest Performance level for three of the six domains and never falling below the Average Performance level. VA Premier also demonstrated strong performance, achieving the Highest Performance level in one domain and achieving the High Performance level in an additional two domains. Magellan demonstrated the lowest performance by achieving the Lowest Performance level for three domains and never once performing above average.

Performance Withhold Program

During 2019, HSAG worked with DMAS to develop a methodology to calculate the MCO results for the Performance Withhold Program (PWP). The 2019 PWP will be a pilot year given the transition to CCC Plus and will use HEDIS and non-HEDIS measures.

Validation of Performance Improvement Projects

DMAS requires the CCC Plus MCOs to conduct two performance improvement projects (PIPs) annually. DMAS selected the topics to address the CMS requirements related to quality outcomes in the areas of timeliness of and access to care and services. The topics for 2019 were:

- *Follow-Up After Hospital Discharge*
- *Ambulatory Care—Emergency Department Visits*

In 2019, the MCOs used the rapid-cycle PIP approach for the two DMAS-selected PIP topics. During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria that were not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of

confidence representing the validity and reliability of the PIP. Table 1-5 details the level of achievement for each module submitted by each MCO for both PIPs. During 2019, the MCOs achieved all the Module 1 and Module 2 validation criteria and were in the process of completing Module 3 to identify potential interventions for the PIPs.

Table 1-5—Performance Improvement Project Results

MCO	PIP Topic	PIP Module Results
Aetna	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
HealthKeepers	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Magellan	*Reduce Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Increasing Follow-up Visits After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Optima	*Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD Asthma, Bronchitis or Emphysema*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
United	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
VA Premier	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved

Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated that the MCOs were able to successfully complete the Module 1 and Module 2 PIP validation requirements. MCOs should continue to follow the PIP rapid-cycle process and participate in trainings provided by the EQRO and request technical assistance as often as needed to improve the success of the PIP process. The MCOs' PIP process would benefit from ensuring:

- Each module is completed accurately, and attention is applied to the details.
- Data and results are calculated and provided accurately.

- Alignment of the SMART Aim methodologies with the processes.
- Continual monitoring of outcomes and making rapid adjustments when needed.
- Identification and testing of innovative, actionable changes.

Member Experience of Care Survey

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-10] survey is nationally recognized as an industry standard for both commercial and public payers. Samples and data collection procedures promote standardized administration of survey instruments and comparability of results. The CAHPS survey asks members to report on and evaluate their experiences with healthcare, covering topics important to members, such as accessibility and quality of services.

The CAHPS surveys were conducted for Virginia's CCC Plus managed Medicaid population to obtain information on adult and child Medicaid members' experiences. For the CCC Plus MCOs, data collection occurred through the administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. MCO top-box scores are shown in Table 1-6.

Table 1-6—CAHPS Top-Box Results

MCO	CAHPS Composite Measure	2019 Rate
Aetna	*Adult: Getting Needed Care*	87.3%*
	Adult: Getting Care Quickly	83.2%
	Child: Shared Decision Making	85.4%*+
	Child: Getting Care Quickly	92.3%
HealthKeepers	*Adult: Getting Needed Care*	87.0%*
	Adult: Getting Care Quickly	88.2%*
	Child: Shared Decision Making	86.4%*
	Child: Getting Care Quickly	92.2%*
Magellan	*Adult: Getting Needed Care*	80.7%
	Child: Shared Decision Making	81.7%+
	Child: Getting Care Quickly	87.8%+
Optima	*Adult: Getting Needed Care*	84.6%
	Adult: Rating of Specialist Seen Most Often	73.5%*
	Child: Shared Decision Making	86.6%*
	Child: Getting Care Quickly	91.9%

[1-10] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

MCO	CAHPS Composite Measure	2019 Rate
United	*Adult: Getting Needed Care*	84.6%
	Child: Shared Decision Making	83.0%+
	Child: How Well Doctors Communicate	96.5%+*
	Child: Getting Care Quickly	87.2%+
VA Premier	*Adult: Getting Needed Care*	87.8%*
	Adult: Getting Care Quickly	87.9%*
	Adult: Customer Service	93.6%*
	Adult: Rating of Personal Doctor	73.7%*
	Child: Shared Decision Making	78.6%+
	Child: Getting Care Quickly	97.3%+*

**Statistically significantly above the 2018 NCQA Medicaid national average.*
+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Note: HealthKeepers scored statistically significantly lower than the 2018 NCQA child Medicaid national averages on two measures: Rating of Health Plan and Customer Service.
Optima scored statistically significantly lower than the 2018 NCQA child Medicaid national averages on two measures: Rating of Health Plan and Rating of All Health Care.

In 2019, all CCC Plus MCOs demonstrated strength in the adult survey in *Getting Needed Care* (three MCOs scored above the 2018 NCQA adult Medicaid national average) and in the child survey in *Shared Decision Making* and *Getting Care Quickly* (two MCOs scored above the 2018 NCQA child Medicaid national average in each category). An area of weakness identified that two MCOs scored below the 2018 NCQA child Medicaid national average for *Rating of Health Plan*.

Overall, the CCC Plus MCOs should focus on maintaining and improving the members' experiences of care as the MCO survey results indicated opportunities for improvement in most domains when compared to the 2018 NCQA child and adult Medicaid national averages. In addition, MCO efforts should also focus on improving survey response rates.

Addiction and Recovery Treatment Services

Medicaid members are prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. On April 1, 2017, Virginia's Medicaid program launched an enhanced substance use disorder (SUD) treatment benefit known as Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with SUDs across the state by providing access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. The ARTS program is a fully integrated physical and behavioral health continuum of care.

According to a February 2020 joint article published by DMAS and VCU in the research journal *Health Affairs*, there was an increase in the number of Medicaid members, after Medicaid expansion, with a

diagnosed SUD.[1-11] More than 69,000 Medicaid members in Virginia had a diagnosed SUD in the second year of the ARTS benefit, including 12,000 adults who enrolled in the three months after the new eligibility rules took effect on January 1, 2019.[1-12] The data showed that 4.4 percent of expansion adults were diagnosed with an SUD compared to 3.6 percent in the traditional Medicaid population. Medicaid eligibility was expanded for adults with family incomes up to 138 percent of the federal poverty level.[1-13]

Diagnosed prevalence of SUDs continued to increase among traditional Medicaid members, from almost 51,000 in the first year of ARTS to more than 57,000 in the second year of ARTS, which represents a 12 percent increase in prevalence between year 1 and 2 of the ARTS benefit. The total number of members with an SUD includes almost 30,000 with an opioid use disorder (OUD) and 24,000 with an alcohol use disorder (AUD). In addition, compared to all Medicaid members, those with SUDs are more likely to have other comorbid conditions, including other mental health disorders. Among Medicaid members with SUDs, 40 percent had a physical health comorbidity, while 45.9 percent had a mental health comorbidity.[1-14]

Services included in the ARTS benefit range from outpatient to inpatient services to include medication-assisted treatment (MAT) for opioid use and AUDs. This includes the full continuum of evidence-based addiction treatment to any of the 1.4 million Medicaid and FAMIS members who need treatment.

By adding the services below into managed care, ARTS promoted full integration of physical health, traditional mental health, and addiction treatment services.

- Inpatient detoxification
- Opioid treatment programs
- Residential treatment
- Office-based opioid treatment
- Partial hospitalization
- Case management
- Intensive outpatient programs
- Peer recovery supports

[1-11] Barnes A, et al., Hospital Use Declines After Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services Program. *Health Affairs*. 2020(2): 238-246.

[1-12] Virginia Department of Medical Assistance Services. Virginia Medicaid Agency Reports Increased Access to Addiction Treatment. Available at: http://www.dmas.virginia.gov/files/links/5220/Virginia%20Medicaid%20Two-Year%20Report%20on%20Addiction%20and%20Recovery%20Treatment%20Services%20Outcomes.pdf. Accessed on: Feb 28, 2020.

[1-13] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report for the Virginia Department of Medical Assistance Services: Addiction and Recovery Treatment Services—Access and Utilization During the Second Year (April 2018–March 2019). Available at: http://dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Feb 28, 2020.

[1-14] Ibid.

According to a recent *Health Affairs* article, an independent evaluation of the second year of the ARTS program (April 2018 through March 2019) conducted by VCU's Department of Health Behavior and Policy, treatment rates continued to rise even as more individuals were seeking services.[1-15] Among Medicaid members in the program prior to expansion, the treatment rate more than doubled, to 49 percent, in the two-year history of ARTS.

- Almost 34,000 members—49 percent of those with SUDs—received SUD treatment. Treatment rates have more than doubled since the year before ARTS.
- About 19,000 members—64 percent of those with an OUD—received OUD treatment.
- Over 10,000 members received treatment for AUD, for a treatment rate of 44 percent. Treatment rates for AUD increased from 30 percent in the first year of ARTS to 44 percent in the second year of ARTS.

There was a continued decline in emergency department visits and acute inpatient hospital admissions related to SUD among Medicaid members. Emergency department visits for OUDs declined 32 percent since the ARTS benefit began, and total visits for all SUDs decreased 7 percent.[1-16]

One factor identified as driving increased access to treatment is growth in the number of providers serving Medicaid members, including more than 4,000 outpatient practitioners. The number of intensive outpatient providers increased from 49 to 137. The ARTS benefit also initiated a new model of care known as Preferred Office-Based Opioid Treatment programs, which pays significantly higher reimbursement rates to qualified providers for MAT and coordination with other medical and social needs.[1-17]

The ARTS program expanded access to MAT by increasing the number of practitioners who were authorized to prescribe buprenorphine. As of 2018, there were a total of 866 waivered prescribers in Virginia, including 165 nurse practitioners and physician assistants. This reflects a 73 percent increase in the number of prescribers since the year before ARTS implementation. The percentage of individuals receiving buprenorphine treatment who were also participating in counseling or psychotherapy also increased from 61 percent to 73 percent between the first and second years of the benefit.[1-18]

[1-15] Barnes A, et al., Hospital Use Declines After Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services Program. Health Affairs. 2020(2): 238-246.

[1-16] Virginia Department of Medical Assistance Services. Virginia Medicaid Agency Reports Increased Access to Addiction Treatment. Available at: http://www.dmas.virginia.gov/files/links/5220/Virginia%20Medicaid%20Two-Year%20Report%20on%20Addiction%20and%20Recovery%20Treatment%20Services%20Outcomes.pdf. Accessed on: Feb 28, 2020.

[1-17] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report for the Virginia Department of Medical Assistance Services: Addiction and Recovery Treatment Services—Access and Utilization During the Second Year (April 2018–March 2019). Available at: http://dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Feb 28, 2020.

[1-18] Ibid.

During the second year of ARTS, 51 percent of members with an OUD received some type of pharmacotherapy for OUD, which reflects a 133 percent increase since the ARTS benefit began. Buprenorphine continued to be the most prevalent form of pharmacotherapy for members with OUD, accounting for 58 percent of pharmacotherapy treatment in the second year of ARTS. Methadone treatment rates also increased from 6 percent of members in the first year of ARTS to 15 percent in the second year of ARTS.[1-19]

Use of services across all American Society of Addiction Medicine (ASAM) levels of care increased greatly in the second year of ARTS:

- **ASAM Level 0.5, Screening, Brief Intervention, and Referral to Treatment:** During the second year of ARTS, 1,274 members had screenings for SUDs, a 21 percent increase from the first year of ARTS.
- **ASAM Level 1, Outpatient Services:** In the second year of ARTS, 5,190 members received services through Preferred Office-Based Opioid Treatment or Opioid Treatment programs, more than 2.7 times the number of members receiving these services in the first year of ARTS.
- **ASAM Level 2, Partial Hospitalization and Intensive Outpatient Services:** During the second year of ARTS, 2,245 members used these services, almost twice the number seen during the first year of ARTS.
- **ASAM Level 3, Short-Term Residential Treatment Services:** About 1,500 members used short-term residential treatment services in the second year of ARTS, four times the number using such services in the first year of ARTS.
- **ASAM Level 4, Medically Managed Inpatient Services:** During the second year of ARTS, 5,756 members used medically managed inpatient services for SUDs, a 34 percent increase from the first year of ARTS.[1-20]

ARTS Performance Measure Development

DMAS contracted with HSAG to identify additional or existing measures for the ARTS program. DMAS and HSAG will review the list of potential existing measures, identify measurement domain gaps, then select and develop measure specifications appropriate for the ARTS program to fill the gaps. Implemented PMV with the selected measures will provide process and outcomes measure results that will allow DMAS to evaluate the effectiveness of the ARTS program and identify opportunities to enhance or improve the program.

[1-19] Ibid.
[1-20] Ibid.

Quality Initiatives

Office of Quality and Population Health

Quality Improvement

DMAS' mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage. In 2019, Virginia Medicaid celebrated its 50th anniversary and successfully oversaw the largest expansion in its history. New eligibility rules elevated membership to 1.4 million individuals. Agency leaders responded to these historic changes by adopting member-focused innovations, including a Medicaid Member Advisory Committee, to provide feedback and ideas for current and futures initiatives. The Office of Quality and Population Health (QPH) continued to build upon the infrastructure of the Office throughout 2019 to include hiring a population health manager and a quality improvement manager. The Office of Value-Based Purchasing focused on a broader set of performance-based payment strategies that linked financial incentives to providers' performance.

The following are examples of the agency-wide quality improvement activities conducted during 2019:

- Building the QPH program infrastructure
- Tracking and analyzing trends for improvement
- Improving member health outcomes/metrics
- Providing guidance in developing, implementing, and monitoring DMAS' comprehensive Quality Strategy as well as measuring quality performance
- Supporting programs to monitor quality metrics at the agency level
- Working across divisions to identify and analyze trends and to recommend quality and population health opportunities for improvement
- Focusing on utilizing meaningful and reliable data to enhance member experiences
- Providing smoking cessation assistance to over 300,000 Virginians through expanded Medicaid
- Transforming the Quality Collaborative through more meaningful topics and participation, resulting in better member impacted initiatives
- Expanding coverage and access to prenatal and postpartum care for pregnant women

6|18 Partnership

Virginia was selected to participate in the Centers for Disease Control and Prevention's (CDC's) 6|18 Initiative. DMAS partnered with the Virginia Department of Health (VDH) to receive comprehensive technical assistance to reduce tobacco use and to improve asthma outcomes in Virginia. The program offered one-on-one technical assistance and other opportunities to help advance quality improvement efforts in the aforementioned areas. The 6|18 initiative had a rich network of resources and prior state participants' experiences and accomplishments, which was helpful and insightful.

Tobacco Goals

- Add preventive services, including smoking cessation, to the Virginia Medicaid state plan.
- Actively engage MCOs in conducting a PIP on smoking cessation.
- Increase outreach to MCOs to explore opportunities for Quitline cost-sharing.
- Propose amending Tobacco 21 legislation.

Activities

- DMAS and VDH worked together to engage MCOs regarding Quitline and opportunities to share data to determine a best approach to cost-sharing.
- DMAS worked with its actuary to conduct an analysis of its rate-setting data to identify potentially preventable and/or medically unnecessary emergency room (ER) visits, hospital admissions, and hospital readmissions (i.e., clinical efficiency [CE]) analysis). DMAS reviewed the data to determine if any of the respiratory conditions stemmed from a history of smoking.
- DMAS initiated PIPs focused on tobacco use cessation in pregnant women and piloted small changes to allow flexibility to plan adjustments throughout the improvement process.

