Commonwealth of Virginia
Department of Medical Assistance Services

2013 Annual Technical Report

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Delmarva Foundation

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2013 Annual Technical Report

Executive Summary

Introduction

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) is responsible for evaluating the quality of care provided to eligible enrollees in contracted managed care organizations (MCOs). To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO).

Various federal policies and regulatory agencies require state Medicaid agencies monitor and assess the quality of care received by MCO members. The Centers for Medicare & Medicaid Services (CMS) requires all states with Medicaid managed care to evaluate certain mandated and optional external quality review (EQR) activities. Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act (BBA) of 1997 and federal EQR regulations, Delmarva assessed each MCO's performance relative to the quality of care, timeliness of services, and accessibility of services. The three mandated external quality review activities are as follows:

1) Validate a sample of each MCO's performance measures—annually;
2) Validate two or more performance improvement projects for each MCO—annually; and,
3) Conduct a comprehensive review of MCO compliance with federal and state operational standards—once every three years.

Additional data results incorporated into this annual evaluation include the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and findings from the focused clinical study, Improving Birth Outcomes through Adequate Prenatal Care. The BBA requires an annual technical report (ATR) that assesses the quality of care delivered to eligible enrollees through the MCOs. This report, as specified in 42 CFR §438.358, consists of an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that an MCO or their contractors, furnish to members enrolled in managed care.

Summary of Findings

Operational Systems Review (OSR)

At the request of DMAS, Delmarva conducted Readiness Reviews of Kaiser Permanente/Virginia (KPVA) and INTotal Health (INTotal), formerly Amerigroup of Virginia, in 2013 to evaluate the readiness of both MCOs to serve eligible enrollees. The KPVA review was conducted on March 20 and 21, 2013 in response to the MCO's planned entry into the Virginia Medicaid program in 2013. The INTotal review was conducted on April 2 and 3, 2013 due to change in ownership of the MCO.

Delmarva evaluated both MCOs compliance with operational standards related to health care services to be provided to Virginia Medicaid enrollees. This assessment evaluated the MCO's compliance with the Virginia managed care contract and with the federal requirements of a Medicaid MCO for:

- Enrollee Rights (ER)
- Grievance System (GS)
- Quality Assessment and Performance Improvement (QAPI)

In preparation for the reviews, Delmarva held Orientation sessions with staff from the MCOs which included an overview of the standards and the review process. After submission of presite documentation by the MCOs, a Delmarva team conducted a two-day onsite review. At the conclusion of the onsite visit and an extensive discussion with both the MCO staff and DMAS, a letter was sent to the MCOs outlining those standards that were not fully "met." Delmarva also produced the review results in a Draft Readiness Review Report that was approved by DMAS and presented to the MCOs. With an opportunity to present additional documentation, the MCOs revised policies and communication materials. Delmarva reviewed these changes and presented the findings in a Final Readiness Review Report. At the completion of the Readiness Reviews, INTotal fully met all elements and KPVA fully met 99% of all elements. KPVA became operational in Virginia on November 1, 2013.

Since 2005, DMAS has required their contracted MCOs to obtain and maintain national accreditation from the National Committee for Quality Assurance (NCQA). NCQA conducts and publishes an annual crosswalk of the NCQA Health Plan Accreditation Standards and Guidelines with the federal Medicaid managed care standards for the BBA operational assessment performance standards. The crosswalk suggests that approximately forty percent of

the federal requirements are equivalent to NCQA's accreditation standards. Further, the BBA allows states to deem their NCQA accredited MCOs to be compliant with the duplicative federal requirements.

The CMS EQR guidelines require a comprehensive OSR at least once every three years. Delmarva last conducted a comprehensive review in CY 2011 for the five MCOs contracted with DMAS at that time. For the first time, this review included the deeming of certain federal requirements based on the NCQA crosswalk. DMAS and Delmarva reviewed the crosswalk of recommended standards that were eligible for deeming by agreement with CMS. With the assistance of Delmarva, DMAS compared the standards and the MCO contractual requirements before deciding which standards to deem for the 2011 comprehensive OSR. DMAS and Delmarva completed this same process using the 2013 NCQA crosswalk to determine deeming for the comprehensive OSR scheduled for 2014. The 2014 OSR will be performed for seven MCOs contracted with DMAS.

Performance Measurement Validation (PMV)

The goal of conducting performance measure validation (PMV) is to evaluate the accuracy of the specific Healthcare Effectiveness Data and Information Set (HEDIS®) measures required by DMAS for MCO reporting. Delmarva evaluated the MCO's compliance with HEDIS® specifications and the accuracy of their reported performance measures for four (Anthem/HealthKeepers, CareNet/Southern Health Services, Optima Family Care, and Virginia Premier Health Plan) of the six Virginia MCOs. MajestaCare was not included in PMV activities since it is under new health plan status. INTotal, formerly Amerigroup of Virginia, was also exempted from PMV actitivies due to change in ownership of the MCO. None of the four MCOs under review encountered any major system issues that affected their ability to accurately calculate and report these measures.

The two measures validated by Delmarva included Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. Although each MCO utilized different systems and procedures for their performance measure reporting, all share the following common strengths:

- The MCOs have well-developed and established systems and processes for HEDIS® reporting.
- For HEDIS 2013(CY2012) , all four MCOs under review used certified HEDIS® software.
- The MCOs implemented new initiatives that continually improved the HEDIS® results for their enrollees.

The MCOs have well-developed and established systems and processes for HEDIS® reporting and none experienced any major issues in processing and reporting HEDIS® measures. All four were successful in implementing the new medical record review process for HEDIS® 2013.

While only four MCOs participated in PMV activities, all six MCOs reported results for HEDIS® 2013 to NCQA and DMAS. The Virginia Medicaid 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 Treatment
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening and LDL-C Control <100mg/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

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:

- Antidepressant Medication Management (Effective Acute Phase Treatment and Effective Continuation Phase Treatment)
- Breast Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Control <100 mg/DL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Comprehensive Diabetes Care- Blood Pressure Control (<140/80mm Hg)
- Use of Appropriate Medications-Asthma (Ages 5-11, Ages12-18, 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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Of the ten rating and composite measures from the Adult category of the CAHPS® survey selected for this report, the Virginia MCO average for five measures compared favorably to the CAHPS® National Medicaid 50th Percentile from 2010 through 2012. In 2012, the Virginia MCO average for six out of the ten selected measures met or exceeded the CAHPS® National Medicaid 50th Percentile. The results for the Children General Population category of the CAHPS® survey compared favorably to the CAHPS® National Medicaid 50th Percentile for seven out of nine measures for calender year 2012.

An additional CAHPS survey was administered in 2013 to parents of child members enrolled in the Family Access to Medical Insurance Security (FAMIS) program. In seven rating and composite measures for FAMIS children in the General Population (those served in the Fee-For-Service and MCO delivery systems) the Virginia average exceeded the CAHPS® National Medicaid 50th Percentile. For FAMIS children with Chronic Conditions (those who experience a consequence associated with a condition) nine ratings and composite measures exceeded the CAHPS® National Medicaid 50th Percentile. In addition, FAMIS received positive satisfaction ratings from more than eight in ten parents/guardians from both populations for multiple composite measures.

Performance Improvement Projects (PIPs)

Designed to achieve significant and sustainable improvement, PIPs can address both clinical and non-clinical areas. DMAS selects project topics based on opportunities for improvement and relevance to the current Medicaid population. DMAS holds the MCOs accountable for the quality of care provided to the Medicaid enrollees.

The validation process expects the PIPs to demonstrate a favorable effect on the health outcomes of their enrollees. The CMS guidelines require PIPs designed, conducted, and reported in a methodologically sound manner. At the direction of DMAS, MCOs were required to continue two PIPs in 2013 that were initially developed in 2012: Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness.

The 2013 validation reviewed the results of the first remeasurement year (CY 2012) against the baseline measurement year (CY 2011). Most of the MCOs identified NCQA Quality Compass 75th or 90th Percentiles as their long-term goals. The methodology appears appropriate in all projects and the MCOs implemented recommendations made by Delmarva during the baseline measurement review to enhance initial interventions.

