Commonwealth of Virginia
Department of Medical Assistance Services

2012 Annual Technical Report

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Delmarva Foundation

Submitted by
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Table of Contents

2012 Annual Technical Report

Executive Summary

Introduction

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

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

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

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

Summary of Findings

Operational Systems Review (OSR)

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

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

MajestaCare was a new MCO that contracted with DMAS to offer services to Virginia enrollees effective January 2012. Delmarva conducted an initial OSR/Readiness Review with MajestaCare prior to this effective delivery date. This review found only minor standard elements not fully meeting requirements prior to acceptance of enrollment. Correction of these policies occurred prior to the follow-up OSR in May 2012.

In both the initial and the follow-up comprehensive OSR of MajestaCare, deeming of standards was not allowed. New health plans are not eligible for NCQA accreditation until they have delivered care to members for at least 18 months. Therefore, MajestaCare was not accredited at the time of the readiness review or the follow-up review and as a result, deeming of standards was not possible. Both comprehensive OSRs consisted of an extensive desk review of presite documentation submitted by the MCO and onsite reviewer visits to MajestaCare. These onsite visits included extensive staff interviews along with observation of certain MCO operations.

Delmarva used comprehensive regulations set forth under the final rule of the BBA, and 42 CFR §438 to evaluate and assess compliance of the following standards:

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

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 five out of six plans. MajestaCare was not included in PMV activities since it is under new health plan status. None of the five 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:

- Experienced and knowledgeable HEDIS® reporting staff are present in the MCOs.
- The MCOs have well-developed and established systems and processes for HEDIS® reporting.
- In CY 2011, only four of the five accredited MCOs used certified HEDIS® software, but in CY 2012, all five used certified software.
- All MCOs developed new and creative outreach approaches that increased compliance and resulted in better HEDIS® rates.
- The MCOs implemented initiatives that continually improved the HEDIS® results for their enrollees.

The MCOs have well-developed and established systems and processes for HEDIS® reporting and none experienced any major issues in processing and reporting HEDIS measures. All MCOs were encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013. MajestaCare is a new plan and exempt from PMV activities for this review cycle.

The Virginia Medicaid MCO average met or exceeded the corresponding HEDIS® 2010, 2011 and 2012 National Medicaid Managed Care 50th Percentile all three years for the following measures:

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

As compared to the HEDIS® 2012 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for 2011 exceeded this benchmark for the following measures:

- Antidepressant Medication Management (Effective Acute Phase Treatment and 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 Poor Control (>9.0%)
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Follow-Up After Hospitalization for Mental Illness (30 Day Follow-Up)
- Use of Appropriate Medications -Asthma (Ages 12-18, Ages 51-64, and Total)
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

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 seven measures compared favorably to the CAHPS® National Medicaid 50th Percentile from 2009 through 2011. In 2011, the Virginia MCO average for nine 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 showed improvement for three of nine measures between 2009 and 2011.

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 new MCO, MajestaCare, was not required to submit PIPs for this time period.

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

A new PIP reporting template, revised by Delmarva and approved by DMAS, reflected the recent CMS changes to the PIP Validation protocol. This baseline year of the new PIPs included a detailed review of the MCOs' individual justification of project topics, data analyses and comprehensive rationales for targeted interventions. This baseline year of the new PIPs included detailed review of the MCOs' individual justification of project topics and determined if their rationales were sufficiently comprehensive. Most of the MCOs identified NCQA Quality Compass 75th or 90th Percentiles as their long-term goals. The 2013 validation will review results of the first remeasurement year and progress made in improvement efforts.

Quality Highlights

- All Virginia MCOs are required to be NCQA accredited. All five MCOs made the list of the top 75 for NCQA's 2012-2013 national rankings for health plans. The newly contracted MCO, MajestaCare, is on an aggressive track to attain NCQA accreditation in 2013.
- DMAS successfully coordinates participation in the MCO collaborative as a forum for sharing of "*best practices.*" All five MCOs have quality initiatives to target identified needs of their enrollee populations.
- The CMS chose Virginia to present their MCO collaborative process as a best practice in Medicaid/CHIP managed care quality improvement. The DMAS Quality Improvement Analyst and the Delmarva Project Director were co-presenters at a plenary session of the CMS 2nd Annual Quality Conference in June 2012.

- The Virginia Medicaid MCO average met or exceeded the associated HEDIS® 2010, 2011 and 2012 National Medicaid Managed Care 50th Percentile all three years for seven measures.
- The Virginia MCO average for HEDIS 2012 exceeded the HEDIS 2012 National Medicaid Managed Care 50th Percentile for 14 performance measures.
- The majority (92 percent) of pregnant women were in the Medicaid for Pregnant Women program while 8 percent were in the FAMIS MOMS program. Reversing a three-year trend, the percentage of pregnant women in the study population and enrolled in a managed care organization (MCO) declined from 74.9 percent in 2010 to 67.5 percent in 2011. The percentage of women enrolled in FFS and PCCM reversed their declining trend and increased enrollment in 2011.
- For the first time, the Improving Birth Outcomes through Adequate Prenatal Care study evaluated a new comparison group of pregnant women. This group was comprised of women who were not continuously enrolled 43 days prior to delivery, but were enrolled on the day of delivery. The majority of these women (57.1 percent) were in the FFS program while 39.5 percent were in managed care.
- Women in the FAMIS MOMS and Medicaid for Pregnant Women programs received adequate prenatal care at rates that were more favorable than the HEDIS® National Medicaid Managed Care Averages in all three years from 2009 to 2011.
- Infants born to women in MCOs had improved low birth weight (LBW) rates from 2009 to 2011 and outperformed the national benchmarks in both 2010 and 2011. LBW rates for FFS enrollees continue to be the least favorable of all delivery systems and when compared with the national benchmarks for all years.
- The rate of infants born prematurely (before 37 completed weeks of pregnancy) in the FAMIS MOMS and Medicaid for Pregnant Women programs improved (decreased) and was more favorable than the national rates for all three years.
- Evaluated for the first time, the rate of infants born before 39 completed weeks of pregnancy for the combined FAMIS MOMS and Medicaid for Pregnant Women programs was 33.7 percent. This rate is better (lower) than the national rate of 38.9 percent.

