

Department of Medical Assistance Services 2014 Managed Care Annual Report

Measurably Better Care, Quality, and Value Through Partnerships

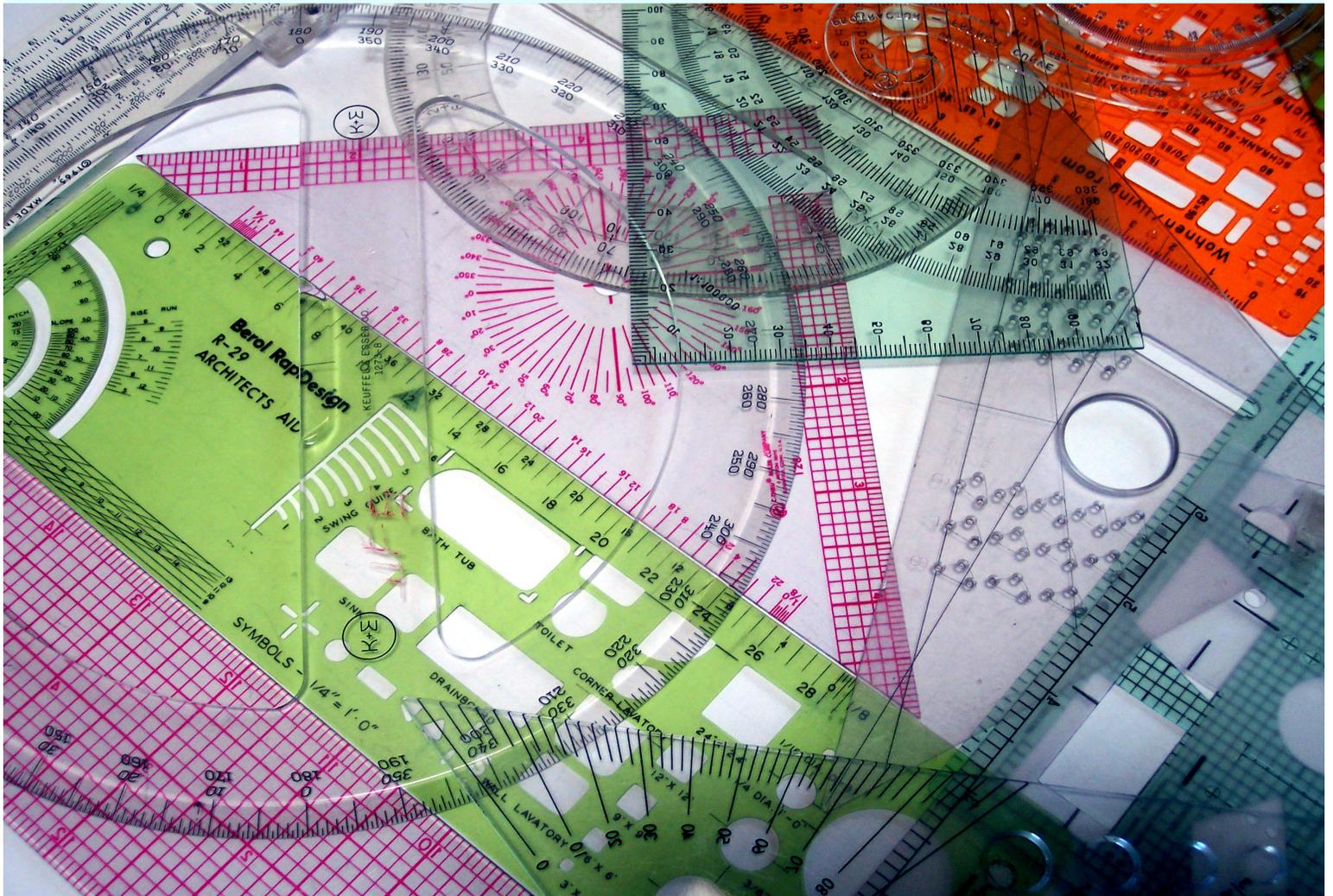


TABLE OF CONTENTS

Introduction	4
Exemplars	5
Virginia’s Medicaid Managed Care Organizations (MEDALLION II)	6
Managed Care at a Glance	7
Medallion History	8
Medallion 3.0	9
Managed Care Technical Manual	10
Program Integrity and Performance Management	11
Foster Care and Adoption Assistance	13
Medallion Care System Partnership (MCSP)	14
Coordinated Care Programs	15
Expedited Enrollment	16
Performance Incentive Program	17
Partnership Platforms	18
Managed Long-Term Acute Care	19
Quality Management	20
Quality Compliance	21
Quality Performance Measures	22
Managed Care Organization Highlights	23

The Health Care Services division would like to acknowledge the hard work and dedication of the Department of Medical Assistance Services divisions of Maternal, Child and Health, Program Operations, Policy, Provider Reimbursement, and Program Integrity, and of the Managed Care Organizations, all of whom, over the past year, played a significant role in helping us achieve Agency and legislative goals.

The success of the Health Care Services division is driven by strong, effective partnerships. It's because of your partnership and commitment to serving the Commonwealth's most vulnerable citizens that our year was successful.

