Commonwealth of Virginia
Department of Medical Assistance Services

2017 External Quality Review Technical Report Medallion 3.0

January 1, 2017–December 31, 2017

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

The Virginia Department of Medical Assistance Services (DMAS) is the single State agency that administers the Medicaid managed care program in the Commonwealth of Virginia (Virginia). As of December 2017, DMAS contracted with six managed care organizations (MCOs) to deliver services to over 795,000 children in low income families; aged, blind, or disabled individuals; pregnant women; certain caretaker parents in Virginia; and including acute care for waiver recipients. Contracted MCOs included Aetna Better Health of Virginia (Aetna); Anthem HealthKeepers Plus (Anthem); INTotal Health (INTotal); Kaiser Permanente; Optima Family Care (Optima); and Virginia Premier Health Plan, Inc. (VA Premier).

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care plans to "provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract." Federal external quality review (EQR) requirements have been further specified in 42 Code of Federal Regulations (CFR) §438.358 and §438.364.

DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct EQR activities and to produce this technical report covering review activities completed during the period of January 1, 2017, through December 31, 2017.

Scope of EQR Activities

HSAG used the results of the mandatory and optional EQR activities, as described in 42 CFR §438.358. The purpose of these activities, in general, is to provide valid and reliable data and information about the MCOs' performance. For the 2017 EQR Technical Report, HSAG used findings from the following EQR activities conducted from January 1, 2017, through December 31, 2017, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services (QAT) provided by each MCO. The assignment of QAT domains for the activities and performance measures are listed in Table 1-3 and Table 1-4.

Mandatory EQR Activities: comprehensive operational systems review (OSR), performance improvement projects (PIPS), and performance measures validation (PMV).

Optional EQR Activities: Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®),[1-1] Calculation of Performance Measures, Focused Studies on Improving Birth Outcomes

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

Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief.

Definitions

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

Quality

The Centers for Medicare & Medicaid Services (CMS) defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-2]

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."[1-3]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-4] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MMP—e.g., processing appeals and providing timely care. In the final 2016 federal managed care regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[1-3] Ibid.
[1-4] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

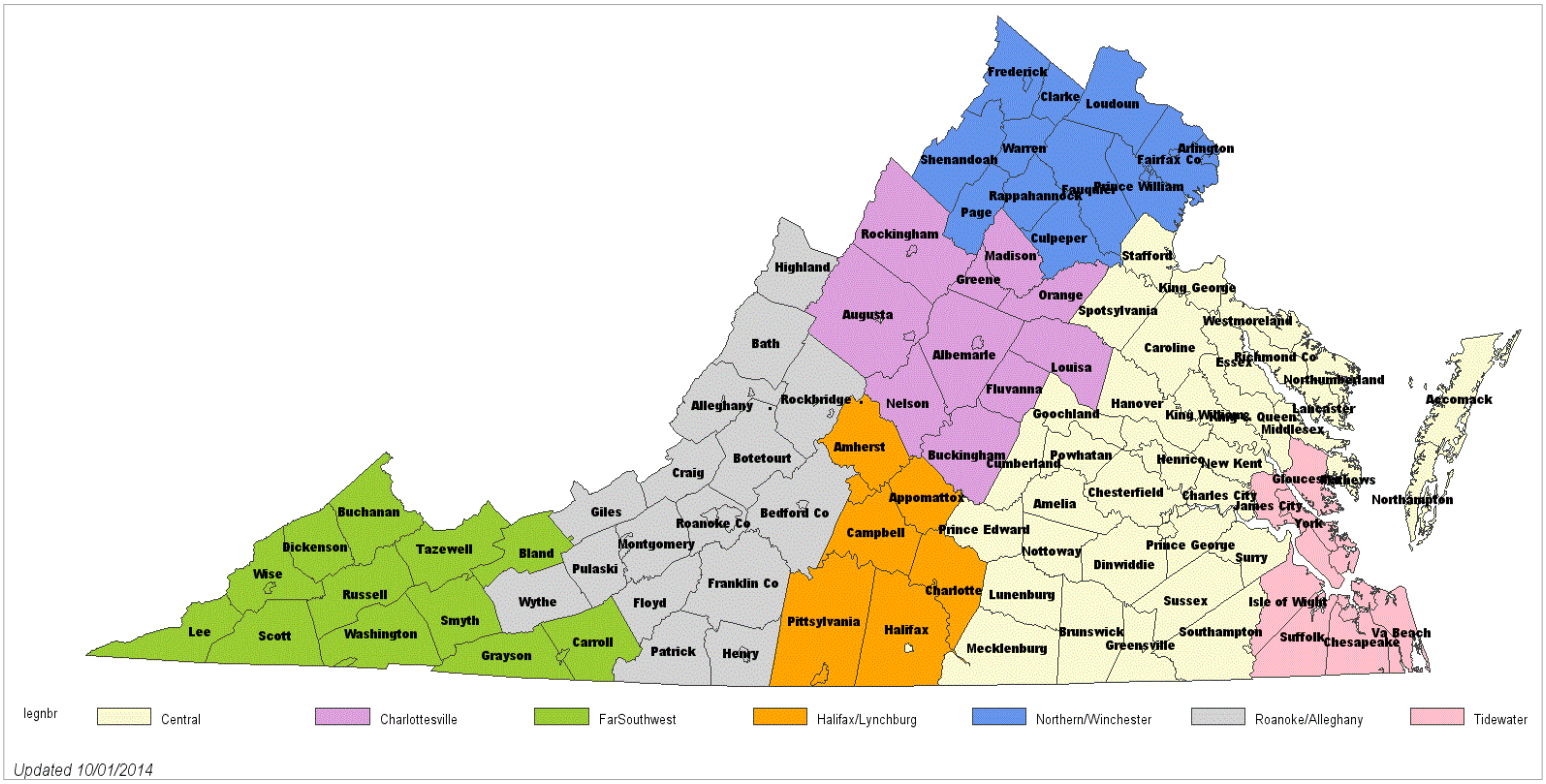
the general rule at 42 CFR §438.206 (a) and by requiring states, at 42 CFR §438.68 (b), to develop both time and distance standards for network adequacy.

Table 1-1—MCO Profiles as of December 2017

MCO	Year Operations Began as MCO in Virginia	Product Lines in Virginia	Medallion 3.0 Enrollment *(approximate)*
Anthem	1996	Medicaid, Commonwealth Coordinated Care (CCC) and CCC Plus, Medicare, Commercial	301,213
Aetna, formerly CoventryCares of Virginia	1996 (CoventryCares) April 1, 2016 (Aetna)	Medicaid, CCC Plus, Commercial	43,211
INTotal* **Acquired by UnitedHealthcare of Mid-Atlantic, Inc. on November 1, 2017.*	2013	Medicaid, CCC Plus	63,007
Kaiser Permanente	2013	Medicaid, Medicare, Commercial	14,307
Optima	1995	Medicaid, CCC Plus, Medicare, Commercial	180,101
VA Premier	1995	Medicaid, CCC, CCC Plus, Medicare, Commercial	193,478

As of December 2017, the six MCOs served more than 795,000 individuals in a Medicaid and Family Access to Medical Insurance Security (FAMIS) managed care program. Table 1-1 shows the enrollment by population for each MCO, and Figure 1-1 displays a map of the managed care regions for the population.

Figure 1-1—Virginia Medallion 3.0 Managed Care Regions



Accreditation

Virginia was among the first states to require that contracted MCOs achieve and maintain health plan accreditation by NCQA. Health plan accreditation involves a rigorous evaluation of the quality of health care and services provided, along with an assessment of clinical and member satisfaction performance measures (the Healthcare Effectiveness Data and Information Set [HEDIS®][1-5] and CAHPS). NCQA accreditation levels include Excellent, Commendable, Accredited, Provisional, and Interim.

Refer to Table 1-2 for the accreditation levels of the contracted MCOs in 2017.[1-6]

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-6] Virginia Medicaid/FAMIS Managed Care Organizations NCQA Accreditation Status. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/MCO%20NCQA%20Accreditation%20Status.pdf. Accessed on: Jan 19, 2018.

Table 1-2—MCO NCQA Accreditation Levels

MCO	Accreditation Level
Aetna	Accredited
Anthem	Commendable
INTotal	Accredited
Kaiser Permanente	Accredited
Optima	Commendable
VA Premier	Accredited

How Conclusions Were Drawn From Performance Measures

To draw conclusions about the quality and timeliness of, and access to, care provided by the MMPs, HSAG assigned each of the performance measures reviewed by the EQR to one or more of these three domains. Assignment to these domains is depicted in Table 1-3.

Table 1-3—EQR and DMAS Activities and Domains

Activity	Quality	Access	Timeliness
NCQA HEDIS Compliance Audit™ and Rate Review	✓	✓	
PMV	✓	✓	✓
PIP Validation	✓	✓	✓
Clinical Focused Study Results	✓	✓	✓
Compliance Review	✓	✓	✓
CAHPS Review	✓	✓	✓
Performance Incentive Awards	✓		✓
Consumer Decision Support Tool	✓	✓	

Aggregating and Analyzing Statewide Data

For each MCO, HSAG analyzed the results obtained from each EQR mandatory activity as well as those obtained from optional activities. From these analyses, HSAG determined which results were applicable to the domains of quality, access to, and timeliness of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and statewide. For each MCO reviewed, HSAG provides the following summary of its key findings, conclusions, and recommendations based on MCO's performance. For a more detailed and comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MMP, please refer to Section 4 of this report.

Overview of Findings and Conclusions

NCQA HEDIS Compliance Audit, Performance Measure Validation, and Rate Review

Table 1-4 shows HSAG's assignment of the performance measures to the areas of quality, timeliness, and access.

Table 1-4—Assignment of Performance Measures to the Quality, Access, and Timeliness to Care Domains

Performance Measure	Quality	Access	Timeliness
Adolescent Well-Care Visits	✓		
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, *Ages 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*		✓	
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 75%—Total	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓

Performance Measure	Quality	Access	Timeliness
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		

Table 1-5 displays the HEDIS 2016 and 2017 Virginia aggregate rates for the DMAS priority measures in the Medallion 3.0 contract. These aggregate rates represent the average of all six MCOs' measure rates weighted by the eligible population. HEDIS 2016 and 2017 rates were also compared to the corresponding NCQA's Quality Compass®,[1-7] national Medicaid health maintenance organization (HMO) 50th percentile. Yellow-shaded boxes indicate that the Virginia aggregate was at or above the national Medicaid 50th percentile.

Table 1-5—Virginia Aggregate HEDIS 2017 Measure Results

Performance Measures	HEDIS 2016	HEDIS 2017
Children's Preventive Care		
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	50.67%	51.53%
Childhood Immunization Status		
Combination 3	78.13%	72.17%
Well-Child Visits in the First 15 Months of Life		
Six or More Well-Child Visits	68.18%	64.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%	77.47%
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	52.50%	52.97%
Cervical Cancer Screening		
Cervical Cancer Screening	63.79%	60.48%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	83.56%	84.72%^
Postpartum Care	62.04%	63.95%^
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services		
Total	87.21%	86.74%
Children and Adolescents' Access to Primary Care Practitioners		

[1-7] Quality Compass® is a registered trademark of NCQA.

Performance Measures	HEDIS 2016	HEDIS 2017
12–24 Months	98.22%	98.12%
25 Months–6 Years	92.19%	92.47%
7–11 Years	93.62%	93.83%
12–19 Years	91.09%	91.58%
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	84.85%	86.51%^
HbA1c Control (<8.0%)	47.85%	48.36%^
Eye Exam (Retinal) Performed	48.75%	50.33%^
Medical Attention for Nephropathy	90.26%	90.65%^
Blood Pressure Control (<140/90 mm Hg)	56.04%	56.25%^
Controlling High Blood Pressure		
Controlling High Blood Pressure	54.01%	57.81%
Medication Management for People With Asthma		
Medication Compliance 75%—Total	29.65%	33.95%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	79.69%	82.27%
Discussing Cessation Medications	48.81%	51.62%
Discussing Cessation Strategies	40.74%	41.72%
Behavioral Health‡		
Antidepressant Medication Management		
Effective Acute Phase Treatment	54.94%	50.36%
Effective Continuation Phase Treatment	40.81%	35.11%
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	44.11%	46.53%
Continuation and Maintenance Phase	56.36%	61.15%
Follow-Up After Hospitalization for Mental Illness		
30-Day Follow-Up	60.22%	64.36%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
Total	51.10%	58.86%

^ *Due to issues discovered during the medical record review process, INTotal was required to report this rate using the administrative method. Therefore, caution should be exercised when comparing these aggregate results to prior years.*

‡ *Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.*

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2016).

Indicates that the HEDIS Rate was at or above the national Medicaid 50th percentile.

Review of the Virginia aggregate for HEDIS 2016 and HEDIS 2017 reflected continued strength across the areas of **quality**, **access**, and **timeliness**. Overall, 22 of 29 measure rates for HEDIS 2017 ranked at

or above the national Medicaid 50th percentile. Six measure rates increased from below the national Medicaid 50th percentile for HEDIS 2016 to at or above the national Medicaid 50th percentile for HEDIS 2017, indicating improved performance compared to national trends. Conversely, two rates moved from at or above the national Medicaid 50th percentile for HEDIS 2016 to below the national Medicaid 50th percentile for HEDIS 2017.

Within the **quality** domain, 17 of 24 measure rates (about 71 percent) ranked at or above the national Medicaid 50th percentile. Of note, although at or above the national Medicaid 50th percentile, the measure rate for *Child Immunization Status—Combination 3* decreased more than 5 percentage points from HEDIS 2016 to HEDIS 2017, indicating an area of concern. Seven measure rates (about 29 percent) in the **quality** domain (*Breast Cancer Screening*; *Comprehensive Diabetes Care—Eye Exam [Retinal] Performed* and *Blood Pressure Control [<140/90 mm Hg]*; *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment;* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*) fell below the national Medicaid 50th percentile, indicating opportunities for improvement for the MCOs. Performance in this domain was relatively consistent from HEDIS 2016 to HEDIS 2017, with most measure rates exhibiting fewer than 5 percentage points change.

For the **access** domain, 10 of 10 measure rates (100 percent) ranked at or above the national Medicaid 50th percentile.

For **timeliness**, all five measure rates (*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*; and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*) ranked at or above the national Medicaid 50th percentile.

Consumer Survey of Quality of Care

The CAHPS surveys were conducted for Virginia's FAMIS fee-for-service (FFS) and managed Medicaid population and for the six Medallion 3.0 MCOs to obtain information on the levels of satisfaction of adult and child Medicaid members. For the Medallion 3.0 MCOs (Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. The mode of CAHPS survey data collection varied slightly among the MCOs.

HSAG conducted the FAMIS CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. These CAHPS surveys were conducted in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements, which included a statewide sample of FAMIS members representative of the entire

population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care).

Statewide MCO Aggregate Results

The Medallion 3.0 contract requires the MCOs to conduct the Child and Adult CAHPS surveys annually and provide the detailed and composite scores to DMAS. For the Medallion 3.0 MCOs (Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. The mode of CAHPS survey data collection varied slightly among the MCOs. Table 1-6 presents the 2016 and 2017 statewide aggregate adult and child Medicaid CAHPS top-box scores (i.e., the percentages of top-level responses) for the global ratings. The statewide aggregate adult and child Medicaid CAHPS scores were compared to the 2016 and 2017 NCQA national adult Medicaid and child Medicaid averages, respectively.[1-8,1-9]

Table 1-6—Comparison of 2016 and 2017 Adult and Child Medicaid CAHPS Results: Global Ratings

	Statewide Aggregate			
	Adult Medicaid		Child Medicaid	
Global Ratings	**2016**	**2017**	**2016**	**2017**
Rating of Health Plan	66.4%	64.1%	74.4%	73.7%
Rating of All Health Care	58.4%	57.3%	70.2%	69.0%
Rating of Personal Doctor	68.3%	69.0%	76.2%	76.0%
Rating of Specialist Seen Most Often	66.5%	67.2%	71.5%	74.9%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

Table 1-7 presents the 2016 and 2017 statewide aggregate adult and child Medicaid CAHPS top-box scores (e.g., the percentage of top-level responses) for the composite measures. The statewide aggregate

[1-8] Statewide Aggregate scores were derived by calculating a mean of the combined scores of the six MCOs (i.e., average of the MCOs' top-box rates combined).

[1-9] For the NCQA national adult and child Medicaid averages, the source for data contained in this publication is Quality Compass® 2016 and 2017 data and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2016 and 2017 include certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

adult and child Medicaid CAHPS scores were compared to the 2016 and 2017 NCQA national adult Medicaid and child Medicaid averages, respectively.

Table 1-7—Comparison of 2016 and 2017 Adult and Child Medicaid CAHPS Results: Composite Measures

	Statewide Aggregate			
	Adult Medicaid		Child Medicaid	
Composite Measures	**2016**	**2017**	**2016**	**2017**
Getting Needed Care	81.2%	84.1%	85.3%	86.2%
Getting Care Quickly	83.9%	83.6%	90.4%	92.1%
How Well Doctors Communicate	90.7%	90.5%	93.8%	94.8%
Customer Service	87.3%	87.7%	86.6%	88.8%
Shared Decision Making	81.7%	79.2%	78.4%	78.1%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

FAMIS Program Aggregate Results

The FAMIS 2017 CAHPS results were also compared to the 2016 results and rates that were statistically significantly higher or lower than the corresponding NCQA national Medicaid averages where highlighted. Table 1-8 presents the 2016 and 2017 FAMIS Medicaid Program CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings. The FAMIS Medicaid Program general child and children with chronic conditions (CCC) CAHPS scores were compared to the 2016 and 2017 NCQA national child Medicaid and CCC Medicaid averages, respectively.[1-10]

Table 1-8—Comparison of 2016 and2017 FAMIS Program General Child and CCC Results: Global Ratings

	Program Aggregate			
	General Child		CCC	
Global Ratings	**2016**	**2017**	**2016**	**2017**
Rating of Health Plan	69.5%	70.5%	70.0%	68.6%
Rating of All Health Care	67.0%	69.8%	67.6%	67.8%

[1-10] For the NCQA national child and CCC Medicaid averages, the source for data contained in this publication is Quality Compass® 2016 and 2017 data and is used with the permission of NCQA. Quality Compass 2016 and 2017 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

	Program Aggregate			
	General Child		CCC	
Global Ratings	**2016**	**2017**	**2016**	**2017**
Rating of Personal Doctor	75.7%	75.2%	76.6%	76.3%
Rating of Specialist Seen Most Often	69.4%+	77.1%+	71.2%	71.7%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

Table 1-9 presents the 2016 and 2017 FAMIS Medicaid Program CAHPS top-box scores (e.g., the percentage of top-level responses) for the composite measures. The FAMIS Medicaid Program general child and CCC CAHPS scores were compared to the 2016 and 2017 NCQA national child Medicaid and CCC Medicaid averages, respectively.

Table 1-9—Comparison of 2016 and 2017 FAMIS Program General Child and CCC Results: Composite Measures

	Program Aggregate			
	General Child		CCC	
Composite Measures	**2016**	**2017**	**2016**	**2017**
Getting Needed Care	83.6%	84.7%	89.5%	85.3%
Getting Care Quickly	91.2%	91.1%	93.3%	92.4%
How Well Doctors Communicate	94.1%	95.0%	94.8%	97.2%
Customer Service	88.4%+	76.3%+	87.6%+	88.3%+
Shared Decision Making	71.8%+	81.1%+	84.8%	83.0%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

In 2017, the FAMIS child and CCC CAHPS ratings did not statistically significantly exceed the national global or composite measure ratings, except for *How Well Doctors Communicate* in the CCC category. For the general child category, *Customer Service* ranked statistically significantly lower than the 2017 NCQA national Medicaid average, with more than a 10 percent decrease from 2016. NCQA standards recommend exercising caution when interpreting results for the FAMIS and CCC CAHPS for *Customer Service* because the response rates were repeatedly low in both 2016 and 2017. Another factor to consider is that the member's or the caregiver's perception of customer service may have been influenced by the member's status as FFS or an MCO member. More specifically, the customer service-

related questions focus on whether the member or the caregiver received the information or help needed and the frequency that the customer service staff treated the member or the caregiver with courtesy and respect. DMAS would need additional information to identify effective intervention strategies to address these customer service satisfaction scores.

PIP Validation

PIPs provide a structured method to assess and improve processes and outcomes for care provided to MCO members. HSAG validates PIPs to determine compliance with the requirements of 42 CFR §438.330(b)(1) and 42 CFR §438.358(b)(i).

From early 2015, DMAS engaged in the review of a more proactive and outcome-oriented approach for having its MCOs conduct PIPs. This led to DMAS discussions with CMS and HSAG regarding implementing a rapid-cycle PIP framework, which HSAG developed, that is a modified version of the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement.[1-11] This approach places greater emphasis on improving outcomes using rapid-cycle improvement methods to pilot small changes. Working with CMS and the respective states that have adopted the framework for the rapid-cycle approach, HSAG has aligned the rapid-cycle PIP process to fit into the current CMS protocols for conducting and validating PIPs. DMAS elected to move forward with adopting the rapid-cycle approach for its redesigned PIP methodology and implemented the process with the MCO contract effective July 1, 2016.

Beginning in 2016, DMAS required that each MCO conduct one PIP related to a priority HEDIS measure for comprehensive diabetes care. During the Medicaid Managed Care Quality Collaborative meeting, this measure was identified by the MCOs and DMAS as one of the HEDIS measures most in need of improvement. The MCOs' PIP activities in 2017 were a continuation of the rapid-cycle PIP processes outlined following. For the rapid-cycle PIP framework, HSAG developed five modules with an accompanying companion guide:

- **Module 1—PIP Initiation**: Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART [specific, measurable, attainable, relevant, and time-bound]), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is outlined and the data collection methodology is described. The data for the SMART Aim will be displayed using a run chart.

[1-11] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Jan 26, 2018.

- **Module 3—Intervention Determination:** In Module 3, the quality improvement activities that can impact the SMART Aim are identified. Through process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a series of Plan, Do, Study, Act (PDSA) cycles.
- **Module 5—PIP Conclusions:** Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

HSAG assigns a confidence rating to the PIP at the end of the project, after intervention testing and all five modules have been completed.

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.
- *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

For PIPs, HSAG reviews module submissions and provides feedback. If all validation criteria are achieved, MCOs progress to the next module of the process. If all criteria are not achieved, MCOs must address HSAG's recommendations in a resubmission of the module and achieve all validation criteria before progressing to the next module. Therefore, no outstanding EQR recommendations existed from the prior validation year. As a general comment, HSAG recommends that MCOs refer to HSAG's PIP Companion Guide when completing the rapid-cycle PIP modules and request technical assistance from HSAG as needed.

In January 2017, HSAG conducted a webinar to provide guidance to the MCOs and DMAS on Module 4 of the rapid-cycle PIP process. At the time of the training, all MCOs had progressed to Module 3 (Intervention Determination) and were scheduled to submit the intervention plan portion of Module 4 to HSAG in March 2017. In addition to the training webinars that HSAG provided, the MCOs sought individual technical assistance throughout the PIP process. HSAG's rapid-cycle PIP validation process facilitated frequent communication with the MCOs throughout the duration of the project. While the MCOs were in the Module 4 intervention testing phase, HSAG periodically requested updates on the progress of the PIP and provided feedback. The MCOs are scheduled to submit Module 5, PIP Conclusions, in February 2018.

PMV Validation

Monitoring of performance measures allows for the assessment of quality of, access to, and timeliness of the care and services provided to Medicaid members. Validation of MCOs' performance measure rates reported to the State during the preceding 12 months is a mandatory EQR activity set forth in 42 CFR §438.358(b)(ii).

As part of performance measurement, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates are accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit conducted by a certified independent auditor.

Each MCO contracted with an NCQA-licensed audit organization (LO) to conduct the HEDIS audit. Additionally, HSAG reviewed the MCO's final audit reports (FARs), information systems (IS)compliance tools, and the Interactive Data Submission System (IDSS) files approved by each MCO's LO. HSAG found that the MCOs' information systems and processes were compliant with the applicable IS standards and the HEDIS reporting requirements.

HSAG's PMV activities included two separate HEDIS measures, *Timeliness of Prenatal Care* and *Medication Management for People With Asthma*, to evaluate further the accuracy of reported performance measure rates. HSAG also conducted PMV on two state measures, *Foster Care Assessments* and *MCO Claims Processing*, as they are key elements in the Performance Incentive Award initiative detailed further later this report.

HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate) for assistance with the performance measure validation. Using the validation methodology and protocols described in Appendix C, HSAG determined results for each performance measure. The CMS PMV protocol identifies two possible validation finding designations for performance measures: Report (R)—Measure data were compliant with HEDIS and DMAS specifications and the data, as reported, were valid. Not Reported (NR)—Measure data were materially biased. HSAG's findings for each MCO's measure designation are summarized in Table 1-10.

Table 1-10—MCO Measure Designation

	Performance Measure	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier
1.	*Foster Care Assessments (Performance Incentive Award (PIA)Measure)*	R	R	R	NR	R	R
2.	*MCO Claims Processing (PIA Measure)*	R	R	R	R	R	R
3.	*Prenatal and Postpartum Care (PPC)—HEDIS 2017* • Timeliness of Prenatal Care	R	R	R*	R	R	R

	Performance Measure	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier
4.	*Medication Management for People with Asthma (MMA)—HEDIS 2017*	R	R	R	R	R	R

* Please note, the HEDIS auditor required INTotal to report this measure administratively for HEDIS 2017. This was due to issues with the MCO's medical record review processes and concerns with data completeness, which would have caused the hybrid rate to be materially biased and, therefore, not reportable.

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

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

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

Performance Measure Documentation—While interviews and system demonstrations provide supplementary information, most validation review findings were based on documentation provided by the MCOs. HSAG reviewed all related documentation, which included the completed Roadmap, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. **HSAG determined that the documentation of performance measure generation by the MCOS was acceptable, excepting** the HEDIS auditor findings noted for INTotal and Kaiser in the MCO-specific findings in Section 5.

Operational Systems Compliance Reviews

HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[1-12] for planning the comprehensive on-site operational systems review

[1-12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2018.

activities. HSAG conducted the planning review activities, evaluation, and aggregation and analysis of findings between fall of 2016 and spring of 2017. HSAG evaluated the degree to which the MCOs complied with federal Medicaid managed care regulations and the associated requirements in the contract between DMAS and each MCO in 12 performance categories (i.e., standards) for the review period from July 1, 2015, through June 30, 2016. HSAG worked with DMAS to identify areas acceptable for deeming wherein the MCOs had complied with NCQA accreditation standards.

Overall, the six MCOs scored high across all standards, with overall compliance rates ranging from 96 percent to 99.5 percent. The lowest aggregate score for a standard was Health Information Systems at 93 percent. All six MCOs achieved 100 percent compliance in four standards; Coordination and Continuity of Care; Provider Selection, Credentialing, and Recredentialing; Member Rights and Protections; and Quality Assessment and Performance Improvement.

MCOs were required to implement corrective action plans (CAPs) for any performance score of *Partially Met* or *Not Met* to bring the MCOs' performance into full compliance. DMAS was responsible for reviewing and monitoring the MCOs' CAPs. Currently, no outstanding corrective actions exist.

Quality Initiatives

The Medallion 3.0 contract requires each MCO to complete federal and state-mandated quality improvement activities such as: participation in a quarterly collaborative; reporting of HEDIS and CAHPS data; participation in PIPs; participation in measurement validation activities; and participation in a performance incentive award program.[1-13] In addition, the Medallion 3.0 Annual Report describes a range of programs and initiatives targeted at specific needs of the member populations, as illustrated in Table 1-11.

Table 1-11—Medallion 3.0 Programs

Medallion 3.0 Populations	Foster Care	Health and Acute Care Program	Oral Health	Disease Case Management
Infants	✓		✓	✓
Children	✓	✓	✓	✓
Pregnant Women		✓	✓	✓
Adults	✓	✓		✓
Aged, Blind, and Disabled	✓	✓	✓	✓

[1-13] Connecting Care. 2017 Medallion 3.0 Annual Report. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/Medallion%203.0%20Annual%20Rpt_SFY2017_final.pdf. Accessed on: Jan 29, 2018.

Throughout 2017, DMAS enhanced its quality improvement initiatives through the development of:

- **Agency-wide Quality Steering Committee**—In 2017, DMAS established an integrated quality governance structure with the creation of a Quality Steering Committee with representatives from Integrated Care, Health Care Services, Provider Reimbursement, and the Office of the Chief Medical Officer. The Quality Steering Committee operates under the direction of DMAS Senior Leadership.
- **Agency-wide Quality Aims**—An overarching aspiration for the updated Quality Strategy was to begin to integrate the quality management program across DMAS by applying the same quality standards and adopting a common set of quality metrics. DMAS goals for superior care, cost effectiveness, and continuous improvement are supported through four publicly promoted quality aims:
  1) Build a Wellness Focused, Integrated System of Care
  2) Focus on Screening and Prevention
  3) Achieve Healthier Pregnancies and Healthier Births
  4) Improve Wellbeing Across the Lifespan
- **Fostering Futures**—Implemented July 1, 2016, enables foster children and some adoptive children over the age of 16 to remain in foster care until the age of 21.

Additionally, DMAS contracted with HSAG to perform additional quality improvement activities related to calculation of performance metrics, designing quality rating systems, and conducting focused studies as highlighted following:

- Calculation of pediatric quality measure results (*National Quality Forum [NQF] #2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*).
- Production of a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results.
- Continuance of the Performance Incentive Award program to improve health outcomes for members in the FAMIS and Medallion 3.0 populations and to promote and incentivize MCOs' high performance on six measures representing two measurement domains (i.e., administrative and HEDIS).
- Conduct three focused studies—Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief.

Information about these non-specific MCO activities is detailed in Section 3–MCO Comparative Information and Quality Strategy Recommendations.

Consumer Decision Support Tool

On May 6, 2016, CMS published the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services

to Medicaid beneficiaries must adopt and implement a quality rating system (QRS) within three years of the final notice of the Medicaid and CHIP QRS. Although the final notice of the QRS has not been released, Medicaid agencies that already have a QRS in place will have an opportunity to use their current QRS with CMS approval. DMAS contracted with HSAG in 2015 (which was a pilot year) to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS performance measure data and CAHPS survey results, which may meet the requirement for a QRS with CMS approval. The tool was developed to help support DMAS' public reporting of MCO performance information to be used by consumers to make informed decisions about their healthcare. Since the pilot year, HSAG has produced a 2016 and 2017 consumer decision support tool using 2016 HEDIS and CAHPS data and 2017 HEDIS and CAHPS data, respectively.

