Commonwealth of Virginia
Department of Medical Assistance Services

Annual Technical Report

January 2015

Delmarva Foundation

Submitted by
Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, Maryland 21601-7098

Table of Contents

2014 Annual Technical Report

Executive Summary

Introduction

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

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

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

Additional data results incorporated into this annual evaluation include:

- Findings from MCO-reported Healthcare Effectiveness Data and Information Set (HEDIS®) measures,
- Findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of MCO members,
- Findings from the focused clinical study, Improving Birth Outcomes through Adequate Prenatal Care, targeted to pregnant members,
- Findings from an evaluation of Asthma Emergency Room Utilization for Virginia FAMIS and Medicaid Members with Asthma, and

These activities were conducted by Delmarva for DMAS as optional EQR activities. The BBA requires an annual technical report (ATR) that assesses the quality of care delivered to eligible enrollees through the MCOs. This report, as specified in 42 CFR §438.358, consists of an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that an MCO or their contractors, furnish to members enrolled in managed care. This report covers EQR activities conducted during calendar year 2014.

Summary of Findings

Operational Systems Review (OSR)

The CMS EQR guidelines require a comprehensive OSR at least once every three years. OSRs were performed for the following DMAS-contracted MCOs in 2014:

- MajestaCare – March 26, 2014*
- Anthem HealthKeepers – March 31, 2014 – April 1, 2014
- CoventryCares of Virginia – April 3, 2014 – April 4, 2014
- Optima Family Cares – April 7, 2014 – April 8, 2014
- Virginia Premier Health Plan – April 10, 2014 – April 11, 2014
- INTotal Health – April 14, 2014 – April 15, 2014
- Kaiser Permanente Virginia – April 21, 2014 – April 22, 2014

** No longer an MCO in Virginia effective December 1, 2014*

Delmarva evaluated MCOs compliance with operational standards related to health care services provided to Virginia Medicaid enrollees. This assessment evaluated the MCO's compliance with the DMAS Medallion 3.0 managed care contract and with the federal requirements of a Medicaid MCO for:

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

DMAS requires their contracted MCOs to obtain and maintain health plan accreditation from the National Committee for Quality Assurance (NCQA). NCQA publishes an annual crosswalk of the NCQA Health Plan Accreditation Standards and Guidelines with the federal Medicaid managed care standards from the BBA. The crosswalk suggests that approximately forty percent of the federal requirements are equivalent to NCQA's accreditation standards. Further, the BBA allows states to deem their NCQA-accredited MCOs to be compliant with the duplicative federal requirements.

The OSRs performed for VA Medicaid MCOs in 2014 included the deeming of certain federal requirements based on the NCQA crosswalk. Delmarva reviewed the crosswalk of standards that were eligible for deeming and presented recommendations for deeming to DMAS. DMAS reviewed Delmarva's recommendations and compared the standards and the MCO contractual requirements before deciding which standards to deem for the 2014 comprehensive OSRs. DMAS determined that deeming could occur for certain ER and QAPI standards; no GS standards were deemed.

In preparation for the reviews, Delmarva made an Orientation presentation to staff from the MCOs at a quarterly DMAS MCO Collaborative meeting. Delmarva provided a written Orientation Manual that included an overview of the standards and the review process. MCOs were required to submit presite documentation for review by Delmarva. Upon receipt of presite documentation, desk reviews were performed for each MCO by a Delmarva team to determine compliance with ER, GS, and QAPI standards that comprise the comprehensive OSR. The desk reviews were followed by onsite reviews at each MCO's office conducted by the Delmarva team. The scope of the onsite review was determined by the Delmarva team's findings from the desk review; any standards that were not scored "fully met", meaning they scored "partially met" or "unmet" were reviewed again during the onsite review. Prior to the onsite review, MCOs were informed of the standards requiring further evaluation onsite and were encouraged to clarify the documentation submitted for the desk review or prepare additional documentation for those standards for review by the Delmarva team onsite. At the conclusion of the onsite visit and following discussion with the MCOs staff and DMAS, an Exit Letter was sent to the MCOs outlining those standards that scored partially met or unmet. Delmarva also produced the review results in a draft OSR Report that was approved by DMAS and disseminated to the MCOs. Upon receipt of the Exit Letter and draft OSR Report, MCOs were provided the opportunity to present additional documentation for any partially met or unmet standards. Delmarva reviewed any additional documentation submitted by MCOs which was incorporated in the findings in a Final OSR Report. All Delmarva Final OSR Reports were reviewed and approved by DMAS before dissemination to the MCOs. In instances where MCOs had standards that did not achieve a score of fully met, MCOs were directed to develop and submit a Corrective Action Plan (CAP). Delmarva reviewed all MCO CAPs, and if they were deemed complete, recommended their approval to DMAS. If CAPs were deemed incomplete MCOs were directed to revise and resubmit them for review and approval.

All MCOs performed favorably on the 2014 OSRs as there were no scores of unmet for any MCOs on the standards reviewed. MajestaCare achieved a score of fully met on all standards.

Anthem HealthKeepers, CoventryCares of Virginia, and Kaiser Permanente Virginia scored fully met on all but one standard. Optima Family Care and INTotal Health scored fully met on all but two standards, and Virginia Premier Health Plan scored fully met on all but three standards. Where applicable, the MCOs developed and submitted CAPs that were approved by DMAS.

Performance Measurement Validation (PMV)

The goal of conducting performance measure validation (PMV) is to evaluate the accuracy of the specific Healthcare Effectiveness Data and Information Set (HEDIS®) measures required by DMAS for MCO reporting. Delmarva evaluated the MCO's compliance with HEDIS® specifications and the accuracy of their reported performance measures for six (Anthem/HealthKeepers, CoventryCares of Virginia, INTotal Health, MajestaCare, Optima Family Care, and Virginia Premier Health Plan) of the seven Virginia MCOs. Kaiser Permanente Virginia was not included in PMV activities since it did not begin Medicaid operations in Virginia until November 2013. None of the six MCOs under review encountered any major system issues that affected their ability to accurately calculate and report these measures.

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

- The MCOs maintain well-developed and established systems and processes for HEDIS® reporting.
- For HEDIS®2014 (CY2013), all six MCOs under review used certified HEDIS® software.

All six MCOs that participated in the PMV process reported results for HEDIS® 2014 to NCQA and DMAS. The Virginia Medicaid MCO average met or exceeded the corresponding HEDIS®2012, 2013 and 2014 National Medicaid Managed Care 50th Percentile for the following measures:

- Antidepressant Medication Management - Effective Continuation Phase Treatment
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening and LDL-C Control <100 mg/dL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

As compared to the benchmark of HEDIS® 2014 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for services provided in 2013 met or exceeded the benchmark for the following measures:

- Antidepressant Medication Management (Effective Continuation Phase Treatment)
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL–C Screening and LDL-C Control <100 mg/DL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Prenatal and Postpartum Care - Timeliness of Prenatal Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Of the ten rating and composite measures from the Adult category of the CAHPS® survey selected for this report, the Virginia MCO average for five measures compared favorably to the CAHPS® National Medicaid 50th Percentile from 2011 through 2013. In 2013, the Virginia MCO average for eight out of the ten selected measures met or exceeded the CAHPS® National Medicaid 50th Percentile. The results for the Children General Population category of the CAHPS® survey compared favorably to the CAHPS® National Medicaid 50th Percentile for five out of nine measures for calendar year 2013.

An additional CAHPS® survey was administered in 2014 to parents of child members enrolled in the Family Access to Medical Insurance Security (FAMIS) program. In four rating and composite measures for FAMIS children in the General Population (those served in the Fee-For-Service and MCO delivery systems) the Virginia average exceeded the CAHPS® National Medicaid 50th Percentile. For FAMIS children with Chronic Conditions (those who experience a consequence associated with a condition) six ratings and composite measures exceeded the CAHPS® National Medicaid 50th Percentile. In addition, FAMIS received positive satisfaction ratings from more than eight in ten parents/guardians from both populations for two rating and one composite measure.

Performance Improvement Projects (PIPs)

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

The validation process expects the MCOs PIPs to demonstrate a favorable effect on the health outcomes of their enrollees. The CMS guidelines require PIPs designed, conducted, and reported in a methodologically sound manner. At the direction of DMAS, MCOs were required to continue in 2014 the two PIPs that were initially developed in 2012 and continued in 2013: Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness.