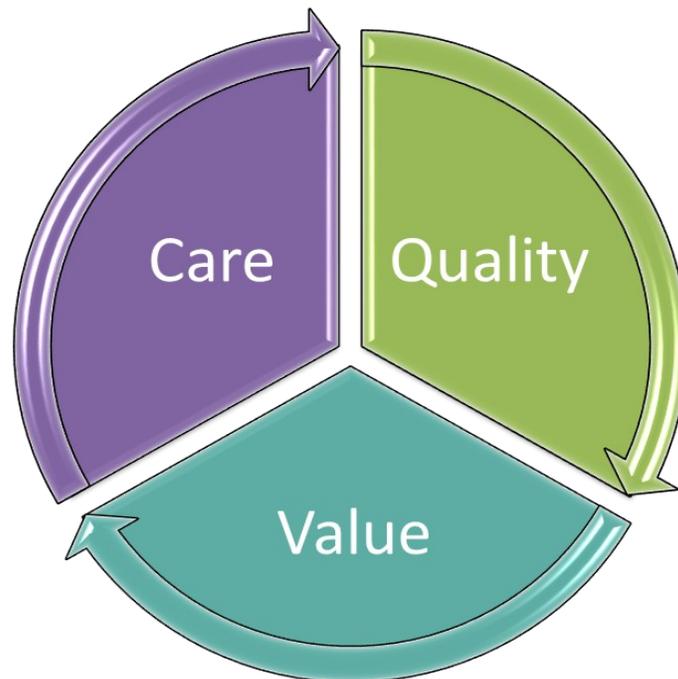
Thank you,

Health Care Services Division

This *Managed Care Annual Report* serves to highlight the progress the Department of Medical Assistance Services (DMAS) and the Managed Care Organizations (MCOs) made over the past year in the provision of health care services to beneficiaries of Medicaid and the Children’s Health Insurance Program (CHIP), also known as Family Access to Medical Insurance Security (FAMIS) in Virginia. This document further serves to provide background information for a more in-depth understanding of the Health Care Services (HCS) division.

MCOs provide access to healthcare services to Medicaid beneficiaries in the Commonwealth of Virginia. Health Care Services (HCS), a division of DMAS, is responsible for the administration and oversight of the Medicaid Managed Care program delivered through the MCOs.

Medicaid Managed Care is driven by excellence in care, quality and value.



Highlights

MEDALLION 3.0

- New Medallion 3.0 Contract & Technical Manual Reformed and Improved Member Access, Data Accountability and Oversight

PHARMACY

- MCO Pharmacy Rebates Yielded \$570 Million since 2010

Program Integrity

- For FY 2012, VA Medicaid Managed Care Payment Error Rate was less than 1%

FOSTER CARE

- 10,000 Children in Foster Care and Adoption Assistance Programs Have Improved Healthcare Access, Preventative Services & Care Coordination via Medicaid Managed Care Program

MEDICAL HOME

- Medallion Care System Partnership (MCSP) – Member Access to Improved and Increased Integrated Service Programs of Care

QUALITY INCENTIVES

- Performance Measure Incentive Program - Financial Incentives for Exceptional Provider Service Quality and Performance Outcomes

PATIENT FOCUSED

- 90% of Children in the Medicaid Managed Care Program Saw Their Primary Care Physician in 2013

Virginia's Medicaid Managed Care Organizations



Managed Care at a Glance

MCOs provide access to health care benefits, preventative care and care coordination for the majority of all Medicaid beneficiaries in the Commonwealth of Virginia. The division of Health Care Services (HCS) is responsible for the administration and oversight of the Medicaid Managed Care services delivered through the MCOs. Additional responsibilities of the division are the administration and oversight of the agency's dental program - *Smiles For Children* and the Fee-For-Service Pharmacy program.

It is a well-known fact that the costs of healthcare have skyrocketed over the past decade and that the cost of Medicaid healthcare services are similarly increasing. The main drivers of Medicaid budget growth are health care costs, increases in enrollment, and service utilization of long term care and behavioral health services. Virginia Medicaid grew 58% percent over the last decade and now consequently represents 22.1% of the total state budget.¹ Today, the Department's Managed Care program provides Medicaid healthcare benefits to over [70% of Medicaid member population, while accounting for 30% of the total cost.](#)²

The focus of managed health care is [prevention](#) and [early appropriate care](#). MCOs are at full, financial risk in an actuarially sound, capitated rate structure (per member, per month) through an annually negotiated contract with the Department. All incurred costs above the annual capitated rate are paid by the MCOs assuring [cost predictability](#) and [cost control](#) for Virginia.

The MCOs ensure the provision of patient-centered, high-quality care and services while providing accountable, cost-predictable Medicaid value for the Commonwealth. Improving member health and service effectiveness keeps members thriving and the cost of care manageable for the Commonwealth.



¹ & ²Division of Budget and Contract Management, Department of Medical Assistance Services

MEDALLION II: Measurably Better Through Partnerships for 18 years

The Medicaid Managed Care program began in 1992 as a Primary Care Case Management (PCCM) delivery system and was called the MEDALLION program. The PCCM program was the first managed care delivery system for Medicaid beneficiaries in Virginia. The MEDALLION program was based upon the concept of building ongoing relationships between providers and Medicaid recipients.

The MEDALLION II (MII) program was developed as a way to offer managed Medicaid benefits through private health plans or Managed Care Organizations (MCOs) through a public/private partnership with the Department. MII began in 1996 in seven localities of the Tidewater region in the midst of rapid and, often, controversial changes to State and Federal policies that directly and positively impacted the perceptions of lawmakers, providers, and Medicaid recipients – regarding managed care.

The MII program underwent numerous geographic expansions from 1997 until 2012 when the program began service in final expansion localities of Southwest Virginia making the program available in all 95 counties and 39 cities across the Commonwealth of Virginia. With the option of two or more health plan choices in every locality through the MII program, the original MEDALLION (PCCM) model was dissolved and MII remained as the Department's single managed care program.

MII has experienced other types of expansions, such as the addition of a new health plan option in specific regions or localities and the addition of two brand new health plans in 2013: INTotal and Kaiser Permanente. Despite these types of set backs, the MII program remains strong due to collective dedication and 18 years of strong, effective partnership between the Department and the MCOs.