The 2016 and 2017 methodology for developing the tool followed the pilot year (i.e., CY 2015 results) process, combining and analyzing HEDIS performance measure data and CAHPS survey results to assess MCOs' performance related to certain areas of interest to consumers and included the same five domains:

- Doctors' Communication
- Getting Care
- Keeping Kids Healthy
- Living With Illness
- Taking Care of Women

A summary score was calculated for each domain by MCO to determine MCO performance. The summary score for each MCO was then compared to the Medicaid MCO Virginia average to determine differences in MCO performance. The Consumer Decision Support Tool used stars to display results for the MCOs, as shown in Table 1-12.

Table 1-12—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 1-13 displays the 2017 Consumer Decision Support Tool results for each MCO.

Table 1-13—2017 Consumer Decision Support Tool Results

MCO	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★	★★	★★	★★	★
Anthem	★★	★★	★★	★	★★★
INTotal	★★	★	★	★	★
Kaiser Permanente	Insufficient Data*	★★	★★	★★	★★★
Optima	★★	★★	★	★★	★
VA Premier	★★	★★★	★★	★★	★★

**Indicates that the MCO did not have sufficient data to receive a rating for this domain.*

The finalized 2017 tool includes an overview of the tool; description of the reporting categories; MCO-specific results; MCO accreditation levels; and background information for consumers choosing a Medicaid MCO, including MCO region assignments and contact details as shown in Appendix F. Additionally, the 2017 Consumer Decision Support Tool results were published in the Connecting Care –2017 Medallion 3.0 Annual Report.[1-14]

The Consumer Decision Support Tool's inclusion of the MCO accreditation level emphasizes the standard of quality and integrity expected of contracted MCOs in Virginia. Virginia was among the first states to require that contracted MCOs achieve and maintain health plan accreditation by NCQA. Health plan accreditation involves a rigorous evaluation of the quality of healthcare and services provided, along with an assessment of clinical and member satisfaction performance measures (HEDIS and CAHPS). NCQA accreditation levels include Excellent, Commendable, Accredited, Provisional, and Interim.

Performance Incentive Awards

The Performance Incentive award initiative was created to provide a financial incentive to Medicaid MCOs to improve the quality, efficiency, and overall value of health care for members in the FAMIS and Medallion 3.0 populations.

For the PIA program, DMAS selected six measures representing two measurement domains (i.e., administrative and HEDIS measures). The measures were consistent in both Year 1 and Year 2.

[1-14] Connecting Care. 2017 Medallion 3.0 Annual Report. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/Medallion%203.0%20Annual%20Rpt_SFY2017_final.pdf. Accessed on: Jan 29, 2018.

The first domain, administrative measures, included the following measures:

- *Assessments of Foster Care Population*
- *MCO Claims Processing*
- *Monthly Reporting Timeliness and Accuracy*

The second domain, HEDIS measures, included the following measures:

- *Childhood Immunization Status—Combination 3*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

The PIA program rewards higher-scoring MCOs to support sustained high performance and imposes financial penalties on lower-scoring MCOs to promote improved performance in the future. The PIA was initiated as a pilot program in 2015; therefore, no actual penalties or awards were implemented that year, and results were shared with the MCOs for input. The MCOs were subject to quality awards or penalties in Program Year 1 (i.e., 2016 results) and will be subject to awards or penalties in Program Year 2 (i.e., 2017 results).

The PIA Program Funds Allocation Model uses the MCO's weighted score sum to allocate funds among MCOs. In addition, the Funds Allocation Model was developed to ensure that the total dollar amount for awards will always be equal to the total dollar amount for penalties, thereby ensuring budget neutrality for DMAS.

If an MCO's weighted score sum is above or below the Virginia average, it is awarded or penalized, respectively. If an MCO's weighted score is equal to the Virginia average, no award or penalty will occur. The amount of the award or penalty, is independent of the Virginia average, and is instead based on the percentage of the maximum possible score (i.e., the highest possible measure score is 3) achieved by the MCO. Please refer to Section 4 of this report for more information regarding the PIA scoring and calculations.

The Program Year 2 (2017) results indicated that four MCOs will be assessed for awards and two MCOS will be assessed penalties for their performance in 2017, the latter of will be collected from the MCOs in Spring 2018. These results, along with the methodology and technical specifications, are anticipated to be posted on the DMAS' website in the second quarter of 2018.

Focused Studies

DMAS contracted with HSAG to conduct, during the 2016–2017 contract year, three focused studies on clinical topics selected by DMAS: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study), improving the health of children in foster care (Foster Care Focused Study), and Dental Utilization in Pregnant Women Data Brief.

Improving Birth Outcomes Through Adequate Prenatal Care

The Birth Outcomes Focused Study was designed to address the following questions:

- ***To what extent do women with births paid by Medicaid receive early and adequate prenatal care?***
- ***What clinical outcomes are associated with Medicaid-paid births?***

The five study indicators were reported in the CY 2014 study and were to be reproduced using probabilistically and deterministically linked data for Virginia Medicaid or FAMIS MOMS recipients with birth registry records to identify births paid by Virginia Medicaid during calendar year 2015. Delays in obtaining birth registry information impacted the study reporting time frame, although the second year's report is scheduled to be released in 2018.

Improving the Health of Children in Foster Care

The Foster Care Focused Study was designed to answer the question: ***To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery?***

DMAS approved the continuation of the study methodology and medical record procurement materials during the 2015–2016 contract year, and HSAG conducted the remaining study tasks (i.e., medical record procurement and abstraction, data analysis, and reporting) during the 2016–2017 contract year. Administrative and medical record data were used to calculate 15 study indicators across three domains (i.e., characteristics of Medicaid members in foster care, preventive care, and behavioral health). During the second year of statewide managed care service delivery, children in foster care with continuous enrollment in managed Medicaid continued to receive expected preventive medical and behavioral health care. For the domains that relied upon medical record documentation, the decreased rates for expected well-child visits and expected immunizations may have been adversely impacted by lower medical record submission rates.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide a data brief on dental utilization among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015. This focused study is designed to provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve prenatal care and birth outcomes among Medicaid and FAMIS members receiving dental services. HSAG will provide an annual data brief to assess dental utilization among pregnant women covered by Virginia Medicaid and FAMIS MOMS using the Deliveries Value Set referenced in the HEDIS technical specifications to identify women with a delivery during the measurement period. The data brief for the first full reporting year (January 1, 2016, through December 31, 2016) will be available in the first half of 2018.

Managed Care Quality Collaborative

The Medicaid Managed Care Quality Collaborative has been active for more than a decade and is facilitated by DMAS QI staff, meeting four times per year in Richmond. The MCOs, the external quality review organization (EQRO), and DMAS have used the collaborative to develop innovative programs and potential solutions to target the needs of Medicaid members as well as to share best practices and lessons learned.

DMAS hosted three Medicaid Managed Care Quality Collaborative meetings with all contracted MCOs in 2017. The purpose of the collaborative meetings was to facilitate the sharing of information among DMAS and the MCOs, with the goal of improving the quality of care and services provided to Medicaid members. The meetings included review of mandatory and optional EQR activity findings, selection of measures for 2017, a review of the DMAS compliance program, foster care program and contract updates, and best practice presentations provided by the MCOs. The best practice topics included coordinating health and wellness with behavioral health, HEDIS data cleansing, waiver audit process, case management system and HEDIS gaps in care capabilities, enhanced care coordination program for behavioral health members, human papillomavirus (HPV) vaccines in adolescents, improving lead screening HEDIS rates, bordering states data sharing model, and improving member connections through real time data.

Statewide Summary of Strengths, Weaknesses, and Overall Conclusions

The Virginia HEDIS 2017 aggregate scores demonstrated continued strength in DMAS performance, with 22 of 29 measure rates for HEDIS 2017 ranked at or above the national Medicaid 50th percentile. The six measure rates that improved to rank at or above the national Medicaid 50th percentile for HEDIS 2017 were *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; *Comprehensive Diabetes Care—Hb1Ac Testing* and *HbA1c Control (<8.0%)*; *Controlling High Blood Pressure*; and *Follow-Up after Hospitalization for Mental Illness—30-Day Follow-Up*.

Within the **quality** domain, 17 of 24 measure rates (about 71 percent) ranked at or above the national Medicaid 50th percentile. For the **access** domain, 10 of 10 measure rates (100 percent) ranked at or above the national Medicaid 50th percentile. For **timeliness**, all five measure rates (*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*; and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*) ranked at or above the national Medicaid 50th percentile.

DMAS has the greatest improvement opportunity in the **quality** domain, where seven quality indicators (about 29 percent) fell below the national Medicaid 50th percentile. As with the 2016 HEDIS results, DMAS demonstrated a continuing opportunity for improvement in *Breast Cancer Screening*; *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)*; *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*.

While the measure rate for *Childhood Immunization Status—Combination 3* remained above the national Medicaid 50th percentile, the 2017 rate decreased more than 5 percentage points from HEDIS 2016, indicating an area of concern. Examination of the individual MCOs' rates for this measure suggests that the decline in immunization rates for four of the six MCOs (Aetna, Anthem, INTotal, and VA Premier) had an adverse impact on the statewide aggregate childhood immunization rates. While these MCOs' rates declined by varying degrees, the relative size of each MCO's member population impacted the decline in rates as well. DMAS and the corresponding MCOs should identify ways to examine childhood immunization rates and the alignment with the *Well-Child Visits in the First 15 Months of Life —Six or More Well-Child Visits* rate more closely to determine the causal relationships.

DMAS should consider including the discussion of improvement opportunities when considering the *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 15 Months of Life — Six or More Well-Child Visits* indicators as a whole at a future quality collaborative meeting. The focus of the discussion would be to collaborate with the MCOs regarding missed opportunities. A missed opportunity for vaccination refers to *any contact with health services by an individual who is eligible for a vaccination*. Missed opportunities are primarily due to a provider failing to simultaneously administer all vaccines for which a child is eligible; false contraindications; health workers' practices, including not opening a multidose vaccine vial for a small number of persons to avoid vaccine wastage; and logistical problems. Obtaining open and honest feedback from the MCO quality representatives will ensure alignment and support for improvement of these rates.

The statewide aggregate CAHPS adult Medicaid global ratings exceeded NCQA national Medicaid averages in three of four categories in 2016 and 2017 (*Rating of Plan, Rating of all Health Care,* and *Rating of Personal Doctor*). Two of five Adult Medicaid CAHPS composite measures exceeded NCQA Medicaid averages in 2016: *Getting Care Quickly* and *Shared Decision Making*. Two of five adult Medicaid CAHPS composite measures exceeded NCQA Medicaid averages in 2017: *Getting Needed Care* and *Getting Care Quickly.* Statewide aggregate CAHPS child Medicaid global ratings exceeded NCQA national Medicaid averages in two of four categories in 2016: *Rating of Health Plan* and *Rating of All Health Care*. Statewide aggregate CAHPS child Medicaid global ratings exceeded NCQA national Medicaid averages in one of four categories in 2017: *Rating of Health Plan.* One of five child Medicaid CAHPS composite measures exceeded NCQA Medicaid averages in 2016 (*Getting Care Quickly*). Three of five child Medicaid CAHPS composite measures exceeded NCQA Medicaid averages in 2017 (*Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate).*

In reviewing the 2017 Consumer Decision Support Tool results, Anthem and Kaiser Permanente each received three stars in the Taking Care of Women domain and VA Premier received three stars in the Getting Care domain. Conversely, INTotal received only one star for four of the six domains: Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women. Optima received only one star in two of the six domains: Keeping Kids Healthy and Taking Care of Women.

Summary of Quality Strategy Recommendations for DMAS

The 2017 technical report is HSAG's third cycle of completing the EQR analysis and reporting for the Commonwealth of Virginia. In these past three years, DMAS has demonstrated continued success in improving the quality of, access to, and timeliness of care and services for the managed Medicaid programs in the Commonwealth of Virginia. In addition to the mandatory EQR activities, DMAS requested HSAG's assistance on the following optional EQR activities: developing and implementing the Consumer Decision Support Tool and the Performance Incentive Award program; conducting three focused studies aimed at improving birth outcomes, the health of children in foster care, and dental utilization among pregnant women; calculating select performance measures; and previously, validating encounter data. DMAS' other notable advancement in quality improvement was the development of the updated Commonwealth of Virginia Department of Medical Assistance Services 2017–2019 Quality Strategy (Quality Strategy). The two key enhancements to this Quality Strategy were the expansion of the Quality Strategy to include all programs (i.e., Medallion 3.0/4.0, CCC and CCC Plus, and FAMIS) and the identification of the stretch performance goal for MCOs to reach the Quality Compass 75th percentile on the priority measures. The Quality Strategy recommendations for DMAS are:

1. Drive the MCOs to advance improvement in the HEDIS priority measures toward NCQA's Quality Compass national Medicaid 75th percentiles.

The Medallion 3.0 managed care contract[1-15] requires that MCOs ensure annual improvement in the HEDIS priority measures (as listed in Table 1-5) until such time that each MCO is performing at least at the 50th percentile for HMOs as reported by NCQA Quality Compass. Thereafter, the MCO must sustain performance at the 50th percentile. Of note, 76 percent of the measures for HEDIS 2017 (22 of 29) ranked at or above the national Medicaid 50th percentile. HSAG recommends that DMAS develop an improvement scale whereby the MCOs are required to develop actionable plans to demonstrate annual improvement toward meeting/exceeding the 75th percentile for key measures identified within the priority measures. The design of the improvement scale could also serve as the foundation to guide DMAS and the MCOs in the development of value-based payment models referenced in the Medallion 4.0 provider contracts.

2. Direct MCOs to focus HEDIS measure improvement efforts that include *Antidepressant Medication Management, Breast Cancer Screening,* and *Medication Management for People With Asthma-Medication Compliance 75%—Total*.

As DMAS evaluates the opportunity to create the recommended improvement scale, DMAS may want to prioritize these three HEDIS measures as the preliminary areas of focus for the improvement scale and require that the MCOs conduct performance improvement activities using the Model for

[1-15] Medallion 3.0 Managed Care Contract—July 1, 2016–June 30, 2017. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/Medallion%203%20Contract%20for%202016-2017%20-%20FINAL%20-%20CLEAN%20-%206-8-16.pdf. Accessed on: Feb 15, 2018.

Improvement.[1-16]. HSAG provides more information about the MCO-specific recommendations in Section 4 that focuses on experience with other states' health plan efforts to improve performance with the *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total* HEDIS measure rates.

3. Ensure MCO executive leadership support for the MCOs' ongoing performance improvement projects (PIPs).

HSAG has observed MCOs in a number of states experiencing challenges with adapting to the more rigorous rapid PIP process methodologies. DMAS should collaborate with each MCO's executive leadership teams to ensure support for these performance improvement activities and equip the senior managers to communicate the vision clearly, consistently, and repeatedly throughout the organization.

As part of HSAG's technical assistance support for PIPs, HSAG assists states with the PDSA reporting processes and is available to discuss results and recommendations. Additionally, HSAG recommends that MCOs use other quality improvement techniques to examine systems and address failures. For example, the Six Sigma performance improvement model—Define, Measure, Analyze, Improve, Control (DMAIC)—is the International Organization for Standardization's (ISO's) highly recognized methodology for facilitating improvement in processes and outcomes.

4. Confirm that the MCOs uphold the provider network contract standards to make medical records available to DMAS and the EQRO in a timely manner.

INTotal's results on the 2017 Consumer Decision Support Tool were impacted by the fact that INTotal was unable to report all of the hybrid HEDIS measures using the hybrid methodology. This issue stemmed from some of the MCO's contracted provider agreements with a third-party health information management company. The Medallion 3.0 contract (14.19.A.II and III) requires the MCOs to have procedures in place to ensure that medical records maintained by network providers are readily available to DMAS and the EQRO in a timely manner. DMAS should require the MCOs to review their provider contracts to ensure that this Medallion 3.0 contract requirement is upheld with all contracted providers.

[1-16] Institute for Healthcare Improvement. "How to Improve." Available at http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 18, 2018.

2. Overview of the Virginia Medicaid Managed Care Program

Medicaid Managed Care in Virginia

Medicaid provides health coverage to millions of Americans including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

In Virginia, Medicaid plays a critical role in the lives of over a million Virginians, providing access to health care for the most vulnerable populations. The impact of Medicaid extends far beyond traditional health coverage, to include comprehensive services such as behavioral health and long-term services and supports (LTSS). Medicaid is the largest payer of behavioral health services in the Commonwealth, providing inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. Medicaid is also the primary funder for LTSS, making it possible for thousands of Virginians to remain in their homes or to access residential care when needed.[2-1]

The Department of Medical Assistance Services

The Department of Medical Assistance Services (DMAS) is the Commonwealth of Virginia's agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models. As of November 2016, 75 percent of Medicaid enrollees received their benefits through managed care and 25 percent of enrollees participated in Medicaid through the FFS model. In 2017, the managed Medicaid populations in Virginia were organized into three programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), and CCC Plus.

Medallion 3.0

Over the past 20 years, the Medallion program has provided acute and primary care services for enrolled members that included pregnant women: low income families with children (LIFC); those receiving temporary assistance for needy families (TANF); aged, blind, and disabled (ABD); and children. Two more recent expansion groups are foster care/adoption assistance (FC/AA) and the health and acute care program (HAP) populations. The Virginia Medallion 3.0 program provides health care coverage statewide to Medicaid members through a mandatory MCO enrollment mechanism for designated eligibility categories for approximately 795,000 members. The primary exclusions are members who are dually eligible for Medicare and Medicaid, who have comprehensive private insurance as primary payers, who reside in nursing homes, and some members who receive services under a home- and community-based waiver. Contracted MCOs included Aetna Better Health of Virginia (Aetna), Anthem HealthKeepers Plus (Anthem), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier).

[2-1] Virginia Department of Medical Assistance Services. 2017 Medicaid at a Glance. Available at: http://www.dmas.virginia.gov/Content_atchs/atchs/MAG%20FINAL_1_13_17_.pdf. Accessed on: Jan 12, 2018.

Commonwealth Coordinated Care MCO Model

Commonwealth Coordinated Care (CCC) is a program that blends and coordinates Medicare and Medicaid benefits for approximately 22,000 dual-eligible enrollees aged 21 or older who live in designated regions around the Commonwealth. Individuals receiving long-term supports and services through nursing facilities and the Elderly or Disabled with Consumer Direction (EDCD) Waiver are also eligible to participate in the CCC managed care program. Three Medicare-Medicaid health plans—Anthem HealthKeepers, Humana, and VA Premier—contracted with CMS and DMAS to provide services under CCC during a four-year demonstration. The contract includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. CMS and DMAS monitor health plan performance and quality by requiring the health plans to report HEDIS data along with quarterly assessment and plan of care completion rates.

DMAS is in the process of modifying the structure of the Medicaid managed care programs to continue to improve care delivery and efficiency. On August 1, 2017, the Commonwealth Coordinated Care Plus (CCC Plus) program began as a new statewide Medicaid managed long-term services and supports program that will serve approximately 214,000 individuals with complex care needs, through an integrated delivery model, across the full continuum of care. During the second half of 2017, the HAP members of Medallion 3.0 populations transitioned to CCC Plus. The ABD and CCC members transitioned to CCC Plus on January 1, 2018.

Virginia Quality Strategy

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

History

DMAS published its first quality strategy in June 2005. The strategy was first updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 managed care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the Proposed Rule to modernize and update the federal Medicaid managed care regulations. It addresses the progression of, and impending changes to, managed care

quality in Virginia. The Addendum served to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy was developed and approved. The third edition was finalized by DMAS on January 31, 2018, for calendar years 2017 through 2019. This third edition aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340. The new federal regulations advance DMAS' mission of better care, healthier people, and smarter spending.

The purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement system consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, timeliness, member satisfaction, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure that Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery steeped in best practices; and make health care more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

Quality Governance

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

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

Data Analytics Strategy

The proactive identification and resolution of issues related to health care quality are dependent upon complete, accurate, and timely data. DMAS' strategy for clinical data focuses on automation, connection, and information. Additionally, through contracting and increased oversight, DMAS has worked to ensure that the participating MCOs and FFS providers submit accurate and timely administrative and clinical data.

Quality Strategy Focus and Priorities

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

The four publicly promoted aims are:

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

Mission

DMAS' mission is to provide a system of high-quality and cost-effective health care services to qualifying Virginians and their families that far exceeds the industry standards for timeliness, access, and quality of care.

Vision

DMAS' vision is to develop an outcomes-based quality program that focuses on the member's health and encourages innovation in health care services and program.

To accomplish these goals, DMAS identifies program-specific objectives (i.e., measurements) and performance targets to guide implementation of interventions. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources. Table 2-1 shows goals and measure examples related to each of DMAS' four aims.

Table 2-1—DMAS Quality Dashboard

DMAS Quality Dashboard
August 28, 2017

Health Aims	Goals	Examples of Measures
Build a Wellness Focused, Integrated System of Care	Strengthen access to primary care network (4.1)	HEDIS: Adults' Access to Primary Care (Preventative/Ambulatory Health Services)
		HEDIS: Children and Adolescents' Access to Primary Care
	Decrease inappropriate utilization and total cost of care	All-Cause PQI Admission Rate
		CMS/NQF #1768: Plan All-Cause Readmissions
		HEDIS: Ambulatory Care - Emergency Department Visits
		Per Capita Healthcare Expenditures (future measure)
	Emphasize member experience of care	CAHPS/HEDIS/NQF #0006: Member Rating of Health Plan
	Integration of behavioral, oral and physical health (4.1)	CMS/HEDIS/NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 rates)
		CMS/NQF #1664: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge
		HEDIS/NQF #0576: Follow Up After Hospitalization for Mental Illness, 7-day Follow Up
		CMS/NQF #2605: Follow Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
		CMS: Transition of Members Between SUD LOCs, hospitals, NF and the Community
	Encourage appropriate management of prescription medications	Use of High-risk Medications in the Elderly
		NCQA: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
		HEDIS: Follow-up Care for Children Prescribed ADHD Medication - Initiation and Continuation/Maintenance Phases
		HEDIS: Antidepressant Medication Management - Effective Acute Phase Treatment, Effective Continuation Phase Treatment
		PQA: Use of Opioids at High Dosage in Persons Without Cancer
		PQA: Use of Opioids from Multiple Providers in Persons Without Cancer
		PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer
Focus on Screening and Prevention	Cancers are prevented or diagnosed at the earliest stage possible (3.4)	HEDIS/NQF #2372: Breast Cancer Screening
		NQF #0034: Colorectal Screening
		HEDIS/NQF #0032: Cervical Cancer Screening
	Prevention of nicotine dependency (3.2)	AMA-PCPI/NQF #0027: Tobacco Use - Screening and Cessation
	Virginians protected against vaccine-preventable diseases (3.3)	HEDIS: Childhood Immunization Status (Combo 10)
		HEDIS: Immunizations for Adolescents
		HEDIS: Pneumococcal Vaccination Status for Older Adults

DMAS Quality Dashboard
August 28, 2017

Health Aims	Goals	Examples of Measures
Focus on Screening and Prevention	Virginians protected against vaccine-preventable diseases (3.3)	HEDIS: Flu Vaccinations
	Support consistency of recommended pediatric screenings	CMS/HEDIS: Annual Preventative Dental Visits
		HEDIS: Well-Child Visits, 1st 15 Months of Life
		HEDIS: Well-Child Visits in 3rd, 4th, 5th, 6th Years of Life
		HEDIS: Adolescent Well-Care Visits (12-21 Years)
		OHSU: Developmental Screening in the First 3 Years of Life
Achieve Healthier Pregnancies and Healthier Births	Virginians plan their pregnancies (2.1)	NQF 2902/OPA: Contraceptive Care - Postpartum Women Ages 15-44
		HEDIS: Postpartum Care Visit
	Improved pre-term birth rate	Early Elective Deliveries Rate
		HEDIS: Timeliness of Prenatal Care
		HEDIS: Frequency of Ongoing Prenatal Care
		CMS/CDC/PQI: Percent of Live Births <2,500 Grams
Maximize Wellbeing Across the Lifespan	Effective management of chronic respiratory disease	PQI 14: Asthma Admission Rate (Ages 2-17)
		PQI 15: Asthma in Younger Adults Admission Rate
		CMS/PQI 05/NQF #0275: COPD and Asthma in Older Adults Admission Rate (2 measures)
	Comprehensive management of diabetes	HEDIS: Comprehensive Diabetes Care
		PQI 01/NQF #0272: PQI Diabetes Short-term Complication Admission Rate
	Effective management of cardiovascular disease	HEDIS/NQF #0018: Controlling High Blood Pressure
	Ensure quality of life for members with intensive healthcare needs	JLARC: Nursing Facility Diversion - # and % of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home & Community Based Services (HCBS) Over Institutional Placement
		Quality of Life and Member Satisfaction Survey CMS-Specific
		Assessments and Reassessments
		Plan of Care and POC Revisions
		Documentation of Care Goals
		JLARC: Transition of Members Between Community Well, LTSS and Nursing Facility - Services and Successful Retention in Lower Care Settings
		JLARC: Nursing Facility Residents Hospitalization and Readmission Rate
		Fall Risk Management: Intervention/Managing Fall Risk
	Provide support for End of Life	% Enrollees with Advanced Directives

3. Comparative Information and Quality Strategy Recommendations

MCO Managed Care Performance in Virginia

To evaluate the MCO's managed care performance in Virginia, DMAS, through the Medallion 3.0 contract, requires each MCO to complete federal and state-mandated quality improvement activities such as participation in a quarterly collaborative meeting, reporting of HEDIS and CAHPS data, participation in performance improvement projects, participation in measurement validation activities, and participation in a performance incentive award program.[3-1]

Additionally, DMAS has contracted with HSAG to perform additional quality improvement activities related to calculation of performance metrics, designing quality rating systems, and conducting focused studies, as highlighted following:

- Calculatepediatric quality measure results (*NQF #2801: Use of First-Line Psychosocial Care for Children and Adolsecents on Antipsychotics*)
- Produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results
- Design the Performance Incentive Award program to improve health outcomes for members in the FAMIS and Medallion 3.0 populations and promote and incentivize MCOs' high performance on six measures representing two measurement domains (i.e., administrative and HEDIS)
- Conduct three focused studies – Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief.

Where applicable, the statewide aggregate results are discussed in the following sections. MCO-specific results are detailed in Section 5—Assessment of MCO Performance.

MCO Comparative and Statewide Aggregate HEDIS Results

Table 3-1 displays, by MCO, the HEDIS 2017 measure rate results compared to the national Medicaid 50th percentiles for HEDIS 2016 and the Virginia aggregate, which represents the average of all six MCOs' measure rates weighted by the eligible population. Yellow-shaded boxes indicate MCO measure rates that were at or above the national Medicaid 50th percentile. Rates performing better than the Virginia aggregates are represented in green font.

[3-1] The Way Forward, 2016 Medallion 3.0 Annual Report: Member Care, Operations, Performance Management, & Innovation. Available at: http://www.dmas.virginia.gov/Content_atchs/m4/Medallion%203.0%20Annual%20Report_The%20Way%20Forward_Approved_02102017.pdf. Accessed on: Jan 22, 2018.

Table 3-1—MCO Comparative and Virginia Aggregate HEDIS 2017 Measure Results

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Children's Preventive Care							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	50.12%	**55.32%**	51.09%	**61.07%**	48.84%	48.84%	**51.53%**
Childhood Immunization Status							
Combination 3	66.42%	**76.39%**	55.72%	**84.64%**	**72.92%**	71.53%	**72.17%**
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	61.22%	**68.06%**	46.38%	59.20%	**67.53%**	63.66%	**64.53%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life							
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.26%	**77.78%**	**78.36%**	**92.44%**	**80.47%**	74.54%	**77.47%**
Women's Health							
Breast Cancer Screening							
Breast Cancer Screening	**53.41%**	52.13%	50.21%	**7.14%**	**54.55%**	52.75%	**52.97%**
Cervical Cancer Screening							
Cervical Cancer Screening	55.26%	**65.28%**	50.61%	**84.29%**	56.85%	60.05%	**60.48%**
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	83.33%	**92.13%**	41.97%^	**96.51%**	83.10%	**85.15%**	**84.72%**
Postpartum Care	**65.36%**	**70.14%**	28.73%^	**90.12%**	60.42%	**64.27%**	**63.95%**
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	85.13%	**86.88%**	84.27%	**89.90%**	85.98%	**88.00%**	**86.74%**
Children and Adolescents' Access to Primary Care Practitioners							
12–24 Months	97.87%	**98.42%**	97.79%	**98.63%**	97.61%	**98.21%**	**98.12%**
25 Months–6 Years	**92.58%**	**93.25%**	**92.79%**	**95.62%**	90.59%	**92.69%**	**92.47%**
7–11 Years	93.12%	**94.28%**	**95.53%**	**95.20%**	92.51%	**93.97%**	**93.83%**
12–19 Years	**91.69%**	**91.75%**	**91.67%**	**91.93%**	90.47%	**92.34%**	**91.58%**
Care for Chronic Conditions							
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing	86.13%	85.19%	85.67%^	**97.44%**	**86.81%**	**87.72%**	**86.51%**

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
HbA1c Control (<8.0%)	45.01%	**54.63%**	5.58%^	**71.79%**	**49.77%**	**48.77%**	**48.36%**
Eye Exam (Retinal) Performed	**52.80%**	46.99%	37.49%^	**86.32%**	**53.94%**	**52.28%**	**50.33%**
Medical Attention for Nephropathy	90.51%	**90.97%**	89.67%^	**96.58%**	90.05%	**90.88%**	**90.65%**
Blood Pressure Control (<140/90 mm Hg)	54.74%	**68.52%**	11.35%^	**85.47%**	52.55%	54.21%	**56.25%**
Controlling High Blood Pressure							
Controlling High Blood Pressure	**61.31%**	**60.19%**	BR	**84.62%**	53.01%	**57.87%**	**57.81%**
Medication Management for People With Asthma							
Medication Compliance 75%—Total	**35.52%**	29.73%	30.93%	22.58%	**34.41%**	**38.55%**	**33.95%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	78.37%	**84.23%**	78.37%	NA	**86.88%**	**83.52%**	**82.27%**
Discussing Cessation Medications	51.61%	**51.84%**	**51.82%**	NA	49.71%	**53.13%**	**51.62%**
Discussing Cessation Strategies	37.86%	40.74%	41.32%	NA	**46.15%**	**42.54%**	**41.72%**
Behavioral Health‡							
Antidepressant Medication Management							
Effective Acute Phase Treatment	**50.95%**	48.76%	**52.25%**	**60.00%**	49.78%	**51.98%**	**50.36%**
Effective Continuation Phase Treatment	34.32%	32.87%	**37.40%**	**42.00%**	**35.71%**	**36.78%**	**35.11%**
Follow-Up Care for Children Prescribed ADHD Medication							
Initiation Phase	**54.96%**	41.88%	**59.45%**	NA	39.81%	**55.38%**	**46.53%**
Continuation and Maintenance Phase	**66.28%**	53.70%	**76.92%**	NA	57.75%	**67.63%**	**61.15%**
Follow-Up After Hospitalization for Mental Illness							
30-Day Follow-Up	60.34%	**65.30%**	64.00%	**82.98%**	63.03%	**64.86%**	**64.36%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	**72.46%**	**60.57%**	**65.00%**	NA	47.47%	**65.49%**	**58.86%**

^ *Due to issues discovered during the medical record review process, INTotal was required to report this rate using the administrative method. Therefore, caution should be exercised when comparing these results to MCOs that reported these rates using the hybrid method and to benchmarks calculated using the administrative and/or hybrid method.*

‡ *Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.*

NA indicates that the MCO followed the specifications but the denominator was too small to report a valid rate.