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 2012 ATR report outlines the specific recommendations for both DMAS and the MCOs.

This represents an opportunity to build on a solid and organized framework to sustain and improve quality indicators in the future. DFMC recommends that DMAS consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates.

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

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

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

2012 Annual Technical Report

Introduction

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

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

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

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

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

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

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

- AMERIGROUP Community Care (Amerigroup)
- Anthem/HealthKeepers, Inc. (formerly Anthem HMOs)
- Optima Family Care (OFC)
- Southern Health Services, Inc. (Care*N*et)
- Virginia Premier Health Plan, Inc. (Va Premier)
- MajestaCare, new MCO effective January 2012

EQRO Activities

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

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

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

- The validation results of the two measures selected by DMAS using the 2012 Healthcare Effectiveness Data and Information Set (HEDIS®). Each MCO also reports 14 additional measures that aggregate their HEDIS® results and include both CHIP and Medicaid enrollees.
- The 2012 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 4.0H survey results of enrollee satisfaction for Children and for Adult Medicaid - HMO.
- The 2012 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 program. Additional data included the State Managed Care Quality Strategy, focused clinical studies (FCS), and the MCO's best and emerging practices for improving quality of care and service.

DMAS Quality Strategy

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

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

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

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

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

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

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

The results of focused clinical studies (FCS) are an important component in DMAS' overall program evaluations and are an optional component of EQR. Delmarva conducted one optional FCS during this review period: Improving Birth Outcomes through Adequate Prenatal Care Study.

This study reported the majority (92 percent) of pregnant women were in the Medicaid for Pregnant Women program while 8 percent were in the FAMIS MOMS program. Reversing a three-year trend, the percentage of pregnant women in the study population and enrolled in a managed care organization (MCO) declined from 74.9 percent in 2010 to 67.5 percent in 2011. The percentage of women enrolled in FFS and PCCM reversed their declining trend and slightly increased enrollment in 2011.

For the first time, this study evaluated a new comparison group of pregnant women. This group of women were not continuously enrolled 43 days prior to delivery, but were enrolled on the day of delivery. The majority of these women (57.1 percent) were in the FFS program while 39.5 percent enrolled in an MCO.

Data analysis showed that women in the FAMIS MOMS and Medicaid for Pregnant Women programs received adequate prenatal care at rates that were more favorable than the HEDIS® National Medicaid Managed Care Averages in all three years from 2009 to 2011.

Rates of low birth weight (LBW) infants born to FAMIS MOMS continued to improve and outperform the Centers for Disease Control and Prevention's (CDC's) national benchmark. Medicaid for Pregnant Women low birth weight rates remained unfavorable compared with the national CDC averages for all three years but trending at improved (lower) rates from 2009 to 2011. FAMIS MOMS is the higher income group of the two programs. Infants born to women in MCOs had improved LBW rates from 2009 to 2011 and outperformed the national benchmarks in both 2010 and 2011. LBW rates for FFS enrollees continue to be the least favorable of all delivery systems and when compared with the national benchmarks for all years.

The rate of infants born prematurely (before 37 completed weeks of pregnancy) in the FAMIS MOMS and Medicaid for Pregnant Women programs improved (decreased) and was more favorable than the national rates for all three years. For the first time, the rate of infants born before 39 completed weeks of pregnancy for the combined FAMIS MOMS and Medicaid for Pregnant Women programs was 33.7 percent. This rate is better (lower) than the national rate of 38.9 percent.

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 all five accredited MCOs making the list of the top 75 for 2012-2013. The newly contracted MCO, MajestaCare, is on an aggressive track to attain NCQA accreditation in 2013.

Best and Emerging Practices for Improving Quality of Care and Service

Each year one of the quarterly MCO Collaborative meetings serves as the annual session for presentation of best practices. DMAS and each MCO selected topics that represented exceptional HEDIS® scores and the following is a brief overview of each MCO presentation in January 2012:

Amerigroup identified an opportunity for improvement in the percentage of adolescent enrollees, 12-21 years of age, who had at least one comprehensive well care visit with a Primary Care Provider (PCP). An analysis revealed specific barriers and specific interventions were designed to target these issues. Results reported that the percentage of adolescents receiving an annual well-care visit increased from 43.93% in 2008 to 47.10% in 2010.

Anthem, HealthKeepers, Inc.'s Future Moms Program offered individualized support of expectant moms to help achieve healthier birth outcomes. The program emphasizes early-risk assessment, provided specialized counseling, care coordination and educational support. Results report that 89% of participants delivered at full term and at normal birth weight with a 16% decrease in expense per mother from 2009 to 2010.