Medallion 3.0

In 2013 the managed care contract was significantly revised and reorganized. In recognition of the substantial improvements and evolution of the MEDALLION II contract and program, the Department is implementing a program name change. Beginning July 1, 2014, the Medicaid managed Care program will be called:



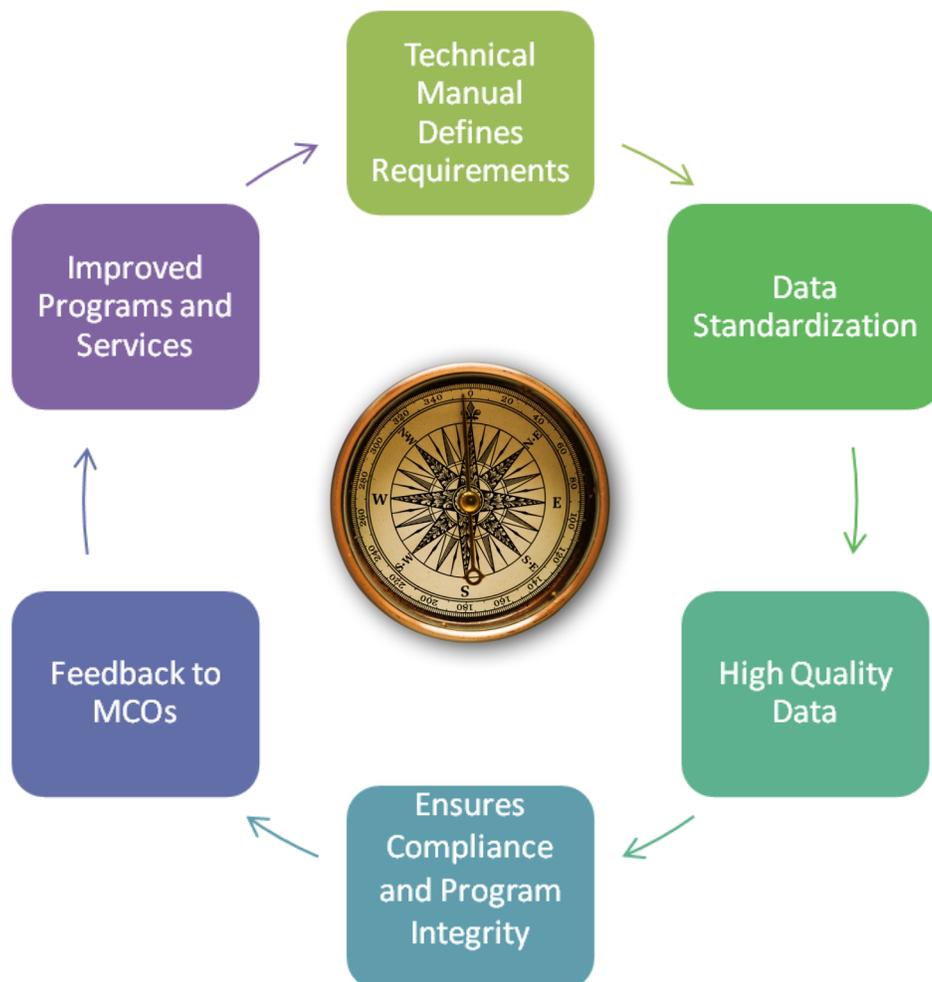
MEDALLION 3.0 reflects the progression of Virginia's managed care delivery and the Commonwealth's focus on improvement in the provision of the high-quality health care to Virginia's Medicaid members.

The Department seeks continued improvements to access and quality for Medicaid services being provided through the health plans. Program improvements, implemented by the HCS team, and revisions to the Medicaid Managed Care contract aim to enhance the overall managed care program with a special focus on access, quality and accountability. Program areas improved over the past year include Program Integrity and Quality Management. Improvements to the contract and program allow for increased program accountability, flexibility and transparency of operations.

Managed Care Technical Manual

The new *Managed Care Technical Manual* was created as a companion document to the Managed Care Contract. The *Technical Manual* communicates standardized requirements to the MCOs regarding encounter data submissions (medical claims paid by MCOs on behalf of Medicaid members). Encounter data is vital to agency operations and may be used for program integrity investigations, pharmacy rebate collection, rate setting, focused quality studies, and reporting to CMS.

The *Managed Care Technical Manual* contains extensive documentation for contract deliverables in the managed care contract. In conjunction with the implementation of the *Technical Manual*, DMAS established secure file transfer capability with each MCO and developed an automated process to assess the MCOs' data submissions.



Program Integrity

Ensuring Program Integrity Through Measurable Accountability

Program Integrity (PI) is the collective term given to activities conducted by the Department of Medical Assistance Services (DMAS) to ensure Medicaid dollars are spent effectively and appropriately. The Program Integrity Division (PID) supports the integrity efforts of the Health Care Services (HCS) division and the Managed Care Organizations (MCOs). Representatives from both divisions serve as DMAS liaisons to the MCOs. These staff evaluate the adequacy of MCO's program integrity policies, procedures and outcomes. Recent changes to the contract have improved the accuracy, consistency and standardization of MCO reports on PI outcomes and clarified the process for reporting cases of potential fraud.

Program Integrity Compliance Audit

The Program Integrity Compliance Audit (PICA) is an annual audit completed by each MCO in an evaluation process of their compliance efforts to prevent, detect and address fraud, waste and abuse. The PICA also serves as a platform for the MCOs to formally showcase their PI best practices. Additionally, the Department ensures that MCO's PI processes and protocols are in compliance by conducting annual desk-top assessments as another quality assurance measure. Due to improved standardization of reporting methods, assessing MCO's PI and compliance is more effective than ever before.

Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU), at the Attorney General's Office, investigates and prosecutes Medicaid fraud, patient abuse and neglect in health care facilities. Through a referral process, defined in the managed care contract, the MCOs make MFCU referrals to DMAS. The Department streamlined the referral process in order to enhance efforts toward the detection of fraud, waste and abuse. These measures allow the Department to suspend payments and recoup money when MFCU determines that an allegation of fraud is credible.

Program Integrity (continued)

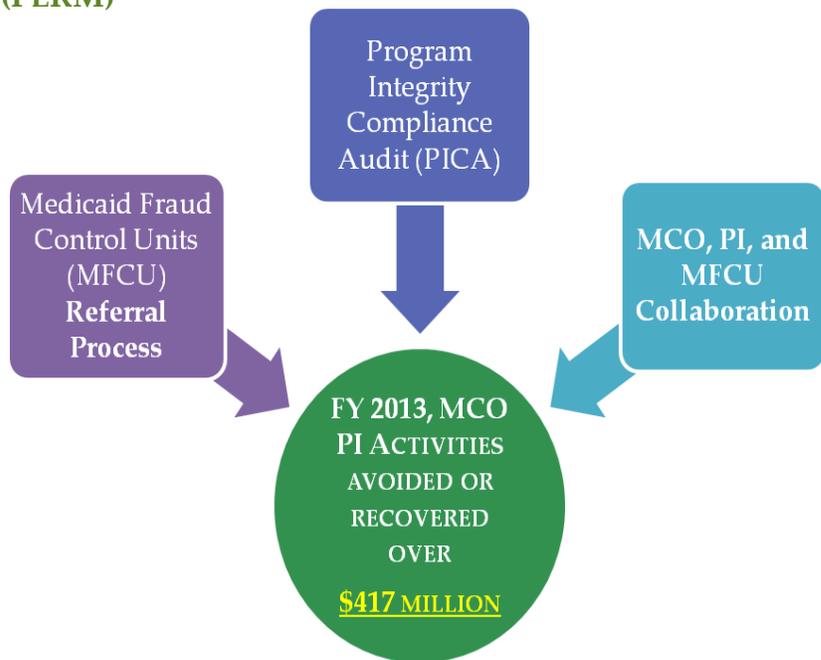
DMAS holds quarterly **Managed Care Program Integrity Collaborative** meetings with PI staff from the MCOs, HCS, PID and the Medicaid Fraud Control Unit (MFCU) of the Attorney General’s Office. MFCU investigates and prosecutes Medicaid fraud, patient abuse and neglect in healthcare facilities. The comprehensive partnership approach to fraud and abuse prevention also provides a platform where the participating organizations may share information about their PI processes and may collaborate on opportunities for improvements in PI efforts.

The **Managed Care Program Integrity Collaborative** was identified as a national **Best Practice Collaborative** by the Centers for Medicare & Medicaid Services in their 2012 Annual Summary Report of Comprehensive Program Integrity Reviews. The Department’s executive management presented the model at a variety of national conferences and to other state Medicaid agency personnel. **DMAS is one of six states to have a single deputy or executive officer over both the PI and Managed Care programs at the same time.** The strength of this organizational structure is the assurance of full cooperation between the PID and Health Care Services divisions in carrying out Department goals for program integrity.

Payment Error Rate Measure (PERM)

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. It is important to note the error rate is not a “fraud rate” but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements.

The National average PERM is 6.1%. For FY 2012, the Medicaid Managed Care program PERM was less than 1%.



Foster Care & Adoption Assistance

Ensuring Better Quality Care and Value for 10,000 Foster Care Children

In alignment with the Department's mission to ensure that children with "special health care needs" receive access to high-quality care and preventative services and as part of the Commonwealth's focus on care coordination, the Governor and the 2012 Virginia General Assembly allowed the Department to expand the enrollment of children in the foster care (FC) and adoption assistance (AA) programs into managed care. This initiative is an extension of the highly successful pilot program introduced in 2011 when children in the Richmond City Department of Social Services foster care program were enrolled into the Medicaid Managed Care program.

The FC and AA into Managed Care expansion process included extensive efforts by

- **Multiple State Agencies**—DMAS, Virginia Department of Social Services (VDSS), Local Departments of Social Services (LDSS)
- **DMAS Contractors**—MCOs, Maximus (enrollment broker), KEPro (service authorizations), and Xerox
- **Countless** stakeholders, advocacy groups, providers and parents.

Over [300 professionals](#) from all participating entities worked to ensure a smooth, phased-in transition for the implementation. Staff from the Department's Maternal and Child Health, Health Care Services, and Program Operations (Eligibility and Enrollment units) divisions; local and regional DSS staff and all Medicaid Managed Care MCOs played a vital role in the planning and implementation of the expansion. The transition was favorably received by all parties involved in the complex process.

Across the state of Virginia, DMAS held [70 on-site trainings](#) for all [95 counties and 38 cities](#) for FC and AA case managers, eligibility workers, parents, and placement agency personnel. System changes, training sessions, monthly stakeholder conference calls and forums were provided by the multi-organizational team. Representatives from all seven MCOs were at every training session to answer questions and to provide information about their health plan. Further, each MCO assigned a special liaison to assist, resolve urgent matters and to be available to FC and AA case workers and parents. The MCO presence at every training and information session proved to be an invaluable resource.

From the 300 children in the FC pilot group, [over 10,000 FC and AA children now have access to coordinated healthcare](#). The enrollment transition was completed on June 1, 2014.