BR indicates that the rate was materially biased.

Note: *MCO measure rates performing better than the Virginia aggregate are represented in green.*

Indicates that the HEDIS 2017 rate was at or above the 2016 national Medicaid 50th percentile.

Among the six MCOs, Anthem displayed consistently high performance in the Children's Preventive Care domain; performance on all four performance measure rates that were compared to benchmarks ranked at or above the 2016 national Medicaid 50th percentile and the Virginia aggregate rate. Rates for Kaiser Permanente for *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* performed approximately 8 and 12 percentage points, respectively, above the next highest performing MCO's rate. Conversely, only three measure rates for Aetna ranked at or above the national Medicaid 50th percentile in the Children's Preventive Care domain and all of Aetna's rates in this domain fell below the Virginia aggregate rates, indicating opportunities for improvement. Of note, INTotal's measure rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was almost 13 percentage points below the next lowest-performing MCO, demonstrating an opportunity for improvement for INTotal.

Within the Women's Health domain, Kaiser Permanente and Anthem performed better than the other MCOs, with at least three measure rates for these MCOs ranking at or above the national Medicaid 50th percentile and above the Virginia aggregate. Furthermore, all four measure rates in this domain for Kaiser Permanente ranked at or above the national Medicaid 50th percentile and exceeded the Virginia aggregate rate, demonstrating an area of strength. Conversely, INTotal demonstrated the most opportunities for improvement as all of the MCO's measure rates fell below the national Medicaid 50th percentile and the Virginia aggregate rate. It should be noted, however, that INTotal reported the *Prenatal and Postpartum Care* measure indicators using the administrative method for HEDIS 2017; therefore, caution should be exercised when comparing these results to MCOs that reported these rates using the hybrid method and to benchmarks calculated using the administrative and/or hybrid methodology. Of note, rates for the *Breast Cancer Screening* measure for all MCOs except Kaiser Permanente fell below the national Medicaid 50th percentile.

The six MCOs ranked at or above the national Medicaid 50th percentile for all *Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primary Care Practitioners* measure rates, demonstrating an area of strength in the Access to Care domain. Further, Anthem, Kaiser Permanente, and VA Premier performed above the Virginia aggregate rate for all five measure rates.

For the Care for Chronic Conditions domain, all MCOs except INTotal exceeded the national Medicaid 50th percentile on over 50 percent of their reportable measure rates. Further, Optima and VA Premier's measure rates for 7 of the 10 indicators (70 percent) ranked at or above the national Medicaid 50th percentile; and at least six of the rates at or above the national Medicaid 50th percentile were at or above the Virginia aggregate rate. Similarly, six of Kaiser Permanente's seven reportable measure rates (about 86 percent) ranked at or above the national Medicaid 50th percentile and the Virginia aggregate rates.

Notably, Kaiser Permanente's reportable measure rates performed approximately 32 and 23 percentage points above the next highest performing MCO for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Controlling High Blood Pressure*, respectively. Conversely, INTotal demonstrated the most opportunities for improvement with only two measure rates ranked at or above the national Medicaid 50th percentile. However, because INTotal reported the *Comprehensive Diabetes Care* measure indicators using the administrative method for HEDIS 2017, caution should be exercised when comparing these results to MCOs that reported these rates using the hybrid method and to benchmarks calculated using the administrative and/or hybrid methodology.

Among the six MCOs, VA Premier demonstrated the best performance in the Behavioral Health domain with four of their six reportable measure rates (66 percent) ranked at or above the national Medicaid 50th percentile and all exceeding the Virginia aggregate rate. Kaiser Permanente was the only MCO to perform at or above the national Medicaid 50th percentile for the *Antidepressant Medication Management* measure indicators. Additionally, Kaiser Permanente's rate for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* was approximately 18 percentage points above the next highest performing MCO, indicating an area of strength for the MCO. Optima demonstrated the most opportunity for improvement within this domain as only one of six reportable rates (about 17 percent) ranked at or above the national Medicaid 50th percentile. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about the MCO performance for measures reported in the Behavioral Health domain.

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 3-2 presents the 2016 and 2017 top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate adult Medicaid CAHPS for the global ratings. The 2016 and 2017 CAHPS scores for each MCO and the statewide aggregate were compared to the 2016 and 2017 NCQA national adult Medicaid averages, respectively.

Table 3-2—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Global Ratings

	Aetna		Anthem		INTotal		Kaiser		Optima		VA Premier		Statewide Aggregate	
Global Ratings	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Rating of Health Plan	58.4%	62.8%	65.2%	63.4%	60.3%	59.2%	57.5%	65.6%	70.2%	67.5%	67.8%	62.9%	66.4%	64.1%
Rating of All Health Care	52.7%	59.4%	60.2%	59.9%	58.5%	50.0%	59.5%	59.0%	60.2%	59.5%	55.8%	54.2%	58.4%	57.3%
Rating of Personal Doctor	62.5%	68.9%	66.2%	70.2%	69.4%	65.6%	66.7%	76.0%	71.5%	69.4%	69.4%	68.0%	68.3%	69.0%

	Aetna		Anthem		INTotal		Kaiser		Optima		VA Premier		Statewide Aggregate	
Global Ratings	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Rating of Specialist Seen Most Often	59.4%	55.7%	63.1%	67.9%	73.7%	67.6%	71.7%	70.4%+	67.9%	67.1%	69.6%	69.1%	66.5%	67.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national adult Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national adult Medicaid averages.

Comparison of the statewide aggregate and MCOs' 2016 adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid average revealed the following summary results:

- Anthem scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- INTotal scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often*.
- Optima scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- VA Premier scored statistically significantly higher than the 2016 NCQA national adult Medicaid average on one measure, *Rating of Health Plan*.
- The Statewide Aggregate scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

Comparison of the statewide aggregate and MCOs' 2017 adult Medicaid CAHPS scores to the 2017 NCQA national adult Medicaid average revealed the following summary results:

- Aetna scored statistically significantly lower than the 2017 NCQA national adult Medicaid average on one measure, *Rating of Specialist Seen Most Often*.
- Anthem scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- Kaiser scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- Optima scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- VA Premier scored statistically significantly higher than the 2017 NCQA national adult Medicaid average on one measure, *Rating of Health Plan*.

- The Statewide Aggregate scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

Table 3-3 presents the 2016 and 2017 top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate adult Medicaid CAHPS for the composite measures. The 2016 and 2017 CAHPS scores for each MCO and the statewide aggregate were compared to the 2016 and 2017 NCQA national adult Medicaid averages, respectively.

Table 3-3—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Composite Measures

	Aetna		Anthem		INTotal		Kaiser		Optima		VA Premier		Statewide Aggregate	
Composite Measures	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Getting Needed Care	81.9%	84.9%	79.8%	80.9%	83.0%	79.9%	80.9%	76.6%	79.8%	86.3%	83.8%	85.8%	81.2%	84.1%
Getting Care Quickly	87.0%	83.9%	83.5%	81.1%	88.1%	82.7%	81.6%	76.9%	83.2%	81.5%	83.4%	88.1%	83.9%	83.6%
How Well Doctors Communicate	88.1%	90.4%	93.1%	91.0%	92.0%	91.5%	89.1%	90.0%	88.6%	90.9%	89.8%	89.4%	90.7%	90.5%
Customer Service	92.6%	84.7%+	87.2%	87.7%	85.4%	84.6%	85.5%+	88.4%+	87.4%	87.3%	86.7%	89.4%	87.3%	87.7%
Shared Decision Making	78.3%	82.3%+	80.7%	77.2%	80.9%	79.4%	78.6%+	79.1%+	81.9%	77.5%	84.0%	81.8%	81.7%	79.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

Comparison of the statewide aggregate and MCOs' 2016 adult Medicaid CAHPS scores to the 2016 NCQA national adult Medicaid average revealed the following summary results:

- Aetna scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on two measures: *Getting Care Quickly* and *Customer Service*.
- Anthem scored statistically significantly higher than the 2016 NCQA national adult Medicaid average on one measure, *How Well Doctors Communicate*.
- INTotal scored statistically significantly higher than the 2016 NCQA national adult Medicaid average on one measure, *Getting Care Quickly*.
- VA Premier scored statistically significantly higher than the 2016 NCQA national adult Medicaid average on one measure, *Shared Decision Making*.
- The Statewide Aggregate scored statistically significantly higher than the 2016 NCQA national adult Medicaid averages on two measures: *Getting Care Quickly* and *Shared Decision Making*.

Comparison of the statewide aggregate and MCOs' 2017 adult Medicaid CAHPS scores to the 2017 NCQA national adult Medicaid averages revealed the following summary results:

- Optima scored statistically significantly higher than the 2017 NCQA national adult Medicaid average on one measure, *Getting Needed Care*.
- VA Premier scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- The Statewide Aggregate scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Please refer to Section 5, Assessment of MCO Performance, for detailed information on statistically significant differences in results for each MCO.

Child Medicaid

Table 3-4 presents the 2016 and 2017 top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate child Medicaid CAHPS for the global ratings. The 2016 and 2017 CAHPS scores for each MCO and the statewide aggregate were compared to the 2016 and 2017 NCQA national child Medicaid averages, respectively.

Table 3-4—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Global Ratings

	Aetna		Anthem		INTotal		Kaiser		Optima		VA Premier		Statewide Aggregate	
Global Ratings	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Rating of Health Plan	68.6%	70.0%	75.5%	76.5%	77.3%	78.0%	65.3%	70.5%	80.1%	75.4%	68.3%	71.3%	74.4%	73.7%
Rating of All Health Care	70.5%	68.2%	68.3%	73.0%	68.0%	70.1%	68.0%	72.4%	74.5%	71.7%	69.9%	65.3%	70.2%	69.0%
Rating of Personal Doctor	73.5%	74.7%	77.1%	75.9%	74.3%	68.2%	72.5%	79.5%	77.0%	80.3%	75.2%	75.5%	76.2%	76.0%
Rating of Specialist Seen Most Often	56.8%+	72.4%+	73.9%+	77.6%	69.4%+	75.0%	77.5%+	74.5%+	72.1%+	80.6%+	71.0%+	71.3%	71.5%	74.9%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

Comparison of the statewide aggregate and MCOs' 2016 child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid average revealed the following summary results:

- Aetna scored statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Rating of Specialist Seen Most Often*.
- Anthem scored statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Rating of Health Plan*.
- INTotal scored statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Rating of Health Plan*.

- Optima scored statistically significantly higher than the 2016 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- The Statewide Aggregate scored statistically significantly higher than the 2016 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

Comparison of the statewide aggregate and MCOs' 2017 child Medicaid CAHPS scores to the 2017 NCQA national child Medicaid average revealed the following summary results:

- Anthem scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- INTotal scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure, *Rating of Health Plan*. INTotal scored statistically significantly lower than the 2017 NCQA national child Medicaid average on one measure, *Rating of Personal Doctor*.
- Optima scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.
- The Statewide Aggregate scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure, *Rating of Health Plan*.

Table 3-5 presents the 2016 and 2017 top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate child Medicaid CAHPS for the composite measures. The 2016 and 2017 CAHPS scores for each MCO and the statewide aggregate were compared to the 2016 and 2017 NCQA national child Medicaid averages, respectively.

Table 3-5—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Composite Measures

	Aetna		Anthem		INTotal		Kaiser		Optima		VA Premier		Statewide Aggregate	
Composite Measures	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Getting Needed Care	88.6%	87.5%	85.8%	82.5%	87.1%	85.2%	80.7%	72.4%	85.2%	88.7%	83.7%	88.0%	85.3%	86.2%
Getting Care Quickly	92.3%	92.2%	91.2%	88.1%	89.2%	86.1%	84.1%	78.5%	90.1%	92.9%	89.8%	95.3%	90.4%	92.1%
How Well Doctors Communicate	93.8%	95.0%	92.7%	93.7%	92.3%	89.2%	91.5%	91.5%	94.5%	94.9%	95.4%	96.4%	93.8%	94.8%
Customer Service	89.9%+	85.6%+	84.7%	86.9%	88.1%	87.6%	88.3%	84.3%	87.0%+	91.2%+	87.8%+	89.7%	86.6%	88.8%
Shared Decision Making	74.6%+	80.4%+	77.6%+	77.9%	73.8%	72.3%	82.3%+	83.4%+	78.6%+	77.3%+	81.5%+	79.0%	78.4%	78.1%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates statistically significantly higher than the 2016 or 2017 NCQA national Medicaid averages.
Cells highlighted in red represent rates statistically significantly lower than the 2016 or 2017 NCQA national Medicaid averages.

Comparison of the statewide aggregate and MCOs' 2016 child Medicaid CAHPS scores to the 2016 NCQA national child Medicaid average revealed the following summary results:

- Aetna scored statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Getting Care Quickly*.
- Kaiser scored statistically significantly lower than the 2016 NCQA national child Medicaid average on one measure, *Getting Care Quickly*.
- VA Premier scored statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *How Well Doctors Communicate*.
- The Statewide Aggregate scored statistically significantly higher than the 2016 NCQA national child Medicaid average on one measure, *Getting Care Quickly*.

Comparison of the statewide aggregate and MCOs' 2017 child Medicaid CAHPS scores to the 2017 NCQA national child Medicaid average revealed the following summary results:

- Aetna scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure, *Getting Care Quickly*.
- INTotal scored statistically significantly lower than the 2017 NCQA national child Medicaid averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.
- Kaiser scored statistically significantly lower than the 2017 NCQA national child Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- Optima scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- VA Premier scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- The Statewide Aggregate scores ranked statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

Please refer to Section 5, Assessment of MCO Performance, for detailed information on each MCO's HEDIS results and items of statistical significance.

Pediatric Quality Measure Results

HSAG calculated the *NQF #2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* (*APP*) performance measure rate for the measurement period of calendar year 2016. The measure steward is NCQA; and in accordance with HEDIS technical measure specifications, *APP* measures the percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions for non-psychotic conditions and had documentation of psychosocial care as first-line treatment. Antipsychotic medications are appropriate for a narrow set of conditions, but are sometimes prescribed to treat non-psychotic conditions (e.g., ADHD, disruptive behavior). Given the health risks associated with antipsychotic medications (e.g., diabetes and weight gain), psychosocial interventions

should be considered prior to prescribing antipsychotic medications.[3-2] Table 3-6 presents *APP* performance measure rates for Virginia, listed as percentages and stratified by geographic region, age group, gender, race category, primary diagnosis category, and prescribing pattern.

Table 3-6—*APP* Measure Results

Rate Stratifications	Results (CY 2016)
Virginia Total Rate	
Virginia Total Rate	68.98%
Rates by Region	
Central Virginia	68.98%
Far Southwest Virginia	81.10%
Halifax	67.16%
Lower Southwest Virginia	62.83%
Northern Virginia	76.69%
Tidewater	68.01%
Upper Southwest Virginia	59.49%
Rates by Age Group	
1–5 Years	41.86%
6–11 Years	70.19%
12–17 Years	69.60%
Rates by Gender	
Male	68.32%
Female	69.90%
Rates by Race Category	
White	66.92%
Black/African American	70.81%
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	90.00%
More than one race/Other/Unknown	63.16%
Rates by Primary Diagnosis Category	
Attention-deficit conduct and disruptive behavior disorders	73.91%
Mood disorders	73.93%
Anxiety disorders	82.88%
Adjustment disorders	79.49%

[3-2] National Committee for Quality Assurance. Healthcare Effectiveness Data and Information Set 2017, Volume 2, Technical Specifications.

Rate Stratifications	Results (CY 2016)
Disorders usually diagnosed in infancy, childhood, or adolescence	53.33%
Other	34.90%
Rates by Prescribing Pattern	
Rural Total	64.35%
White Rural	63.03%
Black/African American Rural	69.32%
Non-Rural Total	70.90%
White Non-Rural	70.67%
Black/African American Non-Rural	71.03%

— *Indicates that the rate is not presented given that the numerator included fewer than 11 cases.*

Regional variation exists in the rates of psychosocial care being used as a first-line treatment, with Upper Southwest Virginia having the lowest rates at 59.49 percent and Far Southwest Virginia having the highest rates at 81.10 percent. Rates indicated that children ages 1 to 5 had the lowest rates of documentation of psychosocial care as first-line treatment, approximately 27 percentage points below the Virginia total. For non-psychotic conditions most commonly associated with the use of antipsychotics in children and adolescents, the rates for ADHD and disruptive disorders, mood disorder, and anxiety disorders, and adjustment disorders had rates of first-line psychosocial care above the Virginia total. Further, a higher percentage of individuals of Hispanic race had documentation of psychosocial care as first-line treatment. Geographical variation exists in the rates of psychosocial care being used as a first-line treatment, with children living in rural areas having the lowest rates at 64.35 percent and children living in non-rural areas having the highest rates at 70.90 percent. While a geographical difference in rates does exist, a large difference does not exist based on race for children living in non-rural areas. However, in rural areas, where adherence is lower, a difference in performance exists based on race, with Blacks performing approximately 6 percentage points higher than Whites.

Consumer Decision Support Tool

DMAS contracted with HSAG in 2016 and 2017 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results. The Consumer Decision Support Tool demonstrates how Virginia Medicaid's MCOs compare to one another in key performance areas. The Consumer Decision Support Tool used stars to display results for the MCOs, as shown in Table 3-7.

Table 3-7—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.

Rating	MCO Performance Compared to Statewide Average	
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 3-8 displays the 2016 and 2017 consumer decision support tool results for each MCO.

Table 3-8—Consumer Decision Support Tool Results, 2016–2017

MCO	Year	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	2016	★★	★★	★	★★	★★
	2017	★★	★★	★★	★★	★
Anthem	2016	★★	★★	★★★	★	★★
	2017	★★	★★	★★	★	★★★
INTotal	2016	★★	★★	★★★	★	★
	2017	★★	★	★	★	★
Kaiser Permanente	2016	★★	★★	★★	★★★	★★★
	2017	Insufficient Data*	★★	★★	★★	★★★
Optima	2016	★★	★★	★	★★	★★★
	2017	★★	★★	★	★★	★
VA Premier	2016	★★	★★	★★	★★★	★★
	2017	★★	★★★	★★	★★	★★

**Indicates that the MCO did not have sufficient data to receive a rating for this domain.*

Overall, performance between 2016 and 2017 has remained fairly consistent. Two MCOs, Kaiser Permanente and VA Premier, have consistently received two-star or three-star ratings for domains with reportable rates. Aetna's performance received mostly two-star ratings excepting one-star ratings received for the Keeping Kids Healthy domain in 2016 and Taking Care of Women domain in 2017. Similarly, Anthem's performance remained consistent, including receiving a one-star rating in the Living With Illness domain in 2016 and 2017. INTotal experienced a decline in performance, receiving one-star ratings for four of five domains in 2017, compared to receiving only two one-star ratings for two domains in 2016. Optima's performance remained fairly consistent between 2016 and 2017; however, Optima experienced a decline from a three-star rating in 2016 to a one-star rating in 2017 in the Taking Care of Women domain.

Performance Incentive Awards

Description of Program

In alignment with goals and objectives of managed care quality improvement in Virginia, the PIA program was created to improve health outcomes for members in the FAMIS and Medallion 3.0 populations as well as to promote and incentivize MCOs' high performance on six measures representing two measurement domains (i.e., administrative and HEDIS). For the first domain, administrative measures, DMAS selected the following measures:

- *Assessments of Foster Care Population*
- *MCO Claims Processing*
- *Monthly Reporting Timeliness and Accuracy*

For the second domain, HEDIS measures, DMAS selected the following measures:

- *Childhood Immunization Status—Combination 3*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

As part of this pay-for-performance incentive program, this year (i.e., Program Year 2) represents the second year that penalties or awards will be implemented. MCOs' administrative and HEDIS measure rates were collected and scored based on a comparison of MCOs' measure rates to predetermined thresholds for the current year. DMAS elected to adopt the same administrative measure and HEDIS measure scoring methodologies from Program Year 1 for Program Year 2.

Administrative measure rates were compared to standards created by DMAS, and MCOs' HEDIS measure rates were compared to national benchmarks for Medicaid managed care as reported in Quality Compass. MCOs' HEDIS measure rates were scored using the following methodology:

- Two points (high performance) were awarded if the 95 percent confidence interval for an MCO's measure rate was above the Quality Compass 50th percentile.
- One point (average performance) was awarded if the 95 percent confidence interval for an MCO's measure rate encompassed the Quality Compass 50th percentile.
- Zero points (low performance) were awarded if the 95 percent confidence interval for an MCO's measure rate was below the 50th Quality Compass percentile.

MCOs also each had opportunity to receive an improvement score (i.e., the third possible point) for HEDIS measures by comparing the HEDIS rate from the prior year to the HEDIS rate for the current year.

- One point was awarded if the MCO showed a statistically significant improvement from the prior year OR the MCO was high performing (i.e., above the Quality Compass 90th percentile) in both years.
- Zero points were awarded if the MCO did not show a statistically significant improvement between years.

For MCOs with administrative measure rates that received a "*Not Reported* (*NR*)" audit result (i.e., the measure data were materially biased or the MCO chose not to report the measure) or HEDIS measure rates that received a "*Biased Rate* (*BR*)" (i.e., the measure data were materially biased), the MCO received a score of zero for that measure. Table 3-9 provides an example of how measures were weighted and scored.

Table 3-9—PIA Measure Weighting and Calculation
EXAMPLE USING MOCK DATA

	Measure Weight	MCO A Measure Scores	MCO A Weighted Scores (MCO Score × Measure Weight)	MCO B Measure Scores	MCO B Weighted Scores (MCO Score × Measure Weight)	MCO C Measure Scores	MCO C Weighted Scores (MCO Score × Measure Weight)
Administrative Measures							
Assessments of Foster Care Population	12%	2	0.24	3	0.36	1	0.12
MCO Claims Processing	12%	2	0.24	2	0.24	0	0.00
Monthly Report Timeliness and Accuracy	10%	1	0.10	3	0.30	3	0.30
HEDIS Measures							
*Childhood Immunization Status—Combination 3**	22%	2/1	0.66	2/1	0.66	0/0	0.00
*Controlling High Blood Pressure**	22%	1/1	0.44	2/1	0.66	1/0	0.22
*Prenatal and Postpartum Care—Timeliness of Prenatal Care**	22%	1/1	0.44	1/0	0.22	0/0	0.00
Calculations							
Weighted Score Sum			2.12		2.44		0.64
Virginia Average			1.733		1.733		1.733
Difference from Average			0.387		0.707		-1.093

**For the HEDIS measure scores, the first number represents the points awarded for performance and the second number represents the points awarded for improvement.*

The Virginia average is calculated by summing each MCO's weighted score sum and dividing by the total number of MCOs. Once the Virginia average is derived, it is used to determine each MCO's difference from the average. The difference from average may be a positive or negative number (e.g., 0.387 for MCO A and -1.093 for MCO C in Table 3-9) indicating whether the MCO's weighted score sum is above (positive) or below (negative) the Virginia average.

The positive or negative funds allocation model will use the MCO's weighted score sum to allocate funds among MCOs. This model was developed to ensure that the total dollar amount for awards will always be equal to the total dollar amount for penalties, to ensure budget neutrality for DMAS. The MCO's weighted score sum is used to determine the Percentage Award Penalty for each MCO. If an MCO's weighted score sum is above or below the Virginia average, it is awarded or penalized, respectively. If an MCO's weighted score is equal to the Virginia average, no award or penalty will be assigned. Table 3-10 demonstrates an example of the funds allocation model using the same example data from Table 3-9.

Table 3-10—PIA Funds Allocation
EXAMPLE USING MOCK DATA

MCO Name	Total Capitation Payment	Maximum At-Risk Amount (Total Capitation Payment × 0.15%)	Percentage Award/ Penalty	Max Award/ Penalty	Max Award	Max Penalty	Final Award	Final Penalty
MCO A	$635,790,000.00	$953,685.00	70.67%	$673,937.40	$673,937.40	-	$275,660.64	-
MCO B	$436,300,000.00	$654,450.00	81.33%	$532,286.00	$532,286.00	-	$217,720.96	-
MCO C	$418,120,000.00	$627,180.00	-78.67%	$(493,381.60)	-	$(493,381.60)	-	$(493,381.60)
Sum					**$1,206,223.40**	**$(493,381.60)**	**$493,381.60**	**$(493,381.60)**

According to Table 3-9, MCO B has a weighted score sum of 2.44. For MCO B, the percentage award is equal to 2.44 divided by 3. This means MCO B has an 81.33 percent award (i.e., the MCO is eligible to receive 81.33 percent of their maximum at-risk amount as an award), as shown in Table 3-10.

Once the percentage award or penalty is determined, the result is multiplied by the maximum at-risk amount (0.15 percent multiplied by the total capitation payments). This calculation determines the MCO's maximum award (max award) or maximum penalty (max penalty). For example, the data in Table 3-10 demonstrates how the MCO's max award or max penalty are calculated. If the total capitation payment amount for MCO B is approximately $436,000,000, then $436,000,000 × 0.15% × 81.33% is approximately $532,000. This means that MCO B has a max award of approximately $532,000.

Finally, to ensure budget neutrality, awards and penalties may need to be reduced. In the example provided in Table 3-9, the penalties do not fully fund the awards for MCO A and MCO B. As a result, the award for both MCO A and MCO B must be reduced to ensure that the max penalty sum amount can fund the max award sum. For this example, MCO B's final award would be calculated as:

$$\textit{MCO B Final Award} = [(\$493{,}381.60 \div \$1{,}206{,}223.40)] \times \$532{,}286.00$$

MCO B's final award is equal to $217,720.96. The same equation is used to calculate MCO A's final award, which is equal to $275,660.64. The calculation of the final award ensures that the awards are equal to the penalties. In the event that the Max Penalty amounts exceed the Max Award amounts, then the awards do not fully claim the penalties, and excess penalties need to be reduced.

Objectives

This initiative was created to provide financial incentive to Medicaid MCOs to improve the quality, efficiency, and overall value of health care in Virginia. As evidenced by the six measures selected by DMAS for inclusion in the PIA calculation, the program aims to assess MCOs' performance of activities demonstrated to contribute to positive health outcomes for members. The PIA program rewards higher-scoring MCOs to support sustained high performance and imposes financial penalties on lower-scoring MCOs to promote improved performance in the future.

Status of 2017 Activity

The 2017 activity represents the second year in which MCOs will be subject to quality awards or penalties. HSAG calculated and finalized PIA results for all six MCOs in Virginia in December 2017. The Program Year 2 PIA results indicated that four MCOs will be assessed for awards and two MCOs will be assessed for penalties for their performance in 2016, to be collected from the MCOs in Spring 2018. All MCOs were notified of their final PIA results, which provided opportunity for all MCOs to review and provide feedback on the results.

Operational Systems Compliance Reviews

CMS requires that DMAS conduct operational systems compliance reviews of each managed Medicaid health plan a minimum of every three years. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[3-3] for planning the comprehensive on-site

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 8, 2018.

operational systems review activities. HSAG conducted the planning review activities, evaluation, and aggregation and analysis of findings between the fall of 2016 and spring of 2017. HSAG evaluated the degree to which the MCOs complied with federal Medicaid managed care regulations and the associated requirements in the contract between DMAS and each MCO in 12 performance categories (i.e., standards) for the review period from July 1, 2015, through June 30, 2016. HSAG worked with DMAS to identify areas acceptable for deeming wherein the MCOs complied with NCQA accreditation standards.

The six MCOs scored high across all standards, with overall compliance rates ranging from 96.2 percent to 99.5 percent. The lowest aggregate score for a standard was the Health Information Systems at 93.3 percent. All six MCOs achieved 100 percent compliance in four standards: Coordination and Continuity of Care; Provider Selection, Credentialing, and Recredentialing; Member Rights and Protections; and Quality Assessment and Performance Improvement.

Table 3-11—Standards and Compliance Scores

Standard #	Standard Name	Aetna	Anthem	INTotal	Kaiser	Optima	VA Premier	MCO Aggregate
Access Standards								
I	Adequacy and Availability of Services	100%	100%	96.2%	100%	100%	100%	**99.4%**
II	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	**100%**
III	Coverage and Authorization of Services	100%	97.7%	95.5%	100%	100%	100%	**98.9%**
IV	Provider Selection, Credentialing, and Recredentialing	100%	100%	100%	100%	100%	100%	**100%**
Structure and Operations Standards								
V	Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%	75.0%	**95.8%**
VI	Member Rights and Protections	100%	100%	100%	100%	100%	100%	**100%**
VII	Member Information/ Enrollment and Disenrollment	92.3%	100%	100%	92.3%	92.3%	96.2%	**95.5%**
VIII	Grievance System	97.4%	100%	94.7%	97.4%	97.4%	94.7%	**96.9%**
XII	Confidentiality of Health Information	100%	100%	100%	90%	100%	90.0%	**96.7%**
Measurement and Improvement Standards								
IX	Practice Guidelines	100%	100%	100%	100%	100%	83.3%	**97.2%**

Standard #	Standard Name	Aetna	Anthem	INTotal	Kaiser	Optima	VA Premier	MCO Aggregate
X	Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	**100%**
XI	Health Information Systems	100%	100%	90.0%	90.0%	90.0%	90.0%	**93.3%**
	Totals	**98.6%**	**99.5%**	**97.2%**	**97.6%**	**98.1%**	**96.2%**	**97.9%**

Total Compliance Score: Elements *Met* were assigned full value (1 point) and elements *Partially Met* were assigned half value (0.5 points). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

MCOs were required to implement corrective action plans (CAPs) for any performance score of *Partially Met* or *Not Met* to bring the MCOs' performance into full compliance. DMAS was responsible for reviewing and monitoring the MCOs' CAPs. Currently, there are no outstanding corrective actions.