The MCOs completed barrier analyses which identified member, provider, and MCO barriers impacting improvement. Targeted interventions were implemented that addressed barriers and a determination was made whether the MCOs actions resulted in increased rates for Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. The PIP results were mixed as the majority of MCOs did not document significant improvement and some documented decreases for the measures. However, some noteworthy findings were documented; Virginia Premier increased its Adolescent Well-Care Visits rate from 44.28 percent to 50.33 percent and CareNet increased its rate of Follow-up After Hospitalization for Mental Illness within 30 days from 67.03 percent to 73.38 percent.

Quality Highlights

- Six Virginia MCOs are NCQA-accredited and five made the list of the top 75 for NCQA's 2013 national rankings for Medicaid health plans. MajestaCare received NCQA New Health Plan Accreditation status in 2013. KPVA has an NCQA survey scheduled in 2014 in which it will pursue accreditation.
- DMAS successfully coordinates participation in the MCO collaborative as a forum for sharing of "best practices." 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.
- The Virginia Medicaid MCO average met or exceeded the associated HEDIS® 2011, 2012 and 2013 National Medicaid Managed Care 50th Percentile all three years for eight measures.
- The Virginia MCO average for HEDIS 2013 exceeded the HEDIS 2013 National Medicaid Managed Care 50th Percentile for 14 performance measures.
- In the Improving Birth Outcomes through Adequate Prenatal Care study,the majority (91.1 percent) of pregnant women in the study population (women were continuously enrolled 43 days prior to delivery) were in the Medicaid for Pregnant Women program while 8.9 percent were in the FAMIS MOMS program in 2012.
- After a decline to 67.5 percent in 2011 that reversed a previous three-year positive trend, the percentage of pregnant women in the study population enrolled in an MCO rebounded to 74.0 percent in 2012.
- After an increase in enrollment in 2011 that reversed a previous three year decline, enrollment in the FFS and PCCM delivery systems in the study population decreased again in 2012. FFS enrollment decreased from 25.8 percent to 24.1 percent while PCCM enrollment decreased dramatically from 6.7 percent to 1.9 percent.

- In the Improving Birth Outcomes through Adequate Prenatal Care study the majority of pregnant womenin the comparison group (women who were not continuously enrolled 43 days prior to delivery, but were enrolled on the day of delivery) in 2012 were in the FFS delivery system (51.8 percent) while 47 percent were in managed care.
- Women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs received adequate prenatal care at rates that compare favorably to the HEDIS® National Medicaid Managed Care Averages in all three years from 2010 to 2012.
- Infants born to women in MCOs had improved low birth weight (LBW) rates from 2011 to 2012 and outperformed the national benchmarks in both 2010 and 2011.
- Rates for overall LBW infants in the PCCM delivery system in 2011 and 2012 reversed their favorable rate from 2010 and compare unfavorably (higher) than the 2011 and 2012 national benchmark. The rate of infants born prematurely (before 37 completed weeks of pregnancy) to women in the study population who are in the FAMIS MOMS and Medicaid for Pregnant Women programs improved (decreased) from 2010 to 2011 but saw a slight increase from 2011 to 2012. The rate compared favorably to the national rate for all three years.
- The percentage (33.7) of infants born at less than 39 completed weeks of gestation to women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs, first reported in 2011, was better than the national rate of 38.9 percent. In 2012 the percentage increased slightly to 34.3 percent but remained better (lower) than the national CDC rate.

Conclusion

The Medicaid MCOs effectively and collaboratively address quality, timeliness, and access to care in their managed care populations. The efforts made to improve quality by DMAS and the MCOs are highly commendable and show continual and consistent improvement. This 2013 ATR report outlines the specific recommendations for both DMAS and the MCOs.

Recommendations include implementing statewide interventions and collaboration with strategic partners who have a shared interest in improving the health outcomes of these vulnerable Virginians.

The MCOs should conduct a root cause analysis to determine disparities and identify barriers in their prenatal population outcomes. For example, African American women recorded the highest (worst) rates of all categories of low birth weights. These outcomes persist even though this subgroup received adequate prenatal care at rates that exceed all racial groups except White women.

DMAS should evaluate results and strategies of other States' Medicaid agencies that implemented statewide partnerships and collaborative efforts to improve the rates of infants born at healthy gestational ages and birth weights. DMAS should review the initial results of the percentage of pregnant women who delivered infants before 39 weeks of gestation. Reducing this percentage is a national initiative of several stakeholders, including the March of Dimes and other Medicaid agencies. Consideration of collaborative expansion to include this opportunity for improvement should be part of the follow-up by DMAS and the MCOs. DMAS has the capability to accurately monitor and evaluate indicator trends over time and can be the catalyst for improvements in this population.

2013 Annual Technical Report

Introduction

The Commonwealth of Virginia Department of Medical Assistance Services (DMAS) is responsible for evaluating the quality of care provided to eligible members enrolled in contracted managed care plans. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS contracted 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, as set forth in the Balanced Budget Act (BBA) of 1997 and federal external quality review (EQR) regulations, Delmarva conducted a comprehensive review of the managed care organizations (MCOs) to assess each plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

For the purposes of evaluating the MCOs, Delmarva has adopted the following definitions for quality, access, and timeliness:

- **Quality**, as it pertains to external quality review, is defined as "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (Centers for Medicare & Medicaid Services [CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D- Quality Assessment and Performance Improvement,* [June 2002]).

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

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001).*

DMAS is responsible for the operational oversight of health care services provided through three delivery systems: managed care, primary care case management (PCCM) and fee-for-service (FFS). Through its managed care delivery system, contracted MCOs provide health care services to eligible enrollees by contracted MCOs. Program design can improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. The seven MCOs contracted with DMAS are:

- Anthem/HealthKeepers, Inc. (formerly Anthem HMOs)
- INTotal Health (formerly Amerigroup of Virginia)
- Kaiser Permanente/Virginia (KPVA), new MCO effective November 2013
- MajestaCare
- Optima Family Care (OFC)
- Southern Health Services, Inc. (Care*N*et)
- Virginia Premier Health Plan, Inc. (Va Premier)

EQRO Activities

States with Medicaid managed care are subject to requirements for an annual assessment, as set forth in the Balanced Budget Act (BBA) of 1997 and in federal regulations detailed in 42CFR §430 Managed Care. Following these standards, Delmarva conducted a comprehensive review of the managed care organizations (MCOs) to assess each plan's compliance with these external quality review requirements. The Center for Medicare & Medicaid Services (CMS) requires the designated EQRO to evaluate MCOs in three mandated EQR categories:

- Validate a sample of each MCO's performance measures - annually;
- Validate two or more performance improvement projects for each MCO - annually; and
- Conduct a comprehensive review of MCO compliance with federal and state operational standards—once every three years.

The BBA also requires an annual technical report (ATR) that assesses the quality of care delivered to enrollees in the managed care delivery system. Delmarva's task was to evaluate each MCO's performance using data and information gathered from the following sources:

- The validation results of the two measures selected by DMAS using the 2013 Healthcare Effectiveness Data and Information Set (HEDIS®). Each MCO also reports 13 additional measures that aggregate their HEDIS® results and include both CHIP and Medicaid enrollees.
- The 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey results of enrollee satisfaction for Children and for Adult Medicaid - HMO.
- The 2013 MCO performance improvement projects (PIPs) validations for two DMAS selected projects.

In addition, Delmarva evaluated other quality-related aspects of the state's managed care delivery system in order to provide a comprehensive assessment of the overall quality improvement strategy. Additional data included the State Managed Care Quality Strategy, focused clinical studies (FCS), and the MCO's best and emerging practices for improving quality of care and service.

DMAS Quality Strategy

DMAS designed the required State Managed Care Quality Strategy as a systematic approach to planning, designing, monitoring, and assessing the quality and appropriateness of the MCOs' care delivery systems. The quality strategy offers standards for quality management and improvement and provides guidelines for compliance.

The goal of the quality strategy is to identify and improve the care received by enrollees with identified health care priority needs and to ensure that quality services are both timely and accessible within the managed care delivery system. The state quality standards include the following with a direct correlation to the CMS-mandated EQR activities. The MCOs must:

- Conduct performance improvement projects
- Submit performance improvement data
- Monitor over-utilization and under-utilization of services
- Monitor the quality and appropriateness of care
- Measure performance - submission of HEDIS® performance studies by MCOs
- Report the status and results of each performance measurement project to include results of quality improvement activities

DMAS has established quality requirements for contracted MCOs that exceed the minimum EQR requirements set forth by CMS for all states. Contracted Medicaid MCOs are required by DMAS to achieve and maintain NCQA accreditation. This achievement is recognized among industry leaders, consumers, purchasers, and providers as the MCO's commitment to continuous quality improvement.