Results and Accomplishments

- DMAS conducted a survey with MCOs to characterize available cessation benefits.
- DMAS collaborated with HSAG to develop a series of five modules to guide the MCOs through rapid-cycle PIPs focused on tobacco cessation in pregnant women.
- DMAS submitted a budget proposal to add preventive services, including smoking cessation, to the Virginia Medicaid state plan.
- Medicaid expansion was implemented and provides smoking cessation coverage to 300,000 Virginians.

Next Steps

- VDH-led discussions with MCOs regarding Quitline cost-sharing are ongoing in partnership with DMAS.
- DMAS intends to develop performance dashboards that allow for assessment of individual MCO and hospital performance in the areas of preventable and/or medically unnecessary ER visits, hospitalizations, and readmissions related to smoking. DMAS is currently in the early stages of developing technical specifications for these metrics.
- HSAG continues to provide technical assistance to MCOs on their tobacco cessation PIPs with frequent contact and feedback to ensure that projects are well-designed at the outset and provide opportunities for mid-course adjustments.

MCO Quality Collaborative and Stakeholder Meetings

The MCO Quality Collaborative served as the main platform for the MCOs, the EQRO, and DMAS to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative was facilitated by DMAS Quality Improvement staff and met monthly, including four on-site meetings in Richmond.

The July 2019 Quality Collaborative was strategically planned and held off-site at a low-income community center in an area where DMAS members resided. The title of the July Medicaid Quality Collaborative was "Moving From Healthcare to Health With a Focus on Health Equity and Social Determinants of Health." The collaborative has been active for more than a decade and continues to be recognized as the pillar for managed care quality in the Commonwealth.

The July Quality Collaborative was symbolic of change, but more importantly, it was symbolic of transformation. The fact that DMAS held a meeting off-site, in a low income neighborhood, and not at the Virginia Medicaid office building on Broad Street, is a reflection of the agency's commitment to fully engage with the community, DMAS' many partners, and its members.

DMAS acknowledges, through deeper engagement, that it will continue to learn and grow in its understanding of the people DMAS serves. Virginians are living longer than before, and medical care is only part of the reason. DMAS understands that people are dealing with complicated life issues while at the same time dealing with healthcare concerns. DMAS members have a holistic view of health, and they are challenging the agency to adapt and adopt a more comprehensive approach to addressing their needs.

As part of this process, DMAS understand that it was imperative that it moved from paying for medical claims based on utilization to paying for health. To be successful, DMAS embraced bold goals. The real work starts with making and securing internal and external commitments to better engage with the community and gain an understanding of the needs of DMAS members.

DMAS had a diverse group of speakers at the Quality Collaborative who addressed the complex needs of members. The first speaker addressed behavioral health transformation for Medicaid. Quality Collaborative participants also heard from a community health worker about her approach to achieving health equity. Next, the keynote speaker, Dr. Jeffrey Brenner, shared strategies on how to deliver better care for complex populations. Finally, participants digested what was learned with a panel discussion including Dr. Brenner and executive leaders from Virginia State agencies.

During 2019, DMAS hosted additional external presentations, such as from the Virginia Hospital & Healthcare Association (VHHA). DMAS also conducted Coffee Talks Care Coordination calls with the MCOs on a weekly basis. The purpose of the calls was to provide training and support to MCO care coordinators and to reinforce DMAS' expectations of the care coordination role and program requirements. DMAS leadership met weekly with the MCOs' executive leadership teams to discuss program-related updates, program development efforts, information related to potential or upcoming changes, and clarification on contract requirements for partnership and collaboration. The DMAS Office of the Chief Medical Officer held monthly meetings with the MCOs' chief medical officers and

pharmacy leads for review and discussion of clinical operations. DMAS also conducted contract monitoring calls every other week with the MCOs. A primary topic for the contract monitoring calls was a review and discussion of the issues log and any outstanding issues that were in the resolution process.

Healthy Birthday Virginia

DMAS, upon the direction of Governor Ralph Northam, developed a series of strategies to end maternal and infant mortality among its members by 2025. As part of this directive, the office of the Secretary of Health and Human Resources convened a diverse group of stakeholders and embarked on a 10-stop listening tour across all regions of the Commonwealth. The events were planned to bring together community organizations, local healthcare providers and hospital systems, elected officials, leaders at state agencies, and other stakeholders to hear from individuals with lived experience and discuss strategies to improve maternal health outcomes.

DMAS is working to implement policy and program improvements to streamline enrollment of pregnant women, increase access to treatment for expecting mothers with an SUD, and strengthen accountability for prenatal and postpartum managed care services. Under previous eligibility rules, most women had access to Medicaid coverage for only a narrow window of time during their pregnancy and for 60 days postpartum. Medicaid expansion enabled more low-income women to receive quality healthcare before, during, and after their pregnancy. Additional strategies adopted by DMAS to improve maternal and infant health outcomes included continuity of coverage, education and outreach, a focus on special populations, and increased accountability and transparency while strengthening partnerships with other stakeholders. DMAS' strategy also strengthened early childhood interventions and curbed tobacco use among pregnant women. DMAS partnered with VDH and the Virginia Department of Behavioral Health & Developmental Services on initiatives to improve birth outcomes.

DMAS Quality Strategy

In 2019, DMAS began the development of its fourth edition of the Quality Strategy, which was submitted to CMS in March 2020. The DMAS Office of Quality and Population Health has developed a robust Quality Strategy that reflects Virginia's focus on quality and addresses the following priorities:

- ARTS program
- Member and provider experience assessments
- Clinical efficiencies
- Connecting to care
- Financial transparency and accountability
- Improved agency member outreach strategies
- Improved agency provider outreach strategies
- Management of at-risk children
- Medicaid Advisory Committee
- Smiles for Children program
- Utilization reviews of critical services

Summary of the Quality and Timeliness of, and Access to Care Furnished by MCOs

The following section provides a high-level overview of examples of the MCOs' performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list.

Quality

The MCOs in Virginia submitted two PIPs for the calendar year 2019 validation cycle. The project topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services.

In 2019, all CCC Plus MCOs demonstrated the provision of quality care and services with the CAHPS survey results indicating that *Shared Decision Making* was a strength, with three MCOs scoring above the 2018 NCQA child Medicaid national average.

Timeliness

The MCOs demonstrated timeliness of care and service delivery as two MCOs scored statistically significantly higher than the 2018 NCQA adult and child Medicaid national averages for the *Getting Care Quickly* composite measure.

The MCOs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of the member's need for services. Overall, the MCOs' quality evaluation demonstrated that the MCOs had policies, procedures, and programs that described their coverage and authorization of service activities and supported timely access to care and services.

Access

CAHPS surveys were conducted for each MCO. Data collection was conducted through the administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. All MCOs used a mixed-mode survey methodology for data collection. The composite measures address different aspects of care (e.g., *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*). In 2019, all CCC Plus MCOs demonstrated strength with the *Getting Needed Care* composite measure for the adult and child Medicaid populations, with three MCOs scoring statistically significantly higher than the 2018 NCQA adult and child Medicaid national averages.

PM validation results indicate that the MCOs demonstrated adequate access to care for adults in several areas including access to primary care services.

Quality Strategy Recommendations for DMAS

In 2017, DMAS developed the third edition of its comprehensive Medicaid Quality Strategy in accordance with 42 CFR §438.340. DMAS objectives are to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and fee-for-service (FFS) programs. DMAS' Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care along with supporting the provision of quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

Quality Strategy Focus and Priorities

DMAS' Quality Strategy is based on four aims, which are based on three foundational guiding principles for meeting the mission and vision. The three guiding principles are superior care, cost effectiveness, and continuous improvement.

The four publicly promoted aims are:

- Build a wellness-focused, integrated system of care.
- Focus on screening and prevention.
- Achieve healthier pregnancies and healthier births.
- Maximize well-being across the lifespan.

DMAS' Quality Strategy for 2017 through 2019 states that the measures in the DMAS Quality Dashboard are prioritized for continuous improvement and selected based on the needs of the populations served and the favorable health outcomes that result when there is adherence to relevant clinical guidelines. DMAS also takes into consideration the availability and reliability of the data used in evaluating performance. DMAS considerations regarding quality improvement measures and benchmarks are especially important when evaluating the more acute and chronic healthcare needs of the CCC Plus population.

The CCC Plus program structure was expanded to continue to improve care delivery and efficiency for individuals with complex care needs. That expansion included the transition of the HAP and the ABD members from Medallion 3.0 to the CCC Plus program. The CCC Plus program is an integrated delivery model that includes care coordination and person-centered care with an interdisciplinary team approach to providing medical services, behavioral health services, and LTSS.

On June 7, 2018, Virginia's Governor signed the State budget that expanded eligibility under Medicaid for approximately 400,000 Virginia adults beginning on January 1, 2019. The CCC Plus program for members enrolled through Medicaid expansion is intended to ensure the delivery of acute and primary care services, prescription drug coverage, behavioral health services, and LTSS through a patient-centered program design.

Strengths

Performance Measures

The Virginia MCOs demonstrated strength in access to care with two PM aggregate rates exceeding the 90th percentile: *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years.*

The MCOs demonstrated strength with the *Getting Care Quickly* composite measure for both the adult and child Medicaid populations, as two of the six MCOs scored statistically significantly higher than the 2018 NCQA Medicaid national averages for each population.

Member Experience of Care Survey

The MCOs also demonstrated strength in adult members being able to access care and services as three of the six CCC Plus MCOs scored statistically significantly higher than the 2018 NCQA adult Medicaid national average for *Getting Needed Care*.

The MCOs demonstrated strength with the *Shared Decision Making* composite measure for the child Medicaid population, as three MCOs scored statistically significantly higher than the 2018 NCQA child Medicaid national average.

Recommendations for Opportunities for Improvement

DMAS should prioritize continuous improvement activities for the CCC Plus populations by focusing on the following areas:

Performance Measures

The Virginia MCOs' aggregate rates fell below the 10th percentile for three measures: *Cervical Cancer Screening*, and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*. HSAG recommends that DMAS focus MCOs on improving results for these areas of care.

Overall, the Virginia aggregate rates for HEDIS 2019 indicated opportunities for improvement, as 20 of 35 (57.1 percent) measure rates fell below the 50th percentile, with 11 of these rates (31.4 percent) falling below the 25th percentile. DMAS' implementation of PWPs provides an opportunity for overall improvement in HEDIS rates, which are indicators of access to and quality and timeliness of care and service delivery.

Performance Improvement Projects

The MCOs' initial submission of PIP Module 1 and Module 2 indicated opportunities for improvement. HSAG recommends that DMAS require that the MCOs participate in trainings provided by the EQRO. HSAG also recommends that MCOs thoroughly review and address the initial validation findings prior to resubmitting the PIP modules and that DMAS require the MCOs to request and actively participate in technical assistance provided by the EQRO as often as needed to improve the success of the PIP process.

Member Experience of Care Survey

MCOs should focus on child members' experiences with their health plan as three MCOs scored statistically significantly lower than the 2018 NCQA child Medicaid national average for *Rating of Health Plan*. In addition, both *Rating of All Health Care* and *Customer Service* received statistically significantly lower scores than the 2018 NCQA child Medicaid national averages for one MCO.

Overall, the MCOs should focus quality improvement efforts on measure scores that were statistically significantly lower than the 2018 NCQA Medicaid national averages and continue to monitor the measures to ensure there are no significant decreases in rates over time.

Overall

HSAG recommends that MCO leadership be actively involved and demonstrate a commitment to quality improvement throughout the organization. MCOs should regularly review their data to identify opportunities for improvement early and implement interventions, using the small tests of change process that is used for PIPs. HSAG also recommends that MCOs include the members' perspectives whenever possible to gain a clear understanding of members' perceptions of care and service delivery and the challenges members encounter in receiving the MCOs' healthcare services.

2. Introduction to the Annual Technical Report

Purpose of Report

As required by CFR 42 §438.364,[2-1] the DMAS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access, timeliness, and quality of care, including:

A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, PIHP, prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]).

Each EQR-related activity conducted in accordance with §438.358 must include:

- Objectives.
- Technical methods of data collection and analysis.
- Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii).
- Conclusions drawn from the data.
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

[2-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Apr 11, 2019.

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2019 EQR Technical Report, HSAG used findings from the EQR activities conducted from January 1, 2019, through December 31, 2019, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services provided to the CCC Plus MCO managed Medicaid members. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated all components of each EQR activity and resulting findings across the continuum of program areas and activities that comprise the CCC Plus program. The composite findings for each MCO were analyzed to identify overarching trends and focus areas for the MCOs.

Scope of External Quality Review (EQR) Activities

At the request of DMAS, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities are briefly described below. Refer to Appendix A—Technical Methods of Data Collection and Analysis—MCOs for a detailed description of each activity's methodology.

Mandatory Activities

Compliance Monitoring—HSAG conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2019, HSAG did not conduct MCO compliance review activities for the CCC Plus program.

Validation of PMs—The purpose of PMV is to assess the accuracy of PMs reported by the MCOs and to determine the extent to which PMs reported by the MCOs follow State specifications and reporting requirements.

DMAS contracted with HSAG to conduct the PMV for each MCO, validating the data collection and reporting processes used to calculate the PM rates. DMAS identified a set of PMs that the MCOs are required to calculate and report. Measures are required to be reported following the specifications provided by DMAS. DMAS identified the measurement period as January 1, 2018, through December 31, 2018.

Validation of Performance Improvement Projects—The MCOs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2019 validation cycle. The results from the CY 2019 PIP validation are presented in this report.

Network Adequacy—With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of MCO, PIHP, and

PAHP networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for MLTSS programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric), obstetricians/gynecologists, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. DMAS has implemented network standards in its contracts with the MCOs.

Optional Activities

Consumer Decision Support Tool—HSAG develops Virginia's Consumer Decision Support Tool (i.e., Quality Rating System) to improve healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the CCC Plus program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.

Performance Withhold Program—HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2019 PWP will use HEDIS and non-HEDIS measures.

Quality Strategy Update—During 2019, DMAS contracted with its EQRO to update the Virginia Quality Strategy. The purpose of the update is to include changes to the Medicaid program including the evolution of CCC to CCC Plus and Medallion 3.0 to Medallion 4.0. The Quality Strategy updates incorporate programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes, and improved health and wellness.

ARTS PM Validation—HSAG validates rates for PMs for the ARTS program selected by DMAS for validation.

- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*
- *Use of Opioids at High Dosage in Persons Without Cancer*
- *Use of Opioids at High Dosage and From Multiple Providers in Persons Without Cancer*
- *Concurrent Use of Opioids and Benzodiazepines*
- *Continuity of Pharmacotherapy for Opioid Use Disorder*

ARTS Measure Specification Development—HSAG identifies, when available, PMs from existing measure sets or develops PMs for the ARTS program.

Organizational Structure of Report

Section 1—Executive Summary

This section of the report presents a summary of the EQR activities. The section also includes high-level findings and conclusions regarding the performance of each MCO.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the scope of the EQR activities and provides a brief description of each section's content.

Section 3—Overview of Virginia's CCC Plus Managed Care Program

This section of the report presents a brief description of the Commonwealth of Virginia's managed care program, services, regions, and populations. This section also presents a brief description of Virginia's quality initiatives.

Section 4—MCO Comparative Information

This section presents methodologically appropriate, comparative information about all MCOs by activity and consistent with the guidance provided in the CMS EQR Protocols. Commonwealth-specific recommendations are also included if applicable. This section includes recommendations for improvements to the quality of healthcare services furnished by the MCOs, including how the Commonwealth can target goals and objectives in the Quality Strategy to better support improvement in the quality of, timeliness of, and access to healthcare services furnished to members.