The 2014 validation reviewed the results of the second remeasurement year (CY 2013) against the first remeasurement year (CY 2012) and the baseline measurement year (CY 2011). Most of the MCOs identified the achievement of NCQA Quality Compass 75th or 90th Percentiles as their long-term goals for both projects. The methodology was appropriate for all projects.

The MCOs completed barrier analyses which identified member, provider, and MCO barriers impacting PIP improvements. Targeted interventions were implemented that addressed barriers and a determination was made whether the MCO's actions resulted in increased rates for Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. The PIP results were mixed as the majority of MCOs did not document significant improvement and some documented decreases for the measures. In particular, the results of the Follow-Up After Hospitalization for Mental Illness measure was impacted by a change in the HEDIS® specifications made by NCQA requiring primary source verification for follow-up visits. This change meant MCOs had to discontinue the use of supplemental data sources such as member self-report in their follow-up visit calculations. Consequently, rates for this measure declined for some MCOs. However, some noteworthy PIP findings were documented; CoventryCares of Virginia and Virginia Premier Health Plan demonstrated sustained improvement in their Adolescent Well-Care Visits rate from the baseline measurement to Remeasurement 2, and INTotal Health demonstrated sustained improvement in its rate of Follow-up After Hospitalization for Mental Illness within 30 days from the baseline measurement to Remeasurement 2 despite the change to the HEDIS® specifications.

Quality Highlights

- Six Virginia MCOs are NCQA-accredited; five with Commendable Status and one with Accredited status. Five Virginia MCOs also made the list of the top 100 health plans for NCQA's 2014-2015 Health Insurance Plan Rankings for Medicaid health plans.
- DMAS successfully coordinates participation in the MCO collaborative as a forum for the sharing of "best practices." At the collaborative MCOs present quality initiatives targeted to meet identified needs of their enrollee populations. Through these initiatives the MCOs have successfully implemented interventions to improve service in critical areas for their enrollees.
- The Virginia Medicaid MCO average met or exceeded the associated HEDIS® 2012, 2013 and 2014 National Medicaid Managed Care 50th Percentile for eight measures.
- The Virginia MCO average for HEDIS®2014 exceeded the HEDIS®2014 National Medicaid Managed Care 50th Percentile for eight performance measures.
- In the Improving Birth Outcomes through Adequate Prenatal Care study, the majority (91.3 percent) of pregnant women in the study population (women were continuously enrolled 43 days prior to delivery) were in the Medicaid for Pregnant Women program while 8.7 percent were in the FAMIS MOMS program in 2013.
- The percentage of pregnant women in the study population enrolled in an MCO increased to 76.2 percent in 2013; an increase from 74.0 percent in 2012.
- Enrollment in the FFS delivery systems in the study population decreased slightly from 24.1 percent in 2012 to 23.8 percent in 2013.
- In the Improving Birth Outcomes through Adequate Prenatal Care study, the majority of pregnant women in the comparison group (women who were not continuously enrolled 43 days prior to delivery, but were enrolled on the day of delivery) in 2013 were in the MCO delivery system (56.1 percent) while 43.9 percent were in FFS.
- Women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs received adequate prenatal care at rates that compare favorably to the HEDIS® National Medicaid Managed Care Averages from 2011 to 2013.
- The combined low birth weight (LBW) rates for women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs in 2013 are generally favorable when compared to the Centers for Disease Control and Prevention (CDC's) national benchmarks for 2012 (final) and 2013 (preliminary).
- LBW rates for FAMIS MOMS in the study population outperformed the CDCs' national benchmarks in 2011, 2012, and 2013.
- The rate of infants born prematurely (before 37 completed weeks of pregnancy) to women in the study population in the FAMIS MOMS and Medicaid for Pregnant Women programs compared favorably to the CDC's national benchmark for all three years.

- Statewide 7.1% of FAMIS and Medicaid members with asthma aged 2 to 20 years had at least one visit to an emergency room for uncontrolled asthma in 2013. The percentage for Black/African American members was 10.0%; more than twice that for Asian, Hispanic/Latino, and White members.

Conclusion

The Medicaid MCOs effectively and collaboratively address quality, timeliness, and access to care in their managed care populations. The efforts made to improve quality by DMAS and the MCOs are highly commendable and show continual and consistent improvement. This 2014 ATR report outlines the specific recommendations for both DMAS and the MCOs.

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

The MCOs should conduct a root cause analysis to determine disparities and identify barriers in their prenatal population and asthma ER use outcomes. For example, African American women recorded the highest (worst) rates of all categories of low birth weights. These outcomes persist even though this subgroup received adequate prenatal care at rates that exceed all racial groups except White women. African Americans also had the highest percentage of FAMIS and Medicaid members aged 2 to 20 years with asthma with at least one visit to an emergency room for uncontrolled asthma.

DMAS should continue to monitor, trend, and compare standardized Birth Registry data to have an accurate trend of prenatal care and birth outcomes as compared with national benchmarks for these populations. DMAS should develop strategies and foster interventions specifically targeting regions, cities, and counties where the percentage of FAMIS and Medicaid members with asthma, aged 2 to 20 years with at least one visit to an emergency room for uncontrolled asthma, exceeds the statewide average. Strategies and interventions to reduce racial disparities among members with asthma should also be designed.

2014 Annual Technical Report

Introduction

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

Following federal requirements for an annual assessment, as set forth in the Balanced Budget Act (BBA) of 1997 and federal external quality review (EQR) regulations, Delmarva conducted a comprehensive review of managed care organizations (MCOs) to assess each plan's performance relative to the quality of care, timeliness of services, and accessibility of services.

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

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

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." *(2014 Standards and Guidelines for the Accreditation of Managed Care Organizations*).

- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2014 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001).*

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

- Anthem HealthKeepers, Inc. (Anthem)
- CoventryCares of Virginia (CCVA)
- INTotal Health (INTotal)
- Kaiser Permanente/Virginia (KPVA)
- MajestaCare*
- Optima Family Care (OFC)
- Virginia Premier Health Plan, Inc. (VPHP)

** No longer an MCO in Virginia effective December 1, 2014*

EQRO Activities

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

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

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

- The validation results of the two measures selected by DMAS using the 2014 Healthcare Effectiveness Data and Information Set (HEDIS®). Each MCO also reports 13 additional measures that aggregate their HEDIS® results and include both CHIP and Medicaid enrollees.
- The 2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey results of enrollee satisfaction for Children and for Adult Medicaid - HMO.
- The 2014 MCO performance improvement projects (PIPs) validations for two DMAS selected projects.

In addition, Delmarva evaluated other quality-related aspects of the state's managed care delivery system in order to provide a comprehensive assessment of the overall quality improvement strategy. Additional data included the State Managed Care Quality Strategy, the Birth Outcomes through Adequate Prenatal Care focused clinical study, the evaluation of Asthma Emergency Room Utilization for Virginia FAMIS and Medicaid Members with Asthma, and the MCO's best and emerging practices for improving quality of care and service.

DMAS Quality Strategy

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

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

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

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

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

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

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

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

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

The 2014 study reported the majority (91.3 percent) of pregnant women in the study population were in the Medicaid for Pregnant Women program while 8.7 percent were in the FAMIS MOMS program. The majority of pregnant women (76.2 percent) were enrolled in an MCO while 23.8 percent were in the FFS delivery system.

Data analysis showed that the adequate prenatal care rate for women in the study population in the FAMIS MOMS and Medicaid for Pregnant Women programs increased from 78.7% in 2011 to 79.1% in 2012 to 79.7% in 2013. These rates compared favorably to the HEDIS® National Medicaid Managed Care Averages from 2011 to 2013.

The combined low birth weight (LBW) rates for women in the study population enrolled in the FAMIS MOMS and Medicaid for Pregnant Women programs decreased to 8.1% in 2013 from 8.7% in 2012. The 2013 rate is generally favorable when compared to the Centers for Disease Control and Prevention (CDC's) national benchmarks for 2012 (final) and 2013 (preliminary).