Care*N*et implemented a Perinatal Program to increase the percentage of women who had a recommended postpartum visit on or between 21 and 56 days after delivery. Their interventions were targeted and comprehensive. Results report that post-partum visits increased and are comparable with the 75th percentile of HEDIS, a goal consistent with DMAS' 2011-2015 Quality Strategy.

Optima Family Care implemented an initiative to increase the percentage of enrollees with persistent asthma who were prescribed appropriate medication for their condition. Using a comprehensive clinical team approach, the rates for enrollees receiving the recommended asthma medication increased and now exceed the national HEDIS® average.

Virginia Premier Health Plan, Inc. improved the percentage of children who had the recommended number of well-child visits with a PCP within the first 15 months of life. VPHP aligned interventions and best practices to overcome identified barriers. Infant visits increased by 8.03 percentage points from 2010 to 2011, a rate 15.8 percentage points above the HEDIS 75th Percentile.

A **MajestaCare** representative presented an incentive program used by another Aetna Medicaid plan in Missouri. The 7-day follow-up after discharge for mental illness indicator rate showed a downward trend. An incentive program offered members in three geographical regions a $25 gift card to Dollar General if they received an outpatient visit with a behavioral health provider within 7 days after discharge for mental illness. Results reported a significant increase (10+ %) for the largest region and a slight increase for the overall aggregate rate over a 2-year period.

The CMS chose Virginia to present their MCO collaborative process as a best practice in Medicaid/CHIP managed care quality improvement. The DMAS Quality Improvement Analyst and the Delmarva Project Director were co-presenters at a plenary session of the CMS 2nd Annual Quality Conference in June 2012.

Operational Systems Review (OSR)

Since 2005, DMAS has required their contracted MCOs to obtain and maintain national accreditation from the NCQA. Forty-one states, including 25 Medicaid programs now recognize or require NCQA accreditation. Per 42 CFR §438.360, states can now use information obtained from a national accrediting organization survey for certain of the mandatory external quality review activities.

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

DMAS with assistance from Delmarva compared the federal and state requirements with designated NCQA standards recommended for deeming. Delmarva identified those standards considered equivalent and eligible for deeming that would be exempt from duplicate review. DMAS reviewed each standard eligible for deeming for a final decision on deeming for 2011. Most, but not all standards eligible for deeming, were determined to be equivalent and deemed by DMAS for this review. Each MCO's most recent NCQA accreditation results were compared with the standards designated as eligible for deeming to validate that survey requirements were met.

The CMS EQR guidelines require that a comprehensive OSR be conducted at least once every three years. The 2011 OSR consisted of an extensive desk review of presite documentation submitted by each MCO. An onsite visit to each MCO included staff interviews along with observation of MCO operations. Delmarva reviewers performed these activities to identify, validate, quantify, and monitor selected BBA standards and designated contractual requirements. Delmarva used certain MCO contractual requirements and the regulations set forth under the final rule of the BBA and 42 CFR §438 to evaluate and assess compliance of the following systems for each MCO:

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

The next OSR is scheduled for CY 2014 and DMAS anticipates allowing for deeming as it did in 2011.

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® 2012 Technical Specifications (Volume 2*).

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

DMAS selected two HEDIS® measures for validation by Delmarva: Adolescent Well-Care Visits and Follow-Up to Hospitalization After Mental Illness. All MCOs submitted the two measures according to the HEDIS® 2012 Technical Specifications. Delmarva recommended that each MCO update their procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS® 2013. Although each MCO utilized different systems and procedures for their performance measure reporting, they continued to share the following common strengths:

- Experienced and knowledgeable HEDIS® reporting staff are present in the MCOs.
- The MCOs have well-developed and established systems and processes for HEDIS® reporting.
- In CY 2011, only four of the five accredited MCOs used certified HEDIS® software, but in CY 2012, all five used certified software.
- All MCOs developed new and creative outreach approaches that increased compliance and resulted in better HEDIS® rates.

HEDIS®

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

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

The following tables present HEDIS® data for each measure for all Virginia Medicaid MCOs for 2009, 2010 and 2011. Calendar year 2009 is reported as HEDIS® 2010, calendar year 2010 is reported as HEDIS® 2011 and calendar year 2011 is reported as HEDIS® 2012. These MCO rates are compared with HEDIS® National Medicaid Managed Care 50th Percentiles for the corresponding time frames. While the DMAS' Quality Strategy sets the goal of HEDIS scores at the 75th percentile, the tables display the HEDIS® National Medicaid Managed Care 90th percentile rates for each measure to encourage stretch-goals.

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

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

Table 1. Comparison of the Virginia Medicaid MCO scores and National Medicaid Managed Care 50th and 90th Percentiles for HEDIS 2012 (CY 2011) to HEDIS 2011 (CY 2010) and HEDIS 2010 (CY 2009).