Section 5—Compliance With Standards

This section presents MCO-specific results and conclusions of the compliance with standards review activity. DMAS conducts Compliance with Standards Monitoring reviews using a three-year cycle. During 2019 the Commonwealth of Virginia monitored the MCOs implementation of contract requirements and the MCOs' corrective action plans from prior years' compliance reviews.

Section 6—Validation of Performance Measures

This section presents MCO-specific results and conclusions of the validation of PMs activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 7—Validation of Performance Improvement Projects

This section presents MCO-specific results and conclusions of the validation of performance improvement project activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 8—Member Experience of Care Survey

This section presents MCO-specific results and conclusions of the member experience of care surveys activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Appendix A—Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- Performance Measure Validation Methodology
- Performance Improvement Project Methodology
- PWP Methodology
- CAHPS Survey Methodology

3. Overview of Virginia's CCC Plus Managed Care Program

Medicaid Managed Care in the Commonwealth of Virginia

Introduction

Medicaid and CHIP provides comprehensive health coverage to approximately 72 million Americans including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities.[3-1] Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

In Virginia, Medicaid plays a critical role in the lives of nearly 1.4 million Virginians, providing access to healthcare for the most vulnerable populations.[3-2] The impact of Medicaid extends far beyond traditional health coverage, to include comprehensive services such as behavioral health and LTSS. Medicaid is also the primary funder for LTSS, making it possible for thousands of Virginians to remain in their homes or to access residential care when needed.

The CCC Plus program's focus is to improve the quality of, access to, and efficiency of healthcare and services and supports for individuals residing in facilities and in home- and community-based settings. The CCC Plus program approaches care delivery through a person-centered program design in which all members receive care coordination services to ensure members receive the services they need. The CCC Plus care coordinators coordinate the care for members enrolled in both Medicare and CCC Plus. The CCC Plus program is an integrated delivery model that includes physical, behavioral health, and SUD services and LTSS. The CCC Plus program incentivizes community living and promotes innovation and value-based payment strategies.

Medicaid is the largest payer of behavioral health services in the Commonwealth, providing inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. Virginia has a comprehensive addiction and recovery treatment services program that provides SUD, OUD, and AUD treatment and services. This program operates under an 1115 waiver, Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency (COMPASS), which provides SUD services through the ARTS delivery system. Virginia has requested an extension of the waiver and requested authority to implement a community engagement program for eligible adult populations. The COMPASS waiver extension is pending CMS approval. The first full year of the demonstration was 2018. The demonstration extends access to certain behavioral and physical health services to uninsured low-income adults with a diagnosis of serious mental illness (SMI) with a goal of

[3-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. October 2019 Medicaid & CHIP Enrollment Data Highlights. Available at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Accessed on: Jan 15, 2020.

[3-2] Virginia Department of Medical Assistance Services. CCC Plus M4 Demographic Population Report, July 2019.

the demonstration to use a targeted benefit package to prevent people with SMI diagnoses from becoming fully and permanently disabled.

The ARTS component of the demonstration, which contributes to a comprehensive statewide strategy to combat prescription drug abuse and OUDs, seeks to expand the SUD benefits package to cover the full continuum of SUD treatment, including short-term residential and inpatient services to all Medicaid-eligible members. The ARTS demonstration was amended to address the substance use crisis by expanding coverage and adding services. The demonstration amendment also expanded Medicaid coverage to former foster care youth who aged out of foster care under the responsibility of another state and were applying for Medicaid in the Commonwealth of Virginia.

Work requirements for adults 19 to 64 years of age are included in the COMPASS waiver. COMPASS also provides a health and wellness program through health and wellness accounts and provides a housing and employment supports benefit for members 18 years or older who have a behavioral health need and a history of chronic homelessness, lengthy stays in institutional settings, frequent ED visits or hospitalizations, frequent turnover or loss of housing as a result of their behavioral health symptoms, or have involvement with the criminal justice system.

The FAMIS MOMS 1115(a) waiver provides health coverage for pregnant women and the FAMIS Select population, which helps families pay for employer-sponsored health insurance. The FAMIS Select program allows families to choose between covering their children through FAMIS or through an employer-sponsored health plan. FAMIS MOMS provides comprehensive healthcare and dental benefits during pregnancy and for two months following the baby's birth. Good healthcare during pregnancy is important for the mom and the baby. FAMIS MOMS encourages pregnant women to get early and regular prenatal care to increase the likelihood for a healthy birth outcome.

Virginia's 1915(b1), (b4), and (c) waivers emphasize DMAS' focus on providing home and community-based services and transition services for individuals 65 years of age and over, physically disabled individuals 0 to 64 years of age, individuals with other disabilities 0 to 64 years of age, and technology dependent individuals of all ages. The 1915(c) waiver provides DMAS the authority to focus on maximizing each individual with developmental disabilities or intellectual disabilities life in his or her community with increased flexibility; new options; and improved access to care, services, and community living. Individuals enrolled in one of the three developmental disability waivers receive their non-waiver services through the CCC Plus program.

For individuals with autism, developmental or intellectual disabilities of any age, and their families, DMAS has implemented a 1915(c) waiver that provides person-centered and family-centered resources, supports, services, and other assistance that encourages community-based living options. The 1915(c) waiver for Virginia Building Independence focuses on providing supports to these individuals to increase independence and integration in community-based settings.

Virginia also participates in the Delivery System Reform Incentive Payment (DSRIP) program through an 1115 Delivery System Transformation Demonstration waiver. The DSRIP has two strategic initiatives that align the MLTSS and DSRIP payments to strengthen and integrate Virginia Medicaid's community delivery structure and accelerate payment reforms toward value-based payments.

The Department of Medical Assistance Services

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models. As of December 2019, more than 90 percent of Medicaid enrollees received their benefits through the managed care model, and less than 10 percent of enrollees participated in Medicaid through the FFS model. In 2019, the managed Medicaid populations in Virginia were organized into two programs: Medallion 4.0 and CCC Plus.

Commonwealth Coordinated Care Plus MCO Model

On August 1, 2017, the CCC Plus program began as the new statewide Medicaid MLTSS program to serve individuals with complex care needs, through an integrated delivery model, across the full continuum of care. As of July 2019, CCC Plus, a program designed to improve care delivery and efficiency for individuals with complex care needs, blends and coordinates Medicare and Medicaid benefits for approximately 244,548 dual-eligible members aged 21 or older, HAP members of Medallion 3.0, and ABD members.[3-3] Individuals receiving LTSS through nursing facilities and the Elderly or Disabled with Consumer-Direction (EDCD) waiver are also eligible to participate in the CCC Plus managed care program. The MCO contract includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. The Centers for Medicare & Medicaid Services and DMAS monitor health plan performance and quality by requiring the health plans to report HEDIS data along with quarterly assessment and plan of care completion rates. The CCC Plus program covers approximately 18 percent of Virginia's Medicaid enrollment and accounts for approximately 69 percent of Virginia's Medicaid expenditures.[3-4]

CCC Plus prioritizes the following:

- Integrated care delivery model
- Full continuum of care
- Person-centered care planning
- Interdisciplinary care teams
- Unified (Medicare/Medicaid) processes, when possible

Medicaid Expansion

On June 7, 2018, Virginia's Governor, Ralph Northam, signed the State budget, which included expanded eligibility under Medicaid for qualified Virginia adults. Approximately 27,919 Medicaid

[3-3] Virginia Department of Medical Assistance Services. CCC Plus M4 Demographic Population Report, July 2019.
[3-4] Virginia Department of Medical Assistance Services. Medicaid Member Advisory Committee Orientation. Available at: https://www.dmas.virginia.gov/files/links/3001/Mtg%20Presentation%20--%20DMAS%20--%20Orientation%20to%20Medicaid.pdf. Accessed on: Feb 5, 2020.

expansion members were added to the CCC Plus program as of July 2019.[3-5] Medicaid expansion coverage began on January 1, 2019, and is administered through a comprehensive system of care. Medicaid expansion provides coverage for eligible individuals, including adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the federal poverty level, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

Coverage for the Medicaid expansion population is provided through the DMAS managed care and FFS delivery systems. Most individuals are enrolled in one of the DMAS managed care programs—Medallion 4.0 or CCC Plus. The Medallion 4.0 and CCC Plus programs contract with the same six MCOs, and all offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. The CCC Plus program provides care coordination services for individuals with more pronounced medical needs and serves as the delivery system that provides coverage for expansion members who are deemed to be "medically complex." Medallion 4.0 serves as the delivery system for expansion individuals who are determined not medically complex. Medically complex individuals include individuals with a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Addiction and Recovery Treatment Services (ARTS)

In 2017, DMAS implemented the ARTS program in the CCC Plus and the Medallion 4.0 programs. The ARTS program focuses on treatment of SUD, OUD, and AUD. Outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; and a decrease in opioid prescriptions. The ARTS program is a fully integrated physical and behavioral health continuum of care that includes:

- Early intervention
- Outpatient services
- Intensive outpatient and partial hospitalization services
- Intensive outpatient services
- Partial hospitalization services
- Residential and inpatient services
- Clinically managed, population-specific, high-intensity residential services
- Clinically managed, high-intensity residential services
- Medically monitored intensive inpatient services
- Medically managed intensive inpatient services

[3-5] Virginia Department of Medical Assistance Services. CCC Plus M4 Demographic Population Report, July 2019.

Virginia Quality Strategy

The HHS CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet.

This section outlines the goals and objectives of DMAS 2017 Quality Strategy as well as the annual evaluation of the strategy for contract year 2019. In addition, the State conducts periodic reviews to examine the scope and content of its Quality Strategy, evaluates the strategy's effectiveness, and updates it as needed. The DMAS Quality Strategy is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States[3-6] and aligns with the HHS National Quality Strategy Aims for better care, affordable care, and healthy people/healthy communities.

DMAS considers its Quality Strategy to be its roadmap for the future. DMAS developed its Medicaid comprehensive Quality Strategy to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs.

DMAS' vision for quality extends beyond the Quality Strategy. Virginia's Quality Strategy serves as the roadmap for developing a dynamic approach to assessing and improving the quality of healthcare and services furnished by the managed care and FFS entities and providers. The mechanisms for assessing quality, timeliness, and access to care vary across the Medicaid programs in Virginia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The strategy requires a succession of incremental steps that DMAS pursues to achieve these quality objectives. The Quality Strategy establishes a strong foundation for quality governance and a comprehensive data analytics strategy.

DMAS' Quality Strategy is based on four aims, which are based on three foundational guiding principles for meeting the mission and vision. The three guiding principles are superior care, cost effectiveness, and continuous improvement.

The four publicly promoted aims are:

- Build a wellness-focused, integrated system of care.
- Focus on screening and prevention.
- Achieve healthier pregnancies and healthier births.
- Maximize well-being across the lifespan.

[3-6] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Jan 24, 2019.

History

DMAS published its first Quality Strategy in June 2005. The strategy was first updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 Managed Care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the proposed rule to modernize and update the federal Medicaid managed care regulations. It addresses the progression of, and impending changes to, managed care quality in Virginia. The Addendum served to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy was developed and approved. The third edition was finalized by DMAS on January 31, 2018, for calendar years 2017 through 2019. This third edition aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340. The new federal regulations advance DMAS' mission of better care, healthier people, and smarter spending.

In 2017, DMAS developed the third edition of its comprehensive Medicaid Quality Strategy in accordance with 42 CFR §438.340. DMAS objective is to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs.

During 2019, DMAS contracted with its EQRO to update the Virginia Quality Strategy. The purpose of the update is to include changes to the Medicaid program including the evolution of CCC to CCC Plus and Medallion 3.0 to Medallion 4.0. The Quality Strategy updates incorporate programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes; and improved health and wellness.

Mission, Vision, Values

The purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement system consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement of the healthcare system.
- Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, timeliness, member satisfaction, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.

- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure that Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery steeped in best practices; and make healthcare more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

Quality Strategy Goals and Objectives

Figure 3-1—DMAS' Quality Strategy Quality Dashboard

Quality Strategy Aims	Goals	Measure Examples
 **Aim 1:** Build a Wellness Focused, Integrated System of Care	**Goal 1:** Strengthen access to primary care network	**Measure 1.1:** HEDIS *Adults' Access to Primary Care Preventive and Ambulatory Health Services*
		Measure 1.2: HEDIS *Children and Adolescents' Access to Primary Care*
	Goal 2: Decrease inappropriate utilization and total cost of care	**Objective 2.1:** All-Cause PQI Admission Rate
		Objective 2.2: CMS/NQF #1768 *All-Cause Readmissions*
		Objective 2.3: HEDIS *Ambulatory Care—Emergency Department Visits*
		Objective 2.4: *Per Capita Healthcare Expenditures* (future Measure)
	Goal 3: Emphasize member experience of care	**Objective 3.1:** CAHPS/HEDIS/NQF #0006: *Member Rating of Health Plan*
	Goal 4: Integration of behavioral, oral and physical health	**Objective 4.1:** CMS/HEDIS/NQF/#0004: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates)
		Objective 4.2: CMS/NQF #1664 SUB-3 *Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge* and SUB 3a *Alcohol and Other Drug Use Disorder Treatment at Discharge*
		Objective 4.3: HEDIS/NQF #0576 *Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up*
		Objective 4.4: CMS/NQF #2605 *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence*
		Objective 4.5: CMS *Transition of Members Between SUD LOCs, Hospitals, NF, and the Community*

Quality Strategy Aims	Goals	Measure Examples
	Goal 5: Encourage appropriate management of prescription medications	**Objective 5.1:** *Use of High-Risk Medications in the Elderly*
		Objective 5.2: NCQA *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
		Objective 5.3: HEDIS *Follow-Up Care for Children Prescribed ADHD Medication—Initiation and Continuation/Maintenance Phases*
		Objective 5.4: HEDIS *Antidepressant Medication Management—Effective Acute Phase Treatment, Effective Continuation Phase Treatment*
		Objective 5.5: PQA *Use of Opioids at High Dosage in Persons Without Cancer*
		Objective 5.6: PQA *Use of Opioids from Multiple Providers in Persons Without Cancer*
		Objective 5.7: PQA *Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer*
 **Aim 2:** Focus on Screening and Prevention	**Goal 6:** Cancers are prevented or diagnosed at the earliest state possible	**Objective 6.1:** HEDIS/NQF #2372 *Breast Cancer Screening Rate*
		Objective 6.2: NQF #0034 *Colorectal Cancer Screening*
		Objective 6.3: HEDIS/NQF #0032 *Cervical Cancer Screening*
	Goal 7: Prevention of nicotine dependency	**Objective 7.1:** AMA PCPI/NQF #0027 *Tobacco Use—Screening and Cessation*
	Goal 8: Virginians protected against vaccine-preventable diseases	**Objective 8.1:** HEDIS *Childhood Immunization Status (Combination 10)*
		Objective 8.2: HEDIS *Immunizations for Adolescents*
		Objective 8.3: HEDIS *Pneumococcal Vaccination Status for Older Adults*
		Objective 8.4: HEDIS *Flu Vaccination*
	Goal 9: Support consistency of recommended pediatric screenings	**Objective 9.1:** CMS/HEDIS *Annual Preventive Dental Visits*
		Objective 9.2: HEDIS *Well-Child Visits, First 15 Months of Life*
		Objective 9.3: HEDIS *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
		Objective 9.4: HEDIS *Adolescent Well-Care Visits (12–21 Years)*