The rate of infants born prematurely (before 37 completed weeks of pregnancy) to women in the study population who are in the FAMIS MOMS and Medicaid for Pregnant Women programs generally remained stable: 8.7% in 2011, 8.9% in 2012, and 8.8% in 2013. These rates compared favorably to the CDC rate for 2011, 2012, and 2013 which was over 11% each year.

The results from other quality evaluations are also important components in DMAS' overall evaluation of managed care and are optional components of EQR. One quality evaluation conducted by Delmarva was the measure of Asthma Emergency Room Utilization for Virginia FAMIS and Medicaid Members with Asthma. The measure analyzed FAMIS and Medicaid members with asthma aged 2 to 20 years who had at least one visit to an ER for uncontrolled asthma in calendar year (CY) 2013. The population for the measure was comprised of 61,087 FAMIS and Medicaid members with asthma between the ages of 2 and 20 years. The measure revealed that 4,363 FAMIS and Medicaid members with asthma (7.1%) between the ages of 2 and 20 years had at least one visit to an emergency room for uncontrolled asthma in 2013.

The results were analyzed statewide by region, county, city, race and ethnicity. Regional analysis revealed that the Tidewater region had the highest percentage of FAMIS and Medicaid members aged 2 to 20 years with asthma with at least one visit to an emergency room for uncontrolled asthma in CY 2013 (10.9%) followed by Central Virginia (7.6%), Halifax (6.0%), and Far Southwest Virginia (5.9%). The counties with the highest percentage of FAMIS and Medicaid members aged 2 to 20 years with asthma with at least one visit to an emergency room for uncontrolled asthma in CY 2013 are Richmond (20.5%), Essex (18.5%), Middlesex (16.7%), and Northumberland (15.4%). Cities with the highest percentages include Franklin (17.9%), Williamsburg (13%), Norfolk (12.5%), Hampton (12%), Newport News (11.9%), and Suffolk (11.9%).

The percentage of FAMIS and Medicaid members aged 2 to 20 years with asthma with at least one visit to an emergency room for uncontrolled asthma in CY 2013 was lowest among Asian (4.0%), Hispanic/Latino (4.5%), and White (4.6%) members. The percentage for Black/African American members (10.0%) was more than twice that for Asian, Hispanic/Latino, and White members.

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

Quality Initiatives

MCO Collaborative

The contracted MCOs are required to participate in the DMAS quality collaborative. The quarterly meetings of DMAS with the MCOs function as a forum to share successful program knowledge on how to improve specific quality measures. This collaborative forum assists with the DMAS mission to enable enrollees to achieve and maintain optimal health. One example of the output from this initiative was the sharing of MCO "best practices" regarding performance improvement projects, quality improvement initiatives, and targeted interventions.
DMAS has continued to see their contracted MCOs improve in NCQA's national ranking for health plans with five accredited MCOs making the list of the top 100 for NCQA's 2014-2015 Health Insurance Plan Rankings for Medicaid health plans.

Best and Emerging Practices for Improving Quality of Care and Service

Each year one of the quarterly MCO Collaborative meetings serves as the annual session for presentation of best practices. DMAS and each MCO selected topics that represented quality initiatives and the following is a brief overview of each MCO presentation occurring in June 2014:

Anthem HealthKeepers, Inc. organized a work group that developed and implemented interventions targeting two CAHPS® composites, *How Well Doctors Communicate* and *Rating of a Personal Doctor* with a goal of achieving the 75th percentile or greater. The interventions focused on providing education to physicians and members on effective communication and improving customer service operations at the MCO to improve members interactions with the MCO.

CoventryCares of Virginia implemented a wrap-around approach to address prenatal and postpartum care. This included the implementation of a Perinatal program that provides high-

risk case management, member education on self-management through newsletters and prenatal and postpartum written packets, provider education on evidenced-based guidelines through newsletters and other written communications, prenatal phone calls and home visits, and transportation services. As a result of its actions, CoventryCares of Virginia reports that the MCO's rates on the Prenatal and Postpartum Care HEDIS® measure is currently in the 50th percentile and has steadily increased since HEDIS® 2011.

INTotal Health implemented an Integrated Service Delivery Model to advance coordination of care between medical and behavioral healthcare providers. INTotal Health indicated that coordinating care between medical and behavioral healthcare providers resulted in members having better access to care and services and savings on MCO healthcare costs. INTotal Health is further evaluating the success of the Integrated Service Delivery Model by measuring for member improvement in the level of ER utilization, inpatient medical and psychiatric care, medication adherence, and outpatient follow-up care.

Kaiser Permanente Virginia achieved very high rates on the HEDIS® breast cancer screening measure for its commercial population through its implementation of a Chronic Care Program. Components of the program include the use of clinical practice guidelines, coordinated care, physician and staff communication, performance reporting and analysis, and member education. The program enables the MCO to provide targeted outreach to members and tailor educational information based on member's age, gender, and health conditions, and also allows members to track online when they are due for lab work, screenings, and vaccines.

NOTE: Kaiser Permanente Virginia's success with breast cancer screening to date has been with its commercial population. The Chronic Care Program is currently being implemented with Medicaid members corresponding with the MCOs entry in the Virginia Medicaid program in November 2013.

MajestaCare's coordinated approach to adopt, and sustain a culture of quality improvement as a New Health Plan included celebrating MCO successes such as meeting internal HEDIS® and CAHPS® goals and achieving NCQA Accreditation. The MCO engaged and encouraged staff and provider network participation in quality activities such as workgroups and committees to develop and implement solutions to problems impacting members such as closing gaps in care. MajestaCare also implemented Pay for Performance and Pay for Quality incentives for providers to promote improved performance in care and service to members.

Optima Family Care implemented a Diabetes Management initiative to raise the MCOs rates by 2% for each of the following diabetes HEDIS® measures: HbA1c testing, LDL-C screening,

Dilated Eye Exams, and Diabetic Blood Pressure screening. Interventions included: staff education, improved member educational materials, quarterly telephone calls to members with diabetes, follow-up with hospitalized diabetics upon discharge, targeted case management, and letters to providers when their assigned members have not completed any required diabetic screenings. Optima Family Care also implemented an electronic medical record system to capture member data regarding screenings and treatment.

Virginia Premier Health Plan, Inc. collaborated with a specialty pharmacy to implement a clinical management program for members prescribed high-cost specialty drugs for complex chronic conditions. The goal of the program is to improve health outcomes for members through enhanced monitoring by dedicated specialty pharmacists. Since its inception the program has resulted in better coordinated medication management for members and reduced pharmacy costs for the MCO.

In addition to the MCO presentations, the best practices Collaborative included a DMAS-organized and facilitated panel discussion with experts from the Virginia Commonwealth University Health System. The panelists included two physicians and a doctor of pharmacy specializing in the fields of Child and Adolescent Psychiatry, Pediatrics, and Pharmacy. The panelists presented on the topic of *"Behavioral Health and Psychotropic Medications Among Children and Adolescents"* providing their unique perspectives and insights regarding how treatment for children and adolescents, particularly medication management, can be better coordinated by their respective disciplines and other health providers, such as MCOs, to ensure good outcomes for children, adolescents, and their families.

Operational Systems Review (OSR)

The CMS EQR guidelines require a comprehensive OSR at least once every three years. In follow-up to the last comprehensive OSRs Delmarva last conducted in CY 2011, OSRs were performed for the following DMAS-contracted MCOs in 2014:

- MajestaCare – March 26, 2014*
- Anthem HealthKeepers – March 31, 2014 – April 1, 2014
- CoventryCares of Virginia – April 3, 2014 – April 4, 2014
- Optima Family Cares – April 7, 2014 – April 8, 2014
- Virginia Premier Health Plan – April 10, 2014 – April 11, 2014
- INTotal Health – April 14, 2014 – April 15, 2014
- Kaiser Permanente Virginia – April 21, 2014 – April 22, 2014

** No longer an MCO in Virginia effective December 1, 2014*

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

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

DMAS requires their contracted MCOs to obtain and maintain health plan accreditation from the National Committee for Quality Assurance (NCQA). NCQA publishes an annual crosswalk of the NCQA Health Plan Accreditation Standards and Guidelines with the federal Medicaid managed care standards from the BBA. The crosswalk suggests that approximately forty percent of the federal requirements are equivalent to NCQA's accreditation standards. Further, the BBA allows states to deem their NCQA-accredited MCOs to be compliant with the duplicative federal requirements.