Other DMAS Activities Related to Quality Improvement

DMAS contracted with HSAG to perform additional quality improvement activities related to these focused studies—Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief.

DMAS contracted with HSAG to conduct, during the 2016–2017 contract year, three focused studies on clinical topics selected by DMAS: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study), improving the health of children in foster care (Foster Care Focused Study), and Dental Utilization in Pregnant Women Data Brief.

Improving Birth Outcomes Through Adequate Prenatal Care

The Birth Outcomes Focused Study was designed to address the following questions:

- ***To what extent do women with births paid by Medicaid receive early and adequate prenatal care?***
- ***What clinical outcomes are associated with Medicaid-paid births?***

The five study indicators were reported in the CY 2014 study and were to be reproduced using probabilistically and deterministically linked data for Virginia Medicaid or FAMIS MOMS recipients with birth registry records to identify births paid by Virginia Medicaid during calendar year 2015. Unanticipated obstacles in obtaining birth registry records from the Virginia Department of Health have impacted the study reporting time frames.

Dental Utilization in Pregnant Women Data Brief

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide a data brief on dental utilization among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015. This focused study is designed to provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve prenatal care and birth outcomes among Medicaid and FAMIS members receiving dental services. HSAG will provide an annual data brief to assess dental utilization among pregnant women covered by Virginia Medicaid and FAMIS MOMS using the Deliveries Value Set referenced in the HEDIS technical specifications to identify women with a delivery during the measurement period. The first full year reporting will be available in 2018.

Foster Child Focused Study

All Virginia foster children receiving Medicaid services were transitioned from FFS programs to managed care no later than June 2014, and DMAS took steps in 2015 and 2016 to continually improve the quality and timeliness of care for these children. DMAS conducted follow-up training with participating local Departments of Social Services (LDSSs) and Medicaid MCOs in 2015 and 2016 to address transition issues among children in foster care. DMAS contracted with HSAG to, beginning in contract year 2015–2016 (CY 2016), conduct focused studies that provide quantitative information about children and adolescents receiving medical services through MCOs.

The CY 2016–2017 (CY 2017) Foster Care Focused Study sought to determine the extent to which children in foster care received the expected preventive and therapeutic medical care in the second year of managed care service delivery. Additionally, the study sought to compare utilization of preventive and therapeutic medical care among children in foster care between the first and second years of managed care service delivery. The study used data from administrative claims and encounters as well as a review of medical records for a statistically valid sample of foster children to examine services received by children in foster care from July 1, 2015, through June 30, 2016.

Overall, 7,030 children in foster care at any time from July 1, 2015, through June 30, 2016, were included in the study population; and 4,282 of these children were continuously enrolled with one or more MCOs throughout the study period, with enrollment gaps totaling no more than 45 days. Demographic characteristics of members continuously enrolled during CY 2017 did not differ substantially from overall study members' characteristics. Additionally, the proportions of members by age, gender, race/ethnicity, and regional categories did not differ between CY 2016 and CY 2017.

The results of the two preventive elements, based on medical record documentation, were impacted by the lower medical record submission rates. Additionally, more CY 2017 cases with submitted records did not have supporting medical record documentation of at least one visit containing the five components of a well-child visit or were missing a comprehensive immunization history, when compared to CY 2016 cases. Consequently, fewer records were received overall; and among the

received records, fewer had comprehensive documentation of well-child visits or complete immunization histories.

To determine the extent to which children in foster care received the expected preventive and therapeutic medical care in the second year of statewide managed care service delivery, 15 study indicators were assessed across three domains:

- Characteristics of Medicaid Members in Foster Care: For all foster children eligible for study inclusion, five indicators in this category provided information on age, sex, race/ethnicity, region of residence, and the degree to which children moved between regions.
- Preventive Care: Four indicators in this category provided information on the degree to which foster children continuously enrolled with one or more MCOs throughout the study period received expected well-child visits, received expected immunizations, visited primary care providers (PCPs), and used dental services. Note: Two of the four indicator (Expected Well-Child Visits and Expected Immunizations) elements were based upon medical record review. Note: These were non-HEDIS measures.
- Behavioral Health: Six indicators in this category provided information on foster children continuously enrolled with one or more MCOs throughout the study period, with specific indicators addressing use of antipsychotic medications (three indicators), children's receipt of follow-up care following hospitalization for mental illness, and the prevalence of children prescribed antidepressant medications or medications for ADHD.

During the second year of statewide managed care service delivery, the following key observations were made:

- Children in foster care continued to receive expected preventive medical and behavioral health care across several domains, with generally stable utilization rates between CY 2016 and CY 2017; with no statistically significant differences in the rates of children accessing PCP-type providers, receiving an annual dental visit, or receiving prescriptions for antidepressant or ADHD medications.
- Statistically significant differences between CY 2016 and CY 2017 for selected behavioral health indicators resulted from changes within small groups of children eligible for the study indicators as well as from changes to the HEDIS technical specifications from which the indicators were developed.
- A statistically significant decrease in dental utilization between CY 2016 and CY 2017 occurred, with substantial dental utilization rate differences by geographic region rather than from other demographic factors (e.g., gender or age).
- More children using antipsychotic medications also received first-line psychosocial care from CY 2016 to CY 2017, and more children hospitalized for mental illness received follow-up care within 30 days of discharge. These findings suggest a higher level of comprehensive behavioral health care among this population during CY 2017.

Recommendations for Virginia's Quality Strategy Focus and Priorities

The Medallion 3.0 managed care contract[3-4] requires that MCOs ensure annual improvement in the HEDIS priority measures (as listed in Table 1-5) until such time that each MCO is performing at least at the national Medicaid 50th percentile for HMOs as reported by NCQA Quality Compass. Thereafter, the MCO must sustain performance at the 50th percentile. Of note, approximately 66 percent of measures for HEDIS 2017 (27 of 37) ranked at or above the national Medicaid 50th percentile. Furthermore, in the updated DMAS Quality Strategy 2017–2019, DMAS indicated that the stretch performance goal for MCOS is to reach the national Medicaid 75th percentile, while recognizing that it may not be realistic to expect all Virginia MCOs to reach the 75th percentile for all priority measures. HSAG recommends that DMAS examine the opportunity for the development of an improvement scale whereby the MCOs demonstrate improvement across performance years, with the goal for each to be meeting the 75th percentile for the priority measures. The design of the improvement scale could also serve as the foundation to guide the MCOs in the development of value-based payment models to be used in the Medallion 4.0 provider contracts.

In addition to increasing the number of HEDIS measures that meet the national Medicaid 50th percentile, all MCOs should focus HEDIS measure improvement efforts on *Antidepressant Medication Management, Breast Cancer Screening,* and *Medication Management for People With Asthma—Medication Compliance 75%—Total.* As DMAS evaluates the opportunity to create the recommended improvement scale, DMAS may want to prioritize these three HEDIS measures as the preliminary areas of focus for the improvement scale and require that the MCOs conduct performance improvement activities using the Model for Improvement.[3-5]

In the MCO-specific recommendations in Section 4, HSAG shared some practices that health plans in other states have utilized to improve performance with the *Antidepressant Medication Management, Breast Cancer Screening,* and *Medication Management for People With Asthma—Medication Compliance* HEDIS measures. These recommendations included:

- For improving *Antidepressant Medication Management* measure rates, MCOs should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving *Breast Cancer Screening* measure rates, MCOs should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCOs should explore the feasibility of partnering with other entities that have mobile mammography units.

[3-4] Medallion 3.0 Managed Care Contract—July 1, 2016–June 30, 2017. Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/Medallion%203%20Contract%20for%202016-2017%20-%20FINAL%20-%20CLEAN%20-%206-8-16.pdf. Accessed on: Feb 15, 2018.

[3-5] Institute for Healthcare Improvement, "How to Improve". Available at http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 18, 2018.

- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCOs should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of the individual members' situations would assist the MCO in determining appropriate care management interventions.

Regarding the MCO's ongoing performance improvement activities related to measures that MCOs are performing below the minimum performance standard, DMAS may consider instituting quarterly check-ins that include a requirement for MCOs to complete small tests of change and report on the progress and results each quarter. HSAG recommends that MCOs identify barriers to improvement in the measures by following the Model for Improvement.

For effective changes, MCOs should develop a plan for sustainability and spread. HSAG has assisted other states with this process and participated in reviews of the MCO PDSA reports, as well as conference calls with MCOs to discuss results and recommendations. Additionally, HSAG recommends that MCOs use other quality improvement techniques to examine systems and address failures. For example, MCOs may use a simple Six Sigma performance improvement model: Define, Measure, Analyze, Improve, Control (DMAIC) to facilitate improvement in processes and outcomes.

Whatever performance improvement tools and methods MCOs choose, leadership should be involved in the process and communicate the vision clearly, consistently, and repeatedly throughout the organization. Teamwork is essential, and including the right people is critical to a successful improvement effort. MCOs should include managers and administrators as well as those who directly deliver health care and services. Data mining and analysis are crucial components; therefore, process improvement teams should also include data analysts. HSAG also recommends that MCOs include members' perspectives whenever possible to gain a clear understanding of the actual challenges members encounter in receiving MCO health care services.

Finally, INTotal's performance based upon the 2017 Consumer Decision Support Tool results were impacted by the fact that INTotal was unable to report all of the hybrid HEDIS measures using the hybrid methodology. According to PMV auditor findings, the issue with reporting the hybrid measures stemmed from inability of the MCO to receive copies of medical records due to some providers' arrangements with a third-party health information management company. The Medallion 3.0 contract (14.19.A.II and III) requires the MCOs to have procedures in place to ensure that medical records maintained by network providers are readily available to DMAS and the EQRO in a timely manner. DMAS should require the MCOs to review their provider contracts to ensure that this Medallion 3.0 contract requirement is upheld with all contracted providers.

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2017 EQR Technical Report, HSAG used findings from the following EQR activities conducted from January 1, 2017, through December 31, 2017, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services (QAT) provided by each MCO.

Mandatory EQR Activities: OSRs, PIPs, and PMVs.

Optional EQR Activities: CAHPS and calculation of performance measures.

HSAG then analyzed the data to determine of common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and statewide.

To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated all components of each EQR activity and resulting findings across the continuum of program areas and activities that comprise the Medallion 3.0 program. The composite findings for each MCO were analyzed to identify overarching trends and focus areas for the MCOs.

MCO-Specific HEDIS Measure Results

The following tables present each MCO's HEDIS 2015, 2016, and 2017 performance measure results and the current performance level relative to the national Medicaid 50th percentile.[4-1] The source of the national Medicaid 50th percentile is NCQA's Quality Compass. Select measures and associated measure indicators were eligible for rotation in 2014 (i.e., *Controlling High Blood Pressure* and *Prenatal and Postpartum Care*) and in 2015 (i.e., *Adolescent Well-Care Visits*; *Childhood Immunization Status*; *Lead Screening in Children*; *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Comprehensive Diabetes Care*). Rotating a measure allowed an MCO to use the audited and reportable hybrid rate from the prior year rather than collecting the measure for the measurement year (MY). Therefore, MCOs' measure rates may be the same for these measures across two years. The year 2016 was the first that measures were not allowed to be rotated based on the NCQA protocol.

In the tables following, yellow-shaded boxes indicate MCO rates that were at or above the national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid HMO 50th percentile rate used for comparison is provided. Current and previous years' NCQA Quality Compass national Medicaid 50th percentiles are provided in Appendix B for reference.

[4-1] The reference to "national Medicaid 50th percentile" is a general term used in this report to reference benchmarking comparisons.

EQR Activity Results for Aetna Better Health of Virginia (Aetna)

Aetna Better Health of Virginia (Aetna), formerly CoventryCares of Virginia, is the Medicaid/FAMIS Plus program offered by Aetna, a multistate health care benefits company headquartered in Hartford, Connecticut. Aetna acquired Coventry Health Care of Virginia in 2013, The name change to Aetna was effective April 1, 2016. To conduct the 2017 EQR, HSAG reviewed Aetna's mandatory and optional EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of, access to, and timeliness of care and services provided by Aetna. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for Aetna.

Performance Measures

Table 4-1 displays the rates for measures Aetna reported for HEDIS 2015, 2016, and 2017. Aetna's HEDIS 2015, 2016, and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Aetna's measure rates that were at or above the corresponding national Medicaid 50th percentile.[4-2] The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4-1—Aetna HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	50.85%	43.87%	50.12%	**48.41%**
Childhood Immunization Status				
Combination 3	60.58%	67.45%	66.42%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	61.99%	61.14%	61.22%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.85%	73.32%	72.26%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	53.80%	53.60%	53.41%	**58.08%**
Cervical Cancer Screening				

[4-2] Aetna was formerly known as CoventryCares. CoventryCares' historical rates (i.e., HEDIS 2015) are presented for comparison.

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Cervical Cancer Screening	—	64.16%	55.26%	**55.94%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	85.64%	87.63%	83.33%	**82.25%**
Postpartum Care	64.89%	65.98%	65.36%	**60.98%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	85.08%	85.13%	**82.15%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	97.36%	97.87%	**95.74%**
25 Months–6 Years	—	91.59%	92.58%	**87.69%**
7–11 Years	—	92.77%	93.12%	**91.00%**
12–19 Years	—	90.53%	91.69%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.21%	83.92%*	86.13%	**85.95%**
HbA1c Control (<8.0%)	48.42%	48.46%*	45.01%	**46.76%**
Eye Exam (Retinal) Performed	54.26%	53.19%*	52.80%	**53.28%**
Medical Attention for Nephropathy	—	91.25%*	90.51%	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	58.15%	58.39%*	54.74%	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	58.56%	59.08%	61.31%	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	27.96%	35.52%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	79.31%	78.37%	**76.59%**
Discussing Cessation Medications	—	52.25%	51.61%	**48.31%**
Discussing Cessation Strategies	—	42.61%	37.86%	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.71%	50.94%	50.95%	**53.38%**
Effective Continuation Phase Treatment	29.25%	33.49%	34.32%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	30.68%	54.96%	**42.19%**
Continuation and Maintenance Phase	—	43.24%	66.28%	**52.47%**
Follow-Up After Hospitalization for Mental Illness				

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
30-Day Follow-Up	54.79%	56.98%	60.34%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	—	41.35%	72.46%	**60.43%**

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

** HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

‡ Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Indicates that the HEDIS rate was at or above the corresponding national Medicaid 50th percentile.

Within the Children's Preventive Care domain, rates for Aetna ranked at or above the national Medicaid 50th percentile for three of the four measure rates (75 percent) in 2017 (*Adolescent Well-Care Visits*, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). Conversely, measure rates for *Childhood Immunization Status—Combination 3* continued to fall below the national Medicaid 50th percentile, indicating opportunities for improvement.

For the Women's Health domain, Aetna's measure rates consistently ranked at or above the national Medicaid 50th percentile for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* from 2015 to 2017. Of note, Aetna's *Cervical Cancer Screening* measure decreased approximately 9 percentage points from HEDIS 2016 to HEDIS 2017.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile for all years reported by MCOs, demonstrating a strength for Aetna.

Aetna's measure rates ranked at or above the national Medicaid 50th percentile for 6 of the 10 Care for Chronic Conditions measure indicators (60 percent) in 2017: *Comprehensive Diabetes Care—HbA1c Testing* and *Medical Attention for Nephropathy*; *Controlling High Blood Pressure*; *Medication Management for People With Asthma—Medication Compliance 75%—Total*; and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications.* Of note, the rate for the *Medication Management for People With Asthma* measure increased by more than 7 percentage points from HEDIS 2016 to HEDIS 2017.

Within the Behavioral Health domain, three of six (50 percent) reportable measure rates (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*) ranked at or above the national Medicaid 50th percentile. Performance for the other three measure rates remained consistent, with slight improvement in performance. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-2 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Aetna's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4-2—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Aetna

	Aetna Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	58.4%	62.8%
Rating of All Health Care	52.7%	59.4%
Rating of Personal Doctor	62.5%	68.9%
Rating of Specialist Seen Most Often	59.4%	55.7%
Composite Measures		
Getting Needed Care	81.9%	84.9%
Getting Care Quickly	87.0%	83.9%
How Well Doctors Communicate	88.1%	90.4%
Customer Service	92.6%	84.7%+ ▼
Shared Decision Making	78.3%	82.3%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Aetna's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- Aetna scored statistically significantly lower in 2017 than in 2016 on one measure, *Customer Service*.

Child CAHPS

Table 4-3 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite

measures. A trend analysis was performed that compared Aetna's 2017 child Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4-3—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Aetna

	Aetna Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	68.6%	70.0%
Rating of All Health Care	70.5%	68.2%
Rating of Personal Doctor	73.5%	74.7%
Rating of Specialist Seen Most Often	56.8%+	72.4%+ ▲
Composite Measures		
Getting Needed Care	88.6%	87.5%
Getting Care Quickly	92.3%	92.2%
How Well Doctors Communicate	93.8%	95.0%
Customer Service	89.9%+	85.6%+
Shared Decision Making	74.6%+	80.4%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Aetna's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- Aetna scored statistically significantly higher in 2017 than in 2016 on one measure, *Rating of Specialist Seen Most Often*.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how Aetna compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Aetna, as shown in Table 4-4.

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

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.

Rating	MCO Performance Compared to Statewide Average	
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4-5 displays Aetna's 2016 and 2017 consumer decision support tool results.

Table 4-5—Aetna's Consumer Decision Support Tool Results, 2016 and2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	★★
Getting Care	★★	★★
Keeping Kids Healthy	★	★★
Living With Illness	★★	★★
Taking Care of Women	★★	★

Aetna's performance remained fairly consistent between 2016 and 2017. The rating for one domain, Keeping Kids Healthy, improved from a one-star rating in 2016 to a two-star rating in 2017. Conversely, the rating for Taking Care of Women declined from a two-star rating in 2016 to a one-star rating in 2017, demonstrating an opportunity for improvement.

Performance Improvement Projects

For validation year 2017, Aetna Better Health of Virginia (Aetna) continued to work on one State-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. In December 2016, Aetna submitted Module 3 for review. HSAG provided written feedback, and the MCO made revisions and resubmitted the module. The MCO progressed to submitting the Module 4 intervention plan in March 2017. HSAG reviewed the intervention plan and provided the MCO with pre-validation review feedback. HSAG subsequently conducted a Module 4 progress check-in with the MCO in May 2017. For the Module 4 progress check-in, the MCO reported an increase in diabetic retinal eye exam compliance since start of intervention testing. The MCO will continue with intervention testing for the PIP until the SMART Aim end date of December 31, 2017.

For the 2017 validation of Aetna's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Providing a step-by-step flow of the current process.
- Aligning the FMEA table with the final process map.
- Updating the definitions for reliability and sustainability of potential interventions.

Aetna revised Module 3 and addressed HSAG's concerns in the resubmission. In its assessment of follow-up to recommendations the MCO indicated having attended HSAG's PIP training, using HSAG's PIP Companion Guide, and having requested technical assistance from HSAG as needed throughout the process.

In March 2017, Aetna submitted the intervention plans of Module 4 for pre-validation review. HSAG did not officially validate Module 4 but included pre-validation review comments for Aetna's consideration prior to beginning intervention testing. Aetna submitted a Module 4 plan for the following interventions:

- Providers schedule diabetic retinal eye exam appointments.
- Providers track eye exam appointments to identify missed provider-scheduled appointments.
- The MCO conducts outreach calls to members.

Table 4-6 below depicts the status of the PIP at the time the annual PIP report was published.

Table 4-6—Status of the *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes* PIP

Module	Status
1. PIP Initiation	Passed in November 2016.
2. SMART Aim Data Collection	Passed in November 2016.
3. Intervention Determination	Passed in January 2017.
4. Plan-Do-Study-Act	Intervention plans submitted in March 2017 for pre-validation review (final submissions scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual report, Aetna was in the intervention testing phase (Module 4). The MCO was advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately if any changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that Aetna's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Key recommendations included:

- Aetna should implement a process and document policies and procedures for reconciling provider data in the related systems.
- Aetna should consult the Managed Care Technical Manual for reporting foster care assessment data and considering implementing additional validations of foster care assessment rates.
- Aetna should initiate the medical record review (MRR) project earlier to ensure that chart chases, record procurement, and abstraction accuracy checks are completed by the HEDIS MRR deadline.

Best and Emerging Practices for Improving Quality of Care and Services

Aetna submitted the following best and emerging practices for 2017.

Promoting Preventive Services

Aetna's quality processes are embedded throughout the organization to produce improved outcomes for members through systematic enhancements. For example, during inbound calls to Member Services and other Aetna functional areas, Aetna's staff discusses gaps in care with the member based on the alerts built into their electronic system. The alerts identify what services the member needs, such as flu shots, well visits, immunizations, pap smears, mammograms, etc. to help keep members healthy. Member Services representatives schedule or transfer calls to HEDIS outreach staff to schedule an appointment with the member's physician, if needed. In addition to alerting or notifying Member Services of the services needed, the alerts are also used by all member-facing areas, such as quality outreach coordinators and care coordination. Aetna ensures that everyone at the health plan who speaks with a member has access to the same data at every point of contact. With every interaction with members, Aetna maximizes the opportunity to promote preventive screenings to continue improving overall health and wellness of members.

Addressing Member Needs in a Culturally Competent Manner

Aetna engages with the culture of communities by hiring and deploying community health workers from the communities they serve. These active, informal leaders can connect with members and their culture and share this information to collaborate on culturally relevant solutions. Behavioral health conditions, poverty, rural isolation, dense urban living, and religion all create the culture of members. To that end, Aetna expanded their definition of "culture" to address these social determinants of health and the impacts of poverty, substance abuse, and mental illness. Aetna's program includes the following:

- Expanded cultural competency training for staff: Aetna has rolled out an expanded cultural-competency training program across the organization that goes beyond annual e-learning. This training program engages individual departments across the health plan to instill a sense of ownership and responsibility for a culturally competent workforce at every level.
- Cultural competency training for providers: Aetna has also created and implemented a provider element to their cultural competency training designed to improve the provider experience for members and to help instill cultural-sensitivity throughout their network.

Better Outcomes for Expectant Mothers

Aetna's overall approach to serving pregnant women includes engagement strategies, services and programs, and care planning. Aetna's emphasis is on early identification and early engagement to get pregnant women into care management before they deliver. Aetna uses a variety of mechanisms for early identification of expectant mothers, including prior authorization; pharmacy data; and direct referrals from providers, community health workers, and peer support specialists. Establishing trusting relationships and providing a motivational framework for members are two important care management priorities for ensuring healthy mothers and babies. Aetna's services and programs help to reduce Cesarean sections and to increase prenatal/postnatal HEDIS rates.

As soon as Aetna learns a member is pregnant—through interactive voice response welcome call questionnaires, 834 enrollment files, self-reporting (by the pregnant woman or her provider), first-fill reports (prescriptions for prenatal vitamins), or claims data—Aetna contacts and engage with the expectant mother to make sure she receives timely care. Aetna conducts care management outreach to pregnant mothers in a culturally sensitive way, addressing each pregnant woman's socioeconomic situation, language preferences, nutritional needs, and personal goals for birth outcomes. Aetna screens all pregnant women for risk factors, including substance use, mental health wellness, and high-risk conditions (e.g., diabetes, asthma, and history of pre-term delivery). Aetna invites pregnant mothers who smoke to participate in the tobacco cessation program. Smoking cessation is a program focus across all regions.

Aetna educates members on the Text4baby program, the largest mobile health initiative in the nation, to help pregnant women and new mothers keep themselves and their babies healthy. The service is for pregnant women and mothers with infants under one year of age. Expectant and new moms receive free text messages containing expert health tips and safety information, timed to correspond to their due date or the baby's birth date. After the delivery, there are additional text messages related to postpartum depression, immunizations, and well-baby checks.

Tapping into Aetna's Community

Aetna hires, trains, and deploys community health workers and peer support specialists to promote health care equity, increase health literacy, and improve the overall health of members through recovery and resiliency. This is especially important for members belonging to priority populations or communities vulnerable to health disparities, substance abuse, and social determinants. Aetna also uses community health workers, population health specialists, care coordinators, and peer support specialists to promote health equity and support members, especially those living in traditionally underserved communities, in fulfilling their health ambitions.

Aetna's peer support specialists share experiences with members, engaging them in person-centered, strengths-based dialogues focused on achieving long-term recovery. As members identify and work toward recovery and resiliency goals, their peer support specialists uphold the member's voice and choice. They join members on their health care journeys and help them realize their personal goals. In addition, they link members to community supports and services and help them better navigate the

service delivery system. Peer support helps members gain self-efficacy in their recovery, which, in turn, results in cost savings, enables pathways, and increases adherence to treatment plans.

Integrated Care Management

Aetna's Care Management (CM) program is "integrated" as it reflects beliefs that care management must address member's medical, behavioral, and social needs in an integrated fashion and must address the full continuum of acute, chronic, and preventive health needs. The program assists members with coordinating medical and/or behavioral health services as well as those available in the community, other resources such as federal programs, local community organizations, faith-based organizations, and/or those not covered in the member's benefit package. Aetna's CM program is a collaborative process of bio psychosocial assessment, planning, facilitation, care coordination, evaluation, and advocacy for service and support options to meet members' and/or family/representative's comprehensive care needs to promote quality and cost-effective outcomes. Aetna delivers a holistic, member-centric care management approach based on members' medical, behavioral, psychosocial, cultural, and spiritual health needs. Aetna's model offers a single point of contact for members enrolled in care management and is sustained by a multidisciplinary team, enabling the evaluation of member needs from multiple perspectives and collaboration among the member's care team.

Care managers use condition-specific assessments, social determinants of health (SDoH) data, and care plan interventions to assist members based on their needs for chronic condition management, thereby including traditional "disease management" within the integrated care management process rather than it being managed separately. Members with diabetes, chronic obstructive pulmonary disorder (COPD), heart failure, asthma, depression, and coronary artery disease are identified by their predictive modeling engine's Consolidated Outreach and Risk Evaluation (CORE) tool, claims, health risk questionnaires, care management assessments, and concurrent review/prior authorization referrals, as well as member and provider referrals.

Integrated Care—Tele-behavioral Health

Aetna's innovation goals are to expand upon a statewide tele-behavioral model and platform with Carilion Health to support broader care interactions across the entire integrated care team. Aetna is currently implementing a pilot using telehealth in PCP offices to integrate behavioral health and is working on creating group therapy remote visits. Wide use of tele-behavioral health could substantially increase the number of members who receive care and counseling, thus improving the overall health of our members.

Carilion psychiatrists and team will be virtually integrated into a PCP's office. For example, if during a visit a member of the care management team determines a psychiatric consultation is needed, Carilion will have physicians on virtual call where a tablet can be brought to a secure room and the member can interact in real time with the distant-site psychiatrist. Aetna will offer the telehealth platform to the entire integrated care team (e.g. health plan, homeless shelter) to use for virtual member or home visits. Aetna will also offer the platform for members to attend virtual group therapy and cognitive behavioral health sessions, with access to smartphone mobile applications such as MyStrength, which offers

ongoing mood evaluation and educational tools to support resiliency, particularly for those with substance use issues and those newly placed in treatment. Aetna will add virtual emergency department visit assessments for cases where members present for behavioral health issues that can be handled virtually or that are better suited for outpatient treatment.

Follow-up to Prior EQR Recommendations

Following are Aetna's responses regarding HEDIS/PMV EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Aetna has its own goals and internal benchmarks and is tracking the 75th and 90th percentiles for key HEDIS measures. Aetna agrees with the recommendation focus on performance measures related to chronic conditions and currently participates with PIA measures. Aetna is in the process of learning small-scale and rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives for the Diabetes PIP. Aetna attended the training for completing modules 4 and 5 on December 12, 2017 and will be submitting their results to HSAG in February 2018.

Following are Aetna's responses regarding the PIP EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Aetna has complied with the recommendation to refer to HSAG's PIP Companion Guide throughout 2016 and has requested technical assistance calls with HSAG as needed throughout the process. Aetna, in conjunction with the other Commonwealth of Virginia MCOs, is currently learning and completing the last two modules for a new rapid cycle PIP approach under the direction of HSAG. Aetna will be ending the PIP on December 31, 2017 and will analyze the data throughout January 2018 for submission to HSAG in February 2018.

Following are Aetna's responses regarding FAMIS Program CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Aetna's Member Services Manager conducts an evaluation of the prior days call volumes daily. A report of the prior day's calls shows the number of calls that come in to the center in 30-minute increments. It shows the numbers of calls offered, answered, and abandoned. Additionally, it shows how long it took for the calls to be answered in that 30-minute period. The analysis of this data allows for changes to be made to staffing based on findings for specific time periods of the day. All call center representatives are required to complete an intensive four-week training program consisting of the following three parts:

- System Training
- Medicaid and Plan Benefits Training
- Telephone Skills Training

The telephone skill training includes cultural competency and soft skill phone etiquette. Additional behavioral health training is conducted to enable staff to recognize when clinical support is needed. All call center representatives are monitored monthly to ensure that they are correctly handling calls. Each time they are monitored they receive feedback from the team lead or manager based on the findings of each call. Aetna is dedicated to making sure the call center staff provides all the required information to callers with the best possible outcomes.

Member Services reports call center data to the State monthly, which includes:

- Total calls offered and received.
- Percentage of total calls abandoned.
- Average speed to answer.
- Average talk time.

Performance goals are established for each of the preceding measures. In addition to the required reporting statistics, the Member Services manager conducts a monthly analysis of call types, average calls per day, average time to abandon, and percentage of calls answered in 30 seconds or less. Analyzing call data allows Member Services to appropriately staff the call center with trained individuals helping to ensure all required and expected call metrics are met.

Aetna is currently in the process of implementing a new provider training program in which Aetna will host provider forums across six regions throughout the Commonwealth. Each region will be assigned a Provider Services representative to facilitate provider training, with the focus being the critical subpopulations within their region.

Training will be tailored to each provider type in addition to addressing unique provider needs. Provider training will consist of an initial training within the first 30 days of contracting via face-to-face training and/or audio-visual conferences. Annual and ongoing trainings will consist of four provider forums encompassing topics such as health literacy, social determinants, member's cultural and ethnic preferences, shared decision making, and listening and effective communication skills. Reinforcement training will be conducted through recurring follow-up through on-site meetings, webinars, provider newsletter, and conference calls.