NCQA accreditation automatically enables the MCOs to meet some of the EQR activities as set forth in the BBA. Two EQR activities are considered "partially deemed" in Virginia. The partially deemed activities include the validation of PIPs and the OSR.

Because the MCOs comply with the HEDIS® technical specifications, DMAS has deemed a number of the PIP validation elements. The 2014 comprehensive OSR, like the 2011 OSR, will include partial deeming for certain standards that are equivalent to and duplicate NCQA accreditation requirements.

Performance measure validation is not deemed in Virginia due to financial relationship rules as stated by CMS as follows: "financial relationship rules prohibit the state from accepting audited data to meet the federal requirements of validating performance measures when the plan has paid for the audit."

The results of focused clinical studies (FCS) are an important component in DMAS' overall evaluation of managed care and are an optional component of EQR. Delmarva conducted one optional FCS during this review period: Improving Birth Outcomes through Adequate Prenatal Care Study. This study focused on pregnant women in the Medicaid for Pregnant Women and FAMIS MOMS programs. The participants were divided into two groups:

- A study population comprised of pregnantwomen who met requirements for continuous enrollment 43 days prior to delivery
- A comparison group comprised of pregnant women who were not continuously enrolled 43 days prior to delivery, but were enrolled on the day of delivery

This study reported the majority (91.1 percent) of pregnant women in the study population were in the Medicaid for Pregnant Women program while 8.9 percent were in the FAMIS MOMS program. The majority of pregnant women (51.8 percent) were in the FFS delivery system while 47 percent were enrolled in an MCO.

Data analysis showed that women in the study population in the FAMIS MOMS and Medicaid for Pregnant Women programs received adequate prenatal care at rates that compare favorably to the HEDIS® National Medicaid Managed Care Averages in all three years from 2010 to 2012.

Infants born to women in MCOs had improved low birth weight (LBW) rates from 2011 to 2012 and outperformed national benchmarks in 2010 and 2011. Rates for overall LBW in the PCCM delivery system in both 2011 and 2012 reversed their favorable rate from 2010 and compare unfavorably (higher) than the 2011 and 2012 national benchmark. PCCM has primarily served the far southwest region of Virginia, which in 2013 was transitioned to managed care.

The rate of infants born prematurely (before 37 completed weeks of pregnancy) to women in the study population who are in the FAMIS MOMS and Medicaid for Pregnant Women programs improved (decreased) from 2010 to 2011 but saw a slight increase from 2011 to 2012. Despite the increase in 2012, the rate compared favorably to the national rate for all three years. The percentage (33.7) of infants born at less than 39 completed weeks of gestation to women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs, first reported in 2011, was better than the national rate of 38.9 percent. In 2012 the percentage increased slightly to 34.3 percent but remained better (lower) than the national CDC rate.

DMAS has integrated continuous quality improvement into their Quality Strategy and their contracts with the MCOs with the expectation to participate in required quality activities. Additionally, the evolution of the MCO Collaborative effort has provided a transparent forum to encourage sharing of best practices among all stakeholders. DMAS will continuously partner with the MCOs to improve the structure, process, and outcomes of care to achieve optimal health for these vulnerable populations.

Quality Initiatives

MCO Collaborative

The contracted MCOs are required to participate in the DMAS quality collaborative. The quarterly meetings of DMAS with the MCOs function as a forum to share successful program knowledge on how to improve specific quality measures. This collaborative forum assists with the DMAS mission to enable enrollees to achieve and maintain optimal health. One example of the output from this initiative was the sharing of MCO “best practices” regarding performance improvement projects, quality improvement initiatives, and targeted interventions.

DMAS has continued to see their contracted MCOs improve in NCQA’s national ranking for health plans with five accredited MCOs making the list of the top 75 for 2012-2013. MajestaCare, which DMAS began contracting with in 2012, attained NCQA New Health Plan Accreditation in 2013.

Best and Emerging Practices for Improving Quality of Care and Service

Each year one of the quarterly MCO Collaborative meetings serves as the annual session for presentation of best practices. DMAS and each MCO selected topics that represented exceptional HEDIS® scores and the following is a brief overview of each MCO presentation in June 2013:

Anthem, HealthKeepers, Inc. improved its 7-day and 30 day follow-up after discharge for mental illness rates. The 7-day rate increased from 43.78 percent in 2011 to 55.43 percent in 2012; the 30-day rate increased from 74.9 percent in 2011 to 87.3 percent in 2012. Targeted interventions included improving communication to members regarding appointments, improving communication between care managers and outreach specialists, and use of an internal data base to monitor outreach efforts.

Care*N*et implemented a wrap-around approach to address breast cancer screening. This included member outreach (incentives, mobile mammography vans), provider education (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.

INTotal Health implemented weekly Clinical Huddles to coordinate care for members with complex needs who require tailored, intensive, and ongoing case management. Members are placed on the Huddle List based on utilization of services, claims data, and referrals from providers and other sources. Clinical Huddle meetings are attended by the plan's senior leadership and since implementation, have helped the MCO reduce duplication of services while providing timely access to quality care tailored to members with complex needs.

MajestaCare's Integrated Care Management team implemented a predictive modeling tool, *Consolidated Outreach and Risk Evaluation* (CORE), to identify high risk members needing outreach and assessment. The CORE tool was employed following unfavorable changes in MajestaCare's utilization trends for pharmacy, emergency room usage, and inpatient admissions after the MCO added 7,000 members from far southwest Virginia in July 2012. Using CORE's data driven approach has enabled the MCO to focus on ways to reduce the unfavorable outcomes cited above.

Optima Family Care implemented an initiative to raise the level awareness among PCPs in addressing the weight, nutrition, and physical activity of members 3 – 17 years old. The MCO specifically targeted increasing this population's rates for body mass index (BMI), nutritional

counseling, and counseling on physical activity. PCPs were provided with various tools such as EPSDT information and clinical guidelines on BMI as well as member education materials. Subsequently, Optima's HEDIS rates for all three measures increased; BMI from 22.20 percent in 2011 to 48.01 percent in 2012, Nutritional Counseling from 33.62 percent in 2011 to 54.87 percent in 2012, and Physical Activity from 23.47 percent in 2011 to 39.60 percent in 2012.

Virginia Premier Health Plan, Inc. improved diabetic retinal exam rate of 55 percent for members aged 18 – 75 exceeded the HEDIS 50th Percentile. VPHP's 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.

Operational Systems Review (OSR)

At the request of DMAS, Delmarva conducted Readiness Reviews of Kaiser Permanente/Virginia (KPVA) and INTotal Health (INTotal), formerly Amerigroup of Virginia, in 2013 to evaluate the readiness of both MCOs to serve eligible enrollees. The KPVA review was conducted on March 20 and 21, 2013 in response to the MCO's planned entry into the Virginia Medicaid program in 2013. The INTotal review was conducted on April 2 and 3, 2013 due to change in ownership of the MCO.

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- Enrollee Rights (ER)
- Grievance System (GS)
- Quality Assessment and Performance Improvement (QAPI)

In preparation for the reviews, Delmarva held Orientation sessions with staff from the MCOs which included an overview of the standards and the review process. After submission of preside documentation by the MCOs, a Delmarva team conducted a two-day onsite review. At the conclusion of the onsite visit and an extensive discussion with both the MCO staff and DMAS, a letter was sent to the MCOs outlining those standards that were not fully "met." Delmarva also produced the review results in a Draft Readiness Review Report that was approved by DMAS and presented to the MCOs. With an opportunity to present additional

documentation, the MCOs revised policies and communication materials. Delmarva reviewed these changes and presented the findings in a Final Readiness Review Report. At the completion of the Readiness Reviews, INTotal fully met all elements and KPVA fully met 99% of all elements. KPVA became operational in Virginia on November 1, 2013.

Since 2005, DMAS has required their contracted MCOs to obtain and maintain national accreditation from the NCQA. Forty-one states, including 29 Medicaid departments now recognize or require NCQA accreditation. Virginia is one of only 12 states that actually requires accreditation. Per 42 CFR §438.360, states can now use information obtained from a national accrediting organization survey for certain of the mandatory external quality review activities.