The OSRs included the deeming of certain federal requirements based on the NCQA crosswalk. Delmarva reviewed the crosswalk of standards that were eligible for deeming by agreement with CMS and presented recommendations to DMAS of those we believed could be deemed. DMAS compared the standards and the MCO contractual requirements before deciding which standards to deem for the 2014 comprehensive OSRs. DMAS determined that deeming could occur for certain ER and QAPI standards; no GS standards were deemed.

In preparation for the reviews, Delmarva made an Orientation presentation to staff from the MCOs at a quarterly DMAS MCO Collaborative meeting. Delmarva provided a written Orientation Manual that included an overview of the standards and the review process. MCOs were required to submit presite documentation for review by Delmarva. Upon receipt of presite documentation, desk reviews were performed for each MCO by a Delmarva team to determine compliance with ER, GS, and QAPI standards that comprise the comprehensive OSR. The desk reviews were followed by onsite reviews at each MCO's office conducted by the Delmarva team. The scope of the onsite review was determined by the Delmarva team's findings from the desk review; any standards that were not scored "fully met", meaning they scored "partially met" or "unmet" were reviewed again during the onsite review. Prior to the onsite review, MCOs were informed of the standards requiring further evaluation and were encouraged to clarify the documentation submitted for the desk review or prepare additional documentation for those standards for review by the Delmarva team onsite. At the conclusion of the onsite visit and following discussion with the MCO's staff and DMAS, an Exit Letter was sent to the MCOs outlining those standards that scored partially met or unmet. Delmarva

also produced the review results in a draft OSR Report that was approved by DMAS and disseminated to the MCOs. Upon receipt of the Exit Letter and draft OSR Report, MCOs were provided the opportunity to present additional documentation for any partially met or unmet standards. Delmarva reviewed any additional documentation submitted by MCOs, which was incorporated in the findings in a Final OSR Report. All Delmarva Final OSR Reports were reviewed and approved by DMAS before dissemination to the MCOs. In instances where MCOs had standards that did not achieve a score of fully met, MCOs were directed to develop and submit a Corrective Action Plan (CAP). Delmarva reviewed all MCO CAPs, and if they were deemed complete, recommended their approval to DMAS. If CAPs were deemed incomplete MCOs were directed to revise and resubmit them for review and approval.

All MCOs performed favorably on the 2014 OSRs as there were no scores of unmet for any MCOs on the standards reviewed. MajestaCare achieved a score of fully met on all standards. Anthem HealthKeepers, CoventryCares of Virginia, and Kaiser Permanente Virginia scored fully met on all but one standard. Optima Family Care and INTotal Health scored fully met on all but two standards, and Virginia Premier Health Plan scored fully met on all but three standards. Where applicable, the MCOs developed and submitted CAPs that were approved by DMAS.

Performance Measurement Validation (PMV)

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

The NCQA requires the accredited MCOs to calculate and submit performance rates for HEDIS® measures used by NCQA for public reporting and benchmarking. DMAS also requires the MCOs to report on a specific subset of HEDIS® measures. The goal in conducting performance measure validation (PMV) is to evaluate the accuracy of the measures and to determine the extent to which the MCO followed specifications for calculating and reporting the measures. Delmarva's Certified HEDIS® Compliance Auditors (CHCA) utilized methods consistent with NCQA's *HEDIS® Compliance Audit Standards, Policies and Procedures (Volume 5*) to assess each MCO's performance measures data collection and reporting processes for conformity with NCQA's *HEDIS® 2014 Technical Specifications (Volume 2*).

The Delmarva validation team conducted an onsite visit to each MCO to evaluate any potential issues identified, and to observe the systems used by the MCO to collect and produce

HEDIS® data. The methodology is consistent with the CMS protocol for conducting Medicaid External Quality Review Activities, Validating Performance Measures. Kaiser Permanente Virginia was excluded from this activity due to its status as a new health plan.

DMAS selected two HEDIS® measures for validation by Delmarva*: Adolescent Well-Care Visits* and *Follow-Up to Hospitalization After Mental Illness*. The six MCOs under review for PMV submitted the two measures according to the HEDIS® 2014 Technical Specifications. Although each MCO utilized different systems and procedures for their performance measure reporting, they continued to share the following common strengths:

- The MCOs maintain well-developed and established systems and processes for HEDIS® reporting.
- For HEDIS®2014 (CY 2013), all six accredited MCOs under review for PMV successfully used certified HEDIS® software.

HEDIS®

HEDIS® is the nationally recognized tool for monitoring the quality of care in health plans. These indicators are considered the "gold standard" in the industry and are used by many of America's health plans to measure performance on identified dimensions of health care and services. DMAS identified 13 HEDIS® measures that best reflect the performance of the contracted managed care organizations. Each of the six accredited MCOs provided DMAS with their HEDIS® scores for the following 13 measures. Some measures, e.g. Comprehensive Diabetes Care, have multiple HEDIS Measure Indicators for which results are calculated.

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

The following tables present HEDIS® data for each measure for all Virginia Medicaid MCOs for calendar years 2011, 2012 and 2013. Calendar year (CY) is the term used to report calendar year for HEDIS®and CAHPS®measures. Calendar year 2011 is reported as HEDIS® 2012, calendar year 2012 is reported as HEDIS® 2013 and calendar year 2013 is reported as HEDIS® 2014. These MCO rates are compared with HEDIS® National Medicaid Managed Care 50th Percentiles for the corresponding time frames. While the DMAS' Quality Strategy sets the goal of HEDIS®scores at the 75th percentile, the tables display the HEDIS® National Medicaid Managed Care 90th percentile rates for each measure to encourage stretch-goals.

NCQA allows certain Medicaid measures to be rotated on a biennial bases to help reduce the overall HEDIS®reporting burden on MCOs. While Virginia allows its MCOs to rotate eligible measures in their annual HEDIS®submission to NCQA, the MCOs are required to report both actual and rotated measures to the State. The Virginia Medicaid Averages presented in this report are calculated with actual rates and can vary from the state average reported for rotated measures in the NCQA Quality Compass. The Virginia Medicaid averages presented in Table 1 for Prenatal and Postpartum Care– Timeliness of Prenatal Care and Prenatal and Postpartum Care– Postpartum Care reflect the rotation of those measures by some MCOs.

NOTE: the Virginia Medicaid averages presented in Table 1 include the 2012 and 2013 results for MajestaCare even though the organization is no longer an MCO in Virginia effective December 1, 2014.

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

Table 1. Comparison of the Virginia Medicaid MCO scores and National Medicaid Managed Care 50th Percentiles for HEDIS®2014 (CY 2013) to HEDIS®2013 (CY 2012) and HEDIS® 2012 (CY 2011) and 90th Percentiles for HEDIS® 2014 (CY 2013).

HEDIS® Measure	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	Virginia Medicaid MCO Average (CY 2013)+	HEDIS® 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS® 2013 (CY 2012) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 90th Percentile*
Adolescent Well-Care Visit	46.7%	46.1%	44.8%	49.3%	47.2%	48.4%	65.6%
Antidepressant Medical Management-Acute Phase Tx	51.7%	52.9%	48.5%	49.4%	51.5%	49.7%	61.1%
Antidepressant Medical Management-Continuation Phase Tx	40.0%	38.0%	34.6%	32.4%	35.7%	33.9%	45.3%
Breast Cancer Screening	49.2%	51.4%	54.3%	50.5%	51.3%	57.4%	71.4%
Childhood Immunization Status Combination 2	69.7%	70.9%	68.8%	75.6%	76.9%	75.3%	83.3%
Childhood Immunization Status Combination 3	65.7%	67.2%	64.0%	72.2%	72.9%	72.3%	80.9%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Screening	83.4%	83.3%	81.6%	82.5%	82.4%	81.4%	87.8%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Control <100 mg/DL	47.9%	48.2%	42.3%	42.4%	41.8%	41.4%	53.0%
Controlling High Blood Pressure	57.3%	55.0%	55.3%	57.5%	56.1%	56.2%	69.8%