MCSP and Integrated Care Model

Better Care, Quality and Value through Integrated Care and Medical Homes

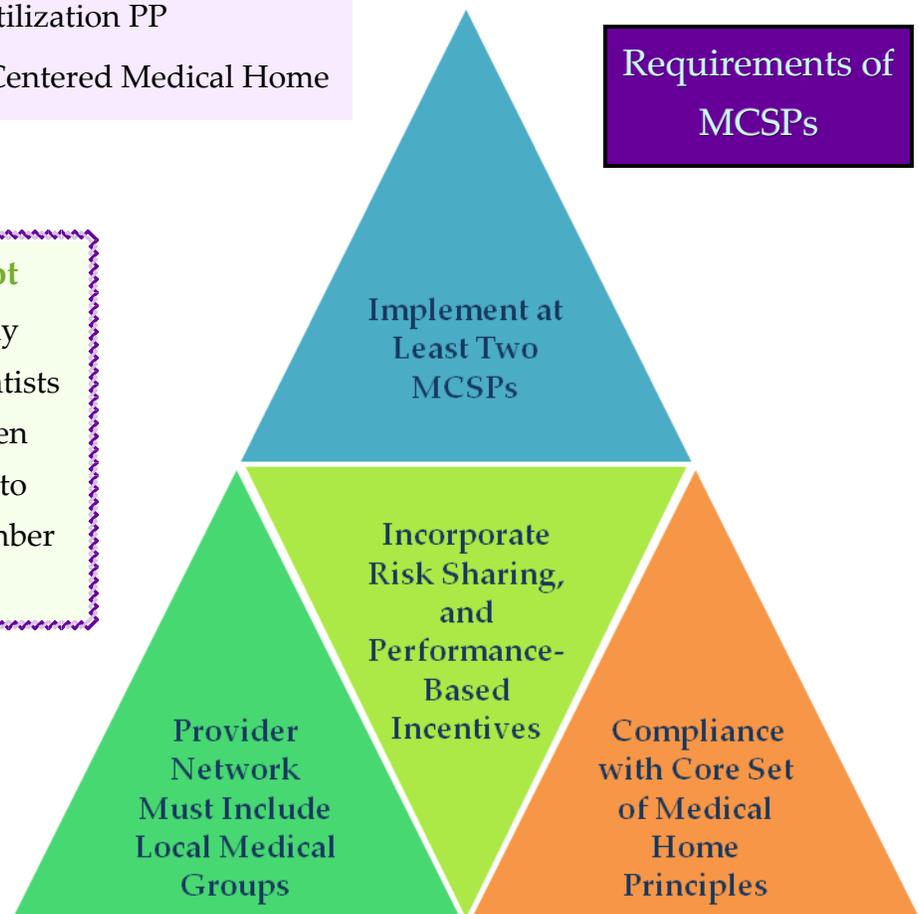
To improve quality of service and encourage cost savings, HCS launched the Medallion Care System Partnership (MCSP) through the new Managed Care Contract in 2013 aligning with the MIRC reform call to link payment and reimbursement to quality and cost containment. The MCSP pilot program was established to improve member health and encourage provider partnerships and participation in innovative approaches to integrated health care service, also known as *Medical Homes*.

The Medical Home model of care integrates service delivery of primary, acute and complex health services providing continuous patient-centered, coordinated and comprehensive health care with select providers.

Current MCSPs at Work:

- Asthma Improvement Pay for Performance (PP)
- Diabetes Improvement PP
- Behavioral Health/Medical Care Coordination
- Asthma, Diabetes, ER Utilization PP
- Wholly-owned Patient Centered Medical Home

Early Dental Home Pilot Program: Establishes early relationships between dentists and the Smiles For Children dental program members to address all aspects of member oral health care.



Coordinated Care Programs

Ensuring Better Quality Care and Value through Care Coordination

In alignment with the Medicaid Innovation and Reform Commission goals, the Department seeks to further develop integrated coordinated care programs to serve Medicaid beneficiaries. Below are three such innovative programs providing care coordination services.

[Commonwealth Coordinated Care \(CCC\)](#)

The Integrated Care (IC) division of the Department oversees the implementation and administration of the new pilot initiative - Commonwealth Coordinated Care (CCC) program. The mission of the CCC is to provide Virginians high quality healthcare and supports by coordinating the benefits of Medicare and Medicaid into a single, person-centered program. The program coordinates care and services through MCOs for eligible individuals who are beneficiaries of both Medicare and Medicaid. The program is designed to be the single entity accountable for coordinating delivery of primary, preventive, acute, behavioral, and long-term care services and supports. The Commonwealth Coordinated Care demonstration project began April 1, 2014 and will continue through December 31, 2017. The MCOs who administer the pilot program are: HealthKeepers Plus, Humana, and Virginia Premier.



[Behavioral Health Services Administrator](#)

Magellan Behavioral Health of Virginia now serves as the Behavioral Health Services Administrator (BHSA) for the Department as of December 1, 2013. Magellan administers all behavioral healthcare services for the Medicaid Fee-For-Service members. The organization provides only non-traditional behavioral health services for members enrolled in the Managed Care programs. The MCOs work in a close partnership with Magellan to ensure continuity of behavioral health care and services.

[PACE](#)

The Program of All-Inclusive Care for the Elderly (PACE) was established in 2007 to assist qualifying adults, age 55 and over, to remain living in their homes. The Program of All-inclusive Care for the Elderly (PACE) is centered on the belief that it is best for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE services are all coordinated through an inter-disciplinary team (IDT) with the full involvement of the individual and their family/ significant other. Services are designed and delivered in a personal manner taking care of the individual's complete medical and supportive care. There are currently 14 PACE sites in Virginia.