NCQA conducts and publishes an annual crosswalk of the NCQA Health Plan Accreditation Standards and Guidelines with the federal Medicaid managed care standards for the BBA operational assessment performance standards. The crosswalk suggests that approximately forty percent of the federal requirements are equivalent to NCQA's accreditation standards. Further, the BBA allows states to deem their NCQA accredited MCOs to be compliant with the duplicative federal requirements.

DMAS with assistance from Delmarva used the 2013 NCQA crosswalk to compare the federal and state requirements with designated NCQA standards recommended for deeming. Delmarva identified those standards considered equivalent and eligible for deeming that would be exempt from duplicate review. DMAS reviewed each standard eligible for deeming for a final decision on deeming for the 2014 comprehensive OSR. Most, but not all standards eligible for deeming, were determined to be equivalent and deemed by DMAS for the 2014 review.

The 2014 OSR will consist of an extensive desk review of presite documentation submitted by each MCO. An onsite visit will also be performed at each MCO including staff interviews along with observation of MCO operations. Delmarva reviewers will perform these activities to identify, validate, quantify, and monitor selected BBA standards and designated contractual requirements. Delmarva will use certain MCO contractual requirements and the regulations set forth under the final rule of the BBA and 42 CFR §438 to evaluate and assess compliance of the following systems for each MCO:

- Enrollee Rights (ER);
- Grievance System (GS); and
- Quality Assessment and Performance Improvement (QAPI).

Performance Measurement Validation (PMV)

In accordance with the BBA, DMAS is required to evaluate the reliability and validity of performance measures reported to the state by contracted MCOs. It is imperative that the reported information be valid and reliable in order to support internal decision-making and to instill confidence in publically reported quality measures.

The NCQA requires the accredited MCOs to calculate and submit performance rates for HEDIS® measures used by NCQA for public reporting and benchmarking. DMAS also requires the MCOs to report on a specific subset of HEDIS® measures. The goal in conducting performance measure validation (PMV) is to evaluate the accuracy of the measures and to determine the extent to which the MCO followed specifications for calculating and reporting the measures. Delmarva's Certified HEDIS® Compliance Auditors (CHCA) utilized methods consistent with NCQA's *HEDIS® Compliance Audit Standards, Policies and Procedures (Volume 5*) to assess each MCO's performance measures data collection and reporting processes for conformity with NCQA's *HEDIS® 2013 Technical Specifications (Volume 2*).

The Delmarva validation team conducted an onsite visit to each MCO to evaluate any potential issues identified and to observe the systems used by the MCO to collect and produce HEDIS® data. The methodology is consistent with the CMS protocol for conducting Medicaid External Quality Review Activities, Validating Performance Measures. MajestaCare was excluded from this activity due to its status as a new health plan.

DMAS selected two HEDIS® measures for validation by Delmarva: Adolescent Well-Care Visits and Follow-Up to Hospitalization After Mental Illness. The four MCOs under review for PMV submitted the two measures according to the HEDIS® 2013 Technical Specifications. Although each MCO utilized different systems and procedures for their performance measure reporting, they continued to share the following common strengths:

- The MCOs have well-developed and established systems and processes for HEDIS® reporting.
- For HEDIS 2013(CY 2012), all four accredited MCOs under review for PMV used certified HEDIS® software
- All MCOs developed new and creative outreach approaches that increased compliance and resulted in better HEDIS® rates.

HEDIS®

HEDIS® is the nationally recognized tool for monitoring the quality of care in health plans. These indicators are considered the "gold standard" in the industry and are used by many of America's health plans to measure performance on identified dimensions of health care and services. DMAS identified 13 HEDIS® measures that best reflect the performance of the contracted managed care organizations. Each of the six accredited MCOs provided DMAS with their HEDIS® scores for the following 13 measures:

- Childhood Immunization Status
- Lead Screening in Children
- Breast Cancer Screening
- Prenatal and Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Adolescent Well-Care Visits
- Comprehensive Diabetes Care (Pediatric and Adult: Ages 18-75)
- Asthma-Appropriate Use of Medication (Pediatric and Adult)
- Cholesterol Management for Patients with Cardiovascular Conditions
- Controlling High Blood Pressure
- Antidepressant Medical Management
- Follow-Up After Hospitalization for Mental Illness

The following tables present HEDIS® data for each measure for all Virginia Medicaid MCOs for calender years 2010, 2011 and 2012. Calender year (CY) is the term used to report calendar year for HEDIS and CAHPS measures. Calender year 2010 is reported as HEDIS® 2011, calender year 2011 is reported as HEDIS® 2012 and calender year 2012 is reported as HEDIS® 2013. These MCO rates are compared with HEDIS® National Medicaid Managed Care 50th Percentiles for the corresponding time frames. While the DMAS' Quality Strategy sets the goal of HEDIS scores at the 75th percentile, the tables display the HEDIS® National Medicaid Managed Care 90th percentile rates for each measure to encourage stretch-goals.

NCQA allows certain Medicaid measures to be rotated on a biennial bases to help reduce the overall HEDIS reporting burden on MCOs. While Virginia allows its MCOs to rotate eligible measures in their annual HEDIS submission to NCQA, the MCOs are required to report both actual and rotated measures to the State. The Virginia Medicaid Averages presented in this report are calculated with actual rates and can vary from the state average reported for rotated measures in the NCQA Quality Compass.

Table 1 displays the aggregate results for the MCOs and national benchmarks.

Table 1. Comparison of the Virginia Medicaid MCO scores and National Medicaid Managed Care 50th and 90th Percentiles for HEDIS 2013 (CY 2012) to HEDIS 2012 (CY 2011) and HEDIS 2011 (CY 2010).

HEDIS Measure	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS 2013 (CY 2012) National Medicaid Managed Care 50th Percentile	HEDIS 2013 (CY 2012) National Medicaid Managed Care 90th Percentile*
Adolescent Well-Care Visit	44.8%	46.7%	46.1%	46.1%	49.3%	47.2%	65.5%
Antidepressant Medical Management-Acute Phase Tx	53.0%	51.7%	52.9%	50.1%	49.4%	51.5%	62.0%
Antidepressant Medical Management-Continuation Phase Tx	38.9%	40.0%	38.0%	32.7%	32.4%	35.7%	46.2%
Breast Cancer Screening	46.4%	49.2%	51.4%	52.4%	50.5%	51.3%	62.9%
Childhood Immunization Status Combination 2	68.9%	69.7%	70.9%	75.1%	75.6%	76.9%	85.4%
Childhood Immunization Status Combination 3	64.9%	65.7%	67.2%	71.0%	72.2%	72.9%	83.1%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Screening	84.1%	83.4%	83.3%	82.5%	82.5%	82.4%	88.8%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Control <100 mg/DL	50.2%	47.9%	48.2%	44.0%	42.4%	41.8%	54.1%
Controlling High Blood Pressure	57.6%	57.3%	55.0%	56.5%	57.5%	56.1%	69.4%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS 2013 (CY 2012) National Medicaid Managed Care 50th Percentile	HEDIS 2013 (CY 2012) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– HbA1c Testing	81.8%	83.2%	85.6%	82.2%	82.4%	83.1%	91.0%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	43.8%	41.6%	43.4%	42.6%	41.9%	43.0%	31.1%
Comprehensive Diabetes Care– HbA1c Control <8%	47.1%	49.8%	49.3%	47.4%	48.7%	48.6%	58.4%
Comprehensive Diabetes Care– Eye (Retinal) Exams	49.5%	50.7%	48.4%	52.9%	52.8%	54.3%	67.6%
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	76.0%	75.8%	75.5%	75.4%	76.2%	76.3%	83.5%
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	39.4%	39.9%	35.7%	35.2%	35.9%	34.5%	43.8%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	77.8%	78.1%	78.4%	78.5%	78.7%	79.2%	85.9%
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	36.0%	36.7%	39.4%	^	39.1%	38.9%	50.6%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed 50th Percentile*	HEDIS 2013 (CY 2012) National Medicaid Managed Care 50th Percentile	HEDIS 2013 (CY 2012) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	58.4%	55.9%	59.1%	61.2%	63.5%	60.7%	74.6%
Follow-Up After Hospitalization for Mental Illness– 7 Days	43.0%	44.5%	41.8%	45.1%	46.1%	44.0%	68.8%
Follow-Up After Hospitalization for Mental Illness– 30 Days	66.5%	68.2%	65.0%	66.6%	67.7%	65.6%	82.0%
Lead Screening in Children	64.0%	67.2%	70.5%	72.2%	71.3%	72.2%	87.0%
Use of Appropriate Medications– Asthma Age 5-11	93.0%	90.6%	90.3%	92.4%	91.5%	90.3%	94.9%
Use of Appropriate Medications– Asthma Age 12-18	86.4%	88.4%	87.8%	^	87.1%	85.9%	92.2%
Use of Appropriate Medications– Asthma Age 19-50	^	67.0%	72.8%	^	75.7%	75.0%	84.3%
Use of Appropriate Medications– Asthma Age 51-64	^	80.7%	70.2%	^	73.8%	72.7%	83.3%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS 2013 (CY 2012) National Medicaid Managed Care 50th Percentile	HEDIS 2013 (CY 2012) National Medicaid Managed Care 90th Percentile*
Use of Appropriate Medications– Asthma Total (Combined Ages)	89.9%	86.8%	86.4%	88.9%	85.9%	84.6%	89.8%
Prenatal and Postpartum Care– Timeliness of Prenatal Care	83.2%	85.2%	86.0%	86.0%	86.1%	85.9%	92.8%
Prenatal and Postpartum Care– Postpartum Care	67.7%	64.7%	63.7%	64.6%	65.0%	64.1%	73.8%
Well-Child Visits in the First 15 Months of Life (Six or more visits)	66.4%	69.7%	67.1%	61.3%	62.8%	64.9%	77.4%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	75.9%	74.2%	73.4%	72.3%	72.2%	72.2%	82.1%