Aetna continues to improve and transform the primary care delivery system extensively across the nation and in Virginia by applying robust care coordination strategies and increasing the use of value-based contracting. Aetna has expanded these efforts in the Commonwealth, where behavioral health integration within practices are encouraged through staffing models or virtual solutions. Aetna contracts with Virginia-licensed PCPs who work in a variety of practice models, including NCQA-accredited patient centered medical homes, health homes, federally qualified health centers (FQHCs), rural health centers (RHCs), community and family health centers, and based on access and availability needs, Aetna also contracts with small groups and individual primary practitioners. Recognizing the special needs of members, such as when a member has intellectual and/or developmental disabilities (ID/DD), renal disease, or heart disease, Aetna assigns his/her specialist, such as a nephrologist or cardiologist, as the

primary provider when appropriate. For members with a serious mental illness or emotional disturbance, the assigned primary provider may be a behavioral health home.

Aetna understands there are providers of various structures, differing capabilities, and many experience levels. Therefore, Aetna collaborates and establishes meaningful, bidirectional communications to truly understand inherent challenges faced by these providers in treating and supporting the Medicaid population.

In addition to the provider training program, geared at enhancing provider communication skills, Aetna recently implemented a Population Health program that employs five regionally based population health specialists. These specialists work with provider organizations to share data through Aetna's CareUnify platform. Population Health specialists are assigned to work directly on-site with provider care teams to support them in their overall population management, including serving as the relationship manager and single point of contact; providing a minimum of monthly reviews on all performance trends, including total cost, quality, and utilization—with guidance on actions to achieve targets; supporting advanced care coordination with the health plan and other providers such as behavioral health; identifying high-risk and emerging high-risk members who need care; supporting practice transformation and workflow redesign; and providing direct training and ongoing education with the CareUnify system. The program is aimed at helping to create new collaborative relationships that drive innovation and ultimately improve health outcomes for members.

Aetna focuses significantly on promoting well-child screenings, immunizations, and access to care in all age groups. Aetna continues to explore innovative ways to use peer supports to help children and teens manage their lifelong chronic conditions. Consequently, Aetna has focused significant resources on promoting well-child screenings, immunizations, and access to care in all age groups. Additionally, Aetna is interested in developing and moderating social media support groups to help young members and teens connect and develop supportive relationships with one another. Aetna is building a system of care functionality in each region and implementing innovative strategies to improve the physical and behavioral health and wellbeing of this population. Furthermore, Aetna is building additional cross-functional relationships in Virginia communities and neighborhoods to strengthen partnerships with providers, government entities, social agencies, community resources, and faith-based organizations.

Following are Aetna's responses regarding Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Aetna continues to embrace telemedicine technology and is currently working with Virginia Commonwealth University (VCU) Health Systems to offer this solution for members in the Central VA region and is working with Carilion to offer this solution for members in the Far Southwest region. The Dynamo® Gaps in Care tool was developed as a process improvement initiative to help guide consistent messaging across different departments that may have an opportunity to speak with a member. Anyone in Member Services, Utilization Management, or Quality Management, who is speaking with the member, may use the Gaps in Care reports. These reports tell Aetna who needs wellness visits or who might be missing preventive screenings in 2016. Each team is also empowered to assist the member with making an appointment and addressing the barriers to care.

At Aetna, quality improvement initiatives are communicated at every level, beginning with the Chief Executive Officer and the Chief Medical Officer to each of their respective direct reports and teams. QI initiatives are shared at various plan level committees, with participating provider involvement. Quality data are available to practitioners to assist them to identify members in need of care. Interventions are implemented using a rapid-cycle monitoring approach and adjusted quickly if found ineffective.

Aetna plans to educate providers on this type of analysis and encourage the use of such during provider education and training sessions in 2018. Aetna will create a workgroup to explore additional methods for obtaining direct patient feedback to improve patient satisfaction. Aetna will consider implementing a PDSA pilot for a couple of high-volume provider sites in 2018.

Aetna believes physician-patient communication is a critical component to patient satisfaction. Aetna promotes physician-patient communication through outreach, training, and technical support in multiple formats, including our Member Advisory Board, handbook, welcome packet, user guides, face-to-face interactions, as well as member navigator support. Aetna's new provider training program will be tailored to each provider type consisting of initial and ongoing training through provider forums. These forums will encompass topics such as health literacy, social determinants, members' cultural and ethnic preferences, shared decision making, listening, and effective communication skills. Reinforcement training will be conducted through recurring follow-up through on-site meetings, webinars, provider newsletter, and conference calls.

Aetna is currently in the process of implementing a new provider training program in which the health plan will host provider forums across six regions throughout the Commonwealth. Each region will be assigned a Provider Services representative to facilitate provider training, with the focus aimed at the critical subpopulations within their region. Training will be tailored to each provider type in addition to addressing unique provider needs.

This year Aetna is focusing on the relationship between the PCP and the specialist to understand if there is effective communication between the two. Aetna also wrote newsletter articles to educate members on how to prepare for a practitioner visit and tips for a successful visit. Members with chronic conditions may be flagged for care management intervention and monitoring, which would include appropriate follow-up with the specialist. To date, Aetna's interventions have been member focused; however, the health plan will explore methods to implement of recommended systems in 2018.

The Aetna provider newsletter is used to address skills training for specialists as well as cultural competency awareness for all providers. Aetna continues to explore different methods of providing more effective communication and education via the Aetna website and provider portal as well. Aetna is embracing telemedicine technology and working with VCU Health Systems to offer this solution to members. Additionally, Aetna has implemented a pilot program for behavioral health with Carilion.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for Aetna.

Within the Children's Preventive Care domain, rates for Aetna ranked at or above the national Medicaid 50th percentile for three of the four measure rates (75 percent) in 2017. For the Women's Health domain, Aetna's *Prenatal and Postpartum Care* measure rates consistently ranked at or above the national Medicaid 50th percentile from HEDIS 2015 to HEDIS 2017.

Aetna's measure rates ranked at or above the national Medicaid 50th percentile for six of the 10 Care for Chronic Conditions measure indicators (60 percent) in 2017. Of note, the rate for *Medication Management for People With Asthma* measure increased by more than 7 percentage points from HEDIS 2016 to HEDIS 2017.

Within the Behavioral Health domain, three of six (50 percent) reportable measure rates (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*) ranked at or above the national Medicaid 50th percentiles.

Aetna's *Childhood Immunization Status—Combination 3* measure rate continued to fall below the national Medicaid 50th percentile (approximately 66 percent) and considering that *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was approximately 61 percent, Aetna should explore opportunities for getting these young children in for well-child visits. The measure rates for *Breast Cancer Screening* and *Cervical Cancer Screening* remained lower than the national Medicaid 50th percentiles. Additionally, Aetna's *Cervical Cancer Screening* measure decreased approximately 9 percentage points from HEDIS 2016 to HEDIS 2017. These Women's Health preventive measures are consistent with the decline observed for the Taking Care of Women domain in the Consumer Decision Support Tool. Finally, despite Aetna's PIP activity related to retinal eye exams, the HEDIS rate for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* declined.

Aetna scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure, *Getting Care Quickly.* Aetna scored statistically significantly higher in 2017 than in 2016 on one measure, *Rating of Specialist Seen Most Often* for the child Medicaid CAHPS.

For adult Medicaid CAHPS, Aetna scored statistically significantly lower in 2017 than in 2016 on *Customer Service.*

2017 Key Recommendations for Aetna

All MCOs need to improve *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total.* In other states,

HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

While Aetna indicated as follow-up to the 2016 EQR recommendations that it maximizes the opportunity to promote preventive screenings when members contact Member Services and that the MCO has HEDIS outreach staff members to assist members in scheduling appointments with providers, Aetna should re-evaluate the effectiveness of these member engagement activities to determine whether better options exist for proactively engaging female members who require breast cancer and/or cervical cancer screenings. More effective member and provider engagement strategies will help improve the *Breast Cancer Screening* and *Cervical Cancer Screening* rates.

Aetna's *Childhood Immunization Status—Combination 3* three-year trend in performance that falls below the national Medicaid 50th percentile indicates that Aetna should identify ways to examine childhood immunization rates and the alignment with the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate closely to determine the causal relationship. Potential circumstances that can affect the immunization rates are the timing and frequency of PCP visits as well as the providers' ability to identify gaps in care. If care gaps can be reported at a provider level, Aetna could target education and outreach to PCPs who need additional support. The Virginia Department of Health supports the Assessment Feedback Incentive Exchange (AFIX) program[4-3] to increase vaccination of children and adolescents by reducing missed opportunities to vaccinate and by improving delivery practices at the provider level. Aetna should consider leveraging these resources for educating providers to look for missed opportunities to complete EPSDT services and immunizations.

[4-3] The Virginia Department of Health—Division of Immunization. Assessment Feedback Incentive Exchange. Available at: http://www.vdh.virginia.gov/immunization/afix/. Accessed on: Feb 15, 2018.

EQR Activity Results for Anthem HealthKeepers Plus (Anthem)

Anthem is a Virginia HMO affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate health care company, headquartered in Indianapolis, Indiana. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for Anthem.

Performance Measures

Table 4-7 displays the rates for measures Anthem reported for HEDIS 2015, 2016, and 2017. Anthem's HEDIS 2015, 2016, and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Anthem's measure rates that were at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4-7—Anthem HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	53.24%	59.49%	55.32%	**48.41%**
Childhood Immunization Status				
Combination 3	72.45%	89.79%	76.39%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	64.63%	72.43%	68.06%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.08%	75.24%	77.78%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	53.71%	51.19%	52.13%	**58.08%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	64.68%	65.28%	**55.94%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.18%	89.74%	92.13%	**82.25%**
Postpartum Care	63.47%	66.20%	70.14%	**60.98%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	87.21%	86.88%	**82.15%**

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.13%	98.42%	**95.74%**
25 Months–6 Years	—	92.81%	93.25%	**87.69%**
7–11 Years	—	94.18%	94.28%	**91.00%**
12–19 Years	—	91.17%	91.75%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.95%	81.48%*	85.19%	**85.95%**
HbA1c Control (<8.0%)	50.93%	53.70%*	54.63%	**46.76%**
Eye Exam (Retinal) Performed	46.51%	47.92%*	46.99%	**53.28%**
Medical Attention for Nephropathy	—	90.28%*	90.97%	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	61.63%	60.42%*	68.52%	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	58.24%	57.94%	60.19%	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	25.92%	29.73%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	78.81%	84.23%	**76.59%**
Discussing Cessation Medications	—	47.01%	51.84%	**48.31%**
Discussing Cessation Strategies	—	39.41%	40.74%	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.03%	47.24%	48.76%	**53.38%**
Effective Continuation Phase Treatment	36.81%	33.63%	32.87%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	40.66%	41.88%	**42.19%**
Continuation and Maintenance Phase	—	51.54%	53.70%	**52.47%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	60.09%	61.46%	65.30%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	—	42.36%	60.57%	**60.43%**

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

** HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

‡ Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Indicates that the HEDIS rate was at or above the corresponding national Medicaid 50th percentile.

For the Children's Preventive Care domain, all four measure rates with benchmarks ranked at or above the national Medicaid 50th percentile for Anthem in 2017. Performance for *Childhood Immunization Status—Combination 3* has been inconsistent from HEDIS 2015 to HEDIS 2017, however, with a decrease of more than 10 percentage points from 2016 to 2017, indicating an opportunity for improvement for Anthem.

Within the Women's Health domain, rates for all measures increased slightly, with three measure rates (*Cervical Cancer Screening*; and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*) ranked at or above the national Medicaid 50th percentile. However, *Breast Cancer Screening* continues to rank below the national Medicaid 50th percentile.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile, indicating an area of strength for Anthem.

Six of the 10 Care for Chronic Conditions' measure rates (60 percent) ranked at or above the national Medicaid 50th percentile for Anthem in 2017, including: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*. The remaining measure rates were relatively stable.

For the Behavioral Health domain, three of Anthem's measure rates (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*) ranked at or above the national Medicaid 50th percentile. Of note, the rate for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* increased in performance from HEDIS 2016 to HEDIS 2017 by more than 15 percentage points, suggesting an area of strength for Anthem. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-8 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Anthem's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4-8—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Anthem

	Anthem Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	65.2%	63.4%
Rating of All Health Care	60.2%	59.9%
Rating of Personal Doctor	66.2%	70.2%
Rating of Specialist Seen Most Often	63.1%	67.9%
Composite Measures		
Getting Needed Care	79.8%	80.9%
Getting Care Quickly	83.5%	81.1%
How Well Doctors Communicate	93.1%	91.0%
Customer Service	87.2%	87.7%
Shared Decision Making	80.7%	77.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Anthem's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences; no statistically significant differences were observed.

Child CAHPS

Table 4-9 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Anthem's 2017 child Medicaid CAHPS scores to corresponding 2016 CAHPS scores.

Table 4-9—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Anthem

	Anthem Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	75.5%	76.5%
Rating of All Health Care	68.3%	73.0%
Rating of Personal Doctor	77.1%	75.9%

	Anthem Child Medicaid	
	2016	2017
Rating of Specialist Seen Most Often	73.9%+	77.6%
Composite Measures		
Getting Needed Care	85.8%	82.5%
Getting Care Quickly	91.2%	88.1%
How Well Doctors Communicate	92.7%	93.7%
Customer Service	84.7%	86.9%
Shared Decision Making	77.6%+	77.9%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Anthem's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences; no statistically significant differences were observed.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how Anthem compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Anthem, as shown in Table 4-10.

Table 4-10—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4-11 displays Anthem's 2016 and 2017 consumer decision support tool results.

Table 4-11—Anthem's Consumer Decision Support Tool Results, 2016 and 2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	★★
Getting Care	★★	★★
Keeping Kids Healthy	★★★	★★
Living With Illness	★	★
Taking Care of Women	★★	★★★

Anthem's performance on the consumer decision support tool demonstrated some differences between 2016 and 2017. The rating for one domain, Taking Care of Women, improved from a two-star rating in 2016 to a three-star rating in 2017, demonstrating a strength. Conversely, the rating for Keeping Kids Healthy declined from a three-star rating in 2016 to a two-star rating in 2017, demonstrating an opportunity for improvement. Further, an opportunity exists to improve performance for the Living With Illness domain given that Anthem received one-star ratings in 2016 and 2017 for this domain.

Performance Improvement Projects

For validation year 2017, Anthem continued to work on one state-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. For the 2017 validation of Anthem's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Including opportunities for improvement in the process map.
- Providing the cause and effect diagram.
- Including subprocesses from the process map in the FMEA.
- Prioritizing failure modes.
- Correcting potential interventions.
- Updating the definitions for reliability and sustainability of potential interventions.

Anthem revised Module 3 and addressed HSAG's concerns in the resubmissions. The MCO indicated in its assessment of follow-up to recommendations that it uses HSAG's PIP Companion Guide and requests technical assistance from HSAG as needed throughout the process.

Table 4–12 depicts the status of the PIP at the time of the annual PIP report.

Table 4–12—Status of the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* PIP

Module	Status
1. PIP Initiation	Passed in November 2016.
2. SMART Aim Data Collection	Passed in October 2016.
3. Intervention Determination	Passed in February 2017.
4. Plan-Do-Study-Act	Intervention plan submitted in March 2017 for pre-validation review (final submission scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP report, Anthem was in the intervention testing phase (Module 4) and advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately if changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that Anthem's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Key recommendations included:

- Create a claims processing timeliness report for claims approaching the 365-day threshold from receipt date.
- Document details used to capture the front-end unsuccessful outreach attempts for foster care assessments to ensure consistency and completeness.

Best and Emerging Practices for Improving Quality of Care and Services

Anthem submitted the following best and emerging practice for 2017.

Improving Lead Screening HEDIS Rate

Anthem's HEDIS rate for lead screening in children has steadily improved since 2015. Current interventions include member/provider outreach and education, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mailers, and Clinic Day events. Future interventions will include offering in-office testing with a user-friendly lead screening kit. Anthem believes this new testing

method can be less invasive and traumatic for a child than a venous collection; a phlebotomist is not needed to complete the collection; and the screening can be done during well-child checkups, which may help increase compliance.

Follow-up to Prior EQR Recommendations

Following are Anthem's responses regarding HEDIS/PMV EQR 2016 recommendations, which have been included, for the greater part. as presented to HSAG.

Anthem's key PIA HEDIS measures all met the national Medicaid 50th percentile for HEDIS 2017; *Childhood Immunization Status—Combination 3* met the 75th percentile, *Controlling High Blood Pressure* met the 50th percentile, and *Prenatal and Postpartum Care*— met the 90th percentile. Anthem continues to focus on preventive care for its members and continues to strive for higher HEDIS percentiles. Disease Managers and Case Managers at Anthem focus on many chronic conditions for members. The Quality Outreach Team conducts Clinic Days for members with chronic conditions such as diabetes and high blood pressure, and the health plan provides gift card incentives for members coming to preventive care Clinic Days. Last, rapid-cycle intervention testing is being used to assess effectiveness of testing of diabetic retinal eye exams to determine initiatives for diabetic members.

Following are Anthem's responses regarding the PIP EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Anthem is actively using HSAG's PIP Companion Guide upon completing each module and section of the PIP. Anthem will continue to communicate openly with HSAG by emailing concerns and questions, and via phone discussions regarding the PIP's process.

Following are Anthem's responses regarding FAMIS Program CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Member satisfaction and opportunities from the *Member Satisfaction Survey* are shared and discussed at Anthem's Health Education Advisory Committee meetings, which consist primarily of members. The *Member Satisfaction Survey* is reviewed and, when issues present, Anthem works to resolve them. Anthem's Quality Department provides numerous health tips during Clinic Day events. Anthem is also encouraging member participation in the CAHPS survey via the Web and providing talking points for Anthem staff to reference when talking with the members.

Anthem's Multicultural Health Programs team, in collaboration with Training Systems Design, developed a new online experience for providers: "Moving Toward Equity in Asthma Care." Anthem has an online provider training document, specific to helping the providers meet the cultural, value, and linguistic needs of the members. The Provider Relations team conducts site visits and conducts trainings, as needed, at providers' offices. The Quality Department also conducts HEDIS Trainings on measures upon request. Last, Anthem is providing targeted education to care management members (Case

Management and Utilization Management) who have had a recent practitioner visit other than with their PCP to inform their PCP of the outcome of the visit.

Anthem integrates behavioral health and physical health with social service needs for children with identified needs. Assessments are completed with reasonable attempts for children, and additional focus is placed on those with special health care needs such as foster care. All members receive an assigned PCP and are placed in a risk tier through Anthem's stratification process and engaged in care coordination or case management accordingly.

Following are Anthem's responses regarding Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

The Provider Care Management Solutions (PCMS) database allows providers access to view which specialists the members have seen. It identifies chronic conditions from claims data to alert and allows the PCP to take the necessary action to provide the appropriate care. It also gives a view of what medication/dosage the member is taking. Anthem supports DMAS' requirements, including coverage of medically necessary telemedicine services. Anthem is currently exploring additional telemedicine platforms for 2018.

Anthem's Clinic Day Program assures that members see appropriate providers. Members are assisted with appointments that are appropriate for the needed services. For preventive services, members see PCPs (e.g., pediatricians); for eye exams, members see ophthalmologists or optometrists; for female related care, members see gynecologists. Anthem has a quality of care process in place that ensures an in-depth review of quality of care issues; the issues are thoroughly investigated, and a Medical Director is engaged as needed. There is an ongoing monitoring process in place for all quality of care issues. In addition, members are matched to providers who have high quality ratings, upon request, and when members fail to select providers.

Educational health literacy information is given out at every Health Education Advisory Committee (HEAC) Member Focus Group and every Clinic Day event. There were four HEACs held in CY 2017 and more than 250 Clinic Day events held in CY 2017. Over 2,902 members were educated at Clinic Day events in CY 2017. Anthem utilizes the max-packing model by identifying all care gaps for each member prior to each Clinic Day event. All gaps are provided to the providers prior to each Clinic Day event so that all or as many gaps as possible can be closed during that one visit— reducing the need for numerous subsequent visits. Physical gaps in care are shared with the Behavioral Health team to share with the Community Services Boards (CSBs), upon request. So, when members are seen at the CSBs, providers close both the physical and the behavioral health care gaps during one visit. Anthem does not require a referral for a member to see a participating specialist. This information is relayed to the member in the member handbook, Section VI—Terms and Conditions, seeing other providers. Anthem has a provider look-up tool on their website for members to use to find a specialist. If they require assistance, they can also call the NCC for help in finding specialists.

Anthem has member materials and health tips that are intended to educate members on diseases like Asthma and Diabetes and on topics like blood pressure, flu shots, etc. Some of these documents assist

members with the types of questions they should ask during doctor's appointments. Case managers may mail to members any material on any specific disease condition. Anthem develops member documents at a 6th grade reading level so they should be easy for members to understand. Anthem also makes materials available in alternative formats as needed by members. Anthem arranges for over-the-phone and in-person interpreter services for members. Over-the-phone interpreter services are provided by Voiance. In person interpreters are provided through CulturaLink and may join members for their provider office visits. For routine provider office visits, members or providers need to request an interpreter five days in advance; for acute care, 24 hours' notice is required.

Anthem's Customer Service team analyzes call patterns and conducts member surveys on a regular basis to determine if their current call center hours are sufficient to meet the members' needs. For certain members' needs, such as grievances, there are mechanisms in place for members to leave messages during after-hours. Anthem has an after-hours nurse line that assists members with their needs 24/7. The NCC has a specialized training program that combines instructor-led, computer-based, and hands-on practice modules to ensure all associates are educated, skilled, and ready for call handling. Anthem continually reviews training module for improvement and enhancement, based on feedback from managers, partners, and quality audit data. Anthem is not collecting provider feedback now. However, the NCC gathers "Voice of Customer" member feedback daily and uses the data to identify training and service opportunities.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for Anthem.

Anthem performed higher than the national Medicaid 50th percentile in most categories. From HEDIS 2016 to HEDIS 2017, Anthem also demonstrated improvement in the Women's Health domain and the rate for *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*.

Performance for *Childhood Immunization Status—Combination 3* has been inconsistent from HEDIS 2015 to HEDIS 2017, and decreased by more than 10 percentage points from 2016 to 2017, indicating opportunities for improvement for Anthem. The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure declined and was below the national Medicaid 50th percentile. Additionally, *Breast Cancer Screening* continues to rank below the national Medicaid 50th percentile.

Anthem scored significantly higher than the NCQA national adult Medicaid CAHPS averages on three measures: *Rating of Health Plan and Rating of All Health Care and Rating of Personal Doctor* in 2017. Anthem scored significantly higher than the NCQA national child Medicaid CAHPS averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.

2017 Recommendations for Anthem

All MCOs need to improve *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total.* In other states, HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

While Anthem's rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* was higher than the 50th percentile, the rate for the *Initiation Phase* indicator was lower than the 50th percentile, suggesting that Anthem needs to make more effort to ensure that children newly prescribed ADHD medication receive timely follow-up care. HSAG has noted improvement in the *Initiation Phase* measure indicator when health plans and state formularies limit the quantity prescribed for new ADHD prescriptions. This requires the member's family or caregivers to seek follow-up care to renew the prescriptions. The MCO's Pharmaceutical and Therapeutics Committee should evaluate the benefits and risks associated with the implementation of this pharmacy benefit system control as a mechanism to drive improved follow-up rates for children newly prescribed ADHD medication.

Anthem's *Childhood Immunization Status—Combination 3* three-year trend performance inconsistencies and the 10 percentage-point decline in 2017 suggest that Anthem should identify ways to examine childhood immunization rates and the alignment with the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate closely to determine the causal relationships. Potential circumstances that can affect immunization rates are the timing and frequency of visits to providers and the providers' ability to identify gaps in care. If care gaps can be reported at a provider level, Anthem could target education and outreach to PCPs who need additional support. The Virginia Department of

Health supports the Assessment Feedback Incentive Exchange (AFIX) program[4-4] to increase vaccination of children and adolescents by reducing missed opportunities to vaccinate and by improving delivery practices at the provider level. Anthem should consider leveraging these resources for educating providers to look for missed opportunities to complete EPSDT services and immunizations.

[4-4] The Virginia Department of Health—Division of Immunization. Assessment Feedback Incentive Exchange. Available at: http://www.vdh.virginia.gov/immunization/afix/. Accessed on: Feb 15, 2018.

EQR Activity Results for INTotal Health (INTotal)

INTotal Health (INTotal), headquartered in Falls Church, Virginia, manages Medicaid health insurance programs in Virginia and is part of Inova, a not-for-profit health care system based in northern Virginia and serving the greater Washington, D.C. area. On November 1, 2017, UnitedHealthcare of the Mid-Atlantic, Inc. acquired INTotal. INTotal will maintain operations through the remainder of the Medallion 3.0 contract. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for INTotal.

Performance Measures

Table 4–13 displays the rates for measures that INTotal reported for HEDIS 2015, 2016, and 2017. INTotal's HEDIS 2015, 2016, and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate INTotal's measure rates that were at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4–13—INTotal HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	46.26%+	50.23%	51.09%	**48.41%**
Childhood Immunization Status				
Combination 3	71.78%	69.91%	55.72%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	61.73%	58.25%	46.38%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.69%	76.90%	78.36%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	45.11%	48.41%	50.21%	**58.08%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	55.94%	50.61%	**55.94%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	72.02%	63.87%	41.97%^	**82.25%**
Postpartum Care	52.55%	45.45%	28.73%^	**60.98%**

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	83.84%	84.27%	**82.15%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	97.60%	97.79%	**95.74%**
25 Months–6 Years	—	93.23%	92.79%	**87.69%**
7–11 Years	—	94.96%	95.53%	**91.00%**
12–19 Years	—	90.21%	91.67%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.89%	87.86%*	85.67%^	**85.95%**
HbA1c Control (<8.0%)	46.96%	39.96%*	5.58%^	**46.76%**
Eye Exam (Retinal) Performed	45.26%	42.16%*	37.49%^	**53.28%**
Medical Attention for Nephropathy	—	90.07%*	89.67%^	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	59.12%	51.43%*	11.35%^	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.50%	49.11%	BR	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	22.49%	30.93%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	74.91%	78.37%	**76.59%**
Discussing Cessation Medications	—	48.39%	51.82%	**48.31%**
Discussing Cessation Strategies	—	36.82%	41.32%	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.31%	52.63%	52.25%	**53.38%**
Effective Continuation Phase Treatment	33.11%	35.20%	37.40%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	54.98%	59.45%	**42.19%**
Continuation and Maintenance Phase	—	70.59%	76.92%	**52.47%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	48.26%	59.45%	64.00%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	—	62.20%	65.00%	**60.43%**

^ *Due to issues discovered during the medical record review process for HEDIS 2017, INTotal was required to report this rate using the administrative method. Therefore, caution should be exercised when comparing these results to rates that may have been reported using the hybrid method in prior years or*

to benchmarks calculated using the administrative and/or hybrid method.

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

[*] *HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

[+] *Indicates that the measure rate was reported using the auditor-locked IDSS file; however, this rate was reported differently in the 2015 Annual Technical Report.*

[‡] *Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.*

BR indicates that the rate was materially biased.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2017 Rate [CY 2016] was at or above the 2016 national Medicaid 50th percentile).

Within the Children's Preventive Care domain, two measure rates (*Adolescent Well-Care Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) in 2017 ranked at or above the national Medicaid 50th percentile for INTotal. Rates for *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* decreased in performance by more than 10 percentage points from HEDIS 2016 to HEDIS 2017 and fell below the national Medicaid 50th percentile.

No measure rates for INTotal in the Women's Health domain ranked at or above the national Medicaid 50th percentiles in 2017, indicating opportunities for improvement. Further, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate decreased by more than 20 percentage points and the *Prenatal and Postpartum Care—Postpartum Care* measure rate declined by more than 15 percentage points, suggesting opportunities for improvement for the MCO. It should be noted, however, that INTotal reported the *Prenatal and Postpartum Care* measure indicators using the administrative method for HEDIS 2017; therefore, caution should be exercised when comparing these results to prior years' rates using the hybrid method and to benchmarks calculated using the administrative and/or hybrid methodology.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile, demonstrating strength for INTotal.

For the Care for Chronic Conditions domain, two of the nine reportable measure rates (about 22 percent) for INTotal ranked at or above the national Medicaid 50th percentile in 2017, including: *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*. Conversely, INTotal's measure rates for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* decreased in performance in 2017 and fell below the national Medicaid 50th percentile by more than 40 percentage points. It should be noted, however, that INTotal reported the *Comprehensive Diabetes Care* measure indicators using the administrative method for HEDIS 2017; therefore, caution should be exercised when comparing these results to prior years' rates using the hybrid method and to benchmarks calculated using the administrative and/or hybrid methodology. Of note, the measure rate for *Controlling High Blood Pressure* was determined to be materially biased (*BR*) and is not included.

Within the Behavioral Health domain, INTotal's measure rates ranked at or above the national Medicaid 50th percentile for four of the six reportable rates (about 67 percent) in 2017. The remaining rates, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, performed slightly below the national Medicaid 50th percentile. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4–14 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared INTotal's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–14—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: INTotal

	INTotal Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	60.3%	59.2%
Rating of All Health Care	58.5%	50.0% ▼
Rating of Personal Doctor	69.4%	65.6%
Rating of Specialist Seen Most Often	73.7%	67.6%
Composite Measures		
Getting Needed Care	83.0%	79.9%
Getting Care Quickly	88.1%	82.7% ▼
How Well Doctors Communicate	92.0%	91.5%
Customer Service	85.4%	84.6%
Shared Decision Making	80.9%	79.4%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

INTotal's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- INTotal scored statistically significantly lower in 2017 than in 2016 on two measures: *Rating of All Health Care* and *Getting Care Quickly*.

Child CAHPS

Table 4–15 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared INTotal's 2017 child Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–15—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: INTotal

	INTotal Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	77.3%	78.0%
Rating of All Health Care	68.0%	70.1%
Rating of Personal Doctor	74.3%	68.2%
Rating of Specialist Seen Most Often	69.4%+	75.0%
Composite Measures		
Getting Needed Care	87.1%	85.2%
Getting Care Quickly	89.2%	86.1%
How Well Doctors Communicate	92.3%	89.2%
Customer Service	88.1%	87.6%
Shared Decision Making	73.8%	72.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

INTotal's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences; no statistically significant differences were observed.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how INTotal compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for INTotal, as shown in Table 4–16.

Table 4–16—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4–17 displays INTotal's 2016 and 2017 consumer decision support tool results.

Table 4–17—INTotal's Consumer Decision Support Tool Results, 2016–2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	★★
Getting Care	★★	★
Keeping Kids Healthy	★★★	★
Living With Illness	★	★
Taking Care of Women	★	★

INTotal experienced a decline in performance between 2016 and 2017. The rating for two domains, Getting Care and Keeping Kids Healthy, declined from a two-star rating and a three-star rating, respectively, to one-star ratings. Please note, this decline in performance is largely due to INTotal's inability to report HEDIS measures using the hybrid methodology. Overall, an opportunity exists for INTotal to improve performance across all domains.