HEDIS Measure	Virginia Medicaid MCO Average (CY 2009)+	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	HEDIS 2010 (CY 2009) National Medicaid Managed Care 50th Percentile*	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 90th Percentile*
Adolescent Well-Care Visit	44.4%	44.8%	46.7%	46.9%	46.1%	49.3%	64.3%
Antidepressant Medical Management-Acute Phase Tx	49.5%	53.0%	51.7%	48.1%	50.1%	49.4%	61.6%
Antidepressant Medical Management-Continuation Phase Tx	33.6%	38.9%	40.0%	31.0%	32.7%	32.4%	42.9%
Childhood Immunization Status Combination 2	71.5%	68.9%	69.7%	76.6%	75.1%	75.6%	84.2%
Childhood Immunization Status Combination 3	66.2%	64.9%	65.7%	71.1%	71.0%	72.2%	82.4%
Breast Cancer Screening	46.2%	46.4%	49.2%	52.0%	52.4%	50.5%	62.4%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Screening	82.3%	84.1%	83.4%	80.9%	82.5%	82.5%	88.8%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Control <100 mg/DL	45.1%	50.2%	47.9%	43.2%	44.0%	42.4%	55.6%
Controlling High Blood Pressure	61.1%	57.6%	57.3%	56.9%	56.5%	57.5%	69.1%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2009)+	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	HEDIS 2010 (CY 2009) National Medicaid Managed Care 50th Percentile*	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– HbA1c Testing	81.0%	81.8%	83.2%	81.1%	82.2%	82.4%	91.1%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	42.7%	43.8%	41.6%	43.2%	42.6%	41.9%	29.0%
Comprehensive Diabetes Care– HbA1c Control <7%	13.3%	20.9%	14.8%	35.5%	35.1%	36.7%	44.0%
Comprehensive Diabetes Care– HbA1c Control <8%	47.4%	47.1%	49.8%	46.6%	47.4%	48.7%	59.4%
Comprehensive Diabetes Care– Eye (Retinal) Exams	48.3%	49.5%	50.7%	54.0%	52.9%	52.8%	69.7%
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	74.7%	76.0%	75.8%	75.4%	75.4%	76.2%	83.5%
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	39.6%	39.4%	39.9%	33.6%	35.2%	35.9%	46.4%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	77.9%	77.8%	78.1%	77.7%	78.5%	78.7%	86.9%
Comprehensive Diabetes Care– Blood Pressure Control (<130/80mm Hg)	31.4%	Measure Retired	Measure Retired	32.5%	Measure Retired	Measure Retired	Measure Retired
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	^	36.0%	36.7%	^	^	39.1%	53.0%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2009)+	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	HEDIS 2010 (CY 2009) National Medicaid Managed Care 50th Percentile*	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 90th Percentile*
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	61.1%	58.4%	55.9%	61.6%	61.2%	63.5%	75.4%
Follow-Up After Hospitalization for Mental Illness– 7 Days	37.8%	43.0%	44.5%	43.5%	45.1%	46.1%	69.6%
Follow-Up After Hospitalization for Mental Illness– 30 Days	59.7%	66.5%	68.2%	62.6%	66.6%	67.7%	84.3%
Lead Screening in Children	56.6%	64.0%	67.2%	71.6%	72.2%	71.3%	86.6%
Use of Appropriate Medications– Asthma Age 5-11 *(CY 20099 Age 5-9)* ◉	91.8%	93.0%	90.6%	92.2%	92.4%	91.5%	95.4%
Use of Appropriate Medications– Asthma Age 12-18 *(CY 2009 Age 10-17)* ◉	85.1%	86.4%	88.4%	^	^	87.1%	92.3%
Use of Appropriate Medications– Asthma Age 19-50	^	^	67.0%	^	^	75.7%	84.9%
Use of Appropriate Medications– Asthma Age 51-64	^	^	80.7%	^	^	73.8%	85.6%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2009)+	Virginia Medicaid MCO Average (CY 2010)+	Virginia Medicaid MCO Average (CY 2011)+	HEDIS 2010 (CY 2009) National Medicaid Managed Care 50th Percentile*	HEDIS 2011 (CY 2010) National Medicaid Managed Care 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed 50th Percentile*	HEDIS 2012 (CY 2011) National Medicaid Managed Care 90th Percentile*
Use of Appropriate Medications–Asthma Total (Combined Ages)	88.7%	89.9%	86.8%	88.6%	88.9%	85.9%	90.6%
Prenatal and Postpartum Care–Timeliness of Prenatal Care	86.4%	83.2%	85.2%	85.9%	86.0%	86.1%	93.3%
Prenatal and Postpartum Care–Postpartum Care	66.3%	67.7%	64.7%	65.4%	64.6%	65.0%	74.5%
Well-Child Visits in the First 15 Months of Life (Six or more visits)	65.2%	66.4%	69.7%	60.4%	61.3%	62.8%	77.3%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	71.2%	75.9%	74.2%	71.7%	72.3%	72.2%	82.9%

+ 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
⊙ CY2009 Age parameters have changed from previous years

The Virginia Medicaid MCO average met or exceeded the corresponding HEDIS® 2010, 2011 and 2012 National Medicaid Managed Care 50th Percentile all three years for the following measures:

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

Since HEDIS®2010, the Virginia Medicaid MCO average improved for the following measures, but fell below the National Medicaid 50th Percentile:

- Adolescent Well-Care Visit
- Breast Cancer Screening
- Comprehensive Diabetes Care - Eye (Retinal) Exams

- Follow-Up After Hospitalization for Mental Illness (7 Day and 30 Day Follow-Up)
- Lead Screening in Children
- Use of Appropriate Medications Asthma (Ages 12-18)

As compared to the HEDIS® 2012 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for 2011 met or exceeded this benchmark for the following measures:

- Antidepressant Medication Management (Effective Acute Phase Treatment and 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 Poor Control (>9.0%)
- Comprehensive Diabetes Care - HbA1c Control (<8.0%)
- Comprehensive Diabetes Care - LDL-C Control (<100/mg/dL)
- Follow-Up After Hospitalization for Mental Illness (30 Day Follow-Up)
- Use of Appropriate Medications-Asthma (Ages 12-18, Ages 51-64, and Total)
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

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 2009, 2010 and 2011.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS® program develops and utilizes standardized surveys 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® program 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 Virginia MCOs' CAHPS® Adult Population and Child General Population surveys for 2010 through 2012 as compared with the 2010- 2012 CAHPS® National Medicaid 50th Percentiles and the 2012 90th percentile. The CAHPS® 2012 data reflects calendar year 2011, the data for calendar year 2010 is reported for the CAHPS® 2011 results and CAHPS® 2010 is based on data reported for calendar year 2009.