Quality Strategy Aims	Goals	Measure Examples
		Objective 9.5: OHSU *Developmental Screening in the First Three Years of Life*
 **Aim 3:** Achieve Healthier Pregnancies and Healthier Babies	**Goal 10:** Virginians plan their pregnancies	**Objective 10.1:** NQF 2902/OPA *Contraceptive Care—Postpartum Women Ages 15–44*
		Objective 10.2: HEDIS *Postpartum Care Visit*
	Goal 11: Improved pre-term birth rate	**Objective 11.1:** *Early Elective Deliveries Rate*
		Objective 11.2: HEDIS *Timeliness of Prenatal Care*
		Objective 11.3: *Frequency of Ongoing Prenatal Care*
		Objective 11.4: CMS/CDC/PQI *Percent of Live Births <2500 Grams*
 **Aim 4:** Maximize Wellbeing Across the Lifespan	**Goal 12:** Effective management of chronic respiratory disease	**Objective 12.1:** PQI 14 *Asthma Admission Rate (Ages 2–17)*
		Objective 12.2: PQI 15 *Asthma in Younger Adults Admission Rate*
		Objective 12.3: CMS/PQI 05/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 13: Comprehensive management of diabetes	**Objective 13.1:** HEDIS *Comprehensive Diabetes Care*
		Objective 13.1: PWI 01/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 14: Effective management of cardiovascular disease	**Objective 14.1:** HEDIS/NQF #0018 *Controlling High Blood Pressure*
	Goal 15: Ensure quality of life for members with intensive healthcare needs	**Objective 15.1:** JLARC *Nursing Facility Diversion Number and Percent of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home and Community-Based Services (HCBS) Over Institutional Placement*
		Objective 15.2: *Quality of Life and Member Satisfaction Survey* CMS-Specific
		Objective 15.3: *Assessments and Reassessments*
		Objective 15.4: *Plan of Care and POC Revisions*
		Objective 15.5: *Documentation of Care Goals*
		Objective 15.6: JLARC *Transition of Members Between Community Well, LTSS and Nursing Facility—Services and Successful Retention in Lower Care Settings*

Quality Strategy Aims	Goals	Measure Examples
		Objective 15.7: JLARC *Nursing Facility Residents Hospitalization and Readmission Rate*
		Objective 15.8: *Fall Risk Management Intervention/Managing Fall Risk*
	Goal 16: Provide support for end of life	**Objective 16.1:** *Percent Enrollees with Advance Directives*

Note: each objective has targeted metrics to measure progress, as well as outlined interventions to advance the objectives.

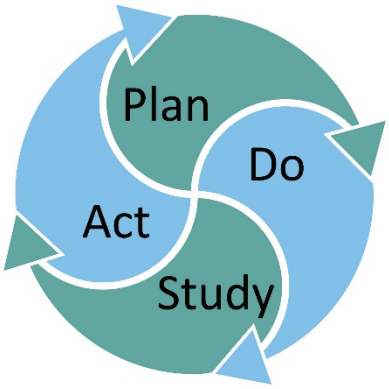
Quality Governance

In 2017, DMAS established an integrated agency-wide quality governance structure with the creation of a Quality Steering Committee with representatives from Integrated Care, Health Care Services, Provider Reimbursement, and the Office of the Chief Medical Officer. The Quality Steering Committee operates under the direction of DMAS Senior Leadership.

The mission of the Quality Steering Committee is to provide cross-agency governance to support the quality delivery of healthcare to all Commonwealth Medicaid programs. The scope of authority includes issue resolution, idea development, setting policy direction, making strategic recommendations (e.g., priority projects and measurement development), and aligning quality priorities with other agency priorities. The scope excludes issues related to compliance, program, and systemic inefficiencies.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DMAS encourages the MCOs to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a Plan-Do-Study-Act (PDSA) cycle, to determine if the benefit of the intervention outweighs the effort and cost.



Another method used by DMAS to promote best and emerging practices among the MCOs was to ensure that the State's contractual requirements for the MCOs were at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). DMAS actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured.

DMAS Quality Initiatives Driving Improvement

Following are some of the initiatives DMAS implemented during the review period that support the improvement of quality of care and services for CCC Plus members, as well as activities that supported the MCOs' quality improvement efforts.

Care Coordination: DMAS hosts weekly interactive webinars with the MCO CCC Plus care coordinators for purposes of training and sharing of best practices. The MCO care coordinators also share success stories and the impact the care coordination interventions have on the quality of the members' lives. The following is an example of success stories described during a care coordinator call.

- An MCO care coordinator had trouble contacting a member recently discharged from an inpatient rehabilitation admission following a clavicle fracture. The care coordinator went to the last known address of the member and was informed the member no longer lived there and was homeless and living in the woods.

  The member could frequently be found panhandling at a busy intersection in an affluent neighborhood. The member was diagnosed with diabetes, major depressive disorder, right above the knee amputation with prosthesis, and right upper extremity hemiplegia with no use of the upper right extremity. The member utilized a walker or wheelchair for ambulation.

  The MCO's care coordinator located the member at the intersection, in a wheelchair, with a sign asking for donations. The care coordinator approached the member, introduced herself, and displayed her identification badge. The care coordinator offered to buy the member lunch. After lunch, the member agreed to complete the health risk assessment (HRA) tool. The member declined information on local shelters. The MCO's care coordinator spoke to the MCO's housing assistance officer who arranged for temporary housing for the member. In addition, the member agreed to accept ride assistance and discussed plans to replace a stolen identification card and social security card. The member also agreed to re-establish care with a PCP.

  The care coordinator utilized a person-centered approach and established rapport through support and assistance for basic needs. The care coordinator addressed the member's immediate and short-term needs by offering resources. It is anticipated that this initial contact with the member will lead to improvements in the member's living conditions, the member re-establishing healthcare with a primary care provider, and accepting future healthcare and support.

CCC Plus Performance Incentive Program

As part of an effort to align with DMAS' value-based purchasing (VBP) initiatives, the CCC Plus program implemented a performance incentive program. This program allows MCOs to earn back a 1 percent quality withhold, or a portion thereof. DMAS determined specific criteria and established methodologies for the performance incentive program.

Secret Shopper Preliminary Work

DMAS has approved a methodology to conduct a secret shopper telephone survey among CCC Plus MCOs. The secret shopper survey will supplement DMAS' comprehensive oversight of each MCO's ability to ensure timely access to care for its members. A secret shopper survey will be conducted to determine member access to primary care providers contracted by the MCOs to serve Medallion 4.0 and/or CCC Plus members.

MCO-Specific Quality Initiatives

DMAS requires each MCO to have a quality improvement program that meets contractual standards at least as stringent as those requirements specified in 42 CFR §438.236–438.242. The MCOs' ongoing program objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

DMAS also requires that the MCOs' quality improvement programs be based on the latest available research around quality assurance and include a method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services). DMAS requires the MCOs to submit annual evaluations of and seek approval from DMAS for any updates to the MCOs' quality improvement programs.

DMAS Quality Improvement Accomplishments

Medicaid Member Advisory Committee

The DMAS director established the Medicaid Member Advisory Committee (MAC). This committee provides a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies.

The committee is made up entirely of Medicaid-enrolled individuals or an authorized representative of a member. The director of DMAS also designates a DMAS staff member to serve on the committee. The committee members examine and provide input on the impact of DMAS services and programs. The purpose of the committee is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS director improve the overall experience for all Virginia Medicaid applicants and members. Committee members serve for at least one year. The MAC meetings are scheduled quarterly and are open to the public and include a public comment period during each meeting.

4. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the CCC Plus program.

Compliance With Standards Monitoring

DMAS conducts Compliance with Standards Monitoring reviews using a three-year cycle. During 2019, DMAS monitored the MCOs' implementation of requirements and corrective action plans from prior years' compliance reviews.

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, CMS required states to:

- Set standards to ensure ongoing state assessment and certification of MCO, PIHP, and PAHP networks
- Set threshold standards to establish network adequacy measures for a specified set of providers
- Establish criteria to develop network adequacy standards for MLTSS program
- Ensure the transparency of network adequacy standards.

The requirement stipulates that states must establish time and distance standards for the following network provider types for the provider type to be subject to such time and distance standards:

- Primary care (adult and pediatric)
- Obstetricians/gynecologists
- Behavioral health
- Specialist (adult and pediatric)
- Hospital
- Pharmacy
- Pediatric dental and
- Additional provider types when they promote the objectives of the Medicaid program

DMAS established time and distance standards and additional network capacity requirements in its contracts with the MCOs. DMAS receives monthly MCO network files and conducts internal analysis to determine network adequacy and compliance with contract network requirements. DMAS is prepared to move forward with the mandatory EQRO network adequacy review once the CMS Protocol is finalized.

Performance Measure Validation (PMV)

To evaluate the MCOs' managed care performance in Virginia, DMAS used a subset of HEDIS and non-HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of MCO populations. To evaluate the accuracy of reported PM data, HSAG conducted, on a subset of PMs and all quality withhold measures, non-HEDIS PMV for the measurement period of January 1, 2018, through December 31, 2018.

To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit. Each MCO contracted with an NCQA LO to conduct the HEDIS audit. Additionally, HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key CCC Plus Medicaid measures for HEDIS 2019.

HSAG's PMV activities included validation of the following measures:

- *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*
- *Follow-Up After Emergency Department Visit for Mental Illness*
- *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
- *COPD or Asthma in Older Adults Admissions Rate (PQI05-AD)*
- *Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*
- *Heart Failure Admissions Rate (PQI08-AD)*

HSAG contracted with Aqurate for assistance with the validation of the PMs above. Using the validation methodology and protocols described in Appendix A, HSAG determined validation results for each PM. The CMS PMV protocol identifies two possible validation designations for PMs: Report (R)—measure data were compliant with DMAS specifications, and the data were valid as reported; or Not Reported (NR)—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 4-1.

Table 4-1—MCO Validation Results

	Performance Measure	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier
1.	*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*	R	R	R	R	R	R

	Performance Measure	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier
2.	*Follow-Up After Emergency Department Visit for Mental Illness*	R	R	R	R	R	R
3.	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	R	R	R	R	R	R
4	*COPD or Asthma in Older Adults Admissions Rate (PQI05-AD)*	R	R	R	R	R	R
5.	*Comprehensive Diabetes Care (excluding HbA1c control <7.0%)*	R	R	R	R	R	R
6	*Heart Failure Admissions Rate (PQI08-AD)*	R	R	R	R	R	R

Additionally, HSAG reviewed several aspects crucial to the calculation of PM data: data integration, data control, and documentation of PM calculations. Following are the highlights of HSAG's validation findings:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by the MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. HSAG determined that the data integration processes for the MCOs were acceptable.

Data Control—The MCO's organizational infrastructure must support all necessary information systems; its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. HSAG validated the MCO's data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation—While interviews and system demonstrations provide supplementary information, most validation review findings were based on documentation provided by the MCOs. HSAG reviewed all related documentation, which included the completed roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. HSAG determined that the documentation of PM generation by the MCOs was acceptable.

MCO Comparative and Statewide Aggregate HEDIS Results

One DMAS Quality Strategy objective is to use HEDIS data whenever possible to measure each MCO's performance with specific indices of quality of, access to, and timeliness of care. As part of the EQR annual technical report, HSAG performs a comparison of rates between MCOs and the Virginia weighted aggregate.

Table 4-2 displays, by MCO, the HEDIS 2019 measure rate results compared to the 50th percentiles and the Virginia aggregate, which represents the average of all six MCOs' measure rates weighted by the eligible population. Yellow-shaded boxes indicate MCO measure rates that were at or above the 50th percentile. Rates performing better than the Virginia aggregates are represented in green font.

Table 4-2—MCO Comparative and Virginia Aggregate HEDIS 2019 Measure Results

Performance Measures	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Access and Preventive Care							
Adults' Access to Preventive/Ambulatory Health Services[1]							
Total	85.91%	**92.38%**	78.29%	**90.82%**	88.97%	**91.63%**	**90.38%**
Adult Body Mass Index (BMI) Assessment							
Adult BMI Assessment	**89.05%**	**93.75%**	NA	81.51%	81.02%	80.78%	**86.76%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]							
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	27.62%	**57.05%**	NA	42.36%	44.55%	42.08%	**47.00%**
Breast Cancer Screening							
Breast Cancer Screening	**54.22%**	42.25%	NA	**54.27%**	46.82%	**52.42%**	**48.34%**
Cervical Cancer Screening							
Cervical Cancer Screening	**36.25%**	30.41%	24.09%	**38.20%**	**35.52%**	**36.01%**	**33.99%**
Children and Adolescents' Access to Primary Care Practitioners							
25 Months–6 Years	**92.58%**	**89.27%**	71.76%	**89.27%**	80.87%	**95.66%**	**89.13%**
7–11 Years	96.60%	**97.12%**	NA	94.75%	93.89%	**98.76%**	**96.87%**
12–19 Years	87.76%	92.71%	NA	90.82%	91.74%	**96.52%**	**92.90%**
Use of Imaging Studies for Low Back Pain							
Use of Imaging Studies for Low Back Pain	68.00%	**74.19%**	67.65%	**72.92%**	**71.62%**	67.53%	**71.39%**
Behavioral Health							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia[1]							
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.11%	**71.75%**	66.86%	**69.75%**	64.84%	**73.63%**	**69.53%**
Antidepressant Medication Management							
Effective Acute Phase Treatment	50.88%	55.56%	56.94%	51.30%	**71.29%**	**71.25%**	**60.05%**
Effective Continuation Phase Treatment	39.65%	42.12%	41.67%	40.00%	**59.68%**	**55.77%**	**47.01%**
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence							
30-Day Follow-Up—Total	11.85%	**12.93%**	**15.57%**	12.18%	**12.62%**	10.21%	**12.42%**
Follow-Up After ED Visit for Mental Illness[2]							
30-Day Follow-Up—Total	60.19%	60.85%	**66.93%**	62.19%	61.68%	**65.05%**	**62.86%**
Follow-Up After Hospitalization for Mental Illness[1]							

Performance Measures	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
7-Day Follow-Up—Total	26.52%	**29.79%**	17.66%	**36.42%**	25.94%	26.94%	**28.40%**
Initiation and Engagement of AOD Abuse or Dependence Treatment							
Initiation of AOD Treatment—Total—Total	**48.93%**	44.54%	27.50%	48.62%	46.68%	**58.73%**	**48.87%**
Engagement of AOD Treatment—Total	**11.07%**	9.29%	10.28%	8.68%	8.08%	**15.11%**	**10.70%**
Taking Care of Children							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	36.25%	**50.61%**	27.74%	**45.50%**	38.44%	41.36%	**42.53%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Total	**35.66%**	29.90%	26.97%	**46.00%**	**37.50%**	**35.92%**	**35.58%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile—Total	60.58%	**66.18%**	59.85%	63.50%	**65.94%**	61.56%	**63.91%**
Counseling for Nutrition—Total	47.93%	**63.50%**	52.55%	**57.42%**	52.80%	50.61%	**57.21%**
Counseling for Physical Activity—Total	42.82%	**54.01%**	42.34%	45.01%	47.45%	42.34%	**47.85%**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life							
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**71.43%**	**70.40%**	48.94%	67.40%	55.83%	**71.78%**	**67.54%**
Living With Illness							
Asthma Medication Ratio[1]							
Total	56.20%	**67.96%**	NA	60.36%	46.97%	62.02%	**62.50%**
Comprehensive Diabetes Care[1]							
HbA1c Testing	83.94%	**91.24%**	**90.51%**	86.62%	**90.40%**	88.56%	**89.12%**
*HbA1c Poor Control (>9.0%)**	54.74%	**38.20%**	62.29%	50.61%	**36.66%**	55.47%	**45.54%**
HbA1c Control (<8.0%)	36.74%	**53.28%**	31.39%	41.36%	**55.37%**	37.47%	**46.43%**
Eye Exam (Retinal) Performed	40.88%	48.18%	37.47%	**55.23%**	**54.32%**	46.47%	**49.41%**
Medical Attention for Nephropathy	**91.48%**	**89.54%**	**92.70%**	82.73%	**91.17%**	**90.51%**	**88.63%**
Blood Pressure Control (<140/90 mm Hg)	41.61%	**57.18%**	43.55%	**51.09%**	**55.37%**	36.98	**50.78**
Controlling High Blood Pressure[2]							
Controlling High Blood Pressure	53.04%	51.82%	40.39%	**57.18%**	**58.64%**	**54.99%**	**54.13%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]							
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**80.89%**	**84.14%**	77.54%	75.57%	79.68%	**83.32%**	**80.45%**

Performance Measures	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	83.33%	**89.83%**	72.08%	**88.97%**	NA	**83.84%**	**83.61%**
Discussing Cessation Medications	**59.62%**	**58.47%**	54.19%	56.85%	NA	**59.69%**	**57.77%**
Discussing Cessation Strategies	46.79%	42.86%	44.44%	46.90%	NA	**56.19%**	**47.44%**
Pharmacotherapy Management of COPD Exacerbation							
Bronchodilator	**89.26%**	40.54%	**91.11%**	**55.18%**	49.03%	40.92%	**49.65%**
Systemic Corticosteroid	**84.96%**	33.54%	**66.67%**	**41.83%**	39.75%	33.92%	**40.76%**

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.
[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
NA indicates that the MCO followed the specifications, but the denominator was too small to report a valid rate.
***Note:** MCO measure rates performing better than the Virginia aggregate are represented in green.*
Indicates that the HEDIS 2019 rate was at or above the 50th percentile.

Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as five of the MCOs exceeded the 50th percentile for at least three of the four measures related to *Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primacy Care Practitioners*. Of note, HealthKeepers and Optima demonstrated the highest performance within the Access and Preventive Care domain, exceeding the 50th percentile for seven of the nine (77.8 percent) and six of the nine (66.6 percent) measure rates in this domain, respectively. Cancer screenings for women represents an area for opportunity Virginia-wide, as all reportable rates for the MCOs fell below the 50th percentile for both the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Additionally, all six MCOs were more than 20 percentage points below the 50th percentile for the *Cervical Cancer Screening* measure. Magellan demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for all four of its reportable rates within the domain.

The MCOs demonstrated strength related to the use of medication to treat mental health conditions within the Behavioral Health domain, as all six MCOs exceeded the 50th percentile for at least two of the three measure rates related to medication management (*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and both *Antidepressant Medication Management* indicators), with four of the MCOs exceeding the 50th percentile for all three measures. Within the Behavioral Health domain, VA Premier demonstrated the highest performance, exceeding the 50th percentile for five of the seven (71.4 percent) measure rates that were compared to national percentiles. Follow-up care for behavioral health conditions represents an opportunity for improvement, as no MCO exceeded the 50th percentile for any of the measure indicators related to *Follow-Up After ED Visits for AOD Abuse or Dependence* or *Follow-Up After Hospitalization for Mental Illness* and only one MCO exceeded the 50th percentile for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* measure indicator. Aetna, Magellan, and Optima demonstrated the lowest

performance within the Behavioral Health domain, falling below the 50th percentile for four of the seven measure rates that were compared to national benchmarks.

Within the Taking Care of Children domain, MCO performance was the highest for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, as four MCO rates exceeded the 50th percentile. Conversely, all six MCOs have opportunities for improvement within this domain related to comprehensive well-child/well-care visits, as none of the MCOs' rates for these measures exceeded the 50th percentile. Magellan demonstrated low performance, falling below the 50th percentile and Virginia aggregate for all measure rates in this domain.

MCO performance within the Living With Illness domain was the highest for *Medical Assistance With Smoking and Tobacco Use Cessation*, with only three of the reportable measure rates falling below the 50th percentile. HealthKeepers had the highest performance, with seven of the 13 (53.8 percent) measure rates compared to benchmarks exceeding the 50th percentile and nine of the 14 (64.3 percent) measure rates exceeding the Virginia aggregate. Conversely, MCO performance was the weakest related to respiratory conditions, as only one MCO exceeded the 50th percentile for both the *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measures. Additionally, with only 12 of the 36 (33.3 percent) measure rates exceeding the 50th percentile, MCO performance was low for *Comprehensive Diabetes Care*, particularly for the *Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)* indicators in which no MCO rates exceeded the 50th percentile. Optima had the lowest performance among the MCOs in the Living with Illness domain by only exceeding the 50th percentile for three of the 13 (23.1 percent) measure rates.

MCO Comparative and Statewide Aggregate PIP Results

In 2019, DMAS required the CCC Plus MCOs to conduct two PIPs. The MCOs used the rapid-cycle PIP approach for the two DMAS selected PIP topics. DMAS selected the topics to address the CMS requirements related to quality outcomes in the areas of timeliness of and access to care and services. The topics for 2019 were:

- *Follow-Up After Hospital Discharge*
- *Ambulatory Care—Emergency Department Visits*

During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from Modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP.

Table 4-3 details the level of achievement for each module submitted by each MCO for both PIPs. During 2019, the MCOs achieved all the Module 1 and Module 2 validation criteria and were in the process of completing Module 3 to identify potential interventions for the PIPs.

Table 4-3—Performance Improvement Project Results

MCO	PIP Topic	PIP Module Results
Aetna	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
HealthKeepers	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Magellan	*Reduce Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Increasing Follow-up Visits After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
Optima	*Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD Asthma, Bronchitis or Emphysema*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
United	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
VA Premier	*Ambulatory Care—Emergency Department Visits*	Module 1: All Criteria Achieved Module 2: All Criteria Achieved
	Follow-Up After Discharge	Module 1: All Criteria Achieved Module 2: All Criteria Achieved

Overall, the results of the MCOs' submission of PIP Module 1 and Module 2 indicated that the MCOs were able to successfully complete the Module 1 and Module 2 PIP validation requirements. The MCOs should continue to follow the PIP rapid-cycle process and participate in trainings provided by the EQRO and request technical assistance as often as needed to improve the success of the PIP process. The MCOs' PIP process would benefit from ensuring:

- Each module is completed accurately, and attention is applied to the details, including defining numerators and denominators correctly.
- Data and results are calculated and provided accurately.
- Alignment of the SMART Aim methodologies with the processes.
- Continual monitoring of the outcomes and making rapid adjustments when needed.

- Identification and testing of innovative, actionable changes.

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 4-4 presents the 2019 top-box scores for each MCO and the statewide aggregate adult Medicaid CAHPS scores for the global ratings and composite measures. The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA adult Medicaid national averages.

Table 4-4—Comparison of 2019 Adult Medicaid CAHPS Results

	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Statewide Aggregate
Global Ratings							
Rating of Health Plan	63.1%	59.3%	59.6%	63.4%	63.5%	62.3%	61.6%
Rating of All Health Care	55.0%	53.7%	56.3%	56.6%	54.7%	55.4%	55.0%
Rating of Personal Doctor	70.4%	68.5%	72.5%	69.4%	64.0%	73.7%	69.6%
Rating of Specialist Seen Most Often	71.1%	72.0%	68.1%	73.5%	70.9%	68.3%	71.0%
Composite Measures							
Getting Needed Care	87.3%	87.0%	80.7%	84.6%	84.6%	87.8%	86.2%
Getting Care Quickly	83.2%	88.2%	79.1%	84.5%	82.0%	87.9%	85.9%
How Well Doctors Communicate	91.5%	91.5%	90.1%	92.0%	90.7%	90.7%	91.2%
Customer Service	90.8%	89.3%	84.8%	90.4%	86.0%	93.6%	90.0%
Shared Decision Making	77.5%	76.4%	76.4%	76.0%	77.5%	79.4%	77.3%

Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Overall, the top-box scores for four measures, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*, for all MCOs (i.e., the statewide aggregate) were statistically significantly higher than the 2018 NCQA Medicaid national averages. The statewide aggregate had only one measure, *Shared Decision Making*, that was statistically significantly lower than the 2018 NCQA Medicaid national average. Aetna, HealthKeepers, Optima, and VA Premier had at least one measure that was statistically significantly higher than the 2018 NCQA Medicaid national average.

Child Medicaid

Table 4-5 presents the 2019 top-box scores for each MCO and the statewide aggregate child Medicaid CAHPS scores for the global ratings and composite measures. The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA child Medicaid national averages.

Table 4-5—Comparison of 2019 Child Medicaid CAHPS Results

	Aetna	HealthKeepers	Magellan	Optima	United	VA Premiere	Statewide Aggregate
Global Ratings							
Rating of Health Plan	65.4%	60.2%	62.8%+	65.7%	52.6%	67.1%+	62.3%
Rating of All Health Care	65.3%	65.0%	60.3%+	62.9%	61.1%+	63.6%+	63.9%
Rating of Personal Doctor	71.9%	77.2%	71.3%+	76.6%	73.5%+	74.2%+	75.7%
Rating of Specialist Seen Most Often	74.3%	70.1%	71.7%+	71.4%	66.7%+	70.2%+	70.5%
Composite Measures							
Getting Needed Care	86.1%	85.4%	88.4%+	85.6%	81.3%+	90.2%+	86.3%
Getting Care Quickly	92.3%	92.2%	87.8%+	91.9%	87.2%+	97.3%+	92.5%
How Well Doctors Communicate	94.3%	92.8%	92.9%+	94.5%	96.5%+	96.4%+	94.0%
Customer Service	92.6%+	79.3%	85.1%+	89.5%	82.2%+	83.8%+	83.1%
Shared Decision Making	85.4%+	86.4%	81.7%+	86.6%	83.0%+	78.6%+	84.5%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Overall, the top-box scores for two measures, *Getting Care Quickly* and *Shared Decision Making*, for all MCOs (i.e., the statewide aggregate) were statistically significantly higher than the 2018 NCQA Medicaid national averages. The statewide aggregate had three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*, that were statistically significantly lower than the 2018 NCQA Medicaid national averages. Magellan was the only MCO that did not have any measure rates that were statistically significantly higher or lower than the 2018 NCQA Medicaid national averages.

Consumer Decision Support Tool

DMAS contracted with HSAG in 2019 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' PM data and survey results for the CCC Plus MCOs. The CCC Plus Consumer Decision Support Tool demonstrates how the Virginia Medicaid MCOs compare to one another in key performance areas. The CCC Plus Consumer Decision Support Tool uses stars to display results for the MCOs, as shown in Table 4-6.

Table 4-6—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.

Rating	MCO Performance Compared to Statewide Average	
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-7 displays the 2019 Consumer Decision Support Tool results for each MCO.

Table 4-7—Consumer Decision Support Tool Results—2019

MCO	Doctors' Communication	Access and Preventive Care	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	★★★	★★★	★★	★★★	★★★
HealthKeepers	★★★	★★★★★	★★★	★★★★★	★★★★★
Magellan	★★★	★	★★★	★	★
Optima	★★★	★★★★★	★★★	★★★★★	★★
United	★★	★★★	★★★	★★★	★★★
VA Premier	★★★★	★★★★	★★★★★	★★★	★★★

For 2019, HealthKeepers demonstrated the strongest performance by achieving the Highest Performance level for three of the six domains and never falling below the Average Performance level. VA Premier also demonstrated strong performance, achieving the Highest Performance level in one domain and achieving the High Performance level in an additional two domains. Magellan demonstrated the lowest performance by achieving the Lowest Performance level for three domains and never once performing above average.

Performance Withhold Program

HSAG developed a methodology to calculate the MCO results for the PWP for DMAS. The 2019 PWP was a pilot year given the transition to CCC Plus and used HEDIS and non-HEDIS measures. Results of the PWP will be reported in 2020.

Activity-Specific Findings—Compliance With Standards Monitoring

During 2019, HSAG did not conduct MCO compliance review activities for the CCC Plus program. During 2019, DMAS monitored the MCOs' implementation of federal and State requirements and corrective action plans from prior years' compliance reviews.

Activity-Specific Findings—Validation of Performance Measures

Overview

This section presents HSAG's findings and conclusions from the PMV EQR activities conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

DMAS uses HEDIS, CMS Child Core Set, and CMS Adult Core Set data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. DMAS' EQRO conducts NCQA HEDIS Compliance Audits of the MCOs annually and reports the HEDIS results to DMAS as well as to NCQA. DMAS' EQRO also conducts annual PMV of certain measures such as the CMS Core Measure Sets, MLTSS measures, and measures pertaining to behavioral health and developmental disability programs. As part of the EQR annual technical report, the EQRO trends each MCO's rates over time and also performs a comparison of the MCOs' rates and a comparison of each MCO's rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring.

DMAS assigns the PMs to the following domains of quality, access, and timeliness (Table 6-1):

Table 6-1—CCC Plus Assignment of Performance Measures to the Quality of, Access to, and Timeliness of Care Domains

HEDIS Performance Measures	Quality	Access	Timeliness
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Adult BMI Assessment	✓		
Care for Older Adults—Advance Care Planning	✓		
Use of High-Risk Medications in the Elderly—At Least One Dispensing Event	✓		
Medication Reconciliation Post-Discharge	✓		✓
Comprehensive Diabetes Care—HbA1c Control (<8%) and *Eye Exam (Retinal) Performed*	✓		

HEDIS Performance Measures	Quality	Access	Timeliness
Controlling High Blood Pressure	✓		
Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and *Bronchodilator*	✓		✓
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total—18–64 and *65+*	✓		

MCO-Specific HEDIS Measure Results

Aetna

Aetna's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Aetna submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with Aetna's data processing, integration, and measure production. HSAG determined that Aetna followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for Aetna.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for Aetna (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* and *7–11 Years*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*

Recommendations for Improvement

HSAG recommends that Aetna work closely with Athena and Aetna's HEDIS auditor to ensure the source of each record in the supplemental data set is clearly identified so Aetna can ensure this data source is compliant with audit guidelines.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Aetna (i.e., fell below the 25th percentile):

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Cervical Cancer Screening*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Asthma Medication Ratio—Total*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

HealthKeepers

HealthKeepers' HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that HealthKeepers submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with HealthKeepers' data processing, integration, and measure production. HSAG determined that HealthKeepers followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for HealthKeepers.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for HealthKeepers (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Adult BMI Assessment*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Asthma Medication Ratio—Total*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*

Recommendations for Improvement

HSAG recommends that HealthKeepers work closely with Care Evolution and HealthKeepers' HEDIS auditor to ensure the source of each record in the supplemental data file is clearly identified so HealthKeepers can ensure this data source is compliant with audit guidelines.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for HealthKeepers (i.e., fell below the 25th percentile):

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

Magellan

Magellan's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Magellan submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with Magellan's data processing, integration, and measure production. HSAG determined that Magellan followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for Magellan.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for Magellan (i.e., ranked at or above the 75th percentile):

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Comprehensive Diabetes Care—HbA1c Testing* and *Medical Attention for Nephropathy*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*

Recommendations for Improvement

HSAG recommends that, for future reporting, Magellan review provider specialty mapping to ensure the mappings are compliant with NCQA provider specialty guidelines.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Magellan (i.e., fell below the 25th percentile):

- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

Optima

Optima's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Optima submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with Optima's data processing, integration, and measure production. HSAG determined that Optima followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for Optima.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for Optima (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*

Recommendations for Improvement

HSAG PMV auditors indicated that Optima's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Optima's systems appear to support accurate PM production.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Optima (i.e., fell below the 25th percentile):

- *Adult BMI Assessment*

- *Cervical Cancer Screening*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

United

United's HEDIS auditor found that the MCO was fully compliant with all IS standards; however, the auditor determined that the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure was not reportable and assigned it an audit designation of Biased Rate (BR) due to issues with United's integration of new and historical data. The rates for all other measures were valid and reportable.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with United's data processing, integration, and measure production. HSAG determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for United.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for United (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years*

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*

Recommendations for Improvement

HSAG recommends that United work closely with its vendors and their HEDIS auditor to ensure the data sources are compliant with audit guidelines to be considered as standard supplemental data sources.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for United (i.e., fell below the 25th percentile):

- *Adult BMI Assessment*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Asthma Medication Ratio—Total*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

VA Premier

VA Premier's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that VA Premier submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

Additionally, based on HSAG's validation of PMs, HSAG had no concerns with VA Premier's data processing, integration, and measure production. HSAG determined that VA Premier followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs.