+ Virginia Medicaid MCO Averages reported for rotated measures may vary from the state averages in Quality Compass
* HEDIS National Medicaid 50th Percentile and 90th Percentile-Quality Compass Medicaid All Lines of Business
^ Measure not collected

The Virginia Medicaid 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 Treatment
- 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

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 (<140/80mm Hg)
- Comprehensive Diabetes Care- Medical Attention to Nephropathy
- Lead Screening in Children
- Prenatal Postpartum Care- Timeliness of Prenatal Care

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

- Antidepressant Medication Management (Effective Acute Phase Treatment and Effective Continuation Phase Treatment)
- Breast Cancer Screening
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Control <100 mg/DL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Comprehensive Diabetes Care- Blood Pressure Control (<140/80mm Hg)
- Use of Appropriate Medications-Asthma (Ages 5-11, Ages12-18, 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

The Virginia Medicaid MCOs implemented initiatives in an effort to improve and sustain HEDIS® results for their enrollees. The success of the managed care delivery system is dependent on these achievements in order to evaluate the health care services provided to these vulnerable populations. Appendix Table A1-1 details all individual MCO results for calender years 2010, 2011 and 2012.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS® surveys are used to obtain consumer information about the health services received. While originally designed to help consumers

select health plans, the measures have evolved into an important tool in the effort to improve health care quality.

The survey data allows for comparison between MCOs by identifying performance variation within reporting periods as well as trends over time. The CAHPS® also makes available comparable data and a Quality Improvement Guide (www.cahps.ahrq.gov/) to assist stakeholders in improving their performance in the specific quality domains addressed by the survey instrument.

The specific domains of quality measured by CAHPS® surveys for the Children and Adult Medicaid populations include the following ratings and composites:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Shared Decision Making

Table 2 displays the aggregate average results of the six Virginia MCOs' CAHPS® Adult Population and Child General Population surveys for 2011 through 2013 as compared with the 2011- 2013 CAHPS® National Medicaid 50th Percentiles and the 2013 90th percentile. The CAHPS® 2013 data reflects calender year 2012, the data for calender year 2011 is reported for the CAHPS® 2012 results and CAHPS® 2011 is based on data reported for calender year 2010.

Table 2. Comparison of the Virginia MCO Average Scores and National Medicaid 50th and 90th Percentile for CAHPS® 2011 (CY 2010) through CAHPS® 2013 (CY 2012). Rating scores are combined answers of 8, 9, and 10. Composite scores are combined answers of Always/Usually, Yes, or A lot/Some/Yes. Advised to Quit Smoking by Doctor or Other Health Professional score is the combined answers of Always, Usually, and Sometimes.

Measure	Virginia MCO Average (CY 2010)+	Virginia MCO Average (CY 2011)+	Virginia MCO Average (CY 2012)+	CAHPS® (CY 2010) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 50th Percentile*	CAHPS® (CY 2012) National Medicaid 50th Percentile*	CAHPS® (CY 2012) National Medicaid 90th Percentile*
CAHPS - Adult Population							
Rating of Health Plan Overall	77.8%	76.7%	76.0%	73.2%	73.9%	74.5%	81.3%
Rating of Health Care Overall	72.6%	71.7%	70.4%	69.1%	70.0%	70.6%	76.3%
Rating of Personal Doctor Overall	78.4%	78.4%	77.7%	76.4%	77.0%	78.7%	82.9%
Rating of Specialist Overall	79.0%	79.7%	80.8%	77.1%	77.2%	79.5%	84.4%
Customer Service Composite	83.2%	82.4%	87.2%	79.5%	80.7%	86.5%	89.5%
Getting Needed Care Composite	78.8%	79.9%	82.0%	77.2%	76.9%	81.0%	85.4%
Getting Care Quickly Composite	81.0%	81.0%	83.4%	81.4%	81.3%	81.5%	85.4%
How Well Doctors Communicate Composite	88.9%	89.0%	88.8%	88.1%	88.0%	89.4%	92.6%
Shared Decision Making Composite	59.8%	62.0%	50.6%	59.6%	60.6%	-	-
Advised to Quit Smoking by a Doctor or Other Health Provider	76.2%	79.6%	78.6%	74.8%	75.2%	76.2%	81.3%
CAHPS - Child General Population							
Rating of Health Plan Overall	86.4%	86.6%	84.4%	82.7%	84.5%	83.5%	88.9%
Rating of Health Care Overall	82.1%	83.7%	84.5%	81.7%	83.4%	83.7%	87.0%

Measure	Virginia MCO Average (CY 2009)+	Virginia MCO Average (CY 2010)+	Virginia MCO Average (CY 2011)+	CAHPS® (CY 2010) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 50th Percentile*	CAHPS® (CY 2012) National Medicaid 50th Percentile*	CAHPS® (CY 2012) National Medicaid 90th Percentile*
Rating of Personal Doctor Overall	86.3%	86.4%	85.6%	84.9%	86.8%	86.9%	90.2%
Rating of Specialist Overall	78.9%	81.1%	86.2%	82.9%	82.3%	84.0%	89.5%
Customer Service Composite	81.2%	84.6%	88.5%	82.3%	82.7%	87.8%	91.2%
Getting Needed Care Composite	77.0%	81.7%	85.1%	80.2%	79.7%	84.7%	90.4%
Getting Care Quickly Composite	84.7%	86.0%	90.1%	88.0%	88.5%	90.1%	94.2%
How Well Doctors Communicate Composite	91.0%	90.8%	93.2%	92.1%	92.1%	93.2%	95.4%
Shared Decision Making Composite	64.7%	67.8%	50.8%	66.4%	69.1%	-	-

® Consumer Assessment of Healthcare Providers and Systems
+ Virginia Medicaid MCO Averages may vary from the state averages in Quality Compass
* CAHPS National Medicaid 50th and 90th Percentiles-Quality Compass Medicaid All Lines of Business
- No comparative benchmarks available

Of the ten rating and composite measures from the Adult category of the CAHPS® survey selected for this report, the Virginia MCO average for five measures compared favorably to the CAHPS® National Medicaid 50th Percentile from 2010 through 2012. In 2012, the Virginia MCO average for six out of the ten selected measures met or exceeded the CAHPS® National Medicaid 50th Percentile. Three of the selected measures showed improvement for the three year period between 2010 and 2012.

The results for two of the nine selected Children measures met or exceeded the National Medicaid 50th Percentile for from 2010 through 2012. Seven out of nine selected measures compared favorably to the National Medicaid 50th Percentile for measurement year 2012. The results for six measures showed improvement for the three year period between 2010 and 2012. An additional CAHPS survey was administered in 2013 to parents of child members enrolled in

the Family Access to Medical Insurance Security (FAMIS) program, The survey included children in the General Population (those served in the Fee-For-Service and MCO delivery systems) and Children With Chronic Conditions (those who experience a consequence associated with a condition).