Table 2. Comparison of the Virginia MCO Average Scores and National Medicaid 50th and 90th Percentile for CAHPS® 2010 (CY 2009) through CAHPS® 2012 (CY 2011). Rating scores are combined answers of 8, 9, and 10.

Measure	Virginia MCO Average (CY 2009)+	Virginia MCO Average (CY 2010)+	Virginia MCO Average (CY 2011)+	CAHPS® (CY 2009) National Medicaid 50th Percentile*	CAHPS® (CY 2010) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 90th Percentile*
CAHPS - Adult Population							
Rating of Health Plan Overall	74.8%	77.8%	76.7%	70.3%	73.2%	73.9%	81.2%
Rating of Health Care Overall	67.4%	72.6%	71.7%	67.4%	69.1%	70.0%	76.2%
Rating of Personal Doctor Overall	75.1%	78.4%	78.4%	76.0%	76.4%	77.0%	82.8%
Rating of Specialist Overall	78.4%	79.0%	79.7%	76.6%	77.1%	77.2%	83.1 %
Customer Service Composite	82.9%	83.2%	82.4%	79.6%	79.5%	80.7%	86.7%
Getting Needed Care Composite	76.7%	78.8%	79.9%	76.3%	77.2%	76.9%	84.5%
Getting Care Quickly Composite	80.3%	81.0%	81.0%	80.5%	81.4%	81.3%	85.6%
How Well Doctors Communicate Composite	86.1%	88.9%	89.0%	87.3%	88.1%	88.0%	91.9%
Shared Decision Making Composite	63.4%	59.8%	62.0%	59.5%	59.6%	60.6%	66.4%
Advised to Quit Smoking by a Doctor or Other Health Provider	72.7%	76.2%	79.6%	37.9%	74.8%	75.2%	81.4%
CAHPS - Child General Population							
Rating of Health Plan Overall	84.8%	86.4%	86.6%	-	82.7%	84.5%	88.6%
Rating of Health Care Overall	82.2%	82.1%	83.7%	-	81.7%	83.4%	86.8%

Measure	Virginia MCO Average (CY 2009)+	Virginia MCO Average (CY 2010)+	Virginia MCO Average (CY 2011)+	CAHPS® (CY 2009) National Medicaid 50th Percentile*	CAHPS® (CY 2010) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 50th Percentile*	CAHPS® (CY 2011) National Medicaid 90th Percentile*
Rating of Personal Doctor Overall	84.8%	86.3%	86.4%	-	84.9%	86.8%	89.5%
Rating of Specialist Overall	84.2%	78.9%	81.1%	-	82.9%	82.3%	87.3%
Customer Service Composite	84.9%	81.2%	84.6%	-	82.3%	82.7%	89.0%
Getting Needed Care Composite	82.6%	77.0%	81.7%	-	80.2%	79.7%	86.7%
Getting Care Quickly Composite	84.5%	84.7%	86.0%	-	88.0%	88.5%	92.2%
How Well Doctors Communicate Composite	90.7%	91.0%	90.8%	-	92.1%	92.1%	94.3%
Shared Decision Making Composite	68.1%	64.7%	67.8%	-	66.4%	69.1%	72.9%

® 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 seven measures compared favorably to the CAHPS® National Medicaid 50th Percentile from 2009 through 2011. In 2011, the Virginia MCO average for nine out of the ten selected measures met or exceeded the CAHPS® National Medicaid 50th Percentile. Six of the selected measures showed improvement for the three year period between 2009 and 2011.

The results for four of the nine selected Children measures met or exceeded the National Medicaid 50th Percentile for CY 2011. The results for Rating of Health Plan Overall, Rating of Personal Doctor Overall, and Getting Care Quickly composites showed improvement for the three year period between 2009 and 2011.

Performance Improvement Projects (PIPs)

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

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

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

At the direction of DMAS, MCOs are required to develop two new PIPs this year:

- *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.

A new PIP reporting template, revised by Delmarva and approved by DMAS, reflected the CMS proposed changes to the PIP Validation protocol. While very similar to the old tool, Delmarva made some modifications in the new template to include the protocol changes. For example,

there is a new question inquiring if the MCO considered input from enrollees with special health needs in the selection of the PIP topic. Delmarva supplemented the instructions of the reporting tool with additional comments and helpful hints to keep in mind while completing the worksheet.

This baseline year of the new PIPs included detailed review of the MCOs' individual justification of project topics and if their rationales were sufficiently comprehensive. Most of the MCOs identified NCQA Quality Compass 75th or 90th Percentiles as their long-term goals. If an MCO identified the 50th percentile as a goal, technical assistance encouraged the MCO to increase their goals. The methodology appears appropriate in all projects and Delmarva made recommendations to enhance initial interventions.

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

Recommendations for DMAS

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

- MCOs with HEDIS® results that meet or exceed the National Medicaid Managed Care 75th - 90th percentile rank, should be encouraged to share "best practice" strategies.
- DMAS should consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates.
- The MCO collaborative should continue coordination by DMAS to encourage sharing of improvement efforts to influence the quality of care provided to managed care enrollees.
- DMAS should continue and expand their practice of inviting additional stakeholders to participate in the MCO collaborative as either external partners or subject matter experts.