As HEDIS 2019 was the first year of reporting PMs for the CCC Plus MCOs, trending of performance to historical rates was not conducted. Please refer to Section 4 for more information on current year PM results for VA Premier.

Strengths

The following HEDIS 2019 measure rates were determined to be strengths for VA Premier (i.e., ranked at or above the 75th percentile):

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*

Recommendations for Improvement

HSAG PMV auditors indicated that VA Premier's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. VA Premier's systems appear to support accurate PM production.

The following HEDIS 2019 measure rates were determined to be opportunities for improvement for VA Premier (i.e., fell below the 25th percentile):

- *Adult BMI Assessment*
- *Cervical Cancer Screening*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*

Assessment of Follow-Up on Prior Recommendations

As CY 2019 was the first year the PM review activity was completed for the MCO, there were no prior recommendations.

Summary of Strengths, Weaknesses, and Overall Conclusions

Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as five of the MCOs exceeded the 50th percentile for at least three of the four measures related to *Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primacy Care Practitioners*. Of note, HealthKeepers and Optima demonstrated the highest performance within the Access and Preventive Care domain, exceeding the 50th percentile for seven of the nine (77.8 percent) and six of the nine (66.6 percent) measure rates in this domain, respectively.

Cancer screenings for women represents an area for opportunity Virginia-wide, as all reportable rates for the MCOs fell below the 50th percentile for both the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Additionally, all six MCOs were more than 20 percentage points below the 50th percentile for the *Cervical Cancer Screening* measure. Magellan demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for all four of its reportable rates within the domain.

The MCOs demonstrated strength related to the use of medication to treat mental health conditions within the Behavioral Health domain, as all six MCOs exceeded the 50th percentile for at least two of the three measure rates related to medication management (*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and both *Antidepressant Medication Management* indicators), with four of the MCOs exceeding the 50th percentile for all three measures. Within the Behavioral Health domain, VA Premier demonstrated the highest performance, exceeding the 50th percentile for five of the seven (71.4 percent) measure rates that were compared to national percentiles. Follow-up care for behavioral health conditions represents an opportunity for improvement, as no MCO exceeded the 50th percentile for any of the measure indicators related to *Follow-Up After ED Visits for AOD Abuse or Dependence* or *Follow-Up After Hospitalization for Mental Illness* and only one MCO exceeded the 50th percentile for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* measure indicator. Aetna, Magellan, and Optima demonstrated the lowest performance within the Behavioral Health domain, falling below the 50th percentile for four of the seven measure rates that were compared to national benchmarks.

Within the Taking Care of Children domain, MCO performance was the highest for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure, as four MCO rates exceeded the

50th percentile. Conversely, all six MCOs have opportunities for improvement within this domain related to comprehensive well-child/well-care visits, as none of the MCOs' rates for these measures exceeded the 50th percentile. Magellan demonstrated low performance, falling below the 50th percentile and Virginia aggregate for all measure rates in this domain.

MCO performance within the Living With Illness domain was the highest for *Medical Assistance With Smoking and Tobacco Use Cessation*, with only three of the reportable measure rates falling below the 50th percentile. HealthKeepers had the highest performance, with seven of the 13 (53.8 percent) measure rates compared to benchmarks exceeding the 50th percentile, and nine of the 14 (64.3 percent) measure rates exceeding the Virginia aggregate. Conversely, MCO performance was the weakest related to respiratory conditions, as only one MCO exceeded the 50th percentile for both the *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* measures. Additionally, with only 12 of the 36 (33.3 percent) measure rates exceeding the 50th percentile, MCO performance was low for *Comprehensive Diabetes Care*, particularly for the *Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)* indicators in which no MCO rates exceeded the 50th percentile. Optima had the lowest performance among the MCOs in the Living with Illness domain by only exceeding the 50th percentile for three of the 13 (23.1 percent) measure rates.

7. Validation of Performance Improvement Projects

Activity-Specific Findings—Validation of Performance Improvement Projects

This section presents HSAG's findings and conclusions from the EQR validation of PIPs conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs have addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objective

As part of the State's Quality Strategy, each CCC Plus MCO is required to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[7-1] Additionally, HSAG's PIP process facilitates frequent communication with the CCC Plus MCOs. HSAG provides written feedback after each module is validated and provides technical assistance for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while CCC Plus MCOs test interventions.

DMAS requires the CCC Plus MCOs to conduct two PIPs annually. The topics initiated in 2019 were:

- *Follow-Up After Hospital Discharge*
- *Ambulatory Care—Emergency Department Visits*

The topics selected by DMAS addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

For each PIP topic, the CCC Plus MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date.

[7-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 22, 2019.

HSAG provided the following parameters to the CCC Plus MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Approach to PIP Validation

In 2019, HSAG obtained the data needed to conduct the PIP validation from the CCC Plus MCOs' module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Module 1 and Module 2.

The CCC Plus MCOs submitted each module according to the approved timeline. After the initial validation of each module, the CCC Plus MCOs received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the CCC Plus MCO progressed to the next phase of the PIP process.

The goal of HSAG's PIP validation is to ensure that DMAS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities the CCC Plus MCO conducted during the PIP. HSAG's scoring methodology evaluates whether the CCC Plus MCO executed a methodologically sound improvement project and confirmed that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the CCC Plus MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the CCC Plus MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the CCC Plus MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Training and Implementation

HSAG trained the CCC Plus MCOs on the PIP submission and validation requirements prior to the Module 1 and Module 2 submission due date in August 2019. HSAG also trained the CCC Plus MCOs on the Module 3 requirements in September 2019 in advance of the Module 3 submissions for validation.

HSAG's rapid-cycle PIP validation process facilitates frequent communication with the CCC Plus MCOs. HSAG provides technical assistance throughout the process. At the onset, HSAG provides feedback to ensure that PIPs are well-designed. CCC Plus MCOs also have opportunities for mid-course corrections. In addition to the PIP module training webinars that HSAG provides, the CCC Plus MCOs may seek ongoing technical assistance.

PIP Validation Status

At the time of this report, all CCC Plus MCOs achieved the Module 1 and Module 2 validation criteria and progressed to Module 3 to identify potential interventions to test for the PIP. HSAG will report the final validation findings for Module 3 and Module 4 in the next annual report.

Recommendations

The CCC Plus MCOs should address all module validation recommendations in the resubmissions in order to advance to intervention testing for the PIPs as rapidly as possible. Once in the intervention testing phase of the PIP, CCC Plus MCOs should evaluate interventions and determine quickly whether changes need to be made. If an intervention is not working, CCC Plus MCOs should start new interventions and monitor for effectiveness. Interventions should be tested for the PIP through the

SMART Aim end date of December 31, 2020. If CCC Plus MCOs have any questions or need technical assistance with their PIPs, they should reach out to HSAG.

Validation Findings

Aetna

In 2019, Aetna started the following DMAS-selected topics: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-1 displays the SMART Aim for each PIP.

Table 7-1—SMART Aim Statements: Aetna

PIP Title	SMART Aim Statement
Ambulatory Care—Emergency Department Visits	By December 31, 2020, decrease the percentage of African American CCC Plus members in the Central Virginia Region zip code 23223 who have had one ambulatory visit and two or more emergency department visits from 47.3 percent to 43.72 percent.
Follow-Up After Discharge	By December 31, 2020, increase the percentage of members aged 45–64 years old in the Central Virginia region who had a post-hospitalization follow up with a PCP or specialist within 30 days of discharge from 29.4 percent to 36.98 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Aetna should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

HealthKeepers

In 2019, HealthKeepers started the following DMAS-selected topics: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-2 displays the SMART Aim for each PIP.

Table 7-2—SMART Aim Statements: HealthKeepers

PIP Title	SMART Aim Statement
Ambulatory Care—Emergency Department Visits	By December 31, 2020, decrease the percentage of CCC Plus members among the Riverside Regional Center-Brentwood practice who have an emergency department visit from 21.77 percent to 16.24 percent.
Follow-Up After Discharge	By December 31, 2020, increase the percentage of CCC Plus member among the Riverside Regional Medical Center – Brentwood who have a follow-up visit within 30 days after discharge from the hospital, from 62.82 percent to 75 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that HealthKeepers should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Magellan

In 2019, Magellan started the following DMAS-selected topics: *Reduce Emergency Department Visits* and *Increasing Follow-up Visits After Discharge*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-3 displays the SMART Aim for each PIP.

Table 7-3—SMART Aim Statements: Magellan

PIP Title	SMART Aim Statement
Reduce Emergency Department Visits	By December 31, 2020, reduce the rate of members who are high utilizers (>5 emergency department visits in 90 days) of the emergency department, by 5 percentage points from 14.1 percent to 9.1 percent, who are assigned to Dr. Diggs, Dr. Patel and Dr. Bhowmik as a primary care provider.
Increasing Follow-up Visits After Discharge	By December 31, 2020, increase by 6.31 percentage points the rate of inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge in the Central Region from 43.69 percent to 50.0 percent.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Magellan should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Optima

In 2019, Optima started the following DMAS-selected topics: *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* and *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-4 displays the SMART Aim for each PIP.

Table 7-4—SMART Aim Statements: Optima

PIP Title	SMART Aim Statement
Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD Asthma, Bronchitis, or Emphysema	By December 31, 2020, decrease the rate of emergency department visits among adult Optima Health Community Care Tidewater regional members with chronic obstructive pulmonary disease (COPD), asthma, bronchitis or emphysema, by 10% (from 1.90 to 1.71).
Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members	By December 31, 2020, increase the percentage of 30-day ambulatory follow-ups with a practitioner among Optima Health Community Care members residing in the Tidewater region with a hospital discharge by 10% (from 68.57% to 75.43%).

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that Optima should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

United

In 2019, United started the following DMAS-selected topics: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-5 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-5—SMART Aim Statements: United

PIP Title	SMART Aim Statement
Ambulatory Care—Emergency Department Visits	By 12/31/2020, the Virginia UnitedHealthcare Commonwealth CCC Plus plan will decrease the percentage of non–emergent ED visits among the EDCD waiver population, from 198.20 per 1000 members to 188.29.
Follow-Up After Discharge	The Virginia UnitedHealthcare CCC Plus plan will increase the percentage of members in the Tidewater and Roanoke regions that have a follow-up visit within 30 days of discharge from the hospital from 54.13% to 58.23% by 12/31/2020.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that United should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

VA Premier

In 2019, VA Premier started the following DMAS-selected topics: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 7-6 displays the SMART Aim for each PIP at the time of the initial validation.

Table 7-6—SMART Aim Statements: VA Premier

PIP Title	SMART Aim Statement
Ambulatory Care—Emergency Department Visits	By 12/31/2020, decrease the rate of (ED) visits among members 20-44 years old from 127.04 to 112.68.
Follow-Up After Discharge	By 12/31/2020, increase the percentage of follow-up within 30 days after discharge among hospitalized members age 18–64 years old from 70% to 75%.

Conclusions and Recommendations

At the time of this report, there were no results to report. HSAG recommended that VA Premier should:

- Attend all module-specific trainings.
- Identify and test innovative, actionable changes for the PIP.
- Continually monitor the outcomes and make rapid adjustments, as needed.
- Request PIP technical assistance from HSAG as often as needed.

Follow-Up to Prior EQR Recommendations

The CCC Plus MCOs did not submit PIPs to HSAG for validation in 2018; therefore, there were no PIP results or EQR recommendations for follow-up in 2019.

Summary of Strengths, Weaknesses, and Overall Conclusions

In 2019, all CCC Plus MCOs submitted Module 1 and Module 2 for the new DMAS-specified PIP topics. The CCC Plus MCOs developed appropriate PIP teams that were included in the initial submissions of Module 1. At the time of this report, the CCC Plus MCOs achieved all the Module 1 and Module 2 validation criteria and were in the process of completing Module 3 to identify potential interventions for the PIP.

Activity-Specific Findings—Consumer Survey of Quality of Care

Overview

This section presents HSAG's MCO-specific results and conclusions of the member experience of care surveys conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs has addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

The CAHPS surveys were conducted for Virginia's CCC Plus managed Medicaid population to obtain information on the levels of satisfaction of adult and child Medicaid members. For the CCC Plus MCOs (Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs.

These CAHPS surveys were conducted in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements.

MCO-Specific Results

Aetna

Table 8-1 and Table 8-2 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for Aetna were compared to the 2018 NCQA adult and child Medicaid national averages.

Table 8-1—Comparison of 2019 Adult Medicaid CAHPS Results: Aetna

	2019
Global Ratings	
Rating of Health Plan	63.1%
Rating of All Health Care	55.0%

	2019
Rating of Personal Doctor	70.4%
Rating of Specialist Seen Most Often	71.1%
Composite Measures	
Getting Needed Care	87.3%
Getting Care Quickly	83.2%
How Well Doctors Communicate	91.5%
Customer Service	90.8%
Shared Decision Making	77.5%
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.	

Aetna's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna scored statistically significantly higher than the 2018 NCQA adult Medicaid national average on one measure, *Getting Needed Care*.

Table 8-2—Comparison of 2019 Child Medicaid CAHPS Results: Aetna

	2019
Global Ratings	
Rating of Health Plan	65.4%
Rating of All Health Care	65.3%
Rating of Personal Doctor	71.9%
Rating of Specialist Seen Most Often	74.3%
Composite Measures	
Getting Needed Care	86.1%
Getting Care Quickly	92.3%
How Well Doctors Communicate	94.3%
Customer Service	92.6%+
Shared Decision Making	85.4%+
+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results. *Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.*	

Aetna's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna scored statistically significantly higher than the 2018 NCQA child Medicaid national average on one measure, *Shared Decision Making*.

CAHPS Recommendations

- HSAG recommends that Aetna continue to monitor the measures to ensure there are no significant decreases in rates over time.