HEDIS® Measure	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	Virginia Medicaid MCO Average (CY 2013)+	HEDIS® 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS® 2013 (CY 2012) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– HbA1c Testing	83.2%	85.6%	84.7%	82.4%	83.1%	83.9%	91.7%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	41.6%	43.4%	45.7%	41.9%	43.0%	44.9%	30.6%
Comprehensive Diabetes Care– HbA1c Control <8%	49.8%	49.3%	46.1%	48.7%	48.6%	45.9%	59.4%
Comprehensive Diabetes Care– Eye (Retinal) Exams	50.7%	48.4%	46.5%	52.8%	54.3%	54.2%	68.0%
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	75.8%	75.5%	76.2%	76.2%	76.3%	76.9%	83.7%
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	39.9%	35.7%	35.5%	35.9%	34.5%	33.9%	45.6%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	78.1%	78.4%	77.8%	78.7%	79.2%	80.0%	86.8%
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	36.7%	39.4%	36.2%	39.1%	38.9%	39.4%	53.2%

HEDIS® Measure	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	Virginia Medicaid MCO Average (CY 2013)+	HEDIS® 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS® 2013 (CY 2012) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	55.9%	59.1%	56.0%	63.5%	60.7%	61.3%	75.2%
Follow-Up After Hospitalization for Mental Illness– 7 Days	44.5%	41.8%	32.5%	46.1%	44.0%	41.9%	63.2%
Follow-Up After Hospitalization for Mental Illness– 30 Days	68.2%	65.0%	57.4%	67.7%	65.6%	64.3%	80.3%
Lead Screening in Children	67.2%	70.5%	67.2%	71.3%	72.2%	70.8%	85.8%
Use of Appropriate Medications– Asthma Age 5-11	90.6%	90.3%	90.5%	91.5%	90.3%	91.1%	95.2%
Use of Appropriate Medications– Asthma Age 12-18	88.4%	87.8%	86.0%	87.1%	85.9%	87.3%	93.0%
Use of Appropriate Medications– Asthma Age 19-50	67.0%	72.8%	70.0%	75.7%	75.0%	76.0%	84.5%
Use of Appropriate Medications– Asthma Age 51-64	72.2%	70.2%	66.3%	73.8%	72.7%	72.2%	80.4%

HEDIS® Measure	Virginia Medicaid MCO Average (CY 2011)+	Virginia Medicaid MCO Average (CY 2012)+	Virginia Medicaid MCO Average (CY 2013)+	HEDIS® 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS® 2013 (CY 2012) National Medicaid Managed Care 50th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 90th Percentile*	HEDIS® 2014 (CY 2013) National Medicaid Managed Care 90th Percentile*
Use of Appropriate Medications–Asthma Total (Combined Ages)	86.8%	86.4%	84.2%	85.9%	84.6%	84.8%	91.4%
Prenatal and Postpartum Care–Timeliness of Prenatal Care	85.2%	86.0%	85.7%	86.1%	85.9%	84.3%	93.1%
Prenatal and Postpartum Care–Postpartum Care	64.7%	63.7%	62.3%	65.0%	64.1%	62.8%	74.0%
Well-Child Visits in the First 15 Months of Life (Six or more visits)	69.7%	67.1%	65.0%	62.8%	64.9%	63.2%	76.9%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	74.2%	73.4%	72.8%	72.2%	72.2%	71.8%	82.7%

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

The Virginia Medicaid MCO average met or exceeded the corresponding HEDIS® 2012, 2013 and 2014 National Medicaid Managed Care 50th Percentile all three years for the following measures:

- Antidepressant Medication Management - Effective Continuation Phase Treatment
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening and LDL-C Control <100 mg/dL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

As compared to the HEDIS® 2014 National Medicaid Managed Care 50th Percentile, the 2013 Virginia MCO average met or exceeded this benchmark for the following measures:

- Antidepressant Medication Management (Effective Continuation Phase Treatment)
- Cholesterol Management for Patients With Cardiovascular Conditions (LDL-C Screening and LDL-C Control <100 mg/DL)
- Comprehensive Diabetes Care - HbA1c Testing
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Prenatal and Postpartum Care- Timeliness of Prenatal Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

The Virginia Medicaid MCOs implemented initiatives in an effort to improve and sustain HEDIS® results for their enrollees. The success of the managed care delivery system is dependent on these achievements in order to evaluate the health care services provided to these vulnerable populations. Appendix Table A1-1 details all individual MCO results for calendar years 2011, 2012 and 2013.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS® surveys are used to obtain consumer information about the health services received. While originally designed to help consumers select health plans, the measures have evolved into an important tool in the effort to improve health care quality.

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

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

- Rating of Health Plan
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting Needed Care
- Getting Care Quickly

- How Well Doctors Communicate
- Shared Decision Making

Table 2 displays the aggregate average results of the six Virginia MCOs' CAHPS® Adult Population and Child General Population surveys for 2012 through 2014 as compared with the 2012-2014 CAHPS® National Medicaid 50th Percentiles and the 2014 90th percentile. The CAHPS® 2014 data reflects calendar year 2013, the CAHPS® 2013 data reflects calendar year 2012, and the CAHPS® 2012 is based on data reported for calendar year 2011.

NOTE: the CAHPS® averages presented in Table 2 include the 2012 and 2013 results for MajestaCare even though the organization is no longer an MCO in Virginia effective December 1, 2014.

Table 2. Comparison of the Virginia MCO Average Scores and National Medicaid 50th Percentile for CAHPS® 2012 (CY 2011) through CAHPS® 2014 (CY 2013) and the 90th Percentile for CAHPS® 2014 (CY 2013). Rating scores are combined answers of 8, 9, and 10. Composite scores are combined answers of Always/Usually, Yes, or A lot/Some/Yes. Advised to Quit Smoking by Doctor or Other Health Professional score is the combined answers of Always, Usually, and Sometimes.

Measure	Virginia MCO Average (CY 2011)+	Virginia MCO Average (CY 2012)+	Virginia MCO Average (CY 2013)+	CAHPS® 2012 (CY 2011) National Medicaid 50th Percentile*	CAHPS® 2013 (CY 2012) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 90th Percentile*
CAHPS® Adult Population							
Rating of Health Plan Overall	76.7%	76.0%	76.5%	73.9%	74.5%	75.5%	81.5%
Rating of Health Care Overall	71.7%	70.4%	72.4%	70.0%	70.6%	71.5%	77.0%
Rating of Personal Doctor Overall	78.4%	77.7%	78.6%	77.0%	78.7%	78.8%	83.1%
Rating of Specialist Overall	79.7%	80.8%	80.7%	77.2%	79.5%	80.6%	85.3%
Customer Service Composite	82.4%	87.2%	87.2%	80.7%	86.5%	87.1%	90.3%
Getting Needed Care Composite	79.9%	82.0%	83.1%	76.9%	81.0%	80.9%	85.6%
Getting Care Quickly Composite	81.0%	83.4%	83.9%	81.3%	81.5%	81.8%	85.5%
How Well Doctors Communicate Composite	89.0%	88.8%	89.9%	88.0%	89.4%	89.8%	92.4%
Shared Decision Making Composite	62.0%	50.6%	54.1%	60.6%	-	50.9%	55.5%
Advised to Quit Smoking by a Doctor or Other Health Provider	79.6%	78.6%	79.9%	75.2%	76.2%	76.8%	81.4%
CAHPS® Child General Population							
Rating of Health Plan Overall	86.6%	84.4%	86.5%	84.5%	83.5%	84.8%	88.7%
Rating of Health Care Overall	83.7%	84.5%	84.4%	83.4%	83.7%	84.7%	88.9%

Measure	Virginia MCO Average (CY 2011)+	Virginia MCO Average (CY 2012)+	Virginia MCO Average (CY 2013)+	CAHPS® 2012 (CY 2011) National Medicaid 50th Percentile*	CAHPS® 2013 (CY 2012) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 90th Percentile*
Rating of Personal Doctor Overall	86.4%	85.6%	85.3%	86.8%	86.9%	87.8%	90.9%
Rating of Specialist Overall	81.1%	86.2%	82.5%	82.3%	84.0%	85.0%	89.5%
Customer Service Composite	84.6%	88.5%	88.4%	82.7%	87.8%	88.1%	91.0%
Getting Needed Care Composite	81.7%	85.1%	87.2%	79.7%	84.7%	85.4%	90.7%
Getting Care Quickly Composite	86.0%	90.1%	90.7%	88.5%	90.1%	90.6%	93.8%
How Well Doctors Communicate Composite	90.8%	93.2%	92.8%	92.1%	93.2%	93.3%	95.6%
Shared Decision Making Composite	67.8%	50.8%	57.3%	69.1%	-	54.9%	60.3%

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

Of the ten rating and composite measures from the Adult category of the CAHPS® survey selected for this report, the Virginia MCO average for five measures compared favorably to the CAHPS® National Medicaid 50th Percentile between calendar years 2011 through 2013. In calendar year 2013, the Virginia MCO average for eight out of the ten selected measures met or exceeded the 2014 CAHPS® National Medicaid 50th Percentile. Three of the selected measures showed improvement for the three year period between calendar years 2011 and 2013.

