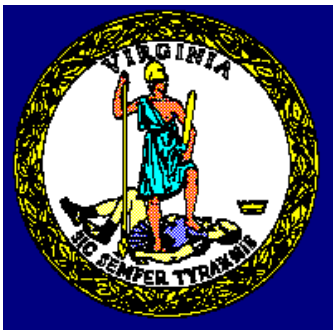


Commonwealth of Virginia
Department of Medical Assistance Services

2016 External Quality Review Technical Report

March 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary 1-1
Introduction 1-1
Purpose of the Report 1-1
Overview of External Quality Review 1-2
2. Commonwealth of Virginia Medicaid Managed Care Overview 2-1
Overview 2-1
Managed Care Organization Profiles 2-1
Planned Initiatives 2-3
3. Commonwealth of Virginia Quality Strategy 3-1
Quality Strategy 3-1
Quality Initiatives 3-2
Maternal and Infant Improvement Project 3-2
Managed Care Quality Collaborative 3-5
Performance Incentive Awards Program 3-6
Consumer Decision Support Tool 3-7
Focused Studies 3-9
4. Compliance Review and Accreditation 4-1
Compliance Review 4-1
Accreditation 4-2
5. Performance Measures 5-1
Introduction 5-1
NCQA HEDIS Compliance Audit Findings 5-1
Performance Measure Validation Findings 5-30
Pediatric Quality Measure Results 5-31
Conclusions 5-32
Recommendations 5-33
6. Performance Improvement Projects 6-1
Introduction 6-1
Rapid-Cycle Approach 6-2
Performance Improvement Project (PIP) Topics and Training 6-3
Conclusions 6-10
Recommendations 6-11
7. Focused Studies 7-1
Improving Birth Outcomes Through Adequate Prenatal Care 7-1
Improving the Health of Children in Foster Care 7-6
Health and Acute Care Program 7-11
8. Encounter Data Validation 8-1
Objectives of EDV Study 8-1
Methods of Data Collection and Analysis 8-1
Summary of Findings 8-1
Conclusions and Recommendations 8-5

9. Consumer Survey of Quality of Care 9-1
Introduction 9-1
FAMIS CAHPS 9-1
Medallion 3.0 CAHPS 9-5
Conclusions and Recommendations 9-11
10. Best and Emerging Practices for Improving Quality of Care and Service 10-1
Anthem 10-1
Aetna Better Health of Virginia 10-3
INTotal 10-4
Kaiser Permanente 10-7
Optima 10-10
VA Premier 10-11
11. Assessment of MCO Follow-Up on Prior Year Recommendations 11-1
Introduction 11-1
NCQA HEDIS Compliance Audit, Performance Measure Validation, and Rate Review EQR 2015 Recommendations 11-1
Performance Improvement Projects EQR 2015 Recommendations 11-4
Consumer Survey of Quality of Care EQR 2015 Recommendations 11-6
Appendix A. Performance Measure Validation Methodology A-1
Appendix B. NCQA Quality Compass 50th Percentile Values B-1
Appendix C. Performance Improvement Projects—Rapid-Cycle Approach C-1
Appendix D. Prenatal Care and Birth Outcomes Focused Study Methodology D-1
Appendix E. Foster Care Focused Study Methodology E-1
Appendix F. Health and Acute Care Program Methodology F-1
Appendix G. Encounter Data Validation Methodology/Scope of Work G-1
Appendix H. Methodology for CAHPS Survey Validation H-1

Acknowledgments and Copyrights

CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

1. Executive Summary

Introduction

The Virginia Department of Medical Assistance Services (DMAS) is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia (Virginia). As of December 2016, DMAS contracted with six managed care organizations (MCOs) to deliver services to over 766,000 children in low income families; aged, blind, or disabled individuals; pregnant women; and certain caretaker parents in Virginia, as well as acute care for waiver recipients. Contracted MCOs included Aetna Better Health of Virginia (Aetna), formerly CoventryCares of Virginia, Anthem HealthKeepers Plus (Anthem), INTotal Health (INTotal), Kaiser Permanente, Optima Family Care (Optima), and Virginia Premier Health Plan, Inc. (VA Premier).

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

DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct EQR activities and to produce this technical report covering review activities completed during the period of January 1, 2016, through December 31, 2016.

Purpose of the Report

The 2016 EQR Technical Report was developed to meet the review and reporting requirements mandated by the SSA, codified in the CFR, and further defined by the Centers for Medicare & Medicaid Services (CMS). This 2016 EQR Technical Report includes a review of the quality outcomes and access to and timeliness of care and services provided to Medicaid managed care members in Virginia.

The EQR of the MCOs included the two federally mandated activities as set forth in 42 CFR §438.358, annual validation of performance measures, and annual validation of performance improvement projects (PIPs). The third federally mandated review activity, review and evaluation of compliance with federal managed care standards and associated State contract requirements, is required to be conducted every three years. This was last conducted in 2014 and addressed in the 2014 EQR report, and corrective actions taken by the MCOs as a result of the 2014 review were included in the 2015 report. Activities for preparation of the 2017 compliance reviews for the MCOs began in 2016 and are included in this report.

In addition, a number of other activities and results are addressed in this report:

- Results of select Healthcare Effectiveness Data and Information Set (HEDIS) measures and review of NCQA HEDIS Compliance Audits.
- Results of NQF #2800: *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)* aggregate measure.
- Results of the three clinical focused studies: Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Health and Acute Care Program.
- Activities related to encounter data validation (EDV).
- Results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for both the Medallion 3.0 and Family Access to Medical Insurance Security (FAMIS) plan populations, including General Child and Children with Chronic Conditions.
- Technical assistance activities related to the Consumer Decision Support Tool.
- Description of best and emerging practices implemented by the MCOs for improving quality of care and service.
- MCOs' follow-up to recommendations made in the 2015 EQR Technical Report.

Overview of External Quality Review

The 2016 EQR Technical Report focuses on a number of distinct EQR and DMAS review and monitoring activities conducted from January 1 through December 31, 2016. As shown in Table 1-1, the activities were conducted to assess the domains of quality of, access to, and/or timeliness of care and services.

Table 1-1—EQR and DMAS Activities and Domains

Activity	Quality	Access	Timeliness
NCQA HEDIS Compliance Audit and Rate Review	✓	✓	–
Performance Measure Validation (PMV)	✓	✓	✓
PIP Validation	✓	✓	✓
Clinical Focused Study Results	✓	✓	✓
Encounter Data Validation Activity	✓	✓	–
Compliance Review	✓	✓	✓
Consumer Satisfaction (CAHPS) Review	✓	✓	✓

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

HSAG reviewed six MCOs' HEDIS final audit reports (FARs), Information Systems (IS) compliance tools, and interactive data submission system (IDSS) files to assess adherence to seven IS standards. In general, the MCOs' information systems and processes were compliant with the applicable NCQA IS standards and the HEDIS reporting requirements related to key quality measures.

In addition, DMAS contracted with HSAG to validate performance measures to assess the accuracy of measure rates reported by the MCOs and to determine the extent to which performance measure calculation followed state specifications and reporting requirements. Two HEDIS measure rates were validated for the six MCOs: *Controlling High Blood Pressure* and *Adults' Access to Preventive/Ambulatory Health Services*, to evaluate further the accuracy of reported performance measure rates. HSAG also conducted PMV on two state measures, *Assessment of Foster Care Children* (Performance Incentive Awards [PIA] measure) and *Timeliness of Claims Payment* (PIA measure).

Table 1-2 displays the HEDIS 2016 Virginia aggregate rates (i.e., calendar year [CY] 2015), which represent the average of all six MCOs' rates weighted by the eligible population, compared to the national Medicaid 50th percentiles for HEDIS 2015.[1-1,1-2]

Table 1-2—Virginia Aggregate HEDIS 2016 Measure Results

Performance Measures	Virginia Aggregate
Children's Preventive Care	
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	50.67%
Childhood Immunization Status	
Combination 3	78.13%
Well-Child Visits in the First 15 Months of Life	
No Well-Child Visits[1]	0.82%
Six or More Well-Child Visits	68.18%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%
Women's Health	
Breast Cancer Screening	
Breast Cancer Screening	52.50%
Cervical Cancer Screening	

[1-1] For the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, the Virginia aggregate rates were not weighted because the MCOs' eligible population sizes were not available.

[1-2] The reference to "national Medicaid 50th percentile" is a general term used in this report to reference the benchmarking comparison made.

Performance Measures	Virginia Aggregate
Cervical Cancer Screening	63.79%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	83.56%
Postpartum Care	62.04%
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	84.21%
45–64 Years	92.30%
65+ Years	91.24%
Total	87.21%
Care for Chronic Conditions	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing[*]	84.85%
HbA1c Control (<8.0%)[*]	47.85%
Eye Exam (Retinal) Performed[*]	48.75%
Medical Attention for Nephropathy[*]	90.26%
Blood Pressure Control (<140/90 mm Hg)[*]	56.04%
Controlling High Blood Pressure	
Controlling High Blood Pressure	54.01%
Medication Management for People With Asthma	
Medication Compliance 50%—Total[2]	54.56%
Medication Compliance 75%—Total	29.65%
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	79.69%
Discussing Cessation Medications	48.81%
Discussing Cessation Strategies	40.74%
Behavioral Health	
Antidepressant Medication Management	
Effective Acute Phase Treatment	54.94%
Effective Continuation Phase Treatment	40.81%
Follow-up Care for Children Prescribed ADHD Medication	
Initiation Phase	44.11%
Continuation and Maintenance Phase	56.36%
Follow-Up After Hospitalization for Mental Illness	
30-Day Follow-Up	60.22%

Performance Measures	Virginia Aggregate
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]	
1–5 Years	54.22%
6–11 Years	50.46%
12–17 Years	51.33%
Total	51.10%

[1] *A lower rate indicates better performance for this measure.*

[2] *This rate was compared to NCQA's Audit Means and Percentiles national Medicaid 50th percentile since this measure was not included in Quality Compass.*

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

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

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 §438.240(b)(1) and 42 CFR §438.240(d)(1–4).

DMAS engaged in the review of a more proactive and outcome-oriented approach for having its MCOs conduct PIPs in early 2015. This led to DMAS discussions with CMS and HSAG regarding implementing a rapid-cycle PIP framework, which HSAG developed, that is a modified version of the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement.[1-3] This approach places greater emphasis on improving outcomes using rapid-cycle improvement methods to pilot small changes. Working with CMS and the respective states that have adopted the framework for the rapid-cycle approach, HSAG has aligned the rapid-cycle PIP process to fit into the current CMS protocols for conducting and validating PIPs. DMAS elected to move forward with adopting the rapid-cycle approach for its redesigned PIP methodology in 2016 and implemented the process with the MCO contract effective July 1, 2016.

DMAS required that each MCO conduct, during 2016, one PIP related to a priority HEDIS measure for comprehensive diabetes care. This measure was identified by the MCOs and DMAS, as part of the MCO Quality Collaborative meeting, as one of the HEDIS measures in the most need of improvement. In the rapid-cycle PIPs, MCOs provide data to justify the topic selection and narrow the focus of the PIP to target a subgroup of the overall HEDIS measure population.

[1-3] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Wednesday, Jan 26, 2017.

HSAG's rapid-cycle PIP process incorporates small-scale intervention testing, using Plan-Do-Study-Act (PDSA) cycles, to improve outcomes. For the rapid-cycle PIP framework, HSAG developed five modules with an accompanying companion guide:

- **Module 1—PIP Initiation**: Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART [specific, measureable, attainable, relevant, and time-bound]), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is outlined and the data collection methodology is described. The data for the SMART Aim will be displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, the quality improvement activities that can impact the SMART Aim are identified. Through the use of process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a series of PDSA cycles.
- **Module 5—PIP Conclusions:** Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

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

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

HSAG provided training to the MCOs on the rapid-cycle approach at the MCO Quality Collaborative meetings, beginning with a high-level overview training in April 2016, followed by trainings on the requirements for Module 1 and Module 2, through December 2016. HSAG also provided one-to-one technical assistance to the MCOs throughout the process, at the MCOs' requests, at the various intervals of submissions and HSAG feedback.

For the 2016 annual validation, HSAG evaluated each MCO's PIP to the point of progression on Module 1 and Module 2 of the rapid-cycle process. The MCOs make corrections to the modules for any deficiencies identified and must pass Module 1 and Module 2 before progressing to Module 3. At the time of the 2016 annual PIP validation reports, all MCOs except one were still in process of making revisions to successfully achieve all review criteria and pass Module 1 and Module 2.

Focused Studies

DMAS contracted with HSAG to conduct three focused studies during the 2015–2016 contract year on clinical topics selected by DMAS: improving birth outcomes through adequate prenatal care (Birth Outcomes Focused Study), improving the health of children in foster care (Foster Care Focused Study), and an assessment of the health and acute care program (HAP Focused Study).

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?*

Five study indicators were calculated to address the study questions; and results were stratified by study and comparison groups, Medicaid program, Medicaid delivery system, and demographic categories.

In addition to this focused study, DMAS contracted HSAG to provide a supplemental data brief on dental utilization among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015.[1-4]

Improving the Health of Children in Foster Care

Conducted during two contract years, the Foster Care Focused Study was designed to answer the question: *To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery?* DMAS approved the study methodology and medical record procurement materials during the 2014–2015 contract year, and HSAG conducted the remaining study tasks (i.e., medical record procurement and abstraction, data analysis, and reporting) during the 2015–2016 contract year.

[1-4] The VA Smiles For Children program covers most dental services for pregnant women ages 21 years and older through their pregnancy and postpartum period. While VA Smiles For Children program coverage terminates at the end of the month following the 60th day after delivery, this assessment focuses on dental services used during the prenatal period. Further information about the program and a list of covered services are available at http://www.dentaquestgov.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-All-groups-522_September-29,-2015.pdf/.

Administrative and medical record data were used to calculate 15 study indicators across three domains (i.e., characteristics of Medicaid members in foster care, preventive care, and behavioral health).

Health and Acute Care Program (HAP)

With analyses conducted in two phases during the 2015–2016 contract year, the HAP focused study used administrative data among a cohort of Medicaid members enrolled in one of five waiver programs[1-5] unified under the Health and Acute Care Program as of December 1, 2014, to address the following question: *To what extent did the managed care members with home- and community-based waivers enrolled in Medallion 3.0 use medical and pharmacy services during the first year of managed care coverage?*

HSAG assembled a member-level analytic dataset examining clinical services received by HAP members during a pre-HAP period (analysis Phase I), evaluating services from December 1, 2013, though November 30, 2014, and a post-HAP period (analysis Phase II) evaluating services from December 1, 2014, through November 30, 2015. Results for each of 20 study indicators were calculated for each member in the study population for each measurement period. Study indicators assessed HAP members' clinical profile across three domains: demographic, clinical, and utilization.

These three focused studies are also published on the DMAS website, and the studies and results were presented to the MCOs at the Medicaid Managed Care Quarterly Quality Collaborative meetings in 2016. DMAS has contracted HSAG to conduct the Birth Outcomes Focused Study and the Foster Care Focused Study during the 2016–2017 contract year using the contract year 2015–2016 focused study results as a baseline for trend analyses.

Encounter Data Validation

For the 2015–2016 contract year, DMAS contracted with HSAG to conduct an Encounter Data Validation (EDV) study to assist DMAS in developing an encounter data program that effectively monitors the accuracy and completeness of encounter data submitted by the MCOs. HSAG submitted the aggregate report to DMAS on January 29, 2016; below are the key findings and recommendations for the three selected activities. In addition, based on the responses received from DMAS on November 18, 2016, DMAS has taken action or plans to take action to address HSAG's recommendations in order to improve its encounter data quality (EDQ) and enhance its encounter monitoring program.

Protocol Review

Through monthly conference calls with key stakeholders from DMAS, HSAG reviewed and discussed existing protocols and procedures for the encounter data processing on the electronic data interchange (EDI) server and the Medicaid Management Information System (MMIS), encounter data testing, and the

[1-5] Waiver programs included: Elderly or Disabled with Consumer Direction (EDCD), Day Support (DS), Intellectual Disability (ID), Individual and Family Developmental Disabilities Support(IFDDS), and Alzheimer's Assisted Living (AAL).

integration between encounter data and member/provider data. Overall, DMAS demonstrates strengths in processing the encounter data from the MCOs and is in the process of improving its encounter monitoring program. Some strengths include documents such as the *Managed Care Technical Manual (MCTM)* and Encounters Test Plan; ability to identify original, void, adjustment, and denied encounters and subsequently determine the final adjudicated records when corrections are made by providers or MCOs; and both DMAS' staff members' thorough understanding of the encounter data processes and their continuous efforts to recognize and resolve issues and improve current processes. Areas for improvement include, but are not limited to, a more transparent and customizable EDI translation process, collaborative and educational seminars or brown bag discussions with appropriate MCO staff, more data sharing with the MCOs, and a more automated MCO provider data update process.

Administrative Analysis

HSAG performed an assessment of encounter data accuracy, completeness, and timeliness using encounter data with dates of service between July 1, 2013, and December 31, 2014, and extracted from the MMIS in or before June 2015. The findings are listed below:

- **Encounter Volume**: The visit/service counts by service month or the monthly visit/service counts per 1,000 member months for inpatient, outpatient facility, practitioner, and pharmacy data were relatively stable over time. This observation indicates that these encounter data are relatively complete, although the submission pattern for the MCOs was not consistent over time. Personal care, laboratory, and transportation encounter types demonstrated less steady monthly visit/service volume over time, which should be investigated further to ensure data completeness.
- **Encounter Timeliness**: DMAS requires that the MCOs submit 95 percent of all encounters within sixty calendar days of the claim payment date. For data submitted between July 1, 2013, and December 31, 2014, only one of the seven encounter types (pharmacy) was in compliance with this standard. Inpatient and outpatient facility encounters presented fairly close proportions of their records within this time frame (both 92.4 percent), and the remaining encounter types submitted between 50.0 percent and 80.4 percent of encounters within 60 days of the MCO payment dates. DMAS reported that a Lag Day edit was introduced as part of the EDQ process in July 2015, and encounter data submitted afterward showed a dramatic improvement in timeliness across all encounter types. Additionally, in order to obtain 90 percent of the visits/services for utilization statistics, DMAS has to wait after the dates of service just over one month for pharmacy services, about four months for laboratory visits, five months for inpatient and outpatient facility services, six months for personal care and practitioner visits, and eight months for transportation services. The results from the two timeliness metrics suggest areas for improvement.
- **Data Element Completeness and Accuracy**: At the data element level, percent present and percent valid were relatively high for all key data elements. This indicates that information accepted into the MMIS for the key data elements is relatively complete and accurate. The missing and invalid values were generally isolated to a few MCOs and specific values. DMAS recently created EDQ edits for physician-administered drugs that fully support the drug rebate process requiring data fields such as National Drug Code (NDC) and Healthcare Common Procedure Coding System (HCPCS) codes. These edits were first introduced to the MCOs via the Managed Care Technical Manual v4.5 in December 2016.

Encounter Monitoring/Reporting Strategies

For the new EDQ process that began on July 1, 2015, HSAG reviewed the technical specifications for the critical and emerging issues and the first three EDQ reports sent to the MCOs. In general, the issues DMAS selected are encounter-specific and associated with contract standards, pharmacy rebates, or particular issues of concern for DMAS. While some error codes are well-defined, others may require further clarification so that MCOs can investigate error codes more effectively. Beyond the EDQ initial implementation phase, DMAS may want to both stratify the results further by encounter type and encourage MCOs to investigate the top error sequence code (ESC) values in the Emerging Issues list monthly. DMAS has not begun related tracking as of this report.

Consumer Survey of Quality of Care

The CAHPS survey is nationally recognized as the industry standard for evaluation of members' experiences with the health care and services they have received. DMAS contracted with HSAG to administer the CAHPS 5.0 Child Survey with the Children with Chronic Conditions measurement set for the statewide FAMIS program. In 2016, the response rate for the FAMIS program was 26.5 percent. The FAMIS program's response rate was greater than the national child Medicaid response rate reported by NCQA for 2016, which was 23.0 percent.

Table 1-3 shows the 2016 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for each global rating and composite measure, respectively, for the FAMIS program's general child population.

Table 1-3—FAMIS Program General Child CAHPS Results

Measure	2016 Rate
Global Ratings	
Rating of Health Plan	69.5%
Rating of All Health Care	67.0%
Rating of Personal Doctor	75.7%
Rating of Specialist Seen Most Often	69.4%+
Composite Measures	
Getting Needed Care	83.6%
Getting Care Quickly	91.2%
How Well Doctors Communicate	94.1%
Customer Service	88.4%+
Shared Decision Making	71.8%+

+ The program had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national child Medicaid average.

The FAMIS program scored at or above the 2015 NCQA national child Medicaid average on six measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

DMAS also contracted with HSAG to report on the results of the CAHPS surveys (Adult and Child) administered by each MCO for the Medallion 3.0 population.

Table 1-4 presents the 2016 adult and child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for the statewide aggregate.[1-6]

Table 1-4—2016 Statewide Aggregate Adult and Child Medicaid CAHPS Results

	Statewide Aggregate	
	Adult Medicaid	**Child Medicaid**
Global Ratings		
Rating of Health Plan	66.4%	74.4%
Rating of All Health Care	58.4%	70.2%
Rating of Personal Doctor	68.3%	76.2%
Rating of Specialist Seen Most Often	66.5%	71.5%
Composite Measures		
Getting Needed Care	81.2%	85.3%
Getting Care Quickly	83.9%	90.4%
How Well Doctors Communicate	90.7%	93.8%
Customer Service	87.3%	86.6%
Shared Decision Making	81.7%	78.4%

Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national adult Medicaid average.

For the adult Medicaid population, the statewide aggregate scored at or above the 2015 NCQA national adult Medicaid average on all measures. In addition, the adult Medicaid statewide aggregate scored 5 or more percentage points higher than the NCQA national adult Medicaid average on two measures: *Rating of Health Plan* and *Rating of All Health Care*. For the child Medicaid population, the statewide aggregate scored at or above the 2015 NCQA national child Medicaid average on all measures, except for *Customer Service*. In addition, the child Medicaid statewide aggregate score was 5 or more percentage points higher than the NCQA national child Medicaid average on one measure, *Rating of Health Plan*.

The MCOs that are contracted with DMAS for delivering care to eligible Medicaid managed care members are the same MCOs that deliver care to FAMIS-eligible members. While the FAMIS CAHPS survey administered by HSAG also includes fee-for-service, the MCO Quality Collaborative is

[1-6] Statewide aggregate scores were derived by calculating a mean of the combined scores of the six MCOs (i.e., weighted average of the MCOs' top-box rates combined).

encouraged to compare the statewide FAMIS program's general child CAHPS survey results to the child Medicaid CAHPS results of the Medallion 3.0 MCOs in aggregate. The details of the survey results and comparison of the MCOs 2016 results, found in Section 9 of this report, provide recommendations for quality improvement initiatives as well as identifying areas of change related to the 2015 results.

Performance Incentive Awards

The PIA program was created to provide 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.

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 so that no actual penalties or awards were implemented and the results were shared with the MCOs for input. The first year the MCOs will be subject to quality awards or penalties will be for 2016.

The PIA program funds allocation model uses each MCO's weighted score sum to allocate funds among MCOs. In addition, the funds allocation model was developed to ensure the total dollar amount for awards will always be equal to the total dollar amount for penalties, which provides 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, then there will be no award or penalty. The amount of the award or penalty is independent of the Virginia average and is instead based on the percentage of the Max Possible Score (i.e., the highest possible measure score = 3) an MCO achieved.

For the PIA program, DMAS selected six measures representing two measurement domains. The measures were consistent in both the pilot year and Program Year 1.

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 following measures:

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

The Program Year 1 (2016) PIA results indicated that four MCOs will be assessed for awards and two MCOs will be assessed for penalties for their performance in 2016, which will be collected from the MCOs in Spring 2017. These results, along with the methodology and technical specifications, are posted on DMAS' website.

Consumer Decision Support Tool

On May 6, 2016, CMS published the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid beneficiaries must adopt and implement a quality rating system (QRS) within three years of the final notice of the Medicaid and CHIP QRS. Although the final notice of the QRS has not been released, Medicaid agencies that already have a QRS in place will have an opportunity to utilize their current QRS with CMS approval. DMAS contracted with HSAG in 2015 (which was a pilot year) to produce a prototype for a Consumer Decision Support Tool using Virginia Medicaid MCOs' performance measure data, which may meet the requirement for a QRS with CMS approval. The tool was developed to help support DMAS' public reporting of MCO performance information to be used by consumers to make informed decisions about their health care. The pilot year enabled DMAS to gain feedback from the MCOs and stakeholders to evaluate the program design and methodology, and determine any changes that would be implemented for future years. The 2015 results were for informational purposes only.

The 2016 methodology for developing the tool followed the 2015 process, combining and analyzing HEDIS 2016 performance measure results and 2016 CAHPS data to assess MCOs' performance related to certain areas of interest to consumers and included the same reporting categories:

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

Each reporting category contained a summary score for each of the six MCOs, which was calculated in order to determine MCO performance. The summary score for each MCO was then compared to the Medicaid MCO Virginia average to determine differences in MCO performance. The tool evaluated performance such as:

- How well doctors involved members in decisions about their care.
- If children regularly received checkups and important shots that helped protect them against serious illness.

The finalized tool included an overview of the tool, description of the reporting categories, MCO-specific results, MCO accreditation levels, and background information for consumers choosing a Medicaid MCO, including MCO region assignments and contact details.

The Consumer Decision Support Tool's inclusion of the MCO accreditation level emphasizes the standard of quality and integrity expected in being a contracted MCO 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, Provisional, and Interim.

The 2016 Consumer Decision Support Tool will be made publicly available (i.e., on DMAS' website) for the first time in 2017.

Quality Initiatives

Maternal and Infant Improvement Project

The Maternal and Infant Improvement Project (MIIP) was created by DMAS in 2014 to improve maternity care for Medicaid and FAMIS beneficiaries. The MIIP is also part of the *Strong Start* program, a grant for *Centering Pregnancy*. The *Centering Pregnancy* program provides women in high-risk pregnancies with individual health assessments, education, and support in group setting classes focused on nutrition and health. The MIIP grant for *Centering Pregnancy* continues until 2017.

Also, through the work of MIIP, effective January 1, 2016, DMAS began paying for breast pumps and breastfeeding support for women enrolled in Medicaid, FAMIS, and FAMIS MOMS. To further align the programs, DMAS also began the coverage of lactation counseling services for pregnant and postpartum women enrolled in the FFS Medicaid, FAMIS, and FAMIS MOMS programs effective January 1, 2016.

Fee-for-Service and Managed Care

Effective March 1, 2015, pregnant women enrolled in Medicaid and FAMIS MOMS who are 21 years of age and older have been eligible to receive comprehensive benefits, excluding orthodontics, through Virginia's nationally recognized *Smiles For Children* program. Pregnant women are also able to access nonemergency transportation services to receive dental care. From March 1, 2015, through September 5, 2016, the number of pregnant women using their dental benefits has steadily climbed to 8,875 members.[1-7]

[1-7] Maternal and Infant Improvement Project (MIIP) Activities Report 2015–2016, published by DMAS.

Managed Care Quality Collaborative

The Medicaid Managed Care Quality Collaborative has been active for more than a decade and is facilitated by DMAS QI staff. The MCOs, the external quality review organization (EQRO), and DMAS use this forum to collaborate to develop innovative programs and potential solutions for the needs of the members, as well as to share best practices and lessons learned, with the goal of improving the quality of care for members. The Quality Collaborative meetings occur four times per year. Some of the topics that have been presented for discussion at the meetings have included:

- Planning the transition to the rapid-cycle performance improvement model and module training for the rapid-cycle PIP to successfully implement the pilot, and the MCOs and DMAS choosing the selected PIP topic of diabetes care.
- MCOs collaborating on the selection of the 2016 measure analysis: *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and two HEDIS measures for validation in 2016: *Blood Pressure Control (hybrid)* and *Adults' Access to Preventive/Ambulatory Health Services.*
- Ciox Health, a shared vendor for all six MCOs, collaborating on opportunities to continue to improve the medical retrieval process.
- Presentation of the three EQRO focused studies and findings: Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Health and Acute Care Program.
- Presentation on the PMV activity, measures, findings, and recommendations.
- Presentations of the PIA program findings.
- Presentation of the FAMIS CAHPS results.

MCOs Best and Emerging Practices for Improving Quality of Care and Services

In addition to the Managed Care Quality Collaborative meetings, the best and emerging practices shared by the MCOs in 2016 displayed a variety of activities initiated and/or expanded upon to continue the focus of improving health outcomes and access to care for members. Below is a list of a few of the activities with a more comprehensive list of the MCOs collective activities described in Section 10 of this report:

Aetna Quality Management staff members visited over 170 practitioner offices this year. The team spent time with office staff talking about HEDIS tips, opportunities to conduct well care during sick visits, closing gaps in care, and removing barriers to well care. Aetna also partnered with practices to make sure they knew about the incentives offered so that they could support and encourage Aetna's efforts to engage the members they also attempted to reach via phone.

Anthem provided a Clinic Day program, which is an initiative between the MCO in partnership with its network providers to host a series of Clinic Day events, outreaching to members who have not completed specific recommended health services and assisting members with setting up provider

appointments. The model includes the providers setting aside multiple days in which members can schedule appointments, the MCO assisting the member prior to the Clinic Day to set up provider appointments, identifying any potential barriers that may impact a "no show," and assisting with member transportation needs.

INTotal initiated a Know Your Benefit outreach, which included a YouTube video that presents benefit information about prenatal, dental, and transportation services available to members, in addition to value-added services such as registration to a local Boys and Girls Club and school physicals.

Kaiser Permanente offered telephonic wellness coaching for lifestyle topics such as stress management, healthy eating, weight management, and tobacco cessation. Members may schedule 20-minute telephone appointments and have unlimited follow-up appointments.

Optima increased use of mobile phones and digital health messaging to educate and support members; encourage members to follow recommended preventive guidelines for preventive care, immunizations, and screenings; and inform members of health plan services and benefits.

VA Premier provides an Atypical Antipsychotics program initiated through a collaborative process between the MCO's Case Management and Pharmacy departments, which promotes care coordination between medical and behavioral health providers. The Pharmacy department receives monthly reports that identify members between ages 7 and 12 with a claim for an antipsychotic medication who have not had a well-child PCP visit within the previous 12 months. The Pharmacy department then mails care coordination letters to both the BH providers and PCPs. The monthly report also triggers outreach for the Case Management Team. Both members and providers are contacted in an effort to arrange primary care well-child visits and coordinate communication between primary medical and behavioral care.

2. Commonwealth of Virginia Medicaid Managed Care Overview

Overview

DMAS administers the Medicaid managed care program in the Commonwealth of Virginia, known as Medallion 3.0, in accordance with Title XIX of the SSA. In addition, DMAS administers the Virginia CHIP, known as FAMIS [Family Access to Medical Insurance Security].

Virginia first implemented Medallion, a Medicaid primary care case management (PCCM) program in four pilot cities in 1993. The program was expanded statewide in 1995 and covered low-income adults and children as well as aged, blind, or disabled individuals. Virginia also offered the Options program, which provided for voluntary managed care enrollment for beneficiaries in certain regions. In 1996, Virginia implemented Medallion II, a comprehensive managed care program in which enrollment was mandatory for most children, low-income adults, and non-dual-eligible aged and disabled individuals. Subsequently, the PCCM program was eliminated and the MCO managed care program was expanded statewide. In July 2014, Medallion 3.0 was implemented, which incorporated new partnership initiatives, quality incentives, foster care, and an expedited enrollment process to facilitate access to services.

In March 2014, DMAS, in partnership with CMS, implemented a Financial Alignment Demonstration program, Commonwealth Coordinated Care (CCC), which integrates Medicaid and Medicare benefits for select dual-eligible enrollees. The CCC program seeks to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports (LTSS) to improve health outcomes for enrollees who often have very complex needs. A separate EQR technical report has been developed for the CCC program, covering the report period of January 1 through December 31, 2016.

Managed Care Organization Profiles

During 2016, DMAS contracted with six qualified MCOs to provide services to managed care members. Following is a brief description of each MCO.

- Aetna Better Health of Virginia (Aetna), formerly CoventryCares of Virginia, is the name of 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.
- Anthem HealthKeepers Plus Offered by HealthKeepers, Inc. (Anthem) is a Virginia health maintenance organization (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.

- INTotal Health (INTotal), headquartered in Falls Church, Virginia, manages Medicaid health insurance programs in Virginia and is part of Inova, a not-for-profit health care system based in northern Virginia serving the greater Washington, D.C. area.
- Kaiser Permanente is a partnership of the not-for-profit Kaiser Foundation Health Plan 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.
- Optima Family Care (Optima) is the name of 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.
- Virginia Premier Health Plan, Inc. (VA Premier) is a local, not-for-profit managed care organization owned by the Virginia Commonwealth University (VCU) Medical Center, headquartered in Richmond, Virginia. The company began operations as a managed care Medicaid health plan in 1996.

Refer to Table 2-1 for MCO profiles as of December 2016.

Table 2-1—MCO Profiles as of December 2016

MCO	Year Operations Began as MCO in Virginia	Product Lines in Virginia
Anthem	1996	Medicaid, Medicare, Commonwealth Coordinated Care, Commercial
Aetna, formerly CoventryCares of Virginia	1996 (CoventryCares) April 1, 2016 (Aetna)	Medicaid, Commercial
INTotal	2013	Medicaid
Kaiser Permanente	2013	Medicaid, Medicare, Commercial
Optima	1995	Medicaid, Medicare, Commercial
VA Premier	1995	Medicaid, Medicare, Commonwealth Coordinated Care, Commercial

As of December 2016, the six MCOs served more than 766,000 individuals in a Medicaid and FAMIS managed care program. Table 2-2 shows the enrollment by population for each MCO, and Figure 2-1 displays a map of the managed care regions for the population.

Table 2-2—Virginia Medicaid Managed Care Enrollment by MCO and Population as of December 2016

MCO	Medallion 3.0	FAMIS	Total
Anthem	262,378	25,669	288,047
Aetna	38,824	2,413	41,237
INTotal	54,162	6,193	60,355
Kaiser Permanente	9,627	1,544	11,171
Optima	165,760	11,130	176,890
VA Premier	177,107	11,746	188,853
Grand Total	707,858	58,695	766,553

Planned Initiatives

Commonwealth Coordinated Care Plus—Managed Long-Term Services and Supports Program

The 2013 Virginia Acts of Assembly directed DMAS to work toward the inclusion of all remaining Medicaid populations and services, including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems. (Item 307.RRRR.4.—http://lis.virginia.gov/131/bud/hb1500chap.pdf.) The 2015 Virginia Acts of Assembly (Item 301.TTT) directed DMAS to further principles of care coordination to all geographic areas, populations, and services under programs administered by the Department. Building off of the successes of the CCC demonstration previously mentioned, DMAS is meeting the stated objectives of the Virginia legislature by creating a mandatory managed care program MLTSS, through the selection of MCPs each committed to being certified as a Dual-Eligible Special Needs Plan (D-SNP) in Virginia.

CCC Plus refers to the delivery of long-term services and supports, including HCBS and institutional-based services, behavioral health services, and acute and primary care services, through capitated Medicaid managed care plans. CCC Plus programs provide an opportunity to create a seamless, integrated health services delivery program, building upon lessons and best practices learned through CCC demonstration. Some goals of MLTSS include:

- Improved quality of life, satisfaction, and health outcomes for individuals enrolled.
- A seamless, one-stop system of services and supports.
- Service coordination that provides assistance in navigating the service environment, ensuring timely and effective transfer of information, and tracking referrals and transitions to identify and overcome barriers.

- Care coordination for individuals with complex needs that integrates the medical and social models of care, ensures individual choice and rights, and includes individuals and family members in decision making using a person-centered model.
- Support for seamless transitions between service/treatment settings.
- Facilitation of communication between providers to improve the quality and cost effectiveness of care.
- Arranging services and supports to maximize opportunities for community living and prevent or delay the need for long-term services and supports.
- Systemwide quality improvement and monitoring.
- Alignment with DMAS' Delivery System Reform Incentive Payment (DSRIP) initiatives.

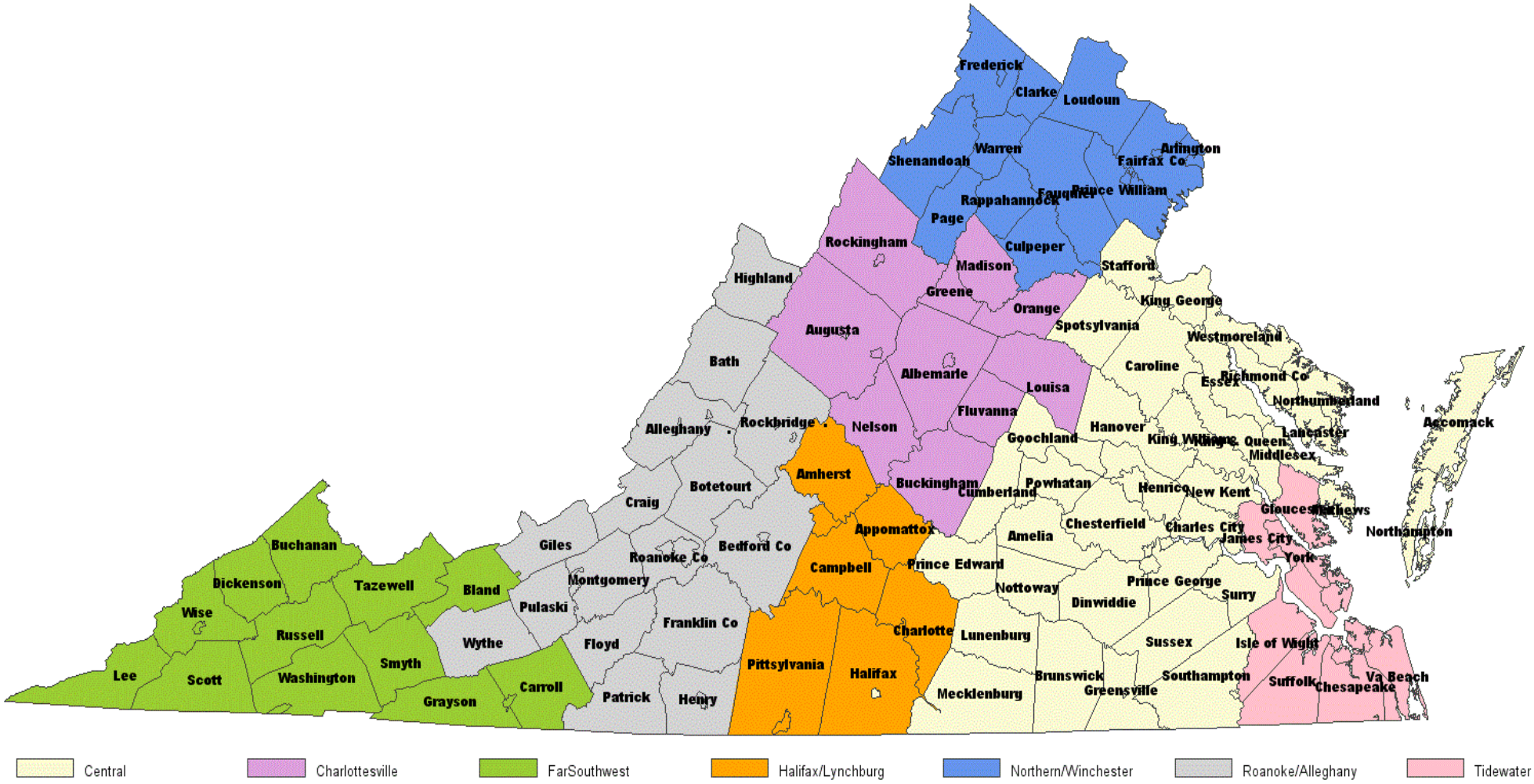
DMAS is still in the procurement process to contract with managed care health plans to deliver MLTSS. The estimated initial go-live date for MLTSS is July 1, 2017. This new statewide Medicaid managed care program will serve approximately 213,000 individuals with complex care needs through an integrated delivery model across the full continuum of care.[2-1]

Reprocurement of the Medallion 3.0 Program

DMAS will be reprocuring the Medallion 3.0 program. A new request for proposal will be released in 2017, and the implementation date will be January 2018. The Medallion 3.0 and FAMIS program will be restructured to serve individuals in the low income families with children (LIFC), FAMIS, FAMIS Moms, and pregnant women covered groups.

[2-1] DMAS memo addressed to All Providers Participating in the Virginia Medicaid Program and FAMIS Program. Oct 31, 2016.

Figure 2-1—Virginia Managed Care Regions



3. Commonwealth of Virginia Quality Strategy

Quality Strategy

42 CFR §438.202(a) requires states with Medicaid managed care to have a written quality strategy. DMAS published its first quality strategy in June 2005. The strategy was 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 an 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. The addendum addresses the progression of, and impending changes to, managed care quality in Virginia. The third edition, an updated comprehensive quality strategy, will be developed and published since the release of the Medicaid and CHIP Managed Care Final Rule in 2016.

The Virginia quality strategy was designed to serve as a blueprint for continuous quality improvement of health care services provided by the Medicaid and CHIP managed care delivery system. Through contractual requirements, DMAS holds MCOs accountable for quality-related activities, review, and results that meet (and in certain areas exceed) federal managed care requirements as set forth in 42 CFR Subparts D and E.

DMAS contracted with HSAG during the 2016 review period to conduct two of the three federally mandated EQR activities, including annual validation of performance measures (refer to Section V) and annual validation of PIPs (refer to Section VI). The third mandated activity, comprehensive review of MCO compliance with standards, was last conducted in 2014 and is to be conducted every three years (refer to Section IV).

In addition to compliance with federal standards, Virginia was one of the first states to require all contracted MCOs to achieve and maintain NCQA accreditation. As of 2016, all six MCOs held accredited or commendable NCQA accreditation status.

DMAS also contracted with HSAG to conduct three focused quality studies, Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care, and Health and Acute Care Program (refer to Section VII); required MCOs to conduct and report results of CAHPS surveys for the Medallion 3.0 and FAMIS populations (refer to Section IX); initiated a program for encounter data validation (refer to Section VIII); and provided technical assistance on the development of a Consumer Decision Support Tool (Section III).

Through its quality strategy, DMAS had a systematic approach in place to monitor and to identify and act on opportunities for improvement in the quality of care and services delivered to MCO members.

Quality Initiatives

Maternal and Infant Improvement Project

The MIIP was created by DMAS to improve maternity care for Medicaid and FAMIS beneficiaries. A multidisciplinary team at DMAS was tasked with the goal of developing and implementing rapid-cycle strategies to increase enrollment of pregnant women and maximize access to maternity care for Medicaid and FAMIS MOMS members.

These five areas of focus provide the foundation for implementing the strategies of MIIP:

1. Data Analysis and Birth Outcomes Focused Study
2. Eligibility Policies and Regulations
3. Communication to Providers and Members
4. Collaborative Opportunities
5. Fee-for-Service and Managed Care

Collaborative Opportunities

MIIP continues to be part of the program *Strong Start*, a grant for *Centering Pregnancy*, until 2017. This program provides to women in high-risk pregnancies individual examinations and group classes focused on nutrition and health.

MIIP team members also worked collaboratively with VDH to conduct further research on VDH birth and death records and to develop a system to identify members with a history of preterm birth. This information will be provided to MCOs to promote increasing outreach services and to identify stakeholders in the area to partner with, all in order to increase access to care.

On the federal level, MIIP members participated in virtual learning initiatives sponsored by the National Association of Medicaid Directors (NAMD) and CMS which focused on reducing low-risk C-sections. Virginia was one of thirteen states selected to participate in an action learning series that focused on improving postpartum care.

Social Media Campaign for Public Advertising and Education

Members of the MIIP team are working together to help advertise and educate the public about Medicaid and FAMIS programs, capitalizing on the impacts of social media venues such as Facebook, YouTube and Twitter. Through these social media outlets, resource lists will be made available which include contact information and data about dental programs, the Virginia Dental Association (VDA), Bright Futures, the Special Supplemental Nutrition Program under Women, Infants, and Children (WIC), and other

pertinent information. The FAMIS and Cover Virginia Facebook pages are the primary outlets being used to post newsworthy and emerging information.

The MIIP team is also collaborating with several pilot programs, through the implementation of social media, to link emergency delivery mothers with information and resources on the Medicaid enrollment process for newborns.

Fee-for-Service and Managed Care

Expansion of *Smiles for Children* Dental Services

On March 1, 2015, DMAS expanded adult dental coverage to include pregnant women ages 21 and over enrolled in Medicaid and FAMIS MOMS through Virginia's nationally recognized *Smiles for Children* program. From March 1, 2015, through September 5, 2016, the number of pregnant women using their dental benefits has steadily climbed to 8,875 members. This gave pregnant women enrolled in Medicaid and FAMIS MOMS the ability to receive appropriate benefits covered by the *Smiles for Children* program, including diagnostic, preventive, restorative, endodontic, periodontic, and prosthodontic services as well as access to non-emergency transportation services to receive dental care and medically necessary oral surgeries.[3-1]

Since the expansion of *Smiles for Children* in March of 2015, monumental impacts have been made, such as:

- Dental benefits have been provided for approximately 45,000 pregnant women in Medicaid and FAMIS.
- Approximately 2,000 dental providers (32.5 percent) are now participating in the network.
- Of eligible Medicaid members 0 through 19 years of age, 54 percent are accessing dental services through the program.
- The Virginia average for children participating in an annual dental visit is now 63.68 percent, surpassing the national average of 48.67 percent.
- Since 2013, the number of non-dental providers applying fluoride varnish has increased by 51.2 percent.[3-2]

Expanding Fee-for-Service Coverage

While a majority of women enrolled in Medicaid and FAMIS MOMS were provided coverage through an MCO, those enrolled in Medicaid through Fee-for-Service were not. Through the work of MIIP, on

[3-1] Maternal and Infant Improvement Project (MIIP) Activities Report 2015–2016, published by DMAS.
[3-2] Virginia Department of Medical Assistance Services. Maternal and Infant Improvement Project (MIIP) Activities Report 2015-2016. Available at: http://www.dmas.virginia.gov/Content_atchs/mch/MIIP%20Activities%20Report_12012016_Approved.pdf. Accessed on: Jan 27, 2017.

January 1, 2016, DMAS began paying for breast pumps and breastfeeding support for women enrolled in Medicaid, FAMIS, and FAMIS MOMS. The coverage encompassed three types of breast pumps: manual, electrical, and hospital grade. As a result, the MIIP team has been developing an FFS and MCO comparison chart for breast pumps, which will be referenced when looking at the three types of breast pumps offered and identifying the specific requirements for each.

Expanded *Plan First* and Family Planning Services

Plan First is Virginia's expanded family planning Medicaid benefit. All income-eligible women and men who do not qualify for any other Medicaid or FAMIS benefit are eligible for *Plan First*. To help prevent women from conceiving again soon after giving birth, members of MIIP are geared toward increasing the use of birth control and long-acting reversible contraceptives (LARC) amongst *Plan First* enrollees. The team's strategy is to conduct research and narrow the focus toward teenagers and recent mothers, through the utilization of social media and Home Visiting Consortium education.

Modification of the Medallion 3.0 Contract

In an effort to improve performance around prenatal and postpartum services for pregnant women, members of MIIP and DMAS conducted several activities aimed at learning about best practices used by MCOs. The MIIP team reviewed the six MCOs under the Medallion 3.0 contract to consider all specific maternal and child programs provided. The team reviewed each incentive and maternity program to evaluate case management, support, and member incentives. This included helping with providing information and care for women at the end of their second or beginning of their third trimester, to ensure that they receive important health benefits before delivering.

Information communicated by the MCOs varied. DMAS encouraged the MCOs to use a more standardized approach for particular initiatives, prompting an analysis of the Medallion 3.0 contract language to ensure that the Department's expectations were explicit to allow review of like variables across all MCOs. Standardized reporting requirements and templates were developed for the MCOs to follow when submitting information to the Department. For example, a standardized reporting template was developed for the maternity programs' policies and procedures. Additionally, a standardized template was created for the annual maternity program summary (a summary of activities conducted, challenges, accomplishments, results of an initiative to support positive birth outcomes, etc.) in the *Managed Care Technical Manual (MCTM*).

These changes were designed to ensure the exchange of best practices, facilitate the Medallion 3.0 contract compliance reviews, and foster further dialogue among the MCOs and DMAS around maternity efforts.

Managed Care Quality Collaborative

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

DMAS hosted quarterly Medicaid Managed Care Quality Collaborative meetings with all contracted MCOs in 2016. The purpose of the collaborative meetings was to facilitate the sharing of information among DMAS and the MCOs, with the goal of improving the quality of care and services provided to Medicaid members.

Some topics presented and/or discussed in these meetings are described below.

MCOs

At the request of the MCOs, Ciox Health, a shared vendor for all six MCOs, presented at the June 2016 meeting on the medical retrieval process. The MCOs had expressed concern with the Healthport/Ciox record retrieval process during the HEDIS audit season, which they believed contributed to their lower HEDIS scores.

Additionally, the MCOs collaborated with DMAS to select the 2016 measure analysis *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and the two HEDIS measures for validation in 2016: *Blood Pressure Control (hybrid)* and *Adults' Access to Preventive/Ambulatory Health Services.*

Performance Improvement Project (PIP) Topics and Training

The planned transition to a rapid-cycle improvement model was implemented in 2016. The MCOs are conducting one DMAS-selected PIP topic focused on diabetes care. The new model is more proactive and outcomes-oriented, placing greater emphasis on improving outcomes using rapid-cycle methods to pilot small changes.

Between January and June 2016, retraining and start-up of the rapid-cycle PIP took place, with training being conducted for MCOs at the Medicaid managed care quarterly Quality Collaborative meetings. From July through December 2016, the MCOs implemented the new rapid-cycle PIP process and HSAG validated each PIP to its point of progression. (Refer to Section 6.)

Performance Incentive Awards Program

Description of Program

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

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

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

- *Child 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 1) represents the first 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. Upon review of the MCOs' pilot year results, DMAS elected to adopt the same administrative measure scoring methodology for Program Year 1 that was used for the pilot year, modifying the HEDIS measure scoring methodology to take into consideration upper and lower confidence intervals of each measure compared to Quality Compass percentile values. In addition, an MCO could also receive an improvement score in 2016 based on comparing the prior year's performance. A total of three possible points can be awarded for each measure.

Administrative measures were compared to standards created by DMAS, and MCOs' HEDIS measure 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 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. If the MCO only had one year of reporting data, then the MCO received one point if the current year score was above the Quality Compass 90th percentile.
- Zero points were awarded if the MCO either did not show a statistically significant change between years or declined.

For MCOs with 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), the MCO received a score of zero for that measure. Once the measures were scored and weighted appropriately, total capitation payment amounts were used to calculate awards and penalties, to a maximum of 0.15 percent of each MCO's total capitation payment.

Objectives

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

Status of 2016 Activity

The 2016 activity is the first 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 November 2016. The Program Year 1 PIA results indicated that four MCOs will be assessed for awards and two MCOs will be assessed for penalties for their performance in 2016, which will be collected from the MCOs in Spring 2017. All MCOs were notified of their final PIA results in December 2016, which provided an opportunity for all MCOs to review and provide feedback on the results.

Consumer Decision Support Tool

Description of Tool

DMAS contracted with HSAG in 2016 to produce a Consumer Decision Support Tool, which may meet the requirements of 42 CFR §438.334, using Virginia Medicaid MCOs' performance measure data.

Specifically, HEDIS 2016 performance measure results and 2016 CAHPS data were combined and analyzed to assess MCOs' performance as related to certain areas of interest to consumers.

To derive the results included within the tool, HSAG scored each MCO's quality of care provided in the following reporting categories: Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women. For each reporting category, a summary score for each MCO was calculated in order 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. Each MCO's performance was categorized into one of three performance categories based on the standardized summary scores and the respective confidence intervals (i.e., below average, average, or above average when compared to the average performance across MCOs). HSAG then used a three-level rating scale to report the category rankings (e.g., a standard scale of one star to three stars). The finalized tool included an overview of the tool, description of the reporting categories, MCO-specific results, MCO accreditation levels, and background information for consumers choosing a Medicaid MCO, including MCO region assignments and contact details.

The Consumer Decision Support Tool's inclusion of the MCO accreditation level emphasizes the standard of quality and integrity expected in being a contracted MCO 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, Provisional, and Interim.

Objectives

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. The tool evaluated individual MCO performance (e.g., how well doctors involved members in decisions about their care, and if children regularly received checkups and important shots that helped protect them against serious illness); therefore, consumers had the opportunity to be better informed in certain areas of interest. Additionally, the tool provided a three-level rating scale with an easy-to-read "picture" of quality performance across MCOs and presented data in a manner that clearly emphasized meaningful differences between MCOs (i.e., one-to-three star rating) to assist consumers when selecting a health plan.

Status of 2016 Activity

In 2016, HSAG calculated and finalized results for six MCOs in Virginia, with this year being the first year that one MCO, Kaiser Permanente, reported all required measures. In an effort to support DMAS' efforts in public reporting, the 2016 Consumer Decision Support Tool will be made publicly available (i.e., on DMAS' website) for the first time in May 2017.

Focused Studies

The methodologies, results, and recommendations of the three focused studies presented in this report: Improving Birth Outcomes Through Adequate Prenatal Care, Improving the Health of Children in Foster Care and the Health and Acute Care Program (refer to Section 7) were presented to the MCOs at the Quality Collaborative meetings.

4. Compliance Review and Accreditation

Compliance Review

Introduction

At 42 CFR§438.358, activities are described related to compliance with standards, one of the three federally mandated activities for Medicaid MCOs. The requirements specify that a review must be conducted within the previous three-year period to determine the MCOs' compliance with standards established by the State to comply with the requirements of 42 CFR §438.204(g) in the areas of access to care, structure and operations, quality measurement and improvement, and applicable elements of DMAS' contract with the MCOs.

Federal requirements indicate that the reviews must be conducted by a state Medicaid agency, its agent that is not a Medicaid managed care organization or pre-paid inpatient health plan, or an EQRO. DMAS contracted with HSAG as its EQRO to conduct the comprehensive on-site operational systems reviews for each of its six contracted MCOs in 2017.

Methodology for Conducting the Comprehensive On-Site Operational Systems Review

HSAG follows 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[4-1] for planning comprehensive review activities. HSAG conducts planning review activities, evaluation, and aggregation and analysis of findings.

As part of these EQR services, DMAS requested that HSAG develop a strategy and recommendations for refining the "deeming" option that DMAS implemented in state fiscal year (SFY) 2014 for its contracted MCOs. Deeming is an option afforded by federal regulations to states allowing—when the required conditions are met—that information obtained from a Medicare or private accreditation review be used to demonstrate MCO compliance with one or more of the EQR activities described at 42 CFR §438.358 relating to the validation of performance improvement projects, validation of performance measures, and compliance review. All Medicaid MCOs participating in the DMAS contract are accredited by NCQA.

In preparation for the SFY 2017 comprehensive operational systems review (OSR) of MCOs, DMAS determined that deeming would be conducted.

[4-1] 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: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

HSAG used the CFRs as the authoritative source of requirement against which accreditation standards and Medicare regulations/standards are compared. The NCQA crosswalk has not been formally approved by CMS. However, NCQA submitted crosswalks to CMS for review and worked closely with CMS during the development of the respective crosswalks. To prepare for and complete each crosswalk, HSAG performed a comprehensive review of the NCQA Medicaid crosswalks and the CFRs set forth in Subpart D of §438. HSAG created a crosswalk table between the relevant NCQA standards and the CFRs. HSAG used the crosswalk information to determine the percentage of comparability of NCQA standards to regulations in the CFRs and to identify those CFRs that CMS allows to be eligible for deeming. HSAG assessed whether or not each accreditation standard met the relevant regulation in the CFR in its entirety or if parts of the standard met the CFR, presented the findings, and proposed recommendations to DMAS based on the evaluations.

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

Refer to Table 4-1 for the accreditation levels of the contracted MCOs in 2016.

Table 4-1—MCO NCQA Accreditation Levels

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

5. Performance Measures

Introduction

One mandatory EQR activity set forth in 42 CFR §438.358 involves validation of MCOs' performance measure rates reported to the State during the preceding 12 months. Further, the MCO must measure and report to the State its performance, using standard measures required by the State, or submit to the State specified data to enable the State to measure MCO performance. Monitoring of performance measures allows for the assessment of quality of, access to, and timeliness of the care and services provided to Medicaid members.

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. Results of these audits are presented below along with MCO-specific rates for DMAS-defined priority HEDIS measures.

In addition, DMAS contracted with HSAG to conduct PMV on two separate HEDIS measures, *Controlling High Blood Pressure* and *Adults' Access to Preventive/Ambulatory Health Services*, to evaluate further the accuracy of reported performance measure rates. HSAG also conducted PMV on two state measures, *Assessment of Foster Care Children* (PIA measure) and *Timeliness of Claims Payment* (PIA measure).

NCQA HEDIS Compliance Audit Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess an MCO's ability to report HEDIS data accurately and reliably. Compliance with the guidelines also helps an auditor to understand an MCO's HEDIS reporting capabilities. For HEDIS 2016, MCOs were assessed on seven IS standards. To assess the MCOs' adherence to the IS standards, HSAG reviewed several documents for the Virginia MCOs. These included the MCOs' FARs, IS compliance tools, and the IDSS files approved by an NCQA-licensed audit organization (LO).

Each Virginia MCO contracted with an LO to conduct the NCQA HEDIS Compliance Audit. The MCOs were able to select the LO of their choice. Overall, the Virginia MCOs consistently maintained the same LOs across reporting years.

As in the prior year, all MCOs contracted with an external software vendor for HEDIS measure production and rate calculation. HSAG reviewed the MCOs' FARs and ensured that these software vendors participated in and passed NCQA's measure certification process. MCOs could purchase the software with certified measures and generate HEDIS measure results internally or provide all data to the software vendor to generate HEDIS measures for them. Either way, using NCQA-certified measure software may reduce the MCO's burden for reporting and helps to ensure rate validity.

HSAG found that, in general, the MCOs' information systems and processes were compliant with the applicable IS standards and the HEDIS reporting requirements related to the key Virginia Medicaid measures for HEDIS 2016.

Key Information Systems Findings—Summary of MCO Final Audit Reports

IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry

This standard assesses whether:

- Industry standard codes are used and all characters are captured.
- Principal codes are identified and secondary codes are captured.
- Nonstandard coding schemes are fully documented and mapped back to industry standard codes.
- Standard submission forms are used and capture all fields relevant to measure reporting, all proprietary forms capture equivalent data, and electronic transmission procedures conform to industry standards.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure the accurate entry of submitted data in transaction files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 1.0, Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry*. All required data elements were captured at a sufficient level of specificity for HEDIS reporting. Only industry standard codes and industry standard forms were accepted. Nonstandard codes, if any, were mapped to industry standard codes appropriately. Adequate validation processes such as built-in edit checks, data monitoring, and quality control audits were in place to ensure that only complete and accurate claims and encounter data were used for HEDIS reporting.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- The organization has procedures for submitting measure-relevant information for data entry and whether electronic transmissions of membership data have necessary procedures to ensure accuracy.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 2.0, Enrollment Data—Data Capture, Transfer, and Entry*. Enrollment data were received from the State. All fields required for HEDIS reporting were captured. The MCOs were able to process eligibility files in a timely manner. Enrollment information housed in the MCOs' systems was reconciled against the enrollment files provided by the State. Adequate checks and balances were in place to ensure data completeness and data accuracy.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

This standard assesses whether:

- Provider specialties are fully documented and mapped to HEDIS provider specialties necessary for measure reporting.
- The organization has effective procedures for submitting measure-relevant information for data entry and whether electronic transmissions of practitioner data are checked to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 3.0, Practitioner Data—Data Capture, Transfer, and Entry*. In general, all MCOs captured provider data accurately and were able to identify rendering provider type for those measures for which this was required. Provider specialties were fully mapped to HEDIS-specified provider types. Adequate controls and edit checks were in place for data entered into the credentialing modules to ensure that only accurate data were used for HEDIS reporting.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

This standard assesses whether:

- Forms capture all fields relevant to measure reporting and whether electronic transmission procedures conform to industry standards and have necessary checking procedures to ensure data accuracy (logs, counts, receipts, hand-off, and sign-off).
- Retrieval and abstraction of data from medical records are reliably and accurately performed.
- Data entry processes are timely and accurate and include sufficient edit checks to ensure accurate entry of submitted data in the files for measure reporting.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 4.0, Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight*. Medical record data were used by all MCOs to report HEDIS hybrid measures. Medical record abstraction tools were reviewed and approved by the MCOs' auditors for HEDIS reporting. Whether through a vendor or by internal staff, all medical record data collection and

review were conducted by qualified and experienced professionals. Sufficient validation processes and edit checks were in place to ensure data completeness and data accuracy.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- The organization has effective procedures for submitting measure-relevant information for data entry and whether electronic transmissions of data have checking procedures to ensure accuracy.
- Data entry processes are timely and accurate and include edit checks to ensure accurate entry of submitted data in transaction files.
- The organization continually assesses data completeness and takes steps to improve performance.
- The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 5.0, Supplemental Data—Capture, Transfer, and Entry*. Supplemental data sources used by the MCOs were verified and approved by the auditors. Proof of service validation was performed on all nonstandard data sources. Validation processes such as reconciliation between original data source and MCO-specific data systems, edit checks, and system validations ensured data completeness and data accuracy. No issues were noted with the use of these data; however, the auditors suggested that MCOs continue to conduct close oversight of their supplemental data systems and processes.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard assesses whether:

- Member call center data are reliably and accurately captured.

IS 6.0 was not applicable to the measures required to be reported by the MCOs.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

This standard assesses whether:

- Nonstandard coding schemes are fully documented and mapped to industry standard codes.
- Data transfers to the HEDIS repository from transaction files are accurate.
- File consolidations, extracts, and derivations are accurate.
- Repository structure and formatting are suitable for measures and enable required programming efforts.
- Report production is managed effectively and operators perform appropriately.

- Measure reporting software is managed properly with regard to development, methodology, documentation, revision control, and testing.
- Physical control procedures ensure measure data integrity such as physical security, data access authorization, disaster recovery facilities, and fire protection.

The organization regularly monitors vendor performance against expected performance standards.

All MCOs were fully compliant with *IS 7.0, Data Integration—Accurate HEDIS Reporting Control Procedures That Support HEDIS Reporting Integrity*. As in the prior year, all MCOs contracted a software vendor producing NCQA-certified measures to calculate HEDIS rates. For all MCOs, adequate monitoring processes were in place to ensure that no data were lost during data transfer to HEDIS repositories. Sufficient vendor oversight was in place for MCOs using software vendors.

MCO-Specific HEDIS Measure Results

The following tables present each MCO's HEDIS 2014, 2015, and 2016 performance measure results and the current performance level relative to the national Medicaid 50th percentile.[5-1] The source of the national Medicaid 50th percentile is NCQA's Quality Compass, with the exception of *Medication Management for People With Asthma—Medication Compliance 50%* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* that were compared to NCQA's HEDIS Audits Means and Percentiles national Medicaid HMO 50th percentiles since NCQA's Quality Compass data were not available. Select measures and associated measure indicators were eligible for rotation in 2014 (i.e., *Controlling High Blood Pressure* and *Prenatal and Postpartum Care*) and in 2015 (i.e., *Adolescent Well-Care Visits; Childhood Immunization Status; Lead Screening in Children; Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Comprehensive Diabetes Care*). Rotating a measure allowed a plan to use the audited and reportable hybrid rate from the prior year rather than collecting the measure for the measurement year (MY). Therefore, MCOs' measure rates may be the same for these measures across two years. Per NCQA protocol, 2016 is the first year that measures cannot be rotated.

In the tables following, yellow-shaded boxes indicate MCO rates that were at or above the national Medicaid 50th percentile. Where possible, NCQA's Quality Compass national Medicaid HMO 50th percentile rate used for comparison is listed. However, for some measures, HSAG is not authorized to publish the exact value of the percentile used; therefore, the cells are shaded gray. Certain measures are not appropriate for comparison to Quality Compass percentiles (i.e., *Well-Child Visits in the First 15 Months of Life—One, Two, Three, Four,* and *Five Well-Child Visits* indicators); therefore, are denoted as "NC." Current and previous years' NCQA Quality Compass national Medicaid 50th percentiles are provided in Appendix B for reference.

[5-1] The reference to "national Medicaid 50th percentile" is a general term used in this report to reference the benchmarking comparison made.

Aetna

Aetna's HEDIS measure results are shown in Table 5-1.[5-2]

Table 5-1—Aetna's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.77%	50.85%	43.87%	**49.15%**
Childhood Immunization Status				
Combination 3	64.58%	60.58%	67.45%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	1.24%	1.02%	1.98%	**1.65%**
One Well-Child Visit	0.74%	1.53%	0.74%	**NC**
Two Well-Child Visits	1.49%	2.55%	2.97%	**NC**
Three Well-Child Visits	6.44%	4.34%	6.44%	**NC**
Four Well-Child Visits	12.62%	10.46%	6.68%	**NC**
Five Well-Child Visits	16.09%	18.11%	20.05%	**NC**
Six or More Well-Child Visits	61.39%	61.99%	61.14%	**59.76%**
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	74.26%	68.85%	73.32%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	60.73%^	53.80%	53.60%	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	64.16%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	88.80%+	85.64%	87.63%	**85.19%**
Postpartum Care	65.03%+	64.89%	65.98%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	81.41%	**81.37%**
45–64 Years	—	—	91.01%	**87.84%**
65+ Years	—	—	90.39%	**87.52%**
Total	—	—	85.08%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	82.87%	83.21%	83.92%*	**86.20%**
HbA1c Control (<8.0%)	47.69%	48.42%	48.46%*	**47.91%**

[5-2] Aetna was formerly known as CoventryCares. CoventryCare's historical rates (i.e., HEDIS 2014 and HEDIS 2015) are presented for comparison.

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Eye Exam (Retinal) Performed	49.54%	54.26%	53.19%*	**54.74%**
Medical Attention for Nephropathy	—	—	91.25%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	59.95%	58.15%	58.39%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.18%+	58.56%	59.08%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	54.44%	
Medication Compliance 75%—Total	—	—	27.96%	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	79.31%	**76.74%**
Discussing Cessation Medications	—	—	52.25%	**46.70%**
Discussing Cessation Strategies	—	—	42.61%	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.12%	46.71%	50.94%	**50.51%**
Effective Continuation Phase Treatment	34.87%	29.25%	33.49%	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	30.68%	**40.79%**
Continuation and Maintenance Phase	—	—	43.24%	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	66.32%	54.79%	56.98%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	NA	
6–11 Years	—	—	44.44%	
12–17 Years	—	—	38.89%	
Total	—	—	41.35%	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

+ Indicates that the measure rate was reported using the auditorlocked IDSS file; however, this rate was reported differently in the 2014 Annual Technical Report, using rates reported directly to DMAS.

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

Within the Children's Preventive Care domain, Aetna's rates met or exceeded the national Medicaid 50th percentile for two of the five measure indicators with benchmarks in 2016, including *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Conversely, Aetna's rate for *Adolescent Well-Care Visits* was at or above the national Medicaid 50th percentile in 2014 and 2015; however, performance declined by almost 7 percentage points from 2015 to 2016, and Aetna did not meet the national Medicaid 50th percentile. Although the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* measure indicator met or exceeded the national Medicaid 50th percentile in 2015, the 2016 measure performance nearly doubled, falling below the national Medicaid 50th percentile, suggesting an opportunity for improvement. Further, although the rates for the *Childhood Immunization Status—Combination 3* measure indicator declined from 2014 to 2015 and increased from 2015 to 2016 by approximately 7 percentage points, the rate continued to fall below the national Medicaid 50th percentile, indicating an opportunity for improvement.

For the Women's Health domain, Aetna's rates consistently met or exceeded the national Medicaid 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators from 2014 to 2016. Further, Aetna's rate for *Cervical Cancer Screening* met or exceeded the national Medicaid 50th percentiles in 2016. Conversely, the rate for *Breast Cancer Screening* declined in performance from 2014 to 2015 by almost 7 percentage points and remained stable from 2015 to 2016, continuing to fall below the national Medicaid 50th percentile, indicating an opportunity for improvement.

For the Access to Care domain, Aetna's rates for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators met or exceeded the national Medicaid 50th percentiles, indicating an area of strength for Aetna.

Aetna's rates met or exceeded the national Medicaid 50th percentiles for seven of the 11 Care for Chronic Conditions measure indicators in 2016: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Medical Attention for Nephropathy, Controlling High Blood Pressure, Medication Management for People With Asthma—Medication Compliance 50%*, and all three *Medical Assistance With Smoking and Tobacco Use Cessation* indicators. Aetna consistently met or exceeded the national Medicaid 50th percentile for *Controlling High Blood Pressure* from 2014 to 2016. Further, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* performed 9.5 percentage points above the national Medicaid 50th percentile in 2016. For the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator, Aetna's rate was below the national Medicaid 50th percentile in 2014; however, the rate increased slightly in 2015 and 2016, resulting in performance at or above the national Medicaid 50th percentile. Two *Comprehensive Diabetes Care* measure indicator rates (*HbAlc Testing* and *Blood Pressure Control [<140/90 mm Hg]*) remained stable from 2014 to 2016 and continued to fall below the national Medicaid 50th percentile. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. Finally, the *Medication Management for People With Asthma—Medication Compliance 75%* measure indicator rate fell slightly below the national Medicaid 50th percentile in 2016, demonstrating opportunities for improvement.

For measure indicators within the Behavioral Health domain, one measure indicator, *Antidepressant Medication Management—Effective Acute Phase Treatment*, met or exceeded the national Medicaid 50th percentile in 2016. Conversely, the *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure indicator rate declined in performance from 2014 to 2015 by over 5 percentage points and improved slightly from 2015 to 2016; however, the rate continued to fall below the national Medicaid 50th percentile. Further, the rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* declined by more than 11 percentage points from 2014 to 2015 and increased slightly in 2016; however, the 2016 rate fell below the national Medicaid 50th percentile by approximately 10 percentage points, suggesting an opportunity for improvement. For 2016, both *Follow-Up Care for Children Prescribed ADHD Medication* measure indicators, *Initiation Phase* and *Continuation and Maintenance Phase*, were approximately 10 and 7 percentage points below the national Medicaid 50th percentile, respectively. Therefore, opportunities exist for improvement in the Behavioral Health domain measures.

Anthem

Anthem's HEDIS measure results are shown in Table 5-2.

Table 5-2—Anthem's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	45.12%	53.24%	59.49%	**49.15%**
Childhood Immunization Status				
Combination 3	58.70%	72.45%	89.79%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.47%	2.13%	0.50%	**1.65%**
One Well-Child Visit	0.70%	0.80%	1.50%	**NC**
Two Well-Child Visits	0.70%	0.80%	1.50%	**NC**
Three Well-Child Visits	3.04%	3.46%	3.51%	**NC**
Four Well-Child Visits	8.88%	9.31%	6.27%	**NC**
Five Well-Child Visits	17.76%	18.88%	14.29%	**NC**
Six or More Well-Child Visits	68.46%	64.63%	72.43%	**59.76%**
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	77.26%	77.08%	75.24%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	54.13%^	53.71%	51.19%	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	64.68%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	88.98%	86.18%	89.74%	**85.19%**
Postpartum Care	63.84%	63.47%	66.20%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	84.40%	**81.37%**
45–64 Years	—	—	92.20%	**87.84%**
65+ Years	—	—	91.12%	**87.52%**
Total	—	—	87.21%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	82.51%	83.95%	81.48%*	**86.20%**
HbA1c Control (<8.0%)	45.07%	50.93%	53.70%*	**47.91%**

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Eye Exam (Retinal) Performed	45.74%	46.51%	47.92%*	**54.74%**
Medical Attention for Nephropathy	—	—	90.28%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	54.93%	61.63%	60.42%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.73%	58.24%	57.94%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	50.36%	
Medication Compliance 75%—Total	—	—	25.92%	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	78.81%	**76.74%**
Discussing Cessation Medications	—	—	47.01%	**46.70%**
Discussing Cessation Strategies	—	—	39.41%	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.11%	50.03%	47.24%	**50.51%**
Effective Continuation Phase Treatment	33.01%	36.81%	33.63%	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	40.66%	**40.79%**
Continuation and Maintenance Phase	—	—	51.54%	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	61.42%	60.09%	61.46%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	NA	
6–11 Years	—	—	43.28%	
12–17 Years	—	—	41.57%	
Total	—	—	42.36%	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

Anthem's Children's Preventive Care measures met or exceeded the national Medicaid 50th percentile for all five measure indicators with benchmarks in 2016: *Adolescent Well-Care Visits*, *Childhood Immunization Status—Combination 3*, *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Anthem also consistently met or exceeded the national Medicaid 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* from 2014 to 2016. Performance for *Adolescent Well-Care Visits* increased approximately 6 percentage points from 2015 to 2016. Further, Anthem's rates for the *Childhood Immunization Status—Combination 3* measure indicator increased by approximately 17 percentage points from 2015 to 2016, demonstrating a strength for Anthem.

Within the Women's Health domain, rates remained stable for all measure indicators from 2014 to 2016. Notably, Anthem consistently met or exceeded the national Medicaid 50th percentile for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* in 2014, 2015, and 2016; and Anthem's rate for *Prenatal and Postpartum Care—Postpartum Care* was at or above the national Medicaid 50th percentile in 2015 and 2016. Further, Anthem met or exceeded the national Medicaid 50th percentile for *Cervical Cancer Screening* in 2016. For the *Breast Cancer Screening* measure, an opportunity for improvement exists for Anthem as the rate fell below the national Medicaid 50th percentile by approximately 7 percentage points.

For the Access to Care domain, Anthem's rates for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators met or exceeded the national Medicaid 50th percentiles, indicating an area of strength for Anthem.

Anthem's rates met or exceeded the national Medicaid 50th percentiles for five of the 11 Care for Chronic Conditions measure indicators with benchmarks in 2016, including *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Medical Attention for Nephropathy*, *Controlling High Blood Pressure*, and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*. For the remaining *Comprehensive Diabetes Care* measure indicators (*HbA1c Testing*, *Eye Exam [Retinal] Performed*, and *Blood Pressure Control [<140/90 mm Hg]*) all rates remained relatively stable for 2014, 2015, and 2016; and only one indicator (*Eye Exam [Retinal] Performed*) was below the national Medicaid 50th percentile by more than 6 percentage points. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. Further, the *Controlling High Blood Pressure* rate remained stable and consistently met or exceeded the national Medicaid 50th percentile for 2015 and 2016, indicating an area of strength for Anthem.

For the Behavioral Health domain, Anthem's rates remained consistent and were at or above the national Medicaid 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*. Anthem's rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator remained stable from 2014 to 2016, although the rate in 2016 fell below the national Medicaid 50th percentile by approximately 5 percentage points, suggesting an opportunity for improvement.

INTotal

INTotal's HEDIS measure results are shown in Table 5-3.

Table 5-3—INTotal's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.05%	46.26%+	50.23%	**49.15%**
Childhood Immunization Status				
Combination 3	69.54%	71.78%	69.91%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	1.99%	2.30%	0.97%	**1.65%**
One Well-Child Visit	0.88%	0.51%	0.97%	**NC**
Two Well-Child Visits	2.87%	2.04%	0.97%	**NC**
Three Well-Child Visits	4.42%	3.83%	3.88%	**NC**
Four Well-Child Visits	9.05%	11.22%	9.22%	**NC**
Five Well-Child Visits	19.65%	18.37%	25.73%	**NC**
Six or More Well-Child Visits	61.15%	61.73%	58.25%	**59.76%**
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	76.82%	78.69%	76.90%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	45.37%^	45.11%	48.41%	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	55.94%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.85%	72.02%	63.87%	**85.19%**
Postpartum Care	61.50%	52.55%	45.45%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	78.75%	**81.37%**
45–64 Years	—	—	90.27%	**87.84%**
65+ Years	—	—	89.63%	**87.52%**
Total	—	—	83.84%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.02%	85.89%	87.86%*	**86.20%**
HbA1c Control (<8.0%)	36.44%	46.96%	39.96%*	**47.91%**
Eye Exam (Retinal) Performed	38.46%	45.26%	42.16%*	**54.74%**

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Medical Attention for Nephropathy	—	—	90.07%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	55.87%	59.12%	51.43%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	54.05%	55.50%	49.11%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	49.22%	
Medication Compliance 75%—Total	—	—	22.49%	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	74.91%	**76.74%**
Discussing Cessation Medications	—	—	48.39%	**46.70%**
Discussing Cessation Strategies	—	—	36.82%	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.96%	48.31%	52.63%	**50.51%**
Effective Continuation Phase Treatment	34.03%	33.11%	35.20%	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	54.98%	**40.79%**
Continuation and Maintenance Phase	—	—	70.59%	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	50.45%	48.26%	59.45%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	NA	
6–11 Years	—	—	NA	
12–17 Years	—	—	66.00%	
Total	—	—	62.20%	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

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

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

Within the Children's Preventive Care domain, INTotal met or exceeded the national Medicaid 50th percentile for three of the five measure indicators with benchmarks in 2016, including *Adolescent Well-Care Visits*, *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.* For the *Adolescent Well-Care Visits* measure, the rate increased by almost 4 percentage points from 2015 and met the national Medicaid 50th percentile in 2016. Further, INTotal's rate decreased by more than 50 percent for the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* indicator from 2015 to 2016, demonstrating a strength for INTotal. Also, INTotal consistently met or exceeded the national Medicaid 50th percentile for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* from 2014 to 2016.

No INTotal rates in the Women's Health domain met the national Medicaid 50th percentiles in 2016, indicating opportunities for improvement. The *Breast Cancer Screening* rate remained relatively stable from 2014 to 2016, and the rate was approximately 10 percentage points below the national Medicaid 50th percentile in 2016. Further, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate decreased in performance from 2015 by approximately 8 percentage points and fell below the national Medicaid 50th percentile in 2016 by over 21 percentage points. For the *Prenatal and Postpartum Care—Postpartum Care* rate, performance declined by approximately 7 percentage points from 2015; and the rate fell below the national Medicaid 50th percentile in 2016 by approximately 17 percentage points.

For the Access to Care domain, INTotal's rates for three of the four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators met or exceeded the national Medicaid 50th percentiles, indicating an area of strength for INTotal.