HealthKeepers

Table 8-3 and Table 8-4 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for HealthKeepers were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-3—Comparison of 2019 Adult Medicaid CAHPS Results: HealthKeepers

	2019
Global Ratings	
Rating of Health Plan	59.3%
Rating of All Health Care	53.7%
Rating of Personal Doctor	68.5%
Rating of Specialist Seen Most Often	72.0%
Composite Measures	
Getting Needed Care	87.0%
Getting Care Quickly	88.2%
How Well Doctors Communicate	91.5%
Customer Service	89.3%
Shared Decision Making	76.4%
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.	

HealthKeepers' 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- HealthKeepers scored statistically significantly higher than the 2018 NCQA adult Medicaid national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Table 8-4—Comparison of 2019 Child Medicaid CAHPS Results: HealthKeepers

	2019
Global Ratings	
Rating of Health Plan	60.2%
Rating of All Health Care	65.0%
Rating of Personal Doctor	77.2%
Rating of Specialist Seen Most Often	70.1%

	2019
Composite Measures	
Getting Needed Care	85.4%
Getting Care Quickly	92.2%
How Well Doctors Communicate	92.8%
Customer Service	79.3%
Shared Decision Making	86.4%

Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

HealthKeepers' 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- HealthKeepers scored statistically significantly higher than the 2018 NCQA child Medicaid national average on two measures: *Getting Care Quickly* and *Shared Decision Making*.
- HealthKeepers scored statistically significantly lower than the 2018 NCQA child Medicaid national average on two measures: *Rating of Health Plan* and *Customer Service*.

CAHPS Recommendations

- HSAG recommends that HealthKeepers focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. HealthKeepers could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that HealthKeepers continue to monitor the measures to ensure there are no significant decreases in rates over time.

Magellan

Table 8-5 and Table 8-6 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for Magellan were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-5—Comparison of 2019 Adult Medicaid CAHPS Results: Magellan

	2019
Global Ratings	
Rating of Health Plan	59.6%
Rating of All Health Care	56.3%
Rating of Personal Doctor	72.5%

	2019
Rating of Specialist Seen Most Often	68.1%
Composite Measures	
Getting Needed Care	80.7%
Getting Care Quickly	79.1%
How Well Doctors Communicate	90.1%
Customer Service	84.8%
Shared Decision Making	76.4%

Magellan's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Table 8-6—Comparison of 2019 Child Medicaid CAHPS Results: Magellan

	2019
Global Ratings	
Rating of Health Plan	62.8%+
Rating of All Health Care	60.3%+
Rating of Personal Doctor	71.3%+
Rating of Specialist Seen Most Often	71.7%+
Composite Measures	
Getting Needed Care	88.4%+
Getting Care Quickly	87.8%+
How Well Doctors Communicate	92.9%+
Customer Service	85.1%+
Shared Decision Making	81.7%+
+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.	

Magellan's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

CAHPS Recommendations

- HSAG recommends that Magellan continue to monitor the measures to ensure there are no significant decreases in rates over time.
- HSAG recommends that Magellan focus on increasing response rates to the CAHPS survey for its child population, so there are greater than 100 respondents for each measure.

Optima

Table 8-7 and Table 8-8 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for Optima were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-7—Comparison of 2019 Adult Medicaid CAHPS Results: Optima

	2019
Global Ratings	
Rating of Health Plan	63.4%
Rating of All Health Care	56.6%
Rating of Personal Doctor	69.4%
Rating of Specialist Seen Most Often	73.5%
Composite Measures	
Getting Needed Care	84.6%
Getting Care Quickly	84.5%
How Well Doctors Communicate	92.0%
Customer Service	90.4%
Shared Decision Making	76.0%
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.	

Optima's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Optima scored statistically significantly higher than the 2018 NCQA adult Medicaid national average on one measure, *Rating of Specialist Seen Most Often*.

Table 8-8—Comparison of 2019 Child Medicaid CAHPS Results: Optima

	2019
Global Ratings	
Rating of Health Plan	65.7%
Rating of All Health Care	62.9%
Rating of Personal Doctor	76.6%
Rating of Specialist Seen Most Often	71.4%
Composite Measures	
Getting Needed Care	85.6%
Getting Care Quickly	91.9%
How Well Doctors Communicate	94.5%

	2019
Customer Service	89.5%
Shared Decision Making	86.6%

Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

Optima's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Optima scored statistically significantly higher than the 2018 NCQA child Medicaid national average on one measure, *Shared Decision Making*.
- Optima scored statistically significantly lower than the 2018 NCQA child Medicaid national average on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

CAHPS Recommendations

- HSAG recommends that Optima focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. Optima could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that Optima continue to monitor the measures to ensure there are no significant decreases in rates over time.

United

Table 8-9 and Table 8-10 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for United were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-9—Comparison of 2019 Adult Medicaid CAHPS Results: United

	2019
Global Ratings	
Rating of Health Plan	63.5%
Rating of All Health Care	54.7%
Rating of Personal Doctor	64.0%
Rating of Specialist Seen Most Often	70.9%
Composite Measures	
Getting Needed Care	84.6%
Getting Care Quickly	82.0%
How Well Doctors Communicate	90.7%

	2019
Customer Service	86.0%
Shared Decision Making	77.5%

United's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Table 8-10—Comparison of 2019 Child Medicaid CAHPS Results: United

	2019
Global Ratings	
Rating of Health Plan	52.6%
Rating of All Health Care	61.1%+
Rating of Personal Doctor	73.5%+
Rating of Specialist Seen Most Often	66.7%+
Composite Measures	
Getting Needed Care	81.3%+
Getting Care Quickly	87.2%+
How Well Doctors Communicate	96.5%+
Customer Service	82.2%+
Shared Decision Making	83.0%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2018 NCQA Medicaid national averages.

United's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- United scored statistically significantly higher than the 2018 NCQA child Medicaid national average on one measure, *How Well Doctors Communicate*.
- United scored statistically significantly lower than the 2018 NCQA child Medicaid national average on one measure, *Rating of Health Plan*.

CAHPS Recommendations

- HSAG recommends that United focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. United could conduct a root cause analysis of study indicators that have been identified as areas of low performance.
- HSAG recommends that United continue to monitor the measures to ensure there are no significant decreases in rates over time.

- HSAG recommends that United focus on increasing response rates to the CAHPS survey for its child population, so there are greater than 100 respondents for each measure.

VA Premier

Table 8-11 and Table 8-12 present the 2019 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2019 CAHPS scores for VA Premier were compared to the 2018 NCQA national adult and child Medicaid averages.

Table 8-11—Comparison of 2019 Adult Medicaid CAHPS Results: VA Premier

	2019
Global Ratings	
Rating of Health Plan	62.3%
Rating of All Health Care	55.4%
Rating of Personal Doctor	73.7%
Rating of Specialist Seen Most Often	68.3%
Composite Measures	
Getting Needed Care	87.8%
Getting Care Quickly	87.9%
How Well Doctors Communicate	90.7%
Customer Service	93.6%
Shared Decision Making	79.4%
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.	

VA Premier's 2019 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier scored statistically significantly higher than the 2018 NCQA adult Medicaid national average on four measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Table 8-12—Comparison of 2019 Child Medicaid CAHPS Results: VA Premier

	2019
Global Ratings	
Rating of Health Plan	67.1%$^{+}$
Rating of All Health Care	63.6%$^{+}$
Rating of Personal Doctor	74.2%$^{+}$
Rating of Specialist Seen Most Often	70.2%$^{+}$

	2019
Composite Measures	
Getting Needed Care	90.2%+
Getting Care Quickly	97.3%+
How Well Doctors Communicate	96.4%+
Customer Service	83.8%+
Shared Decision Making	78.6%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2018 NCQA Medicaid national averages.

VA Premier's 2019 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier scored statistically significantly higher than the 2018 NCQA child Medicaid national average on one measure, *Getting Care Quickly*.

CAHPS Recommendations

- HSAG recommends that VA Premier continue to monitor the measures to ensure there are no significant decreases in rates over time.
- HSAG recommends that VA Premier focus on increasing response rates to the CAHPS survey for its child population, so there are greater than 100 respondents for each measure.

Conclusions and Recommendations

Follow-Up to Prior EQR Recommendations

The CCC Plus MCOs did not conduct member experience of care surveys in 2018; therefore, there were no survey results or EQR recommendations for follow-up in 2019.

Summary of Strengths, Weaknesses, and Overall Conclusions

In 2019, all CCC Plus MCOs demonstrated strength in the adult survey in *Getting Needed Care* (three MCOs scored above the 2018 NCQA adult Medicaid national average) and in the child survey in *Shared Decision Making* and *Getting Care Quickly* (two MCOs scored above the 2018 NCQA child Medicaid national average in each category). An area of weakness identified that two MCOs scored below the 2018 NCQA child Medicaid national average for *Rating of Health Plan*.

Overall, the CCC Plus MCOs should focus on maintaining and improving the members' experience of care as the MCO survey results indicated opportunities for improvement in most domains when compared to the 2018 NCQA child and adult Medicaid national averages. MCO efforts should also focus on improving survey response rates.

Appendix A. Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- Performance Measure Validation Methodology
- CCC Plus Consumer Decision Support Tool Methodology
- Rapid-Cycle PIP Validation Approach Methodology
- CAHPS Survey Methodology

These methodologies have been taken from the final, DMAS-approved versions of their respective reports.

Performance Measure Validation Methodology

Overview

The Virginia Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the Commonwealth of Virginia. DMAS refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). The DMAS CCC Plus Program is an integrated delivery model that includes medical services, behavioral health services, and long-term services and supports (LTSS). DMAS contracts with six privately owned managed care organizations (MCOs) to deliver services to members enrolled in its Medicaid, CHIP and CCC Plus programs. The six MCOs are Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, UnitedHealthcare of the Mid-Atlantic, Inc., Optima Health (Sentara), and Virginia Premier Health Plan, Inc. These six MCOs are contracted for both the Medallion 4.0 and CCC Plus programs.

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described in the Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2). The purpose of performance measure validation (PMV) is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. According to the EQR protocol[A-1] developed by CMS, the mandatory PMV activity may

[A-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: May 22, 2019.

be performed by the State Medicaid agency, an agent that is not an MCO, or an external quality review organization (EQRO).

To meet the PMV requirements, DMAS contracted with Health Services Advisory Group, Inc. (HSAG), under Task D3, G1, and G2 to conduct the PMV for each MCO, validating the data collection and reporting processes used for the calculation of the performance measure rates for the Medallion 4.0 and CCC Plus programs. HSAG has contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures.

Annually, DMAS identifies a set of performance measures that the MCOs are required to calculate and report. Five of the measures selected for the Medallion 4.0 program were selected from the Healthcare Effectiveness Data and Information Set (HEDIS®)[A-2] developed by the National Committee for Quality Assurance (NCQA) and one measure was developed by DMAS. For the CCC Plus program, four measures were NCQA HEDIS measures and two measures were from the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). The measurement period identified by DMAS is measurement year (MY) 2018 (January 1, 2018, through December 31, 2018) for HEDIS and Core set measures and State fiscal year (SFY) 2019 (July 1, 2018, through June 30, 2019) for the one state specific measure for Medallion 4.0. Table A-2 lists the selected performance measures, the method required for data collection, and the specifications that the MCOs were required to use for Medallion 4.0 and CCC Plus.

Objectives

The primary objectives of the PMV process are to evaluate the accuracy of the performance measure data collected by the MCO and determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure. A measure-specific review was performed on a subset of CCC MCO performance measures, all part of quality withhold measures, to evaluate the accuracy of reported performance measure data. PMV results will provide DMAS additional information for MCO quality withhold payments.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities for MCOs, HSAG obtained a list of the performance measures that were selected by DMAS for validation.

[A-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

HSAG then prepared a document request letter that was submitted to the MCOs outlining the steps in the PMV process. The document request letter included a request for source code/software programming or process steps used to generate the performance measure data element values for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timetable for completion, and instructions for submission. HSAG responded to any audit-related questions received directly from the MCOs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with MCOs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from MCOs.

Based on the scope of the validation, HSAG assembled a validation team based on the full complement of skills required for validating the specific performance measures and conducting the PMV for each MCO. The team was composed of a lead auditor and several team members.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data HSAG reviewed and how HSAG conducted an analysis of these data:

- **NCQA's HEDIS 2019 Roadmap:** The MCOs completed and submitted the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** The MCOs completed and submitted an ISCAT for HSAG's review of the required DMAS-developed measures. HSAG used responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs completed the medical record review (MRR) section within the Roadmap. In addition, The MCOs submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data abstracted by the MCOs. HSAG followed NCQA's guidelines to validate the integrity of the MRR processes used by the MCOs and then used the MRR validation results to determine if the findings impacted the audit results for each performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that generated the performance measures using source code were required to submit source code for each performance measure being validated. HSAG completed line-by-line reviews of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree

of bias (if any). MCOs that did not use source code were required to submit documentation describing the steps taken for performance measure generation.

- **Supporting documentation:** HSAG requested documentation that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, and identified issues or areas needing clarification for further follow-up.

On-Site Activities

HSAG conducted an on-site visit with the MCOs. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCO staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT documentation and Roadmap documentation:** The review included processes used for collecting, storing, validating, and reporting performance measure rates. This session was designed to be interactive with key MCO staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes:** The evaluation included a review of the information systems, focusing on the processing of claims, processing of enrollment and disenrollment data, and tracking of changes. HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the performance measures.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each MCO provided a listing of the data that it had reported to DMAS to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS and Core Set measures. HSAG selected a random sample from the submitted data and these records were reviewed live in the MCO's systems during the on-

site review for verification, which provided the MCO an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the MCO. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCOs have system documentation which supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and the on-site visit and revisited the documentation requirements for any post-on-site activities.

Post-On-Site Activities

After the on-site visit, HSAG reviewed any final performance measure data submitted by the MCOs and follow-up with each MCO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issues identified from the rate review was communicated to the MCO as a corrective action as soon as possible so that the data could be revised before the PMV report was issued. HSAG worked closely with DMAS and the MCO if corrected measure data were required.

HSAG prepared a PMV report for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS PMV Protocol identifies possible validation results for performance measures, which are defined in the table below.

Table A-1—Validation Results and Definitions for Performance Measures

Report (R)	Measure data were compliant with DMAS specifications and the data, as reported, were valid.
Not Reported (NR)	Measure data were materially biased.

According to the CMS protocol, the validation result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Reported" (NR). It is possible for a single audit element to receive a validation result of NR when the impact of the error associated with that element biased the reported performance measure rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Report" (R).

Any corrective action that could not be implemented in time was noted in the MCOs' PMV report under recommendations. If the corrective action was closely related to accurate rate reporting, HSAG rendered a particular measure as NR.

Performance Measures List for SFY 2019

The following table lists the performance measures selected by DMAS, the method (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs are required to use.

Table A-2—2018 Performance Measures Selected by DMAS for Validation for Medallion 4.0 and CCC Plus

Performance Measures for Medallion 4.0	Specifications	Methodology
Foster Care Assessments	DMAS	Hybrid*
Adolescent Well-Care Visits	HEDIS	Hybrid
Childhood Immunization Status- combo 3	HEDIS	Hybrid
Children and Adolescents' Access to Primary Care Practitioners	HEDIS	Admin
Prenatal and Postpartum Care	HEDIS	Hybrid
Comprehensive Diabetes Care	HEDIS	Hybrid
* Hybrid refers to a review of both the administrative data system as well as foster care assessments contained in the MCOs' care/case management systems.		