The results for three of the nine selected Children measures met or exceeded the CAHPS® National Medicaid 50th Percentile between calendar years 2011 through 2013. Five out of nine selected measures compared favorably to the National Medicaid 50th Percentile for calendar

year 2013. The results for six measures showed improvement for the three year period between calendar years 2011 and 2013.

An additional CAHPS® survey was administered in 2014 to parents of child members enrolled in the Family Access to Medical Insurance Security (FAMIS) program. The survey included children in the General Population (those served in the Fee-For-Service and MCO delivery systems) and Children With Chronic Conditions (those who experience a consequence associated with a condition).

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

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

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

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

- Access to Prescription Medicine
- Family Centered Care: Personal Doctor Who Knows Child
- Access to Specialized Services
- Coordination of Care for Children with Chronic Conditions

Table 3 displays the aggregate average results for the Virginia FAMIS CAHPS® Child General Population and Children With Chronic Conditions Population surveys for 2014 as compared with the 2014 CAHPS® National Medicaid 50th and 90th Percentiles.

Table 3. Comparison of the Virginia FAMIS Average Scores and National Medicaid 50th and 90th Percentile for CAHPS® 2014 (CY 2013). Rating scores are combined answers of 8, 9, and 10. Composite scores are combined answers of Always/Usually, Yes, or A lot/Some/Yes.

Measure	Virginia FAMIS 2014 CAHPS®	CAHPS® 2014 (CY 2013) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 90th Percentile*
Children General Population			
Rating of Health Plan Overall	84.0%	84.8%	88.7%
Rating of Health Care Overall	88.0%	84.7%	88.9%
Rating of Personal Doctor Overall	88.0%	87.8%	90.9%
Rating of Specialist Overall	88.0%	85.0%	89.5%
Customer Service Composite	88.0%	88.1%	91.0%
Getting Needed Care Composite	83.0%	85.4%	90.7%
Getting Care Quickly Composite	88.0%	90.6%	93.8%
How Well Doctors Communicate Composite	94.0%	93.3%	95.6%
Coordination of Care Composite	81.0%	81.8%	86.3%
Health Promotion and Education Composite	68.0%	71.5%	76.5%
Shared Decision Making Composite	51.0%	54.9%	60.3%
Children With Chronic Conditions Population			
Rating of Health Plan Overall	78.0%	81.0%	86.2%

Measure	Virginia FAMIS 2014 CAHPS®	CAHPS® 2014 (CY 2013) National Medicaid 50th Percentile*	CAHPS® 2014 (CY 2013) National Medicaid 90th Percentile*
Rating of Health Care Overall	86.0%	83.7%	87.2%
Rating of Personal Doctor Overall	85.0%	87.0%	89.3%
Rating of Specialist Overall	90.0%	85.7%	88.1%
Customer Service Composite	87.0%	88.7%	91.9%
Getting Needed Care Composite	87.0%	86.9%	90.8%
Getting Care Quickly Composite	91.0%	93.7%	95.0%
How Well Doctors Communicate Composite	94.0%	93.8%	95.8%
Coordination of Care Composite	79.0%	80.7%	83.8%
Health Promotion and Education Composite	78.0%	78.1%	82.4%
Shared Decision Making Composite	55.0%	60.9%	65.1%
Family Centered Care: Getting Needed Information Composite	90.0%	90.7%	93.8%
Access to Prescription Medicine Composite	90.0%	91.6%	94.5%
Family Centered Care: Personal Doctor Who Knows Child Composite	90.0%	91.0%	92.6%
Access to Specialized Services Composite	82.0%	79.9%	82.5%
Coordination of Care for Children with Chronic Conditions Composite	81.0%	77.9%	80.5%

In four rating and composite measures for the FAMIS General Population, the Virginia average exceeded the CAHPS® National Medicaid 50th Percentile. For FAMIS Children with Chronic Conditions six ratings and composite measures exceeded the CAHPS® National Medicaid 50th Percentile.

Performance Improvement Projects (PIPs)

DMAS requires contracted Medicaid MCOs to conduct annual PIPs designed to achieve significant improvement, sustained over time, in clinical and non-clinical areas. DMAS selects project topics based on opportunities for improvement and relevance to the current Medicaid population. DMAS holds the MCOs accountable for the quality of care provided to the Medicaid enrollees.

The validation process expects the PIPs to demonstrate a favorable effect on the health outcomes of their enrollees. The CMS guidelines require PIPs designed, conducted, and reported in a methodologically sound manner. Delmarva uses the Centers for Medicare & Medicaid Services (CMS) protocol, *Validating Performance Improvement Projects—A Mandatory Protocol for External Quality Reviews Version 2.0, September 2012*, as a guideline in PIP review activities.

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

At the direction of DMAS, MCOs are required to continue two PIPs in 2014 that were initially developed in 2012:

- *Adolescent Well-Care Visits*

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

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

The 2014 validation reviewed the results of the second remeasurement year (CY 2013) against the first remeasurement year (CY 2012) and the baseline measurement year (CY 2011). Most of the MCOs identified NCQA Quality Compass 75th or 90th Percentiles as their long-term goals. The methodology is appropriate in all projects.

The MCOs completed barrier analyses which identified member, provider, and MCO barriers impacting improvement. Targeted interventions were implemented that addressed barriers and a determination was made whether the MCOs actions resulted in increased rates for Adolescent Well-Care Visits and Follow-Up After Hospitalization for Mental Illness. The PIP results were mixed as the majority of MCOs did not document significant improvement and some documented decreases for the measures. The results of the Follow-Up After Hospitalization for Mental Illness measure were impacted by a change in the HEDIS® specifications made by NCQA requiring primary source verification of follow-up visits and discontinuing the use of supplemental data sources such as member self-report. Consequently, rates for this measure declined for some MCOs. However, some noteworthy findings were documented; CoventryCares of Virginia and Virginia Premier Health Plan demonstrated sustained improvement in their Adolescent Well-Care Visits rate from the baseline measurement to remeasurement 2, and INTotal Health demonstrated sustained improvement in its rate of Follow-up After Hospitalization for Mental Illness within 30 days from the baseline measurement to remeasurement 2 despite the change to the HEDIS® specifications.

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

Recommendations for DMAS

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

- MCOs with HEDIS® results that meet or exceed the National Medicaid Managed Care 75th - 90th percentile rank, should be encouraged to share "best practice" strategies.
- DMAS should consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates.
- The MCO collaborative should continue coordination by DMAS to encourage sharing of improvement efforts to influence the quality of care provided to managed care enrollees.

- DMAS should continue and expand the practice of inviting additional stakeholders to participate in the MCO collaborative as either external partners or subject matter experts.

Recommendations for the Virginia MCOs

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

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

Conclusions for DMAS

- DMAS has continued to see their contracted MCOs excel in NCQA's national ranking for health plans. Five Virginia MCOs made the list of the top 100 for NCQA's 2014-2015 Health Insurance Plan Rankings for Medicaid health plans.

Conclusions for the Virginia MCOs

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

Appendix

Table A1-1 2012-2014 MCO HEDIS® Rates (CY 2011 – CY 2013)□ *

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Antidepressant Medical Management– Acute Phase Tx	37.5%	54.6%	48.1%	51.4%	51.7%	50.1%	49.1%	50.5%	49.0%	NA	46.3%	45.4%	51.5%	44.9%	75.1%	56.2%	52.5%
Antidepressant Medical Management – Continuation Phase Tx	24.1%	39.7%	33.0%	41.9%	36.5%	34.9%	41.5%	34.4%	34.0%	NA	36.8%	28.7%	36.4%	32.4%	63.7%	42.8%	36.8%
Breast Cancer Screening	47.9%	49.5%	54.1%	54.0%	59.7%	60.7%	45.6%	48.3%	45.4%	NA	NA	50.5%	50.3%	57.4%	48.0%	49.2%	53.7%
Childhood Immunization Status Combination 2	72.0%	72.3%	63.6%	69.5%	71.1%	71.1%	66.1%	78.5%	75.1%	NR	70.7%	70.6%	70.6%	70.6%	70.3%	61.8%	61.6%
Childhood Immunization Status Combination 3	68.1%	67.6%	58.7%	63.1%	65.0%	64.6%	64.7%	75.7%	69.5%	NR	67.9%	67.0%	67.0%	66.0%	65.7%	60.5%	57.4%
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Control <100 mg/DL	49.8%	49.8%	40.5%	43.4%	42.5%	39.1%	45.8%	43.2%	34.3%	NA	NA	41.0%	60.0%	55.2%	59.4%	45.7%	42.4%
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Screening	83.1%	83.1%	80.8%	84.2%	83.9%	84.6%	86.8%	93.2%	84.8%	NA	NA	79.8%	78.0%	80.0%	83.0%	78.4%	77.7%

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Controlling High Blood Pressure	63.1%	55.7%	55.7%	55.6%	57.2%	56.7%	54.0%	54.1%	54.1%	60.9%	58.4%	56.4%	51.2%	54.5%	57.7%	51.0%	52.3%
Comprehensive Diabetes Care– HbA1c Testing	85.0%	85.0%	82.5%	80.3%	80.5%	82.9%	85.7%	87.8%	85.0%	90.7%	88.1%	82.4%	85.5%	84.4%	82.6%	84.3%	85.3%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	35.9%	35.9%	44.8%	43.5%	46.5%	44.0%	41.4%	44.4%	56.7%	49.1%	39.5%	47.0%	39.5%	41.7%	40.0%	44.7%	47.7%
Comprehensive Diabetes Care– HbA1c Control <8%	55.8%	55.8%	45.1%	49.4%	45.3%	47.7%	51.2%	48.8%	36.4%	45.4%	52.5%	45.1%	52.2%	50.6%	47.5%	48.2%	44.0%
Comprehensive Diabetes Care– Eye (Retinal) Exams	52.6%	52.6%	45.7%	54.6%	58.6%	49.5%	48.6%	53.4%	38.5%	22.2%	41.3%	43.1%	48.6%	48.6%	54.5%	55.2%	55.1%

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	39.1%	39.1%	33.2%	36.2%	33.6%	33.1%	40.9%	35.0%	25.1%	16.7%	30.9%	29.9%	55.7%	53.0%	53.6%	34.3%	37.5%
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	76.3%	76.3%	74.7%	73.9%	70.3%	74.3%	82.3%	80.3%	79.2%	75.9%	78.2%	70.8%	75.3%	76.4%	75.6%	74.7%	74.6%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	77.1%	77.1%	76.7%	77.0%	72.3%	79.4%	80.5%	80.3%	79.0%	81.5%	75.1%	79.3%	82.3%	82.9%	76.3%	76.7%	73.4%
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	36.3%	38.0%	35.9%	36.2%	39.7%	35.7%	37.4%	42.1%	36.8%	42.6%	39.5%	32.3%	33.1%	34.1%	41.3%	40.6%	35.0%
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	56.0%	62.0%	54.9%	57.5%	61.8%	60.0%	53.0%	59.0%	55.9%	63.0%	62.1%	50.8%	51.8%	52.3%	62.0%	57.2%	50.8%

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Follow-Up After Hospitalization for Mental Illness– 30 Days	87.3%	75.6%	61.4%	67.0%	73.4%	66.3%	47.3%	52.1%	50.5%	46.3%	47.0%	76.8%	76.8%	62.6%	62.4%	65.5%	56.8%
Follow-Up After Hospitalization for Mental Illness– 7 Days	55.4%	53.7%	33.9%	46.5%	48.4%	42.9%	24.0%	29.0%	24.6%	20.7%	24.0%	57.7%	60.1%	39.7%	38.6%	38.6%	30.0%
Lead Screening in Children	59.7%	66.4%	61.7%	67.8%	72.8%	67.6%	68.9%	70.6%	66.5%	NR	65.2%	67.9%	72.2%	71.6%	71.5%	70.4%	70.9%
Use of Appropriate Medications – Asthma Age 5-11	90.2%	89.5%	90.8%	88.8%	93.2%	90.6%	91.5%	87.6%	90.1%	NR	NA	91.8%	91.5%	91.8%	90.8%	89.9%	89.3%

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Use of Appropriate Medications–Asthma Age 12-18	87.7%	85.3%	87.3%	92.0%	89.8%	83.3%	87.3%	90.7%	86.5%	NR	NA	89.0%	87.4%	88.4%	86.1%	85.8%	84.3%
Use of Appropriate Medications–Asthma Age 19-50	65.5%	65.0%	68.8%	54.1%	71.0%	66.7%	67.5%	85.0%	76.8%	NR	NA	79.6%	74.9%	74.0%	68.5%	68.3%	63.7%
Use of Appropriate Medications–Asthma Age 51-64	69.6%	65.3%	58.3%	NR	^	NA	NR	NA	NA	NA	NA	73.2%	73.9%	76.5%	73.8%	71.3%	64.2%
Use of Appropriate Medications–Asthma Total (Combined Ages)	85.5%	84.8%	85.4%	87.4%	87.9%	83.0%	88.0%	87.9%	86.4%	NR	80.9%	88.3%	86.9%	87.0%	84.8%	84.6%	82.3%
Prenatal and Postpartum Care–Timeliness of Prenatal Care	91.4%	89.0%	89.0%	87.7%	88.8%	84.5%	87.6%	86.9%	86.9%	83.8%	86.4%	75.1%	83.7%	83.7%	84.4%	83.9%	83.7%
Prenatal and Postpartum Care–Postpartum Care	70.0%	63.8%	63.8%	67.4%	65.0%	61.3%	56.9%	61.5%	61.5%	60.3%	59.6%	62.3%	65.3%	65.3%	66.7%	66.0%	62.5%
Adolescent Well-Care Visit	44.2%	44.2%	45.1%	48.6%	48.9%	49.8%	49.1%	44.4%	43.1%	41.7%	37.5%	47.2%	47.2%	46.5%	44.3%	50.3%	46.6%

Measure	AHKs HEDIS® 2012 (CY 2011)	AHKs HEDIS® 2013 (CY 2012)	AHKs HEDIS® 2014 (CY 2013)	CCVA HEDIS® 2012 (CY 2011)	CCVA HEDIS® 2013 (CY 2012)	CCVA HEDIS® 2014 (CY 2013)	INTotal HEDIS® 2012 (CY 2011)	INTotal HEDIS® 2013 (CY 2012)	INTotal HEDIS® 2014 (CY 2013)	MJC HEDIS® 2013 (CY 2012)	MJC HEDIS® 2014 (CY 2013)	OFC HEDIS® 2012 (CY 2011)	OFC HEDIS® 2013 (CY 2012)	OFC HEDIS® 2014 (CY 2013)	VPHP HEDIS® 2012 (CY 2011)	VPHP HEDIS® 2013 (CY 2012)	VPHP HEDIS® 2014 (CY 2013)
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.9%	73.9%	77.3%	74.1%	74.8%	74.3%	79.2%	81.2%	76.8%	67.8%	65.3%	73.2%	71.8%	71.3%	70.8%	71.1%	71.7%
Well-Child Visits in the First Fifteen Months of Life Six or more visits	66.2%	66.2%	68.5%	61.8%	63.3%	61.4%	70.4%	64.8%	61.2%	NR	60.1%	71.8%	71.8%	70.6%	78.1%	69.5%	68.2%