Recommendations for the Virginia MCOs

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

- MCOs are encouraged to update procedures and processes to address the new Medical Record Review Validation (MRRV) process instituted by NCQA for HEDIS 2013.
- MCOs with the best HEDIS® results compared with the National Medicaid Managed Care 90th percentile rates, should continue to share successful intervention strategies.
- MCOs should conduct a root-cause or barrier analyses for those HEDIS® measures not meeting the HEDIS® National Medicaid Managed Care 50th percentile.
- Targeted PIP interventions need to reflect gap analyses and identify specific barriers to improve the results of population sub-groups.
- All MCOs should implement specific recommendations identified for improvement from all EQR activities.

Conclusions for DMAS

- DMAS has continued to see their contracted MCOs excel in NCQA's national ranking for health plans with all five accredited MCOs making the list of the top 75 for 2012-2013. The newly contracted MCO, MajestaCare, is on an aggressive track to attain NCQA accreditation in 2013.

Conclusions for the Virginia MCOs

- These mature MCOs demonstrated well-developed, in-house HEDIS® reporting processes.
- The MCO collaborative is an effective forum for sharing of local and national "best practices" that increase effectiveness in both PIP initiatives and HEDIS® results.

Appendix

Table A1-1 MCO Rates (CY 2009 – CY 2011)□ *

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Antidepressant Medical Management– Acute Phase Tx	51.3%	47.4%	49.1%	42.3%	46.5%	37.5%	43.6%	48.0%	51.4%	45.1%	45.8%	45.4%	65.4%	77.5%	75.1%
Antidepressant Medical Management – Continuation Phase Tx	35.9%	34.2%	41.5%	27.2%	29.2%	24.1%	24.8%	35.0%	41.9%	29.3%	29.9%	28.7%	50.8%	66.0%	63.7%
Childhood Immunization Status Combination 2	77.7%	77.3%	66.1%	75.7%	70.4%	72.0%	60.4%	63.9%	69.5%	68.2%	63.4%	70.6%	75.4%	69.3%	70.3%
Childhood Immunization Status Combination 3	73.5%	73.8%	64.7%	71.1%	66.0%	68.1%	55.1%	58.0%	63.1%	62.3%	59.2%	67.0%	69.3%	67.6%	65.7%
Breast Cancer Screening	45.7%	43.8%	45.6%	47.6%	47.8%	47.9%	41.3%	42.4%	54.0%	48.9%	50.3%	50.5%	47.6%	47.8%	48.0%
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Screening	90.5%	93.8%	86.8%	80.0%	84.5%	83.1%	80.4%	83.8%	84.2%	78.2%	76.4%	79.8%	82.2%	82.0%	83.0%

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Control <100 mg/DL	41.9%	64.1%	45.8%	47.8%	48.6%	49.8%	39.3%	42.7%	43.4%	38.9%	37.5%	41.0%	57.4%	58.2%	59.4%
Controlling High Blood Pressure	66.4%	64.0%	54.0%	66.4%	57.7%	63.1%	54.1%	55.4%	55.6%	55.5%	50.3%	56.4%	63.0%	60.8%	57.7%
Comprehensive Diabetes Care– HbA1c Testing	84.5%	85.0%	85.7%	79.1%	78.4%	85.0%	75.0%	82.2%	80.3%	83.1%	82.0%	82.4%	83.4%	81.6%	82.6%
Comprehensive Diabetes Care– Poor HbA1c Control >9% *(lower rate is better)*	44.2%	39.8%	41.4%	39.3%	40.6%	35.9%	43.9%	51.1%	47.0%	49.2%	47.7%	43.5%	36.7%	39.9%	40.0%
Comprehensive Diabetes Care– HbA1c Control <7%	NR	NR	NR	NR	36.1%	NR	29.3%	28.8%	36.7%	NR	NR	NR	37.4%	39.4%	37.3%
Comprehensive Diabetes Care– HbA1c Control <8%	49.5%	52.1%	51.2%	40.8%	49.7%	55.8%	42.5%	44.7%	49.4%	51.6%	41.3%	45.1%	52.4%	47.6%	47.5%
Comprehensive Diabetes Care– Eye (Retinal) Exams	48.9%	46.4%	48.6%	55.9%	57.5%	52.6%	41.4%	43.2%	54.6%	43.9%	47.4%	43.1%	51.5%	53.1%	54.5%

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Comprehensive Diabetes Care– Lipid Profile LDL-C Screening	83.2%	83.4%	82.3%	74.3%	76.9%	76.3%	67.2%	75.3%	73.9%	73.5%	72.4%	70.8%	75.4%	72.2%	75.6%
Comprehensive Diabetes Care– LDL-C Control (<100 mg /dL)	38.4%	42.7%	40.9%	38.8%	42.3%	39.1%	30.8%	29.2%	36.2%	37.6%	32.1%	29.9%	52.6%	50.6%	53.6%
Comprehensive Diabetes Care– Medical Attention to Nephropathy	77.6%	79.1%	80.5%	81.6%	79.8%	77.1%	74.7%	77.0%	77.0%	79.8%	79.2%	79.3%	75.7%	73.9%	76.3%
Comprehensive Diabetes Care– Blood Pressure Control (<130/80mm Hg)	26.5%	36.7%	Measure Retired	35.4%	34.7%	Measure Retired	55.5%	28.6%	Measure Retired	25.9%	25.3%	Measure Retired	30.5%	31.8%	Measure Retired
Comprehensive Diabetes Care– Blood Pressure Control (<140/80mm Hg)	^	41.1%	37.4%	^	37.9%	36.3%	^	37.1%	36.2%	^	26.8%	32.3%	^	37.1%	41.3%
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	68.2%	65.0%	53.0%	66.4%	59.9%	56.0%	53.6%	61.8%	57.5%	53.3%	46.6%	50.8%	64.1%	58.8%	62.0%