Performance Improvement Projects

For validation year 2017, INTotal continued to work on one state-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. For the 2017 validation of INTotal's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Linking sections of the process map.
- Revising potential interventions.
- Updating the definitions for reliability and sustainability of proposed interventions.

INTotal revised its Module 3 and addressed HSAG's concerns in the resubmission. The MCO indicated in its assessment of follow-up to recommendations that it attended HSAG's PIP training, uses HSAG's PIP Companion Guide, and requests technical assistance from HSAG as needed throughout the process.

In March 2017, INTotal submitted the intervention plan of Module 4 for pre-validation review. HSAG did not officially validate Module 4 but included pre-validation review comments for INTotal's consideration prior to beginning intervention testing. INTotal submitted a Module 4 plan for the following intervention:

- Appointment reminders and transportation assistance

Table 4–18 depicts the status of the PIP at the time of the annual report.

Table 4–18—Status of the *Let's Check Our Eyes!* PIP

Module	Status
1. PIP Initiation	Passed in November 2016.
2. SMART Aim Data Collection	Passed in December 2016.
3. Intervention Determination	Passed in February 2017.
4. Plan-Do-Study-Act	Intervention plan submitted in March 2017 for pre-validation review (final submission scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP report, INTotal was in the intervention testing phase (Module 4) and advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately if changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that INTotal's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Key recommendations included:

- Work toward automation of data transfer to ensure provider data uniformity.
- Implement process improvements for capturing provider fax numbers to help support the expedited MRR timeline for HEDIS 2018.

- Incorporate "assessment completed by" and "date completed" field into the paper version of the foster care assessment forms to ensure accurate reporting to DMAS.

Best and Emerging Practices for Improving Quality of Care and Services

INTotal submitted the following best and emerging practices for 2017.

Improved Foster Care HRA Completion Rate

INTotal's clinical outreach team engaged with local Department of Social Services workers to support completion of assessments if foster parents unavailable. With this additional engagement of secure electronic communication, INTotal was able to increase the completion rate month over month with 30 to60 percent improvement over the same period the previous year.

Maternity Outreach

With the reimplementation of a daily ED report in the third quarter for seven hospitals in Northern Virginia, INTotal's clinical team was able to add another mechanism to outreach prenatal members. With this outreach, INTotal has secured another 23 maternity risk assessments for the last quarter of 2017, facilitating case management services for those high-risk pregnancies. In addition to the ED outreach, INTotal added the maternity pre-screening risk assessment to the member portal in September. This addition allows new members who may be pregnant to initiate a self-screening prior to plan identification. This process is being reviewed for effectiveness. Early results have not been impactful.

Remove Breast Pump Preauthorization Requirements

INTotal recognized the importance of breastfeeding and the timely delivery of a breast pump immediately following the birth to support this initiative. Pre-authorization was a barrier to timely breast pump acquisition. In 2017 INTotal removed the barrier and wanted hospital discharge planners or members to be able to secure a pump immediately following the birth. A review of breast pump utilization was completed to determine if use was increased. The number of claims increased almost 100 percent from 2016 to 2017 even though the number of births remained somewhat static. This preliminary data may be a proxy representing an increase in breastfeeding or, at the least, an increase in support of breastfeeding.

Follow-up to Prior EQR Recommendations

Following are INTotal's responses regarding HEDIS/PMV EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

For measurement year 2018 HEDIS, INTotal Health has adopted the "stretch" performance target of the 90th percentile with a minimum goal of at least the national Medicaid 50th percentile for all DMAS key

HEDIS measures. INTotal Health's Quality Team prioritized the 2017 HEDIS clinical provider gap closure outreach and work plan to first meet or exceed the national Medicaid 50th percentile benchmark. In 2017, INTotal Health maintained focus on the key HEDIS measure, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, leveraging HSAG training in quality improvement methodology including small-scale rapid-cycle intervention testing. Last, INTotal Health also collaborated with other MCOs sharing in successful improvements including alerting network providers to the availability of office-based lead screening kits.

Following are INTotal's responses regarding the PIP EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

During 2017, INTotal Health staff attended all HSAG webinars offered as well as reviewed the HSAG PIP Companion Guide. INTotal Health will continue to reach out to HSAG to request additional assistance as needed. INTotal revised its modules and resubmitted them for validation. INTotal addressed some of HSAG's concerns in the Module 1 resubmission; however, some corrections were still needed. For Module 2, INTotal did not address opportunities for improvement regarding claims completeness, the data collection methodology, and the SMART Aim run chart. The MCO received technical assistance from HSAG prior to resubmitting the modules for a second time. Table 6-3 of the EQR technical report depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016.

- An additional resubmission was required.
- Module 3 was completed in March 2017.
- Module 4 was partially completed in April 2017.
- Modules 4 and 5 will be completed by HSAG's required date of February 2018.

INTotal is currently working with HSAG to ensure accurate completion of these modules.

Following are INTotal's responses regarding FAMIS Program and Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

In 2017, INTotal maintained quality practices initiated in 2016 to improve the health and well-being of members and to strengthen the collaboration with providers and community partners. These include:

- INTotal case managers contact hospital discharge planners of members hospitalized for behavioral health reasons, immediately following notification of the hospitalization. This helps both to coordinate follow-up care for the member and meet the 30-day follow-up appointment measure. A goal for 2017 was to engage with members while the members were hospitalized to establish relationships and hopefully to increase the number of members agreeing to case management. A review of a year's data revealed no correlation with outcome improvement or increased case management participation for members hospitalized for behavioral health reasons.
- INTotal partnered with a pediatric practice to provide additional behavioral health services for pediatric members with behavioral health diagnoses. Pediatricians, psychiatrist, and social workers

at the practice, along with case management staff from INTotal, continued to meet monthly to conduct rounds of selected members. Supporting INTotal members with an on-site child psychiatrist as well as care coordination model of care has improved communication among providers.

- INTotal Health's Maternal and Child Health program partnered with Babies "R" Us and offered community-based education for its members that included child birth education, child care education, breastfeeding education, and coordination of care services.
- The neonatal intensive care unit (NICU) Care Management Program connected all NICU members and parents with care managers for ongoing coordination of care. This improved post-hospitalization support has encouraged parents to develop relationships with INTotal's care managers and has supported timely follow-up for infants and mothers postpartum.
- Starting July 1, 2016, INTotal entered a value-based contract with the Inova Health System, covering all INTotal members in Inova's "catchment" area. An element of the program is designed to set aside a portion of shared savings to fund quality activities in the community. INTotal committed a minimum of $200,000 in funding for the "Quality Fund" during the first two years of the contract. INTotal and Inova are using those dollars to extend an Inova maternity outreach program to all low- and medium-risk pregnancies in the Northern Virginia region. INTotal will continue its more intense outreach program for high-risk pregnancies in the region.
- INTotal identified appointment "no shows" as a challenge to both member wellness and provider office frustration. A "no show" letter was developed for use among any practice wishing to use it. Case management partnered with the "no show" goal by creating a one-page transportation guide for provider offices and outreached repeated "no show" members to assess barriers to adherence.
- INTotal embraces its multicultural membership and supports effective communication through many routes; Our community member advocate is bilingual, call center staff are bilingual, member-facing inquiry website allows members to communicate with an allied health professional in Spanish, and the plan arranges for in-person interpreters for providers when requested.
- In July 2016, INTotal Health selected a new third-party administrator for provision of administrative services, including the Member Call Center. For three months in 2016, from August through October, the call center did not meet the goals for calls answered within 30 seconds, abandonment rate, and average speed to answer. In response to this performance, in the first quarter of 2017 the call center added staff, increased training of existing staff to answer questions more quickly and accurately, and adjusted schedules to better cover peak member call periods. Also, INTotal met weekly with call center leaders to review call timeliness and effectiveness, inform them of upcoming changes, and provide additional training on topics including appeals and grievances and the new Addiction and Recovery Treatment Services (ARTS) benefit. INTotal leaders monitored call data closely daily, weekly, and monthly. Because of these interventions, the member call center performance for calls answered within 30 seconds, abandonment rate, and average speed to answer consistently met or exceeded the goals beginning in the second quarter, from April 2017 forward to date.

INTotal reviewed in depth the CAHPs survey with respect to *Rating of a Personal Doctor, How Well Doctors Communicate*, and *Shared Decision-Making.* Planned interventions for 2018 include:

- Working with the survey vendor to better understand the methodology used and how to construct a member survey that will assist INTotal to elevate the importance of these topics.
- Conducting a member survey to better understand the perceptions by members regarding these questions.
- Working with provider groups to better understand how they see the opportunities to better provide communication.
- Communicating with members on the importance of shared decision making.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for INTotal.

As in previous years, INTotal's HEDIS scores fell below the national Medicaid 50th percentile in some areas. The exceptions were with INTotal's performance in the Access to Care and Behavioral Health domains. The five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile. Within the Behavioral Health domain, four of the six reportable rates ranked at or above the national Medicaid 50th percentile. The remaining rates, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, performed slightly below the national Medicaid 50th percentile.

In addition to the year-to-year trend of underperformance, INTotal experienced substantive declines in several measures. Rates for *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* decreased in performance by more than 10 percentage points from HEDIS 2016 to HEDIS 2017. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate decreased by more than 20 percentage points, and the *Prenatal and Postpartum Care—Postpartum Care* measure rate declined by more than 15 percentage points. INTotal's measure rates for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* decreased in performance in 2017 and fell below the national Medicaid 50th percentile by more than 40 percentage points. Of note, the measure rate for *Controlling High Blood Pressure* was determined to be materially biased (BR) and is not included.

Regarding member satisfaction, INTotal scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure, *Rating of Health Plan*. Conversely, INTotal scored significantly lower than the 2017 NCQA national adult Medicaid average on *Rating of All Health Care* and *Getting Care Quickly*. INTotal's scores declined for all global ratings in 2017, despite significant improvement in *Rating of all Health Care* and in *Specialist Seen Most Often* in 2016. When compared to 2017 national child Medicaid averages, INTotal scored significantly lower for *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Shared Decision Making*.

2017 Recommendations for INTotal

All MCOs need to improve *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total*. In other states, HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

INTotal would benefit from an increased focus on improving outcomes in *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* since the results fell below the statewide aggregate and the national Medicaid 50th percentile. Of note, these measures were reported using the hybrid method. These measures are related to preventive care for children under two; therefore, INTotal should seek to identify the barriers associated with these children receiving appropriate preventive care. With that understanding, INTotal should improve the outcomes with the development of targeted intervention strategies for these children.

INTotal's continued performance trends are indicative of the inherent opportunities to improve, which is evident of INTotal's performance on the 2017 Consumer Decision Support Tool. However, these results were impacted by INTotal's inability to report all hybrid HEDIS measure rates using the hybrid methodology. According to the PMV auditor findings, the issue with reporting the hybrid measures stemmed from inability of INTotal to receive copies of medical records from the providers. INTotal is required by contract to have procedures in place to ensure that medical records maintained by network providers are readily available to DMAS and the EQRO in a timely manner. INTotal should enhance its processes for proactively addressing the issues related to reporting any HEDIS measure rate that is dependent upon medical record documentation.

Finally, United Healthcare's acquisition of INTotal in late 2017 may provide INTotal with new insights and resources for improving health plan operations and quality improvement outcomes.

EQR Activity Results for Kaiser Permanente

Kaiser Permanente is a partnership of the not-for-profit Kaiser Foundation Health Plan, Inc. and its regional operating subsidiaries, Kaiser Foundation Hospitals and the Permanente Medical Groups. The company was founded in 1945 and is based in Oakland, California. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for Kaiser Permanente.

Performance Measures

Table 4–19 displays the rates for measures Kaiser Permanente reported for HEDIS 2016 and 2017. Kaiser Permanente did not report rates for HEDIS 2015; therefore, rates are not displayed. Furthermore, due to Kaiser Permanente's small population size for HEDIS 2016, caution should be exercised when comparing rates to HEDIS 2017 performance. Kaiser Permanente's HEDIS 2016 and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Kaiser Permanente's measure rates that were at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4–19—Kaiser Permanente HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	—	58.04%	61.07%	**48.41%**
Childhood Immunization Status				
Combination 3	—	67.80%	84.64%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	—	44.79%	59.20%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	74.76%	92.44%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	NA	77.14%	**58.08%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	80.17%	84.29%	**55.94%**
Prenatal and Postpartum Care				

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Timeliness of Prenatal Care	—	90.26%	96.51%	**82.25%**
Postpartum Care	—	89.14%	90.12%	**60.98%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	87.23%	89.90%	**82.15%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	95.92%	98.63%	**95.74%**
25 Months–6 Years	—	92.83%	95.62%	**87.69%**
7–11 Years	—	97.83%	95.20%	**91.00%**
12–19 Years	—	92.73%	91.93%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	—	97.18%*	97.44%	**85.95%**
HbA1c Control (<8.0%)	—	77.46%*	71.79%	**46.76%**
Eye Exam (Retinal) Performed	—	88.73%*	86.32%	**53.28%**
Medical Attention for Nephropathy	—	97.18%*	96.58%	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	—	78.87%*	85.47%	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	75.56%	84.62%	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	NA	22.58%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	NA	NA	**76.59%**
Discussing Cessation Medications	—	NA	NA	**48.31%**
Discussing Cessation Strategies	—	NA	NA	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	60.00%	**53.38%**
Effective Continuation Phase Treatment	—	NA	42.00%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	NA	NA	**42.19%**
Continuation and Maintenance Phase	—	NA	NA	**52.47%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	77.78%	82.98%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Total	—	NA	NA	**60.43%**

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

** HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

‡ Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

NA indicates that the MCO followed the specifications but the denominator was too small to report a valid rate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2017 Rate [CY 2016] was at or above the 2016 national Medicaid 50th percentile).

Measure rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile for three of the four measure rates (75 percent) in the Children's Preventive Care domain (*Adolescent Well-Care Visits*; *Childhood Immunization Status—Combination 3*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) in 2017. The remaining rate, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, fell slightly below the national Medicaid 50th percentile.

All four measure rates within the Women's Health domain for Kaiser Permanente ranked at or above the national Medicaid 50th percentile. Of note, the measure rates performed above the national Medicaid 50th percentile by more than 10 percentage points for all indicators, and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate improved by more than 5 percentage points from 2016 to 2017.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile, indicating an area of strength for Kaiser Permanente.

For the Care for Chronic Conditions domain, rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile for six of the seven reportable measure rates (about 86 percent), including all five *Comprehensive Diabetes Care* indicators and *Controlling High Blood Pressure*. Conversely, the rate for *Medication Management for People With Asthma—Medication Compliance 75%—Total* fell short of the national Medicaid 50th percentile by more than 8 percentage points, indicating an area of opportunity for the MCO.

For the Behavioral Health domain, all three reportable measure rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile. In addition, the rate for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* exceeded the national Medicaid 50th percentile by approximately 19 percentage points, indicating a strength for Kaiser Permanente. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4–20 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Kaiser Permanente's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–20—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Kaiser Permanente

	Kaiser Permanente Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	57.5%	65.6%
Rating of All Health Care	59.5%	59.0%
Rating of Personal Doctor	66.7%	76.0%▲
Rating of Specialist Seen Most Often	71.7%	70.4%+
Composite Measures		
Getting Needed Care	80.9%	76.6%
Getting Care Quickly	81.6%	76.9%
How Well Doctors Communicate	89.1%	90.0%
Customer Service	85.5%+	88.4%+
Shared Decision Making	78.6%+	79.1%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Kaiser Permanente's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- Kaiser Permanente scored statistically significantly higher in 2017 than in 2016 on one measure, *Rating of Personal Doctor*.

Child CAHPS

Table 4–21 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Kaiser Permanente's 2017 child Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–21—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Kaiser Permanente

	Kaiser Permanente Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	65.3%	70.5%
Rating of All Health Care	68.0%	72.4%
Rating of Personal Doctor	72.5%	79.5%▲
Rating of Specialist Seen Most Often	77.5%+	74.5%+
Composite Measures		
Getting Needed Care	80.7%	72.4%
Getting Care Quickly	84.1%	78.5%
How Well Doctors Communicate	91.5%	91.5%
Customer Service	88.3%	84.3%
Shared Decision Making	82.3%+	83.4%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Kaiser Permanente's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- Kaiser Permanente scored statistically significantly higher in 2017 than in 2016 on one measure, *Rating of Personal Doctor*.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how Kaiser Permanente compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Kaiser Permanente as shown in Table 4–22.

Table 4–22—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.

Rating	MCO Performance Compared to Statewide Average	
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4–23 displays Kaiser Permanente's 2016 and 2017 consumer decision support tool results.

Table 4–23—Kaiser Permanente's Consumer Decision Support Tool Results, 2016–2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	*Insufficient Data
Getting Care	★★	★★
Keeping Kids Healthy	★★	★★
Living With Illness	★★★	★★
Taking Care of Women	★★★	★★★

**Indicates that the MCO did not have sufficient data to receive a rating for this domain.*

Kaiser Permanente's performance remained fairly consistent between 2016 and 2017 for domains with reportable ratings. The rating for one domain, Living With Illness, declined from a three-star rating in 2016 to a two-star rating in 2017, demonstrating an opportunity for improvement. Kaiser Permanente received a three-star rating for the Taking Care of Women domain in 2016 and 2017, demonstrating a strength.

Performance Improvement Projects

For validation year 2017, Kaiser continued to work on one state-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. For the 2017 validation of Kaiser's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Including opportunities for improvement in the process map.
- Including data or health plan experience to support the selected subprocesses.
- Documenting the process used for failure mode ranking.
- Correcting potential interventions.
- Updating the definitions for reliability and sustainability of proposed interventions.

Kaiser revised Module 3 and addressed HSAG's concerns in the resubmission. The MCO indicated in its assessment of follow-up to recommendations that it was fully compliant with modules 1 through 3 for the PIP and that all HSAG's recommendations have been incorporated into the project design.

In March 2017 Kaiser submitted the intervention plans of Module 4 for pre-validation review. HSAG did not officially validate Module 4 but included pre-validation review comments for Kaiser's consideration prior to beginning intervention testing. Kaiser submitted a Module 4 plan for the following interventions:

- Create a standardized script that addresses reasons for screening, which staff would use when calling members.
- Add the language preference of members to the report, and have the caller use the language line.

Table 4–24 depicts the status of the PIP at the time of this report.

Table 4–24—Status of the *Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes* PIP

Module	Status
1. PIP Initiation	Passed in November 2016.
2. SMART Aim Data Collection	Passed in November 2016.
3. Intervention Determination	Passed in January 2017.
4. Plan-Do-Study-Act	Intervention plans submitted in March 2017 for pre-validation review (final submissions scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP report, Kaiser was in the intervention testing phase (Module 4) and advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately if changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that Kaiser Permanente's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid, excepting the foster care assessment measure, which was deemed not reportable. Key recommendations included:

- As noted in previous PMV audits, Kaiser Permanente was advised that the documentation of the medical visit does not meet the DMAS requirements for conducting and documenting the foster care

assessment and to refer to the Managed Care Technical Manual for the foster care assessment reporting specifications.

- Kaiser Permanente should use the monthly foster care roster provided by DMAS to reconcile/confirm members requiring an assessment.
- Kaiser Permanente should ensure continuity of oversight and management of the PMV activities for VA Medicaid reporting.
- Kaiser Permanente should take necessary steps to ensure that only clean claims are reported in the *MCO Claims Processing* measure.

Best and Emerging Practices for Improving Quality of Care and Services

Kaiser submitted the following best and emerging practices for 2017.

Human Papilloma Virus (HPV) Vaccination

Kaiser Permanente has been providing and encouraging HPV vaccines for both boys and girls for many years; years before NCQA began including boys in the HEDIS measure. The systems and workflows in place to improve HPV vaccination rates for these adolescents include tracking vaccination administration in KP HealthConnect, Kaiser Permanente's electronic medical record. Each day, the primary care team's clinical assistant reviews the day's appointments against a list of members with gaps in care according to the Commonwealth of Virginia EPSDT Periodicity Chart. EPSDT alerts have been incorporated into KP HealthConnect to alert clinicians of required services at the point of care. In addition, order templates have been created in KP HealthConnect for ease of ordering and documenting EPSTD components, such as HPV immunizations. Appointments for the second vaccine are made at the time that the first vaccine is administered.

To support outreach, a centralized quality team sends secure messages or letters to adolescents' parents/guardians reinforcing the timing and importance of HPV vaccines. If the HPV series is not initiated or completed based on this outreach, the parent/guardian will receive a phone call from the PCP's office. The PCP's office retrieves this list from a section of KP HealthConnect specifically designed to list patients who have received a secure message or letter and have not responded by receiving the needed care. An appointment does not need to be made for this (or any other) vaccine; an adolescent can walk in to any Kaiser Permanente pediatrics or family practice office and get the vaccine any time the department is open. Parents/guardians who use My Health Manager at http://health.kaiserpermanente.org (kp.org), the patient portal, receive alerts when the vaccine is due or overdue. Monthly performance reports at the regional, medical office building, and PCP levels provide feedback to physicians to support improvement activities. An education campaign (including materials provided during PCP visits, online, and via first-class mail) was created for adolescents and families regarding the importance of HPV vaccine as cancer prevention, with the educational messages carried throughout the outreach efforts.

Early Childhood Vaccinations

In 2017, Kaiser Permanente initiated a multi-modal education campaign to encourage infant and toddler vaccines by age two. Large, colorful banners and posters are displayed in Kaiser Permanente medical office building lobbies and waiting areas where families of infants and young toddlers congregate, with messages about the required immunizations by the age of two. In addition, magnets, bibs, and appointment cards were developed with the immunization schedule and provided to families with newborns and infants. These materials all reinforce the need for a complete set of immunizations by the time a child turns two years of age.

Online Personal Action Plan

The "Personal Action Plan" within My Medical Record at http://health.kaiserpermanente.org/ kp.org or on the Kaiser Permanente app under "Medical Record" provides tailored information based on a member's age, gender, and chronic condition(s), indicating whether the recipient is at goal and/or has completed recommended care. The online "Personal Action Plan" is available to members age 18 and over who are not pregnant, in both English and Spanish. The information is updated daily based on information found in a member's medical record or obtained through a claim. A mobile-accessible platform allows members to click to call the clinical call center, schedule an appointment, or email their physicians directly from the tool. The tool provides online videos on a variety of topics that can be opened from the site.

Case Management

Kaiser Permanente uses a comprehensive case management strategy to assist high-risk and special needs members through our integrated care delivery system. Upon enrollment, members identified as having special needs are triaged through case management and receive targeted outreach to meet milestones in various care regimens. Additionally, Kaiser Permanente case management surveys these members for social determinants of health that may impact their lives negatively. In 2017, Kaiser Permanente began using the "Your Current Life Situation (YCLS)" questionnaire to facilitate appropriate identification of members and the challenges they face, and to provide the care they need in the most culturally and developmentally appropriate manner. The core domains of the YCLS include housing and concerns about living situation, financial hardship, food insecurity, transportation problems, stress, a single-question checklist (to determine areas with which a member wants help), instrumental social support (to determine if a member has enough help with activities of daily living (ADLs)or has someone to call if needed), and identify who completed the questionnaire. Members engaged in case management for three months or longer are resurveyed to determine if case management services have made a positive impact on the member's health and well-being.

Follow-up to Prior EQR Recommendations

Following are Kaiser's responses regarding HEDIS/PMV EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Kaiser Permanente is continuously looking for ways to improve our quality of care, access to care, coordination of health care services, and patient satisfaction. Kaiser Permanente employs a multi-pronged approach to ensure ongoing quality improvement in our delivery system. Kaiser Permanente quality improvement initiatives focus on aspects of care delivery that improve overall quality and reduce costs, including appropriate screening for cancer, annual monitoring of patients with ongoing conditions, decreasing wait times, and reducing hospital readmissions. Kaiser Permanente has followed and continues to follow the Rapid Improvement Model (RIM) as a framework for developing, testing, implementing, and measuring change initiatives. All members of the health care team are involved in quality improvement. Kaiser Permanente uses Unit Based Teams (UBTs) made up of clinic staff, physicians, and managers to work collaboratively to solve problems and enhance quality for tangible and quantifiable results using the RIM model for improvement.

Following are Kaiser's responses regarding the PIP EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Kaiser Permanente's PIP focused on diabetes care is titled "Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes." Kaiser Permanente is fully compliant for Modules 1, 2, and 3 and is approved for continuation of Module 4. Recommendations from HSAG have been incorporated into the project design and rapid-cycle improvement project concluding in December 2017.

Following are Kaiser's responses regarding Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

In 2017, Kaiser Permanente has made significant strides in access and service through continued focus and operational and quality improvements on multiple fronts. To improve the experience and satisfaction of members, some of the 2017 Kaiser Permanente access initiatives included: (1) the addition of provider FTEs to enhance appointment supply; (2) improved schedule templates and scheduling practices to provide enhanced flexibility to our members; and (3) enhanced access to both primary and specialty care through the use of telemedicine such as eVisits, integrated video visits, and secure messaging with the Health Care Teams to improve geo access and same day and next day access.

Kaiser Permanente implemented several structural and procedural changes in the clinical contact centers. The largest change and service improvement initiated this year was the implementation of the Specialty Contact Center. This has substantially improved member experience and satisfaction for members calling to make an appointment with Kaiser Permanente specialty departments. This effort involved over 17,000 hours of training as well as porting 185 phone numbers across 25 specialty departments. In addition, members called the Nurse Advice Line over 6,000 times this year with symptoms that indicated a possible 911 medical emergency. Kaiser Permanente's skilled advice nurses worked in collaboration with emergency care physicians to determine whether the symptoms warranted a 911 emergency call or if alternative emergent/urgent care settings were more appropriate. Kaiser Permanente also focused on one-call resolution and implementation of a warm transfer process to ensure that caller needs are met fully on every call. This included continued focus on servicing and training staff to better assist members on the dedicated Medicaid phone line.

Further building on the objective to improve the experience of all members, Kaiser Permanente expanded, implemented, and improved execution of several key digital technology initiatives including: (1) augmenting the secure messaging system program to include text reminders for members to schedule their annual health assessments; (2) enabling members to request their medical records online; (3) enabling members to easily transfer their prescriptions, reorder refills and set up refill reminders via kp.org and the MyKP Meds mobile application; and (4) adding kiosks to provide a self-check-in option, offering convenience and reduced wait time for members.

Kaiser Permanente is in the process of implementing an 18-month service culture transformation that reflects their commitment to ensuring that the level of service excellence grows with their membership. Known as the "One KP Experience," the program focuses on a "Respect Me, Know Me, and Guide Me" model that supports all interactions that Kaiser has with members and with each other. To date, Kaiser Permanente has completed 30 percent of the planned experiential sessions in which all employees will participate. This year alone, over 95 percent of Kaiser employees have completed the first two components of training.

Kaiser Permanente's operating model includes embedding Unit-Based Teams (UBTs) consisting of staff and labor representatives trained to make targeted operational improvements within their work units. Kaiser Permanente believes that involvement and collaboration at every level of the organization are key to driving workable and sustainable improvements.

Kaiser Permanente recognizes the importance of effective communication between providers and members. To support ongoing improvement in patient-provider communication, providers were trained on how to implement changes in their practice that could measurably improve member satisfaction. Targeted physician training was provided on best practices and resources for better patient communication. Training and resources included tip sheets on how to improve care communication to members from different ethnic backgrounds, those with disabilities, and women and young adults.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for Kaiser Permanente.

Most HEDIS measure rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile. The Women's Health domain performed above the national Medicaid 50th percentile by more than 10 percentage points for all indicators, and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate improved by more than 5 percentage points in 2017. All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile with most rates performing higher than 90 percent. For the Care for Chronic Conditions domain, rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile for six of the seven reportable measure rates (about 86 percent), including all five *Comprehensive Diabetes Care* indicators and *Controlling High Blood Pressure*. For the Behavioral Health domain, all three reportable measure rates for Kaiser Permanente ranked at or above the national Medicaid 50th percentile. In addition, the rate for

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up exceeded the national Medicaid 50th percentile by approximately 19 percentage points. Kaiser Permanente's rates for the following measures were not displayed due to small denominators: *Medical Assistance With Smoking and Tobacco Use Cessation, Follow-Up Care for Children Prescribed ADHD Medication,* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.*

Kaiser Permanente's two measure rates that fell below the national Medicaid 50th percentile were *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Medication Management for People With Asthma—Medication Compliance 75%—Total*.

Kaiser Permanente also performed significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*. This MCO also experienced significant improvement in 2017 on *Rating of Personal Doctor* for both adult and child Medicaid CAHPS. Conversely, the MCO scored significantly lower than the 2017 NCQA national child Medicaid averages on *Getting Needed Care* and *Getting Care Quickly*.

2017 Recommendations for Kaiser Permanente

All MCOs need to improve *Antidepressant Medication Management, Breast Cancer Screening,* and *Medication Management for People With Asthma—Medication Compliance 75%—Total.* In other states, HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

Kaiser Permanente's high performance trends for the HEDIS measures are indicative of the benefits of an integrated care system that relies upon unified electronic medical health records for its members. In consideration of Kaiser Permanente's low child Medicaid CAHPS scores on *Getting Needed Care* and *Getting Care Quickly* and the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child*

Visits score being lower than the 50th percentile, Kaiser Permanente should examine scheduling practices and primary care provider availability to ensure that the managed Medicaid children in Virginia have adequate access to care.

EQR Activity Results for Optima Family Care (Optima)

Optima Family Care (Optima) is the Medicaid managed care product offered by Optima Health. A service of Sentara, Optima is a not-for-profit health care organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for Optima.