The specific domains of quality measured by CAHPS® surveys for the FAMIS General Population include the following ratings and composites:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Coordination of Care
- Health Promotion and Education
- Shared Decision Making

The specific domains of quality measured by CAHPS® surveys for the FAMIS Children with Chronic Conditions include the following ratings and composites:

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Coordination of Care
- Health Promotion and Education

- Shared Decision Making
- Family Centered Care: Getting Needed Information
- Access to Prescription Medicine
- Family Centered Care: Personal Doctor Who Knows Child
- Access to Specialized Services
- Coordination of Care for Children with Chronic Conditions

Table 3 displays the aggregate average results for the Virginia FAMIS CAHPS® Child General Population and Children With Chronic Conditions Population surveys for 2013 as compared with the 2013 CAHPS® National Medicaid 50th and 90th Percentiles.

Table 3. Comparison of the Virginia FAMIS Average Scores and National Medicaid 50th and 90th Percentile for CAHPS® 2013 (CY 2012). Rating scores are combined answers of 8, 9, and 10. Composite scores are combined answers of Always/Usually, Yes, or A lot/Some/Yes.

Measure	Virginia FAMIS 2013 CAHPS	CAHPS® (MY 2012) National Medicaid 50th Percentile*	CAHPS® (MY 2012) National Medicaid 90th Percentile*
Children General Population			
Rating of Health Plan Overall	84.0%	83.5%	88.9%
Rating of Health Care Overall	85.0%	83.7%	87.0%
Rating of Personal Doctor Overall	89.0%	86.9%	90.2%
Rating of Specialist Overall	85.0%	84.0%	89.5%
Customer Service Composite	89.0%	87.8%	91.2%
Getting Needed Care Composite	86.0%	84.7%	90.4%
Getting Care Quickly Composite	89.0%	90.1%	94.2%
How Well Doctors Communicate Composite	94.0%	93.2%	95.4%
Coordination of Care Composite	81.0%	_	_
Health Promotion and Education Composite	69.0%	_	_
Shared Decision Making Composite	73.0%	-	-

Measure	Virginia FAMIS 2013 CAHPS	CAHPS® (MY 2012) National Medicaid 50th Percentile*	CAHPS® (MY 2012) National Medicaid 90th Percentile*
Children With Chronic Conditions Population			
Rating of Health Plan Overall	84.0%	82.0%	87.2%
Rating of Health Care Overall	87.0%	81.9%	86.7%
Rating of Personal Doctor Overall	91.0%	86.4%	89.8%
Rating of Specialist Overall	87.0%	84.5%	89.7%
Customer Service Composite	92.0%	89.0%	92.5%
Getting Needed Care Composite	88.0%	86.8%	91.5%
Getting Care Quickly Composite	93.0%	92.6%	94.8%
Well Doctors Communicate Composite	95.0%	93.4%	95.3%
Coordination of Care Composite	81.0%	_	_
Health Promotion and Education Composite	79.0%	_	_
Shared Decision Making Composite	77.0%	_	_
Family Centered Care: Getting Needed Information Composite	92.0%	90.5%	94.1%
Access to Prescription Medicine Composite	92.0%	91.0%	94.9%
Family Centered Care: Personal Doctor Who Knows Child Composite	90.0%	89.6%	92.1%
Access to Specialized Services Composite	76.0%	77.2%	81.8%
Coordination of Care for Children with Chronic Conditions Composite	74.0%	76.9%	81.4%

In seven rating and composite measures for the FAMIS General Population the Virginia average exceeded the CAHPS® National Medicaid 50th Percentile. For FAMIS Children with Chronic Conditions nine ratings and composite measures exceeded the CAHPS® National Medicaid 50th Percentile. FAMIS received positive satisfaction ratings from more than eight in ten parents/guardians from both populations regarding their child's Personal Doctor, Specialist,

Health Care overall, and Health Plan overall. FAMIS also received positive scores from both populations for three composite measures: How Well Dcotors Communicates, Getting Care Quickly, and Customer Service.

Performance Improvement Projects (PIPs)

The Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) requires contracted Medicaid managed care organizations (MCOs) conduct annual performance improvement projects (PIPs). PIPs are designed to achieve significant improvement, sustained over time, in clinical and non-clinical areas. DMAS selects project topics based on opportunities for improvement and relevance to the current Medicaid population. DMAS holds the MCOs accountable for the quality of care provided to the Medicaid enrollees.

The validation process expects the PIPs to demonstrate a favorable effect on the health outcomes of their enrollees. The CMS guidelines require PIPs designed, conducted, and reported in a methodologically sound manner. Delmarva uses the Centers for Medicare & Medicaid Services (CMS) protocol, *Validating Performance Improvement Projects—A Mandatory Protocol for External Quality Reviews, Version 2.0, December 1, 2011*, as a guideline in PIP review activities.

Using the CMS protocol as a guide, Delmarva assesses each PIP across a 10-step process. The 10 validation components include reviewing the selected study topics, and questions and indicators in relation to the identified study population. Delmarva evaluates the MCO sampling methodologies and data collection procedures using the CMS protocols. Delmarva reviews the strategies targeted by the MCO to achieve improvement along with their analysis of data results and their interpretation of study outcomes. Finally, Delmarva assesses whether reported improvement is *real* improvement and if it achieved sustained results.

At the direction of DMAS, MCOs are required to continue two PIPs in 2013 initially developed in 2012:

- *Adolescent Well-Care Visits*

  The measure identifies the percentage of enrollees 12-21 years of age who had at least one comprehensive well-care visit with a PCP or obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.

- *Follow-Up After Hospitalization for Mental Illness*

  The indicators identify the percentage of enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 and 30 days of discharge.

The 2013 validation reviewed the results of the first remeasurement year (CY 2012) against the baseline measurement year (CY 2011). Most of the MCOs identified NCQA Quality Compass 75th or 90th Percentiles as their long-term goals. The methodology appears appropriate in all projects and the MCOs implemented recommendations made by Delmarva during the baseline measurement review to enhance initial interventions.

The MCOs completed barrier analyses which identified member, provider, and MCO barriers impacting improvement. Targeted interventions were implemented that addressed barriers and a determination was made whether the MCOs actions resulted in increased rates for Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. The PIP results were mixed as the majority of MCOs did not document significant improvement and some documented decreases for the measures. However, some noteworthy findings were documented; Virginia Premier increased its Adolescent Well-Care Visits rate from 44.28 percent to 50.33 percent and CareNet increased its rate of Follow-up After Hospitalization for Mental Illness within 30 days from 67.03 percent to 73.38 percent.

MCOs should continue to share and adopt “best practices” from both local peers and national resources. An intervention that promotes one-to-one contact or outreach with enrollees and providers can be effective for sub-groups needing improvement. Finally, developing strategies to strive for more significant improvement (i.e., statistically significant rate increases) and targeting the HEDIS® National Medicaid Managed Care 90th Percentile as a stretch goal over the average should be considered.

Recommendations for DMAS

After evaluating all EQR results for quality, access, and timeliness of care in the managed care delivery system, Delmarva developed the following recommendations for DMAS:

- MCOs with HEDIS® results that meet or exceed the National Medicaid Managed Care 75th - 90th percentile rank, should be encouraged to share “best practice” strategies.
- DMAS should consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates.

- The MCO collaborative should continue coordination by DMAS to encourage sharing of improvement efforts to influence the quality of care provided to managed care enrollees.
- DMAS should continue and expand their practice of inviting additional stakeholders to participate in the MCO collaborative as either external partners or subject matter experts.

Recommendations for the Virginia MCOs

Based on the evaluation of the EQR activities conducted, Delmarva has developed the following recommendations for the MCOs:

- For PMV, all plans are encouraged to target to improve efforts to data capture for both PMV measures.
- MCOs are also encouraged to continue efforts to educate providers on ways to improve documentation of anticipatory guidance in both traditional and electronic health records (EHR) for the Adolescent Well-Care measure.
- MCOs with the best HEDIS® results compared with the National Medicaid Managed Care 90th percentile rates, should continue to share successful intervention strategies.
- MCOs should continue to conduct a root-cause or barrier analyses for those HEDIS® measures not meeting the HEDIS® National Medicaid Managed Care 50th percentile.
- Targeted PIP interventions need to reflect gap analyses and identify specific barriers to improve the results of population sub-groups.
- All MCOs should implement specific recommendations identified for improvement from all EQR activities.

Conclusions for DMAS

- DMAS has continued to see their contracted MCOs excel in NCQA's national ranking for health plans with five accredited MCOs making the list of the top 75 for 2012-2013. Another MCO, MajestaCare, achieved NCQA new health plan accreditation in 2013.

Conclusions for the Virginia MCOs

- All MCOs reviewed in PMV continued to demonstrate well-developed, in-house HEDIS® reporting processes.
- The MCO collaborative is an effective forum for sharing of local and national "best practices" that increase effectiveness in both PIP initiatives and HEDIS® results.

Appendix

Table A1-1 MCO HEDIS Rates (CY 2010 – CY 2012)□*

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet /SHS HEDIS 2012 (CY 2011)	CareNet /SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	Majesta Care HEDIS 2013 (CY 2012)
Antidepressant Medical Management– Acute Phase Tx	47.4%	49.1%	50.4%	46.5%	37.5%	54.6%	48.0%	51.4%	51.7%	45.8%	45.4%	51.5%	77.5%	75.1%	56.2%	NA
Antidepressant Medical Management – Continuation Phase Tx	34.2%	41.5%	34.4%	29.2%	24.1%	39.7%	35.0%	41.9%	36.5%	29.9%	28.7%	36.4%	66.0%	63.7%	42.8%	NA
Breast Cancer Screening	43.8%	45.6%	48.3%	47.8%	47.9%	49.5%	42.4%	54.0%	59.7%	50.3%	50.5%	50.3%	47.8%	48.0%	49.2%	NA
Childhood Immunization Status Combination 2	77.3%	66.1%	78.5%	70.4%	72.0%	72.3%	63.9%	69.5%	71.1%	63.4%	70.6%	70.6%	69.3%	70.3%	61.8%	NA
Childhood Immunization Status Combination 3	73.8%	64.7%	75.7%	66.0%	68.1%	67.6%	58.0%	63.1%	65.0%	59.2%	67.0%	67.0%	67.6%	65.7%	60.5%	NA
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Control <100 mg/DL	64.1%	45.8%	43.2%	48.6%	49.8%	49.8%	42.7%	43.4%	42.5%	32.1%	41.0%	60.0%	58.2%	59.4%	45.7%	NA
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Screening	93.8%	86.8%	93.2%	84.5%	83.1%	83.1%	83.8%	84.2%	83.9%	72.4%	79.8%	78.0%	82.0%	83.0%	78.4%	NA

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal (formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet /SHS HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	Majesta Care HEDIS 2013 (CY 2012)
Controlling High Blood Pressure	64.0%	54.0%	54.1%	57.7%	63.1%	55.7%	55.4%	55.6%	57.2%	50.3%	56.4%	51.2%	60.8%	57.7%	51.0%	60.9%
Comprehensive Diabetes Care– HbA1c Testing	85.0%	85.7%	87.8%	78.4%	85.0%	85.0%	82.2%	80.3%	80.5%	82.0%	82.4%	85.5%	81.6%	82.6%	84.3%	90.7%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	39.8%	41.4%	44.4%	40.6%	35.9%	35.9%	51.1%	47.0%	46.5%	47.7%	43.5%	39.5%	39.9%	40.0%	44.7%	49.1%
Comprehensive Diabetes Care– HbA1c Control <8%	52.1%	51.2%	48.8%	49.7%	55.8%	55.8%	44.7%	49.4%	45.3%	41.3%	45.1%	52.2%	47.6%	47.5%	48.2%	45.4%
Comprehensive Diabetes Care– Eye (Retinal) Exams	46.4%	48.6%	53.4%	57.5%	52.6%	52.6%	43.2%	54.6%	58.6%	47.4%	43.1%	48.6%	53.1%	54.5%	55.2%	22.2%

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet /SHS HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	MajestaCare HEDIS 2013 (CY 2012)
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	42.7%	40.9%	35.0%	42.3%	39.1%	39.1%	29.2%	36.2%	33.6%	32.1%	29.9%	55.7%	50.6%	53.6%	34.3%	16.7%
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	83.4%	82.3%	80.3%	79.8%	76.3%	76.3%	75.3%	73.9%	70.3%	64.3%	70.8%	75.3%	72.2%	75.6%	74.7%	75.9%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	79.1%	80.5%	80.3%	79.8%	77.1%	77.1%	77.0%	77.0%	72.3%	79.2%	79.3%	82.3%	73.9%	76.3%	76.7%	81.5%
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	41.1%	37.4%	42.1%	37.9%	36.3%	38.0%	37.1%	36.2%	39.7%	26.8%	32.3%	33.1%	37.1%	41.3%	40.6%	42.6%
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	65.0%	53.0%	59.0%	59.9%	56.0%	62.0%	61.8%	57.5%	61.8%	46.6%	50.8%	51.8%	58.8%	62.0%	57.2%	63.0%

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal (formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet /SHS HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	Majest aCare HEDIS 2013 (CY 2012)
Follow-Up After Hospitalization for Mental Illness– 7 Days	31.2%	24.0%	29.0%	43.8%	55.4%	53.7%	49.4%	46.5%	48.4%	58.1%	57.7%	60.1%	32.7%	38.6%	38.6%	20.7%
Follow-Up After Hospitalization for Mental Illness– 30 Days	55.8%	47.3%	52.1%	74.9%	87.3%	75.6%	70.7%	67.0%	73.4%	74.8%	76.8%	76.8%	56.1%	62.4%	65.5%	46.3%
Lead Screening in Children	69.0%	68.9%	70.6%	56.3%	59.7%	66.4%	63.7%	67.8%	72.8%	64.3%	67.9%	72.2%	66.7%	71.5%	70.4%	NA
Use of Appropriate Medications– Asthma Age 5-11⊙	96.0%	91.5%	87.6%	89.4%	90.2%	89.5%	94.3%	88.8%	93.2%	94.1%	91.8%	91.5%	91.3%	90.8%	89.9%	NA

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	Majest aCare HEDIS 2013 (CY 2012)
Use of Appropriate Medications– Asthma Age 12-18	^	87.3%	90.7%	^	87.7%	85.3%	^	92.0%	89.8%	^	89.0%	87.4%	^	86.1%	85.8%	NA
Use of Appropriate Medications– Asthma Age 19-50	^	67.5%	85.0%	^	65.5%	65.0%	^	54.1%	71.0%	^	79.6%	74.9%	^	68.5%	68.3%	NA
Use of Appropriate Medications– Asthma Age 51-64	^	NA	NA	^	69.6%	65.3%	^	NA	NA	^	73.2%	73.9%	^	73.8%	71.3%	NA
Use of Appropriate Medications– Asthma Total (Combined Ages) ☐	94.3%	88.0%	87.9%	85.3%	85.5%	84.8	90.1%	87.4%	87.9%	91.7%	88.3%	86.9%	88.4%	84.8%	84.6%	NA
Prenatal and Postpartum Care– Timeliness of Prenatal Care	79.4%	87.6%	86.9%	88.5%	91.4%	89.0%	87.4%	87.8%	88.8%	75.1%	75.1%	83.7%	85.6%	84.4%	83.9%	83.8%
Prenatal and Postpartum Care– Postpartum Care	64.0%	56.9 %	61.5%	70.0%	70.0%	63.8%	70.6%	67.4%	65.0%	62.3%	62.3%	65.3%	71.5%	66.7%	66.0%	60.3%
Adolescent Well-Care Visit	47.1%	49.1%	44.4%	40.5%	44.2%	44.2%	49.1%	48.6%	48.9%	45.3%	47.2%	47.2%	42.1%	44.3%	50.3%	41.7%

Measure	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2013 (CY 2012)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet /SHS HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2013 (CY 2012)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	OFC HEDIS 2013 (CY 2012)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)	VPHP HEDIS 2013 (CY 2012)	Majesta Care HEDIS 2013 (CY 2012)
Well-Child Visits in the First 15 Months of Life Six or more visits	60.4%	70.4%	64.8%	62.8%	66.2%	66.2%	58.3%	61.8%	63.3%	66.0%	71.8%	71.8%	84.7%	78.1%	69.5%	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	80.7%	79.2%	81.2%	73.6%	73.9%	73.9%	72.2%	74.1%	74.8%	76.3%	73.2%	71.8%	76.4%	70.8%	71.1%	67.8%