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Follow-Up After Hospitalization for Mental Illness– 7 Days	16.3%	31.2%	24.0%	36.2%	43.8%	55.4%	43.7%	49.4%	46.5%	61.6%	58.1%	57.7%	31.0%	32.7%	38.6%
Follow-Up After Hospitalization for Mental Illness– 30 Days	40.7%	55.8%	47.3%	62.5%	74.9%	87.3%	60.4%	70.7%	67.0%	78.2%	74.8%	76.8%	56.9%	56.1%	62.4%
Lead Screening in Children	60.4%	69.0%	68.9%	50.0%	56.3%	59.7%	57.6%	63.7%	67.8%	59.1%	64.3%	67.9%	55.7%	66.7%	71.5%
Use of Appropriate Medications– Asthma Age 5-11[◉]	95.9%	96.0%	91.5%	86.1%	89.4%	90.2%	93.0%	94.3%	88.8%	91.3%	94.1%	91.8%	92.9%	91.3%	90.8%
Use of Appropriate Medications– Asthma Age 12-50- [◉]	87.2%	91.3%	NR	78.5%	79.9%	NR	85.8%	85.8%	NR	86.6%	89.2%	NR	87.5%	85.7%	NR

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Use of Appropriate Medications–Asthma Age 12-18	^	^	87.3%	^	^	87.7%	^	^	92.0%	^	^	89.0%	^	^	86.1%
Use of Appropriate Medications–Asthma Age 19-50	^	^	67.5%	^	^	65.5%	^	^	54.1%	^	^	79.6%	^	^	68.5%
Use of Appropriate Medications–Asthma Age 51-64	^	^	NA	^	^	95.2%	^	^	73.2%	^	^	NA	^	^	73.8%
Use of Appropriate Medications–Asthma Total (Combined Ages) ◉	92.3%	94.3%	88.0%	82.6%	85.3%	85.5%	89.6%	90.1%	87.4%	88.9%	91.7%	88.3%	90.0%	88.4%	84.8%
Prenatal and Postpartum Care–Timeliness of Prenatal Care	86.6%	79.4%	87.6%	87.3%	88.5%	91.4%	88.7%	87.4%	87.8%	79.8%	75.1%	75.1%	89.5%	85.6%	84.4%
Prenatal and Postpartum Care–Postpartum Care	63.9%	64.0%	569 %	65.5%	70.0%	70.0%	67.3%	70.6%	67.4%	64.3%	62.3%	62.3%	70.3%	71.5%	66.7%
Adolescent Well-Care Visit	47.2%	47.1%	49.1%	40.7%	40.5%	44.2%	46.8%	49.1%	48.6%	40.8%	45.3%	47.2%	46.7%	42.1%	44.3%

Measure	AMG HEDIS 2010 (CY 2009)	AMG HEDIS 2011 (CY 2010)	AMG HEDIS 2012 (CY 2011)	Anthem HMOs HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2011 (CY 2010)	Anthem HMOs HEDIS 2012 (CY 2011)	CareNet/ SHS HEDIS 2010 (CY 2009)	CareNet/ SHS HEDIS 2011 (CY 2010)	CareNet/ SHS HEDIS 2012 (CY 2011)	OFC HEDIS 2010 (CY 2009)	OFC HEDIS 2011 (CY 2010)	OFC HEDIS 2012 (CY 2011)	VPHP HEDIS 2010 (CY 2009)	VPHP HEDIS 2011 (CY 2010)	VPHP HEDIS 2012 (CY 2011)
Well-Child Visits in the First 15 Months of Life Six or more visits	64.1%	60.4%	70.4%	66.0%	62.8%	66.2%	48.9%	58.3%	61.8%	70.4%	66.0%	71.8%	76.6%	84.7%	78.1%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	77.2%	80.7%	79.2%	71.2%	73.6%	73.9%	65.3%	72.2%	74.1%	70.8%	76.3%	73.2%	71.3%	76.4%	70.8%

□ Comparative rates for Virginia MCOs and HEDIS 2012-Quality Compass Medicaid All Lines of Business can be found on Table 1
NA The denominator was too small to report a valid rate
NR The measure was calculated but the rate was materially biased, *or* the rate was not chosen to be reported
⊙ CY2009 Age parameters have changed from previous years
^ Measure not collected
*For rotated measures the actual MCO rates reported to DMAS may differ from rates reported in Quality Compass