Performance Measures

Table 4–25 displays the rates for measures Optima reported for HEDIS 2015, 2016, and 2017. Optima's HEDIS 2015, 2016, and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Optima's measure rates that were at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4–25—Optima HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	46.53%	44.44%	48.84%	**48.41%**
Childhood Immunization Status				
Combination 3	65.97%	72.69%	72.92%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	70.56%	67.76%	67.53%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.39%	74.17%	80.47%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	55.87%	54.92%	54.55%	**58.08%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	65.80%	56.85%	**55.94%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.29%	81.71%	83.10%	**82.25%**
Postpartum Care	58.28%	59.03%	60.42%	**60.98%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	86.67%	85.98%	**82.15%**

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.62%	97.61%	**95.74%**
25 Months–6 Years	—	90.98%	90.59%	**87.69%**
7–11 Years	—	92.00%	92.51%	**91.00%**
12–19 Years	—	89.59%	90.47%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	84.95%	89.35%*	86.81%	**85.95%**
HbA1c Control (<8.0%)	53.70%	52.55%*	49.77%	**46.76%**
Eye Exam (Retinal) Performed	45.83%	48.84%*	53.94%	**53.28%**
Medical Attention for Nephropathy	—	90.74%*	90.05%	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	56.71%	56.71%*	52.55%	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	48.72%	51.39%	53.01%	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	31.45%	34.41%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	80.69%	86.88%	**76.59%**
Discussing Cessation Medications	—	46.42%	49.71%	**48.31%**
Discussing Cessation Strategies	—	44.38%	46.15%	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.39%	48.80%	49.78%	**53.38%**
Effective Continuation Phase Treatment	33.38%	35.40%	35.71%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	38.77%	39.81%	**42.19%**
Continuation and Maintenance Phase	—	47.76%	57.75%	**52.47%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	63.66%	53.58%	63.03%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	—	49.11%	47.47%	**60.43%**

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

** HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

‡ Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2017 Rate [CY 2016] was at or above the 2016 national Medicaid 50th percentile).

For the Children's Preventive Care domain, all four measure rates in 2017 ranked at or above the national Medicaid 50th percentiles for Optima. Performance for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* increased by more than 5 percentage points from HEDIS 2016 to HEDIS 2017, indicating an area of strength.

For the Women's Health domain, two of Optima's measure rates (*Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) ranked at or above the national Medicaid 50th percentile. Of note, the measure rate for *Cervical Cancer Screening* decreased in performance by more than 9 percentage points in HEDIS 2017.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile, demonstrating an area of strength for Optima.

Optima's measure rates ranked at or above the national Medicaid 50th percentile for 7 of the 10 Care for Chronic Conditions measure indicators (70 percent). Further, Optima ranked at or above the national Medicaid 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* and *HbA1c Control (<8.0%)* measure indicators from 2015 to 2017. The measure rate for *Controlling High Blood Pressure* has increased slightly from 2015 to 2017, falling just below the national Medicaid 50th percentile.

Within the Behavioral Health domain, only one measure rate (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*) for Optima ranked at or above the national Medicaid 50th percentile, with the remaining five rates falling below the national Medicaid 50th percentile with relatively stable performance. Although the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure rate increased by approximately 10 percentage points, performance has been inconsistent from 2015 to 2017 and indicates an area of opportunity. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4–26 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–26—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: Optima

	Optima Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	70.2%	67.5%
Rating of All Health Care	60.2%	59.5%
Rating of Personal Doctor	71.5%	69.4%
Rating of Specialist Seen Most Often	67.9%	67.1%
Composite Measures		
Getting Needed Care	79.8%	86.3%▲
Getting Care Quickly	83.2%	81.5%
How Well Doctors Communicate	88.6%	90.9%
Customer Service	87.4%	87.3%
Shared Decision Making	81.9%	77.5%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Optima's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- Optima scored statistically significantly higher in 2017 than in 2016 on one measure, *Getting Needed Care*.

Child CAHPS

Table 4–27 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2017 child Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–27—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: Optima

	Optima Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	80.1%	75.4%

	Optima Child Medicaid	
	2016	2017
Rating of All Health Care	74.5%	71.7%
Rating of Personal Doctor	77.0%	80.3%
Rating of Specialist Seen Most Often	72.1%+	80.6%+
Composite Measures		
Getting Needed Care	85.2%	88.7%
Getting Care Quickly	90.1%	92.9%
How Well Doctors Communicate	94.5%	94.9%
Customer Service	87.0%+	91.2%+
Shared Decision Making	78.6%+	77.3%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

Optima's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences; no statistically significant differences were observed.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how Optima compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Optima as shown in Table 4–28.

Table 4–28—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4–29 displays Optima's 2016 and 2017 consumer decision support tool results.

Table 4–29—Optima's Consumer Decision Support Tool Results, 2016–2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	★★
Getting Care	★★	★★
Keeping Kids Healthy	★	★
Living With Illness	★★	★★
Taking Care of Women	★★★	★

Optima's performance on the consumer decision support tool remained fairly consistent between 2016 and 2017. The rating for one domain, Taking Care of Women, declined from a three-star rating in 2016 to a one-star rating in 2017, demonstrating an opportunity for improvement. Optima also received a one-star rating for the Keeping Kids Healthy domain in 2016 and 2017, demonstrating an opportunity for improvement. Optima received a two-star rating for the Doctors' Communication, Getting Care, and Living With Illness domains in 2016 and 2017.

Performance Improvement Projects

For validation year 2017, Optima continued to work on one state-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. For the 2017 validation of Optima's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Including all steps in the process map.
- Documenting the rationale for the selected failure modes.
- Correcting potential interventions.

Optima revised Module 3 and addressed HSAG's concerns in the resubmission. The MCO did not reference PIPs in its assessment of follow-up to recommendations.

In March 2017, Optima submitted the intervention plan of Module 4 for pre-validation review. HSAG did not officially validate Module 4 but included pre-validation review comments for Optima's consideration prior to beginning intervention testing. Optima submitted a Module 4 plan for the following intervention:

- The provider contacts the case manager, who addresses transportation issues.

Table 4–30 depicts the status of the PIP at the time of the annual PIP report.

Table 4–30—Status of the *Diabetic Retinal Exam Compliance Rate* PIP

Module	Status
1. PIP Initiation	Passed in October 2016.
2. SMART Aim Data Collection	Passed in December 2016.
3. Intervention Determination	Passed in January 2017.
4. Plan-Do-Study-Act	Intervention plan submitted in March 2017 for pre-validation review (final submission scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP report, Optima was in the intervention testing phase (Module 4) and advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately if changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that Optima's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Key recommendations included:

- Optima should enhance processes used for generating the claims processing timeliness data instead of relying upon manual calculations and ensure that only clean claims are included in the report.
- Optima should reduce the manual components used for foster care assessment measure reporting and ensure that only newly enrolled/newly eligible members are reported.
- Optima should scan completed foster care assessment forms to assist with data verification.

Best and Emerging Practices for Improving Quality of Care and Services

Optima submitted the following best and emerging practices for 2017.

To continuously improve HEDIS measures, Optima implemented the 2016 HEDIS Improvement Initiative. The Initiative's executive sponsor was Thomas Lundquist, MD, Chief Medical Officer, and included membership identified by Optima's Quality Improvement Leadership Team. The initiative involved a focused effort to improve HEDIS measures utilizing the methodology piloted by Optima in 2015 to improve colorectal screening.

In addition, the Optima's communications team developed a strategic communication goal to improve and better position Optima's HEDIS measures, as well as educate members on health plan offerings through proactive member communication and outreach. Optima's communication plan established a schedule for member outreach to target and improve HEDIS measures and send reminders for prevention screenings and care. In 2017, the HEDIS improvement initiative team transitioned into a population health workgroup comprised of medical directors and department leaders in areas such as disease management, clinical operations, quality improvement, wellness, marketing and communications. This cross-functional team allows collaboration and differing perspectives, thus driving innovative approaches to clinical quality.

Optima supports the DMAS Quality Collaborative and utilizes the information provided and lessons learned from its team members toward improving the wellness of their members.

Follow-up to Prior EQR Recommendations

Following are Optima's responses regarding PIP 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Optima completed the diabetic eye exam PIP for this year utilizing the Rapid Cycle process that was introduced by HSAG. Optima is working to complete a few modifications to the PIP, such as correcting the Smart Aim end date, correcting the denominator statement, and charting progress accurately. All the corrections were based on HSAG's review of Module 1–3.

Following are Optima's responses regarding Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Optima initiated a new Preventive Care gap alert program in 2017. During all inbound member phone calls, the system will prompt the staff member if the member has a gap in care. Optima can educate members during each phone call on the importance of receiving necessary care from appropriate health care providers. Optima can also assist with finding a provider, making an appointment and securing transportation. This initiative provided over 56,000 educational reminders on immunizations, diabetes care, well child care and cancer screenings in 2017.

Optima provides a dynamic health and wellness program, MyLife MyPlan. This program is member-centric and designed to meet the needs of members at every level of the health continuum. Coordination of services is crucial to maximize efficiency, improve satisfaction, and influence positive behavior change. All Optima members receive wellness resources, including access to health coaches and a personalized wellness plan. Coordination of services is crucial to maximize efficiency, improve satisfaction, and influence positive behavior change. Optima's health-coaching partner, WebMD, offers members a comprehensive online activities tool which delivers a personalized, interactive, and motivational experience to help members act and sustain healthy behaviors in a fun way. In addition, Optima offers a variety of publications to members at no cost. Optima's Patient Identification Manager

(PIM) Reminder system is a computer-based direct mail program designed to reach members and physicians every month to promote health. Initiatives include mammography and cervical cancer screening reminders, immunization postcards, and birthday cards that include preventive health guidelines.

Optima has committed to improving the health literacy of members with the use of the Krames patient education materials. Optima stated that Krames Patient Education is recognized for its ability to improve comprehension, enhance engagement, and empower people to take control of their health. The new English and Spanish editions are focused on health literacy and patient engagement that support shared decision making and informed consent.

Optima provides effective communication to members who have limited English proficiency and/or are non-English speaking by partnering with Language Access Network vendor. In addition, Optima coordinates pre-scheduled on-site interpretation sessions in the family care physician offices.

Optima embarked on a journey to develop a client-centered plan of care across the continuum. In this model, the case managers use a collaborative approach to deliver quality care, increase efficiency of available resources while maximizing benefit. In the past there were multiple departments, consisting of Utilization Management, Community Based Case Management, Behavioral Health and Disease Management. Presently, these departments have been combined as one integrated team, to coordinate appropriate health interventions and care plans. As a result, Optima is better able to assist members and address needs of the holistic member. One care coordinator can assist a member with medical, behavioral health or social determinants, providing the member with a single point of entry to the plan.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for Optima.

For the Children's Preventive Care domain, all four measure rates in 2017 ranked at or above the national Medicaid 50th percentiles. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure increased by more than 5 percentage points in 2017. The *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rates ranked at or above the national Medicaid 50th percentile for the Women's Health domain, although the rate for *Cervical Cancer Screening* declined in performance by almost 9 percentage points from HEDIS 2016 to 2017. The other two Women's Health measures (*Breast Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care*) fell slightly below the national 50th percentile. All five measure rates within the Access to Care domain ranked at or above the national 50th percentile. Optima's Care for Chronic Conditions measure rates ranked at or above the national 50th percentile; and the *Comprehensive Diabetes Care—HbA1c Testing* and *HbA1c Control (<8.0%)* measure indicators have consistently ranked at or above the national 50th percentile each year, although *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* indicator *Controlling Blood Pressure for Diabetics* decreased

by 4 percentage points. While *Controlling High Blood Pressure* fell below the national Medicaid 50th percentile, it has been marginally improving each year.

Within the Behavioral Health domain, Optima had only one measure rate (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*) ranked at or above the national Medicaid 50th percentile. While the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure rate increased by approximately 10 percentage points, performance has been inconsistent from HEDIS 2015 to HEDIS 2017.

Optima scored significantly higher than the 2017 NCQA national adult Medicaid averages for *Rating of Health Plan, Rating of All Health Care,* and *Getting Needed Care*. Furthermore, Optima scored significantly higher than the 2017 NCQA national child Medicaid averages for *Rating of Health Plan, Rating of Personal Doctor,* and *Rating of Specialist Seen Most* Often, Getting Needed Care, and Getting Care Quickly.

2017 Recommendations for Optima

All MCOs need to improve *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total*. In other states, HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

While Optima's measure rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* was higher than the national Medicaid 50th percentile, the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure rate was lower than the 50th percentile, suggesting that Optima needs to make more effort to ensure that children newly prescribed ADHD medication receive timely follow-up care. HSAG has noted improvement in the

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase measure when health plans and state formularies limit the quantity prescribed for new ADHD prescriptions. As a side note, when state and/or health plan formularies limit the quantity prescribed for new ADHD prescriptions, this may result in an improvement in the *Initiation Phase* measure indicator rates. This intervention requires the member's family or caregivers to seek follow-up care to renew prescriptions. The MCO's Pharmaceutical and Therapeutics Committee should evaluate the benefits and risks associated with the implementation of this pharmacy benefit system control as a mechanism to drive improved follow-up rates for children newly prescribed ADHD medication.

EQR Activity Results for Virginia Premier Health Plan, Inc. (VA Premier)

Virginia Premier Health Plan, Inc. (VA Premier) is a local, not-for-profit managed care organization owned by the VCU Medical Center, headquartered in Richmond, Virginia. The company began operations as a managed care Medicaid health plan in 1996. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for VA Premier.

Performance Measures

Table 4–31 displays the rates for measures that VA Premier reported for HEDIS 2015, 2016, and 2017. VA Premier's HEDIS 2015, 2016, and 2017 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate VA Premier's measure rates that were at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentile for HEDIS 2016 is also provided for reference.

Table 4–31—VA Premier HEDIS 2015, 2016, and 2017 Results

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.67%	45.70%	48.84%	**48.41%**
Childhood Immunization Status				
Combination 3	72.41%	72.19%	71.53%	**71.06%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	69.32%	67.99%	63.66%	**59.57%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.73%	70.42%	74.54%	**71.42%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	52.43%	52.44%	52.75%	**58.08%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	61.92%	60.05%	**55.94%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.89%	80.13%	85.15%	**82.25%**
Postpartum Care	63.33%	60.93%	64.27%	**60.98%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	—	88.86%	88.00%	**82.15%**

Performance Measures	HEDIS 2015 Rate (CY 2014)	HEDIS 2016 Rate (CY 2015)	HEDIS 2017 Rate (CY 2016)	NCQA Quality Compass 50th Percentile for HEDIS 2016[1]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.58%	98.21%	**95.74%**
25 Months–6 Years	—	92.05%	92.69%	**87.69%**
7–11 Years	—	94.06%	93.97%	**91.00%**
12–19 Years	—	92.73%	92.34%	**89.37%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	86.20%	84.43%*	87.72%	**85.95%**
HbA1c Control (<8.0%)	49.46%	39.08%*	48.77%	**46.76%**
Eye Exam (Retinal) Performed	53.64%	49.47%*	52.28%	**53.28%**
Medical Attention for Nephropathy	—	89.62%*	90.88%	**90.51%**
Blood Pressure Control (<140/90 mm Hg)	61.86%	50.99%*	54.21%	**59.73%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	59.47%	51.35%	57.87%	**54.78%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	—	33.39%	38.55%	**31.28%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	84.75%	83.52%	**76.59%**
Discussing Cessation Medications	—	50.00%	53.13%	**48.31%**
Discussing Cessation Strategies	—	40.47%	42.54%	**43.82%**
Behavioral Health‡				
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.29%	68.89%	51.98%	**53.38%**
Effective Continuation Phase Treatment	35.89%	54.87%	36.78%	**38.06%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	54.78%	55.38%	**42.19%**
Continuation and Maintenance Phase	—	66.33%	67.63%	**52.47%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	66.44%	64.75%	64.86%	**63.94%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	—	64.12%	65.49%	**60.43%**

— Indicates that the measure was not required; therefore, rates are not presented for historical years (i.e., HEDIS 2015 or HEDIS 2016).

** HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing HEDIS 2016 rates to prior years and to national Medicaid benchmarks.*

‡ Certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2017 Rate [CY 2016] was at or above the 2016 national Medicaid 50th percentile).

For the Children's Preventive Care domain, all four measure rates in 2017 ranked at or above the national Medicaid 50th percentiles for VA Premier, demonstrating strength for the MCO.

For the Women's Health domain, three of VA Premier's measure rates (*Cervical Cancer Screening*; and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*) ranked at or above the national Medicaid 50th percentile. Of note, the measure rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* increased in performance by more than 5 percentage points in 2017.

All five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentile, indicating an area of strength for VA Premier.

VA Premier's measure rates ranked at or above the national Medicaid 50th percentile for 7 of the 10 Care for Chronic Conditions measure indicators (70 percent). Further, the measure rate for *Medication Management for People With Asthma—Medication Compliance 75%—Total* increased more than 5 percentage points from 2016 to 2017. Although the *Controlling High Blood Pressure* measure rate increased by more than 5 percentage points and ranked at or above the national Medicaid 50th percentile, performance has been inconsistent from 2015 to 2017 and indicates an area of opportunity.

Within the Behavioral Health domain, VA Premier's measure rates ranked at or above the national Medicaid 50th percentile for four of the six reportable rates. The remaining rates, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, performed slightly below the national Medicaid 50th percentile. It should be noted that certain behavioral health services are provided by a third party, Magellan. As a result, caution should be exercised when making conclusions about MCO performance for measures reported in the Behavioral Health domain.

Consumer Survey Quality of Care

Adult CAHPS

Table 4–32 presents the 2016 and 2017 MCO-specific and statewide aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2017 adult Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–32—Comparison of 2016 and 2017 Adult Medicaid CAHPS Results: VA Premier

	VA Premier Adult Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	67.8%	62.9%
Rating of All Health Care	55.8%	54.2%

	VA Premier Adult Medicaid	
	2016	2017
Rating of Personal Doctor	69.4%	68.0%
Rating of Specialist Seen Most Often	69.6%	69.1%
Composite Measures		
Getting Needed Care	83.8%	85.8%
Getting Care Quickly	83.4%	88.1%
How Well Doctors Communicate	89.8%	89.4%
Customer Service	86.7%	89.4%
Shared Decision Making	84.0%	81.8%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

VA Premier's 2016 and 2017 adult Medicaid CAHPS scores were compared for statistically significant differences; no statistically significant differences were observed.

Child CAHPS

Table 4–33 presents the 2016 and 2017 MCO-specific and statewide aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2017 child Medicaid CAHPS scores to its corresponding 2016 CAHPS scores.

Table 4–33—Comparison of 2016 and 2017 Child Medicaid CAHPS Results: VA Premier

	VA Premier Child Medicaid	
	2016	2017
Global Ratings		
Rating of Health Plan	68.3%	71.3%
Rating of All Health Care	69.9%	65.3%
Rating of Personal Doctor	75.2%	75.5%
Rating of Specialist Seen Most Often	71.0%+	71.3%
Composite Measures		
Getting Needed Care	83.7%	88.0%
Getting Care Quickly	89.8%	95.3%▲
How Well Doctors Communicate	95.4%	96.4%

	VA Premier Child Medicaid	
	2016	2017
Customer Service	87.8%+	89.7%
Shared Decision Making	81.5%+	79.0%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2017 than in 2016.*
▼ *statistically significantly lower in 2017 than in 2016.*

VA Premier's 2016 and 2017 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary result:

- VA Premier scored statistically significantly higher in 2017 than in 2016 on one measure, *Getting Care Quickly*.

Consumer Decision Support Tool

The 2017 Consumer Decision Support Tool demonstrated how VA Premier compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for VA Premier as shown in Table 4–34.

Table 4–34—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★	**Above Virginia Medicaid Average**	The MCO's performance was above average compared to all Virginia Medicaid MCOs.
★★	**Virginia Medicaid Average**	The MCO's performance was average compared to all Virginia Medicaid MCOs.
★	**Below Virginia Medicaid Average**	The MCO's performance was below average compared to all Virginia Medicaid MCOs.

Table 4–35 displays VA Premier's 2016 and 2017 consumer decision support tool results.

Table 4–35—VA Premier's Consumer Decision Support Tool Results, 2016–2017

Domain	2016 Results	2017 Results
Doctors' Communication	★★	★★
Getting Care	★★	★★★
Keeping Kids Healthy	★★	★★

Domain	2016 Results	2017 Results
Living With Illness	★★★	★★
Taking Care of Women	★★	★★

VA Premier's performance on the consumer decision support tool remained fairly consistent between 2016 and 2017. The rating for one domain, Getting Care, improved from a two-star rating in 2016 to a three-star rating in 2017. Conversely, the Living With Illness domain experienced a decline in performance from a three-star rating in 2016 to a two-star rating in 2017.

Performance Improvement Projects

For validation year 2017, VA Premier continued to work on one state-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. For the 2017 validation of VA Premier's PIP, the MCO completed and submitted Module 3 (Intervention Determination). For the initial review, HSAG identified opportunities for improvement that included:

- Including opportunities for improvement in the process map.
- Defining and prioritizing all failure modes.
- Documenting the rationale for the selected failure modes.
- Correcting potential interventions.
- Updating the definitions for reliability and sustainability of proposed interventions.

VA Premier revised Module 3 and addressed HSAG's concerns in the resubmission. The MCO indicated in its assessment of follow-up to recommendations that it used technical assistance with HSAG to complete all modules within the required time frame.

In March 2017, VA Premier submitted the intervention plan of Module 4 for pre-validation review. HSAG did not officially validate Module 4 but included pre-validation review comments for VA Premier's consideration prior to beginning intervention testing. VA Premier submitted a Module 4 plan for the following intervention:

- Use telehealth (digital tele-retinal imaging) for eye screenings.

Table 4–36 below depicts the status of the PIP at the time of the annual PIP report.

Table 4–36—Status of the *Comprehensive Diabetes Care: Eye Exams* PIP

Module	Status
1. PIP Initiation	Passed in November 2016.
2. SMART Aim Data Collection	Passed in November 2016.

Module	Status
3. Intervention Determination	Passed in January 2017.
4. Plan-Do-Study-Act	Intervention plan submitted in March 2017 for pre-validation review (final submission scheduled to be submitted in February 2018).
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP report, VA Premier was in the intervention testing phase (Module 4) and advised to:

- Test interventions until the SMART Aim end date (December 31, 2017).
- Provide Module 4 progress updates when requested.
- Make changes based on Module 4 progress update recommendations.
- Request technical assistance from HSAG when needed.
- Contact HSAG and DMAS immediately changes are made to the PIP.

PMV Recommendations

HSAG PMV auditors indicated that VA Premier's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Key recommendations included that VA Premier should:

- Validate programming logic to ensure that only clean claims are included in the *MCO Claims Processing* measure.
- Document the foster care assessment data collection processes and ensure that scanned images of paper assessments are available for data verification purposes.
- Assess new member outreach processes and time frames for conducting foster care assessments and ensure that documentation is completed timely.

Best and Emerging Practices for Improving Quality of Care and Services

VA Premier submitted the following best and emerging practices for 2017.

Elderly and Disabled with Consumer Direction (EDCD) Waiver Audit Process

DMAS delegated EDCD quality medical record review audits via site visits to the MMPs in June 2014, with audits initiating in September 2014. Site visits include audits of the following types of claims: Personal Care, Respite Care, Adult Day Healthcare, Personal Emergency Response System, and Service Facilitator. Audit volumes are based upon the total number of EDCD claims and enrollees in an assigned

quarter. A statistical analysis is completed with a 95 percent confidence interval and a 5 percent error rate. Site visits are conducted for service facilitators and agencies.

The content of the review consists of the following:

- Policies and procedures
- Personnel files
- Clinical quality of care
- Quality of staff
- Home visits
- Member satisfaction

Since the rollout of the program, the quality staff have continued to refine processes. Adaptability to change has been a programmatic success. The audit waiver tool was automated, streamlining the process; and data are entered in the field while on site. This eliminated the redundancy of completing a paper tool in the field, then taking it to the office to enter in the database. The program uses automated data aggregation and reporting. The program staff have continued to include a brief notification call to the agencies to verify office hours, addresses, contact person(s), and location of records. This has proven to be very helpful in streamlining VA Premier's processes and enhancing the communication strategy with EDCD providers. The program continues the newly instituted process whereby VA Premier asks providers if they have experienced a recent audit. The goal is to help eliminate unnecessary travel and increase EDCD provider audit communications. All site audits for agencies continue to be unannounced. Site audits for service facilitators are scheduled with the service facilitators at mutually convenient times. DMAS has recognized the electronic auditing program as a best practice.

Data Sharing with Bordering States

VA Premier initiated conversations with the North Carolina Department of Health (NCDH) during October 2015 related to gaining access to immunization data for members. VA Premier's HEDIS team was informed that the series of steps to take to gain access included: (1) completing the 2015 HEDIS agreement and returning with information for members, (2) completing the user confidentiality agreement, and (3) registering for an account. Other states' systems and registries to which we reached out included the following:

- West Virginia Statewide Immunization Information System (WVSIIS)
- Tennessee Immunization Information System (TennIIS)
- ImmuNet: Maryland's Immunization Information Registry (MIIS)
- Kentucky Immunization Registry (KYIR)

West Virginia and Kentucky had system issues and could not respond until their system changes were completed. Numerous phone conversations and conference calls were held to initiate the process in the various states. This started the journey of relationship building.

Multiple parties were involved in the process of securing data from the bordering states. The steps in the process included:

- Agreements
- Mapping
- Secure FTP
- Testing
- Gatekeeper
- Data transfers

The quality and contracting departments worked together to make sure that agreements were signed and all paperwork was submitted and approved. This process went through various iterations for security reasons. The next phase involved information technology (IT)and the business warehouse teams with data mapping. IT completed data mapping and building secure FTPs for data exchanges. Test files were created, and joint meetings were held with key individuals within each of the states.

A gatekeeper was put in place to ensure that the process was moving and to identify any roadblocks to meeting the HEDIS 2017 timelines. This individual frequently reached out to counterparts within the bordering states to engage when a lag in responses to requests occurred or with questions about file layout and the like. This person was instrumental in keeping the project on task. Data transfers were completed and data mapped to the HEDIS sample project. This best practice had the following results:

- *Childhood Immunization Status Combination 3*
  - Exceeded the national Medicaid 50th percentile
  - Met PIA measure target Established successful data integration
- Members identified in the sample had improved care, which attests that services were provided

HEDIS Software showed what impact the bordering states' supplemental data had on the project. Based upon the data transferred from the bordering states, VA Premier realized a 17.46 percent gain on the *Childhood Immunization Status—Combination 3* rate. VA Premier believes that similar improvements will come with more bordering states' data exchange and transfers.

Follow-up to Prior EQR Recommendations

Following are VA Premier's responses regarding HEDIS/PMV EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

VA Premier commits to meeting and exceeding DMAS' standards on performance measures. Their Quality Improvement (QI) department annually collects and reports out HEDIS data according to contract requirements. Staff members analyze HEDIS data to identify opportunities to improve all measures. VA Premier works to ensure annual improvement in these Medicaid HEDIS measures with

the goal of achieving and sustaining performance at the 50th percentile for HMOs as reported by Quality Compass. Internally, VA Premier established goals to achieve the 75th percentile or greater for each of these measures. Through their QI processes, VA Premier achieved significant improvements on HEDIS measures in 2016 and 2017. VA Premier will continue to evaluate system performance on identified HEDIS measures using applicable year's NCQA Technical Specifications and aligning with DMAS' requirements.

VA Premier is committed to meeting DMAS' goals for PIA measures. To improve performance, VA Premier initiated an organization-wide improvement plan. VA Premier conducted a root cause analysis to better understand the factors that contributed to performance scores and identified specific strategies to track interim PIA results and increase scores including the following:

- Enhanced operational oversight
- Improved data collection and tracking
- Population health strategies
- Staff recruitment and training

These actions have helped to improve VA Premier's HEDIS results for 2017. In addition, to increase oversight of HEDIS results, VA Premier implemented strategies for regularly reviewing measures and assessing the effectiveness of improvement initiatives, which included:

- HEDIS Oversight Committee—This committee reviews measures, evaluates the effectiveness of improvement strategies, and addresses operational issues that may impact performance.
- Frequent surveillance of HEDIS measures—VA Premier developed interim reports using administrative data to predict HEDIS results and to identify and focus improvements.

VA Premier implemented several initiatives to improve data collection processes and enhance ability to act to engage members in care, including:

- Incorporating immunization data from surrounding states for members living near the border, resulting in a 17 percent improvement with immunization rates.
- Implementing alerts in the care management system to notify staff to conduct outreach to pregnant members and new mothers in need of prenatal and postpartum care.
- Improving record abstraction processes through weekly meetings with the VA Premier vendor to identify and remove any barriers to gathering and reviewing records to calculate HEDIS performance.

In VA Premier's experience, connecting members to care is critical for improving health outcomes and meeting HEDIS performance standards. VA Premier developed targeted strategies to engage members, including:

- Enhanced member education materials to include a health calendar with monthly areas of focus (such as breast cancer screening month) to remind members to complete wellness visits.
- Conducted targeted outreach calls to members with gaps in care and to remind members of upcoming well-care milestones.
- Contacted parents (through the Watch Me Grow program) to remind them of well-child visits.
- Partnered with the University of Virginia to offer diabetic retinopathy screenings using telehealth.
- Implemented behavioral health homes, which provided member outreach and education.

To further promote a culture of quality throughout VA Premier, staff training focused on steps to take to improve member access to care. VA Premier also increased the number of quality management staff and enhanced their training as described following:

- Recruited and hired additional quality staff.
- Enhanced and consolidated staff training using interactive technology.
- Developed a new training module that highlights any changes to HEDIS methodologies from the previous year and provides up-to-date information for auditors.

As a result, staff reported increased satisfaction with training and indicated that they feel more prepared to conduct HEDIS audits.

Lastly, as part of continuous quality improvement approach, VA Premier remains focused on continuing to meet and exceed DMAS' standards. The following strategies continue:

- Automating data scrubbing processes, which allows clinical staff to focus on audits.
- Incorporating PIA measures in monthly dashboards.
- Using heat maps to identify care gaps at regional levels for targeted interventions.
- Implementing a year-round strategy for analyzing and improving HEDIS rates.
- Conducting ongoing member outreach to close gaps in care.

Following are VA Premier's responses regarding the PIP EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

HSAG recommends that MCOs refer to HSAG's PIP Companion Guide when completing the rapid-cycle PIP modules and request technical assistance from HSAG as needed. VA Premier used the EQRO advisory services to complete all required modules (1 through 4) within the required time frame. Module 5—Conclusion is not due until February 2018. VA Premier followed the EQRO's recommendations for the resubmission of the following modules:

- (Module 1) Corrected the baseline rates for the narrowed focus providers.
- (Module 2) Provided the documentation of claims data completeness within 30 days.

- (Module 2) Documented the data collection interval.
- (Module 2) Labeled the SMART Aim run chart axes accurately.

All resubmitted modules were approved by the EQRO.

Following are VA Premier's responses regarding FAMIS Program CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

Concerning customer service, coordination of care, and shared decision making, VA Premier will spread to the FAMIS Program quality improvement activities implemented in the Medallion 3.0 quality program and proven to be effective.