□ Comparative rates for Virginia MCOs and HEDIS 2012-Quality Compass Medicaid All Lines of Business can be found on Table 1
NA The denominator was too small to report a valid rate
NR The measure was calculated but the rate was materially biased, *or* the rate was not chosen to be reported
^ Measure not collected
*For rotated measures the actual MCO rates reported to DMAS may differ from rates reported in Quality Compass

Table A1-2 MCO CAHPS® (CY 2010 –CY 2012)□*

Measure	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	INTotal (formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2013 (CY 2012)	CareNet/ SHS CAHPS 2011 (CY 2010)	CareNet/ SHS CAHPS 2012 (CY 2011)	CareNet /SHS CAHPS 2013 (CY 2012)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	OFC CAHPS 2013 (CY 2012)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)	VPHP CAHPS 2013 (CY 2012)	MajestaCare HEDIS 2013 (CY 2012)
	CAHPS- Adult Population															
Rating of Health Plan Overall	67.9%	68.8%	67.6%	82.4%	79.0%	79.0%	78.6%	77.1%	75.8%	80.4%	83.6%	83.8%	79.4%	74.9%	76.8%	73.2%
Rating of Health Care Overall	64.1%	67.6%	64.9%	75.0%	73.5%	71.6%	74.8%	72.1%	70.0%	74.9%	74.4%	76.0%	74.0%	70.8%	71.4%	68.7%
Rating of Personal Doctor Overall	75.8%	79.2%	73.4%	76.9%	79.8%	76.8%	76.0%	76.1%	78.7%	81.9%	79.7%	81.0%	81.6%	77.3%	79.3%	77.1%
Rating of Specialist Overall	76.2%	78.5%	82.2%	83.3%	80.3%	82.8%	80.6%	80.3%	73.4%	83.6%	79.6%	81.4%	71.5%	80.0%	85.7%	79.5%
Customer Service Composite	81.0%	81.4%	82.4%	86.6%	NA	86.8 %	86.8%	86.5%	90.5%	76.7%	83.6%	86.0%	84.8%	78.3%	89.5%	87.7%
Getting Needed Care Composite	68.6%	69.0%	78.0%	84.5%	86.5%	84.8%	78.1%	79.5%	81.2%	82.9%	82.2%	80.6%	79.7%	82.5%	83.2%	83.9%
Getting Care Quickly Composite	78.2%	77.0%	81.7%	82.9%	85.5%	84.5%	80.2%	80.8%	82.0%	81.2%	79.6%	81.8%	82.3%	82.1%	84.5%	86.1%
How Well Doctors Communicate Composite	86.6%	85.7%	86.7%	89.6%	92.2%	90.3%	90.0%	89.5%	88.8%	90.1%	89.8%	89.3%	88.3%	87.8%	88.8%	88.8%
Shared Decision Making Composite	54.5%	56.3%	46.5%	59.6%	64.6%	56.7%	60.6%	62.6%	53.0%	62.6%	64.6%	47.7%	61.9%	62.1%	50.6%	48.9%

Measure	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2013 (CY 2012)	CareNet/ SHS CAHPS 2011 (CY 2010)	CareNet/ SHS CAHPS 2012 (CY 2011)	CareNet /SHS CAHPS 2013 (CY 2012)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	OFC CAHPS 2013 (CY 2012)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)	VPHP CAHPS 2013 (CY 2012)	Majesta Care HEDIS 2013 (CY 2012)
Advised to Quit Smoking by a Doctor or Other Health Provider	79.8%	85.9%	81.0%	75.7%	79.4%	79.8%	76.1%	82.5%	78.2%	70.2%	69.9%	73.0%	79.1%	80.3%	79.9%	79.8%
	CAHPS- Child General Population															
Rating of Health Plan Overall	87.9%	84.6%	84.5%	88.8%	89.0%	90.8%	84.3%	86.6%	83.2%	86.0%	88.6%	88.9%	85.2%	84.2%	83.3%	75.9%
Rating of Health Care Overall	84.8%	80.3%	81.7%	83.0%	82.5%	86.6%	79.8%	86.2%	85.0%	83.0%	83.7%	84.5%	79.9%	85.7%	87.7%	81.4%
Rating of Personal Doctor Overall	86.1%	81.9%	82.3%	84.2%	85.3%	86.9%	87.6%	88.7%	86.3%	86.6%	88.3%	85.2%	86.8%	87.8%	89.0%	84.2%
Rating of Specialist Overall	NA	74.6%	87.5%	NA	NA	NA	77.3%	78.9%	NA	80.0%	83.0%	79.5%	79.5%	88.0%	91.5%	NA
Customer Service Composite	76.0%	80.3%	86.6%	NA	NA	88.1 %	85.8%	85.0%	91.3%	80.7%	88.6%	88.4%	82.4%	84.6%	87.0%	89.7%
Getting Needed Care Composite	65.5%	68.1%	76.6%	NA	NA	83.4 %	80.9%	83.6%	87.1%	80.2%	86.1%	85.5%	81.3%	88.9%	88.5%	89.6%
Getting Care Quickly Composite	72.6%	76.2%	81.8%	85.4%	84.5%	89.4%	87.4%	85.9%	92.5%	87.3%	92.2%	92.7%	90.7%	91.4%	91.5%	92.9%
How Well Doctors Communicate Composite	86.2%	84.2%	89.4%	91.6%	89.8%	92.5%	91.9%	94.3%	95.4%	93.2%	92.5%	93.9%	92.2%	93.1%	96.0%	92.2%

Measure	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	INTotal(formerly AMG) HEDIS 2013 (CY 2012)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2013 (CY 2012)	CareNet/SHS CAHPS 2011 (CY 2010)	CareNet/SHS CAHPS 2012 (CY 2011)	CareNet/SHS CAHPS 2013 (CY 2012)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	OFC CAHPS 2013 (CY 2012)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)	VPHP CAHPS 2013 (CY 2012)	Majesta Care HEDIS 2013 (CY 2012)
Shared Decision Making Composite	64.8%	58.7%	42.1%	64.6%	NA	NA	65.9%	72.6%	55.1%	61.8%	69.2%	53.9%	66.5%	70.5%	52.0%	NA

□ Comparative rates for Virginia MCOs and HEDIS 2012-Quality Compass Medicaid All Lines of Business can be found on Table 2
NA Denominator too small to calculate a reliable rate
* The actual MCO rates reported to DMAS may vary from MCO rates reported in Quality Compass

Additional Information for CAHPS Measures in Table 2

The consumer experience with health care is an important part of quality of care and can affect the outcome of care. Survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) provide helpful insights that can be used to identify areas for improvement in member care.

NCQA provides technical specifications and standardized protocols for conducting and reporting results from the CAHPS surveys. Providing an additional layer of certainty, all Virginia MCOs use NCQA Certified CAHPS Survey Vendors. The summary results reported in Table 2 of this report reflect consumer perceptions through rating and composite scores as well as the *Advised Smokers and Tobacco Users to Quit* indicator from the *Medical Assistance With Smoking and Tobacco Use Cessation* measure. The purpose of this addendum is to provide a general explanation of how the percentages in Table 2 for the ratings and composite measures, as well as the *Advised Smokers and Tobacco Users to Quit* indicator, are derived.

The **rating scores**, in accordance with the CAHPS protocol, show the results of survey questions that ask respondents to rate four health care concepts on a scale of 0-10, where 0 is the worst possible and 10 the best possible. The scores presented in Table 2 are the sum of positive responses that were scored 8, 9, and 10. The four concepts for respondents to rate included all health care, their personal doctor, their health plan, and the specialist seen most often.

The **composite scores**, according to the CAHPS protocol, provide insight into current main areas of concern or composite areas. Composite scores are obtained from responses to several survey questions that ask respondents how often they (or their child) received care under certain conditions. Each composite looks at a specific situation and has two or more underlying questions. All questions for each composite have the same potential response categories: Never, Sometimes, Usually, or Always. The composite scores in Table 2 are summary rates based on the sum of proportional averages for questions in each composite where the response was Usually or Always. The composite categories are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

The last measure for the Adult CAHPS results in Table 2 is the *Advised Smokers and Tobacco Users to Quit* indicator from the *Medical Assistance With Smoking and Tobacco Use Cessation* measure. This score utilizes a **two-year rolling average** and is based on the percentage of members who indicated that they Sometimes, Usually or Always received advice to quit smoking or stop using tobacco by a doctor or health care practitioner. This indicator along with the rating and composite scores in Table 2 provide a comprehensive picture of the consumer's experience with their health care and their providers.