Performance Measures for CCC Plus	Specifications	Methodology
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS	Admin
Follow-up after Emergency Department Visit for Mental Illness	HEDIS	Admin
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	HEDIS	Admin
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admissions rate (PQI05-AD)	ADULT CORE SET	Admin
Comprehensive Diabetes Care	HEDIS	Hybrid
Heart Failure Admissions Rate (PQI08-AD)	ADULT CORE SET	Admin

CCC Plus Consumer Decision Support Tool Methodology

Project Overview

Virginia's Department of Medical Assistance Services (DMAS) contracted with Health Services Advisory Group, Inc. (HSAG) to analyze 2019 Healthcare Effectiveness Data and Information Set (HEDIS®)[A-3] results, including 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-4] data from six Virginia Managed Care Organizations (MCOs) serving the Commonwealth Coordinated Care Plus (CCC Plus) population for presentation in the 2019 CCC Plus Consumer Decision Support Tool. The CCC Plus Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

For this activity, HSAG received the MCOs' CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2019. The *HEDIS 2019 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2019 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Reporting Categories

The CCC Plus Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Doctors' Communication:** Includes adult CAHPS composites and items on consumer perceptions about how well their doctors communicate and shared decision making. This category includes overall ratings of personal doctors and specialists seen most often. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care:** Includes adult CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' and children's access to care. In addition, this category includes HEDIS measures that measure how well MCOs perform related to preventive screenings of body mass index (BMI), breast cancer, and cervical cancer, as well as appropriate treatment for acute bronchitis and low back pain.

[A-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[A-4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- **Behavioral Health:** Includes HEDIS measures that assess how often members receive medications, appropriate care, and follow-up services for mental illness and alcohol and other drug (AOD) abuse or dependence.
- **Taking Care of Children:** Includes HEDIS measures regarding how often preventive services and appropriate treatment are provided to child members (e.g., immunizations, well-child/well-care visits, and metabolic monitoring for children and adolescents on antipsychotics).
- **Living With Illness:** Includes HEDIS measures related to the appropriate treatment for people who have chronic conditions (e.g., diabetes, high blood pressure, chronic obstructive pulmonary disease [COPD]). In addition, this category includes HEDIS measures that assess medication management for people with asthma and schizophrenia or bipolar disorder.

Measures Used In Analysis

DMAS, in collaboration with HSAG, chose measures for this year's CCC Plus Consumer Decision Support Tool based on a number of factors. In an effort to align with the Performance Withhold Program (PWP), the HEDIS measures evaluated as part of the PWP will be included in this analysis, as well as many measures required by the CCC Plus Technical Manual for reporting.[A-5] Per NCQA specifications, the CAHPS 5.0H Adult Medicaid Health Plan Survey instrument was used for the adult population.

Table A-3 lists the 46 measure indicators, nine CAHPS and 37 HEDIS, and their associated weights.[A-6,A-7] Weights will be applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally in the derivation of the final results. Please see section VI for more detail on comparing MCO performance.

Table A-3—MCO CCC Plus Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Category: Doctors' Communication	
Adult Medicaid—*How Well Doctors Communicate* (CAHPS Composite)	1
Adult Medicaid—*Shared Decision Making* (CAHPS Composite)	1

[A-5] Virginia Department of Medical Assistance Services. *CCC Plus Technical Manual*. Version 2.6. Available at: https://www.dmas.virginia.gov/files/links/4543/CCC%20Plus%20Technical%20Manual%20(Version%202.6).pdf. Accessed on: Sept 5, 2019.

[A-6] Several child measures, including all child CAHPS results and some HEDIS measure indicators (*Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *Childhood Immunization Status—Combination 3*, *Immunizations for Adolescents—Combination 2*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*, and *Well-Child Visits in the First 15 Months of Life*) were excluded from the 2019 CCC Plus Consumer Decision Support Tool based on insufficient data reported by half of the MCOs. These measures will be reevaluated for inclusion in a future CCC Plus Consumer Decision Support Tool.

[A-7] The *Medication Management for People With Asthma* measure was not included in the analyses as this measure is no longer endorsed by the National Quality Forum (NQF). Additionally, two HEDIS measures are being retired in 2020 (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* and *Annual Monitoring for Patients on Persistent Medications*); therefore, these measures were excluded from the 2019 CCC Plus Consumer Decision Support Tool.

Measures	Measure Weight
Adult Medicaid—*Rating of Personal Doctor* (CAHPS Global Rating)	1
Adult Medicaid—*Rating of Specialist Seen Most Often* (CAHPS Global Rating)	1
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3
Discussing Cessation Strategies	1/3
Category: Access and Preventive Care	
Adult Medicaid—*Getting Needed Care* (CAHPS Composite)	1
Adult Medicaid—*Getting Care Quickly* (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	1/3
45–64 Years	1/3
65+ Years	1/3
Children and Adolescents' Access to Primary Care Practitioners	
25 Months–6 Years	1/3
7–11 Years	1/3
12–19 Years	1/3
Adult BMI Assessment	1
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	1
Use of Imaging Studies for Low Back Pain	1
Breast Cancer Screening	1
Cervical Cancer Screening	1
Category: Behavioral Health	
Initiation and Engagement of AOD Dependence Treatment	
Initiation of AOD Treatment—Total	1/2
Engagement of AOD Treatment—Total	1/2
Follow-Up After Emergency Department (ED) Visit for AOD Dependence—30-Day Follow-Up—Total	*1*
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	*1*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	*1*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	*1*
Antidepressant Medication Management	

Measures	Measure Weight
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Category: Taking Care of Children	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	*1*
Adolescent Well-Care Visits	*1*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	1
Category: Living With Illness	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	1/6
HbA1c Poor Control (>9.0%)	1/6
HbA1c Control (<8.0%)	1/6
Eye Exam (Retinal) Performed	1/6
Blood Pressure Control (<140/90 mm Hg)	1/6
Medical Attention for Nephropathy	1/6
Controlling High Blood Pressure	1
Asthma Medication Ratio—Total	1
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	1/2
Bronchodilator	1/2
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1

Missing Values

In general, HEDIS and CAHPS data contain three classes of missing values:

- *Not Reported (NR)*—MCOs chose not to submit data, even though it was possible for them to do so.

- *Biased Rate (BR)*—MCOs' measure rates were determined to be materially biased in a HEDIS Compliance Audit™.[A-8]
- *Not Applicable (NA)*—MCOs were unable to provide a sufficient amount of data (e.g., too few members met the eligibility criteria for a measure).

In developing scores and ratings for the reporting categories, HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned the minimum rate.
- Rates with a *BR* designation were assigned the minimum rate.
- Rates with an *NA* designation were assigned the average value.

For measures with an *NA* audit result, HSAG used the mean of non-missing observations across all MCOs. For measures with an *NR* or *BR* audit result, HSAG used the minimum value of the non-missing observations across all MCOs. This minimized the disadvantage for MCOs that were willing but unable to report data and ensured that MCOs did not gain advantage from intentionally failing to report complete and accurate data. If half of the plans had an *NR, BR,* or *NA* for any measure, then the measure was excluded from the analysis.

For MCOs with *NR, BR,* and *NA* audit results, HSAG used the average variance of the non-missing observations across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.

Additionally, HSAG replaced missing values where an MCO reported data for at least 50 percent of the indicators in a reporting category. If an MCO was missing more than 50 percent of the measures that comprised a reporting category, HSAG gave the MCO a designation of "Insufficient Data" for that category.

Comparing MCO Performance

HSAG computed five summary scores for each MCO, as well as the summary mean values for the MCOs as a group. Each score was a standardized score where higher values represented more favorable performance. Summary scores for the five reporting categories (Doctors' Communication, Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG combined the top-box responses (i.e., "Usually/Always," "9/10," and "Yes", where applicable) for each individual question as described in *HEDIS 2019 Volume 3:*

[A-8] NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

Specifications for Survey Measures. The combined responses were then modified to either a 0 or 1 to calculate the plan average percentage for each CAHPS item.

2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

$$\frac{p_k(1-p_k)}{n_k-1}$$

where: p_k = MCO k score
n_k = number of members in the measure sample for MCO k

For CAHPS global rating measures, the variance was calculated as follows:

$$\frac{1}{n}\frac{\sum_{i=1}^{n}(x_i-\bar{x})^2}{n-1}$$

where: x_i = response of member i
$\bar{x}$ = the mean score for MCO k
n = number of responses in MCO k

For CAHPS composite measures, the variance was calculated as follows:

$$\frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\bar{x}_j)}{n_j}\right)^2$$

where: j = 1,…,m questions in the composite measure
i = 1….,n_j members responding to question j
x_{ij} = response of member i to question j (1, 2, or 3)
$\bar{x}_j$ = MCO mean for question j
N = members responding to at least one question in the composite

3. For MCOs with *NA* and *NR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category rating.
6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO *k*, HSAG calculated the category variance, CV_k, as: $CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$

where: j = 1,…,m HEDIS or CAHPS measures in the summary

V_j = variance for measure j

c_j = group standard deviation for measure j

w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MCO summary measure scores. The difference score, d_k, was calculated as d_k = MCO k score – group mean.

9. For each MCO k, HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

$$Var(d_k) = \frac{P(P-2)}{P^2} CV_k + \frac{1}{P^2} \sum_{k=1}^{P} CV_k$$

where: P = total number of MCOs

CV_k = category variance for MCO k

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI and 68 percent CI were calculated around each difference score to identify plans that were significantly higher than or significantly lower than the mean. Plans with differences significantly above or below zero at the 95 percent confidence level received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. Plans with differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent confidence level, received High Performance and Low Performance designations, respectively. A plan was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. Plans that do not fall either above or below zero at the 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formulas for calculating the CIs were:

$$95\%\ CI = d_k \pm 1.96\sqrt{Var(d_k)}$$

$$68\%\ CI = d_k \pm \sqrt{Var(d_k)}$$

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs. The CCC Plus Consumer Decision Support Tool displays results for each MCO as follows:

Table A-4—2019 CCC Plus Consumer Decision Support Tool–Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.

Rating	MCO Performance Compared to Statewide Average	
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Deliverables

For the 2019 CCC Plus Consumer Decision Support Tool activity, HSAG provided DMAS with the following deliverables:

- Results report displaying star ratings and NCQA accreditation status levels for each MCO (i.e., Excellent, Commendable, Accredited, Provisional, or Interim) for DMAS to post on its website for public comment.
- Individual measure rates and summary results for each MCO in Microsoft Excel file format.

HSAG's Rapid-Cycle PIP Validation Approach Methodology

HSAG's PIP approach guides CCC Plus plans through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change should require fewer resources and allow more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, CCC Plus plans have an opportunity to determine the effectiveness of changes prior to expanding successful interventions. HSAG developed a series of five modules that CCC Plus plans complete as they progress through the PIP.

Module 1—PIP Initiation

The objective of this module is to ask and answer the first fundamental question of the Model for Improvement: "What are we trying to improve?" In Module 1, CCC Plus plans outline the project's framework. The framework includes the topic rationale, data supporting the need to improve the selected topic, members who make up the PIP team, and the key driver diagram that defines the aim, factors that influence achievement of the aim, and interventions that can lead to the desired improvement.

Module 2—SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim Data Collection

The objective for this module is to ask and answer the second fundamental question of the Model for Improvement: "How will we know that a change is an improvement?" In Module 2, CCC Plus plans define how and when it will be known that improvement is happening. CCC Plus plans define the SMART Aim measure, data collection methodology, data collection plan, and develop a SMART Aim measure run chart.

Module 3—Intervention Determination

The objective for this module is to ask and answer the third fundamental question of the Model for Improvement: "What changes can we make that will result in improvement?" In Module 3, CCC Plus plans identify potential interventions that can impact the SMART Aim using quality improvement activities. The MCO's PIP team employs a step-by-step process that uses process mapping and failure modes effect analysis (FMEA) to determine interventions that may be tested using Plan-Do-Study-Act (PDSA).

Module 4—PDSA

In Module 4, CCC Plus plans test interventions that have the potential to impact the SMART Aim using PDSA cycles. CCC Plus plans document details about the change and an evaluation plan. Based on testing, CCC Plus plans analyze the data and summarize results. CCC Plus plans subsequently determine what needs to be done with the intervention based on what was learned from the test (i.e., adopt, adapt, abandon, continue testing). CCC Plus plans complete a Module 4 submission form for each intervention that it tests for the PIP.

Module 5—PIP Conclusions

In Module 5, CCC Plus plans summarize key findings, comparison of successful and unsuccessful interventions, and outcomes. CCC Plus plans synthesize all data collected, information gathered, and lessons learned to document the impact of the PIP and to consider how any demonstrated improvement can be shared and used as a foundation for further improvement going forward. CCC Plus plans submit the PIP's final key driver diagram, SMART Aim run chart with mapped interventions, and FMEA. Additionally, the MCO will update Module 3's intervention determination table if it selected an intervention to test in Module 4 that was not identified in Module 3.

PIP Validation Overview

HSAG's methodology for validating PIPs is a consistent, structured process that uses standardized scoring. HSAG validates PIPs annually to the point of progression using criteria that it developed to align with CMS PIP validation protocols and rapid-cycle improvement principles. The validation process determines if DMAS and other key stakeholders can have confidence in the CCC Plus plans' reported PIP results.

HSAG provides DMAS and the CCC Plus plans with a PIP Validation Tool for each submitted module that consists of validation criteria necessary for successful completion of a valid PIP. HSAG scores the criteria as *Achieved* or *Not Achieved* and provides detailed written feedback and recommendations. HSAG provides general comments for achieved criteria when enhanced documentation would demonstrate a stronger application of the PIP requirements. HSAG also provides annual MCO-specific PIP Validation Reports that include the validation findings and recommendations for improvement.

CAHPS Survey Methodology

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in Aetna, Anthem, Magellan, Optima, United, and VA Premier with their MCO and healthcare experiences.

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the CCC Plus MCOs, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[A-9] The mode of CAHPS survey data collection varied slightly among the MCOs. Anthem, Magellan, United, and VA Premier used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. Aetna used an enhanced Internet mixed-mode methodology for their adult and child populations. Optima used an enhanced Internet mixed-mode methodology of data collection for its adult Medicaid members and a mixed-mode methodology for its child Medicaid members. Following NCQA's standard HEDIS timeline, adult members and

[A-9] Anthem, Magellan, Optima, and United administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.0H Child Survey without the CCC measurement set. For purposes of this report, the child Medicaid CAHPS results presented for Anthem, Magellan, Optima, and United represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2019.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[A-10] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (53 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey, 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions [CCC] measurement set, and 83 items for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[A-11] These measures included four global ratings and five composite scores. The global ratings reflected members' overall experience with their health plan, all healthcare, personal doctor, and specialist. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A top-box response or top-box score for the composite measures was defined as a response of "Usually/Always" or "Yes."

The 2019 CAHPS scores for each MCO and the statewide aggregate were compared to the 2018 NCQA Medicaid national averages.[A-12] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national

[A-10] Aetna contracted with the Center for the Study of Services (CSS); Anthem, Magellan, and United contracted with DSS Research; and Optima and VA Premier both contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

[A-11] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[A-12] Quality Compass 2018 data serve as the source for the 2018 NCQA CAHPS adult Medicaid and child Medicaid national averages.

average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

It is important to note that NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2019 for the CCC Plus MCOs.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.0H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 24, 28, and 35. For the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. For the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 30, 45, 49, and 54. Eligible members included the entire sample minus ineligible members. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.