Expedited Enrollment

Ensuring Better Care through Expedited Enrollment

After more than a year in the planning and development process, the HCS team expects that beginning August 1st all members who qualify for enrollment into our Medicaid Managed Care program will experience the new Expedited Enrollment process.

Expedited Enrollment shortens the period between Medicaid eligibility determination and enrollment into a health plan. This enrollment process provides faster member access to care coordination, case management, 24-hour nurse advice lines, enhanced provider networks and specialty care.

The new process streamlines the process of enrolling into an MCO while providing adequate time to select and/or change plans. Additional changes were made to reduce enrollment disruption. Members who change addresses will receive notification of all plans available in the new locality and are given the opportunity to change plans while maintaining coverage.



Easy and fast return to plan after an enrollment change

Decreased care disruptions and enrollee confusion



Provides generous time to select plan

Stops disenrollment due to address (FIPS) changes



Performance Incentive Program

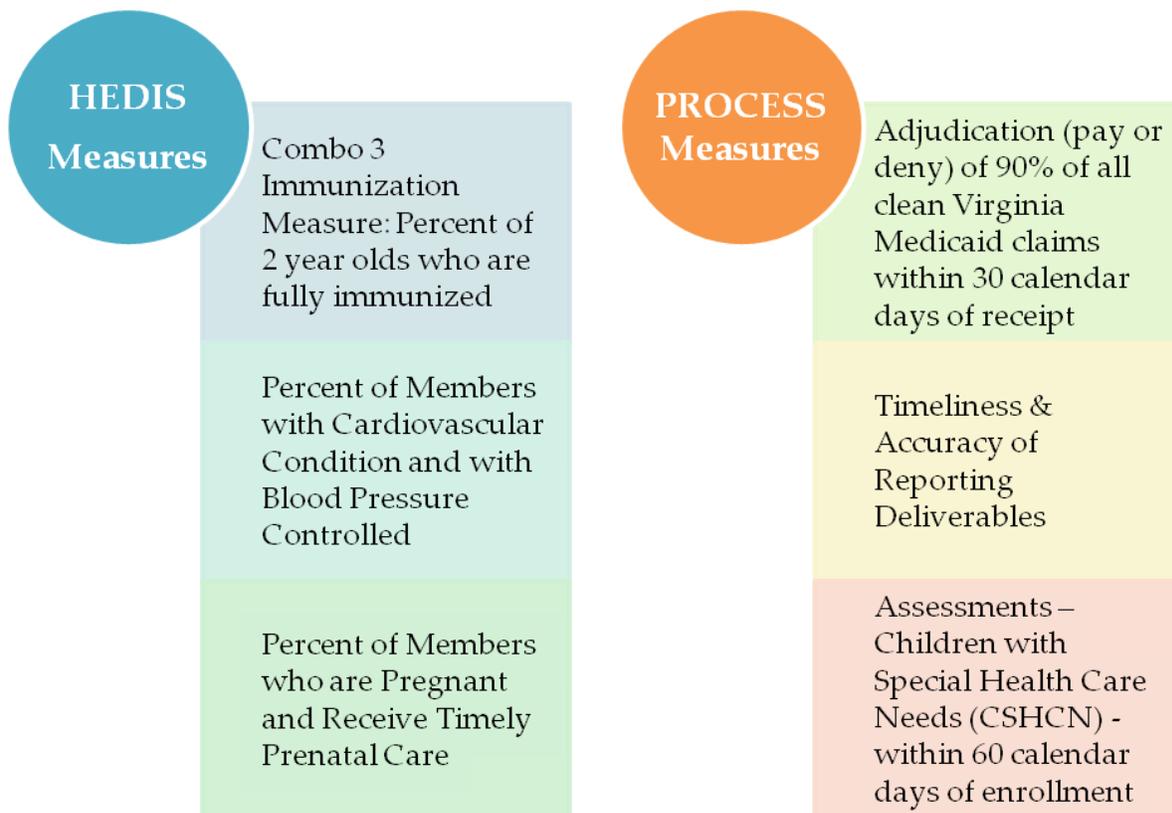
Assuring Better Care, Quality and Value through Performance Measures

Improving the health of our members while controlling health care costs is a top priority. The Performance Measure Incentive Program provides financial incentives for quality and cost containment outcomes ensuring continuous focus on member's health while remaining alert to healthcare costs and value. The goal of the program is to reward a health plan's performance and awards the MCO's focus on quality healthcare to beneficiaries. The evaluation tool, which is in the final phases of development, includes assessments of performance on three HEDIS metrics and three process metrics (See graph). Fiscal awards will be proportionate to the extent that the MCO achieves benchmarks for each measure.

The Performance Measure Incentive Program was created by the efforts of the HCS and Provider Reimbursement divisions of DMAS, the MCOs, and the Virginia Health Plan Association who brought representatives from the state of Michigan to assist the program development team.

The program will be implemented in a three-year phased-in schedule.

Performance Measure Incentive Program Metrics



Partnership Platforms

Ensuring Better Care, Quality and Value through Partnership Platforms

Quality Collaborative

The Quality Collaborative is an annual forum for sharing MCO “Best Practices” regarding performance, quality improvement and targeted interventions. At the collaborative MCOs present quality initiatives targeted to meet identified needs of their enrollee populations. Through these initiatives the MCOs have successfully implemented interventions to improve service in critical areas for their enrollees.

Provider Forums

Outcomes are improved by a functioning, patient focused collaborative between DMAS, providers, and MCOs. These forums offer a platform where by the provider community and the MCOs, along with DMAS, discuss topics of interest to providers and other stakeholders. Recent Provider Forums have been held in Abingdon and Northern Virginia.