The Quality Satisfaction Committee (QSC) is an internal, cross-functional QI team that facilitates the integration of a culture of QI throughout the organization, focusing on member and provider experience. Member Services is an integral part of this committee due to the call center's impact on customer service. Agenda topics consist of: CAHPS data and drilldown of questions scored five points below the National Average based on Quality Compass, provider satisfaction, and access to care. Also, the committee was restructured for efficiency and combined all lines of business reporting member experience. The focus areas for the committee were: Member and Enrollee Advisory Committees, member grievances, member surveys to include CAHPS for Medicaid and Medicare members, enrollee satisfaction, *Enrollee Quality of Life and Home & Community Based Services* survey, case management and disease management surveys, practitioner grievances, practitioner surveys for provider satisfaction, access to care, and availability of appointments.

VA Premier coordinates members' medical, behavioral, and psychosocial support needs within its Care Coordination and Continuity of Care System for all members, based on need. VA Premier conducts predictive modeling and stratification to identify members' risk levels. VA Premier continually stratifies members to identify health changes that may warrant enrollment in the VA Premier case management program. VA Premier stratifies members based on claims-driven needs and provides care coordination to all members who require such supports at the right time, in the right location, and at the right level of intensity. VA Premier provides care coordination 24 hours a day, seven days a week through care coordinators and Nurse Line. Members can also access culturally and linguistically competent education and referral services as well as appropriate health and wellness services any time through the MyVirginiaHealth portal.

VA Premier embed dedicated care coordinators in provider practices, including two Federally Qualified Health Centers (FQHCs), to facilitate care coordination and link members to supports and services. As a result of this program, inpatient admissions per 1,000 have decreased by 12.3 percent, all-cause readmissions have decreased by 12.3 percent, and post-hospitalization follow-up contact has increased by 66 percent.

VA Premier's community partnership of health systems, area agencies on aging, independent physicians' groups, and other health and human service providers collaborate to effectively transition members to the community to reduce readmissions. Through this partnership, readmission rates have decreased to 12.2 percent, exceeding our target of 19.9 percent.

VA Premier's person-centered model of care places the member in the driver's seat and engages members in completing the health risk assessment (HRA). VA Premier meets members where they are and provides needed services and supports to help members achieve positive health outcomes, learn self-management, and maintain their health in the community setting of their choice. VA Premier accomplishes this by explaining the role of the care coordinator and the benefits of participating in the case management program, if applicable. VA Premier provides members and families with information related to their numerous benefits, programs, and initiatives—all designed to help members achieve an optimal state of health. VA Premier recognizes the important role that families play in encouraging members to engage in their health. With the member's permission, care coordinators interview families and caregivers as they are often a wealth of information regarding the member's medical and/or behavioral health conditions, medications, providers, and other health-related needs.

Following are VA Premier's responses regarding Medallion 3.0 CAHPS EQR 2016 recommendations, which have been included, for the greater part, as presented to HSAG.

VA Premier has implemented quality improvement initiatives to specifically target preventive care within their member population. Some of the initiatives are outlined below:

- Alerts or flags are attached to member files in the eligibility system. When a Member Services call agent or care coordinator is on the phone with a member and accesses the eligibility on a member, an "alert" will let the phone agent know if the member has care gaps for specific preventive health care such as immunizations, well-child visits, mammograms, or cervical cancer screening. The agent/coordinator may discuss the importance of the services with the member or schedule an appointment, if needed. Also, the call may be routed to the Quality Line for further assistance.
- Targeted outreach phone calls are made to members due for well-child and/or adolescent care visits as well as for prenatal care appointments.
- Prevention letters are sent to members as reminders of needed services.
- A text message-based program was implemented to educate and support members; encourage them to follow recommended guidelines for preventive care, immunizations, and screenings; and inform them of health plan services and benefits.
- VA Premier provides a single, toll-free point of contact phone number that members may access 24 hours a day, seven days a week for assistance.

VA Premier ensures member access to the right type of service for specific needs by maintaining provider referral rosters that include, but are not limited to, community-based agencies, State agencies, safety-net providers, teaching hospitals, and facilities that support access to the full Commonwealth of Virginia Department of Medical Assistance Services continuum of care for members. VA Premier continually updates such lists, ensuring that information is current and that providers and members have access to necessary information.

Members do not need a referral or prior authorization to see an in-network specialist. Utilization management provides ongoing assessment of members' over- and under-utilization of services. If the care

coordinator or utilization management staff identifies a need for a specialist, that VA Premier care coordinator will discuss this with the member's PCP. If the member requires specialized care and authorization to an out-of-network provider, the referring provider will begin the preauthorization process. The member's care coordinator provides follow-up. In addition to ensuring that VA Premier holds contracts and makes referrals to specialists such as those providers who treat high-risk/maternal fetal medicine needs, neuropsychologists, and pediatric specialists, VA Premier offers a range of specialized case management programs for individuals with specialized care needs.

VA Premier uses health educators, medical outreach representatives, care coordinators, and disease management coordinators to assist members and their families to learn to self-direct care. VA Premier connects the member and the member's family to tools and resources that consider cultural and language preferences, functional and cognitive needs, and health literacy levels. VA Premier tools and resources include written materials, individual care coordinator or health educator coaching, and community-based classes on nutrition and disease management. Members are provided handouts titled, "Questions to Ask Your Doctor" to engage the member in the decision-making process.

VA Premier works to provide optimal customer service to all members. VA Premier identifies ways to promote the delivery of services in a culturally competent manner to all members—including those with limited English proficiency and diverse cultural and ethnic backgrounds.

VA Premier trains internal staff, care coordinators, and providers to understand the kinds of health care attitudes, values, customs, and beliefs that impact member access and outcomes. Training covers the following elements:

- Defining culture, stereotype, prejudice, and other terms.
- Understanding how values, beliefs, and attitudes influence the way people relate to those different from themselves.
- Identifying perceived barriers.

Member Operations' core premise ensures that members receive the highest quality customer service from staff, physicians, hospitals and other health care providers through effective practices and member-focused administrative services. In addition, Member Operations instituted a comprehensive training plan for staff, which includes telephone skills training focusing on cultural competency, conflict management, and soft skill phone etiquette. VA Premier call center agents are monitored frequently to ensure that they are handling calls appropriately. Agents are monitored and receive feedback from the manager based on the findings of each call. The call center monitors calls through various metrics including call abandonment, calls answered timely, and calls offered or answered according to language.

Summary of Strengths, Weaknesses, and Overall Conclusions

The following highlights the key information used to develop high-level EQR technical report recommendations for VA Premier.

Most HEDIS measure rates for VA Premier ranked at or above the national Medicaid 50th percentile. All five measure rates in the Access to Care domain, all four measure rates in the Children's Preventive Care domain, and three measure rates in the Women's Health domain exceeded the national Medicaid 50th percentile. Of note, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* increased by more than 5 percentage points in 2017. Seven of the 10 Care for Chronic Conditions measure rates exceeded the national Medicaid 50th percentile, with the measure rates for *Medication Management for People With Asthma—Medication Compliance 75%—Total* and *Controlling High Blood Pressure* increasing by more than 5 percentage points from HEDIS 2016 to HEDIS 2017. The rates for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140-90 mm Hg)*, though, fell below the national Medicaid 50th percentile.

Within the Behavioral Health domain, VA Premier's measure rates ranked at or above the national Medicaid 50th percentile for four of the six reportable rates. The remaining rates, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, experienced substantive declines in performance in 2017 and fell below the national Medicaid 50th percentile in 2017.

For the adult Medicaid CAHPS survey, VA Premier scored significantly higher than the national adult Medicaid averages on *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly*. VA Premier scored significantly higher on *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* for the child Medicaid CAHPS survey when compared to the 2017 national child Medicaid averages.

2017 Recommendations for VA Premier

All MCOs need to improve *Antidepressant Medication Management*, *Breast Cancer Screening*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total*. In other states, HSAG has observed improvement in performance when managed Medicaid plans managed Medicaid plans focus intervention efforts on the following:

- For improving *Antidepressant Medication Management* measure rates, the MCO should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
- For improving the *Breast Cancer Screening* measure rates, the MCO should seek to identify the root cause of lower breast cancer screening rates (e.g., rural communities, limited providers). If lower *Breast Cancer Screening* rates are due to network adequacy factors, the MCO should explore the feasibility of partnering with other entities that have expanded mammography services, such as mobile mammography units.
- For improving *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rates, the MCO should monitor members with ED or inpatient admissions for asthma-related conditions and conduct member outreach and education to better understand the individual members' barriers to achieving 75 percent compliance with asthma medications. Having a better

understanding of individual members' situations would assist the MCO in determining appropriate care management interventions.

VA Premier should also establish mechanisms to monitor members prescribed antidepressant medications. Early identification and collaboration with the behavioral health providers providing treatment also may be beneficial in improving the rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*.

Appendix A. CAHPS Survey Methodology

CAHPS Surveys

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in the FAMIS program, Aetna Better Health of Virginia (Aetna), Anthem Health Keepers Plus (Anthem), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier) with their MCO and health care experiences.

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the Medallion 3.0 MCOs, Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[A-1] The mode of CAHPS survey data collection varied slightly among the MCOs. Anthem, Kaiser Permanente, and VA Premier used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for their adult and child populations. Aetna, INTotal, and VA Premier used an enhanced Internet mixed-mode methodology for both their adult and child populations. Optima used an enhanced Internet mixed-mode methodology of data collection for its adult Medicaid members and an enhanced mixed-mode methodology for its child Medicaid members. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2017.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[A-2] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child

[A-1] INTotal and Kaiser Permanente administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.0 Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for INTotal and Kaiser Permanente represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[A-2] Aetna contracted with the Center for the Study of Services (CSS), Anthem and Kaiser Permanente both contracted with DSS Research, INTotal contracted with Morpace Inc., and Optima and VA Premier both contracted with SPH Analytics (formerly The Myers Group) to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[A-3] These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate).

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

For Medallion 3.0, the 2016 and 2017 CAHPS scores for each MCO and the statewide aggregate were compared to the 2016 and 2017 NCQA national Medicaid averages, respectively.[A-4] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

Additionally, a trend analysis was performed for each MCO that compared its 2017 CAHPS scores to its corresponding 2016 scores to determine whether there were statistically significant differences. Scores that were statistically significantly higher in 2017 than in 2016 are noted with green upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2016 are noted with red downward (▼) triangles. Scores in 2017 that were not statistically significantly different from scores in 2016 are not noted with triangles.

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

[A-3] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[A-4] Quality Compass 2016 and 2017 data serve as the source for the 2016 and 2017 NCQA CAHPS adult Medicaid and child Medicaid national averages, respectively.

FAMIS CAHPS

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. The CAHPS surveys were conducted per the Centers for Medicare & Medicaid Services' (CMS') CAHPS reporting requirements under the Children's Health Insurance Program Reauthorization Act (CHIPRA). In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care).

Based on NCQA protocol, child members included as eligible for the survey were 17 years of age or younger as of December 31, 2016. A mixed-mode methodology for data collection was utilized (i.e., mailed surveys followed by computer assisted telephone interviewing [CATI] of non-respondents to the mailed surveys). Parents or caretakers of child members completed the surveys between the time period of March to June 2017. The surveys were administered in English and Spanish. Members identified as Spanish speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the chronic conditions measurement set includes a standardized set of 83 items that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and children with chronic conditions members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data. An analysis of the CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-5]

For the FAMIS program, the survey questions were categorized into nine measures of satisfaction.[A-6] These measures included four global ratings and five composite measures. The global measures (also referred to as global ratings) reflected patients' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly").

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the five composite scores, the percentage of

[A-5] National Committee for Quality Assurance. *HEDIS® 2017, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

[A-6] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*, or the five CCC composite measures and items. Therefore, reported results are limited to the four global ratings and five composite measures.

respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

The FAMIS program's general child and CCC populations' survey findings were compared to 2016 and 2017 NCQA CAHPS child and CCC Medicaid national averages, respectively.[A-7] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of reporting the FAMIS CAHPS results, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2017 for the Medallion 3.0 MCOs, and from March to June 2017 for the FAMIS program.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 30, 45, 49, and 54. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition populations' CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program members enrolled in FFS and managed care). The FAMIS CAHPS survey results are summarized in the Executive Summary section of this report.

[A-7] The source for the 2016 and 2017 NCQA national child and CCC Medicaid averages for the general child population and children with chronic conditions population is Quality Compass® 2016 and 2017 data.

Appendix B. NCQA Quality Compass 50th Percentile Values

NCQA Quality Compass 50th Percentile Values

For reference, included in Table B-1, are NCQA Quality Compass national Medicaid HMO 50th percentile values for HEDIS 2014, 2015, and 2016 measures evaluated for the MCOs.

Table B-1—NCQA Quality Compass 50th Percentile Values

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2014	NCQA Quality Compass 50th Percentile for HEDIS 2015	NCQA Quality Compass 50th Percentile for HEDIS 2016
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	48.51%	49.15%	48.41%
Childhood Immunization Status			
Combination 3	72.33%	71.53%	71.06%
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	62.86%	59.76%	59.57%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.76%	72.02%	71.42%
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	57.37%^	58.34%	58.08%
Cervical Cancer Screening			
Cervical Cancer Screening	—	61.05%	55.94%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	84.30%	85.19%	82.25%
Postpartum Care	62.84%	62.77%	60.98%
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services			
Total	—	83.84%	82.15%
Children and Adolescents' Access to Primary Care Practitioners			
12–24 Months	—	—	95.74%
25 Months–6 Years	—	—	87.69%
7–11 Years	—	—	91.00%
12–19 Years	—	—	89.37%
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	83.88%	86.20%	85.95%*

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2014	NCQA Quality Compass 50th Percentile for HEDIS 2015	NCQA Quality Compass 50th Percentile for HEDIS 2016
HbA1c Control (<8.0%)	46.43%	47.91%	46.76%*
Eye Exam (Retinal) Performed	54.14%	54.74%	53.28%*
Medical Attention for Nephropathy	—	81.75%	90.51%*
Blood Pressure Control (<140/90 mm Hg)	61.31%	62.23%	59.73%*
Controlling High Blood Pressure			
Controlling High Blood Pressure	56.46%	57.53%	54.78%
Medication Management for People With Asthma			
Medication Compliance 75%—Total	—	29.60%	31.28%
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	—	76.74%	76.59%
Discussing Cessation Medications	—	46.70%	48.31%
Discussing Cessation Strategies	—	42.50%	43.82%
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	49.66%	50.51%	53.38%
Effective Continuation Phase Treatment	33.93%	34.02%	38.06%
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	40.79%	42.19%
Continuation and Maintenance Phase	—	50.61%	52.47%
Follow-Up After Hospitalization for Mental Illness			
30-Day Follow-Up	64.63%	66.64%	63.94%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	—		60.43%

[1] *NCQA Quality Compass 50th percentiles for HEDIS 2016 values are provided for informational purposes.*

[*] *HEDIS significantly modified the specifications for this measure beginning with HEDIS 2016. Caution should be exercised when comparing 2016 (or later) to NCQA Quality Compass 50th Percentiles to prior years.*

[^] *HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. Caution should be exercised when comparing 2014 (or later) to NCQA Quality Compass 50th Percentiles to prior years.*

— Although NCQA Quality Compass national Medicaid 50th percentiles may be available for these measures, these measures were not required for measure reporting prior to HEDIS 2016 or HEDIS 2017; therefore, national Medicaid 50th percentiles are not displayed.

Indicates that the measure was required for measure reporting in HEDIS 2016; however, NCQA Quality Compass national Medicaid 50th percentiles were not available.

Appendix C. Performance Measure Validation Methodology

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (MCOs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) described in the Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2) requires state Medicaid agencies to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012, the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an external quality review organization (EQRO).

The Commonwealth of Virginia refers to its Children's Health Insurance Program (CHIP) as Family Access to Medical Insurance Security (FAMIS). The Department of Medical Assistance Services (DMAS) contracted with six privately owned MCOs to deliver services to members who were enrolled in the State's Medicaid and CHIP programs. Health Services Advisory Group, Inc. (HSAG), the EQRO for DMAS, conducted the PMV for each MCO.

HSAG validated a set of performance measures identified by DMAS that were reported by the MCOs for their Medicaid and FAMIS populations. HSAG conducted the validation in accordance with CMS' PMV protocol cited above. HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures.

Description of Validation Activities

Pre-Audit Strategy

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

HSAG then prepared a document request letter that was submitted to MCOs outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure; a completed HEDIS 2017 Record of Administration, Data Management, and Processes (Roadmap); a completed Information Systems Capabilities Assessment Tool (ISCAT); any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions

for submission. HSAG also forwarded a letter that included requested documentation needed to complete the medical record review validation (MRRV) process. HSAG responded to any audit-related questions received directly from the MCOs during the pre-on-site phase.

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

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed this data:

- **NCQA's HEDIS 2017 Roadmap:** The MCOs completed and submitted the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** The MCOs completed and submitted an ISCAT for HSAG's review of the required DMAS-developed measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs completed the medical record review (MRR) section within the Roadmap. In addition, the MCOs submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample, but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the MCOs. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and then used the MRRV results to determine if the findings impacted the audit results for each performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

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

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCO staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap documentation:** This session was designed to be interactive with key MCO staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, foster care risk assessment, and claims systems and processes:** The evaluation included a review of the information systems, focusing on the processing of claims, processing of enrollment and disenrollment data, and tracking of foster care eligibility and assessments. This review included confirming that systems and processes were in place to identify completed foster care assessments.
  HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the performance measure.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary Source Verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each MCO provided a listing of the data that it had reported to DMAS to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS measures, completed health risk assessment data for the *Assessments of Foster Care Children* measure, and a subset of requested claims data for the claim processing timeliness measure.
  HSAG selected a random sample from the submitted data and requested that the MCO provide proof of service documents or system screenshots that allowed for validation against the source data in the system. These data were also reviewed live in the MCO's systems during the on-site review for verification, which provided the MCO an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting.

There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the MCO.

Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCOs have system documentation which supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

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

Post-On-Site Activities

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

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

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

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

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

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure as "NR."

Appendix D. Performance Improvement Project Methodology

HSAG's Rapid-Cycle PIP Approach

HSAG's approach will guide the MCOs through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, plans will have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale. HSAG has developed a series of five modules that the plans will complete as they move through the PIP. HSAG will provide technical assistance throughout the process, with frequent contact and feedback to ensure that PIPs are well-designed at the onset and provide opportunities for mid-course corrections.

Module 1—PIP Initiation

In this stage, the MCO will outline its project's framework. The framework should include the topic rationale, plan-specific data supporting the need to improve the selected topic, the plan's staff members who make up the project team, and the key driver diagram that defines the system and measures for improvement. The objective of this module is to ask and answer the first fundamental question of the Model for Improvement: "What are we trying to improve?"

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

In this stage, the MCO will define how and when to make known that improvement is happening. Its PIP team will develop the SMART Aim measure and the real-time data collection methodology. The objective for this module is to ask and answer the second fundamental question of the Model for Improvement: "How will we know that a change is an improvement?"

Module 3—Intervention Determination

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

Module 4—PDSA

In this stage, the MCO's selected interventions that can impact the SMART Aim are tested using a series of PDSA cycles. The plan will complete a separate Module 4 for each intervention it tests. Each test of change should start small and ramp up to a larger scale if it is determined to be successful.

Module 5—PIP Conclusions

In this final stage, the MCO will summarize key findings, comparisons of successful and unsuccessful interventions, and outcomes achieved. This stage also includes assessing the sustainability of the improvement achieved. The MCO will submit its final key driver diagram, final SMART Aim run chart, final process map, and final FMEA. Essentially, Module 5 serves as a change package for the PIP. It allows others who may want to adapt this PIP in other settings to be aware of the specific circumstances of the project's environment.

HSAG's PIP approach requires up-front preparation to allow for a more structured scientific approach to quality improvement. It is imperative that each managed care plan track the project throughout the PIP. The process is structured into four phases, and in most cases a PIP will last up to 18 months. In the first (initiation) phase, HSAG will work with each MCO and DMAS to determine the timeline for the four phases. The MCO must complete and pass Modules 1 and 2 before moving on to Module 3. HSAG will provide significant technical assistance and feedback in the first phase to ensure that the basic infrastructure (Modules 1 through 2) is sound before the MCO progresses to completing and submitting Module 3 (second phase). HSAG will review and evaluate Module 3 and will provide feedback to the MCO before it is approved to starting testing interventions. In the third phase, the MCO will test the interventions on a small scale using a series of PDSA cycles. This will be the longest phase because the MCO may test a number of interventions. Completion of Module 5 (fourth phase) will occur once all interventions have been tested and the analysis of the PDSA cycles is complete. This approach is a very iterative process among HSAG, the MCO, and DMAS during all phases.

HSAG will validate PIPs annually to the point of PIP progression using validation criteria that were developed to align with CMS validation protocols and rapid-cycle principles. The validation process will also determine if DMAS and other key stakeholders can have confidence in the reported PIP results. HSAG will provide DMAS and the MCOs with a PIP Validation Tool. The tool will include the criteria for each evaluation element and for each module, and whether the MCO achieved the criteria. For any evaluation element that did not achieve the required criteria, HSAG will provide detailed written feedback and recommendations. Following are the level of confidence definitions:

☐ High confidence

High confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.

☐ Confidence

Confidence = the PIP was methodologically sound; achieved the SMART Aim goal; and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.

☐ Low confidence

Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

☐ Reported PIP results were not credible = The PIP methodology was not executed as approved.

Appendix E. Comprehensive Operational Systems Review Methodology

HSAG followed the guidelines set forth in CMS' EQR Protocol 1: *Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012 for planning the comprehensive on-site operational systems review activities. HSAG conducted planning review activities, evaluation, and aggregation and analysis of findings.

Planning Review Activities

HSAG performed a series of planning activities in preparation for the evaluation phase of the review, including the development of comprehensive review documents. As a mechanism to assess MCOs' compliance with the standards under the scope of the review, HSAG developed, in collaboration with DMAS, a compliance review tool, as well as specific file review tools in the areas of clinical denials, appeals, and grievances.

In addition, HSAG developed an information packet to be provided to the MCOs. The information packet contained a timeline; on-site audit agenda; documentation submission requirements; compliance review tool; and clinical denial, appeal, and grievance file review tools. HSAG distributed a customized information packet to each MCO on December 16, 2016, prior to the scheduled 2017 on-site review.

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other MCO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCOs' key staff members.

The table below lists the major data sources HSAG used in determining the MCOs' performance in complying with requirements and the time period to which the data applied.

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2015–June 30, 2016
Information obtained through interviews	July 1, 2015–June 30, 2016
Information obtained from a review of a sample of the MCOs' records for file reviews	July 1, 2015–June 30, 2016

Communication With the MCOs

HSAG established early communication with the MCOs through written notice of the upcoming reviews, providing the opportunity for MCOs to identify date preferences for the on-site review. HSAG established on-site dates with DMAS, taking into consideration the MCOs' date preferences. Communication with the MCOs continued via a group informational telephone conference on October 25, 2016. In addition, pre-on-site audit calls with each MCO took place approximately two to three weeks prior to the on-site review.

Document Submission

HSAG requested that the MCOs populate the compliance review tool with supporting documentation and upload the source documents to HSAG's secure SharePoint site prior to the on-site review, by January 31, 2017. HSAG provided each MCO with a list of cases selected for each file review one week prior to the on-site review. The MCOs had all of these case files available for the on-site audit.

Evaluation Phase

The evaluation phase consisted of a desk review of documentation gathered from the various data sources prior to the on-site visit, an on-site review of additional documentation and staff interviews, and the assignment of element scores.

On-Site Review Organization

The on-site review occurred over two consecutive days. On the first day of the review, the HSAG review team conducted an opening conference, with introductions and a review of the agenda and logistics. The team of reviewers confirmed that documents requested by HSAG were available.

Day two of the on-site review allowed for discussion and follow-up on any outstanding issues. The team of reviewers continued their reviews and interviews of key staff members for completion of each standard. Data collected from these activities were documented in the review tool.

On the final day of the review, the review team completed any outstanding review tasks, developed a summary of the team's preliminary findings, and provided the MCO with information concerning the next steps of the process. This information was shared with the MCO and DMAS during the exit conference conducted at the end of the second day of the review.

Scoring Methodology

HSAG used a three-point scoring methodology, and elements were scored based on *Met*, *Partially Met*, and *Not Met* criteria. These scores indicate the degree to which the MCOs' performance complied with the requirements. A designation of *N/A* was used when a requirement was not applicable to an MCO during the review period.

Met indicates full compliance defined as *both* of the following:

- All documentation and data sources reviewed for a regulatory provision, or component thereof, are present and provide supportive evidence of congruence.
- Staff members provide responses to reviewers that are consistent with each other, with the data and documentation reviewed, and with the regulatory provision.

Partially Met indicates partial compliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance defined as *either* of the following:

- Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.
- Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

For those provisions with multiple components, key components of the provision that could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision and any findings of *Not Met* resulted in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

When assessing each element for compliance, HSAG used the results from the clinical denial, appeal, and grievance file review tools; policies and procedures; systems demonstrations; staff member interviews; and other MCO-provided documentation. HSAG assessed for congruence among all data

sources as well as patterns of compliance or noncompliance when all data sources are taken into consideration.

Data Aggregation and Analysis of Findings

Scores of *Met*, *Partially Met*, and *Not Met* will indicate the degree to which the MCOs' performance complied with the requirements. This scoring methodology is consistent with CMS' final protocol, set forth in its *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

From the scores it assigns for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the 12 standards and an overall percentage-of-compliance score across the 12 standards. HSAG calculated the total score for each of the standards by adding the score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.5 points), and *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the values of the scores and dividing the result by the total number of applicable requirements).

Deliverables

Based on the results of data aggregation and analysis, HSAG produced draft MCO-specific reports for each comprehensive review and forwarded them to DMAS and the MCOs prior to issuing final reports.

Next Steps

Final MCO-specific reports include scores of *Met*, *Partially Met*, and *Not Met*, which indicate the degree to which the MCOs' performance complied with requirements. MCOs are required to develop and implement a corrective action plan (CAP) for any performance score of *Partially Met* or *Not Met* to bring the MCOs' performance into full compliance with the requirement.

All CAPs are due to DMAS no later than 30 calendar days following the receipt of the *2015–2016 External Quality Review of Compliance with Standards* report. DMAS will review and approve the CAPs to ensure they sufficiently address the interventions needed to bring performance into compliance with standards. Once approved, CAP activities and interventions will begin. Follow-up monitoring will occur to ensure that all planned activities and interventions were completed.

VIRGINIA MEDICAID MANAGED CARE QUALITY

CONSUMER DECISION SUPPORT TOOL 2017-2018

Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid MCO. This tool shows how well the different MCOs provide care and services in various performance areas. The ratings for each area summarize how the MCO performs on a number of related standards.

Key

Above Virginia Medicaid MCO Average ★★★

Virginia Medicaid MCO Average ★★

Below Virginia Medicaid MCO Average ★

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna*	Accredited	★★	★★	★★	★★	★
Anthem	Commendable	★★	★★	★★	★	★★★
INTotal	Accredited	★★	★	★	★	★
Kaiser Permanente	Excellent	—	★★	★★	★★	★★★
Optima	Commendable	★★	★★	★	★★	★
VA Premier	Accredited	★★	★★★	★★	★★	★★

*formerly CoventryCares
— indicates the MCO did not have enough data to receive a rating.

What is Measured in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members
- Doctors involve members in decisions about their care

Getting Care
- Members get the care they need, when they need it

Keeping Kids Healthy
- Children get regular checkups and important shots that help protect them against serious illness

Living With Illness
- Members with asthma, diabetes, high blood pressure, and depression get the care they need by getting tests, checkups, and the right medicine

Taking Care of Women
- Women get tests for breast and cervical cancer to help find these diseases early
- Moms get care before and after their baby is born to help keep mom and baby healthy

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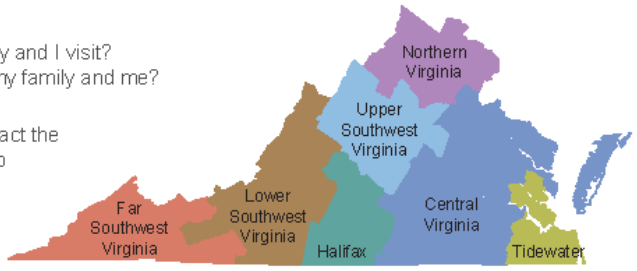
Choosing a Medicaid Managed Care Organization

Your health care is important, and choosing the MCO that best meets your needs is also important. Here are some questions to ask yourself before you pick an MCO:

- How well did each MCO perform in each performance area in this tool?
- Which MCO has all or most of the doctors, providers, and hospitals that my family and I visit?
- Which MCO has doctors with office hours and locations that are convenient for my family and me?
- Which MCO offers extra services that I want to use?

You may have other questions or concerns that are important to you. You can contact the MCOs using the information below. They can tell you which doctors are available to you and what extra services they offer. You can also call the **Medicaid Managed Care HelpLine** at 1-800-643-2273. HelpLine staff can answer your questions and help you decide which MCO is best for you and your family.



MCO	Contact Information	Available in the Following Regions
Aetna Better Health of Virginia (Aetna)*	1-800-279-1878 www.aetnabetterhealth.com/virginia	Central Virginia, Far Southwest Virginia, Halifax, Lower Southwest Virginia
Anthem HealthKeepers Plus (Anthem)	1-800-901-0020 www.anthem.com/vamedicaid	Available in all regions.
INTotal Health (INTotal)	1-855-323-5588 www.intotalhealth.org	Far Southwest Virginia, Lower Southwest Virginia, Northern Virginia, Upper Southwest Virginia
Kaiser Permanente	1-855-249-5025 thrive.kaiserpermanente.org/medicaid/virginia	Northern Virginia
Optima Family Care (Optima)	1-800-881-2166 www.optimahealth.com/plans/family-care	Available in all regions.
Virginia Premier Health Plan (VA Premier)	1-800-727-7536 www.virginiapremier.com	Available in all regions.

*formerly Coventry Cares

Information as of December 2017

For More Information:

Visit the Virginia Department of Medical Assistance Services online at: www.dmas.virginia.gov and Virginia's Medicaid Managed Care online at: www.virginiamanagedcare.com.

About This Tool

The 2017 Virginia MCO Consumer Decision Support Tool utilizes results from HEDIS and CAHPS. Calendar year 2016 data were used to derive 2017 reporting year rates. This report was compiled by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Department of Medical Assistance Services (DMAS).

About the Accreditation Levels

Accreditation levels as of December 2017 are based on compliance with the National Committee for Quality Assurance's (NCQA's) rigorous requirements and the MCOs performance on Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures. The highest level of accreditation an MCO can receive is Excellent, followed by Commendable, and then Accredited. For more information regarding accreditation levels as of December 2017, visit: http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels.