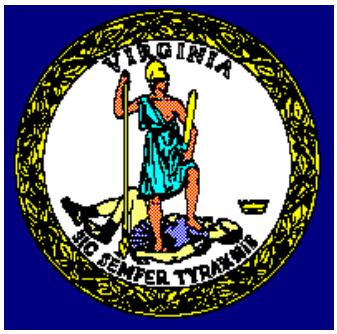


Commonwealth of Virginia
Department of Medical Assistance Services

2018 External Quality Review Technical Report Medallion 3.0

January 1, 2018–December 31, 2018

April 2019

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Virginia Department of Medical Assistance Services (DMAS) is the single State agency that administers the Medicaid managed care program in the Commonwealth of Virginia (Virginia). From July 1, 2015, to July 31, 2018, DMAS contracted with six managed care organizations (MCOs) to deliver Medallion 3.0 services. As of November 2018, the Medallion 3.0 MCOs covered approximately 113,000 members, including children in low income families; aged, blind, or disabled individuals; pregnant women; certain caretaker parents in Virginia; and waiver recipients of acute care. Medallion 3.0 contracted MCOs included Aetna Better Health of Virginia (Aetna), Anthem HealthKeepers Plus (Anthem), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier).

During 2017, DMAS conducted a procurement for its Medallion 4.0 program, replacing Medallion 3.0 in 2018. DMAS awarded Medallion 4.0 contracts to six MCOs for the provision of Medicaid- and Family Access to Medical Insurance Security (FAMIS)-covered services statewide through six regions in Virginia: Central Virginia, Charlottesville/Western, Northern/Winchester, Roanoke/Alleghany, Southwest, and Tidewater. DMAS implemented the Medallion 4.0 program over a four-month period that began August 1, 2018 (Table 1-1). The Medallion 4.0 contracted MCOs included Aetna Better Health of Virginia (Aetna), Anthem HealthKeepers Plus (Anthem), Magellan Complete Care of Virginia (Magellan), Optima Family Care (Optima), UnitedHealthcare of the Mid-Atlantic (United), and Virginia Premier Health Plan, Inc. (VA Premier). The transition to Medallion 4.0 was completed in December 2018.

Table 1-1—Medallion 4.0 Regional Effective Dates

Medallion 4.0 Managed Care Regional Effective Dates	
Region	**Effective Dates**
Tidewater	August 1, 2018
Central	September 1, 2018
Northern/Winchester	October 1, 2018
Charlottesville/Western	November 1, 2018
Roanoke/Alleghany	December 1, 2018
Southwest	December 1, 2018

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires that states which operate Medicaid managed care plans "provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract." Federal external quality review

(EQR) requirements have been further specified in 42 Code of Federal Regulations (CFR) §438.358 and §438.364.

DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct EQR activities and to produce this technical report covering review activities completed during the period of January 1, 2018, through December 31, 2018.

Scope of EQR Activities

HSAG used the results of the mandatory and optional EQR activities, as described in 42 CFR §438.358, to determine the quality outcomes, timeliness of, and access to covered care and services. The purpose of these activities, in general, is to provide valid and reliable data and information about the MCOs' performance. For the 2018 EQR Technical Report, HSAG used findings from the following EQR activities conducted from January 1, 2018, through December 31, 2018, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services (QAT) provided by each MCO. The assignment of QAT domains for the activities and performance measures are listed in Table 1-5 and Table 1-6.

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

Optional EQR Activities: annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®),[1-1] calculation of performance measures, focused studies on Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief.

Definitions

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

Quality

The Centers for Medicare & Medicaid Services (CMS) defines "quality" in the 2016 final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services

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

consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-2]

Access

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

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-4] NCQA adds additional clarity by further stating that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing authorization requests, grievances, and appeals; and providing timely care. In the final 2016 federal managed care regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206 (a) and by, at 42 CFR §438.68 (b), requiring states to develop both time and distance standards for network adequacy. Table 1-2 shows the enrollment by population for each MCO.

Table 1-2—MCO Profiles and Enrollment as of November 2018

MCO	Year Operations Began as MCO in Virginia	Product Lines in Virginia	Medallion 4.0 Approximate Enrollment
Anthem	1996	Medicaid, Commonwealth Coordinated Care (CCC) and CCC Plus, Medicare, Commercial	239,044
Aetna, formerly CoventryCares of Virginia	1996 (CoventryCares) April 1, 2016 (Aetna)	Medicaid, CCC Plus, Commercial	47,673

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

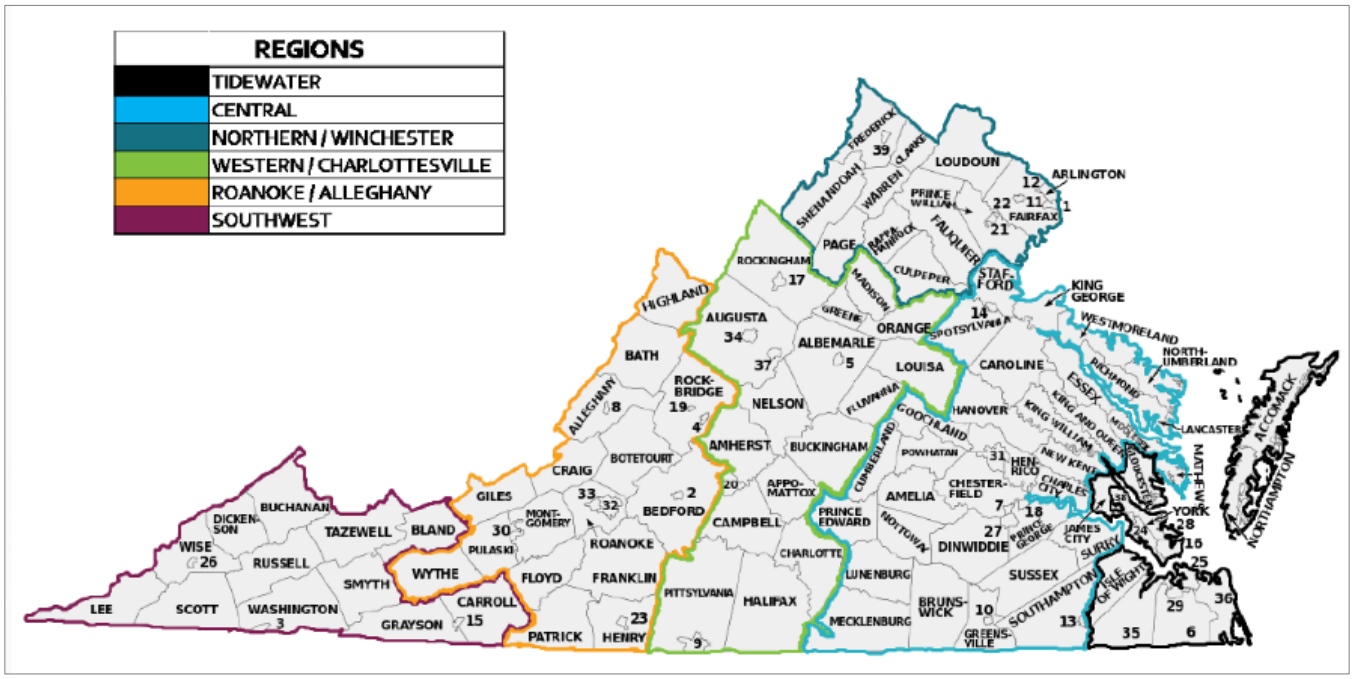
MCO	Year Operations Began as MCO in Virginia	Product Lines in Virginia	Medallion 4.0 Approximate Enrollment
INTotal* Acquired by UnitedHealthcare of Mid-Atlantic, Inc. on November 1, 2017.	2013	Medicaid, CCC Plus	0
Kaiser Permanente*	2013	Medicaid, Medicare, Commercial	0
Magellan	2018	Medicaid, CCC Plus, Medicare, Commercial	23,016
Optima	1995	Medicaid, CCC Plus, Medicare, Commercial	152,504
UnitedHealthcare of the Mid-Atlantic, Inc.	2018	Medicaid, CCC Plus, Medicare, Commercial	58,292
VA Premier	1995	Medicaid, CCC, CCC Plus, Medicare, Commercial	121,358

**Medallion 3.0 MCOs that were not awarded a Medallion 4.0 contract.*

As of November 2018, the six Medallion 4.0 MCOs served more than 640,000 individuals in the Medicaid and FAMIS managed care programs.

Figure 1-1 displays a map of the managed care regions for the Medallion 4.0 population.

Figure 1-1—Medallion 4.0 Managed Care Regional Map



Accreditation

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

Refer to Table 1-3 for the accreditation levels of the contracted Medallion 3.0 MCOs through July 31, 2018. Refer to Table 1-4 for the accreditation levels of the contracted Medallion 4.0 MCOs beginning August 1, 2018.

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

Table 1-3—MCO NCQA Accreditation Levels (MCOs Effective Through July 31, 2018)

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

Table 1-4—MCO NCQA Accreditation Levels (MCOs Effective August 1, 2018)

MCO	Accreditation Level
Aetna	Accredited
Anthem	Commendable
Magellan	In process
Optima	Commendable
United	In process
VA Premier	Accredited

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality and timeliness of, and access to, care provided by the MCOs, HSAG assigned each of the EQRO activities reviewed by the EQR to one or more of three domains. Assignment to these domains is depicted in Table 1-5.

Table 1-5—EQR and DMAS Activities and Domains

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

Aggregating and Analyzing Statewide Data

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

Overview of Findings and Conclusions

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

Table 1-6 shows HSAG's assignment of the performance measures to the areas of quality, timeliness, and access.

Table 1-6—Assignment of Performance Measures to the Quality, Access, and Timeliness to Care Domains

Performance Measure	Quality	Access	Timeliness
Children's Preventive Care			
Adolescent Well-Care Visits	✓		
Childhood Immunization Status—Combination 3	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*		✓	

Performance Measure	Quality	Access	Timeliness
Care for Chronic Conditions			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 75%—Total	✓		
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*	✓		
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	✓		
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		

Table 1-7 displays the HEDIS 2017 and HEDIS 2018 Virginia aggregate rates for the DMAS priority measures in the Medallion 3.0 contract. These aggregate rates represent the average of all six MCOs' measure rates weighted by the eligible population. HEDIS 2017 and HEDIS 2018 rates were also compared to the corresponding NCQA's Quality Compass®,[1-6] national Medicaid health maintenance organization (HMO) 50th percentile. Yellow-shaded boxes indicate that the Virginia aggregate was at or above the national Medicaid 50th percentile.

Table 1-7—Virginia Aggregate HEDIS 2017 and HEDIS 2018 Measure Results

Performance Measures	Virginia Aggregate HEDIS 2017	Virginia Aggregate HEDIS 2018
Children's Preventive Care		
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	51.53%	54.10%
Childhood Immunization Status		

[1-6] Quality Compass® is a registered trademark of NCQA.

Performance Measures	Virginia Aggregate HEDIS 2017	Virginia Aggregate HEDIS 2018
Combination 3	72.17%	71.18%
Well-Child Visits in the First 15 Months of Life		
Six or More Well-Child Visits	64.53%	65.55%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.47%	77.81%
Women's Health		
Breast Cancer Screening[1]		
Breast Cancer Screening	—	52.14%
Cervical Cancer Screening		
Cervical Cancer Screening	60.48%	63.31%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	84.72%	83.39%
Postpartum Care	63.95%	62.04%
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services		
Total	86.74%	85.13%
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	98.12%	96.95%
25 Months–6 Years	92.47%	91.82%
7–11 Years	93.83%	93.70%
12–19 Years	91.58%	91.61%
Care for Chronic Conditions		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	86.51%	85.82%
HbA1c Control (<8.0%)	48.36%	50.63%
Eye Exam (Retinal) Performed	50.33%	50.74%
Medical Attention for Nephropathy	90.65%	90.87%
Blood Pressure Control (<140/90 mm Hg)	56.25%	59.34%
Controlling High Blood Pressure		
Controlling High Blood Pressure	57.81%	58.73%
Medication Management for People With Asthma		
Medication Compliance 75%—Total	33.95%	35.81%
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit	82.27%	82.55%
Discussing Cessation Medications	51.62%	51.91%

Performance Measures	Virginia Aggregate HEDIS 2017	Virginia Aggregate HEDIS 2018
Discussing Cessation Strategies	41.72%	41.91%
Behavioral Health‡		
***Antidepressant Medication Management*[2]**		
Effective Acute Phase Treatment	50.36%	53.48%
Effective Continuation Phase Treatment	35.11%	37.90%
***Follow-Up Care for Children Prescribed ADHD Medication*[2]**		
Initiation Phase	46.53%	47.63%
Continuation and Maintenance Phase	61.15%	61.15%
***Follow-Up After Hospitalization for Mental Illness*[1]**		
30-Day Follow-Up	—	61.11%
***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*[2]**		
Total	58.86%	61.27%

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

Review of the Virginia aggregate for HEDIS 2017 and HEDIS 2018 reflected continued strength across the areas of **quality**, **access**, and **timeliness**. Overall, 19 of 27 measure rates (approximately 70 percent) for HEDIS 2018 ranked at or above the national Medicaid 50th percentiles. The *Antidepressant Medication Management* measure rates increased from below the national Medicaid 50th percentiles for HEDIS 2017 to at or above the national Medicaid 50th percentiles for HEDIS 2018, indicating improved performance compared to national trends. Conversely, four measure rates moved from above the national Medicaid 50th percentiles for HEDIS 2017 to below the national Medicaid 50th percentiles for HEDIS 2018.

Within the **quality** domain, 14 of 22 measure rates (approximately 64 percent) performed at or above the national Medicaid 50th percentiles. Despite slight increases in performance, four measure rates (approximately 18 percent) in the **quality** domain continued to fall below the national Medicaid 50th percentiles, indicating opportunities for improvement for the MCOs. Performance in this domain was relatively consistent from HEDIS 2017 to HEDIS 2018, with no measure rates changing by more than 5 percentage points.

For the **access** domain, seven of nine measure rates (approximately 78 percent) ranked at or above the national Medicaid 50th percentiles. Measure rates for *Prenatal and Postpartum Care* demonstrated slight declines in performance, now falling below the national Medicaid 50th percentiles.

For **timeliness**, two of four measure rates (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*) ranked at or above the national Medicaid 50th percentiles for HEDIS 2018. As noted previously, the *Prenatal and Postpartum Care* measure rates demonstrated a slight decline in performance, to now fall below the national Medicaid 50th percentiles.

Consumer Survey of Quality of Care

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

HSAG conducted the FAMIS CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. These CAHPS surveys were conducted in accordance with the Children's Health Insurance Program Reauthorization Act (CHIPRA) reporting requirements, which included a statewide sample of FAMIS members representative of the entire population of children covered by Virginia's Title XXI program (Children's Health Insurance Program [CHIP] members in FFS or managed care).

Statewide MCO Statewide Aggregate Results

The Medallion 3.0 contract requires the MCOs to conduct the Child and Adult CAHPS surveys annually and provide the detailed and composite scores to DMAS. For the Medallion 3.0 MCOs (Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs. The mode of CAHPS survey data collection varied slightly among the MCOs. Table 1-8 presents the 2017 and 2018 statewide aggregate adult and child Medicaid CAHPS top-box scores (i.e., the percentages of top-level responses) for the global ratings. The statewide

aggregate adult and child Medicaid CAHPS scores were compared to the 2017 and 2018 NCQA national adult Medicaid and child Medicaid averages, respectively.[1-7,1-8]

Table 1-8—Comparison of 2017 and 2018 Adult and Child Medicaid CAHPS Results: Global Ratings

	Statewide Aggregate			
	Adult Medicaid		Child Medicaid	
Global Ratings	**2017**	**2018**	**2017**	**2018**
Rating of Health Plan	64.1%	62.1%	73.7%	74.0%
Rating of All Health Care	57.3%	56.2%	69.0%	70.3%
Rating of Personal Doctor	69.0%	69.1%	76.0%	77.1%
Rating of Specialist Seen Most Often	67.2%	65.2%	74.9%	73.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Table 1-9 presents the 2017 and 2018 statewide aggregate adult and child Medicaid CAHPS top-box scores (e.g., the percentage of top-level responses) for the composite measures. The statewide aggregate adult and child Medicaid CAHPS scores were compared to the 2017 and 2018 NCQA national adult Medicaid and child Medicaid averages, respectively.

Table 1-9—Comparison of 2017 and 2018 Adult and Child Medicaid CAHPS Results: Composite Measures

	Statewide Aggregate			
	Adult Medicaid		Child Medicaid	
Composite Measures	**2017**	**2018**	**2017**	**2018**
Getting Needed Care	84.1%	84.3%	86.2%	85.9%
Getting Care Quickly	83.6%	83.4%	92.1%	88.8%
How Well Doctors Communicate	90.5%	92.1%	94.8%	94.1%
Customer Service	87.7%	86.5%	88.8%	84.9%

[1-7] Statewide aggregate scores were derived by calculating a mean of the combined scores of the six MCOs (i.e., average of the MCOs' top-box rates combined).

[1-8] For the NCQA national adult and child Medicaid averages, the source for data contained in this publication is Quality Compass® 2017 and 2018 data and is used with by permission of the NCQA. Quality Compass 2017 and 2018 include certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

	Statewide Aggregate			
	Adult Medicaid		Child Medicaid	
Composite Measures	**2017**	**2018**	**2017**	**2018**
Shared Decision Making	79.2%	78.5%	78.1%	79.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in *yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.*
Cells highlighted in *red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.*

FAMIS Program Statewide Aggregate Results

The FAMIS 2018 CAHPS results were also compared to the 2017 results and rates that were statistically significantly higher or lower than the corresponding NCQA national Medicaid averages where highlighted. Table 1-10 presents the 2017 and 2018 FAMIS Medicaid Program CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings. The FAMIS Medicaid Program general child and children with chronic conditions (CCC) CAHPS scores were compared to the 2017 and 2018 NCQA national child Medicaid and CCC Medicaid averages, respectively.[1-9]

Table 1-10—Comparison of 2017 and 2018 FAMIS Program General Child and CCC Results: Global Ratings

	Program Statewide Aggregate			
	General Child		CCC	
Global Ratings	**2017**	**2018**	**2017**	**2018**
Rating of Health Plan	70.5%	70.9%	68.6%	69.6%
Rating of All Health Care	69.8%	70.8%	67.8%	67.2%
Rating of Personal Doctor	75.2%	78.1%	76.3%	74.4%
Rating of Specialist Seen Most Often	77.1%+	83.3%+	71.7%	74.8%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Table 1-11 presents the 2017 and 2018 FAMIS Medicaid Program CAHPS top-box scores (the percentage of top-level responses) for the composite measures. The FAMIS Medicaid Program general

[1-9] For the NCQA national child and CCC Medicaid averages, the source for data contained in this publication is Quality Compass® 2017 and 2018 data and is used with permission of NCQA. Quality Compass 2017 and 2018 include certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

child and CCC CAHPS scores were compared to the 2017 and 2018 NCQA national child Medicaid and CCC Medicaid averages, respectively.

Table 1-11—Comparison of 2017 and 2018 FAMIS Program General Child and CCC Results: Composite Measures

	Program Statewide Aggregate			
	General Child		CCC	
Composite Measures	**2017**	**2018**	**2017**	**2018**
Getting Needed Care	84.7%	87.2%	85.3%	87.2%
Getting Care Quickly	91.1%	89.6%	92.4%	91.7%
How Well Doctors Communicate	95.0%	94.3%	97.2%	94.6%
Customer Service	76.3%+	83.9%+	88.3%+	89.1%+
Shared Decision Making	81.1%+	80.0%+	83.0%	82.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Performance Improvement Project (PIP) Validation

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

In 2015, DMAS engaged in a more proactive and outcomes-oriented approach for having MCOs conduct PIPs that HSAG developed based on the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement.[1-10] This approach places greater emphasis on improving outcomes using rapid-cycle improvement methods to pilot small changes. Working with CMS, HSAG aligned the rapid-cycle PIP process with the current CMS protocols for conducting and validating PIPs. For the rapid-cycle PIP framework, HSAG developed five modules with an accompanying companion guide. The modules are as follows:

- Module 1—PIP Initiation: Module 1 outlines the framework for the project and includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART [specific, measurable, attainable, relevant, and time-bound]), and completing a key driver diagram.

[1-10] Langley GL, Moen R, Nolan KM, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Jan 26, 2018.

- Module 2—SMART Aim Data Collection: In Module 2, the SMART Aim measure is outlined and the data collection methodology is described. The SMART Aim data are displayed using a run chart.
- Module 3—Intervention Determination: In Module 3, quality improvement activities which may impact the SMART Aim are identified. Using process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, MCOs select interventions to test in Module 4.
- Module 4—Plan-Do-Study-Act (PDSA): Interventions identified in Module 3 are tested and evaluated through PDSA cycles.
- Module 5—PIP Conclusions: Module 5 summarizes key findings, outcomes achieved, and lessons learned.

DMAS implemented the rapid-cycle PIP process with MCOs effective July 1, 2016. Each MCO conducted one PIP related to a priority HEDIS measure for comprehensive diabetes care. Each MCO reviewed its data to determine a specific focus of the PIP. The projects concluded December 31, 2017; and MCOs submitted Module 4 and Module 5 for validation in February 2018. HSAG's PIP Validation Methodology is included as Appendix D.

Performance Measure Validation (PMV)

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

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

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

HSAG's PMV activities included two separate HEDIS measures, *Breast Cancer Screening* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*, to evaluate further the accuracy of reported performance measure rates. HSAG also conducted PMV on two State measures, *Foster Care Assessments* and *MCO Claims Processing*, key elements in the Performance Incentive Award initiative further detailed later this report.

HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate) for assistance with the performance measure validation. Using the validation methodology and protocols described in Appendix C, HSAG determined results for each performance measure. The CMS PMV protocol identifies two

possible validation finding designations for performance measures: Report (R)—Measure data were compliant with HEDIS and DMAS specifications and the data, as reported, were valid. Not Reported (NR)—Measure data were materially biased. HSAG's findings for each MCO's measure designation are summarized in Table 1-12.

Table 1-12—MCO Measure Designation

	Performance Measure	Aetna	Anthem	UHC/ INTotal	Kaiser Permanente	Optima	VA Premier
1.	*Foster Care Assessments (Performance Incentive Award [PIA] Measure)*	R	R	R	NR	R	R
2.	*MCO Claims Processing (PIA Measure)*	R	R	R	R	R	R
3.	*Breast Cancer Screening (BCS) (HEDIS 2018)*	R	R	R	R	R	R
4.	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) (HEDIS 2018)*	R	R	R	R	R	R

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

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

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

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

Medallion 4.0 Readiness Reviews

During 2018 DMAS and HSAG conducted Medallion 4.0 readiness reviews of the six managed care plans. The purpose of the Medallion 4.0 readiness review was to assess that the contracted managed care organizations of Virginia had ability and capacity to perform the Medicaid managed care functions described in the Medallion 4.0 Medicaid/FAMIS managed care request for proposal 2017-03. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[1-11] to conduct the readiness reviews. During the Medallion 4.0 readiness review process, HSAG reviewed the following standards and scored the MCOs as follows (Table 1-13).

Table 1-13—Medallion 4.0 Readiness Review Statewide Aggregate Results

Standard Number	Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier	Total Statewide Aggregate Score
I	Continuity and Coordination of Care	**100%**	**94.4%**	**97.2%**	**100%**	**86.1%**	**88.9%**	**94.4%**
II	Behavioral Health Services and Substance Abuse Treatment Services	**100%**	**100%**	**96.9%**	**100%**	**96.9%**	**93.8%**	**97.9%**
III	Coverage and Authorization of Services	**100%**	**100%**	**98.4%**	**98.4%**	**95.3%**	**90.6%**	**97.1%**
IV	Credentialing and Recredentialing	**100%**	**95.8%**	**100%**	**95.8%**	**100%**	**100%**	**98.6%**
V	Enrollment and Disenrollment	**100%**	**100%**	**100%**	**100%**	**95.0%**	**85%**	**96.7%**
VI	Grievances and Appeals	**100%**	**97.4%**	**92.1%**	**100%**	**94.7%**	**100%**	**97.4%**
VII	Provider Engagement, Contracting, Subcontracts, and Delegation	**100%**	**95.5%**	**96.2%**	**100%**	**81.8%**	**72.7%**	**91.2%**
VIII	Provider Participation	**75.0%**	**100%**	**100%**	**100%**	**75.0%**	**50.0%**	**83.3%**

[1-11] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 16, 2019.

Standard Number	Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier	Total Statewide Aggregate Score
IX	Health Information Systems	**93.8%**	**100%**	**87.5%**	**93.8%**	**100%**	**81.3%**	**92.7%**
X	Quality Assessment and Performance Improvement Program	**100%**	**100%**	**96.2%**	**100%**	**92.3%**	**86.4%**	**95.7%**
	Total Score	**98.9%**	**98.2%**	**96.6%**	**98.9%**	**93.0%**	**89.0%**	**95.8%**

Total Score: *Complete* elements are assigned one point each. *Progress Sufficient to Meet Operations* elements are assigned 0.5 points each. *Not Met* elements are assigned zero points each. Elements marked *Not Applicable* are not counted in the total applicable elements for each standard. The total statewide aggregate score is calculated by dividing the total score by the total applicable elements. Totals are rounded to the nearest tenth of a percent.

MCOs not achieving a "Met" for any element within a standard were required to submit corrective action plans to bring them into compliance with federal and State-specific contract requirements. HSAG reviewed the MCO corrective action plans using the following criteria to evaluate sufficiency of the corrective action plans.

- Completeness of the corrective action plan in addressing each required action and assigning a responsible individual, a timeline and completion date, and specific future actions and interventions.
- Degree to which the planned activities and interventions meet the intent of the requirement.
- Appropriateness of the timeline for correcting the deficiency.

The MCOs were approved for Medallion 4.0 implementation once their corrective action plans were approved and implemented and no apparent operational, administrative, service delivery, or systems-related deficiencies existed that could impede ability and capacity to satisfactorily perform the managed care responsibilities outlined in the Medallion 4.0 contract.

Medicaid Expansion Readiness Reviews

During 2018, DMAS and HSAG conducted Medicaid expansion readiness reviews of the six managed care plans for both the CCC Plus and the Medallion 4.0 programs. The purpose of the Medicaid expansion readiness review was to assess that the contracted MCOs of Virginia had ability and capacity to perform the Medicaid managed care functions for both their current Medicaid membership and the Medicaid expansion anticipated enrollment in order to implement the program on January 1, 2019. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September

2012[1-12] to conduct the readiness reviews. During the Medallion 4.0 readiness review process, in addition to reviewing the organizational structure, staffing, and network adequacy requirements, HSAG reviewed the following standards (Table 1-14).

Table 1-14—Medicaid Expansion Readiness Review Statewide Aggregate Results

Standard Number	Medicaid Expansion Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier	Total Statewide Aggregate Score
I	Availability of Services	**83.3%**	**83.3%**	**84.6%**	**83.3%**	**83.3%**	**83.3%**	**83.6%**
II	Assurances of Adequate Capacity and Services	**85.7%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**
III	Coverage and Authorization of Services	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
IV	Provider Selection	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
V	Member Rights and Protections	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VI	Health Information Systems	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VII	Enrollment and Disenrollment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VIII	Member Information	**100%**	**95.0%**	**100%**	**100%**	**100%**	**100%**	**99.2%**
	Total Score	**93.6%**	**91.7%**	**93.9%**	**93.6%**	**93.6%**	**93.6%**	**93.3%**

Total Score: *Complete* elements are assigned one point each. *Progress Sufficient to Meet Operations* elements are assigned 0.5 points each. *Not Met* elements are assigned zero points each. Elements marked *Not Applicable* are not counted in the total applicable elements for each standard. The total statewide aggregate score is calculated by dividing the total score by the total applicable elements. Totals are rounded to the nearest tenth of a percent.

The MCOs were approved for Medicaid expansion implementation when no operational, administrative, service delivery, or systems-related deficiencies were apparent that would impede ability and capacity to satisfactorily perform the managed care responsibilities outlined in the MCO's Medallion 4.0 contract, which included additional requirements for Medicaid expansion.

[1-12] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 16, 2019.

Addiction and Recovery Treatment Services

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an evaluation of the Addiction and Recovery Treatment Services (ARTS) program. Following are the major finding statements from a report published by the VCU evaluation team about changes in access to and utilization of addiction treatment services during the first year of ARTS.

More Medicaid members with substance use disorders are receiving treatment.

Table 1-15 displays substance use disorder (SUD) data before and after implementation of the ARTS program. The percentage of Medicaid members with a substance use disorder who received any treatment increased from 24 percent before ARTS to 40 percent by the end of the first year of ARTS.

Table 1-15—SUD Treatment

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of members with a substance use disorder (SUD)	49,440	50,857	3%
Members with SUD receiving any SUD treatment	12,089	20,436	69%
Percentage of members receiving SUD treatment	24%	40%	64%

More Medicaid members with opioid use disorders are receiving treatment.

Table 1-16 displays opioid use disorder data before and after implementation of the ARTS program. The percentage of Medicaid members with an opioid use disorder who received any treatment increased from 46 percent before ARTS to 63 percent by the end of the first year of ARTS.

Table 1-16—OUD Treatment

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of members with opioid use disorder (OUD)	17,914	20,712	16%
Members with OUD receiving any OUD treatment	8,322	12,980	56%
Percentage receiving OUD treatment	46%	63%	35%

Fewer emergency department visits occurred related to opioid use disorders.

Table 1-17 displays emergency department (ED) data before and after implementation of the ARTS program. The number of ED visits related to opioid use disorders decreased by 25 percent during the first 10 months of ARTS. This compares with a 9 percent decrease in ED visits for all Medicaid members.

Table 1-17—ED Visits

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
ED visits related to opioid use disorder	5,016	3,756	-25%
Total ED visits for all Medicaid members	786,698	714,743	-9%

Fewer prescriptions written for opioid pain medications.

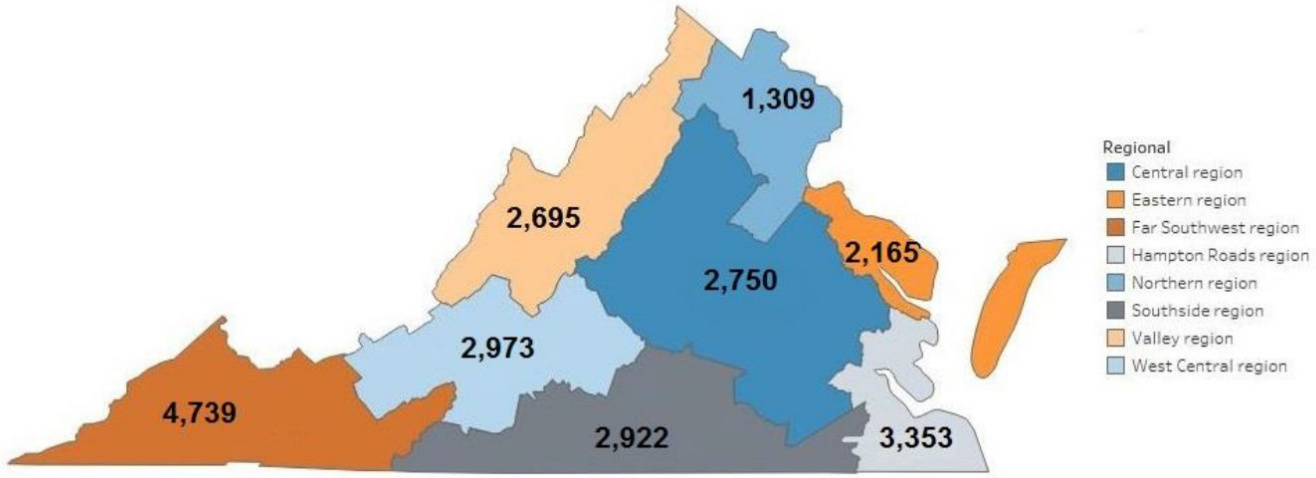
Table 1-18 displays number of prescriptions written for opioid pain medication data before and after implementation of the ARTS program. The number of prescriptions written for opioid pain medications among Medicaid members decreased by 27 percent by the end of the first year of ARTS.

Table 1-18—Number of Prescriptions Written for Opioid Pain Medication

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of prescriptions written for opioid pain medications	549,442	399,790	-27%
Number of prescriptions written for opioid pain medications per 10,000 members	3,811	2,761	-28%

Figure 1-2 displays the number of prescriptions written for opioid pain medications per 10,000 Medicaid members. The number of prescriptions for opioid pain medications per 10,000 Medicaid members varies widely across Virginia regions.

Figure 1-2—Number of Prescriptions for Opioid Pain Medication



Quality Initiatives

The Medallion 3.0 and the Medallion 4.0 contracts require each MCO to complete federal and state-mandated quality improvement activities such as participation in a quarterly quality collaborative, reporting of HEDIS and CAHPS data, participation in PIPs, participation in measurement validation activities, and participation in a performance incentive award program.[1-13] In addition, the Medallion Program Annual Report describes a range of activities and initiatives targeted at specific needs of member populations, as illustrated in Table 1-19.

Table 1-19—Medallion 3.0 Programs

Medallion 3.0 and 4.0 Populations	Foster Care	Health and Acute Care Program	Oral Health	Disease Case Management
Infants	✓		✓	✓
Children	✓	✓	✓	✓
Pregnant Women		✓	✓	✓
Adults	✓	✓		✓
Aged, Blind, and Disabled	✓	✓	✓	✓

Throughout 2018, DMAS enhanced its quality improvement initiatives through the development of:

[1-13] Connecting Care. 2017 Medallion 3.0 Annual Report. Available at: http://www.dmas.virginia.gov/files/links/792/2017%20Annual%20Technical%20Report.pdf. Accessed on: Jan 30, 2019.

- **Contract Award to Replace the Medicaid Management Information System (MMIS)**—On June 11, 2018, DMAS awarded the Medicaid Enterprise System Provider Services Solution contract to DXC Technology Services, LLC for the replacement of the MMIS system. DMAS also awarded a contract to Deloitte Consulting, LLP for the integration services solution of the MMIS system. A third contract was awarded to Accenture State Healthcare Services, LLC for the operations service solutions of the MMIS system.
- **Contract Award of MedEx Marketing Administrator—**On October 30, 2018, DMAS awarded a contract to J.R. Reingold & Associates for the MedEx Marketing Administrator Services. The purpose of the contract is a coordinated marketing effort supporting the goals of enrolling eligible residents of the Commonwealth of Virginia in Medicaid expansion. R.R. Reingold & Associates are responsible for evaluating the best channels of communicating to the public and for procuring media placements which may include television, radio, social media, digital media, mobile applications, public transportation/transit ads, or various forms of outdoor advertising.
- **Focus on Social Determinants of Health—**DMAS and the MCOs focused education, training, and interventions on social determinants of health (SDoH), which are the various conditions that communities experience in the places where members live, learn, work, and play; and which have an effect on health risks and outcomes. DMAS focused on five key areas including economic stability, health and health care, education, social and community contexts, and neighborhood and built environments.
- **Agencywide Quality Aims**—An overarching aspiration related to the Quality Strategy was to integrate the quality management (QM) program across DMAS by applying the same quality standards and adopting a common set of quality metrics. DMAS goals for superior care, cost effectiveness, and continuous improvement are supported through four publicly promoted quality aims:
  1. Build a wellness-focused, integrated system of care.
  2. Focus on screening and prevention.
  3. Achieve healthier pregnancies and healthier births.
  4. Improve well being across the lifespan.

DMAS contracted with HSAG to perform additional quality improvement activities related to calculation of performance metrics, designing quality rating systems, and conducting focused activities, including:

- Calculation of pediatric quality measure results (*Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [*APC*]).
- Production of a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results for the Medallion 4.0 program.
- Continuing of the Performance Incentive Award program to improve health outcomes for members in the FAMIS and Medallion 3.0 populations and to promote and incentivize MCOs' high performance on six measures representing two measurement domains (i.e., administrative and HEDIS).

- Conduct four focused studies—Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and two Dental Utilization in Pregnant Women Data Briefs.

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

Consumer Decision Support Tool

On November 8, 2018, CMS published the Medicaid and CHIP Managed Care Proposed Rule (CMS-2408-P) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid beneficiaries must adopt and implement a quality rating system (QRS). Although the final technical specifications for the QRS have not been released, Medicaid agencies with a QRS already in place will have an opportunity to use their current QRS to meet CMS requirements. CMS will require states preferring use of an alternative QRS to submit their methodologies, including the list of performance measures included in the QRS. DMAS contracted with HSAG in 2015 (which was a pilot year) to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS performance measure data and CAHPS survey results, which may meet the CMS requirement for a QRS. The tool was developed to help support DMAS' public reporting of MCO performance information to be used by consumers to make informed decisions about their health care. This is the fourth year, including the pilot year, that HSAG produced the Consumer Decision Support Tool using the MCOs' data.

HSAG combined and analyzed HEDIS 2018 performance measure data and CAHPS survey results for 2018 to assess MCOs' performance related to certain areas of interest to consumers and included the following five domains:

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

A summary score was calculated for each domain by MCO to determine MCO performance. The summary score for each MCO was then compared to the Medicaid MCO Virginia average to determine differences in MCO performance. Unlike in prior years, the 2018 Consumer Decision Support Tool used a five-level rating scale (i.e., prior years' tools used a three-level rating scale). The Consumer Decision Support Tool used stars to display results for the MCOs, as shown in Table 1-20.

Table 1-20—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was 1 standard deviation above the Virginia Medicaid average.
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was 1 standard deviation below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations below the Virginia Medicaid average.

Table 1-21 displays the 2018 Consumer Decision Support Tool results for each MCO. Please note, Kaiser Permanente was not included in the 2018 Consumer Decision Support Tool as Kaiser Permanente is no longer providing services to Medicaid members as of the end of calendar year (CY) 2018.

Table 1-21—2018 Consumer Decision Support Tool Results

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

**In the tool posted to DMAS' website and included in Appendix F, INTotal is referred to as UnitedHealthcare.*

The finalized 2018 tool includes an overview of the tool; description of reporting categories; MCO-specific results; MCO accreditation levels; and background information for consumers choosing a Medicaid MCO, including MCO contact details as shown in Appendix F.

The Consumer Decision Support Tool's inclusion of the MCO accreditation level emphasizes the standards of quality and integrity expected of contracted MCOs in Virginia. Virginia was among the first states to require that contracted MCOs achieve and maintain health plan accreditation by NCQA. Health plan accreditation involves a rigorous evaluation of the quality of health care and services provided along with an assessment of clinical and member satisfaction performance measures (HEDIS and

CAHPS). NCQA accreditation levels include Excellent, Commendable, Accredited, Interim, and Provisional.

Performance Incentive Awards

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

For the PIA program, DMAS selected six measures representing two measurement domains (i.e., administrative and HEDIS measures) for Year 3. The measures were consistent with both Year 1 and Year 2.

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

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

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

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

The PIA program rewards higher-scoring MCOs to support sustained high performance and imposes financial penalties on lower-scoring MCOs to promote improved performance in the future. The PIA was initiated as a pilot program in 2015; therefore, no actual penalties or awards were implemented that year, and results were shared with the MCOs for input. The MCOs were subject to quality awards or penalties in Program Year 1 (i.e., 2016 results), Program Year 2 (i.e., 2017 results), and will be subject to awards or penalties in Program Year 3 (i.e., 2018 results).

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

If an MCO's weighted score sum is above or below the Virginia average, it is awarded or penalized, respectively. If an MCO's weighted score is equal to the Virginia average, no award or penalty will occur. The amount of the award or penalty is independent of the Virginia average, and is instead based on the percentage of the maximum possible score (i.e., the highest possible measure score is 3) achieved

by the MCO. Please refer to Section 4 of this report for more information regarding the PIA scoring and calculations.

The Program Year 3 (2018) results indicated that two MCOs will be assessed for awards and four MCOs will be assessed penalties for their performance in 2018, the latter of which will be collected from the MCOs in Spring 2019. These results, along with the methodology and technical specifications, are anticipated to be posted on the DMAS' website by the end of the second quarter of 2019.

Focused Studies

DMAS selected the following clinical topics for the 2018 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study); improving the health of children in foster care (Foster Care Focused Study); and Perinatal Dental Utilization.

Improving Birth Outcomes Through Adequate Prenatal Care

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

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

The Birth Outcomes Focused Study included five study indicators: percentage of births with early and adequate prenatal care, percentage of births by gestational estimate, percentage of newborns with low birth weight, percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth, and percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth. Study indicator results by study population are presented in Table 1-22.

Table 1-22—Overall Study Findings by Indicator and Population Group Among Singleton Births, Measurement Year (MY) 2015

Study Indicator	2015 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
Births With Early and Adequate Prenatal Care	77.6%	21,289	76.6	3,782	69.2	Yes
Preterm Births (< 37 Weeks Gestation)*	7.8%	2,533	9.0	592	10.5	Yes
Newborns With Low Birth Weight (< 2,500g)*	6.3%	2,361	8.4	474	8.4	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	7,165	25.9	2,049	37.2	Yes

Study Indicator	2015 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth*	N/A	2,009	7.3	546	9.9	Yes

The national benchmark for *Births With Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmarks for *Preterm Births* and *Newborns With Low Birth Weight* were identified from calendar year 2015 national data available from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS)[1-14] final data for 2015. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.
*A lower rate is better.

Results of the Birth Outcomes Focused Study found that births to women in the study population fared better than those in the comparison group for the following indicators: *Births With Early and Adequate Prenatal Care*, *Preterm Births* and *Newborns With ≥1 ED Visit in the 30 Days Following Birth*. Births in the comparison group outperformed the study population for the indicator *Newborns With ≥2 PCP Visits in the 30 Days Following Birth*; that is, a greater percentage of children born to mothers in the comparison group had two or more visits with a PCP-type provider in the 30 days following birth compared to children born to mothers in the study population. In MY 2015 results differences between the study population and comparison group were statistically significant for all indicators except *Newborns With Low Birth Weight (<2,500g)*.

During 2018, HSAG also initiated the third annual Birth Outcomes Focused Study, covering births occurring during MY 2016 and MY 2017 and using a methodology similar to prior studies. Results from this study are scheduled to be released in 2019.

Dental Utilization in Pregnant Women Data Briefs

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide annual data briefs on dental utilization among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015. During 2018, HSAG completed Dental Utilization in Pregnant Women Data Briefs for two study periods, covering MY 2016 and MY 2017. The Dental Utilization in Pregnant Women Data Briefs included all women with deliveries during each MY; however, due to methodological changes between the MYs, MY 2016 and MY 2017 results are not comparable.

Table 1-23 and Table 1-24 present the number and percentage of women in the study population who received dental services during pregnancy in each of the study periods, MY 2016 and MY 2017.

[1-14] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National Vital Statistics Reports; vl66 no 1. Hyattsville, MD: National Center for Health Statistics. 2017. Available at: https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf. Accessed on: Jan 17, 2019.

Table 1-23—MY 2016 Dental Utilization Among Pregnant Women by Study Indicator

Measure	MY 2016 Count of Deliveries	MY 2016 Percentage of Deliveries (n=30,176)	MY 2016 Percentage of Pregnant Women With Any Dental Service (n=4,026)
Any Dental Service*	**4,026**	**13.34**	**100**
Preventive Dental Service	2,619	8.68	65.05
Dental Fillings	1,400	4.64	34.77
Simple or Surgical Extractions	1,140	3.78	28.32
Pulpotomies or Pulpectomies (root canals)	639	2.12	15.87
Crowns	349	1.16	8.67

* A woman may have had more than one prenatal dental service; therefore, the counts of deliveries for each dental service category do not sum to the overall number of deliveries among women with any dental service.

During MY 2016, 4.83 percent of women in the study population received both preventive and restorative[1-15] dental services during pregnancy.

Table 1-24—MY 2017 Perinatal Dental Utilization by Study Indicator

Measure	MY 2017 Count of Deliveries	MY 2017 Percentage of Deliveries Among Study Population (n=32,297)	MY 2017 Percentage of Deliveries Among Women with Any Perinatal Dental Service (n=6,374)
Any Dental Service*	**6,374**	**19.7**	**100.0**
Adjunctive General Services	1,114	3.4	17.5
Crowns	1,180	3.7	18.5
Diagnostic Services	6,122	19.0	96.0
Endodontics	2,404	7.4	37.7
Periodontics	1,384	4.3	21.7
Preventive Services	210	0.7	3.3
Prosthodontics	3,254	10.1	51.1
Restorative Services Including Crowns	3,556	11.0	55.8
Surgery or Extractions	2,264	7.0	35.5

* A woman may have had more than one dental service during the perinatal period; therefore, the counts of deliveries for each dental service category do not sum to the overall number of deliveries among women with any dental service.

[1-15] Restorative services include fillings, crowns, extractions, or pulpotomies/pulpectomies.

The MY 2017 study results indicated that more women received dental services during the prenatal period than during the postpartum period, and 30.5 percent of deliveries occurred among women who received dental services during both the prenatal and postpartum periods.

Results of the study also identified regional differences in the utilization of any dental services and preventive dental services during pregnancy. Table 1-25 presents the number and percentage of women in the study population who received dental services during pregnancy, by the woman's region of residence during MY 2016; and Table 1-26 presents the study population results for MY 2017.

Table 1-25—MY 2016 Dental Utilization Among Pregnant Women by Region of Residence

Region	Count of Pregnant Women	Count of Women Receiving Dental Services During Pregnancy	Percentage of Women Receiving Dental Services During Pregnancy	Count of Women Receiving Preventive Dental Services During Pregnancy	Percentage of Women Receiving Preventive Dental Services During Pregnancy*
	MY 16	**MY 16**	**MY 16**	**MY 16**	**MY 16**
Central	7,191	1,061	14.75	723	68.14
Charlottesville	1,929	239	12.39	171	71.55
Far Southwest	1,435	235	16.38	145	61.7
Halifax-Lynchburg	1,458	167	11.45	75	44.91
Roanoke-Alleghany	2,807	366	13.04	171	46.72
Tidewater	6,384	917	14.36	529	57.69
Winchester-Northern	8,971	1,041	11.6	805	77.33
No Region Identified	1	0	0	0	0
Total	**30,176**	**4,026**	**13.34**	**2,619**	**65.05**

*As a percentage of women who received any dental service during pregnancy.

Table 1-26—MY 2017 Perinatal Dental Utilization by Region of Residence

Region	Count of Deliveries	Count of Deliveries Among Women Receiving Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Perinatal Dental Services	Count of Deliveries Among Women Receiving Preventive Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Preventive Perinatal Dental Services*
	MY 17	**MY 17**	**MY 17**	**MY 17**	**MY 17**
Central	8,085	1,838	22.7	964	52.4
Charlottesville	2,048	378	18.5	188	49.7

Region	Count of Deliveries	Count of Deliveries Among Women Receiving Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Perinatal Dental Services	Count of Deliveries Among Women Receiving Preventive Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Preventive Perinatal Dental Services*
Far Southwest	1,508	384	25.5	197	51.3
Halifax-Lynchburg	1,649	209	12.7	86	41.1
Roanoke-Alleghany	2,862	523	18.3	216	41.3
Tidewater	6,817	1,402	20.6	680	48.5
Winchester-Northern	9,327	1,640	17.6	923	56.3
No Region Identified	1	0	0	0	0
Total	**32,297**	**6,374**	**19.7**	**3,254**	**51.1**

*As a percentage of women who received any dental service during pregnancy.

While the VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services, relatively few eligible women received prenatal and/or postpartum dental services.

During MY 2017, overall dental utilization among pregnant women and receipt of preventive dental services varied by age, and study findings identified that more women received dental services during the prenatal period than during the postpartum period. Utilization of dental services also varied by region, with the Halifax-Lynchburg region having the lowest percentage of women receiving perinatal dental services.

Foster Care Focused Study

The CY 2017–2018 Foster Care Focused Study was designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care in the third year of managed care service delivery. Additionally, the study sought to compare utilization of preventive and therapeutic medical care among children in foster care between the first and third year of managed care service delivery. Measurement years (MYs) were defined from July 1 through June 30, with MY 2017 covering July 1, 2016, through June 30, 2017.

To address the study goals, HSAG used administrative and medical record data to calculate 15 study indicators across three domains:

- Characteristics of Medicaid Members in Foster Care
- Preventive Care

- Behavioral Health

During the third year of statewide managed care service delivery for children in foster care, key observations included a statistically significant increase in the proportion of children having at least one visit with a PCP-type provider between MY 2015 and MY 2017 as well as an observed decrease in the proportion of children with no administrative record of visits with a PCP-type provider. Overall, study findings suggest that most children in foster care are receiving preventive care under managed care service delivery.

Results across the behavioral health indicators related to antipsychotic medication use show improvements in medication management oversight as well as high levels of compliance with first-line therapy recommendations for children with off-label drug use.[1-16]

Trends in antidepressant and attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD) medication prevalence among children in foster care underscore the need to document and monitor medication uptake across age groups and geographic regions. Overall, these findings indicate that children in foster care are receiving first-line behavioral health care consistently.

Statewide Summary of Strengths, Weaknesses, and Overall Conclusions

Summary of Quality Strategy Recommendations for DMAS

Quality Strategy Focus and Priorities

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

The four publicly promoted aims are:

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

The 2018 technical report is HSAG's fourth cycle completing the EQR analysis and reporting for the Commonwealth of Virginia. In the past four years DMAS has demonstrated continued success in improving the quality of, access to, and timeliness of care and services for the managed Medicaid

[1-16] "Off-label" drug use was defined for these study indicators using HEDIS 2017 technical specifications listed in Appendix A. Scenarios considered to be off-label drug use for this measure include cases in which a child is prescribed an antipsychotic medication in the absence of a diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder.

programs in the Commonwealth of Virginia. In addition to the mandatory EQR activities, DMAS requested HSAG's assistance with the following optional EQR activities:

- Developing and implementing the Consumer Decision Support Tool and the Performance Incentive Award program
- Conducting four focused studies aimed at improving birth outcomes, the health of children in foster care, and dental utilization among pregnant women
- Calculating select performance measures
- Validating encounter data

DMAS' other notable advancement in quality improvement was the development of the updated Commonwealth of Virginia Department of Medical Assistance Services 2017–2019 Quality Strategy (Quality Strategy). The two key enhancements to this Quality Strategy were the expansion of the Quality Strategy to include all programs (i.e., Medallion 3.0/4.0, CCC and CCC Plus, and FAMIS) and the identification of the stretch performance goal for MCOs to reach the Quality Compass 75th percentiles on priority measures. The HSAG Quality Strategy recommendations for DMAS are:

- **Drive MCOs, related to the HEDIS priority measures, to advance improvement toward NCQA's Quality Compass national Medicaid 75th percentiles.**

  The Medallion 4.0 managed care contract[1-17] requires that MCOs ensure annual improvement in the HEDIS priority measures (as listed in Table 1-7) until such time that each MCO is performing at least at the national Medicaid 50th percentile for HMOs as reported by NCQA Quality Compass. Thereafter, the MCO must sustain performance at the 50th percentile. Of note, approximately 70 percent of measures for HEDIS 2018 (19 of 27) ranked at or above the national Medicaid 50th percentiles, compared to 75.8 percent in 2017. Furthermore, in the updated DMAS Quality Strategy 2017–2019, DMAS indicated that the stretch performance goal for MCOs is to reach the national Medicaid 75th percentiles, recognizing that it may not be realistic to expect all Virginia MCOs to reach the 75th percentile for all priority measures.

- **Direct MCOs to focus HEDIS measure improvement efforts that include *Follow-Up Care for Children Prescribed ADHD Medications, Antidepressant Medication Management, Prenatal and Postpartum Care, Medication Management for People With Asthma,* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.***

  DMAS may want to prioritize these HEDIS measures as the preliminary areas of focus and require that MCOs conduct performance improvement activities using the Model for Improvement.[1-18]

[1-17] Medallion 3.0 Managed Care Contract. Available at: http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf Accessed on: Jan 30, 2019.

[1-18] Institute for Healthcare Improvement. "How to Improve." Available at http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Jan 17, 2019.

HSAG provides more information about the MCO-specific recommendations in Section 4, focusing on experience with other states' health plan efforts to improve performance in these measures.

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

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

  HSAG recommends that MCOs use other quality improvement techniques to examine systems and address failures. For example, the Six Sigma performance improvement model—Define, Measure, Analyze, Improve, Control (DMAIC)—is the International Organization for Standardization's (ISO's) highly recognized methodology for facilitating improvement in processes and outcomes. DMAS should ensure that:

  – Rapid-cycle PIP topics align with the State's Quality Strategy and are based on data which identify the current member health, functional status, and/or satisfaction improvement needs of each MCO. Additionally, DMAS should consider MCO input for the PIP topic(s) selection.
  – Senior management is directly involved in the PIP process. Senior management can ensure that the team's efforts align with the organizational strategy and provide resources to overcome barriers on behalf of the team. Without senior management support, the core PIP team may not be able to make the changes necessary to improve the process. If needed, DMAS should collaborate with each MCO's executive leadership team to ensure support and resources for performance improvement activities.
  – MCOs focus on testing fundamental changes designed for long-term impact. This may include creating a new system of performance and designing or redesigning some aspect(s) of the system. MCOs should avoid testing reactive changes that have short-term effect of keeping a system running but not improving it.
  – MCOs continue quality improvement efforts for the PIPs after validation has concluded. HSAG encourages MCOs to build on lessons learned and to continue to test changes using a rapid-cycle approach.
  – MCOs have a comprehensive understanding of the rapid-cycle PIP process by using the PIP Reference Guide and requesting technical assistance from HSAG as often as needed.
  – MCOs' PIP results, analysis, and key findings are reported accurately and in alignment with the approved methodology. Inconsistencies in final analysis results lead to questions in the EQRO review about validity and reliability of the information provided.

- **Ensure that MCOs build collaboration opportunities in the community and with providers to improve the access to, quality of, and timeliness of care and services.**

  HSAG has observed MCOs in a number of states experiencing improved outcomes using collaborations and partnerships with community organizations, providers, vendors, and family and caregivers. MCOs should be encouraged to continue to build and strengthen these relationships to have greater impact on member care. HSAG has seen demonstrated success in states with the following:

  – Leveraging educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.
  – Leveraging pharmacies and pharmacists to build upon the trust that patients have in provider and caregivers to improve outcomes.
  – Expanding collaborations such as the Maternal and Infant Improvement Project (MIIP)[1-19] to include other agencies pursuing similar objectives (e.g., the Virginia Department of Health's (VDH's) Family Home Visiting Program). Such collaboration allows influential groups to design interventions without duplicating efforts and may allow respective stakeholders to reach larger audiences.
  – MCOs leveraging their relationships with providers and community partners to provide opportunities to work with obstetrical practices to: conduct reminder calls the day before scheduled appointments, assist with ensuring that transportation is arranged for the appointment by completing warm transfers to the transportation vendors during reminder calls, and provide additional educational opportunities such as parenting classes.
  – Focusing efforts on collaborating with and incentivizing PCPs or health home providers to ensure that medication refills are monitored. In other state Medicaid programs, Medicaid MCOs utilize their internal pharmacy departments successfully to: conduct follow-up on medication refills, outreach to review medications upon discharge from inpatient stays or emergency department visits, and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.
  – Learning from high-performing providers best practices that may be shared with other providers treating individuals diagnosed with chronic conditions.

[1-19] Virginia Department of Medical Assistance Services. Maternal and Infant Improvement Project (MIIP) Activities Report 2015-2016. Available at: http://www.dmas.virginia.gov/files/links/887/Maternal%20and%20Infant%20Improvement%20Project%20(MIIP)%20Activities%20Report%202015%20-%202016.pdf
Accessed on Jan 30, 2019.

2. Overview of the Virginia Medicaid Managed Care Program

Medicaid Managed Care in Virginia

Medicaid provides health coverage to approximately 73 million Americans including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government. CMS approves Section 1115 demonstrations and waiver authorities in section 1915 of the Social Security Act as vehicles that states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). During 2018 Virginia had the following CMS-approved waivers:

- 1915 (b1), 1915(b4), 1915 (c): CCC Plus
- 1915 (c): VA Community Living
- 1915 (c): VA Family and Individual Support
- 1915 (c): VA Building Independence
- 1915 (c):VA Technology Assisted
- 1915 (c): Virginia's Alzheimer's Assisted Living
- 1115: FAMIS MOMS and FAMIS Select
- 1915 (c): Children's Mental Health Waiver Psychiatric Residential Treatment Facility (PRTF)

In Virginia, Medicaid plays a critical role in the lives of over a million Virginians, providing access to health care for the most vulnerable populations. The impact of Medicaid extends far beyond traditional health coverage, to include comprehensive services such as behavioral health and long-term services and supports (LTSS). Medicaid is the primary funder for LTSS, making it possible for thousands of Virginians to remain in their homes or to access residential care when needed.[2-1] Virginia's eligibility rules are among the strictest in the nation. Most of Virginia's Medicaid dollars are spent on care for older adults and individuals with disabilities.

Virginia has a comprehensive addiction and recovery treatment services program that provides substance use disorder (SUD), opioid use disorder (OUD), and alcohol use disorder (AUD) treatment and services. This program operates an 1115 waiver, the Virginia Governor's Access Plan (GAP) and ARTS Delivery System Transformation waiver, approved by CMS on September 21, 2017. The waiver program has been re-named COMPASS: Creating Opportunities for Medicaid Participants to Achieve Self-Sufficiency. Virginia has requested an extension of the waiver and requested authority to implement a community engagement program for eligible adult populations. The COMPASS waiver extension is pending CMS approval. The first full year of the demonstration was 2018. The demonstration extends access to certain behavioral and physical health services to uninsured low-income adults with diagnosis of serious mental illness (SMI). The goal of the GAP component of the

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

demonstration is to use a targeted benefit package to prevent people with SMI diagnoses from becoming fully and permanently disabled. The ARTS component of the demonstration, which contributes to a comprehensive statewide strategy to combat prescription drug abuse and OUDs, seeks to expand the SUD benefits package to cover the full continuum of SUD treatment, including short-term residential and inpatient services to all Medicaid-eligible members. The GAP/ARTS demonstration was amended to address the substance use crisis impacting the GAP population by expanding coverage and adding services for GAP enrollees. The demonstration amendment also expanded Medicaid coverage to former foster care youth who aged out of foster care under the responsibility of another state and were applying for Medicaid in the Commonwealth of Virginia.

Medicaid is the largest payer of behavioral health services in the Commonwealth, providing inpatient and outpatient services that support quality of life in the community for those in need of behavioral health support. Medicaid dollars are paid to doctors, hospitals, dentists, health clinics, and other providers who care for members. In Virginia one dollar of every six is spent overall in the health care system. More than one dollar in every three is provided to safety net hospitals and health centers, and one dollar in every two is spent on long-term care services.

The Department of Medical Assistance Services

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models. As of December 2018, 75 percent of Medicaid enrollees received their benefits through managed care and 25 percent of enrollees participated in Medicaid through the FFS model. In 2018, the managed Medicaid populations in Virginia were organized into two programs: Medallion 3.0 which transitioned into the Medallion 4.0 beginning in August 2018 and Commonwealth Coordinated Care Plus (CCC Plus).

Medallion 3.0 MCO Model

Over the past 20 years, the Medallion program has provided acute and primary care services for enrolled members including pregnant women; low income families with children (LIFC); those receiving temporary assistance for needy families (TANF); aged, blind, and disabled (ABD); and children. Two more recent expansion groups were foster care/adoption assistance (FC/AA) and the health and acute care program (HAP) populations. The Virginia Medallion 3.0 program provides health care coverage statewide to Medicaid members through a mandatory managed care organization (MCO) enrollment mechanism for designated eligibility categories for approximately 795,000 members. The primary exclusions were members dually eligible for Medicare and Medicaid, who had comprehensive private insurance as primary payers, who resided in nursing homes, and some members who received services under a home- and community-based waiver. Contracted MCOs included Aetna Better Health of Virginia (Aetna), Anthem HealthKeepers Plus (Anthem), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier). Medallion 3.0 transitioned to Medallion 4.0 using a phased-in approach beginning in August 2018.

Medallion 4.0 MCO Model

The Medallion 4.0 program, phased in from August 2018 through December 2018, contracts with six MCOs and is intended to ensure the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for most of Virginia's Medicaid Title XIX members and for all members of FAMIS, Virginia's Title XXI Children's Health Insurance Program (CHIP). The Medallion 4.0 population includes children, low income parents and caretaker relatives living with children, pregnant women, FAMIS members, and current and former foster care and adoption assistance children. The Medallion 4.0 program serves approximately 72 percent of Virginia's Medicaid enrollment and accounts for approximately 32 percent of Virginia's Medicaid expenditures.

Medallion 4.0 focuses on the following objectives:[2-2]

- Evolving from the Medallion 3.0 foundation.
- Serving over 700,000 healthy, connected Medicaid and FAMIS members and their communities.
- Engaging health systems and stakeholders.
- Providing holistic and integrated care.
- Adding new services and populations.
- Providing flexible delivery systems and payment models.
- Growing stronger through improved quality, data, and reporting.

Commonwealth Coordinated Care Plus MCO Model

The Commonwealth Coordinated Care Plus (CCC Plus), a program designed to improve care delivery and efficiency for individuals with complex care needs, blends and coordinates Medicare and Medicaid benefits for approximately 210,000 dual-eligible enrollees aged 21 or older, health and acute care program (HAP) members of Medallion 3.0, and the ABD members. Individuals receiving long-term supports and services through nursing facilities and the Elderly or Disabled with Consumer Direction (EDCD) Waiver are also eligible to participate in the CCC Plus managed care program. Care is delivered in an integrated delivery model, across the full continuum of care. The MCO contract includes provisions for person-centered care planning, interdisciplinary care teams, care coordination services, provider credentialing, access to services, unified appeals and grievances, and closely monitored quality of services. CMS and DMAS monitor health plan performance and quality by requiring the health plans to report HEDIS data along with quarterly assessment and plan of care completion rates. The CCC Plus program covers approximately 28 percent of Virginia's Medicaid enrollment and accounts for approximately 68 percent of Virginia's Medicaid expenditures.

CCC Plus focuses on the following:

- Integrated care delivery model
- Full continuum of care

[2-2] Medallion 4.0 Medicaid Managed Care Program website available at: https://www.virginiamanagedcare.com/home Accessed on Dec 26, 2018.

- Person-centered care planning
- Interdisciplinary care teams
- Unified (Medicare/Medicaid) processes when possible

Medicaid Expansion

On June 7, 2018, Virginia's Governor, Governor Northam, signed the State budget, which included expanded eligibility under Medicaid for approximately 400,000 Virginia adults. Medicaid expansion coverage begins on January 1, 2019, and will be administered through a comprehensive system of care.

Coverage for the Medicaid expansion population is provided through the DMAS managed care and fee-for-service delivery systems. Most individuals will be enrolled in one DMAS managed care program—Medallion 4.0 or CCC Plus. The Medallion 4.0 and CCC Plus programs contract with the same six MCOs, and all offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. CCC Plus provides care coordination services for individuals with more pronounced medical needs and serves as the delivery system that provides coverage for expansion members who are deemed to be "medically complex." Medallion 4.0 will serve as the delivery system for expansion members who are determined not medically complex. Medically complex individuals include individuals with a complex medical or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Medicaid expansion provides coverage for eligible individuals, including adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the federal poverty level, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

Addiction and Recovery Treatment Services (ARTS)

In 2017 DMAS implemented the ARTS program in the CCC Plus and the Medallion 4.0 programs. The ARTS program focuses on treatment of SUD, OUD, and AUD. Outcomes are measured through reductions in SUD, OUD, and AUD emergency department utilization; inpatient admissions; and decreasing opioid prescriptions. The ARTS program is a fully integrated physical and behavioral health continuum of care that includes:

- Early intervention.
- Outpatient services.
- Intensive outpatient and partial hospitalization services.
- Intensive outpatient services.
- Partial hospitalization services.
- Residential and inpatient services.
- Clinically managed, population-specific, high-intensity residential services.
- Clinically managed, high-intensity residential services.

- Medically monitored intensive inpatient services.
- Medically managed intensive inpatient services.

Virginia Quality Strategy

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

History

DMAS published its first quality strategy in June 2005. The strategy was first updated in May 2011 to include the CHIP managed care delivery system and to provide a framework for the five-year period through 2015. In December 2015, DMAS issued Addendum 1 (Addendum) to the 2011–2015 managed care Quality Strategy as a companion to the previously published second edition. This Addendum was the result of the May 2015 release of the proposed rule to modernize and update the federal Medicaid managed care regulations. It addresses the progression of, and impending changes to, managed care quality in Virginia. The Addendum served to extend the 2011–2015 DMAS Quality Strategy to cover the gap period until the third edition of the Quality Strategy was developed and approved. The third edition was finalized by DMAS on January 31, 2018, for calendar years 2017 through 2019. This third edition aligns with the requirements detailed in the revised federal regulations, specifically 42 CFR §438.340. The new federal regulations advance DMAS' mission of better care, healthier people, and smarter spending.

The purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement system consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement of the health care system.
- Provide a framework for DMAS to implement a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP systems. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, timeliness, member satisfaction, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.

- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure that Virginia Medicaid and CHIP recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery steeped in best practices; and make health care more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.

DMAS' vision for quality extends beyond the Quality Strategy. The Quality Strategy serves as the blueprint for developing a dynamic approach to assessing and improving the quality of health care and services furnished by the managed care and fee-for-service programs.

Quality Governance

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

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

Data Analytics Strategy

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

Quality Strategy Focus and Priorities

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

The four publicly promoted aims are:

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

Mission

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

Vision

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

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

Table 2-1—DMAS Quality Dashboard

DMAS Quality Dashboard
August 28, 2017

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

DMAS Quality Dashboard
August 28, 2017

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

3. Comparative Information and Quality Strategy Recommendations

MCO Managed Care Performance in Virginia

To evaluate the MCO's managed care performance in Virginia, DMAS, through the Medallion 3.0 and the Medallion 4.0 contracts, requires each MCO to complete federal and State-mandated quality improvement activities such as participation in quarterly collaborative meetings, reporting of HEDIS and CAHPS data, participation in performance improvement projects, participation in measurement validation activities, and participation in a performance incentive award program.[3-1]

Additionally, DMAS contracted with HSAG to perform the following additional quality improvement activities related to calculating performance metrics, designing quality rating systems, conducting readiness reviews, and conducting focused studies:

- Calculate pediatric quality measure results (*Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [*APC*]).
- Produce a Medallion 4.0 Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results.
- Design the Performance Incentive Award program to improve health outcomes for members in the FAMIS and Medallion 3.0 populations, and promote and incentivize MCOs' high performance on six measures representing two measurement domains.
- Conduct readiness review activities of the six managed care organizations forimplementation of the Medallion 4.0 program and for Medicaid expansion.
- Conduct four focused studies—Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Dental Utilization in Pregnant Women Data Brief for calendar years 2016 and 2017.

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

MCO Comparative and Statewide Aggregate HEDIS Results

Table 3-1 displays, by MCO, the HEDIS 2018 measure rate results compared to the national Medicaid 50th percentiles for HEDIS 2017 and the Virginia aggregate, which represents the average of all six MCOs' measure rates weighted by the eligible population. Yellow-shaded boxes indicate MCO measure rates at or above the national Medicaid 50th percentiles. Rates performing better than the Virginia aggregates are represented in green font.

[3-1] The Way Forward, 2016 Medallion 3.0 Annual Report: Member Care, Operations, Performance Management, & Innovation. Available at: http://www.dmas.virginia.gov/files/links/789/Medallion%203.0%20Annual%20Report%20The%20Way%20Forward.pdf. Accessed on: Jan 30, 2019.

Table 3-1—MCO Comparative and Virginia Aggregate HEDIS 2018 Measure Results

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Children's Preventive Care							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	53.04%	**61.18%**	**58.15%**	**64.59%**	47.20%	49.15%	**54.10%**
Childhood Immunization Status							
Combination 3	65.45%	**72.26%**	70.07%	**81.46%**	69.10%	**72.02%**	**71.18%**
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	64.48%	**69.34%**	51.82%	62.53%	**66.39%**	63.99%	**65.55%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life							
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.40%	**79.32%**	76.64%	**86.90%**	**78.89%**	74.70%	**77.81%**
Women's Health							
Breast Cancer Screening[1]							
Breast Cancer Screening	**52.35%**	**52.50%**	48.65%	**81.18%**	**54.24%**	50.30%	**52.14%**
Cervical Cancer Screening							
Cervical Cancer Screening	60.10%	**65.43%**	56.20%	**85.08%**	**66.17%**	59.12%	**63.31%**
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	77.86%	**89.05%**	60.58%	**93.67%**	79.75%	**84.43%**	**83.39%**
Postpartum Care	**64.72%**	**62.53%**	46.72%	**88.81%**	57.97%	**66.18%**	**62.04%**
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	83.63%	**85.18%**	82.15%	**89.27%**	84.08%	**86.68%**	**85.13%**
Children and Adolescents' Access to Primary Care Practitioners							
12–24 Months	**97.05%**	**97.16%**	**97.42%**	96.42%	96.56%	96.78%	**96.95%**
25 Months–6 Years	91.39%	**92.57%**	**93.08%**	**93.49%**	90.78%	91.08%	**91.82%**
7–11 Years	93.00%	**94.43%**	**94.66%**	**97.09%**	92.40%	93.58%	**93.70%**
12–19 Years	90.09%	**92.03%**	**91.81%**	**94.41%**	90.42%	**92.28%**	**91.61%**

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Care for Chronic Conditions							
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing	81.02%	82.48%	**87.35%**	**97.69%**	83.45%	**91.24%**	**85.82%**
HbA1c Control (<8.0%)	47.20%	**55.72%**	39.66%	**71.68%**	45.50%	**51.09%**	**50.63%**
Eye Exam (Retinal) Performed	**55.23%**	45.74%	48.66%	**84.39%**	**52.31%**	**53.28%**	**50.74%**
Medical Attention for Nephropathy	**91.97%**	89.78%	88.08%	**99.42%**	88.32%	**93.92%**	**90.87%**
Blood Pressure Control (<140/90 mm Hg)	58.39%	**64.48%**	**60.10%**	**88.44%**	56.20%	55.47%	**59.34%**
Controlling High Blood Pressure							
Controlling High Blood Pressure	**59.12%**	**60.58%**	49.64%	**84.87%**	56.59%	**59.12%**	**58.73%**
Medication Management for People With Asthma							
Medication Compliance 75%—Total	30.27%	30.23%	33.28%	**37.78%**	34.40%	**44.16%**	**35.81%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	80.42%	**89.92%**	75.50%	NA	**85.10%**	81.82%	**82.55%**
Discussing Cessation Medications	**55.91%**	**58.30%**	46.71%	NA	48.41%	50.23%	**51.91%**
Discussing Cessation Strategies	40.11%	**44.83%**	38.93%	NA	**44.76%**	40.91%	**41.91%**
Behavioral Health‡							
Antidepressant Medication Management							
Effective Acute Phase Treatment	44.97%	48.95%	**57.82%**	36.51%	48.54%	**64.16%**	**53.48%**
Effective Continuation Phase Treatment	27.02%	32.86%	**39.39%**	28.57%	34.60%	**48.54%**	**37.90%**
Follow-Up Care for Children Prescribed ADHD Medication							
Initiation Phase	**51.98%**	43.92%	**54.24%**	NA	41.36%	**56.07%**	**47.63%**
Continuation and Maintenance Phase	55.70%	55.93%	**72.37%**	NA	56.84%	**68.07%**	**61.15%**

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Follow-Up After Hospitalization for Mental Illness[1]							
30-Day Follow-Up	60.75%	**61.80%**	45.82%	**66.67%**	**64.99%**	59.11%	**61.11%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	**65.91%**	58.80%	**65.69%**	NA	57.43%	**65.61%**	**61.27%**

[1] *Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, comparisons to benchmarks are not performed for this measure.*

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

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

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

Indicates that the HEDIS 2018 rate was at or above the national Medicaid 50th percentile.

For HEDIS 2018, the MCOs demonstrated overall strength related to access to care, as evidenced by measure rates for all MCOs ranking above the national Medicaid 50th percentiles for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Children and Adolescents' Access to Primary Care Practitioners*. Additionally, five of six MCOs ranked above the national Medicaid 50th percentiles for *Well-Child Visits in the First 15 Months of Life* and *Adults' Access to Preventive/Ambulatory Health Services*. Of note, Anthem performed above the Virginia aggregate for all of these measure rates, indicating positive performance by the MCO.

Five of the six MCOs ranked above the national Medicaid 50th percentile for the *Cervical Cancer Screening* measure, with INTotal being the only MCO below the 50th percentile and falling more than 7 percentage points below the Virginia aggregate. Conversely, opportunities exist to improve care surrounding pregnancy for the MCOs, as half of the *Prenatal and Postpartum Care* measure rates fell below the national Medicaid 50th percentiles. Of note, both *Prenatal and Postpartum Care* measure rates for INTotal were below the Virginia aggregate by more than 15 percentage points. Anthem and Kaiser Permanente were the highest performers within the Women's Health domain, with both MCOs performing above the Virginia aggregate for all four measure rates within this domain.

Inconsistencies in performance among the MCOs within the Care for Chronic Conditions domain demonstrates a need for targeted improvement efforts for these members. Kaiser Permanente was the only MCO above the Virginia aggregate and national Medicaid 50th percentiles for all reportable measure rates within this domain, demonstrating strength for the MCO. Additionally, performance for the rates in the Behavioral Health domain was inconsistent as INTotal and VA Premier were the only MCOs to rank above the national Medicaid 50th percentiles and the Virginia aggregate for all Behavioral Health measures comparable to benchmarks. Of note, *Antidepressant Medication Management* indicates an area with opportunities for improvement as four MCOs fell below the national Medicaid 50th percentile and the Virginia aggregate.

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 3-2 presents the 2017 and 2018 top-box scores (i.e., percentages of top-level responses) for each MCO and the statewide aggregate adult Medicaid CAHPS scores for the global ratings. The 2017 and 2018 CAHPS scores for each MCO and the statewide aggregate were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 3-2—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Global Ratings

	Aetna		Anthem		INTotal		Kaiser Permanente		Optima		VA Premier		Statewide Aggregate	
Global Ratings	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Rating of Health Plan	62.8%	60.2%	63.4%	63.8%	59.2%	57.3%	65.6%	64.6%	67.5%	62.0%	62.9%	59.6%	64.1%	62.1%
Rating of All Health Care	59.4%	54.9%	59.9%	62.4%	50.0%	60.5%	59.0%	53.9%	59.5%	52.6%	54.2%	44.5%	57.3%	56.2%
Rating of Personal Doctor	68.9%	68.7%	70.2%	73.3%	65.6%	61.1%	76.0%	63.8%	69.4%	65.1%	68.0%	65.5%	69.0%	69.1%
Rating of Specialist Seen Most Often	55.7%	58.2%+	67.9%	69.7%	67.6%	60.7%+	70.4%+	75.0%+	67.1%	63.2%+	69.1%	59.4%+	67.2%	65.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

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

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

Comparison of the statewide aggregate and MCOs' 2018 adult Medicaid CAHPS scores to the 2018 NCQA national adult Medicaid averages revealed the following summary results:

- Anthem scored statistically significantly higher than the 2018 NCQA national adult Medicaid averages on two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.
- VA Premier scored statistically significantly lower than the 2018 NCQA national adult Medicaid average on one measure: *Rating of All Health Care*.

Table 3-3 presents the 2017 and 2018 top-box scores (i.e., percentages of top-level responses) for each MCO and the statewide aggregate adult Medicaid CAHPS scores for the composite measures. The 2017 and 2018 CAHPS scores for each MCO and the statewide aggregate were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 3-3—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Composite Measures

	Aetna		Anthem		INTotal		Kaiser Permanente		Optima		VA Premier		Statewide Aggregate	
Composite Measures	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Getting Needed Care	84.9%	86.4%	80.9%	86.5%	79.9%	79.9%+	76.6%	70.7%+	86.3%	81.4%	85.8%	82.8%	84.1%	84.3%
Getting Care Quickly	83.9%	86.4%+	81.1%	84.5%	82.7%	78.4%+	76.9%	67.2%+	81.5%	81.2%	88.1%	83.9%	83.6%	83.4%
How Well Doctors Communicate	90.4%	90.7%	91.0%	94.2%	91.5%	91.9%+	90.0%	88.3%+	90.9%	90.7%	89.4%	89.3%	90.5%	92.1%
Customer Service	84.7%+	89.0%+	87.7%	83.2%	84.6%	88.5%+	88.4%+	89.6%+	87.3%	91.4%+	89.4%	87.8%+	87.7%	86.5%
Shared Decision Making	82.3%+	81.3%+	77.2%	80.0%	79.4%	82.4%+	79.1%+	81.6%+	77.5%	72.0%+	81.8%	79.3%+	79.2%	78.5%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

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

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

Comparison of the statewide aggregate and MCOs' 2018 adult Medicaid CAHPS scores to the 2018 NCQA national adult Medicaid averages revealed the following summary results:

- Anthem scored statistically significantly higher than the 2018 NCQA national adult Medicaid averages on two measures: *Getting Needed Care* and *How Well Doctors Communicate*.

- Kaiser Permanente scored statistically significantly lower than the 2018 NCQA national adult Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- Optima scored statistically significantly lower than the 2018 NCQA national adult Medicaid average on one measure: *Shared Decision Making*.

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

Child Medicaid

Table 3-4 presents the 2017 and 2018 top-box scores (i.e., percentages of top-level responses) for each MCO and the statewide aggregate child Medicaid CAHPS scores for the global ratings. The 2017 and 2018 CAHPS scores for each MCO and the statewide aggregate were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 3-4—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Global Ratings

	Aetna		Anthem		INTotal		Kaiser Permanente		Optima		VA Premier		Statewide Aggregate	
Global Ratings	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Rating of Health Plan	70.0%	70.1%	76.5%	73.9%	78.0%	79.4%	70.5%	70.1%	75.4%	77.9%	71.3%	69.8%	73.7%	74.0%
Rating of All Health Care	68.2%	69.6%	73.0%	67.9%	70.1%	73.0%	72.4%	66.5%	71.7%	74.7%	65.3%	69.5%	69.0%	70.3%
Rating of Personal Doctor	74.7%	76.5%	75.9%	74.3%	68.2%	76.0%	79.5%	73.3%	80.3%	78.3%	75.5%	81.3%	76.0%	77.1%
Rating of Specialist Seen Most Often	72.4%+	67.6%+	77.6%	67.1%+	75.0%	77.6%+	74.5%+	62.7%+	80.6%+	79.7%+	71.3%	78.1%	74.9%	73.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

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

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

- The statewide aggregate score was statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure: *Rating of Health Plan*.

Comparison of the statewide aggregate and MCOs' 2018 child Medicaid CAHPS scores to the 2018 NCQA national child Medicaid averages revealed the following summary results:

- INTotal scored statistically significantly higher than the 2018 NCQA national child Medicaid average on one measure: *Rating of Health Plan*.
- Optima scored statistically significantly higher than the 2018 NCQA national child Medicaid average on one measure: *Rating of Health Plan*.
- VA Premier scored statistically significantly higher than the 2018 NCQA national child Medicaid average on one measure: *Rating of Personal Doctor*.

Table 3-5 presents the 2017 and 2018 top-box scores (i.e., percentages of top-level responses) for each MCO and the statewide aggregate child Medicaid CAHPS scores for the composite measures. The 2017 and 2018 CAHPS scores for each MCO and the statewide aggregate were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 3-5—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Composite Measures

	Aetna		Anthem		INTotal		Kaiser Permanente		Optima		VA Premier		Statewide Aggregate	
Composite Measures	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Getting Needed Care	87.5%	88.9%+	82.5%	83.5%	85.2%	83.9%	72.4%	69.8%	88.7%	89.2%	88.0%	88.2%	86.2%	85.9%
Getting Care Quickly	92.2%	94.3%	88.1%	85.2%	86.1%	86.2%	78.5%	80.6%	92.9%	90.7%	95.3%	93.4%	92.1%	88.8%
How Well Doctors Communicate	95.0%	96.9%	93.7%	92.3%	89.2%	91.2%	91.5%	87.7%	94.9%	94.8%	96.4%	97.3%	94.8%	94.1%
Customer Service	85.6%+	85.0%+	86.9%	83.8%+	87.6%	86.6%	84.3%	80.6%+	91.2%+	82.7%+	89.7%	88.4%	88.8%	84.9%
Shared Decision Making	80.4%+	76.1%+	77.9%	81.5%+	72.3%	66.1%+	83.4%+	70.5%+	77.3%+	79.1%+	79.0%	81.3%	78.1%	79.2%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

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

- Aetna scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure: *Getting Care Quickly*.
- INTotal scored statistically significantly lower than the 2017 NCQA national child Medicaid averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.
- Kaiser Permanente scored statistically significantly lower than the 2017 NCQA national child Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.

- Optima scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- VA Premier scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate*.
- The statewide aggregate scores were statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Getting Needed Care, Getting Care Quickly*, and *How Well Doctors Communicate*.

Comparison of the statewide aggregate and MCOs' 2018 child Medicaid CAHPS scores to the 2018 NCQA national child Medicaid averages revealed the following summary results:

- Aetna scored statistically significantly higher than the 2018 NCQA national child Medicaid averages on two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.
- Anthem scored statistically significantly lower than the 2018 NCQA national child Medicaid average on one measure: *Getting Care Quickly*.
- INTotal scored statistically significantly lower than the 2018 NCQA national child Medicaid averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.
- Kaiser Permanente scored statistically significantly lower than the 2018 NCQA national child Medicaid averages on four measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service*.
- VA Premier scored statistically significantly higher than the 2018 NCQA national child Medicaid averages on three measures: *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate*.
- The statewide aggregate score was statistically significantly lower than the 2018 NCQA national child Medicaid average on one measure: *Customer Service*.

Please refer to Section 4—Assessment of MCO Performance, for detailed information on each MCO's HEDIS results and items of statistical significance.

Pediatric Quality Measure Results

HSAG calculated the *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* (*APC*) performance measure rate for the 2017 measurement period. HSAG followed the Centers for Medicare & Medicaid Services (CMS) Core Set of Children's Health Care Quality Measures for Medicaid and Children's Health Insurance Program (CHIP) 2018 Technical Specifications. *APC* measures the percentage of children and adolescents ages 1 to 17 years treated with antipsychotic medications and on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement period. This measure is important because the frequency of prescribing antipsychotics in children has increased rapidly. Additionally, children and adolescents prescribed antipsychotics are

more at risk for health concerns. These concerns include weight gain, metabolic effects, hyperprolactinemia, and extrapyramidal side effects (e.g., anxiety, distress, paranoia). Further, the risks of multiple concurrent antipsychotics have not been fully investigated, but general guidelines caution against prescribing multiple antipsychotics in children and adolescents.[3-2] Table 3-6 presents *APC* performance measure rates for Virginia, listed as percentages and stratified by geographic region, gender, race category, and prescribing pattern. A lower rate indicates better performance for this measure.

Table 3-6—*APC* Measure Results

Rate Stratifications	Results (CY 2017)*
Virginia Total Rate	
Virginia Total Rate	2.76%
Rates by Region	
Central Virginia	2.96%
Far Southwest Virginia	4.43%
Halifax	—
Lower Southwest Virginia	—
Northern Virginia	—
Tidewater	2.49%
Upper Southwest Virginia	—
Rates by Gender	
Male	2.95%
Female	2.46%
Rates by Race Category	
White	3.08%
Black/African American	2.36%
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	—
More than one race/Other/Unknown	—
Rates by Prescribing Pattern	
Rural Total	2.16%
Non-Rural Total	3.08%

** For this measure, a lower rate indicates better performance.*
— Indicates that the rate is not presented given that the numerator included fewer than 11 cases or the denominator included fewer than 30 cases.

[3-2] National Committee for Quality Assurance. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC). Available at: https://www.ncqa.org/hedis/measures/use-of-multiple-concurrent-antipsychotics-in-children-and-adolescents/. Accessed on: Dec 10, 2018.

Overall, the Virginia total rate for CY 2017 fell between the national Medicaid 25th and 50th percentiles, indicating opportunities to reduce the number of children and adolescents prescribed multiple antipsychotics. Regional variation exists in the reportable rates of multiple antipsychotics being prescribed, with Far Southwest Virginia having the highest rate at 4.43 percent and Tidewater having the lowest rate at 2.49 percent. Rates indicated that more males were treated with multiple antipsychotics. Further, a higher percentage of individuals of White race were treated with multiple antipsychotics compared to other races. Geographical variation exists in the rate for treating children with multiple antipsychotics, with children in non-rural areas having the highest rate at 3.08 percent and children living in rural areas having the lowest rate at 2.16 percent.

Consumer Decision Support Tool

DMAS contracted with HSAG in 2018 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data and survey results. The Consumer Decision Support Tool demonstrates how Virginia Medicaid's MCOs compare to one another in key performance areas. The 2018 methodology used a five-level rating scale compared to the three-level rating scale used for 2017; therefore, comparisons to prior year Consumer Decision Support Tools is not appropriate. Additionally, the exclusion of Kaiser Permanente from this year's Consumer Decision Support Tool also means that comparisons of MCO performance across years cannot be made. Please refer to Section 4 for more information on current year results.

Performance Incentive Awards

Description of Program

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

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

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

- *Childhood Immunization Status—Combination 3*
- *Controlling High Blood Pressure*

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

As part of this pay-for-performance incentive program, this year (i.e., Program Year 3) represents the third year that penalties or awards will be implemented. MCOs' administrative and HEDIS measure rates were collected and scored based on a comparison of MCOs' measure rates to predetermined thresholds for the current year. DMAS used the same administrative measure and HEDIS measure scoring methodologies across all program years.

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

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

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

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

For MCOs with administrative measure rates that received a "*Not Reported* (*NR*)" audit result (i.e., the measure data were materially biased or the MCO chose not to report the measure) or HEDIS measure rates that received a "*Biased Rate* (*BR*)" (i.e., the measure data were materially biased), the MCO received a score of zero for that measure. Table 3-7 provides an example of how measures were weighted and scored.

Table 3-7—PIA Measure Weighting and Calculation
EXAMPLE USING MOCK DATA

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

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

The Virginia average is calculated by summing each MCO's weighted score sum and dividing by the total number of MCOs. Once the Virginia average is derived, it is used to determine each MCO's difference from the average. The difference from average may be a positive or negative number (e.g., 0.387 for MCO A and -1.093 for MCO C in Table 3-7) indicating whether the MCO's weighted score sum is above (positive) or below (negative) the Virginia average.

The positive or negative funds allocation model will use the MCO's weighted score sum to allocate funds among MCOs. This model was developed to ensure that the total dollar amount for awards will always be equal to the total dollar amount for penalties, to ensure budget neutrality for DMAS. The MCO's weighted score sum is used to determine the percentage award penalty for each MCO. If an MCO's weighted score sum is above or below the Virginia average, it is awarded or penalized, respectively. If an MCO's weighted score is equal to the Virginia average, no award or penalty will be

assigned. Table 3-8 demonstrates an example of the funds allocation model using the same example data from Table 3-7.

Table 3-8—PIA Funds Allocation
EXAMPLE USING MOCK DATA

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

According to Table 3-7, MCO B has a weighted score sum of 2.44. For MCO B, the percentage award is equal to 2.44 divided by 3. This means that MCO B has an 81.33 percent award (i.e., the MCO is eligible to receive 81.33 percent of their maximum at-risk amount as an award), as shown in Table 3-8.

Once the percentage award or penalty is determined, the result is multiplied by the maximum at-risk amount (0.15 percent multiplied by the total capitation payments). This calculation determines the MCO's maximum award (max award) or maximum penalty (max penalty). For example, the data in Table 3-8 demonstrate how the MCO's max award or max penalty are calculated. If the total capitation payment amount for MCO B is approximately $436,000,000, then $436,000,000 × 0.15% × 81.33% is approximately $532,000. This means that MCO B has a max award of approximately $532,000.

Finally, to ensure budget neutrality, awards and penalties may need to be reduced. In the example provided in Table 3-7, the penalties do not fully fund the awards for MCO A and MCO B. As a result, the awards for both MCO A and MCO B must be reduced, to ensure that the max penalty sum amount can fund the max award sum. For this example, MCO B's final award would be calculated as:

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

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

Objectives

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

Status of 2018 Activity

The 2018 activity represents the third year in which MCOs will be subject to quality awards or penalties. HSAG calculated and finalized PIA results for all six MCOs in Virginia in December 2018. The Program Year 3 PIA results indicated that two MCOs will be assessed for awards and four MCOs will be assessed for penalties for their performance in 2017, to be collected from the MCOs in Spring 2019. All MCOs were notified of their final PIA results, which provided opportunity for all MCOs to review and provide feedback about those results.

Operational Systems Compliance Reviews

Medallion 4.0

The Medallion 4.0 program, through the contracted MCOs, ensures the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for most of Virginia's Medicaid Title XIX members, members of FAMIS, and Virginia's Title XXI CHIP. The primary objective of the readiness review process is to assess ability and capacity of the MCOs to satisfactorily perform key operational and administrative functions, service delivery, and financial and systems management outlined in the Medallion 4.0 contract. HSAG conducted Medallion 4.0 readiness reviews of the six MCOs to ensure readiness to serve the Medallion 4.0 population. Table 3-9 displays, by MCO, the Medallion 4.0 readiness review results.

Table 3-9—Medallion 4.0 Readiness Review Results

Standard Number	Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier
I	Continuity and Coordination of Care	**100%**	**94.4%**	**97.2%**	**100%**	**86.1%**	**88.9%**
II	Behavioral Health Services and Substance Abuse Treatment Services	**100%**	**100%**	**96.9%**	**100%**	**96.9%**	**93.8%**

Standard Number	Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier
III	Coverage and Authorization of Services	**100%**	**100%**	**98.4%**	**98.4%**	**95.3%**	**90.6%**
IV	Credentialing and Recredentialing	**100%**	**95.8%**	**100%**	**95.8%**	**100%**	**100%**
V	Enrollment and Disenrollment	**100%**	**100%**	**100%**	**100%**	**95.0%**	**85%**
VI	Grievances and Appeals	**100%**	**97.4%**	**92.1%**	**100%**	**94.7%**	**100%**
VII	Provider Engagement, Contracting, Subcontracts and Delegation	**100%**	**95.5%**	**96.2%**	**100%**	**81.8%**	**72.7%**
VIII	Provider Participation	**75.0%**	**100%**	**100%**	**100%**	**75.0%**	**50.0%**
IX	Health Information Systems	**93.8%**	**100%**	**87.5%**	**93.8%**	**100%**	**81.3%**
X	Quality Assessment and Performance Improvement Program	**100%**	**100%**	**96.2%**	**100%**	**92.3%**	**86.4%**
	Total Score	**98.9%**	**98.2%**	**96.6%**	**98.9%**	**93.0%**	**89.0%**

Total Score: *Complete* elements are assigned one point each. *Progress Sufficient to Meet Operations* elements are assigned 0.5 points each. *Not Met* elements are assigned zero points each. Elements marked *Not Applicable* are not counted in the total applicable elements for each standard. Totals are rounded to the nearest tenth of a percent.

The MCOs were approved for Medallion 4.0 implementation when no operational, administrative, service delivery, or systems-related deficiencies appeared present which would impede the ability and capacity to satisfactorily perform the Medallion 4.0 managed care responsibilities outlined in the MCO's Medallion 4.0 contract.

Medicaid Expansion

The Medicaid expansion benefit plan includes all services currently covered by Medicaid for the existing populations as well as additional federally-required adult preventive care and disease management programs. Medicaid expansion provides coverage for adults ages 19 through 64 who are not Medicare-eligible, who have income from 0 percent to 138 percent of the federal poverty level (FPL), and who are not already eligible for mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability). Medallion 4.0 will serve as the delivery system for expansion individuals who are determined not to be medically complex. The primary objective for the readiness reviews conducted by HSAG was to assess ability and capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the CMS Medicaid Expansion Gateway tool. HSAG conducted Medicaid expansion readiness reviews of the six Medallion 4.0 MCOs to ensure readiness to serve the existing

Medallion 4.0 and the expansion population beginning on January 1, 2019. Table 3-10 displays, by MCO, the Medicaid expansion readiness review results.

Table 3-10—Medicaid Expansion Readiness Review Results

Standard Number	Medicaid Expansion Readiness Review Standard	Aetna	Anthem	Magellan	Optima	United	VA Premier
I	Availability of Services	**83.3%**	**83.3%**	**84.6%**	**83.3%**	**83.3%**	**83.3%**
II	Assurances of Adequate Capacity and Services	**85.7%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**	**85.7%**
III	Coverage and Authorization of Services	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
IV	Provider Selection	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
V	Member Rights and Protections	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VI	Health Information Systems	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VII	Enrollment and Disenrollment	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
VIII	Member Information	**100%**	**95.0%**	**100%**	**100%**	**100%**	**100%**
	Total Score	**93.6%**	**91.7%**	**93.9%**	**93.6%**	**93.6%**	**93.6%**

Total Score: *Complete* elements are assigned one point each. *Progress Sufficient to Meet Operations* elements are assigned 0.5 points each. *Not Met* elements are assigned zero points each. Elements marked *Not Applicable* are not counted in the total applicable elements for each standard. Totals are rounded to the nearest tenth of a percent.

The MCOs were approved for Medicaid expansion implementation when no operational, administrative, service delivery, or systems-related deficiencies appeared to be present that would impede ability and capacity to satisfactorily perform the Medicaid expansion managed care responsibilities outlined in the MCO's Medallion 4.0 contract.

Addiction and Recovery Treatment Services

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an evaluation of the Addiction and Recovery Treatment Services (ARTS) program. Below are the major findings from a report published by the VCU evaluation team about changes in access to and utilization of addiction treatment services during the first year of ARTS.

More Medicaid members with substance use disorders are receiving treatment.

Table 3-11 displays substance use disorder (SUD) data before and after implementation of the ARTS program. The percentage of Medicaid members with a substance use disorder who received any treatment increased from 24 percent before ARTS to 40 percent by the end of the first year of ARTS.

Table 3-11—SUD Treatment

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of members with a substance use disorder (SUD)	49,440	50,857	3%
Members with SUD receiving any SUD treatment	12,089	20,436	69%
Percentage receiving SUD treatment	24%	40%	64%

More Medicaid members with opioid use disorders are receiving treatment.

Table 3-12 displays opioid use disorder data before and after implementation of the ARTS program. The percentage of Medicaid members with an opioid use disorder who received any treatment increased from 46 percent before ARTS to 63 percent by the end of the first year of ARTS.

Table 3-12—OUD Treatment

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of members with opioid use disorder (OUD)	17,914	20,712	16%
Members with OUD receiving any OUD treatment	8,322	12,980	56%
Percentage receiving OUD treatment	46%	63%	35%

Fewer emergency department visits occurred related to opioid use disorders.

Table 3-13 displays emergency department (ED) data before and after implementation of the ARTS program. The number of ED visits related to opioid use disorders decreased by 25 percent during the first 10 months of ARTS. This compares with a 9 percent decrease in ED visits for all Medicaid members.

Table 3-13—ED Visits

Measure	Before ARTS April 2016–January 2017	After ARTS April 2017–January 2018	Percentage Change
ED visits related to opioid use disorder	5,016	3,756	-25%
Total ED visits for all Medicaid members	786,698	714,743	-9%

Fewer prescriptions written for opioid pain medications.

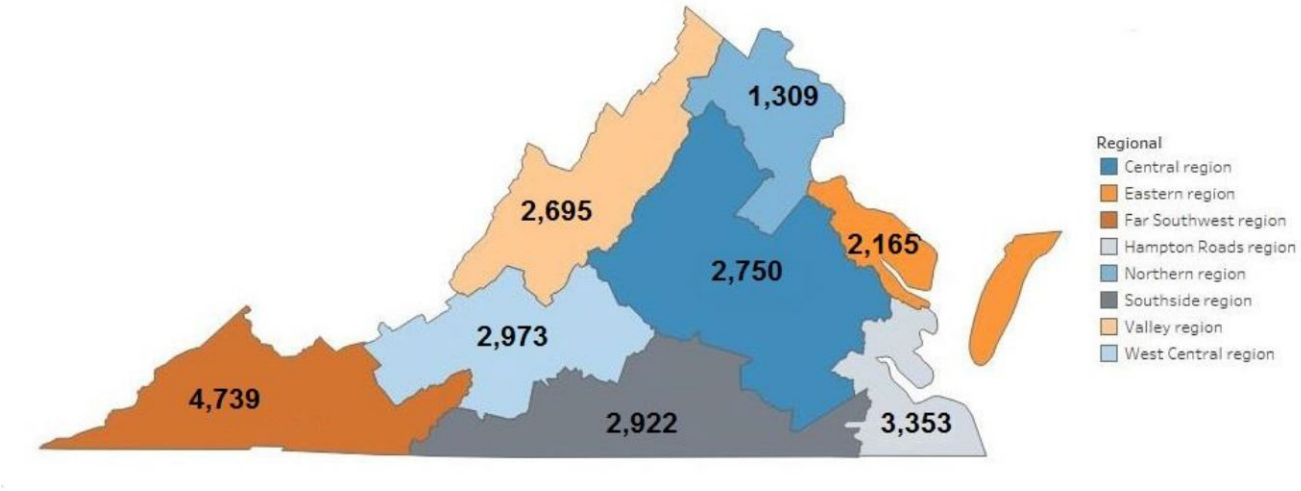
Table 3-14 displays number of prescriptions written for opioid pain medication data before and after implementation of the ARTS program. The number of prescriptions written for opioid pain medications among Medicaid members decreased by 27 percent during the first year of ARTS.

Table 3-14—Number of Prescriptions Written for Opioid Pain Medication

Measure	Before ARTS April 2016–March 2017	After ARTS April 2017–March 2018	Percentage Change
Total number of prescriptions written for opioid pain medications	549,442	399,790	-27%
Number of prescriptions written for opioid pain medications per 10,000 members	3,811	2,761	-28%

Figure 3-1 displays the number of prescriptions written for opioid pain medications per 10,000 Medicaid members. The number of prescriptions for opioid pain medications per 10,000 Medicaid members varies widely across Virginia regions.

Figure 3-1—Number of Prescriptions for Opioid Pain Medication



Other DMAS Activities Related to Quality Improvement

DMAS selected the following clinical topics for the 2018 contract year: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study), improving the health of children in foster care (Foster Care Focused Study, and Perinatal Dental Utilization).

Improving Birth Outcomes Through Adequate Prenatal Care

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

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

The Birth Outcomes Focused Study included five study indicators: percentage of births with early and adequate prenatal care; percentage of births by gestational estimate; percentage of newborns with low birth weight; percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth; and percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth. The five study indicators reported in the contract year 2016 study were reproduced using probabilistically and deterministically linked data for Virginia Medicaid or FAMIS MOMS recipients with birth registry records to identify births paid by Virginia Medicaid during calendar year 2015. This is the second year of the Birth Outcomes Focused Study, which used the same

methodology from the first year (measurement year [MY] 2014). The study population included women continuously enrolled in the Medicaid for Pregnant Women (MPW), the FAMIS MOMS (FM), or an "Other Medicaid"[3-3] (OM) program for a minimum of 43 days prior to and including the date of delivery. The comparison group included women covered by one of the three Medicaid program groups on the date of delivery but without prior continuous enrollment. Study indicator results by study population are presented in Table 3-15.

Table 3-15—Overall Study Findings by Indicator and Population Group Among Singleton Births, MY 2015

Study Indicator	2015 National Benchmark[1]	Study Population		Comparison Group		Statistically Significant Difference (Yes/No)
		n	%	n	%	
Births With Early and Adequate Prenatal Care	77.6%	21,289	76.6	3,782	69.2	Yes
Preterm Births (< 37 Weeks Gestation)	7.8%	2,533	9.0	592	10.5	Yes
Newborns With Low Birth Weight (< 2,500g)	6.3%	2,361	8.4	474	8.4	No
Newborns With ≥ 2 PCP Visits in the 30 Days Following Birth	N/A	7,165	25.9	2,049	37.2	Yes
Newborns With ≥ 1 ED Visit in the 30 Days Following Birth	N/A	2,009	7.3	546	9.9	Yes

[1] The national benchmark for *Births with Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmarks for *Preterm Births* and *Newborns with Low Birth Weight* were identified from calendar year 2015 national data available from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS)[3-4] final data for 2015. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.

Results of the Birth Outcomes Focused Study found that births to women in the study population fared better than those in the comparison group for the following indicators: *Births With Early and Adequate Prenatal Care*, *Preterm Births* and *Newborns With ≥1 ED Visit in the 30 Days Following Birth*. Births in the comparison group outperformed the study population for the indicator *Newborns With ≥2 PCP Visits in the 30 Days Following Birth*; that is, a greater percentage of children born to mothers in the comparison group had two or more visits with a PCP-type provider in the 30 days following birth compared to children born to mothers in the study population. In MY 2015 results differences between the study population and comparison group were statistically significant for all indicators except *Newborns With Low Birth Weight (<2,500g)*.

[3-3] The "Other Medicaid" category includes births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women programs (i.e., the pregnancy aid categories). Births among the OM programs may also include women with Medicaid coverage for emergency services only.

[3-4] Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final data for 2015. National Vital Statistics Reports; vl66 no 1. Hyattsville, MD: National Center for Health Statistics. 2017. Available at https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01.pdf.

During 2018, HSAG also initiated the third annual Birth Outcomes Focused Study, covering births occurring during MY 2016 and MY 2017 and using a methodology similar to prior studies. Results from this study are scheduled to be released in 2019.

Dental Utilization in Pregnant Women Data Briefs

As a supplement to the Birth Outcomes Focused Study, DMAS contracted HSAG to provide annual data briefs on dental utilization among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015. This focused study is designed to provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve prenatal care and birth outcomes among Medicaid and FAMIS members receiving dental services.

HSAG completed Dental Utilization in Pregnant Women Data Briefs for two study periods, covering measurement year (MY) 2016 and MY 2017. The Dental Utilization in Pregnant Women Data Briefs included all women with deliveries during each MY; however, due to methodological changes between the MYs, MY 2016 and MY 2017 results are not comparable.

Table 3-16 and Table 3-17 present the number and percentage of women in the study population who received dental services during pregnancy in each of the study periods, MY 2016 and MY 2017.

Table 3-16—MY 2016 Dental Utilization Among Pregnant Women by Study Indicator

Measure	MY 2016 Number	MY 2016 Percentage of Study Population (n=30,176)	MY 2016 Percentage of Pregnant Women With Any Dental Service (n=4,026)
Any Dental Service	4,026	13.34	100
Preventive Dental Service	2,619	8.68	65.05
Dental Fillings	1,400	4.64	34.77
Simple or Surgical Extractions	1,140	3.78	28.32
Pulpotomies or Pulpectomies (root canals)	639	2.12	15.87
Crowns	349	1.16	8.67

During MY 2016, 4.83 percent of women in the study population received both preventive and restorative[3-5] dental services during pregnancy.

[3-5] Restorative services include fillings, crowns, extractions, or pulpotomies/pulpectomies.

Table 3-17—MY 2017 Perinatal Dental Utilization by Study Indicator

Measure	MY 2017 Count of Deliveries	MY 2017 Percentage of Deliveries Among Study Population (n=32,297)	MY 2017 Percentage of Deliveries Among Women with Any Perinatal Dental Service (n=6,374)
Any Dental Service*	**6,374**	**19.7**	**100.0**
Adjunctive General Services	1,114	3.4	17.5
Crowns	1,180	3.7	18.5
Diagnostic Services	6,122	19.0	96.0
Endodontics	2,404	7.4	37.7
Periodontics	1,384	4.3	21.7
Preventive Services	210	0.7	3.3
Prosthodontics	3,254	10.1	51.1
Restorative Services Including Crowns	3,556	11.0	55.8
Surgery or Extractions	2,264	7.0	35.5

* A woman may have had more than one dental service during the perinatal period; therefore, the counts of deliveries for each dental service category do not sum to the overall number of deliveries among women with any dental service.

During MY 2017, the study results indicated that more deliveries occurred to women receiving dental services during the prenatal period than during the postpartum period, and 30.5 percent of deliveries occurred among women who received dental services during both the prenatal and postpartum periods.

Results of the study also identified regional differences in the utilization of any dental services and preventive dental services during pregnancy. Table 3-18 and Table 3-19 presents the number and percentage of women in the study population who received dental services during pregnancy by the woman's region of residence in each of the study periods, MY 2016 and MY 2017.

Table 3-18—MY 2016 Dental Utilization Among Pregnant Women by Region of Residence

Region	Count of Pregnant Women	Count of Women Receiving Dental Services During Pregnancy	Percentage of Women Receiving Dental Services During Pregnancy	Count of Women Receiving Preventive Dental Services During Pregnancy	Percentage of Women Receiving Preventive Dental Services During Pregnancy*
	MY 16	**MY 16**	**MY 16**	**MY 16**	**MY 16**
Central	7,191	1,061	14.75	723	68.14
Charlottesville	1,929	239	12.39	171	71.55
Far Southwest	1,435	235	16.38	145	61.70

Region	Count of Pregnant Women	Count of Women Receiving Dental Services During Pregnancy	Percentage of Women Receiving Dental Services During Pregnancy	Count of Women Receiving Preventive Dental Services During Pregnancy	Percentage of Women Receiving Preventive Dental Services During Pregnancy*
Halifax-Lynchburg	1,458	167	11.45	75	44.91
Roanoke-Alleghany	2,807	366	13.04	171	46.72
Tidewater	6,384	917	14.36	529	57.69
Winchester-Northern	8,971	1,041	11.6	850	77.33
No Region Identified	1	0	0	0	0
Total	**30,176**	**4,026**	**13.34**	**2,619**	**65.05**

*As a percentage of women who received any dental service during pregnancy.

Table 3-19—MY 2017 Perinatal Dental Utilization by Region of Residence

Region	Count of Deliveries	Count of Deliveries Among Women Receiving Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Perinatal Dental Services	Count of Deliveries Among Women Receiving Preventive Perinatal Dental Services	Percentage of Deliveries Among Women Receiving Preventive Perinatal Dental Services*
	MY 17	**MY 17**	**MY 17**	**MY 17**	**MY 17**
Central	8,085	1,838	22.7	964	52.4
Charlottesville	2,048	378	18.5	188	49.7
Far Southwest	1,508	384	25.5	197	51.3
Halifax-Lynchburg	1,649	209	12.7	86	41.1
Roanoke-Alleghany	2,862	523	18.3	216	41.3
Tidewater	6,817	1,402	20.6	680	48.5
Winchester-Northern	9,327	1,640	17.6	923	56.3
No Region Identified	1	0	0	0	0
Total	**32,297**	**6,374**	**19.7**	**3,254**	**51.1**

*As a percentage of women who received any dental service during pregnancy.

The VA Smiles For Children program provides pregnant women with a critically important opportunity to receive dental services; however, relatively few eligible women received dental service during

pregnancy. During MY 2016, slightly less than two-thirds of the pregnant women with encounters for dental services received preventive dental services.

Overall dental utilization among pregnant women and receipt of preventive dental services varied by region. Study findings in MY 2017 identified that more women received dental services during the prenatal period than during the postpartum period. Utilization of dental services also varied by region, with the Halifax-Lynchburg region having the lowest percentage of women receiving dental services and the lowest percentage of women receiving preventive dental services.

Foster Care Focused Study

Most Virginia foster children receiving Medicaid services were transitioned from fee-for-service (FFS) programs to managed care no later than June 2014, and DMAS took steps from 2015 through 2018 to continually improve quality and timeliness of care for these children. However, some Medallion 3.0 children in foster care continued in FFS. DMAS conducted follow-up training with participating local Departments of Social Services (LDSSs) and Medicaid MCOs in 2015 and 2016 to address transition issues among children in foster care. Beginning in contract year 2015–2016 , DMAS contracted HSAG to conduct focused studies that provide quantitative information about children and adolescents receiving medical services through the contracted MCOs.

The CY 2017–2018 (CY 2018) Foster Care Focused Study was designed to determine the extent to which children in foster care received the expected preventive and therapeutic medical care in the third year of managed care service delivery. Additionally, the study sought to compare utilization of preventive and therapeutic medical care among children in foster care between the first and third years of managed care service delivery. Measurement years (MYs) were defined as being from July 1 through June 30, beginning with MY 2015: July 1, 2014, through June 30, 2015.

For each MY, HSAG used administrative and medical record data to calculate 15 study indicators across three domains:

- *Characteristics of Medicaid Members in Foster Care*: Five indicators in this category provided information on age, sex, race and ethnicity, region of residence, and the degree to which children moved between regions—for all foster children eligible for study inclusion.
- *Preventive Care:* Four indicators in this category provided information on the degree to which foster children continuously enrolled with one or more MCOs throughout the study period received expected well-child visits and expected immunizations and used PCPs and dental services.
- *Behavioral Health:* Six indicators in this category provided information on foster children continuously enrolled with one or more MCOs throughout the study period, with specific indicators addressing utilization of antipsychotic medications (three indicators), children's receipt of follow-up care following hospitalization for mental illness, and prevalence of children prescribed antidepressant medications or medications for attention deficit hyperactivity disorder (ADHD).

Additionally, behavioral health indicators for MY 2015 and MY 2016 were recalculated using HEDIS 2017 technical specifications to ensure comparability across study years.

Overall, 7,599 children in foster care at any time from July 1, 2016, through June 30, 2017 (i.e., MY 2017), were included in the study population; and 4,770 of these children were continuously enrolled with one or more MCOs throughout the study period, each with enrollment gaps totaling no more than 45 days. The proportion of children continuously enrolled in Medicaid increased from 57.0 percent in MY 2015 to 62.8 percent during MY 2017. This is the highest proportion of continuously enrolled children observed across the three MYs. Of the 7,599 children in the MY 2017 study population, 62.8 percent were also in the MY 2016 study population, and 39.3 percent were in the MY 2015 study population. Overall, 38.7 percent were in the study population for all three study years, and 57.7 percent among this group were continuously enrolled for all three MYs.[3-6]

During the third year of statewide managed care service delivery for children in foster care, key observations noted that access to PCP-type providers and utilization of dental services among continuously enrolled members was relatively stable from MY 2015 through MY 2017. Additionally, the increase in the proportion of children having at least one visit with a PCP-type provider between MY 2015 and MY 2017 was statistically significant as was an observed decrease in the proportion of children with no administrative record of visits with a PCP-type provider. Overall, study findings suggest that most children in foster care are receiving preventive care under managed care service delivery.

Results across the behavioral health indicators suggest that foster children continuously enrolled with one or more MCOs received thorough, consistent care, though areas for improvement do exist. Overall, indicators related to antipsychotic medication use show improvements in medication management oversight and high levels of compliance with first-line therapy recommendations for children with off-label drug use.[3-7]

Rates of follow-up care within seven days among foster children hospitalized for mental illness highlight an opportunity for improvement. While seven-day follow-up rates were highest during MY 2015, the number of children hospitalized and the number of hospitalizations assessed for follow-up occurring within 30 days of hospital discharge increased significantly during MY 2016 and MY 2017. In contrast to seven-day follow-up findings, 30-day follow-up was consistently higher across study years—with rates at or above 79.0 percent—with a slight decrease during MY 2016.

Trends in antidepressant and attention deficit disorder (ADD)/attention deficit hyperactivity disorder (ADHD) medication prevalence among children in foster care underscore the need to document and monitor medication uptake across age groups and geographic regions. Overall, these findings indicate

[3-6] While this text compares findings between MYs 2015 and 2017, an assessment of trends or changes among children continuously placed in foster care from July 1, 2014, through June 30, 2017, was beyond the scope of the CY 2018 focused study.

[3-7] "Off-label" drug use was defined for these study indicators using HEDIS 2017 technical specifications. Scenarios considered to be "off-label" drug use for this measure include cases in which a child is prescribed an antipsychotic medication in the absence of a diagnosis of schizophrenia, bipolar disorder, or other psychotic disorder.

that children in foster care are receiving first-line behavioral health care consistently. Additionally, the consistently high rate of psychosocial care among children prescribed antipsychotic medications may indicate that children in foster care are receiving medication management care when clinically complex medications are prescribed.

Recommendations for Virginia's Quality Strategy Focus and Priorities

Quality Strategy Focus and Priorities

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

The four publicly promoted aims are:

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

The Medallion 4.0 managed care contract[3-8] requires that MCOs ensure annual improvement in the HEDIS priority measures until such time that each MCO is performing at least at the national Medicaid 50th percentile for HMOs as reported by NCQA Quality Compass. Thereafter, the MCO must sustain performance at the 50th percentile. Of note, approximately 70 percent of measures for HEDIS 2018 (19 of 27) ranked at or above the national Medicaid 50th percentiles, compared to 75.8 percent in 2017. Furthermore, in the updated DMAS Quality Strategy 2017–2019, DMAS indicated that the stretch performance goal for MCOs is to reach the national Medicaid 75th percentiles, recognizing that it may not be realistic to expect all Virginia MCOs to reach the 75th percentile for all priority measures. HSAG recommends that DMAS examine the opportunity for the development of an improvement scale whereby MCOs demonstrate improvement across performance years, with the goal of each being to meet the 75th percentile for the priority measures. The design of the improvement scale could also serve as the foundation to guide MCOs in the development of value-based payment models to be used in the Medallion 4.0 provider contracts.

Overall, the Virginia total rate for CY 2018 performed between the national Medicaid 25th and 50th percentiles, indicating opportunities to reduce the number of children and adolescents prescribed multiple antipsychotics. Regional variation exists in the reportable rates of multiple antipsychotics being

[3-8] Medallion 3.0 Managed Care Contract. Available at: http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20Contract%20(07.26.2018).pdf. Accessed on: Jan 30, 2019.

prescribed, with Far Southwest Virginia having the highest rate at 4.43 percent and Tidewater having the lowest rate at 2.49 percent. Rates indicated that more males were treated with multiple antipsychotics. Further, a higher percentage of individuals of White race were treated with multiple antipsychotics compared to other races. Geographical variation exists in the rate for treating children with multiple antipsychotics, with children in non-rural areas having the highest rate at 3.08 percent and children living in rural areas having the lowest rate at 2.16 percent.

In addition to increasing the number of HEDIS measures that meet the national Medicaid 50th percentiles, all MCOs should focus HEDIS measure improvement efforts on *Antidepressant Medication Management, Prenatal and Postpartum Care, Follow-Up After Hospitalization for Mental Illness,* and *Care for Chronic Condition* measures. DMAS may want to prioritize these HEDIS measures and require that the MCOs conduct performance improvement activities using the Model for Improvement.[3-9]

In the MCO-specific recommendations in Section 4, HSAG shared some practices that health plans in other states have used to improve performance. These recommendations included:

DMAS Quality Strategy Aim #1: Build a wellness-focused, integrated system of care.

- For improving *Follow-Up Care for Children Prescribed ADHD Medications*, MCOs should limit the quantity prescribed for new ADHD prescriptions and conduct outreach to the member's family or caregivers to educate them on the need for continued use and benefits of the prescribed medication. Members should be encouraged to seek and receive assistance in scheduling follow-up care to renew prescriptions.
- For improving *Follow-Up Care for Children Prescribed ADHD Medications*, MCOs should limit the quantity prescribed for new ADHD prescriptions, which may result in an improvement in the Initiation Phase measure indicator rates. This intervention requires the member's family or caregivers to seek follow-up care to renew prescriptions, which also provides an opportunity for the member to receive well-child visits; immunizations; and other needed Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) services.
- For improving *Antidepressant Medication Management* measure rates, MCOs should leverage the educational tools and resources that the contracted pharmacy benefit management companies have available to support member adherence with antidepressant medications.

DMAS Quality Strategy Aim #2: Focus on screening and prevention.

DMAS' current transition to the Medallion 4.0 program for Medicaid MCOs provides opportunity for DMAS to align quality improvement topics with care management goals for children in foster care. HSAG offers the following recommendations, based on findings related to the Foster Care Focused Study:

[3-9] Institute for Healthcare Improvement, "How to Improve". Available at http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Feb 18, 2018.

- The generally stable study indicator results between MY 2015 and MY 2017 reveal that Virginia foster children are accessing and using health care services. To assess the extent to which foster children's health care access and utilization are comparable to access and utilization for other children receiving Medicaid benefits, DMAS should consider modifying future iterations of the Foster Care Focused Study to add a comparison population. Note that as DMAS implements Medallion 4.0, regional inclusion may not be complete until 2019. Consequently, DMAS should consider conducting comparative analyses in the second year of the Medallion 4.0 program (i.e., calendar year 2020).
  - Study indicators could be calculated for children in foster care and children receiving Title XXI and/or Title XIX services under managed care to assess the degree to which children in foster care use preventive, physical, and behavioral health services as compared to other children receiving Medicaid benefits.
- Children in foster care are prescribed a variety of medications that merit active monitoring. As DMAS continues the transition to the Medallion 4.0 Medicaid Managed Care Program, HSAG recommends conducting planned data mining activities to review prescription drug utilization, including providers' prescribing patterns and appropriate clinical monitoring of children receiving specific classes of medications (e.g., antidepressants). Based on the data mining results, DMAS can assess the extent to which utilization of specific drugs is coordinated with care services.
- Approximately 40 percent of MY 2017 study members were present in the MY 2015 and MY 2016 study populations, underscoring the viability of a longitudinal study on health status, health care access, and utilization patterns among children in foster care. DMAS should consider data mining activities focused on children continuously enrolled in foster care for extended periods of time (e.g., greater than one year) to assess long-term health care service utilization and satisfaction with care.

DMAS Quality Strategy Aim #3: Achieve healthier pregnancies and healthier births.

DMAS' transition to the Medallion 4.0 program provides opportunity for DMAS and the MCOs to reassess existing quality improvement strategies related to peripartum care and resulting clinical outcomes among neonates. Moving forward, the MCOs' quality initiatives should be designed to ensure alignment with Medallion 4.0's targeted topics regarding maternity services and services for infants (i.e., 0 to 3 years). HSAG offers the following recommendations based on findings from the Improving Birth Outcomes Focused Study:

- DMAS should expand collaborations such as that with the MIIP[3-10] to include other agencies pursuing similar objectives (e.g., VDH's Family Home Visiting Program). Such collaboration allows influential groups to design interventions without duplicating efforts and may allow respective stakeholders to reach larger audiences.

[3-10] Virginia Department of Medical Assistance Services. Maternal and Infant Improvement Project (MIIP) Activities Report 2015-2016. Available at: http://www.dmas.virginia.gov/files/links/887/Maternal%20and%20Infant%20Improvement%20Project%20(MIIP)%20Activities%20Report%202015%20-%202016.pdf. Accessed on Jan 30, 2019.

- The generally stable study indicator results between CY 2014 and CY 2015 may be indicative of underlying issues related to health care access among women and newborns receiving services under Virginia Medicaid, FAMIS, and FAMIS MOMS. As such, DMAS should consider conducting a focused evaluation of access to care to determine the availability of and members' ability to access: PCPs, including pediatricians; providers of prenatal and postpartum care; and facilities related to perinatal care (e.g., hospitals and freestanding birth centers, pharmacies, and laboratory and x-ray providers). In addition to considering providers' capacity and availability, evaluation should include an assessment of potential sociodemographic and clinical factors influencing members' access to perinatal care. Results from an access evaluation will aid DMAS in determining barriers experienced by women seeking perinatal care and looking to establish consistent primary care for their newborns.
  - DMAS may use existing or planned provider network evaluation results to determine the extent to which MCOs' utilization management policies may impact members' abilities to receive timely, clinically-appropriate care before, during, and after a pregnancy. Such efforts may be aligned with the Medallion 4.0 focus on long-acting reversible contraceptives (LARCs) to determine the extent to which postpartum care is available, accessible, and used as an opportunity to educate members about reproductive health options.
- For improving the Prenatal and Postpartum Care measure rates, MCOs should leverage relationships with providers and community partners to: provide opportunities to partner with obstetrical practices to conduct reminder calls the day before scheduled appointments, assist with ensuring that transportation is arranged for the appointment by completing warm transfers to the transportation vendors, and provide additional educational opportunities such as parenting classes.

DMAS Quality Strategy Aim #4: Maximize well being across the lifespan.

- For improving the *Medication Management for People With Asthma*; *Antidepressant Medication Management*; *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measures, MCOs should focus quality improvement efforts on ensuring that members are monitored appropriately and are consistent in taking long-term medications. MCOs should review the declines in medication management performance to ensure that providers are appropriately monitoring members on long-term medications.
- For improving Care for Chronic Conditions measure rates, MCOs should focus efforts on collaborating with and incentivizing PCPs or health home providers to ensure that medication refills are monitored. In other state Medicaid programs, Medicaid MCOs utilize their internal pharmacy departments successfully to: conduct follow-up on medication refills, outreach to review medications upon discharge from inpatient stays or emergency department visits, and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.
- For improving Care for Chronic Conditions measure rates, MCOs should focus efforts on identifying PCPs with strong chronic disease member outcomes and encourage members to use these providers for their medical homes. MCOs have an opportunity to learn from high-performing providers best practices that may be shared with other providers treating individuals diagnosed with chronic conditions.

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

HSAG recommends that MCOs use other quality improvement techniques to examine systems and address failures. For example, MCOs may use a simple Six Sigma performance improvement model: Define, Measure, Analyze, Improve, Control (DMAIC) to facilitate improvement in processes and outcomes.

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

4. Assessment of MCO Performance

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2018 EQR Technical Report, HSAG used findings from the following EQR activities conducted from January 1, 2018, through December 31, 2018, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services (QAT) provided by each MCO.

Mandatory EQR Activities: OSRs, PIPs, and PMVs.

Optional EQR Activities: CAHPS and calculation of performance measures.

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

To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated all components of each EQR activity and resulting findings across the continuum of program areas and activities that comprise the Medallion 3.0 and Medallion 4.0 programs. The composite findings for each MCO were analyzed to identify overarching trends and focus areas for the MCOs.

MCO-Specific HEDIS Measure Results

The following tables present each MCO's HEDIS 2016, 2017, and 2018 performance measure results and the current performance level relative to the national Medicaid 50th percentiles.[4-1] The source of the national Medicaid 50th percentile is NCQA's Quality Compass.

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

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

Aetna, formerly CoventryCares of Virginia, is the Medicaid/FAMIS Plus program offered by Aetna, a multistate health care benefits company headquartered in Hartford, Connecticut. Aetna acquired Coventry Health Care of Virginia in 2013, The name change to Aetna was effective April 1, 2016. To conduct the 2017 EQR, HSAG reviewed Aetna's mandatory and optional EQR activities. Those results were analyzed and evaluated to develop conclusions and make recommendations about the quality of,

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

access to, and timeliness of care and services provided by Aetna. This section provides the high-level results and notable findings for the mandatory and optional EQR activities performed for Aetna.

Performance Measures

Table 4-1 displays the rates for measures that Aetna reported for HEDIS 2016, 2017, and 2018. Aetna's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Aetna's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-1—Aetna HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.87%	50.12%	53.04%	**50.12%**
Childhood Immunization Status				
Combination 3	67.45%	66.42%	65.45%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	61.14%	61.22%	64.48%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.32%	72.26%	76.40%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	52.35%	—
Cervical Cancer Screening				
Cervical Cancer Screening	64.16%	55.26%	60.10%	**58.48%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	87.63%	83.33%	77.86%	**83.56%**
Postpartum Care	65.98%	65.36%	64.72%	**64.38%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	85.08%	85.13%	83.63%	**82.21%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	97.87%	97.05%	**95.70%**
25 Months–6 Years	—	92.58%	91.39%	**87.87%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
7–11 Years	—	93.12%	93.00%	**90.77%**
12–19 Years	—	91.69%	90.09%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.92%	86.13%	81.02%	**87.10%**
HbA1c Control (<8.0%)	48.46%	45.01%	47.20%	**48.87%**
Eye Exam (Retinal) Performed	53.19%	52.80%	55.23%	**55.11%**
Medical Attention for Nephropathy	91.25%	90.51%	91.97%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	58.39%	54.74%	58.39%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	59.08%	61.31%	59.12%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	27.96%	35.52%	30.27%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	79.31%	78.37%	80.42%	**77.05%**
Discussing Cessation Medications	52.25%	51.61%	55.91%	**49.71%**
Discussing Cessation Strategies	42.61%	37.86%	40.11%	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	50.94%	50.95%	44.97%	**51.89%**
Effective Continuation Phase Treatment	33.49%	34.32%	27.02%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	30.68%	54.96%	51.98%	**44.80%**
Continuation and Maintenance Phase	43.24%	66.28%	55.70%	**55.90%**
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	60.75%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	41.35%	72.46%	65.91%	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

For HEDIS 2018, Aetna demonstrated strong performance related to access to care for pediatric members, as evidenced by all indicators for *Children and Adolescents' Access to Primary Care Practitioners* and all measure rates related to well-care visits performing above the national Medicaid 50th percentiles. Of note, the measure rate for *Childhood Immunization Status—Combination 3* has declined over time and is more than 6 percentage points below the national Medicaid 50th percentile. Given that Aetna is performing above the national Medicaid 50th percentiles for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, this may indicate an opportunity to work with PCPs to ensure that they are providing and documenting comprehensive services during these visits.

The rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* fell more than 5 percentage points below the national Medicaid 50th percentile and declined in performance by nearly 10 percentage points compared to HEDIS 2016, indicating an opportunity to improve care for female members while they are pregnant.

Additionally, Aetna demonstrated an overall decline in performance from HEDIS 2017 to HEDIS 2018 for the following measure rates related to prescription medications: *Medication Management for People With Asthma—Medication Compliance 75%—Total* (more than 5 percentage points); *Antidepressant Medication Management—Effective Acute Phase Treatment* (nearly 6 percentage points) and *Effective Continuation Phase Treatment* (more than 7 percentage points); *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* (nearly 3 percentage points) and *Continuation and Maintenance Phase* (more than 10 percentage points); and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* (almost 7 percentage points). Aetna should examine these declines in performance to ensure that providers are appropriately monitoring members who are on long-term medications.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-2 presents the 2017 and 2018 MCO-specific adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Aetna's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Aetna were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-2—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Aetna

	Aetna Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	62.8%	60.2%
Rating of All Health Care	59.4%	54.9%
Rating of Personal Doctor	68.9%	68.7%
Rating of Specialist Seen Most Often	55.7%	58.2%+
Composite Measures		
Getting Needed Care	84.9%	86.4%
Getting Care Quickly	83.9%	86.4%+
How Well Doctors Communicate	90.4%	90.7%
Customer Service	84.7%+	89.0%+
Shared Decision Making	82.3%+	81.3%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Aetna's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna scored statistically significantly lower than the 2017 NCQA adult Medicaid national average on one measure: *Rating of Specialist Seen Most Often*.
- Aetna did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

Child CAHPS

Table 4-3 presents the 2017 and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Aetna's 2018 child Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Aetna were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 4-3—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Aetna

	Aetna Child Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	70.0%	70.1%
Rating of All Health Care	68.2%	69.6%
Rating of Personal Doctor	74.7%	76.5%
Rating of Specialist Seen Most Often	72.4%+	67.6%+
Composite Measures		
Getting Needed Care	87.5%	88.9%+
Getting Care Quickly	92.2%	94.3%
How Well Doctors Communicate	95.0%	96.9%
Customer Service	85.6%+	85.0%+
Shared Decision Making	80.4%+	76.1%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Aetna's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Aetna scored statistically significantly higher than the 2017 NCQA national child Medicaid average on one measure: *Getting Care Quickly*.
- Aetna scored statistically significantly higher than the 2018 NCQA national child Medicaid averages on two measures: *Getting Care Quickly* and *How Well Doctors Communicate*.
- Aetna did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

Consumer Decision Support Tool

The 2018 Consumer Decision Support Tool demonstrated how Aetna compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Aetna, as shown in Table 4-4.

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

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-5 displays Aetna's 2018 Consumer Decision Support Tool results.

Table 4-5—Aetna's Consumer Decision Support Tool Results, 2018

Domain	2018 Results
Doctors' Communication	★★★
Getting Care	★★★
Keeping Kids Healthy	★★★
Living With Illness	★★
Taking Care of Women	★★★

For 2018, Aetna demonstrated average performance compared to the other MCOs for most domains, with the exception of the Living With Illness domain, which received a two-star rating, demonstrating opportunities for improvement in this domain.

Performance Improvement Projects

In 2018, Aetna submitted a continuation of one State-mandated PIP for validation. Aetna's PIP topic, *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*, addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' quality strategy. The focus of the PIP was to increase eye exams for diabetic members 18 to 75 years of age assigned to one of four primary care providers. In Module 1, Aetna set a SMART Aim goal to increase each provider's rate by December 31, 2017, as follows:

1. Dr. Richard Jackson, from 25 percent to 62 percent (Provider A)
2. Dr. Damian Covington, from 67 percent to 100 percent (Provider B)
3. Dr. Esther Ajjarapu, from 64 percent to 100 percent (Provider C)
4. Dr. Richard Peebles, from 55 percent to 82 percent (Provider D)

Table 4-6 outlines the SMART Aim measure for the PIP.

Table 4-6—SMART Aim Measure

PIP Topic	SMART Aim Measure
Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes	The rate of continuously enrolled Aetna members who are diagnosed with diabetes, 18 to 75 years of age with no more than one gap of up to 45 days during the 12-month rolling measurement period, who have Dr. A, B, C, or D as their primary care physician and identified as receiving a dilated retinal exam during the measurement period.

For validation year 2018, Aetna submitted Module 4 and Module 5 for the PIP. Table 4-7 displays progression of the PIP.

Table 4-7—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in November 2016.
2. SMART Aim Data Collection	All validation criteria achieved in November 2016.
3. Intervention Determination	All validation criteria achieved in January 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for three interventions. Aetna tested the following interventions:

1. Providers A, B, and C schedule diabetic retinal eye exams for members.
2. Providers A, B, and C identify missed screening appointments.
3. The MCO conducts outreach calls for members assigned to Provider D.

Aetna abandoned the second and third interventions and documented the following lessons learned:

- Results identified that the MCO's providers share the same challenges and difficulty in locating members. Incorrect demographics create a strong barrier to successfully outreaching members.
- Data showed that more than 50 percent of the members had one or more of the following indicators that present additional challenges: severe mental illness, repetitive inpatient episodes and/or

excessive emergency department utilization, substance abuse and/or opioid dependence requiring medication contracts and/or routine drug testing, or terminal illness.

In the Module 5 validation, HSAG analyzed Aetna's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined overall methodological validity of the PIP as well as overall success in achieving the SMART Aim goal. The SMART Aim measure results for Aetna's *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes* PIP are shown in Table 4-8.

Table 4-8—SMART Aim Measure Results

SMART Aim Measure	Narrowed Focus Provider	Baseline	SMART Aim Goal	Highest Rate Achieved
Eye exams for diabetic members assigned to one of four providers	Provider A	25.0%	62.0%	64.0%
	Provider B	67.0%	100.0%	60.0%
	Provider C	64.0%	100.0%	50.0%
	Provider D	55.0%	82.0%	100.0%

Aetna achieved the SMART Aim goal for two of the four providers, Provider A and Provider D; however, that improvement could not be linked to the tested interventions. Provider B's and Provider C's performance remained below the baseline. HSAG assigned *Low Confidence* to the PIP.

Addiction and Recovery Treatment Services

During the Medallion 4.0 readiness review process, HSAG reviewed the status of Aetna's implementation of the ARTS program. HSAG found that the behavioral health services policies submitted by Aetna included all requirements specified in its contract with DMAS (including identification of which members were eligible and which were excluded from the ARTS program) such as when members were admitted to psychiatric residential treatment facilities (PRTFs), and administering and covering any professional medical services provided in the therapeutic group home (TGH). Aetna worked with the Behavioral Health Services Administrator (BHSA) to prevent unnecessary institutional placements and to ensure coordination of medical, ARTS, and mental health services for Aetna members. Aetna also offered transportation and pharmacy services for the provision of BHSA services. Aetna updated its maternity care policy to ensure that pregnant women were screened and received ARTS services as needed. Aetna's policies and procedures included coverage of residential treatment services consisting of PRTFs and TGHs for the Medallion 4.0 members—effective April 1, 2019.

Best and Emerging Practices for Improving Quality of Care and Services

Aetna submitted the following best and emerging practices for 2018.

Provider and Member Collaboration to Promote Prevention

As an enhancement to Aetna's established gaps in care initiatives, Aetna has hired additional staff dedicated solely to conducting outreach to members identified as needing preventive care and services. Aetna provides assistance to members with scheduling an appointment for the preventive screening as well as arranging necessary transportation assistance at the time the appointment is scheduled. Additionally, the Aetna outreach coordinators are assigned specific areas and providers with which to work to review gap-in-care reports, address practice questions or concerns, and coordinate member services and programs.

The QM Team partners with providers throughout Virginia to conduct "mini-clinics" by establishing specific days and appointment times for members needing preventive services such as well visits, immunizations, diabetes care, testing, and blood pressure monitoring. The Quality Team is on-site to deliver incentives for completing visits in addition to providing program information, updating member information, and initiating collaboration activities with the provider and office staff.

Aetna also provided and conducted educational lunches for providers and their staff. These "lunch and learn" sessions provided a venue to review the practice's pertinent HEDIS information, outreach programs, and general practice questions and concerns.

Aetna is currently working on implementing a new incentive program that will pilot childhood immunizations, to include challenges and activities related to the HEDIS measure.

Aetna is piloting a new incentive program in collaboration with the American Cancer Society to help increase awareness about colon cancer screenings. Sent to members and providers are co-branded mailers that include information related to screenings as well as the various options available for colorectal cancer screenings.

Improving Pre- and Postnatal Outcomes

Aetna recently completed the final draft of a new baby book, "Let's Go Baby," that serves as an educational tool and is replete with resources for members. The book, in a professional, user-friendly format, summarizes what the health plan offers to pregnant members, new moms, and their babies.

Aetna is in the process of implementing a new initiative to collaborate with providers to identify pregnant women earlier so as to promote earlier prenatal care and services with an emphasis on high-risk pregnant members. The project is slated to begin in January 2019.

Health Care Equity and Addressing Social Determinants of Health (SDoH)

Aetna care managers, using condition-specific assessments, social determinants of health data, and care plan interventions provide individualized support based on members' needs. Aetna care managers conduct face-to-face visits and meet members where they are to gain better understanding of each

member's environment. Engaging in conversation, asking for clarity and feedback, helps to ensure that members understand and agree with their plans of care.

Aetna's care management system is able to capture health care equity data with the utilization of assessments specific to economic stability, education, social and community context, health and health care, and neighborhood and built environment. Aetna also has a companywide SharePoint site dedicated to housing resources related to social determinants of health. This resource is a library of educational documents, including research and statistical reports that address determinants such as economic stability, education, health care, neighborhood, and built environment; this library provides social and community context.

Integrative Care Management (ICM) Restructure

Aetna has restructured the ICM program to assign members to care managers according to special populations and is developing care managers into subject matter experts (SMEs) for targeted areas including but not limited to pregnancy, early intervention, foster children, and behavioral health. Additionally, care managers attend utilization management concurrent review rounds for collaboration and proactive discharge planning and identification of member needs for members who are currently hospitalized. Any members not currently engaged in care coordination are each assigned to a registered nurse (RN) or licensed clinical social worker (LCSW) or licensed professional counselor (LPC) for follow up directly after those members are discharged from inpatient hospital episodes.

Follow-Up to Prior EQR Recommendations

The Medallion 3.0 contract ended in 2018. The Medallion 4.0 program MCO contracts were awarded and implementation occurred August 2018 through December 2018. MCOs were required to focus on implementation of the Medallion 4.0 program and preparation for implementation of Medicaid expansion on January 1, 2019, rather than on implementing interventions or corrective actions for recommendations made for the Medallion 3.0 program that ended in 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

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

HEDIS Performance Measures

Aetna demonstrated a strength related to access to care for pediatric members, with all HEDIS 2018 performance measures related to well-care visits performing above the national Medicaid 50th percentiles.

Aetna's performance measure rates reflect a weakness in the area of childhood immunizations with the HEDIS 2018 *Childhood Immunization, Combination 3* rate of 65 percent continuing to decline with a rate more than 6 percentage points below the national Medicaid 50th percentile of 72 percent.

Aetna's rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* fell more than 5 percentage points below the national Medicaid 50th percentile of 84 percent and declined in performance by nearly 10 percentage points to 78 percent compared to the HEDIS 2016 rate (88 percent), indicating a weakness and an opportunity for Aetna to increase the provision of care for members while they are pregnant.

Aetna demonstrated an overall weakness in performance measures related to prescription medications, with declines in rates ranging from about 3 percent to more than10 percent from HEDIS 2017 to HEDIS 2018 for the following measure rates: *Medication Management for People With Asthma—Medication Compliance 75%—Total* (more than 5 percentage points), *Antidepressant Medication Management—Effective Acute Phase Treatment* (nearly 6 percentage points) and *Effective Continuation Phase Treatment* (more than 7 percentage points), *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* (nearly 3 percentage points) and *Continuation and Maintenance Phase* (more than 10 percentage points), and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* (almost 7 percentage points).

Performance Measure Validation

Aetna demonstrated a strength with its performance measure data being compliant with HEDIS and DMAS specifications. The data, as reported, were valid. Aetna's performance measures were reportable.

CAHPS

For adult Medicaid CAHPS, Aetna did not score statistically significantly higher or lower than the 2018 NCQA adult Medicaid national average nor statistically significantly higher or lower in 2018 than in 2017 on any measure.

Aetna scored statistically significantly higher than the 2018 NCQA child Medicaid national average on two measures, *Getting Care Quickly* and *How Well Doctors Communicate,* indicating a strength for Aetna. Aetna did not score statistically significantly higher or lower in 2018 than in 2017 on any measure for the child Medicaid CAHPS.

2018 Key Recommendations for Aetna

HEDIS Recommendations

Aetna showed strength in many HEDIS performance measures with numerous rates scoring above the HEDIS 50th percentile. However, results also identified continued opportunities for improvement.

- Given that Aetna is performing above the national Medicaid 50th percentile for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, this may provide an opportunity to ensure that no opportunities are missed to work with PCPs to ensure provision and documentation of comprehensive services during these visits. HSAG recommends that Aetna work with PCPs to ensure that children's health visits provide opportunities for children to receive recommended immunizations timely and for developmental screenings to be completed.
- Aetna's rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* has continued to decline since 2016. Aetna should develop and implement quality initiatives focused on ensuring that members are informed about and using prenatal care as well as participating in their postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provides opportunities to partner with obstetrical practices to conduct reminder calls the day before scheduled appointments, to assist with ensuring that transportation is arranged for appointments by completing warm transfers to transportation vendors, and to provide additional educational opportunities such as parenting classes.
- Aetna should review the declines in medication management performance to ensure that providers are appropriately monitoring members on long-term medications. Aetna should focus efforts on medications used for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward overall medication management for members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy departments to conduct follow-up on medication refills, outreach to review medications upon member discharge from an inpatient stay or an emergency department visit, and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.

PMV Recommendations

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

- Aetna should continue to build quality checks into existing processes to ensure that the foster care assessment (FCA) data reported to DMAS are accurate and complete and include the Analytics and Informatics Team in this process. Aetna should develop an interrater reliability process to ensure that foster care assessment data reported to DMAS are accurate and complete. Training programs should be developed and implemented when issues are identified related to accuracy or completeness of data.
- Aetna should ensure following measure specifications related to completing assessments within 60 days. Aetna should develop a quality review process or interrater reliability process to ensure accuracy and completeness of assessments and resulting data.
- Aetna should continue efforts and allocate resources to complete the assessments as early as possible because of the challenges associated with completing assessments within the required time frame. Aetna should review its staffing structure to ensure that adequate staffing levels are maintained to meet the required time frames for completing assessments.
- For 2019, Federally Qualified Health Center (FQHC) mapping to PCP type criteria will change; so, Aetna is encouraged to review the updated criteria and work with its auditor to be prepared to comply with the more stringent requirements for such mapping. Aetna should maintain documentation that demonstrates the changes made to ensure that the FQHC PCP mapping process was tested and accurately completed.

PIP Recommendations

Aetna received a *Low Confidence* score for its State-mandated PIP, *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. HSAG recommends that Aetna:

- Work to address the key driver related to ability to locate members for outreach.
- Proactively estimate the approximate total number of members eligible for interventions prior to testing to help ensure meaningful evaluation results and ability to impact the SMART Aim.
- Ensure that the narrative summary of overall key findings and interpretation of results are reported accurately.
- Consider tailoring future interventions to address specific needs of the special needs populations which may require additional assistance and/or more intense monitoring.
- Report a more thorough analysis of results for the PIP—numerators and denominators for SMART Aim monthly measurements, total number of members outreached, number of members outreached successfully, number of members scheduled for eye exams who subsequently attended those eye exams.

CAHPS Recommendations

- HSAG recommends reviewing the measures included in the CAHPS adult global rating "All Health Care" as an area of focus and quality improvement.
- For the CAHPS child global rating of "Specialist Seen Most Often" and the CAHPS child composite rating of "Shared Decision Making," opportunities exist to provide outreach and education to providers—particularly specialty providers—related to effective communication with members and to developing patient-centered focus related to member care and treatment.

EQR Activity Results for Anthem HealthKeepers Plus (Anthem)

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

Performance Measures

Table 4-9 displays the rates for measures that Anthem reported for HEDIS 2016, 2017, and 2018. Anthem's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Anthem's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-9—Anthem HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	59.49%	55.32%	61.18%	**50.12%**
Childhood Immunization Status				
Combination 3	89.79%	76.39%	72.26%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	72.43%	68.06%	69.34%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.24%	77.78%	79.32%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	52.50%	—
Cervical Cancer Screening				
Cervical Cancer Screening	64.68%	65.28%	65.43%	**58.48%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	89.74%	92.13%	89.05%	**83.56%**
Postpartum Care	66.20%	70.14%	62.53%	**64.38%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	87.21%	86.88%	85.18%	**82.21%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.42%	97.16%	**95.70%**
25 Months–6 Years	—	93.25%	92.57%	**87.87%**
7–11 Years	—	94.28%	94.43%	**90.77%**
12–19 Years	—	91.75%	92.03%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	81.48%	85.19%	82.48%	**87.10%**
HbA1c Control (<8.0%)	53.70%	54.63%	55.72%	**48.87%**
Eye Exam (Retinal) Performed	47.92%	46.99%	45.74%	**55.11%**
Medical Attention for Nephropathy	90.28%	90.97%	89.78%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	60.42%	68.52%	64.48%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.94%	60.19%	60.58%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	25.92%	29.73%	30.23%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	78.81%	84.23%	89.92%	**77.05%**
Discussing Cessation Medications	47.01%	51.84%	58.30%	**49.71%**
Discussing Cessation Strategies	39.41%	40.74%	44.83%	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	47.24%	48.76%	48.95%	**51.89%**
Effective Continuation Phase Treatment	33.63%	32.87%	32.86%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	40.66%	41.88%	43.92%	**44.80%**
Continuation and Maintenance Phase	51.54%	53.70%	55.93%	**55.90%**
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	61.80%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	42.36%	60.57%	58.80%	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

Anthem performed above the national Medicaid 50th percentiles for 18 of the 27 (approximately 67 percent) measures compared to benchmarks for HEDIS 2018, demonstrating high performance. Of note, all measures in the Children's Preventive Care and Access to Care domains remained above the national Medicaid 50th percentiles. Conversely, performance for *Prenatal and Postpartum Care—Postpartum Care* and *Comprehensive Diabetes Care* indicate opportunities for improvement for Anthem. The measure rate for *Prenatal and Postpartum Care—Postpartum Care* declined by more than 7 percentage points from HEDIS 2017 to HEDIS 2018 to now fall below the national Medicaid 50th percentile. Additionally, performance for four of the five *Comprehensive Diabetes Care* indicators declined slightly and three indicators (*HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Medical Attention for Nephropathy*) fell below the national Medicaid 50th percentiles.

Further, five of the six (approximately 83 percent) measure rates related to prescription medications (*Medication Management for People With Asthma*; *Antidepressant Medication Management*; *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*) remained or fell below the national Medicaid 50th percentiles and indicate that improvement efforts should be focused on ensuring that members are monitored appropriately and remain on long-term medications.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-10 presents the 2017 and 2018 MCO-specific aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Anthem's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Anthem were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-10—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Anthem

	Anthem Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	63.4%	63.8%
Rating of All Health Care	59.9%	62.4%
Rating of Personal Doctor	70.2%	73.3%
Rating of Specialist Seen Most Often	67.9%	69.7%
Composite Measures		
Getting Needed Care	80.9%	86.5%▲
Getting Care Quickly	81.1%	84.5%

	Anthem Adult Medicaid	
	2017	2018
How Well Doctors Communicate	91.0%	94.2%
Customer Service	87.7%	83.2%
Shared Decision Making	77.2%	80.0%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Anthem's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Anthem scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on three measures: *Rating of Health Plan, Rating of All Health Care,* and *Rating of Personal Doctor*.
- Anthem scored statistically significantly higher than the 2018 NCQA national adult Medicaid averages on four measures: *Rating of All Health Care*, *Rating of Personal Doctor, Getting Needed Care,* and *How Well Doctors Communicate*.
- Anthem scored statistically significantly higher in 2018 than in 2017 on one measure: *Getting Needed Care*.

Child CAHPS

Table 4-11 presents the 2017 and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Anthem's 2018 child Medicaid CAHPS scores to corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Anthem were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 4-11—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Anthem

	Anthem Child Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	76.5%	73.9%
Rating of All Health Care	73.0%	67.9%
Rating of Personal Doctor	75.9%	74.3%

	Anthem Child Medicaid	
	2017	2018
Rating of Specialist Seen Most Often	77.6%	67.1%+
Composite Measures		
Getting Needed Care	82.5%	83.5%
Getting Care Quickly	88.1%	85.2%
How Well Doctors Communicate	93.7%	92.3%
Customer Service	86.9%	83.8%+
Shared Decision Making	77.9%	81.5%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Anthem's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Anthem scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on two measures: *Rating of Health Plan* and *Rating of All Health Care*.
- Anthem scored statistically significantly lower than the 2018 NCQA national child Medicaid averages on one measure: *Getting Care Quickly*.
- Anthem did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

Consumer Decision Support Tool

The 2018 Consumer Decision Support Tool demonstrated how Anthem compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Anthem, as shown in Table 4-12.

Table 4-12—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.

Rating	MCO Performance Compared to Statewide Average	
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-13 displays Anthem's 2018 Consumer Decision Support Tool results.

Table 4-13—Anthem's 2018 Consumer Decision Support Tool Results

Domain	2018 Results
Doctors' Communication	★★★★
Getting Care	★★★
Keeping Kids Healthy	★★★★
Living With Illness	★★★
Taking Care of Women	★★★★★

Overall, Anthem received the highest star ratings compared to the other MCOs for the Doctors' Communication and Keeping Kids Healthy domains. Additionally, Anthem was one of two MCOs that received a five-star rating for the Taking Care of Women domain, demonstrating a strength.

Performance Improvement Projects

In 2018, Anthem submitted a continuation of one State-mandated PIP for validation. Anthem's PIP topic, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' quality strategy. The focus of the PIP was to increase eye exams for diabetic members 18 to 75 years of age assigned to a high-volume, low-performing provider. In Module 1, Anthem set a goal to increase the rate from 27.67 percent to 32.00 percent by December 31, 2017.

Table 4-14 outlines the SMART Aim measure for the PIP.

Table 4-14—SMART Aim Measure

PIP Topic	SMART Aim Measure
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed.	The rate of Riverside Provider Group diabetic members ages 18 to 75 years of age with diabetes type 1 and 2 who received their eye exam (retinal) performed in the 12-month rolling measurement period.

For validation year 2018, Anthem submitted Modules 4 and 5 for the PIP. Table 4-15 displays progression of the PIP.

Table 4-15—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in November 2016.
2. SMART Aim Data Collection	All validation criteria achieved in October 2016.
3. Intervention Determination	All validation criteria achieved in February 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for one intervention:

- Holding a pre-scheduled clinic day event.

Anthem adapted the intervention to facilitate more engagement with providers and documented the following lessons learned:

- The MCO should contact the provider's office two weeks before the scheduled clinic day event to ensure enough time to schedule appointments.
- The MCO should increase the number of ophthalmologists engaged in the clinic day event to ensure that provider engagement in the program is not at risk.

In the Module 5 validation, HSAG analyzed Anthem's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. The SMART Aim measure results for Anthem's *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* PIP are shown in Table 4-16.

Table 4-16—SMART Aim Measure Results

SMART Aim Measure	Baseline	SMART Aim Goal	Highest Rate Achieved
Diabetic retinal eye exam rates for members 18 to 75 years of age paneled to Riverside Provider Group	27.7%	32.0%	42.1%

Anthem achieved the SMART Aim goal; however, it did not include clear data for the clinic day intervention, linking it to the improvement. HSAG assigned *Low Confidence* to the PIP.

Addiction and Recovery Treatment Services

During the Medallion 4.0 readiness review process, HSAG reviewed the status of Anthem's implementation of the ARTS program. HSAG found that the behavioral health services policies submitted by Anthem included all requirements specified in its contract with DMAS (including identification of which members were eligible and which were excluded from the ARTS program), such as when members were admitted to PRTFs, and administration and coverage of any professional medical services provided in the TGH. Anthem worked with the Behavioral Health Services Administrator (BHSA) to prevent unnecessary institutional placements and to ensure coordination of medical, ARTS, and mental health services for Anthem members. Anthem also offered transportation and pharmacy services for the provision of BHSA services. Anthem's policies and procedures included coverage of residential treatment services consisting of PRTFs and TGH for the Medallion 4.0 members, effective April 1, 2019.

The 2018 Anthem Maternal Child Services Obstetrical and Newborn Case Management Program Description delineated the many sources of identification for pregnant women, to ensure completion of the prenatal risk screening to identify high-risk pregnant members. Anthem designed the risk screening tool to assist in assigning members to risk groups to determine the appropriate level of case management. One mission of Anthem's program involved improving access to and completion of postpartum care visits, and the obstetrics case management process included screening for postpartum depression. The program included a focus on substance use by pregnant members and reducing behavioral health risks in pregnancy. Anthem developed the Access to Care for Substance Abuse for Pregnant Women policy and procedure. This policy detailed the processes for ensuring that pregnant women with history of substance abuse have access to ARTS services and supports.

Best and Emerging Practices for Improving Quality of Care and Services

Anthem submitted the following best and emerging practices for 2018.

HEDIS Taskforce

Anthem's HEDIS task force is a quality collaboration with behavioral health, utilization management, case management, outreach, marketing, long-term services and supports (LTSS), provider solutions, and the HEDIS team to address care gaps and determine strategic planning for initiatives, HEDIS and CAHPS.

Social Determinants of Health

Anthem deploys a Member Safety Advisory Team composed of professionals who are specific contacts for safety issues. Team members are invited to every critical incident debrief meeting to contribute to education, highlight resources, or provide support after the incident. This team remains as a contact for care coordinators to reach out to for additional advice or support.

Provider Support Team

The Provider Support Team helps support and cultivate a partnership with Anthem's highest volume providers in addressing quality, care coordination, and member experience in order to improve the quality of care that members receive.

Behavioral Health Homes

Anthem uses imbedded practitioners at Community Service Boards and other behavioral health providers to address physical health needs while addressing mental health needs.

Patient Safety-Critical Incident Debrief Meetings

Quality and clinical teams meet monthly to discuss abuse and/or sentinel cases from the previous month, support needs for care coordinators, and resources for Anthem's members and care coordinators.

Healthy Rewards

Members are rewarded in conjunction with the Clinic Day Event organized by the Quality Team. Members are mailed fliers to attend a clinic day event. Once the member attends the clinic day event and has received services from his or her provider for the noncompliant measure(s), the member qualifies for the healthy reward incentive.

Health Education Advisory Committee/Member Education Advisory Group

Advisory Committee meetings are held to ensure communication and an ongoing exchange of information with new and existing members to confirm that members understand benefits, policies, and procedures; and to identify additional member health education needs.

Follow-Up to Prior EQR Recommendations

The Medallion 3.0 contract ended in 2018. The Medallion 4.0 program MCO contracts were awarded and implementation occurred August 2018 through December 2018. MCOs were required to focus on implementation of the Medallion 4.0 program and preparation for implementation of Medicaid expansion to begin on January 1, 2019, rather than to implement interventions or corrective actions for recommendations made for the Medallion 3.0 program that ended in 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

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

HEDIS Performance Measures

Anthem demonstrated strength in the Children's Preventive Care domain with all measure rates being above the HEDIS Medicaid national 50th percentiles.

Anthem demonstrated strength performing above the 2018 HEDIS national Medicaid 50th percentiles for 18 of the 27 (approximately 67 percent) measures compared to benchmarks. All measures in the Children's Preventive Care and Access to Care domains remained above the national Medicaid 50th percentiles.

An identified weakness for Anthem continued to be improving performance for *Prenatal and Postpartum Care—Postpartum Care* and *Comprehensive Diabetes Care.* The measure rate for *Prenatal and Postpartum Care—Postpartum Care* declined by more than 7 percentage points from HEDIS 2017 to HEDIS 2018 to now fall below the national Medicaid 50th percentile. Performance for four of the five *Comprehensive Diabetes Care* indicators declined slightly, and rates for three indicators (*HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Medical Attention for Nephropathy*) fell below the national Medicaid 50th percentiles.

Five of the six (approximately 83 percent) HEDIS 2018 measure rates related to prescription medications (*Medication Management for People With Asthma*; *Antidepressant Medication Management*; *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*; and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*) remained or fell below the national Medicaid 50th percentiles and are considered areas of weakness for Anthem.

Performance Measure Validation

Anthem demonstrated a strength in HEDIS performance measure data. Anthem's HEDIS data were compliant with HEDIS and DMAS specifications, and the rates as reported were valid and reportable.

CAHPS

Anthem scored statistically significantly higher than the 2018 NCQA adult Medicaid national averages on four measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, and *How Well Doctors Communicate.* Anthem scored statistically significantly higher in 2018 than in 2017 on one measure for the adult Medicaid CAHPS, *Getting Needed Care*. These areas represented strengths for Anthem.

Anthem scored statistically significantly lower than the 2018 NCQA child Medicaid national average on one measure: *Getting Care Quickly*. *Getting Care Quickly* was a demonstrated weakness for Anthem. Anthem did not score statistically significantly higher or lower in 2018 than in 2017 on any measure for the child Medicaid CAHPS.

2018 Recommendations for Anthem

HEDIS Recommendations

Anthem showed strength in HEDIS performance measures, with many measures scored above the HEDIS 50th percentiles. However, results also identified continued opportunities for improvement.

- Anthem's *Childhood Immunization Status—Combination 3* three-year trend performance inconsistencies and the 18 percentage-point decline suggest that Anthem should identify ways to examine childhood immunization rates and consider the alignment with the *Well-Child Visits in the First 15 Months of Life —Six or More Well-Child Visits* rate closely to determine the causal relationships. Potential circumstances that can affect immunization rates are timing and frequency of visits to providers and the providers' ability to identify gaps in care, also referred to as "missed opportunities." If care gaps can be reported at a provider level, HSAG recommends that Anthem use the opportunity to target education and outreach to PCPs who need additional support. The Virginia Department of Health supports the Assessment Feedback Incentive Exchange (AFIX) program[4-2] to increase vaccination of children and adolescents by reducing missed opportunities to vaccinate and by improving delivery practices at the provider level. HSAG recommends that Anthem consider leveraging these resources for educating providers to look for missed opportunities to complete EPSDT services and immunizations.

[4-2] The Virginia Department of Health—Division of Immunization. Assessment Feedback Incentive Exchange. Available at: http://www.vdh.virginia.gov/immunization/afix/. Accessed on: Feb 15, 2018.

- Anthem's performance for *Prenatal and Postpartum Care—Postpartum Care* indicates an opportunity for improvement. The measure rate for *Prenatal and Postpartum Care—Postpartum Care* declined by more than 7 percentage points from HEDIS 2017 to HEDIS 2018, falling below the national Medicaid 50th percentile. HSAG recommends that Anthem use performance improvement processes to develop interventions to reverse the trend in rates and to improve prenatal and postpartum care and service delivery. HSAG recommends that Aetna develop and implement quality initiatives focused on ensuring that members are informed and using prenatal care as well as participating in postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provide opportunities to partner with obstetrical practices to: conduct reminder calls the day before scheduled appointments, assist with ensuring that transportation is arranged for appointments by completing warm transfers to the transportation vendors, and provide additional educational opportunities such as parenting classes.
- Anthem's performance in *Comprehensive Diabetes Care* indicates an opportunity for improvement. Anthem's performance for four of the five *Comprehensive Diabetes Care* indicators declined slightly, and rates for three indicators (*HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Medical Attention for Nephropathy*) fell below the national Medicaid 50th percentile. HSAG recommends that, for persons diagnosed with diabetes, Anthem focus interventions on improving the rate at which members receive recommended care and services. HSAG recommends that Anthem consider identifying PCPs with strong diabetes outcomes and encourage members to utilize these providers as their medical homes. Anthem has opportunity to learn from high-performing providers best practices which may be shared with other providers treating individuals diagnosed with diabetes.
- Five of the six (approximately 83 percent) measure rates related to prescription medications (Medication Management for People With Asthma; Antidepressant Medication Management; Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase; and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics) remained at or fell below the national Medicaid 50th percentiles. HSAG recommends that quality improvement efforts be focused on ensuring that members are monitored appropriately and remain on long-term medications as prescribed. HSAG recommends that Anthem review the declines in medication management performance to ensure that providers are appropriately monitoring members on long-term medications. HSAG recommends that Anthem focus efforts on medications for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward the overall medication management of members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy department successfully to conduct follow-up on medication refills, outreach to review medications upon member discharge from an inpatient stay or an emergency department visit, and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.
- HSAG recommends that Anthem implement processes to limit quantity prescribed for new ADHD prescriptions and conduct outreach to the member's family or caregivers to educate them on the need for continued use and benefits of the prescribed medication. Members should be encouraged to seek and receive assistance in scheduling follow-up care to renew the prescriptions.

- HSAG continues to recommend that Anthem leverage its pharmacy benefit manager (PBM)'s educational tools and resources to support member adherence with antidepressant medications.

PMV Recommendations

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

- Anthem should continue to monitor claims inventory reports closely to ensure that reporting requirements are met.
- Anthem should continue to monitor eligibility requirements for its foster care population closely and perform some double checks as needed before reporting, to ensure accuracy. Further, Anthem should establish interrater reliability processes to ensure accuracy in reporting.
- Anthem should more closely monitor hard-copy assessments received and ensure that staff members are trained to scan and enter the foster care assessment (FCA) data promptly upon receipt and according to existing policies and procedures. HSAG also recommends that Anthem implement interrater reliability processes to ensure consistency in completing, scanning, and entering data. Interrater reliability processes provide opportunity to conduct staff training when discrepancies or errors are identified,
- In 2019, FQHC mapping to PCP provider type criteria will change; and HSAG recommends that Anthem review the updated criteria and work with its auditor to be prepared to comply with the more stringent mapping requirements.

PIP Recommendations

Anthem received a *Low Confidence* score for its State-mandated PIP, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* . HSAG recommends that Anthem:

- Ensure understanding of the rapid-cycle PIP process and requirements.
- Address all Module 4 pre-validation review feedback in the final submission of Module 4.
- Submit a Module 4 for each intervention it tests.
- Report a more thorough analysis of results for the PIP—numerators and denominators for SMART Aim monthly measurement; number of members who received an intervention; and, subsequently, number of members compliant (at least monthly).

CAHPS Recommendations

- Anthem had overall declines in the Children's CAHPS scores. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to children.

EQR Activity Results for INTotal Health (INTotal)

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

Performance Measures

Table 4-17 displays the rates for measures that INTotal reported for HEDIS 2016, 2017, and 2018. INTotal's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate INTotal's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-17—INTotal HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	50.23%	51.09%	58.15%	**50.12%**
Childhood Immunization Status				
Combination 3	69.91%	55.72%	70.07%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	58.25%	46.38%	51.82%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.90%	78.36%	76.64%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	48.65%	—
Cervical Cancer Screening				
Cervical Cancer Screening	55.94%	50.61%	56.20%	**58.48%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	63.87%	41.97%^	60.58%	**83.56%**
Postpartum Care	45.45%	28.73%^	46.72%	**64.38%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	83.84%	84.27%	82.15%	**82.21%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	97.79%	97.42%	**95.70%**
25 Months–6 Years	—	92.79%	93.08%	**87.87%**
7–11 Years	—	95.53%	94.66%	**90.77%**
12–19 Years	—	91.67%	91.81%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	87.86%	85.67%^	87.35%	**87.10%**
HbA1c Control (<8.0%)	39.96%	5.58%^	39.66%	**48.87%**
Eye Exam (Retinal) Performed	42.16%	37.49%^	48.66%	**55.11%**
Medical Attention for Nephropathy	90.07%	89.67%^	88.08%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	51.43%	11.35%^	60.10%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	49.11%	BR	49.64%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	22.49%	30.93%	33.28%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	74.91%	78.37%	75.50%	**77.05%**
Discussing Cessation Medications	48.39%	51.82%	46.71%	**49.71%**
Discussing Cessation Strategies	36.82%	41.32%	38.93%	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	52.63%	52.25%	57.82%	**51.89%**
Effective Continuation Phase Treatment	35.20%	37.40%	39.39%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	54.98%	59.45%	54.24%	**44.80%**
Continuation and Maintenance Phase	70.59%	76.92%	72.37%	**55.90%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	45.82%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	62.20%	65.00%	65.69%	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

^ Due to issues discovered during the medical record review process, INTotal was required to report this rate using the administrative method for HEDIS 2017. Therefore, caution should be exercised when comparing these results to benchmarks calculated using the administrative and/or hybrid method and to HEDIS 2018 rates.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

For HEDIS 2018, INTotal demonstrated strength with the performance related to prescription medications, as evidenced by the following measure rates ranking above the national Medicaid 50th percentiles: *Antidepressant Medication Management*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*. Despite falling just below the national Medicaid 50th percentile, the *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rate increased by more than 10 percentage points from HEDIS 2016 to HEDIS 2018, further indicating positive performance related to appropriate utilization of medications.

INTotal's performance demonstrated that young children and adolescents are accessing care and receiving required well-child visits, with the measure rates for *Children and Adolescents' Access to Primary Care Practitioners*, *Adolescent Well-Care Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* ranking above the national Medicaid 50th percentiles. However, the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure rate fell more than 10 percentage points below the national Medicaid 50th percentile and declined by more than 6 percentage points from HEDIS 2016, indicating that infants are not receiving the appropriate number of well-care visits. Given that approximately 26 percent of infant members had five of the six required visits, this measure represents an opportunity for improvement for future years.

Conversely, only one measure rate within the Women's Health and Care for Chronic Conditions domains ranked above the national Medicaid 50th percentiles, indicating that members most in need of critical services may not be receiving timely and effective care, as demonstrated by the following measure rates falling more than 5 percentage points below the national Medicaid 50th percentiles: *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (nearly 23 percentage points) and *Postpartum Care* (more than 17 percentage points); *Comprehensive Diabetes Care—HbA1c Control*

(<8.0%) (more than 9 percentage points) and *Eye Exam (Retinal) Performed* (more than 6 percentage points); and *Controlling High Blood Pressure* (more than 7 percentage points). INTotal should focus improvement efforts to ensure that mothers and members with chronic conditions obtain appropriate services.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-18 presents the 2017 and 2018 MCO-specific aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared INTotal's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for INTotal were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-18—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: INTotal

	INTotal Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	59.2%	57.3%
Rating of All Health Care	50.0%	60.5%
Rating of Personal Doctor	65.6%	61.1%
Rating of Specialist Seen Most Often	67.6%	60.7%+
Composite Measures		
Getting Needed Care	79.9%	79.9%+
Getting Care Quickly	82.7%	78.4%+
How Well Doctors Communicate	91.5%	91.9%+
Customer Service	84.6%	88.5%+
Shared Decision Making	79.4%	82.4%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

INTotal's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences; no differences were observed.

Child CAHPS

Table 4-19 presents the 2017 and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared INTotal's 2018 child Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for INTotal were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 4-19—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: INTotal

	INTotal Child Medicaid	
	2017	**2018**
Global Ratings		
Rating of Health Plan	78.0%	79.4%
Rating of All Health Care	70.1%	73.0%
Rating of Personal Doctor	68.2%	76.0%▲
Rating of Specialist Seen Most Often	75.0%	77.6%+
Composite Measures		
Getting Needed Care	85.2%	83.9%
Getting Care Quickly	86.1%	86.2%
How Well Doctors Communicate	89.2%	91.2%
Customer Service	87.6%	86.6%
Shared Decision Making	72.3%	66.1%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ statistically significantly higher in 2018 than in 2017.
▼ statistically significantly lower in 2018 than in 2017.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

INTotal's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- INTotal scored statistically significantly higher than the 2017 and 2018 NCQA national child Medicaid average on one measure: *Rating of Health Plan*. INTotal scored statistically significantly

lower than the 2017 NCQA national child Medicaid average on one measure: *Rating of Personal Doctor*.

- INTotal scored statistically significantly lower than the 2017 and 2018 NCQA national child Medicaid averages on two measures: *How Well Doctors Communicate* and *Shared Decision Making*.
- INTotal scored statistically significantly higher in 2018 than in 2017 on one measure: *Rating of Personal Doctor*.

Consumer Decision Support Tool

The 2018 Consumer Decision Support Tool demonstrated how INTotal compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for INTotal, as shown in Table 4-20.

Table 4-20—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-21 displays INTotal's 2018 Consumer Decision Support Tool results.

Table 4-21—INTotal's 2018 Consumer Decision Support Tool Results

Domain	2018 Results
Doctors' Communication	★
Getting Care	★★
Keeping Kids Healthy	★★★
Living With Illness	★
Taking Care of Women	★

For 2018, INTotal received one-star ratings for the Doctors' Communication, Living With Illness, and Taking Care of Women domains, demonstrating opportunities for improvement.

Performance Improvement Projects

In 2018, INTotal submitted a continuation of one State-mandated PIP for validation. INTotal's PIP topic, *Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members)* addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' quality strategy. The focus of the PIP was to increase eye exams for diabetic members 18 to 75 years of age who were assigned to one of four primary care providers. INTotal set a goal to increase the combined retinal eye exam rate from 34.1 percent to 40.1 percent by December 31, 2017.

Table 4-22 outlines the SMART Aim measure for the PIP.

Table 4-22—SMART Aim Measure

PIP Topic	SMART Aim Measure
Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members)	The rate of diabetic members 18 to 75 years of age, residing in Virginia, who have Dr. Gonzalez, Dr. Titha, Dr. Singer, or Dr. Yousuf as an assigned primary care provider, and had an eye exam by an eye care professional during the measurement year or a negative retinal or eye exam in the year prior to the measurement year.

For validation year 2018, INTotal submitted Modules 4 and 5 for the PIP. Table 4-23 displays progression of the PIP.

Table 4-23—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in November 2016.
2. SMART Aim Data Collection	All validation criteria achieved in December 2016.
3. Intervention Determination	All validation criteria achieved in February 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for two interventions:

- Outreach to members for appointment reminders and transportation assistance.
- Member incentive for completed eye exams.

INTotal abandoned the interventions and documented the following lessons learned:

- Calling members multiple times was resource intensive.
- Members expressed frustration at being called multiple times.
- Staff turnover can have a negative effect on the project.

In the Module 5 validation, HSAG analyzed INTotal's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. The SMART Aim measure results for INTotal's *Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members)* PIP are shown in Table 4-24.

Table 4-24—SMART Aim Measure Results

SMART Aim Measure	Baseline	SMART Aim Goal	Highest Rate Achieved
Dilated retinal eye exams for diabetic members 18 to 75 years of age assigned to one of four providers	34.1%	40.1%	47.1%

Even though INTotal achieved the SMART Aim goal, it appeared that the MCO may not have reported the SMART Aim measure results using a rolling 12-month methodology as approved in Module 2. Additionally, no clear linkage existed between the tested interventions and the improvement. HSAG assigned *Low Confidence* to the PIP.

Addiction and Recovery Treatment Services

INTotal was not selected as a Medallion 4.0 MCO; therefore, implementation of the ARTS program was not reviewed during the Medallion 4.0 readiness review process.

Best and Emerging Practices for Improving Quality of Care and Services

INTotal/United submitted the following best and emerging practices for 2018.

Pay-for-Performance

United implemented a pay-for-performance program for practitioners under INTotal Health to incentivize them for providing preventive services for members and submitting claims for selected HEDIS procedures. The purpose of the program was to increase the number of members who received preventive care and accurately reflect services through claims submissions.

Pharmacy Benefit Manager (PBM) Reminder System

Working with the PBM, United developed a reminder system that notifies the prescribing provider when members miss filling their prescriptions. This was implemented for chronic conditions such as depression, asthma, and diabetes to increase members' adherence to their medication schedules.

Lead Screening Education

United provided education on lead screening to high-volume practitioners along with a lead screening kit provided by LabCorp to increase the number of children receiving appropriate screening.

Postpartum Care Coordination

United offered postpartum care coordination for the mother and newborn after delivery. This included member outreach for education, postpartum depression screening, and removal of the breast pump prior-authorization requirement. Practitioner interventions included education and assisting with scheduling member appointments. A certified lactation consultant who made home visits for maternal lactation education was also available.

Access to Care

United improved appointment access through "huddles" of key clinical and network team members who routinely reviewed access issues. During these huddle sessions, the team identified interventions like "single-case agreements" and redirection to an available practitioner to help members get care when care was needed.

Community Partnerships

United supported community partnerships, such as Healthy You activities with the Girl Scouts and participated in events promoting health and wellness across the Commonwealth (e.g., quarterly community conversations at Child Health Investment Partnership of the Roanoke Valley, National Health Center Week at the Greater Prince William Community Health Center, Boys & Girls Clubs Countywide Camp Carnival Celebration, and Shady Grove Baptist Church's annual health fair).

Follow-Up to Prior EQR Recommendations

The Medallion 3.0 contract ended in 2018. The Medallion 4.0 program MCO contracts were awarded and implementation occurred August 2018 through December 2018. MCOs were required to focus on implementation of the Medallion 4.0 program and preparation for implementation of Medicaid expansion to begin on January 1, 2019, rather than to implement interventions or corrective actions for recommendations made for the Medallion 3.0 program that ended in 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

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

HEDIS Performance Measures

As in previous years, INTotal's HEDIS scores fell below the national Medicaid 50th percentile in some areas. The exceptions were with INTotal's performance in the Access to Care and Behavioral Health domains. Four of the five measure rates within the Access to Care domain ranked at or above the national Medicaid 50th percentiles, representing a strength for INTotal. The fifth measure, *Adults' Access to Ambulatory/Preventive Care,* fell slightly below the 50th percentile.

A strength for INTotal was identified within the Behavioral Health domain, with five of the six reportable rates ranked at or above the national Medicaid 50th percentile. The rates for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, showed strength—with rates trending higher.

For HEDIS 2018, INTotal demonstrated strength with the performance related to prescription medications, as evidenced by the following measure rates ranking above the national Medicaid 50th percentiles: *Antidepressant Medication Management*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*.

INTotal's measure rates for *Comprehensive Diabetes Care*, with the exception of one indicator, increased, with one rate, *Hemoglobin A1c (HbA1c) Testing* being above the national Medicaid 50th percentile. Although the Comprehensive Diabetes Care measure indicators improved, the *HbA1c Control (<8.0%)* and *Eye Exam (Retinal) Performed* were still at least 10 percent lower than the national Medicaid 50th percentiles, considered a weakness for INTotal.

Despite falling just below the national Medicaid 50th percentile, INTotal exhibited strength in the *Medication Management for People With Asthma—Medication Compliance 75 Percent—Total.* INTotal's measure rate increased by more than 10 percentage points from HEDIS 2016 to HEDIS 2018, further indicating INTotal's positive performance related to appropriate utilization of medications.

INTotal's performance demonstrated that young children and adolescents are accessing care and receiving required well-child visits, with the measure rates for *Children and Adolescents' Access to Primary Care Practitioners*, *Adolescent Well-Care Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* ranking above the national Medicaid 50th percentiles. Based on the rates for these performance measures, an opportunity exists to identify best practices.

The *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure rate fell more than 10 percentage points below the national Medicaid 50th percentile and declined by more than 6 percentage points from HEDIS 2016, indicating a performance weakness for INTotal. The performance measure results may indicate that infants are not receiving the appropriate number of well-care visits.

The Women's Health and Care for Chronic Conditions domains were weaknesses for INTotal. Measures ranked below the national Medicaid 50th percentiles, which may be an indication that members most in need of critical services may not be receiving timely and effective care—as demonstrated by the

following measure rates falling more than 5 percentage points below the national Medicaid 50th percentiles: *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (nearly 23 percentage points) and *Postpartum Care* (more than 17 percentage points); *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* (more than 9 percentage points) and *Eye Exam (Retinal) Performed* (more than 6 percentage points); and *Controlling High Blood Pressure* (more than 7 percentage points).

Performance Measure Validation

Strengths for INTotal were that its performance measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. INTotal's performance measures were reportable.

CAHPS

For the adult Medicaid CAHPS, INTotal did not score statistically significantly higher or lower than the 2018 NCQA adult Medicaid national average nor statistically significantly higher or lower in 2018 than in 2017 on any measure.

Indicating a strength, INTotal scored statistically significantly higher than the 2018 NCQA national child Medicaid average on one measure, *Rating of Health Plan*; but, INTotal scored statistically significantly lower for *How Well Doctors Communicate* and *Shared Decision Making,* indicating a weakness in this area. Additionally, INTotal scored statistically significantly higher in 2018 than in 2017 on one measure, *Rating of Personal Doctor,* for the child Medicaid CAHPS, indicating a strength for the MCO.

2018 Recommendations for INTotal

HEDIS Recommendations

INTotal is not a continuing MCO for Medallion 4.0 The following recommendations are provided for consideration only.

INTotal's continued performance trends are indicative of inherent opportunities to improve, demonstrated by INTotal's performance on the 2018 Consumer Decision Support Tool. INTotal continued to be challenged in several HEDIS performance measures, with some scoring below the national Medicaid HEDIS 50th percentiles.

- INTotal should review current interventions for effectiveness and discontinue those that are not improving care or outcomes. INTotal saw positive improvements in several *Comprehensive Diabetes Care* indicators. HSAG recommends that INTotal review the quality improvement work implemented, identify best practices, and use the best practices to drive improvement in other similar HEDIS measure rates.

- INTotal should focus improvement efforts to ensure that members with chronic conditions obtain appropriate services. HSAG recommends that INTotal focus interventions on improving the rate at which members receive recommended care and services for chronic conditions. HSAG recommends that INTotal consider identifying PCPs with strong chronic disease outcomes and encourage members to utilize these providers as their medical homes. INTotal has an opportunity to learn best practices from high-performing providers that may be shared with other providers treating individuals diagnosed with chronic conditions.
- The *Well-Child Visits in the First Fifteen Months of Life* measure represents an opportunity for improvement. Approximately 26 percent of infant members each had five of the six required well-child visits. This measure was reported using the hybrid method. The measures are related to preventive care for children under two years of age; therefore, INTotal should seek to identify the barriers associated with children receiving appropriate preventive care. INTotal should improve outcomes with the development of targeted intervention strategies for these children. INTotal should focus quality improvement efforts on ensuring that members complete the sixth required well-child visit timely.
- For HEDIS 2018, INTotal demonstrated strength in prescription medication performance, as evidenced by the following measure rates ranking above the national Medicaid 50th percentiles: *Antidepressant Medication Management*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*. INTotal should identify successful interventions used and determine if implementation of best practices may have a similar positive impact on other measures. HSAG's work with other states has identified best practices in medication management, such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy departments successfully to conduct follow-up on medication refills, outreach to review medications upon discharge from an inpatient stay or an emergency department visit, and reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.

PMV Recommendations

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

- Continue efforts to move to a more automated method to produce the foster care assessment measure data, and test the data produced from the new software to ensure that data accurately reflect the MCO's performance.
- Continue strong oversight of the production of the foster care assessment (FCA) measure.
- Review future iterations of the final audit report carefully to ensure that each supplemental source and the measure(s) it impacts is (are) complete.

- Continue close oversight of delegates, strive to obtain complete data, and monitor all provider data entry into Vistar and Exeter for accuracy. INTotal should implement interrater reliability processes for the data entry activity to improve accuracy.
- Review revised criteria for FQHC to PCP mapping for HEDIS 2019 to ensure that the more stringent criteria are met. INTotal should document process changes completed for the auditor's review.
- Continue to monitor third-party administrator's performance closely to ensure that DMAS claims processing timeliness standards are met.

PIP Recommendations

INTotal received a *Low Confidence* score for its State-mandated PIP, *Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members)*. INTotal should:

- Ensure that the PIP results align with the approved methodology.
- Submit a Module 4 plan for each intervention prior to intervention testing. Interventions selected for testing should address a key driver or identified failure.
- Report a more thorough analysis of results for the PIP. In addition to tracking the number of members who scheduled an appointment because of member outreach, the MCO should provide a summary of results for how many of those members subsequently attended those eye exams. The MCO should also provide information for how many members requested transportation assistance to the appointment.

CAHPS Recommendations

- INTotal experienced declines in both the Adults CAHPS and the Children's CAHPS global and composite scores. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to adults and children.

EQR Activity Results for Kaiser Permanente

Kaiser Permanente is a partnership of the not-for-profit Kaiser Foundation Health Plan, Inc. and its regional operating subsidiaries, Kaiser Foundation Hospitals and the Permanente Medical Groups. The company was founded in 1945 and is based in Oakland, California. This section provides high-level results and notable findings for the mandatory and optional EQR activities performed for Kaiser Permanente. Kaiser Permanente was not a successful offeror for the 2018 Medallion 4.0 contract.

Performance Measures

Table 4-25 displays the rates for measures that Kaiser Permanente reported for HEDIS 2016, 2017, and 2018. Due to Kaiser Permanente's small population size for HEDIS 2016, caution should be exercised when comparing rates to HEDIS 2017 and 2018 performance. Kaiser Permanente's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Kaiser Permanente's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-25—Kaiser Permanente HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	58.04%	61.07%	64.59%	**50.12%**
Childhood Immunization Status				
Combination 3	67.80%	84.64%	81.46%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	44.79%	59.20%	62.53%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.76%	92.44%	86.90%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	81.18%	—
Cervical Cancer Screening				
Cervical Cancer Screening	80.17%	84.29%	85.08%	**58.48%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	90.26%	96.51%	93.67%	**83.56%**
Postpartum Care	89.14%	90.12%	88.81%	**64.38%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	87.23%	89.90%	89.27%	**82.21%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.63%	96.42%	**95.70%**
25 Months–6 Years	—	95.62%	93.49%	**87.87%**
7–11 Years	—	95.20%	97.09%	**90.77%**
12–19 Years	—	91.93%	94.41%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	97.18%	97.44%	97.69%	**87.10%**
HbA1c Control (<8.0%)	77.46%	71.79%	71.68%	**48.87%**
Eye Exam (Retinal) Performed	88.73%	86.32%	84.39%	**55.11%**
Medical Attention for Nephropathy	97.18%	96.58%	99.42%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	78.87%	85.47%	88.44%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	75.56%	84.62%	84.87%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	NA	22.58%	37.78%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	NA	NA	NA	**77.05%**
Discussing Cessation Medications	NA	NA	NA	**49.71%**
Discussing Cessation Strategies	NA	NA	NA	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	NA	60.00%	36.51%	**51.89%**
Effective Continuation Phase Treatment	NA	42.00%	28.57%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	NA	NA	NA	**44.80%**
Continuation and Maintenance Phase	NA	NA	NA	**55.90%**
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	66.67%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	NA	NA	NA	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

Kaiser Permanente performed above the national Medicaid 50th percentile for 19 of the 21 (approximately 90 percent) measures with reportable rates that were compared to benchmarks for HEDIS 2018, demonstrating overall strength for the MCO. Of note, all reportable measure rates in the Children's Preventive Care, Women's Health, Access to Care, and Care for Chronic Conditions domains were above the national Medicaid 50th percentiles. Conversely, measure rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* demonstrated declines in performance of approximately 23 and 13 percentage points, respectively, to now fall below the national Medicaid 50th percentiles, indicating that Kaiser Permanente has opportunities to improve medication compliance for members on antidepressants.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-26 presents the 2017 and 2018 MCO-specific aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Kaiser Permanente's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Kaiser Permanente were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-26—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Kaiser Permanente

	Kaiser Permanente Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	65.6%	64.6%
Rating of All Health Care	59.0%	53.9%
Rating of Personal Doctor	76.0%	63.8% ▼
Rating of Specialist Seen Most Often	70.4%+	75.0%+
Composite Measures		
Getting Needed Care	76.6%	70.7%+
Getting Care Quickly	76.9%	67.2%+
How Well Doctors Communicate	90.0%	88.3%+
Customer Service	88.4%+	89.6%+
Shared Decision Making	79.1%+	81.6%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Kaiser Permanente's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Kaiser Permanente scored statistically significantly higher than the 2017 NCQA national adult Medicaid averages on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- Kaiser Permanente scored statistically significantly lower than the 2018 NCQA national adult Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- Kaiser Permanente scored statistically significantly lower in 2018 than in 2017 on one measure: *Rating of Personal Doctor*.

Child CAHPS

Table 4-27 presents the 2017and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Kaiser Permanente's 2018 child Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Kaiser Permanente were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 4-27—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Kaiser Permanente

	Kaiser Permanente Child Medicaid	
	2017	**2018**
Global Ratings		
Rating of Health Plan	70.5%	70.1%
Rating of All Health Care	72.4%	66.5%
Rating of Personal Doctor	79.5%	73.3%
Rating of Specialist Seen Most Often	74.5%+	62.7%+
Composite Measures		
Getting Needed Care	72.4%	69.8%
Getting Care Quickly	78.5%	80.6%
How Well Doctors Communicate	91.5%	87.7%
Customer Service	84.3%	80.6%+
Shared Decision Making	83.4%+	70.5%+▼

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Kaiser Permanente's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Kaiser Permanente scored statistically significantly lower than the 2017 NCQA national child Medicaid averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- Kaiser Permanente scored statistically significantly lower than the 2018 NCQA national child Medicaid averages on four measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service*.
- Kaiser Permanente scored statistically significantly lower in 2018 than in 2017 on one measure: *Shared Decision Making*.

Consumer Decision Support Tool

Kaiser Permanente was not included in the 2018 Consumer Decision Support Tool as Kaiser Permanente is no longer providing services to Medicaid members as of the end of CY 2018.

Performance Improvement Projects

In 2018, Kaiser Permanente submitted a continuation of one State-mandated PIP for validation. Kaiser Permanente's PIP topic, *Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes,* addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' quality strategy. The focus of the PIP was to increase eye exams for diabetic members 18 to 75 years of age. The total population was only 110 members; therefore, the MCO included all eligible members in the PIP and did not select a narrowed focus. Kaiser Permanente set a goal to increase the rate to 88 percent by December 31, 2017.

Table 4-28 outlines the SMART Aim measure for the PIP.

Table 4-28—SMART Aim Measure

PIP Topic	SMART Aim Measure
Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes	The rate of adults continuously enrolled for at least one year, 18 to 75 years of age by the end of the measurement time frame, who qualify for the HEDIS Comprehensive Diabetes Care population with either type 1 or type 2 diabetes and had a qualified screening for diabetic retinopathy.

For validation year 2018, Kaiser Permanente submitted Module 4 and Module 5 for the PIP. Table 4-29 displays progression of the PIP.

Table 4-29—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in November 2016.
2. SMART Aim Data Collection	All validation criteria achieved in November 2016.
3. Intervention Determination	All validation criteria achieved in January 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for two interventions:

- Add the language preference of members and ensure that callers use the language line.
- Create and disseminate a standardized script for staff making calls.

Kaiser Permanente abandoned the interventions and documented the following lesson learned:

- The MCO should examine population sizes, not just rates, when identifying locations to pilot interventions. When the population size is small, the MCO should consider testing interventions at more facilities.

In the Module 5 validation, HSAG analyzed Kaiser Permanente's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. The SMART Aim measure results for Kaiser Permanente's *Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes* PIP are shown in Table 4-30.

Table 4-30—SMART Aim Measure Results

SMART Aim Measure	Baseline	SMART Aim Goal	Highest Rate Achieved
Retinal eye exams for continuously enrolled diabetic members, 18 to 75 years of age.	83.6%	88.0%	Between 87 and 88 percent*

* HSAG was not able to determine the exact rate based on the data provided in the submission.

Based on the run chart, the highest SMART Aim measure rate achieved was between 87 and 88 percent in March 2017. Thereafter, the rate declined and remained below the baseline from August 2017 through November 2017. HSAG assigned *Low Confidence* to the PIP and recommended that Kaiser Permanente:

- Test an intervention until the SMART Aim end date. If intervention(s) are deemed ineffective, the MCO should modify the intervention(s) and/or select a new intervention for testing.
- Include numerators and denominators for SMART Aim monthly measurements for a more robust analysis.

- Clearly report all intervention evaluation results.

Addiction and Recovery Treatment Services

Kaiser Permanente was not selected as a Medallion 4.0 MCO; therefore, implementation of the ARTS program was not reviewed during the Medallion 4.0 readiness review process.

Best and Emerging Practices for Improving Quality of Care and Services

Kaiser Permanente was not asked to submit the best and emerging practices for 2018 as Kaiser Permanente is no longer providing services to Medicaid members in Virginia as of the end of CY 2018.

Follow-Up to Prior EQR Recommendations

Kaiser Permanente was not asked to submit a follow-up to prior EQR recommendations as Kaiser Permanente is no longer providing services to Medicaid members in Virginia as of the end of CY 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

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

HEDIS Performance Measures

Kaiser Permanente demonstrated strength with performance above the national Medicaid 50th percentile for 19 of the 21 (approximately 90 percent) measures with reportable rates that were compared to benchmarks for HEDIS 2018, demonstrating overall strength for the MCO.

Kaiser Permanente demonstrated strength with reportable measure rates in the Children's Preventive Care, Women's Health, Access to Care, and Care for Chronic Conditions domains appearing above the national Medicaid 50th percentiles.

Measure rates for *Antidepressant Medication Management—Initiation Phase* and *Continuation and Maintenance Phase* demonstrated declines in performance of approximately 23 and 13 percentage points, respectively, to fall below the national Medicaid 50th percentile, indicating a weakness in Kaiser Permanente for performance in medication compliance for members on antidepressants.

Performance Measure Validation

A strength for Kaiser Permanente was that its performance measure data were compliant with HEDIS and DMAS specifications; and the data, as reported, were valid. Kaiser Permanente's performance measures were reportable.

CAHPS

Kaiser performed statistically significantly lower than the 2018 NCQA adult Medicaid national averages on two CAHPS measures: *Getting Needed Care* and *Getting Care Quickly.* Kaiser Permanente also scored statistically significantly lower in 2018 than in 2017 on one measure for the adult Medicaid CAHPS, *Rating of Personal Doctor*. These satisfaction ratings are considered a weakness for Kaiser Permanente.

Kaiser Permanente showed weakness in its 2018 Child Medicaid CAHPS survey, which scored statistically significantly lower than the 2018 NCQA child Medicaid national averages on *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. Kaiser Permanente also scored statistically significantly lower in 2018 than in 2017 on one measure, *Shared Decision Making*.

2018 Recommendations for Kaiser Permanente

Kaiser Permanente is not a continuing MCO for the Medallion 4.0 program. Recommendations were not developed for Kaiser Permanente as Kaiser Permanente is no longer providing services to Medicaid members as of the end of CY 2018.

EQR Activity Results for Magellan Complete Care of Virginia (Magellan)

Magellan was not a Medallion 3.0 MCO. Therefore, no EQR activity results exist to include in the annual technical report. Magellan was included in the Medallion 4.0 and the Medicaid expansion readiness reviews. Magellan's readiness review results may be found in "Section 3, Comparative Information and Quality Strategy Recommendations" of this report. Oversight of the ARTS program implementation was reviewed during the Medallion 4.0 readiness reviews. Highlights of the review are described following.

Addiction and Recovery Treatment Services

During the Medallion 4.0 readiness review process, HSAG reviewed the status of Magellan's implementation of the ARTS program. HSAG found that the behavioral health services policies submitted by Magellan included all requirements specified in its contract with DMAS (including identification of which members were eligible and which were excluded from the ARTS program) such as when members were admitted to PRTFs, and administration and coverage of any professional medical services provided in the TGH. Magellan worked with the Behavioral Health Services Administrator (BHSA) to prevent unnecessary institutional placements and to ensure coordination of medical, ARTS, and mental health services for Magellan members. Magellan also offered transportation and pharmacy services for the provision of BHSA services. Magellan's policies and procedures included coverage of residential treatment services consisting of PRTFs and TGH for the Medallion 4.0 members, effective April 1, 2019.

EQR Activity Results for Optima Family Care (Optima)

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

Performance Measures

Table 4-31 displays the rates for measures that Optima reported for HEDIS 2016, 2017, and 2018. Optima's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate Optima's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-31—Optima HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.44%	48.84%	47.20%	**50.12%**
Childhood Immunization Status				
Combination 3	72.69%	72.92%	69.10%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	67.76%	67.53%	66.39%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.17%	80.47%	78.89%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	54.24%	—
Cervical Cancer Screening				
Cervical Cancer Screening	65.80%	56.85%	66.17%	**58.48%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.71%	83.10%	79.75%	**83.56%**
Postpartum Care	59.03%	60.42%	57.97%	**64.38%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
Total	86.67%	85.98%	84.08%	**82.21%**

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	97.61%	96.56%	**95.70%**
25 Months–6 Years	—	90.59%	90.78%	**87.87%**
7–11 Years	—	92.51%	92.40%	**90.77%**
12–19 Years	—	90.47%	90.42%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	89.35%	86.81%	83.45%	**87.10%**
HbA1c Control (<8.0%)	52.55%	49.77%	45.50%	**48.87%**
Eye Exam (Retinal) Performed	48.84%	53.94%	52.31%	**55.11%**
Medical Attention for Nephropathy	90.74%	90.05%	88.32%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	56.71%	52.55%	56.20%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	51.39%	53.01%	56.59%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	31.45%	34.41%	34.40%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	80.69%	86.88%	85.10%	**77.05%**
Discussing Cessation Medications	46.42%	49.71%	48.41%	**49.71%**
Discussing Cessation Strategies	44.38%	46.15%	44.76%	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	48.80%	49.78%	48.54%	**51.89%**
Effective Continuation Phase Treatment	35.40%	35.71%	34.60%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	38.77%	39.81%	41.36%	**44.80%**
Continuation and Maintenance Phase	47.76%	57.75%	56.84%	**55.90%**
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	64.99%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	49.11%	47.47%	57.43%	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

Optima's performance for HEDIS 2018 demonstrated that members have adequate access to care and that young members are receiving required well-child visits, as evidenced by all measure rates in the Access to Care domain and measure rates for *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* ranking above the national Medicaid 50th percentiles. Additionally, the measure rate for *Cervical Cancer Screening* increased to be similar to HEDIS 2016 performance and exceeded the national Medicaid 50th percentile by more than 7 percentage points, indicating appropriate screenings for cervical cancer.

Conversely, the measure rate for *Childhood Immunization Status—Combination 3* declined by nearly 4 percentage points from HEDIS 2017 to now fall below the national Medicaid 50th percentile. Given that Optima is performing above the national Medicaid 50th percentiles for *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, this may indicate an opportunity to ensure that PCPs are providing and documenting comprehensive services during these visits.

Of note, Optima's measure rates for *Prenatal and Postpartum Care* declined in performance and fell below the national Medicaid 50th percentile. With *Postpartum Care* falling more than 6 percentage points below the national Medicaid 50th percentile, Optima has opportunities to increase care for female members while they are pregnant.

Optima has opportunities to improve care related to management of chronic conditions. Performance for four of five *Comprehensive Diabetes Care* indicators declined, and all indicators fell below the national Medicaid 50th percentiles for HEDIS 2018. Despite increasing by more than 5 percentage points since HEDIS 2016, the *Controlling High Blood Pressure* measure continued to fall below the national Medicaid 50th percentile. Additionally, all but one measure rate (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*) in the Behavioral Health domain fell below the national Medicaid 50th percentiles, indicating improvement opportunities related to these conditions.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-32 presents the 2017 and 2018 MCO-specific aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Optima were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-32—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: Optima

	Optima Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	67.5%	62.0%
Rating of All Health Care	59.5%	52.6%
Rating of Personal Doctor	69.4%	65.1%
Rating of Specialist Seen Most Often	67.1%	63.2%+
Composite Measures		
Getting Needed Care	86.3%	81.4%
Getting Care Quickly	81.5%	81.2%
How Well Doctors Communicate	90.9%	90.7%
Customer Service	87.3%	91.4%+
Shared Decision Making	77.5%	72.0%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Optima's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Optima scored statistically significantly higher than the 2017 NCQA adult Medicaid national averages on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care.*
- Optima scored statistically significantly lower than the 2018 NCQA national adult Medicaid average on one measure: *Shared Decision Making*.
- Optima did not score statistically significantly higher or lower in 2018 than in 2017 for any measure.

Child CAHPS

Table 4-33 presents the 2017 and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2018 child Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for Optima were compared to the 2017 and 2018 NCQA national child Medicaid averages, respectively.

Table 4-33—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: Optima

	Optima Child Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	75.4%	77.9%
Rating of All Health Care	71.7%	74.7%
Rating of Personal Doctor	80.3%	78.3%
Rating of Specialist Seen Most Often	80.6%+	79.7%+
Composite Measures		
Getting Needed Care	88.7%	89.2%
Getting Care Quickly	92.9%	90.7%
How Well Doctors Communicate	94.9%	94.8%
Customer Service	91.2%+	82.7%+
Shared Decision Making	77.3%+	79.1%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

Optima's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- Optima scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.
- Optima scored statistically significantly higher than the 2018 NCQA national child Medicaid average on one measure: *Rating of Health Plan*.
- Optima did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

Consumer Decision Support Tool

The 2018 Consumer Decision Support Tool demonstrated how Optima compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for Optima, as shown in Table 4-34.

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

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-35 displays Optima's 2018 Consumer Decision Support Tool results.

Table 4-35—Optima's 2018 Consumer Decision Support Tool Results

Domain	2018 Results
Doctors' Communication	★★★
Getting Care	★★★
Keeping Kids Healthy	★★
Living With Illness	★★
Taking Care of Women	★★★★★

For 2018, Optima was one of two MCOs that received a five-star rating for the Taking Care of Women domain, demonstrating strength. Conversely, Optima received two-star ratings for the Keeping Kids Healthy and Living With Illness domains, demonstrating opportunities for improvement.

Performance Improvement Projects

In 2018, Optima submitted a continuation of one State-mandated PIP for validation. Optima's PIP topic, *Diabetic Retinal Exam Compliance Rate*, addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' quality strategy. The focus of the PIP was to increase eye exams for diabetic members 18 to 75 years of age who reside in one of 10 identified ZIP codes and have Integrated Eye Network as an eye care professional. Optima set a goal to increase the rate by 10 percentage points, to 48 percent by December 31, 2017.

Table 4-36 outlines the SMART Aim measure for the PIP.

Table 4-36—SMART Aim Measure

PIP Topic	SMART Aim Measure
Diabetic Retinal Exam Compliance Rate	The rate of diabetic patients 18 to 75 years of age, residing in one of the 10 identified ZIP codes, who have Integrated Eye Network as an eye care professional, and who have completed an annual eye exam within the last year.

For validation year 2018, Optima submitted Module 4 and Module 5 for the PIP. Table 4-37 displays progression of the PIP.

Table 4-37—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in October 2016.
2. SMART Aim Data Collection	All validation criteria achieved in December 2016.
3. Intervention Determination	All validation criteria achieved in January 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for one intervention:

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

Optima abandoned the intervention and documented the following lessons learned:

- The MCO should remind members to update their demographic data.
- The MCO's partnership with Integrated Eye Network was beneficial in early identification of eye diseases (e.g., glaucoma and retinopathy).

In the Module 5 validation, HSAG analyzed Optima's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. The SMART Aim measure results for Optima's *Diabetic Retinal Exam Compliance Rate* PIP are shown in Table 4-38.

Table 4-38—SMART Aim Measure Results

SMART Aim Measure	Baseline	SMART Aim Goal	Highest Rate Achieved
Eye exams for diabetic patients 18 to 75 years of age, residing in the 10 identified ZIP Code areas and who have Integrated Eye Network as their eye care provider	38.0%	48.0%	49.2%

Based on the run chart data, the MCO met the SMART Aim goal in September 2017; thereafter, the SMART Aim measure showed an upward trend, with the highest rate of 49.2 percent occurring in November and December 2017. Even though the MCO achieved the SMART Aim goal, the MCO did not provide evidence linking improvement to the tested intervention. HSAG assigned *Low Confidence* to the PIP.

Addiction and Recovery Treatment Services

The Maternity Identification and Care—Partners in Pregnancy policy contained the statement that the Partners in Pregnancy program goals included ensuring access to and increased utilization of early prenatal care, including identifying and serving high-risk pregnant members. Optima's policy also included implementation of the ARTS program, specifically for pregnant women with substance abuse diagnoses.

Optima also developed the Behavioral Health Services/ARTS-Including Mental Health and Substance Abuse Services Care Coordination policy that stated that Optima Health authorized services for inpatient, outpatient, emergency care, and prescription drug benefits. The policy also indicated that Optima followed the Mental Health Parity and Addition Equity Act and included confirmation that the classification of benefits would be the same for mental health or substance use disorder as those provided for medical and surgical benefits. The policy noted that Optima Health did not apply cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, or prescription drugs) that accumulated separately from any established medical or surgical benefits in the same classification.

The Behavioral Health Services/ARTS-Including Mental Health and Substance Abuse Services Care Coordination policy confirmed that Optima provided behavioral therapy under EPSDT to members with developmental delays such as autism and intellectual disabilities when such members exhibited intensive behavioral challenges and were authorized for services. Optima covered behavioral therapy under EPSDT services to individuals under 21 year of age who met the medical necessity. The policy indicated that a child's physician, nurse practitioner, or physician assistant—through inter-periodic/problem-focused visits or an EPSDT screening or well-child visit—could identify the need for behavioral therapy. Optima also reiterated that therapy services were provided within the everyday routines and activities in which the families participate as required through EPSDT program and early intervention program guidelines.

Best and Emerging Practices for Improving Quality of Care and Services

Optima submitted the following best and emerging practices for 2018.

Cultural Diversity

Optima was successful in creating and refining a cultural diversity and associated plan to ensure that services are provided in a respectful and meaningful way. The cultural diversity plan was designed to promote a culture of social awareness and cultural sensitivity.

As an integrated health system, Optima collaborated with Sentara regarding corporate training initiatives and internal policy updates.

The civil rights coordinators attended training events to gain a better understanding of diversity, laws, and regulations. Staff were educated through various means such as orientations, videos, computer learning modules, e-mail blasts, and briefs containing videos or other informational material. Along with other mandatory trainings, clinical teams were educated on how to access the internal Community Resource Guide and reference links.

To ensure that language and translation needs are met, Optima's language access telephone line and member email are monitored daily. A quality reporting database was instituted to ensure that the highest level of interpreting and translation services are available to members. Quality reports are monitored daily by the Compliance Department for trending and tracking of service interruptions and complaints. Membership data were also monitored to determine the need for any additional language or cultural provisions.

Given the increasingly diverse populations served, the Cultural Diversity Plan and educational material continue to evolve.

Preventive Care Gap Closure

One way that Optima attempts to close gaps in care and increase HEDIS results is to use incoming phone calls made to Optima. When a member calls Member Services and provides his or her Optima Health identification number, a pop-up message appears advising the representative that the member may be missing a preventive health screening. At that time, the representative will inform the member of any missed screening(s) and advise to call the provider to schedule an appointment.

Optima expanded its eye exam program based on significant improvement in its PIP results. Using a telephonic reminder system, members were called and advised that it was time to schedule their next eye exam. Members were each helped at time of call to be transferred to an eye exam provider to schedule an appointment.

Member Outreach and Education

Optima implemented new outreach programs to support pregnant moms and address literacy in youth. Additional outreach programs and clinical initiatives to improve HEDIS outcomes will be launched in 2019.

Eat Healthy and Manage Weight

Optima developed a program to provide fresh produce and healthy brand discounts to Medicaid members through weekly grocery discounts. This program will help members choose healthy food options, changing their health profiles; and will promote food stability. Weekly communications will be distributed with health and food tips via e-mails, website postings, and the MCO's mobile app. Optima expects to launch the program in 2019.

Maternity Care and Literacy

Optima has partnered with local hospitals to host baby showers for Optima family care members in each of the six regions in Virginia. The goals of the baby shower are to support pregnant moms and their families and to offer opportunities to celebrate and provide maternity and parenting education. The event includes food; a tour around the labor and delivery unit; and educational discussions on safe sleep, postpartum depression, and breastfeeding, along with other informative topics.

Optima launched its Read, Learn, Grow program designed to encourage and support reading among young people and their families in all six regions of Virginia by providing one hundred performances of the puppet production "Open a Book." The performance:

- Included original songs and material promoting the value of reading.
- Locations included but were not limited to schools, early learning centers, preschools, libraries, community centers, museums, and community festivals.
- Distributed 38,000 original children's books, designed specifically for children and their families.

Follow-Up to Prior EQR Recommendations

The Medallion 3.0 contract ended in 2018. The Medallion 4.0 program MCO contracts were awarded and implementation occurred August 2018 through December 2018. MCOs were required to focus on implementation of the Medallion 4.0 program and preparation for implementation of Medicaid expansion to begin on January 1, 2019, rather than to implement interventions or corrective actions for recommendations made for the Medallion 3.0 program that ended in 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

HEDIS Performance Measures

Optima demonstrated strength in its performance for HEDIS 2018, indicating that members have adequate access to care and that young members are receiving required well-child visits, as evidenced by all measure rates in the Access to Care domain and measure rates for *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* ranking above the national Medicaid 50th percentiles.

Optima demonstrated strength in the measure rate for *Cervical Cancer Screening,* which increased to be similar to HEDIS 2016 performance and exceeded the national Medicaid 50th percentile by more than 7 percentage points, indicating appropriate screenings for cervical cancer.

Optima demonstrated a weakness in the measure rate for *Childhood Immunization Status—Combination 3* which declined by nearly 4 percentage points from HEDIS 2017, falling below the national Medicaid 50th percentile.

Another weakness for Optima is found in its measure rates for *Prenatal and Postpartum Care,* which declined in performance and fell below the national Medicaid 50th percentiles. The *Postpartum Care* rate declined more than 6 percentage points below the national Medicaid 50th percentile.

Optima demonstrated weakness in its management of chronic conditions. Performance for four of five *Comprehensive Diabetes Care* indicators declined, and all indicators fell below the national Medicaid 50th percentile for HEDIS 2018. Despite increasing by more than 5 percentage points since HEDIS 2016, the *Controlling High Blood Pressure* measure continued to fall below the national Medicaid 50th percentile.

Optima also had evidence of weakness in the Behavioral Heath domain. All but one measure rate (*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*) fell below the national Medicaid 50th percentile.

Performance Measure Validation

Strengths for Optima were that its performance measure data were compliant with HEDIS and DMAS specifications and that data, as reported, were valid. Optima's performance measures were reportable.

CAHPS

Optima scored statistically significantly lower than the 2018 NCQA adult Medicaid national average on one measure, *Shared Decision Making,* indicating a weakness for the MCO. Conversely, Optima scored statistically significantly higher than the 2018 NCQA child Medicaid national average for *Rating of Health Plan,* indicating a strength for the MCO. For the adult and child Medicaid CAHPS, the MCO did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

2018 Recommendations for Optima

HEDIS Recommendations

Optima performed above the national Medicaid 50th percentiles for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measures. HSAG recommends that Optima identify opportunities during these visits to ensure that PCPs are providing and documenting comprehensive well-child and preventive health services such as immunizations. Best practices identified in other states include ensuring that opportunities such as providing childhood and adolescent immunizations and completing developmental screenings are not missed during these visits.

With the *Postpartum Care* rate falling more than 6 percentage points below the national Medicaid 50th percentile, HSAG recommends that Optima identify opportunities to outreach to pregnant members and to providers to increase care for female members while they are pregnant. HSAG recommends that Optima develop and implement quality initiatives focused on ensuring that members are informed about and practicing prenatal care and that members participate in their postpartum care visits. Prenatal and postpartum care work in some state Medicaid programs provide opportunities to partner with obstetrical practices to conduct reminder calls the day before the scheduled appointment, assist with ensuring that transportation is arranged for the appointment by completing warm transfers to the transportation vendors, and provide additional educational opportunities such as parenting classes.

Performance for four of five *Comprehensive Diabetes Care* indicators declined, and all indicators fell below the national Medicaid 50th percentile for HEDIS 2018. Despite increasing by more than 5 percentage points since HEDIS 2016, the *Controlling High Blood Pressure* measure continued to be below the national Medicaid 50th percentile. HSAG recommends that Optima identify quality improvement opportunities to improve care related to management of chronic conditions. Optima should focus efforts on medications for chronic diseases such as asthma, depression, and ADHD. Lessons learned should be applied toward the overall medication management of members. HSAG's work with other states has identified best practices in medication management such as working with PCPs or health home providers to ensure that medication refills are completed. Medicaid MCOs in some states utilize their internal pharmacy department to conduct follow-up on medication refills, to outreach to review medications upon member discharge from an inpatient stay or an emergency department visit, and to reconcile medications for the elderly or members with comorbid conditions requiring multiple prescriptions.

HSAG recommends that Optima, in the Behavioral Health domain, review performance measure rates that fell below the national Medicaid 50th percentile and identify quality improvement opportunities to improve performance.

Optima's measure rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* continued to be higher than the national Medicaid 50th percentile, and the

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase measure rate continued to be lower than the 50th percentile. Documentation reviewed during readiness reviews did not suggest that Optima had implemented recommendations made in the 2017 annual technical report, including opportunities for the MCO to limit in its formulary the quantity prescribed for new ADHD prescriptions. HSAG has found that when state and/or health plan formularies limit the quantity prescribed for new ADHD prescriptions this may result in improvement in the *Initiation Phase* measure indicator rates. This intervention requires the member's family or caregivers to seek follow-up care to renew prescriptions, which also provides an opportunity for the member to receive well-child visits, immunizations, and other needed EPSDT services. HSAG recommends that Optima follow up on the 2017 recommendation that the MCO's Pharmaceutical and Therapeutics Committee evaluate the benefits and risks associated with implementation of this pharmacy benefit system control as a mechanism to drive improved follow-up rates for children newly prescribed ADHD medication.

PMV Recommendations

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

- Ensure that the FCA measure documentation in Performance Clinical Systems (PCS) Symphony provides sufficient detail to identify the source of the information used to complete the assessment. HSAG recommends that Optima implement interrater reliability processes to ensure consistency and accuracy in data entry.
- Optima mapped FQHCs to the PCP provider types for HEDIS 2018; therefore, the MCO should ensure that the updated criteria for this mapping are met for HEDIS 2019.
- Optima should explore creating a data feed from Echo to Consumer Science Corporation (CSC). This would mitigate manual data entry and instill greater confidence in data accuracy.

PIP Recommendations

Optima received a *Low Confidence* score for its State-mandated PIP, *Diabetic Retinal Exam Compliance Rate*. HSAG recommends that Optima:

- Provide a clear data collection plan for each component of the intervention.
- Provide intervention evaluation data that include monthly numerator and denominator numbers related to how many members were contacted by outreach; how many of those members needed transportation; and, subsequently, how many of those members each received a diabetic eye exam.
- Test an intervention until the SMART Aim end date.
- Report results using the approved rolling 12-month methodology, including the numerators and denominators for each SMART Aim monthly measurement.

CAHPS Recommendations

Optima experienced declines in both the Adult CAHPS and the Children's CAHPS global and composite scores. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to adults and children.

EQR Activity Results for UnitedHealthcare of the Mid-Atlantic (United)

United was not a Medallion 3.0 contracted MCO. Therefore, the EQR activities were not performed during 2018 for this MCO. United is a contracted MCO for the Medallion 4.0 program, which became effective on August 1, 2018. United's readiness review results may be found in "Section 3, Comparative Information and Quality Strategy Recommendations" of this report. Oversight of the ARTS program implementation was reviewed during the Medallion 4.0 readiness reviews. Highlights of the review are described following.

Addiction and Recovery Treatment Services

United's Healthy First Steps (HFS) Program documentation provided a comprehensive overview of United's approach to achieving the best health outcomes for infants and pregnant women. United ensured access to early prenatal care through a multi-faceted approach to earlier identification and engagement of pregnant members, along with identification of high-risk pregnant members. The HFS document outlined the processes for enrolling high-risk pregnant members into intensive case management. The Medallion 4.0 readiness review results identified that United had not completed all necessary requirements necessary to successfully implement the ARTS program and was required to complete corrective actions.

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

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

Performance Measures

Table 4-39 displays the rates for measures that VA Premier reported for HEDIS 2016, 2017, and 2018. VA Premier's HEDIS 2016, 2017, and 2018 rates were also compared to the corresponding NCQA's Quality Compass national Medicaid HMO 50th percentile. Yellow-shaded boxes indicate VA Premier's measure rates at or above the corresponding national Medicaid 50th percentile. The NCQA Quality Compass national Medicaid 50th percentiles for HEDIS 2017 are also provided for reference.

Table 4-39—VA Premier HEDIS 2016, 2017, and 2018 Results

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	45.70%	48.84%	49.15%	**50.12%**
Childhood Immunization Status				
Combination 3	72.19%	71.53%	72.02%	**71.58%**
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	67.99%	63.66%	63.99%	**62.06%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.42%	74.54%	74.70%	**72.45%**
Women's Health				
Breast Cancer Screening[1]				
Breast Cancer Screening	—	—	50.30%	—
Cervical Cancer Screening				
Cervical Cancer Screening	61.92%	60.05%	59.12%	**58.48%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	80.13%	85.15%	84.43%	**83.56%**
Postpartum Care	60.93%	64.27%	66.18%	**64.38%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				

Performance Measures	HEDIS 2016 Rate (CY2015)	HEDIS 2017 Rate (CY2016)	HEDIS 2018 Rate (CY2017)	NCQA Quality Compass 50th Percentile for HEDIS 2017
Total	88.86%	88.00%	86.68%	**82.21%**
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	—	98.21%	96.78%	**95.70%**
25 Months–6 Years	—	92.69%	91.08%	**87.87%**
7–11 Years	—	93.97%	93.58%	**90.77%**
12–19 Years	—	92.34%	92.28%	**89.52%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	84.43%	87.72%	91.24%	**87.10%**
HbA1c Control (<8.0%)	39.08%	48.77%	51.09%	**48.87%**
Eye Exam (Retinal) Performed	49.47%	52.28%	53.28%	**55.11%**
Medical Attention for Nephropathy	89.62%	90.88%	93.92%	**90.27%**
Blood Pressure Control (<140/90 mm Hg)	50.99%	54.21%	55.47%	**60.60%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	51.35%	57.87%	59.12%	**56.93%**
Medication Management for People With Asthma				
Medication Compliance 75%—Total	33.39%	38.55%	44.16%	**33.33%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	84.75%	83.52%	81.82%	**77.05%**
Discussing Cessation Medications	50.00%	53.13%	50.23%	**49.71%**
Discussing Cessation Strategies	40.47%	42.54%	40.91%	**43.90%**
Behavioral Health‡				
Antidepressant Medication Management[2]				
Effective Acute Phase Treatment	68.89%	51.98%	64.16%	**51.89%**
Effective Continuation Phase Treatment	54.87%	36.78%	48.54%	**36.19%**
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	54.78%	55.38%	56.07%	**44.80%**
Continuation and Maintenance Phase	66.33%	67.63%	68.07%	**55.90%**
Follow-Up After Hospitalization for Mental Illness[1]				
30-Day Follow-Up	—	—	59.11%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]				
Total	64.12%	65.49%	65.61%	**61.77%**

[1] Due to changes in the technical specifications for this measure for HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed for this measure.

[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.

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

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

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

For HEDIS 2018, VA Premier ranked above the national Medicaid 50th percentiles for 23 of the 27 (approximately 85 percent) measure rates compared to benchmarks, demonstrating high performance from the MCO. Of note, all measures in the Women's Health, Access to Care, and Behavioral Health domains ranked above the national Medicaid 50th percentiles. VA Premier has opportunities to improve care for the three measure rates that have been consistently below the national Medicaid 50th percentiles: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)*; and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*.

Consumer Survey Quality of Care

Adult CAHPS

Table 4-40 presents the 2017 and 2018 MCO-specific aggregate adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2018 adult Medicaid CAHPS scores to its corresponding 2017 CAHPS scores. In addition, the 2017 and 2018 CAHPS scores for VA Premier were compared to the 2017 and 2018 NCQA national adult Medicaid averages, respectively.

Table 4-40—Comparison of 2017 and 2018 Adult Medicaid CAHPS Results: VA Premier

	VA Premier Adult Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	62.9%	59.6%
Rating of All Health Care	54.2%	44.5%
Rating of Personal Doctor	68.0%	65.5%
Rating of Specialist Seen Most Often	69.1%	59.4%+
Composite Measures		
Getting Needed Care	85.8%	82.8%
Getting Care Quickly	88.1%	83.9%
How Well Doctors Communicate	89.4%	89.3%
Customer Service	89.4%	87.8%+
Shared Decision Making	81.8%	79.3%+

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ *statistically significantly higher in 2018 than in 2017.*
▼ *statistically significantly lower in 2018 than in 2017.*
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

VA Premier's 2017 and 2018 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier scored statistically significantly higher than the 2017 NCQA adult Medicaid national averages on three measures: *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly*.
- VA Premier scored statistically significantly lower than the 2018 NCQA national adult Medicaid average on one measure: *Rating of All Health Care*.
- VA Premier did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

Child CAHPS

Table 4-41 presents the 2017 and 2018 MCO-specific aggregate child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2018 child Medicaid CAHPS scores to its corresponding 2017 CAHPS scores.

Table 4-41—Comparison of 2017 and 2018 Child Medicaid CAHPS Results: VA Premier

	VA Premier Child Medicaid	
	2017	2018
Global Ratings		
Rating of Health Plan	71.3%	69.8%
Rating of All Health Care	65.3%	69.5%
Rating of Personal Doctor	75.5%	81.3%▲
Rating of Specialist Seen Most Often	71.3%	78.1%
Composite Measures		
Getting Needed Care	88.0%	88.2%
Getting Care Quickly	95.3%	93.4%
How Well Doctors Communicate	96.4%	97.3%
Customer Service	89.7%	88.4%
Shared Decision Making	79.0%	81.3%

+ indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ statistically significantly higher in 2018 than in 2017.
▼ statistically significantly lower in 2018 than in 2017.
Cells highlighted in yellow represent rates that are statistically significantly higher than the 2017 or 2018 NCQA national Medicaid averages.
Cells highlighted in red represent rates that are statistically significantly lower than the 2017 or 2018 NCQA national Medicaid averages.

VA Premier's 2017 and 2018 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

- VA Premier scored statistically significantly higher than the 2017 NCQA national child Medicaid averages on three measures: *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate*.
- VA Premier scored statistically significantly higher than the 2018 NCQA national child Medicaid averages on four measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- VA Premier scored statistically significantly higher in 2018 than in 2017 on one measure: *Rating of Personal Doctor*.

Consumer Decision Support Tool

The 2018 Consumer Decision Support Tool demonstrated how VA Premier compared to other Virginia Medicaid MCOs in key domains. The Consumer Decision Support Tool used stars to display results for VA Premier as shown in Table 4-42.

Table 4-42—Consumer Decision Support Tool Results—Performance Ratings

Rating	MCO Performance Compared to Statewide Average	
★★★★★	**Highest Performance**	The MCO's performance was 1.96 standard deviations or more above the Virginia Medicaid average.
★★★★	**High Performance**	The MCO's performance was between 1 and 1.96 standard deviations above the Virginia Medicaid average.
★★★	**Average Performance**	The MCO's performance was within 1 standard deviation of the Virginia Medicaid average.
★★	**Low Performance**	The MCO's performance was between 1 and 1.96 standard deviations below the Virginia Medicaid average.
★	**Lowest Performance**	The MCO's performance was 1.96 standard deviations or more below the Virginia Medicaid average.

Table 4-43 displays VA Premier's 2018 Consumer Decision Support Tool results.

Table 4-43—VA Premier's 2018 Consumer Decision Support Tool Results

Domain	2018 Results
Doctors' Communication	★★★
Getting Care	★★★

Domain	2018 Results
Keeping Kids Healthy	★★★
Living With Illness	★★★★★
Taking Care of Women	★★★

For 2018, VA Premier was the only MCO to receive a five-star rating for the Living With Illness domain, demonstrating strength.

Performance Improvement Projects

In 2018, VA Premier submitted a continuation of one State-mandated PIP for validation. VA Premier's PIP topic, *Comprehensive Diabetes Care: Eye Exams*, addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The topic represents a key area of focus for improvement and is part of DMAS' Quality Strategy. The focus of the PIP was to increase the eye exam compliance rate for diabetic members 18 to 75 years of age who receive care at one of four FQHCs. VA Premier set a goal to increase the rate to 32.4 percent by December 31, 2017.

Table 4-44 outlines the SMART Aim measure for the PIP.

Table 4-44—SMART Aim Measure

PIP Topic	SMART Aim Measure
Comprehensive Diabetes Care: Eye Exams	The rate of diabetic members (type 1 and type 2) 18 to 75 years of age who receive care at one of four FQHCs and had a retinal or dilated eye exam.

For validation year 2018, VA Premier submitted Module 4 and Module 5 for the PIP. Table 4-45 displays progression of the PIP.

Table 4-45—PIP Progression

Module	Status
1. PIP Initiation	All validation criteria achieved in November 2016.
2. SMART Aim Data Collection	All validation criteria achieved in November 2016.
3. Intervention Determination	All validation criteria achieved in January 2017.
4. Plan-Do-Study-Act	Submitted and validated in February/March 2018.
5. PIP Conclusions	Submitted and validated in February/March 2018.

The MCO submitted a final Module 4 (Intervention Testing) for one intervention:

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

VA Premier planned to adapt the intervention by expanding it to other FQHCs and documented the following lessons learned:

- The MCO should train more than one person in the facility and use of equipment at various facilities.
- The MCO should provide aid and resources to health centers to manage the process.
- The MCO should educate care coordinators to remind members to obtain needed services.
- The MCO's medical directors can be valuable resources to engage health center physicians.
- The MCO should use Member Operations and Medical Outreach staff to the fullest capacity for outreach efforts.
- The MCO should collaborate with facility staff to conduct barrier analyses on no-shows and missed appointments.
- The MCO should use the internal care management system as a tool for cross communication.
- The MCO should assign a project manager to manage communication between the facility and MCO.

In the Module 5 validation, HSAG analyzed VA Premier's PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. The SMART Aim measure results for VA Premier's *Comprehensive Diabetes Care: Eye Exams* PIP are shown in Table 4-46.

Table 4-46—SMART Aim Measure Results

SMART Aim Measure	Baseline	SMART Aim Goal	Highest Rate Achieved
Eye exams for the diabetic population 18 to 75 years of age at four FQHCs	27.4%	32.4%	43.3%

The MCO met the SMART Aim goal in September 2016; thereafter, the data demonstrated an upward trend through December 2016, followed by a sharp drop of 29.7 percentage points in January 2017. In 2017, the rates again followed an increasing trend, with the highest rate of 43.3 percent occurring in December 2017. The final rate in December 2017 was very similar to the rate in December 2016. Even though the MCO achieved the SMART Aim goal, it appeared that the MCO tracked a cumulative rate. HSAG assigned *Low Confidence* to the PIP.

Addiction and Recovery Treatment Services

During the Medallion 4.0 readiness review process, HSAG reviewed the status of VA Premier's implementation of the ARTS program. HSAG found that the behavioral health services policies submitted by VA Premier included all requirements specified in its contract with DMAS (including identification of which members were eligible and which were excluded from the ARTS program) such

as when members were admitted to PRTFs, and administration and coverage of any professional medical services provided in the TGH. VA Premier worked with the Behavioral Health Services Administrator (BHSA) to prevent unnecessary institutional placements and to ensure coordination of medical, ARTS, and mental health services for VA Premier members. VA Premier also offered transportation and pharmacy services for the provision of BHSA services. VA Premier's policies and procedures included coverage of residential treatment services consisting of PRTFs and TGH for the Medallion 4.0 members, effective April 1, 2019.

VA Premier implemented policies and procedures that followed the formulary, based on requirements established by DMAS and listed drugs approved for the ARTS program. VA Premier's policies and procedures outlined steps concerning the patient utilization and safety management program designed to promote proper medication management. VA Premier policies also addressed that VA Premier provided medical transportation to all Medicaid covered services, including providing transportation to pharmacy services necessary for the treatment of mental health and substance abuse issues, including carved-out services.

Best and Emerging Practices for Improving Quality of Care and Services

VA Premier submitted the following best and emerging practices for 2018.

Social Determinants of Health

VA Premier's social determinants of health (SDoH) program is called "Healthy People 2020." The program addresses social determinants of health with goals of ending health disparities, promoting health, and creating social and physical environments that promote good health. VA Premier has employed initiatives and interventions addressing SDoH, including:

- Emergency food pantry in Roanoke to assist members with emergency food needs.
- Red Bag Initiative—statewide VA Premier specific program to assist members with obtaining basic hygiene items.
- Group "baby shower" to identify and provide needed baby care items and education.
- Food Farmacy Program—improve access to locally sourced, fresh food options.
- Fit4Kids—Health education and programs to increase access to healthy foods in the Central Region.
- On Our Own of Charlottesville—A homelessness prevention program.
- Mom's Meals—referral program for members discharging from an inpatient stay who are identified upon screening to be at high risk for nutritional deficiency. This program provides from two weeks of prepared meals (tailored to the member's preference and prescribed diet) up to a 30-day supply.
- Exploration of micro-grants to assist with transportation to non-medical appointments to combat social isolation.

- Updated social work assessment to focus solely on SDoH as well as specific SDoH interventions that are included in the member's individual care plan (ICP) or plan of care (POC).

Vendor Support Program

VA Premier and vendor staff require ongoing training and education related to specific roles and responsibilities, monitoring activities, and how to report compliance concerns or questions. The vendor has structured capabilities to deliver and track outcomes of staff training including general compliance; fraud, waste, and abuse; and detailed procedures in support of the delegated functions. The vendor support team was developed during 2018 to consolidate the relationship and operational performance management of medical management vendors. The team serves as the liaison between VA Premier key stakeholders and vendors supporting medical management activities.

Key Performance Measures

VA Premier's vendors' performance will be monitored ongoing with a formal review no less than annually. The types of routine monitoring activities performed by VA Premier will vary based on past performance with the vendor and nature of services performed. Type and frequency of monitoring will be documented for each vendor, including evidence of the monitoring activities. VA Premier is in process of establishing key performance metrics designed to measure vendor services. VA Premier is working to develop associated service-level agreement reporting for applicable vendors, contract review and evaluation, invoicing and payment processes, and pricing strategies.

Communication and Oversight

The Vendor Support Program, in conjunction with the Delegate Oversight Team (DOT), will position VA Premier to ensure that members are receiving quality care. The DOT includes members of the compliance and quality management teams as well as the designated members of management who own the business relationships with the vendors and the operational business owners of the processes being delegated. DOT reviews and approves performance monitoring activities; oversee the vendors' implementation of corrective action plans, if needed; and allows VA Premier to demonstrate deliberate and organized oversight of the delegated vendors.

Follow-Up to Prior EQR Recommendations

The Medallion 3.0 contract ended in 2018. The Medallion 4.0 program MCO contracts were awarded and implementation occurred August 2018 through December 2018. MCOs were required to focus on implementation of the Medallion 4.0 program and preparation for implementation of Medicaid expansion to begin on January 1, 2019, rather than to implement interventions or corrective actions for recommendations made for the Medallion 3.0 program that ended in 2018.

Summary of Strengths, Weaknesses, and Overall Conclusions

HEDIS Performance Measures

VA Premier demonstrated strength overall in its HEDIS 2018 performance measure rates. VA Premier ranked above the national Medicaid 50th percentile for 23 of the 27 (approximately 85 percent) measure rates compared to benchmarks, demonstrating high performance from the MCO.

All measures in the Women's Health, Access to Care, and Behavioral Health domains ranked above the national Medicaid 50th percentiles, demonstrating strength for VA Premier.

Within the Behavioral Health domain, VA Premier's measure rates ranked at or above the national Medicaid 50th percentiles for the five reportable rates. The *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, experienced substantive increases in performance in 2018 and were once again above the national Medicaid 50th percentiles.

VA Premier demonstrated a weakness in three measure rates that have been consistently below the national Medicaid 50th percentiles: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)*; and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*. These three measures, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)*, were also below the national Medicaid 50th percentiles in 2017.

Performance Measure Validation

VA Premier demonstrated a strength in its performance measure data. VA Premier was compliant with HEDIS and DMAS specifications; and the data, as reported, were valid. VA Premier's performance measures were reportable.

CAHPS

For the adult Medicaid CAHPS survey, VA Premier scored statistically significantly lower than the 2018 adult Medicaid national average for *Rating of All Health Care* but did not score statistically significantly higher or lower in 2018 than in 2017 on any measure.

VA Premier scored statistically significantly higher on *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* for the child Medicaid CAHPS survey when compared to the 2018 child Medicaid national averages. Furthermore, VA Premier scored statistically significantly higher in 2018 than in 2017 on one measure, *Rating of Personal Doctor*.

2018 Recommendations for VA Premier

HEDIS Recommendations

HSAG recommends that VA Premier continue the interventions implemented in 2018 that contributed to the increase in rates for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment,* from the decline experienced in 2017. VA Premier should continue to establish mechanisms to monitor members prescribed antidepressant medications. Early identification and collaboration with the behavioral health providers providing treatment may be beneficial in improving rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*. HSAG recommends that successful quality improvement activities that resulted in the increased performance measure rates be monitored closely to ensure that improvements are sustained.

PMV Recommendations

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

- Explore ways to verify denominator and numerator counts thoroughly before reporting; use all available DMAS resources to verify that members in question meet criteria.
- Review claims processing data more rigorously prior to reporting, looking at volume trending over time.
- Continue to explore mechanisms to enable production of claims processing measure data that do not require manual verification (e.g., confirming "clean" claim counts).
- Continue to monitor electronic data interchange (EDI) claims loads closely and conduct reconciliations to ensure that all claims are flowing through the process as expected.
- For HEDIS 2019, work with its HEDIS auditor and FQHCs to ensure that the MCO is able to meet NCQA's updated criteria for mapping FQHCs to the PCP provider type.

PIP Recommendations

VA Premier received a *Low Confidence* score for its State-mandated PIP, *Comprehensive Diabetes Care: Eye Exams*. VA Premier should:

- Provide a comprehensive intervention methodology and submit a Module 4 for each intervention tested.

- Provide clear intervention evaluation data that include results for each component of the evaluation plan.
- Report accurate results following the approved rolling 12-month methodology, including the numerators and denominators for each SMART Aim monthly measurement.

CAHPS Recommendations

VA Premier experienced declines in both the adult CAHPS and child CAHPS global and composite scores. VA Premier demonstrated positive results in *Rating of Personal Doctor* in the child global score. HSAG recommends reviewing data points and trends in customer calls, grievances and appeals, prior authorization denials, and quality of care concerns to identify opportunities to address member concerns and improve member satisfaction rates related to care provided to adults and children.

Appendix A. CAHPS Survey Methodology

CAHPS Surveys

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in the FAMIS program, Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier with their MCO and health care experiences.

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the Medallion 3.0 MCOs, Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[A-1] The mode of CAHPS survey data collection varied slightly among the MCOs. Anthem and Kaiser Permanente used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. Aetna, INTotal, and VA Premier used an enhanced Internet mixed-mode methodology for both their adult and child populations. Optima used an enhanced Internet mixed-mode methodology of data collection for its adult Medicaid members and a mixed-mode methodology for its child Medicaid members. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2018.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[A-2] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child

[A-1] Anthem and Kaiser Permanente administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.0 Child Survey without the chronic conditions measurement set. For purposes of this report, the child Medicaid CAHPS results presented for Anthem and Kaiser Permanente represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[A-2] Aetna contracted with the Center for the Study of Services (CSS), Anthem and Kaiser Permanente both contracted with DSS Research, INTotal contracted with Morpace Inc., and Optima and VA Premier both contracted with SPH Analytics to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (53 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[A-3] These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., "Getting Needed Care" and "How Well Doctors Communicate").

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always"; or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For Medallion 3.0, the 2017 and 2018 CAHPS scores for each MCO and the statewide aggregate were compared to the 2017 and 2018 NCQA national Medicaid averages, respectively.[A-4] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

Additionally, a trend analysis was performed for each MCO that compared its 2018 CAHPS scores to its corresponding 2017 scores to determine whether there were statistically significant differences. Scores that were statistically significantly higher in 2018 than in 2017 are noted with green upward (▲) triangles. Scores that were statistically significantly lower in 2018 than in 2017 are noted with red downward (▼) triangles. Scores in 2018 that were not statistically significantly different from scores in 2017 are not noted with triangles.

It is important to note that NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

[A-3] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*. Therefore, reported results are limited to the four global ratings and five composite measures.

[A-4] Quality Compass 2017 and 2018 data serve as the source for the 2017 and 2018 NCQA CAHPS adult Medicaid and child Medicaid national averages, respectively.

FAMIS CAHPS

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. The CAHPS surveys were conducted per the Centers for Medicare & Medicaid Services' (CMS') CAHPS reporting requirements under the Children's Health Insurance Program Reauthorization Act (CHIPRA). In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care).

Based on NCQA protocol, child members included as eligible for the survey were 17 years of age or younger as of December 31, 2017. A mixed-mode methodology for data collection was utilized (i.e., mailed surveys followed by computer assisted telephone interviewing [CATI] of non-respondents to the mailed surveys). Parents or caretakers of child members completed the surveys between the time period of March to June 2018. The surveys were administered in English and Spanish. Members identified as Spanish speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey with the chronic conditions measurement set includes a standardized set of 83 items that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and children with chronic conditions members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data. An analysis of the CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-5]

For the FAMIS program, the survey questions were categorized into nine measures of satisfaction.[A-6] These measures included four global ratings and five composite measures. The global measures (also referred to as global ratings) reflected patients' overall satisfaction with their health plan, all health care, personal doctor, and specialist. The composite scores were derived from sets of questions to address different aspects of care (e.g., "Getting Needed Care" or "Getting Care Quickly").

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). For each of the five composite scores, the percentage of

[A-5] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.

[A-6] For purposes of this report, CAHPS survey results are not reported for the two individual item measures: *Coordination of Care* and *Health Promotion and Education*, or the five CCC composite measures and items. Therefore, reported results are limited to the four global ratings and five composite measures.

respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

The FAMIS program's general child and CCC populations' survey findings were compared to 2017 and 2018 NCQA CAHPS child and CCC Medicaid national averages, respectively.[A-7] A statistically significant difference was identified by using the confidence interval for each measure rate. Statistically significant differences are noted with colors. A cell was highlighted in yellow if the lower bound of the confidence interval was higher than the national average. However, if the upper bound of the confidence interval was lower than the national average, then a cell was highlighted in red.

NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result. However, for purposes of reporting the FAMIS CAHPS results, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Caution should be exercised when interpreting results for those measures with fewer than 100 respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2018 for the Medallion 3.0 MCOs, and from March to June 2018 for the FAMIS program.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.0H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 24, 28, and 35. For the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. For the CAHPS 5.0 Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 30, 45, 49, and 54. Eligible members included the entire sample minus ineligible members. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were

[A-7] The source for the 2017 and 2018 NCQA national child and CCC Medicaid averages for the general child population and children with chronic conditions population is Quality Compass® 2017 and 2018 data.

mentally or physically incapacitated. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic condition populations' CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program members enrolled in FFS and managed care). The FAMIS CAHPS survey results are summarized in the Executive Summary section of this report.

Appendix B. NCQA Quality Compass 50th Percentile Values

NCQA Quality Compass 50th Percentile Values

For reference, included in Table B-1, are NCQA Quality Compass national Medicaid HMO 50th percentile values for HEDIS 2015, 2016, and 2017 measures evaluated for the MCOs.

Table B-1—NCQA Quality Compass 50th Percentile Values

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2015	NCQA Quality Compass 50th Percentile for HEDIS 2016	NCQA Quality Compass 50th Percentile for HEDIS 2017
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	49.15%	48.41%	50.12%
Childhood Immunization Status			
Combination 3	71.53%	71.06%	71.58%
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	59.76%	59.57%	62.06%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.02%	71.42%	72.45%
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	58.34%	58.08%	—
Cervical Cancer Screening			
Cervical Cancer Screening	61.05%	55.94%	58.48%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	85.19%	82.25%	83.56%
Postpartum Care	62.77%	60.98%	64.38%
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services			
Total	83.84%	82.15%	82.21%
Children and Adolescents' Access to Primary Care Practitioners			
12–24 Months	—	95.74%	95.70%
25 Months–6 Years	—	87.69%	87.87%
7–11 Years	—	91.00%	90.77%
12–19 Years	—	89.37%	89.52%
Care for Chronic Conditions			
Comprehensive Diabetes Care[1]			

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2015	NCQA Quality Compass 50th Percentile for HEDIS 2016	NCQA Quality Compass 50th Percentile for HEDIS 2017
Hemoglobin A1c (HbA1c) Testing	86.20%	85.95%	87.10%
HbA1c Control (<8.0%)	47.91%	46.76%	48.87%
Eye Exam (Retinal) Performed	54.74%	53.28%	55.11%
Medical Attention for Nephropathy	81.75%	90.51%	90.27%
Blood Pressure Control (<140/90 mm Hg)	62.23%	59.73%	60.60%
Controlling High Blood Pressure			
Controlling High Blood Pressure	57.53%	54.78%	56.93%
Medication Management for People With Asthma			
Medication Compliance 75%—Total	29.60%	31.28%	33.33%
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	76.74%	76.59%	77.05%
Discussing Cessation Medications	46.70%	48.31%	49.71%
Discussing Cessation Strategies	42.50%	43.82%	43.90%
Behavioral Health			
Antidepressant Medication Management[2]			
Effective Acute Phase Treatment	50.51%	53.38%	51.89%
Effective Continuation Phase Treatment	34.02%	38.06%	36.19%
Follow-Up Care for Children Prescribed ADHD Medication[2]			
Initiation Phase	40.79%	42.19%	44.80%
Continuation and Maintenance Phase	50.61%	52.47%	55.90%
Follow-Up After Hospitalization for Mental Illness			
30-Day Follow-Up	66.64%	63.94%	—
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]			
Total		60.43%	61.77%

[1] *Due to changes in the technical specifications for this measure for HEDIS 2016, exercise caution when comparing 2016 (or later) NCQA Quality Compass 50th percentiles to prior years.*

[2] *Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when comparing 2017 NCQA Quality Compass 50th percentiles to prior years.*

— Although NCQA Quality Compass national Medicaid 50th percentiles may be available for these measures, these measures were not required for measure reporting for HEDIS 2016; therefore, national Medicaid 50th percentiles are not displayed. This symbol may also indicate that NCQA recommended a break in trending; therefore, national Medicaid 50th percentiles are not displayed.

Indicates that the measure was required for measure reporting in HEDIS 2016; however, NCQA Quality Compass national Medicaid 50th percentiles were not available.

Appendix C. Performance Measure Validation Methodology

CMS requires that states, through their contracts with MCOs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory EQR activities that the Balanced Budget Act of 1997 (BBA) described in the Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2) requires state Medicaid agencies to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012, the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not an MCO, or an external quality review organization (EQRO).

The Commonwealth of Virginia refers to its Children's Health Insurance Program (CHIP) as Family Access to Medical Insurance Security (FAMIS). DMAS contracted with six privately owned MCOs to deliver services to members who were enrolled in the State's Medicaid and CHIP programs. HSAG, the EQRO for DMAS, conducted the PMV for each MCO.

HSAG validated a set of performance measures identified by DMAS that were reported by the MCOs for their Medicaid and FAMIS populations. HSAG conducted the validation in accordance with CMS' PMV protocol cited above. HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities, HSAG obtained a list of the performance measures that were selected by DMAS for validation.

HSAG then prepared a document request letter that was submitted to MCOs outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure; a completed HEDIS 2018 Record of Administration, Data Management, and Processes (Roadmap); a completed Information Systems Capabilities Assessment Tool (ISCAT); any additional supporting documentation necessary to complete the audit; a timetable for completion; and instructions for submission. HSAG also forwarded a letter that included requested documentation needed to complete the medical record review validation (MRRV) process. HSAG responded to any audit-related questions received directly from the MCOs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided the MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with the MCOs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from MCOs.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed this data:

- **NCQA's HEDIS 2018 Roadmap:** The MCOs completed and submitted the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** The MCOs completed and submitted an ISCAT for HSAG's review of the required DMAS-developed measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs completed the medical record review (MRR) section within the Roadmap. In addition, the MCOs submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG did not request a convenience sample, but conducted an over-read of approximately 30 records from the hybrid sample to ensure the accuracy of the hybrid data being abstracted by the MCOs. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and then used the MRRV results to determine if the findings impacted the audit results for each performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

HSAG conducted an on-site visit with the MCOs. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key MCO staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap documentation:** This session was designed to be interactive with key MCO staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, foster care risk assessment, and claims systems and processes:** The evaluation included a review of the information systems, focusing on the processing of claims, processing of enrollment and disenrollment data, and tracking of foster care . assessments. This review included confirming that systems and processes were in place to identify completed foster care assessments.

  HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the performance measure.
- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary Source Verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each MCO provided a listing of the data that it had reported to DMAS to HSAG from which HSAG selected a sample. These data included numerator positive records for HEDIS measures, completed health risk assessment data for the *Assessments of Foster Care Children* measure, and a subset of requested claims data for the claim processing timeliness measure.

  HSAG selected a random sample from the submitted data and requested that the MCO provide proof of service documents or system screenshots that allowed for validation against the source data in the system. These data were also reviewed live in the MCO's systems during the on-site review for verification, which provided the MCO an opportunity to explain its processes as needed for any

exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the MCO.

Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCOs have system documentation which supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and the on-site visit, and revisited the documentation requirements for any post-on-site activities.

Post-On-Site Activities

After the on-site visit, HSAG reviewed any final performance measure data submitted by the MCOs and follow-up with each MCO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issues identified from the rate review was communicated to the MCOs as a corrective action as soon as possible so that the data could be revised before the PMV report was issued. HSAG worked closely with DMAS and the MCOs if corrected measure data were required.

HSAG prepared a PMV report for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS PMV Protocol identifies possible validation results for performance measures, which are defined in the table below.

Table C-1—Validation Results and Definitions for Performance Measures

Report (R)	Measure data were compliant with DMAS specifications and the data, as reported, were valid.
Not Reported (NR)	Measure data were materially biased.

According to the CMS protocol, the validation result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Reported" (NR). It is possible for a single audit element to receive a validation result of NR when the impact of the error associated with that element biased the reported performance measure rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Report" (R).

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure as "NR."

Appendix D. Performance Improvement Project Methodology

HSAG's Rapid-Cycle PIP Approach

HSAG's PIP approach guides MCOs through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change should require fewer resources and allow more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, MCOs have an opportunity to determine the effectiveness of changes prior to expanding successful interventions. HSAG developed a series of five modules that MCOs complete as they progress through the PIP.

Module 1—PIP Initiation

The objective of this module is to ask and answer the first fundamental question of the Model for Improvement: "What are we trying to improve?" In Module 1, MCOs outline the project's framework. The framework includes the topic rationale, data supporting the need to improve the selected topic, members who make up the PIP team, and the key driver diagram that defines the aim, factors that influence achievement of the aim, and interventions that can lead to the desired improvement.

Module 2—SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim Data Collection

The objective for this module is to ask and answer the second fundamental question of the Model for Improvement: "How will we know that a change is an improvement?" In Module 2, MCOs define how and when it will be known that improvement is happening. MCOs define the SMART Aim measure, data collection methodology, data collection plan, and develop a SMART Aim measure run chart.

Module 3—Intervention Determination

The objective for this module is to ask and answer the third fundamental question of the Model for Improvement: "What changes can we make that will result in improvement?" In Module 3, MCOs identify potential interventions that can impact the SMART Aim using quality improvement activities. The MCO's PIP team employs a step-by-step process that uses process mapping and failure modes effect analysis (FMEA) to determine interventions that may be tested using Plan-Do-Study-Act (PDSA).

Module 4—PDSA

In Module 4, MCOs test interventions that have the potential to impact the SMART Aim using PDSA cycles. MCOs document details about the change and an evaluation plan. Based on testing, MCOs analyze the data and summarize results. MCOs subsequently determine what needs to be done with the intervention based on what was learned from the test (i.e., adopt, adapt, abandon, continue testing). MCOs complete a Module 4 submission form for each intervention that it tests for the PIP.

Module 5—PIP Conclusions

In Module 5, MCOs summarize key findings, comparison of successful and unsuccessful interventions, and outcomes. MCOs synthesize all data collected, information gathered, and lessons learned to document the impact of the PIP and to consider how any demonstrated improvement can be shared and used as a foundation for further improvement going forward. MCOs submit the PIP's final key driver diagram, SMART Aim run chart with mapped interventions, and FMEA. Additionally, the MCO will update Module 3's intervention determination table if it selected an intervention to test in Module 4 that was not identified in Module 3.

Validation Overview

HSAG's methodology for validating PIPs is a consistent, structured process that uses standardized scoring. HSAG validates PIPs annually to the point of progression using criteria that it developed to align with CMS PIP validation protocols and rapid-cycle improvement principles. The validation process determines if DMAS and other key stakeholders can have confidence in the MCOs' reported PIP results.

HSAG provides DMAS and the MCOs with a PIP Validation Tool for each submitted module that consists of validation criteria necessary for successful completion of a valid PIP. HSAG scores the criteria as *Achieved* or *Not Achieved* and provides detailed written feedback and recommendations. HSAG provides general comments for achieved criteria when enhanced documentation would demonstrate a stronger application of the PIP requirements. HSAG also provides annual MCO-specific PIP Validation Reports that include the validation findings and recommendations for improvement.

Upon completion of the PIP with the MCOs' submission and validation of Modules 4 and 5, HSAG reports the overall validity and reliability of the findings for each PIP as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- *Confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however,

there was not a clear link between all quality improvement processes and the demonstrated improvement.

- *Low confidence* = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- *Reported PIP results were not credible* = The PIP methodology was not executed as approved.

Technical Assistance

HSAG's rapid-cycle PIP validation process facilitates frequent communication with the MCOs. HSAG provides technical assistance throughout the process. At the onset, HSAG provides feedback to ensure that PIPs are well-designed. MCOs also have opportunities for mid-course corrections. In addition to the PIP module training webinars that HSAG provides, the MCOs may seek ongoing technical assistance.

Appendix E. Medallion 4.0 Readiness Review Methodology

Introduction

DMAS is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia. The Medallion 4.0 program, through the contracted MCOs, will ensure the delivery of acute and primary care services, prescription drug coverage, and behavioral health services for Virginia's Medicaid and FAMIS members. More specifically, the Medallion 4.0 population includes low income families with children, pregnant women, FAMIS (CHIP), and children with special health care needs.

Medallion 4.0 focuses on the following objectives[E-1]:

- Evolving from the Medallion 3.0 foundation
- Serving over 700,000 healthy, connected Medicaid and FAMIS members and their communities
- Engaging health systems & stakeholders
- Providing holistic and integrated care
- Adding new services and populations
- Flexible delivery systems and payment models
- Growing stronger through improved quality, data and reporting

On December 1, 2017, DMAS announced the intent to award contracts to six MCOs for the provision of Medicaid covered services statewide through six regions: Central Virginia, Charlottesville/Western, Northern and Winchester, Roanoke/Alleghany, Southwest, and Tidewater. The MCOs are:

- Aetna Better Health of Virginia (Aetna)
- Anthem HealthKeepers Plus (Anthem)
- Magellan Complete Care of Virginia, LLC (Magellan)
- Optima Health Plans (Optima)
- UnitedHealthcare of the Mid-Atlantic, Inc. (United)
- Virginia Premier Health Plan, Inc. (VA Premier)

42 CFR (Code of Federal Regulations §438.66) describes the state monitoring requirements, including MCO readiness reviews when states implement a managed care program. The regulation further states that the readiness review ***must be started*** at least three months prior to the contract effective date and that the results must be submitted to CMS for approval.

[E-1] Medallion 4.0 Medicaid Managed Care Program website available at: http://www.dmas.virginia.gov/#/med4. Accessed on Jan 30, 2019.

The readiness reviews included both a desk review and on-site reviews for each MCO entity. The readiness reviews assessed the ability and the capacity of the MCOs to perform satisfactorily in the following functional areas:

Operations/Administration

- Administrative staffing and resources
- Delegation and oversight of MCO responsibilities
- Enrollee and provider communications
- Grievances and appeals
- Member services and outreach
- Provider network management
- Program integrity/compliance

Service Delivery

- Case management/care coordination/service planning
- Quality improvement
- Utilization review

Financial Management

- Financial reporting and monitoring
- Financial solvency

Systems Management

- Claims management
- Encounter data and enrollment information management

Additionally, DMAS wanted to ensure that the MCOs would be able to comply with the requirements set forth in the Virginia Administrative Code (VAC) and the Medallion 4.0 contract requirements. DMAS contracted with HSAG as its EQRO to design and help implement the comprehensive readiness reviews for the six MCOs. DMAS implemented Medallion 4.0 over a five-month period beginning August 1, 2018. The readiness reviews were completed by April 30, 2018, and the reports were finalized in July 2018.

Objective and Scope of the Review

The primary objectives of the readiness reviews conducted by HSAG were to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions, service delivery, and systems management. DMAS is responsible for evaluating the MCOs' financial

management competencies and ability to comply with other administrative responsibilities. The MCOs were expected to remediate deficiencies that HSAG and DMAS deemed critical prior to contract implementation and the non-critical items in accordance with the MCO remediation plans reviewed by HSAG and approved by DMAS.

To accomplish these objectives, HSAG, in collaboration with DMAS, defined the scope of the review by conducting a comprehensive evaluation and prioritization of the following:

- The federal and State regulations, with an emphasis on the Medicaid and CHIP Managed Care Final Rule published on April 25, 2016.[E-2]
- Critical contractual elements related to the quality, timeliness, and access to care.
- The Medallion 3.0 MCOs' 2017 operational systems review findings and remediation activities, where applicable.
- Managed Medicaid benefits and services that are a new offering in the Medallion program.
- Future opportunities for Medicaid expansion in the Commonwealth of Virginia.

In summary, the Medallion 4.0 readiness reviews targeted the 2016 Final Rule regulations, the Medallion 4.0 contractual requirements, and the MCOs' ability to seamlessly accommodate Medicaid expansion through a legislative increase in beneficiaries and/or expansion of benefits.

Methodology for Conducting the Readiness Reviews

HSAG readiness review methodology aligns with the guidelines and processes set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[E-3] Utilizing the CMS EQR Protocol 1, HSAG assessed each MCO's ability to comply with the readiness review standards and report on the findings.

[E-2] CMS Medicaid and CHIP Managed Care Final Rule. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on Jan 22, 2019.

[E-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 22, 2019.

Planning Review Activities

This methodology document represents the initial planning activities for the readiness review. Upon DMAS' approval of the methodology and high-level timeline, HSAG proceeded with the design of the comprehensive review tools and finalization of the timeline. HSAG developed, in collaboration with DMAS, desk review tools and operational checklists for requirements that relate to tangible work products (e.g., member handbook, provider manual, subcontracts, and information systems standards).

In addition, HSAG developed preliminary and kick-off readiness review webinars and readiness review information packets for the MCOs. The webinars and information packets contained an overview of the readiness review processes, timeline, documentation submission requirements, and the readiness review tools. HSAG finalized the presentations and corresponding readiness review materials approximately one week prior to each scheduled webinar. At the preliminary webinar, HSAG provided a proposed readiness review site visit schedule and work with DMAS and the MCOs to finalize the on-site review dates.

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, Virginia rules, and contract requirements, HSAG and DMAS obtained information from a wide range of written documents produced by the MCOs, including, but not limited to, the following:

- Written policies and procedures
- Organizational staffing plans, job descriptions, and key personnel resumes
- The provider manual and other communication materials for providers
- MCO-maintained files for practitioner contracting and credentialing
- The member handbook and other written informational materials
- Subcontractor agreements
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the readiness review through interaction, discussions, and interviews with the MCOs' key staff members.

Communication With the MCOs

HSAG established early communication with the MCOs through written notice of the readiness reviews and dates for the preliminary and kick-off webinars. HSAG managed ongoing communications with the MCOs and provided technical assistance throughout the readiness review processes. DMAS was required to approve all the MCO-wide communications, as well as the readiness review findings and corrective action plans. Individual MCO communications were managed as the need arose, and DMAS prior-approval of communication occurred on an as-needed basis. HSAG coordinated with DMAS and the MCOs to finalize the site visit dates after the preliminary readiness review webinar. Brief pre-on-site review calls were offered to each MCO approximately two to three weeks prior to the on-site reviews to address MCO-specific questions.

Document Submission

HSAG required the MCOs to populate the readiness review tools with supporting documentation and upload the source documents to HSAG's secure portals on or before the desk review tool submission deadline identified in the Readiness Review Timeline. HSAG collaborated with DMAS to establish the most efficient and secure protocol for MCO document submission (e.g., DMAS SharePoint versus HSAG secure file transfer protocol [FTP] site). Upon conclusion of the on-site reviews, the MCOs were required to submit additional documentation. Finally, MCOs were required to submit corrective action plans for any deficiencies identified during the readiness reviews.

Evaluation Phase

The evaluation phase consisted of a desk review of documentation submitted by the MCOs, an on-site review of additional documentation, staff interviews, and the assignment of element scores.

Desk Review Process

Upon receipt of the desk review tools, the MCOs had three weeks to submit the completed desk review tool and supporting documentation. Upon receipt of the desk review materials, the HSAG review teams conducted the desk review for the assigned MCOs. A more detailed description of HSAG's review processes follows:

Approximately five weeks prior to the on-site reviews, the HSAG project leader conducted training of the readiness review teams. The training for the six reviewers was intended to ensure quality and consistency with the ratings, maintain review process efficiencies, and provide DMAS and the MCOs with actionable feedback. Then, approximately one month prior to the on-site reviews, the HSAG review teams conducted the in-depth desk reviews. The reviewers were required to have the preliminary

desk review findings and lists of follow-up items and interview questions prepared in advance of the on-site visits. DMAS had the opportunity to review these site visit materials in advance of the on-site visits.

On-Site Review Organization

The on-site review occurred over a period of two consecutive days. On the first day of the review, the HSAG review team conducted an opening conference, with introductions and a review of the agenda and logistics. The team of reviewers confirmed that documents requested by HSAG were available. The team used separate rooms to begin case or document reviews and/or key staff member interviews for each of the standards.

Day two of the on-site review allowed for discussion and follow-up on any outstanding issues. The team of reviewers continued their reviews and interviews of key staff members for completion of each standard. At the conclusion of the second day, HSAG developed a high-level summary of the team's preliminary findings and information concerning the next steps of the process. This information was shared with the MCOs and DMAS during the exit conference conducted at the end of the on-site review.

Scoring Methodology

From a review of documents, observations, and interviews with key staff members during the on-site readiness review, the HSAG reviewers assigned a score for each element and an aggregate score for each standard in the Readiness Review Evaluation tool. In collaboration with DMAS, HSAG identified certain elements that were considered more critical to the successful launch of a managed care program. Each element was given a score of *Complete*, *Progress Sufficient to Meet Operations*, *Incomplete*, or *Incomplete—Critical*.

HSAG's scoring is based upon the following:

- ***Complete*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the policies and/or processes described in documentation.
- ***Progress Sufficient to Meet Operations*** indicates substantive compliance defined as most of the following:
  - A substantive portion of the documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were frequently able to provide responses to reviewers that were consistent with each other and with the policies and/or processes described in documentation.
- ***Incomplete*** indicates noncompliance defined as *either* of the following:

  - A portion of the documentation was unclear or contained conflicting information that did not address the regulatory requirement.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified, and any findings of *Incomplete* would result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.
- ***Incomplete—Critical*** indicates noncompliance (defined above) and requires that the MCO correct a deficiency prior to commencing services.

From the scores HSAG reviewers assigned for each of the requirements, HSAG calculated a total percentage-of-complete score for each of the standards and an overall percentage-of-complete score across the standards. HSAG also calculated scores for each of the checklists reviewed, along with any of the optional activities, for example provider network adequacy and systems testing.

Deliverables

Based on the results of data aggregation and analysis, HSAG produced draft MCO-specific reports and forwarded them to DMAS for initial review. After a two-week review period, HSAG finalized the reports and distributed them to the MCOs along with corrective action plan (CAP) templates for the MCOs to complete and submit back to HSAG for review. HSAG evaluated the MCOs' CAPs and shared the findings and recommendations with DMAS. DMAS reviewed and approved the CAPs to ensure they sufficiently addressed the interventions needed to ensure the MCOs perform satisfactorily with the regulatory and contractual requirements. Follow-up monitoring by DMAS occurred to ensure that all planned activities and interventions were completed.

Appendix F. Consumer Decision Support Tool

VIRGINIA MEDICAID MANAGED CARE QUALITY

CONSUMER DECISION SUPPORT TOOL 2018–2019

Comparing Virginia Medicaid Managed Care Organizations

Choosing a managed care organization (MCO) that works best for you and your family is important. This tool is designed to help eligible members choose a Medicaid MCO. This tool shows how well the different MCOs provide care and services in various performance areas. The ratings for each area summarize how the MCO performs on a number of related standards.

Key

Highest Performance	★★★★★
High Performance	★★★★
Average Performance	★★★
Low Performance	★★
Lowest Performance	★

MCO	Accreditation Level	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	Accredited	★★★	★★★	★★★	★★	★★★
Anthem	Accredited	★★★★	★★★	★★★★	★★★	★★★★★
Optima	Accredited	★★★	★★★	★★	★★	★★★★★
UnitedHealthcare*	Accredited	★	★★	★★★	★	★
VA Premier	Commendable	★★★	★★★	★★★	★★★★★	★★★
Magellan	**New	**New	**New	**New	**New	**New

*Formerly INTotal.
**Due to Magellan being a new plan in 2018, data does not allow for comparisons to other plans. Magellan will be included in future tools.

What is Measured in Each Performance Area?

Doctors' Communication
- Doctors explain things well to members

Getting Care
- Members get the care they need, when they need it

Keeping Kids Healthy
- Children get regular checkups and important shots that help protect them against serious illness

Living With Illness
- Members with asthma, diabetes, high blood pressure, and depression get the care they need by getting tests, checkups, and the right medicine

Taking Care of Women
- Women get tests for breast and cervical cancer to help find these diseases early
- Moms get care before and after their baby is born to help keep mom and baby healthy

Page 1 of 2, Published 11/2018

Choosing a Medicaid Managed Care Organization

Your health care is important, and choosing the MCO that best meets your needs is also important. Here are some questions to ask yourself before you pick an MCO:

- How well did each MCO perform in each performance area in this tool?
- Which MCO has all or most of the doctors, providers, and hospitals that my family and I visit?
- Which MCO has doctors with office hours and locations that are convenient for my family and me?
- Which MCO offers extra services that I want to use?

You may have other questions or concerns that are important to you. You can contact the MCOs using the information below. They can tell you which doctors are available to you and what extra services they offer. You can also call the **Medicaid Managed Care HelpLine** at 1-800-643-2273. HelpLine staff can answer your questions and help you decide which MCO is best for you and your family.

MCO	Contact Information
Aetna Better Health of Virginia (Aetna)	1-800-279-1878 www.aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus (Anthem)	1-800-901-0020 www.anthem.com/vamedicaid
Magellan Complete Care of Virginia (Magellan)	1-800-424-4518 www.mccofva.com
Optima Family Care (Optima)	1-800-881-2166 www.optimahealth.com/plans/family-care
UnitedHealthcare Community Plan of Virginia (UnitedHealthcare)*	1-844-752-9434 www.uhccommunityplan.com/va
Virginia Premier Health Plan (VA Premier)	1-800-727-7536 www.virginiapremier.com

*Formerly INTotal

Information as of November 2018

For More Information:

Visit the Virginia Department of Medical Assistance Services online at: www.dmas.virginia.gov and Virginia's Medicaid Managed Care online at: www.virginiamanagedcare.com.

About This Tool

The 2018 Virginia MCO Consumer Decision Support Tool utilizes results from HEDIS and CAHPS. Calendar year 2017 data were used to derive 2018 reporting year rates. This report was compiled by Health Services Advisory Group, Inc. (HSAG) in collaboration with the Department of Medical Assistance Services (DMAS).

About the Accreditation Levels

Accreditation levels as of November 2018 are based on compliance with the National Committee for Quality Assurance's (NCQA's) rigorous requirements and the MCOs performance on Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures. The highest level of accreditation an MCO can receive is Excellent, followed by Commendable, Accredited, Interim, and then Provisional. For more information regarding accreditation levels as of November 2018, visit: http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels.

Appendix G. Medicaid Expansion Readiness Review Methodology

Introduction

DMAS is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia. On June 7, 2018, Governor Northam signed the new state budget that will expand eligibility under Medicaid for approximately 400,000 Virginia adults. Medicaid expansion coverage began on January 1, 2019, and will be administered through a comprehensive system of care.

The Medicaid program includes the Medallion 4.0 and the Commonwealth Coordinated Care Plus (CCC Plus) programs. The Medallion 4.0 population includes low income families with children, pregnant women, FAMIS (CHIP), and children with special health care needs. Medallion 4.0 contracted MCOs deliver acute and primary care services, prescription drug coverage, and behavioral health services for Virginia's Medicaid and FAMIS members. The CCC Plus program is a Medicaid managed long-term services and supports (MLTSS) program that serves individuals with complex needs who are 65+ years of age, adults and children with disabilities, dual and non-dual individuals receiving LTSS (facility and community based), and Developmentally Disabled Waiver participants for non-waiver services. The CCC Plus program contracted MCOs coordinate care through a patient-centered program design using an integrated delivery model that includes medical and behavioral health services and long-term services and supports. The Medicaid expansion benefit plan will include all services currently covered by Medicaid for the existing populations as well as additional federally-required adult preventive care and disease management programs.

Medicaid expansion will provide coverage for eligible individuals, including adults ages 19–64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the Federal Poverty Level, and who are not already eligible for a mandatory coverage group (e.g., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

Coverage for Medicaid expansion individuals will be provided through the DMAS managed care and fee-for-service delivery systems. The majority of individuals will be enrolled in one of the DMAS managed care programs, Medallion 4.0 and CCC Plus. The Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs) (see Table G-1), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. CCC Plus provides care coordination services for individuals with a higher level of acuity and will serve as the delivery system that provides coverage for individuals who are deemed to be "medically complex." Medallion 4.0 will serve as the delivery system for individuals who are determined not to be medically complex. Medically complex individuals include persons with serious and complex medical and behavioral health conditions that impair their ability to perform activities of daily living. The Medically Complex category also includes individuals who require long-term services and supports.

Table G-1—Medallion 4.0 Managed Care Organizations

MCOs
Aetna Better Health of Virginia (Aetna)
Anthem HealthKeepers Plus (Anthem)
Magellan Complete Care of Virginia, LLC (Magellan)
Optima Health Plans (Optima)
UnitedHealthcare of the Mid-Atlantic, Inc. (United)
Virginia Premier Health Plan, Inc. (VA Premier)

42 CFR §438.66 (Code of Federal Regulations) describes the state monitoring requirements, including MCO readiness reviews when states implement or expand a managed care program. The regulation further states that the readiness review ***must be started*** at least three months prior to the contract effective date and that the results must be submitted to CMS for approval.

HSAG conducted readiness reviews for each of the MCOs to evaluate the MCOs' ability and capacity to comply with the federal and State Medicaid expansion requirements. The primary objective of the readiness reviews conducted by HSAG was to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the CMS Medicaid Expansion Gateway tool.

HSAG's methodology for the Medicaid expansion readiness reviews included desk reviews that incorporated documents, results and the follow-up on corrective action plans of the six MCOs' Medallion 4.0 readiness reviews, and when possible, the readiness review results of the same MCOs' CCC Plus readiness reviews. The readiness review standards that HSAG completed are based on the CMS Medicaid Expansion Gateway tool. HSAG's readiness review focused on the following MCO standards specific to Medicaid expansion:

- Networks and network adequacy
- MCO 834 process
- New benefits
- Enhanced services verification
- Member identification cards
- Member materials
- Call center capacity
- Claims processing capacity
- Staffing
- Website
- Staff training and coordination

Objective and Scope of the Review

The primary objective of the Medicaid expansion readiness reviews conducted by HSAG was to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions, service delivery, and systems management. The MCOs were expected to remediate deficiencies that HSAG and DMAS deemed critical prior to contract implementation and the non-critical deficiencies prior to contract implementation. Readiness review elements scored as *Incomplete* (see scoring methodology below) indicate noncompliance and required that the MCO correct a deficiency with the submission of a corrective action plan reviewed by HSAG and approved by DMAS prior to implementation of Medicaid expansion.

To accomplish these objectives, HSAG, in collaboration with DMAS, defined the scope of the review by conducting a comprehensive evaluation and prioritization of the following:

- The CMS Medicaid expansion requirements as outlined in federal rule and in the Gateway tool
- Commonwealth of Virginia Medicaid expansion requirements
- DMAS MCO contractual requirements related to Medicaid expansion
- 2016 Federal Managed Care Final Rule

HSAG used, whenever possible, the documentation, results, findings, and corrective action activities of the Medallion 4.0 MCOs' 2018 and CCC Plus 2017 readiness reviews. In summary, the Medicaid expansion readiness reviews targeted the CMS requirements, Commonwealth of Virginia requirements, 2016 Final Managed Care Rule regulations, and DMAS MCO contractual requirements focused on Medicaid expansion and the MCOs' ability to seamlessly accommodate Medicaid expansion through a legislative increase in beneficiaries and/or expansion of benefits.

Methodology for Conducting the Readiness Reviews

HSAG readiness review methodology aligns with the guidelines and processes set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[G-1] Utilizing the CMS EQR Protocol 1, HSAG assessed each MCO's ability to comply with the readiness review standards and report on the findings.

[G-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 22, 2019.

Planning Review Activities

This methodology document represents the initial planning activities for the readiness review. Upon DMAS' approval of the methodology and high-level timeline, HSAG proceeded with updating the approved readiness review tools with Medicaid expansion requirements using, as much as possible, the Medallion 4.0 and CCC Plus readiness review tool, and finalization of the timeline. HSAG collaborated with DMAS regarding the standards and elements included in the desk review tools for Medicaid expansion. As noted above, the readiness review activities included evaluations of provider network adequacy and information systems capabilities for care and service delivery and claims payment focused on Medicaid expansion requirements. HSAG developed kick-off readiness review webinars and readiness review information packets for the MCOs. The webinars and information packets contained an overview of the HSAG readiness review processes; timeline; documentation submission requirements; and the readiness review tools.

Description of Data Obtained

To assess the MCOs' compliance with Medicaid expansion federal regulations, Virginia rules, and contract requirements, HSAG and DMAS obtained information from a wide range of written documents including, but not limited to, the following:

- Results of the CCC Plus readiness reviews
- Results of the Medallion 4.0 readiness reviews
- MCO corrective action plans and follow-up activities
- Updated policies, procedures and processes specific to Medicaid expansion
- Review of 834 transaction's accommodation of Medicaid expansion data elements
- Review of system configuration documentation for new Medicaid expansion benefits
- Organizational staffing and hiring plans
- Call Center and claims processing staffing plans relative to anticipated volumes
- Training and coordination schedule and curriculum
- Enhanced services verification
- Member information updated with Medicaid expansion benefits and requirements
- Provider information updated with Medicaid expansion benefits and requirements
- Provider, subcontractor and vendor contracts as applicable to Medicaid expansion requirements
- MCO websites
- Network data and information
- Narrative and/or data reports across a broad range of performance and content areas related to Medicaid expansion

HSAG obtained additional information for the readiness review through discussions and interviews with the MCOs' key staff members, as necessary.

Communication With the MCOs

HSAG established early communication with the MCOs through written notice of the readiness reviews and dates for the kick-off webinars. HSAG managed ongoing communications with the MCOs and provided technical assistance throughout the readiness review process. DMAS was required to approve all the MCO-wide communications, as well as the readiness review findings and corrective action plans. Individual MCO communications were managed as the need arose, and DMAS prior-approval of communication occurred on an as-needed basis.

Document Submission

HSAG required the MCOs to populate the readiness review tools with supporting documentation and upload the source documents to the DMAS secure SharePoint site on or before the desk review tool submission deadline identified in the Readiness Review Timeline. MCOs were required to highlight compliant information within submissions for review purposes. MCOs were required to submit corrective action plans for any deficiencies identified during the readiness reviews.

Evaluation Phase

The evaluation phase consisted of a desk review of documentation submitted by the MCO, staff interviews (as necessary), and the assignment of element scores.

Desk Review Process

Upon receipt of the desk review tools, the MCOs had three weeks to submit the completed desk review tool and supporting documentation. Upon receipt of the desk review materials, the HSAG review team conducted the desk review for the MCOs. A more detailed description of HSAG's review processes follows:

The HSAG project leader conducted training of the readiness review team. The training for the reviewers was intended to ensure quality and consistency with the ratings, maintain review process efficiencies, and provide DMAS and the MCOs with actionable feedback. The HSAG review team conducted in-depth desk reviews that included MCO-submitted documentation and results of the previous Medallion 4.0 and CCC Plus readiness reviews. The reviewers were required to have the preliminary desk review findings and lists of follow-up items and interview questions prepared for any follow-up conference calls or WebEx reviews that were needed.

Scoring Methodology

From a review of documents, observations, and interviews with key staff members during the readiness review, the HSAG reviewers assigned a score for each element and an aggregate score for each standard in the Readiness Review Evaluation tool. Each element was given a score of *Complete*, *Progress Sufficient to Meet Operations*, *Incomplete*, or *Incomplete—Critical*.

HSAG's scoring is based upon the following:

- ***Complete*** indicates full compliance defined as ***all of*** the following:
  - All documentation was present.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the MCO met this requirement.
  - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members provided responses consistent with the policies and/or processes described in documentation.
- ***Progress Sufficient to Meet Operations*** indicates substantive compliance defined as ***most of*** the following:
  - A substantive portion of the documentation listed was present.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) may have contained some but not all information needed to ascertain how the MCO met this requirement.
  - Staff members frequently provided responses consistent with the policies and/or processes described in documentation.
  - The documentation may not have included the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
- ***Incomplete*** indicates noncompliance defined as ***any of*** the following:
  - A substantive portion of the documentation was unclear or contained conflicting information that did not address the regulatory and/or contractual requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the MCO met this requirement.
  - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.

- For those elements with multiple components, key components of the element could be identified; and, if the reviewer was unable to assess the MCO's ability and capacity to meet the requirement based upon the information submitted, any deficiencies identified could result in an overall finding of *Incomplete* regardless of the findings noted for the remaining components.

If an MCO was noncompliant with an element and was required to submit a corrective action plan prior to Medicaid expansion, HSAG's criteria for evaluating the sufficiency of the correction action plans was:

- The completeness of the corrective action plan in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Corrective action plans that did not meet the above criteria required resubmission to DMAS by the MCO until they were approved by DMAS. Implementation of the corrective action plan could begin once approval was received.

From the scores HSAG reviewers assign for each of the requirements, HSAG calculated a total percentage-of-complete score for each of the standards and an overall percentage-of-complete score across the standards.

Deliverables

Based on the results of data aggregation and analysis, HSAG produced draft MCO-specific reports and forwarded them to DMAS for initial review. After a two-week review period, HSAG finalized the reports and distributed them to the MCOs along with corrective action plan (CAP) templates for the MCOs to complete and submit back to HSAG for review. HSAG evaluated the MCOs' CAPs and shared the findings and recommendations with DMAS. DMAS reviewed and approved the CAPs to ensure they sufficiently addressed the interventions needed to ensure the MCOs perform satisfactorily with the regulatory and contractual requirements. Follow-up monitoring by DMAS occurred to ensure that all planned activities and interventions were completed.