□ Comparative rates for Virginia MCOs and HEDIS®20142-Quality Compass Medicaid All Lines of Business can be found on Table 1
NA The denominator was too small to report a valid rate
NR The measure was calculated but the rate was materially biased, *or* the rate was not chosen to be reported
^ Measure not collected
*For rotated measures the actual MCO rates reported to DMAS may differ from rates reported in Quality Compass

AHKs – Anthem HealthKeepers
CCVA – CoventryCares of Virginia
INTotal – INTotal Health
MJC – MajestaCare
OFC – Optima Family Cares
VPHP – Virginia Premier Health Plan

Table A1-2 2012-2014 MCO CAHPS® (CY 2011 –CY 2013)□*

Measure	AHKs CAHPS® 2012 (CY 2011)	AHKs CAHPS® 2013 (CY 2012)	AHKs CAHPS® 2014 (CY 2013)	CCVA CAHPS® 2012 (CY 2011)	CCVA CAHPS® 2013 (CY 2012)	CCVA CAHPS® 2014 (CY 2013)	INTotal CAHPS® 2012 (CY 2011)	INTotal CAHPS® 2013 (CY 2012)	INTotal CAHPS® 2014 (CY 2013)	MJC CAHPS® 2013 (CY 2012)	MJC CAHPS® 2014 (CY 2013)	OFC CAHPS® 2012 (CY 2011)	OFC CAHPS® 2013 (CY 2012)	OFC CAHPS® 2014 (CY 2013)	VPHP CAHPS® 2012 (CY 2011)	VPHP CAHPS® 2013 (CY 2012)	VPHP CAHPS® 2014 (CY 2013)
CAHPS- Adult Population																	
Rating of Health Plan Overall	79.0%	79.0%	80.0%	77.1%	75.8%	80.0%	68.8%	67.6%	69.0%	73.2%	75.0%	83.6%	83.8%	80.0%	74.9%	76.8%	75.0%
Rating of Health Care Overall	73.5%	71.6%	75.8%	72.1%	70.0%	71.5%	67.6%	64.9%	69.4%	68.7%	70.80%	74.4%	76.0%	77..1%	70.8%	71.4%	70.0%
Rating of Personal Doctor Overall	79.8%	76.8%	76.576. 0%	76.1%	78.7%	83.0%	79.2%	73.4%	75.7%	77.1%	77.4%	79.7%	81.0%	81.0%	77.3%	79.3%	78.0%
Rating of Specialist Overall	80.3%	82.8%	79.4%	80.3%	73.4%	86.6%	78.5%	82.2%	81.0%	79.5%	76.6%	79.6%	81.4%	81.1%	80.0%	85.7%	79.4%
Customer Service Composite	NA	86.8%	87.0%	86.5%	90.5%	89.0%	81.4%	82.4%	84.0%	87.7%	90.0%	83.6%	86.0%	90.0%	78.3%	89.5%	83.0%
Getting Needed Care Composite	86.5%	84.8%	85.0%	79.5%	81.2%	85.0%	69.0%	78.0%	78.0%	83.9%	83.0%	82.2%	80.6%	86.0%	82.5%	83.2%	82.0%
Getting Care Quickly Composite	85.5%	84.5%	85.0%	80.8%	82.0%	84.0%	77.0%	81.7%	84.0%	86.1%	84.0%	79.6%	81.8%	83.0%	82.1%	84.5%	83.0%
How Well Doctors Communicate Composite	92.2%	90.3%	90.0%	89.5%	88.8%	91.0%	85.7%	86.7%	91.0%	88.8%	90.0%	89.8%	89.3%	90.0%	87.8%	88.8%	88.0%
Shared Decision Making Composite	64.6%	56.7%	52.0%	62.6%	53.0%	74.0%	56.3%	46.5%	48.0%	48.9%	45.0%	64.6%	47.7%	56.0%	62.1%	50.6%	50.0%

Measure	AHKs CAHPS® 201 (CY 2011)	AHKs CAHPS® 2013 (CY 2012)	AHKs CAHPS® 2014 (CY 2013)	CCVA CAHPS® 2012 (CY 2011)	CCVA CAHPS® 2013 (CY 2012)	CCVA CAHPS® 2014 (CY 2013)	INTotal CAHPS® 2012 (CY 2011)	INTotal CAHPS® 2013 (CY 2012)	INTotal CAHPS® 2014 (CY 2013)	MJC CAHPS® 2013 (CY 2012)	MJC CAHPS® 2014 (CY 2013)	OFC CAHPS® 2012 (CY 2011)	OFC CAHPS® 2013 (CY 2012)	OFC CAHPS® 2014 (CY 2013)	VPHP CAHPS® 2012 (CY 2011)	VPHP CAHPS® 2013 (CY 2012)	VPHP CAHPS® 2014 (CY 2013)
Advised to Quit Smoking by a Doctor or Other Health Provider	79.4%	79.8%	78.0%	82.5%	78.2%	81.0%	85.9%	81.0%	79.0%	79.8%	80.0%	69.9%	73.0%	78.0%	80.3%	79.9%	83.0%
CAHPS- Child General Population																	
Rating of Health Plan Overall	89.0%	90.8%	92.0%	86.6%	83.2%	85.0%	84.6%	84.5%	88.0%	75.9%	81.0%	88.6%	88.9%	87.0%	84.2%	83.3%	86.0%
Rating of Health Care Overall	82.5%	86.6%	87.0%	86.2%	85.0%	83.0%	80.3%	81.7%	84.0%	81.4%	84.0%	83.7%	84.5%	87.0%	85.7%	87.7%	82.0%
Rating of Personal Doctor Overall	85.3%	86.9%	86.0%	88.7%	86.3%	86.0%	81.9%	82.3%	85.0%	84.2%	83.0%	88.3%	85.2%	85.0%	87.8%	89.0%	86.0%
Rating of Specialist Overall	NA	NA	NA	78.9%	NA	80.0%	74.6%	87.5%	86.0%	NA	NA	83.0%	79.5%	82.0%	88.0%	91.5%	NA
Customer Service Composite	NA	88.1%	86.0%	85.0%	91.3%	88.0%	80.3%	86.6%	88.0%	89.7%	NA	88.6%	88.4%	89.0%	84.6%	87.0%	91.0%
Getting Needed Care Composite	NA	83.4%	83.0%	83.6%	87.1%	88.0%	68.1%	76.6%	84.0%	89.6%	87.0%	86.1%	85.5%	90.0%	88.9%	88.5%	91.0%
Getting Care Quickly Composite	84.5%	89.4%	88.0%	85.9%	92.5%	91.0%	76.2%	81.8%	85.0%	92.9%	94.0%	92.2%	92.7%	92.0%	91.4%	91.5%	94.0%
How Well Doctors Communicate Composite	89.8%	92.5%	93.0%	94.3%	95.4%	94.0%	84.2%	89.4%	90.0%	92.2%	94.0%	92.5%	93.9%	94.0%	93.1%	96.0%	92.0%

Measure	AHKs CAHPS® 2012 (CY 2011)	AHKs CAHPS® 2013 (CY 2012)	AHKs CAHPS® 2014 (CY 2013)	CCVA CAHPS® 2012 (CY 2011)	CCVA CAHPS® 2013 (CY 2012)	CCVA CAHPS® 2014 (CY 2013)	INTotal CAHPS® 2012 (CY 2011)	INTotal CAHPS® 2013 (CY 2012)	INTotal CAHPS® 2014 (CY 2013)	MJC CAHPS® 2013 (CY 2012)	MJC CAHPS® 2014 (CY 2013)	OFC CAHPS® 2012 (CY 2011)	OFC CAHPS® 2013 (CY 2012)	OFC CAHPS® 2014 (CY 2013)	VPHP CAHPS® 2012 (CY 2011)	VPHP CAHPS® 2013 (CY 2012)	VPHP CAHPS® 2014 (CY 2013)
Shared Decision Making Composite	NA	NA	NA	72.6%	55.1%	69.0%	58.7%	42.1%	49.0%	NA	NA	69.2%	53.9%	55.0%	70.5%	52.0%	56.0%

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

AHKs – Anthem HealthKeepers
CCVA – CoventryCares of Virginia
INTotal – INTotal Health
MJC – MajestaCare
OFC – Optima Family Cares
VPHP – Virginia Premier Health Plan

Additional Information for CAHPS® Measures in Table 2

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

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

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

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

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