Table A1-2 MCO CAHPS® (CY 2009 – CY 2011)□*

Measure	AMG CAHPS 2010 (CY 2009)	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2010 (CY 2009)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	CareNet/ SHS CAHPS 2010 (CY 2009)	CareNet/ SHS CAHPS 2011 (CY 2010)	CareNet/ SHS CAHPS 2012 (CY 2011)	OFC CAHPS 2010 (CY 2009)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	VPHP CAHPS 2010 (CY 2009)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)
CAHPS- Adult Population															
Rating of Health Plan Overall	64.6%	67.9%	68.8%	76.3%	82.4%	79.0%	78.7%	78.6%	77.1%	80.4%	80.4%	83.6%	74.0%	79.4%	74.9%
Rating of Health Care Overall	63.1%	64.1%	67.6%	67.8%	75.0%	73.5%	69.5%	74.8%	72.1%	72.7%	74.9%	74.4%	64.2%	74.0%	70.8%
Rating of Personal Doctor Overall	70.3%	75.8%	79.2%	76.6%	76.9%	79.8%	73.6%	76.0%	76.1%	80.9%	81.9%	79.7%	73.9%	81.6%	77.3%
Rating of Specialist Overall	76.6%	76.2%	78.5%	85.0%	83.3%	80.3%	73.9%	80.6%	80.3%	81.6%	83.6%	79.6%	74.9%	71.5%	80.0%
Customer Service Composite	77.3%	81.0%	81.4%	86.4%	86.6%	NA	88.3%	86.8%	86.5%	NA	76.7%	83.6%	79.7%	84.8%	78.3%
Getting Needed Care Composite	69.1%	68.6%	69.0%	80.5%	84.5%	86.5%	78.8%	78.1%	79.5%	78.7%	82.9%	82.2%	76.5%	79.7%	82.5%
Getting Care Quickly Composite	69.8%	78.2%	77.0%	82.9%	82.9%	85.5%	83.3%	80.2%	80.8%	81.8%	81.2%	79.6%	83.5%	82.3%	82.1%
How Well Doctors Communicate Composite	81.5%	86.6%	85.7%	87.9%	89.6%	92.2%	84.5%	90.0%	89.5%	89.6%	90.1%	89.8%	86.9%	88.3%	87.8%
Shared Decision Making Composite	59.4%	54.5%	56.3%	63.0%	59.6%	64.6%	65.0%	60.6%	62.6%	66.7%	62.6%	64.6%	62.7%	61.9%	62.1%

Measure	AMG CAHPS 2010 (CY 2009)	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2010 (CY 2009)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	CareNet/ SHS CAHPS 2010 (CY 2009)	CareNet/ SHS CAHPS 2011 (CY 2010)	CareNet/ SHS CAHPS 2012 (CY 2011)	OFC CAHPS 2010 (CY 2009)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	VPHP CAHPS 2010 (CY 2009)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)
Advised to Quit Smoking by a Doctor or Other Health Provider	73.6%	79.8%	85.9%	73.3%	75.7%	79.4%	69.9%	76.1%	82.5%	70.0%	70.2%	69.9%	76.8%	79.1%	80.3%
CAHPS- Child General Population															
Rating of Health Plan Overall	84.6%	87.9%	84.6%	86.8%	88.8%	89.0%	84.1%	84.3%	86.6%	85.9%	86.0%	88.6%	82.7%	85.2%	84.2%
Rating of Health Care Overall	80.3%	84.8%	80.3%	79.4%	83.0%	82.5%	82.5%	79.8%	86.2%	85.8%	83.0%	83.7%	83.1%	79.9%	85.7%
Rating of Personal Doctor Overall	80.0%	86.1%	81.9%	82.4%	84.2%	85.3%	83.1%	87.6%	88.7%	89.0%	86.6%	88.3%	89.7%	86.8%	87.8%
Rating of Specialist Overall	NA	NA	74.6%	NA	NA	NA	84.4%	77.3%	78.9%	82.2%	80.0%	83.0%	86.1%	79.5%	88.0%
Customer Service Composite	NA	76.0%	80.3%	NA	NA	NA	87.9%	85.8%	85.0%	86.4%	80.7%	88.6%	80.5%	82.4%	84.6%
Getting Needed Care Composite	NA	65.5%	68.1%	NA	NA	NA	78.9%	80.9%	83.6%	85.8%	80.2%	86.1%	83.1%	81.3%	88.9%
Getting Care Quickly Composite	69.5%	72.6%	76.2%	84.6%	85.4%	84.5%	89.4%	87.4%	85.9%	89.2%	87.3%	92.2%	89.8%	90.7%	91.4%
How Well Doctors Communicate Composite	85.1%	86.2%	84.2%	91.3%	91.6%	89.8%	91.0%	91.9%	94.3%	92.4%	93.2%	92.5%	93.6%	92.2%	93.1%

Measure	AMG CAHPS 2010 (CY 2009)	AMG CAHPS 2011 (CY 2010)	AMG CAHPS 2012 (CY 2011)	Anthem HMOs CAHPS 2010 (CY 2009)	Anthem HMOs CAHPS 2011 (CY 2010)	Anthem HMOs CAHPS 2012 (CY 2011)	CareNet/ SHS CAHPS 2010 (CY 2009)	CareNet/ SHS CAHPS 2011 (CY 2010)	CareNet/ SHS CAHPS 2012 (CY 2011)	OFC CAHPS 2010 (CY 2009)	OFC CAHPS 2011 (CY 2010)	OFC CAHPS 2012 (CY 2011)	VPHP CAHPS 2010 (CY 2009)	VPHP CAHPS 2011 (CY 2010)	VPHP CAHPS 2012 (CY 2011)
Shared Decision Making Composite	NA	64.8%	58.7%	63.4%	64.6%	NA	72.2%	65.9%	72.6%	70.0%	61.8%	69.2%	66.6%	66.5%	70.5%

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

Additional Information for CAHPS Measures in Table 2

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

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

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

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

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