MCO Site Visits

MCO Site Visits occur for two reasons: Contract monitoring and business relationship building. These site visits allow the Department or designated entity to review the performance of the MCO in relation to the performance standards outlined in the Medicaid managed care contract. The Department values the very important partnership with the MCOs and each year the MCOs are visited by the HCS management team to discuss topics of mutual interests.

MCO Local Presence

The MCOs are highly committed to serving their members. The community involvement of the MCOs keeps members and providers informed and allow for insights and meaningful collaboration with DMAS on member health care.



Managed Long Term Acute Care

Ensuring Better Care, Quality and Value through Care Partnerships

Continuing the Department's commitment to expanding the Managed Care program and care coordination to additional populations, effective November 1, 2014, the Department will enroll individuals in the Elderly or Disabled with Consumer-Direction (EDCD) waiver into managed care for acute care services only. MCOs will provide acute and primary medical care services, pharmacy related services, and transportation to medical appointments. Long term care (LTC) waiver services will be handled under the current processes. This initiative allows the Commonwealth to "expand principles of care coordination to all geographic areas, populations, and services under programs administered by the department" as directed in the 2011 Virginia Appropriations Act and as part of Phase 3 reforms under the Medicaid Innovation and Reform Commission.

EDCD Members Transition to Managed Care Acute Services November 1, 2014



Acute and Primary Care

Transportation



Pharmacy Services

Quality Management

Ensuring Measurable Quality Care Management

Ensuring that members of Medicaid managed care receive the highest level of quality of care is at the center of quality care management efforts. Through the contract with the MCOs, the Department requires each plan to obtain and maintain accreditation with the National Committee for Quality Assurance (NCQA) - the most widely-recognized health plan accreditation program in the United States.



To assess and determine the performance level of each MCO, HCS reviews performance measures captured through NCQA's Quality Compass — a tool to measure, evaluate, and benchmark plan performance. Two sets of data are used: *Healthcare Effectiveness Data and Information Set* (HEDIS) and *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) measures.



HEDIS measures are the nationally recognized **gold standard** for measuring performance on important dimensions of care and service. CAHPS measures capture member experiences with health care and services. The MCO contract standard requires that MCOs meet the 50th percentile each year on specific quality of care metrics as reported through NCQA's Quality Compass.

Quality Compliance

Ensuring Better Care, and Quality Services through Performance Standards

To ensure that the managed health care delivered through the MCOs meets acceptable standards for quality, access, and timeliness, DMAS contracts with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). Following federal requirements for an annual assessment, Delmarva assesses each MCO's performance relative to quality of care, timeliness of services, and accessibility of services.

EQRO Findings

The Medicaid MCOs effectively and collaboratively address quality, timeliness, and access to care in their managed care populations in compliance with contract requirements.

As compared to the benchmark of HEDIS® 2013 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for services provided in 2012 met or exceeded the benchmark for the following measures:

90%

Of Children in the Medicaid Managed Care Program saw their PCP in 2013

MCOs Met or Quality and Service Exceeded Benchmarks in:

- Antidepressant Medication Management
- Breast Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care- Blood Pressure Control (<140/80mm Hg)
- Use of Appropriate Medications-Asthma (Ages 5-11, Ages 12-18, and Total)
- Prenatal and Postpartum Care- Timeliness of Prenatal Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Quality Measures

Measurably Better Care, Service and Quality

Since HEDIS®2011, the Virginia Medicaid MCO average improved each year for the following measures:

- Breast Cancer Screening
- Childhood Immunization Status - (Combination 2 and 3)
- Comprehensive Diabetes Care – HbA1c Testing
- Comprehensive Diabetes Care - Blood Pressure Control (<140/80mmHg)
- Comprehensive Diabetes Care- Medical Attention to Nephropathy
- Lead Screening in Children
- Prenatal Postpartum Care- Timeliness of Prenatal Care

VA MCO average met or exceeded the corresponding HEDIS® 2011, 2012 and 2013 National Medicaid Managed Care 50th Percentile all three years for the following measures:

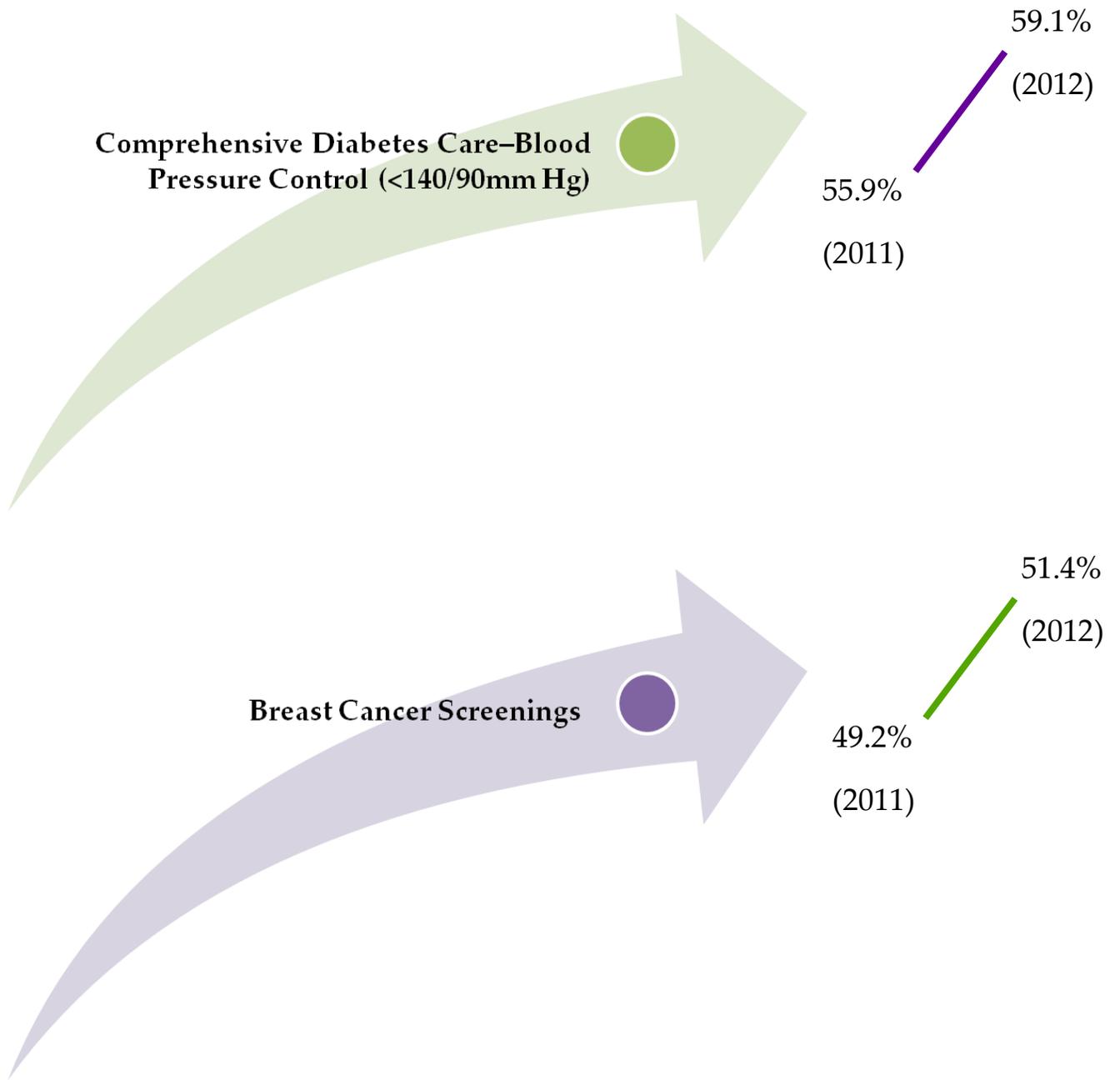
- Antidepressant Medication Management - Effective Acute Phase Treatment
- Antidepressant Medication Management - Effective Continuation Phase Tx
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening and LDL-C Control <100 mg/dL)
- Comprehensive Diabetes Care - LDL-C Control (<100 mg/dL)
- Use of Appropriate Medications Asthma (Total)
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

VA MCO average met or exceeded the corresponding CAHPS® 2011 & 2012 Adult Population and Child General Population National Medicaid Managed Care 50th Percentile for the following measures:

- Adult & Child – Rating of Overall Health Plan
- Adult & Child – Rating of Specialist Overall
- Adult & Child – Customer Service Composite
- Adult & Child – Getting Needed Care Composite
- Adult & Child – Getting Care Quickly composite
- Adult & Child – Customer Service Composite

Quality Measures

MCO Performance Above and Beyond Expectations Year Over Year



MCO Quality Highlights

 <p>Anthem. HealthKeepers Plus Offered by HealthKeepers, Inc.</p>	<p>Improved appointment, care manager and outreach specialist communications and implemented the use of internal data base monitoring of outreach. These efforts improved the 7-day and 30 day follow-up rates after a mental health discharge. The 7-day rate increased from 43.78% (2011) to 55.43% (2012); the 30-day rate increased from 74.9% (2011) to 87.3% (2012).</p>
 <p>COVENTRYCARESSM of Virginia formerly known as CareNet</p>	<p>Implemented a wrap-around approach to address breast cancer screening. This included member incentives, mobile mammography vans, provider visits, portal enhancements, and health plan enhancements (member tracking system, HEDIS workgroups). As a result, the breast cancer screening rate improved from 42.4% in 2011 to 54.03 percent in 2012.</p>
 <p>IN Total HealthSM Every Time. Every Touch.</p>	<p>Implemented weekly Clinical Huddles to coordinate care for members who require tailored, intensive, and ongoing case management. Clinical Huddle meetings are attended by senior leadership and helped reduce duplication of services and improved timely access.</p>
 <p>KAISER PERMANENTE[®]</p>	<p>Joined the Virginia Medicaid Managed Care Organization line up in November 2013.</p>
 <p>MajestaCareSM A Health Plan of CARLION CLINIC</p>	<p>Implemented a predictive modeling tool, <i>Consolidated Outreach and Risk Evaluation (CORE)</i>, to identify high risk members needing outreach and assessment. CORE's data driven approach has enabled the MCO to focus on ways to positively impact outcomes.</p>
 <p>Optima Health Family Care</p>	<p>Implemented an initiative to raise awareness among PCPs in addressing the weight, nutrition, and physical activity of members 3 – 17 years olds—to increase the number of measures taken for body mass index (BMI), nutritional counseling, and counseling on physical activity. Rates for all 3 HEDIS measures increased; BMI from 22.20% (2011) to 48.01% (2012), Nutritional Counseling from 33.62% (2011) to 54.87% (2012), and Physical Activity from 23.47% (2011) to 39.60% (2012).</p>
 <p>VA Premier Health Plan, Inc.</p>	<p>Improved diabetic retinal exam rate of 55 percent for members aged 18 – 75 and thus exceeded the HEDIS 50th Percentile. Interventions focused on improving member and provider education and satisfaction by employing Quality Nurses to educate and assist members and providers about the importance of diabetic retinal exams. The Quality Nurses also scheduled eye exams and worked with Case Managers and Disease Managers to ensure access and coordination of care.</p>