For the Care for Chronic Conditions domain, INTotal met or exceeded the national Medicaid 50th percentile for three of the 11 measure indicators with benchmarks in 2016, including *Comprehensive Diabetes Care—HbA1c Testing* and *Medical Attention for Nephropathy*, and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications.* INTotal also consistently met or exceeded the national Medicaid 50th percentile for *Comprehensive Diabetes Care—HbA1c Testing* from 2014 to 2016. Conversely, INTotal's rate for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* met or exceeded the national Medicaid 50th percentile in 2015, but performance subsequently declined by 7 percentage points and fell below the national Medicaid 50th percentile in 2016. For the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator, INTotal's rate was relatively stable from 2014 to 2015; however, performance declined in 2016 by almost 8 percentage points, suggesting an opportunity for improvement. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. INTotal's rate for *Controlling High Blood Pressure* decreased by approximately 6 percentage points from 2015 and fell below the national Medicaid 50th percentile by approximately 8 percentage points in 2016.

For the Behavioral Health domain, INTotal met or exceeded the national Medicaid 50th percentile for six of the seven reportable rates that were compared to national Medicaid benchmarks: both *Antidepressant Medication Management* indicators, both *Follow-up Care for Children Prescribed ADHD Medication* indicators, and both *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicators with reportable rates. Further, although INTotal's

performance for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator increased by approximately 11 percentage points from 2015, the rate fell below the national Medicaid 50th percentile by approximately 7 percentage points in 2016.

Kaiser Permanente

Kaiser Permanente's HEDIS measure results are shown in Table 5-4. Kaiser Permanente did not report rates for HEDIS 2014 and HEDIS 2015; therefore, rates are not displayed. Further, due to Kaiser Permanente's small population size for HEDIS 2016, please use caution when interpreting results.

Table 5-4—Kaiser Permanente's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	—	—	58.04%	**49.15%**
Childhood Immunization Status				
Combination 3	—	—	67.80%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	—	—	1.04%	**1.65%**
One Well-Child Visit	—	—	1.04%	**NC**
Two Well-Child Visits	—	—	0.00%	**NC**
Three Well-Child Visits	—	—	2.08%	**NC**
Four Well-Child Visits	—	—	16.67%	**NC**
Five Well-Child Visits	—	—	34.38%	**NC**
Six or More Well-Child Visits	—	—	44.79%	**59.76%**
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%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	—	NA	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	80.17%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	—	—	90.26%	**85.19%**
Postpartum Care	—	—	89.14%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	87.42%	**81.37%**
45–64 Years	—	—	90.16%	**87.84%**
65+ Years	—	—	78.26%	**87.52%**
Total	—	—	87.23%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	—	—	97.18%*	**86.20%**
HbA1c Control (<8.0%)	—	—	77.46%*	**47.91%**
Eye Exam (Retinal) Performed	—	—	88.73%*	**54.74%**

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Medical Attention for Nephropathy	—	—	97.18%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	—	—	78.87%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	—	75.56%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	NA	
Medication Compliance 75%—Total	—	—	NA	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	NA	**76.74%**
Discussing Cessation Medications	—	—	NA	**46.70%**
Discussing Cessation Strategies	—	—	NA	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	—	NA	**50.51%**
Effective Continuation Phase Treatment	—	—	NA	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	NA	**40.79%**
Continuation and Maintenance Phase	—	—	NA	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	—	77.78%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	NA	
6–11 Years	—	—	NA	
12–17 Years	—	—	NA	
Total	—	—	NA	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

Within the Children's Preventive Care domain, Kaiser Permanente met or exceeded the national Medicaid 50th percentile for three of the five measure indicators with benchmarks in 2016, including *Adolescent Well-Care Visits, Well-Child Visits in the First 15 Months of Life—No Well-Child Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. For the *Adolescent Well-Care Visits* measure, the 2016 rate exceeded the national Medicaid 50th percentile by almost 9 percentage points, indicating an area for strength for Kaiser Permanente. Conversely, the rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* in 2016 fell below the national Medicaid 50th percentile by approximately 15 percentage points, indicating an opportunity for improvement.

Within the Women's Health domain, Kaiser Permanente's measure rates met or exceeded the national Medicaid 50th percentile for three measure indicators with reportable rates and benchmarks in 2016, including *Cervical Cancer Screening* and both *Prenatal and Postpartum Care* indicators. For the *Cervical Cancer Screening* measure, the rate in 2016 exceeded the national Medicaid 50th percentile by approximately 19 percentage points. Similarly, the *Prenatal and Postpartum Care—Postpartum Care* rate in 2016 exceeded the national Medicaid 50th percentile by approximately 26 percentage points, indicating an area of strength for Kaiser Permanente.

For the Access to Care domain, Kaiser Permanente's rates for three of the four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators met or exceeded the national Medicaid 50th percentile, indicating an area of strength for Kaiser Permanente.

For the Care for Chronic Conditions measure set, Kaiser Permanente met or exceeded the national Medicaid 50th percentile for all six measure indicators with reportable rates and benchmarks in 2016, including all five *Comprehensive Diabetes Care* measure indicators and *Controlling High Blood Pressure*. All *Comprehensive Diabetes Care* measure indicator rates exceeded the national Medicaid 50th percentiles by almost 11 percentage points (*HbA1c Testing*) and up to approximately 34 percentage points (*Eye Exam [Retinal] Performed*). However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. Further, the *Controlling High Blood Pressure* rate exceeded the national Medicaid 50th percentile by approximately 18 percentage points, suggesting an area of strength for Kaiser Permanente.

For the Behavioral Health domain, Kaiser Permanente met or exceeded the national Medicaid 50th percentile for one measure indicator with a reportable rate and benchmarks in 2016: *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*. Further, the rate for this measure exceeded the national Medicaid 50th percentile by approximately 11 percentage points, indicating a strength for Kaiser Permanente.

Optima

Optima's HEDIS measure results are shown in Table 5-5.

Table 5-5—Optima's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	46.53%	46.53%	44.44%	**49.15%**
Childhood Immunization Status				
Combination 3	65.97%	65.97%	72.69%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.56%	0.56%	1.37%	**1.65%**
One Well-Child Visit	1.39%	1.39%	0.55%	**NC**
Two Well-Child Visits	2.22%	2.22%	3.01%	**NC**
Three Well-Child Visits	3.33%	3.33%	2.46%	**NC**
Four Well-Child Visits	6.94%	6.94%	7.92%	**NC**
Five Well-Child Visits	15.00%	15.00%	16.94%	**NC**
Six or More Well-Child Visits	70.56%	70.56%	67.76%	**59.76%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.32%	71.39%	74.17%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	57.43%^	55.87%	54.92%	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	65.80%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.66%	75.29%	81.71%	**85.19%**
Postpartum Care	65.34%	58.28%	59.03%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	83.74%	**81.37%**
45–64 Years	—	—	91.96%	**87.84%**
65+ Years	—	—	92.76%	**87.52%**
Total	—	—	86.67%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	84.41%	84.95%	89.35%*	**86.20%**
HbA1c Control (<8.0%)	50.56%	53.70%	52.55%*	**47.91%**
Eye Exam (Retinal) Performed	48.55%	45.83%	48.84%*	**54.74%**

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Medical Attention for Nephropathy	—	—	90.74%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	52.34%	56.71%	56.71%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	54.53%	48.72%	51.39%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	54.80%	
Medication Compliance 75%—Total	—	—	31.45%	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	80.69%	**76.74%**
Discussing Cessation Medications	—	—	46.42%	**46.70%**
Discussing Cessation Strategies	—	—	44.38%	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	44.85%	46.39%	48.80%	**50.51%**
Effective Continuation Phase Treatment	32.05%+	33.38%	35.40%	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	38.77%	**40.79%**
Continuation and Maintenance Phase	—	—	47.76%	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	62.61%	63.66%	53.58%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	66.67%	
6–11 Years	—	—	44.58%	
12–17 Years	—	—	50.57%	
Total	—	—	49.11%	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

+ Indicates that the measure rate was reported using the auditor-locked IDSS file; however, this rate was reported differently in the 2014 Annual Technical Report using rates reported directly to DMAS.

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

For the Children's Preventive Care domain, Optima met or exceeded the national Medicaid 50th percentiles for four of the five measure indicators with benchmarks in 2016, including *Childhood Immunization Status—Combination 3*, *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Also, Optima consistently met or exceeded the national Medicaid 50th percentiles for the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits* measure indicators from 2014 to 2016. Further, Optima's *Childhood Immunization Status—Combination 3* rate increased by approximately 7 percentage points from 2015 in order to meet or exceed the national Medicaid 50th percentile in 2016, indicating an area of strength for Optima.

For the Women's Health domain, one of Optima's rates, *Cervical Cancer Screening*, met the national Medicaid 50th percentiles in 2016. Optima's *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate declined by approximately 8 percentage points from 2014 to 2015; however, the rate increased by approximately 6 percentage points from 2015 to 2016. Further, Optima met or exceeded the national Medicaid 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator in 2014; however, the rate decreased by approximately 7 percentage points from 2014 to 2015, and remained stable from 2015 to 2016. Therefore, opportunities exist for Optima to improve performance in the Women's Health domain.

For the Access to Care domain, Optima met or exceeded the national Medicaid 50th percentile for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, indicating an area of strength for Optima.

Optima's rates met or exceeded the national Medicaid 50th percentile in 2016 for seven of the 11 Care for Chronic Conditions measure indicators with benchmarks: three of the five *Comprehensive Diabetes Care* measure indicators (*HbA1c Testing, HbA1c Control (<8.0%)*, and *Medical Attention for Nephropathy*), both *Medication Management for People With Asthma* measure indicators, and two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* indicators. Further, Optima met or exceeded the national Medicaid 50th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* and *HbA1c Control (<8.0%)* measure indicators from 2014 to 2016. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. In addition, the *Controlling High Blood Pressure* rate remained stable from 2014 to 2016; however, the rate fell below the national Medicaid 50th percentile by approximately 6 percentage points in 2016, indicating an opportunity for improvement.

Two of Optima's rates in the Behavioral Health domain met or exceeded the national Medicaid 50th percentile in 2016, including *Antidepressant Medication Management—Effective Continuation Phase* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–5 Years*. The remaining measure rates remained stable in performance from 2014 to 2016. However, the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* rate decreased by approximately 10 percentage points from 2015 to 2016, and fell below the national Medicaid 50th percentile by approximately 13 percentage points, indicating an opportunity for improvement.

VA Premier

VA Premier's HEDIS measure results are shown in Table 5-6.

Table 5-6—VA Premier's HEDIS Measure Results

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	46.58%	49.67%	45.70%	**49.15%**
Childhood Immunization Status				
Combination 3	57.40%	72.41%	72.19%	**71.53%**
Well-Child Visits in the First 15 Months of Life				
No Well-Child Visits[2]	0.66%	0.00%	0.44%	**1.65%**
One Well-Child Visit	0.88%	1.77%	1.32%	**NC**
Two Well-Child Visits	2.21%	1.55%	2.21%	**NC**
Three Well-Child Visits	3.09%	5.96%	3.75%	**NC**
Four Well-Child Visits	11.04%	7.73%	8.83%	**NC**
Five Well-Child Visits	13.91%	13.69%	15.45%	**NC**
Six or More Well-Child Visits	68.21%	69.32%	67.99%	**59.76%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.74%	73.73%	70.42%	**72.02%**
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	53.68%^	52.43%	52.44%	**58.34%**
Cervical Cancer Screening				
Cervical Cancer Screening	—	—	61.92%	**61.05%**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.66%	84.89%	80.13%	**85.19%**
Postpartum Care	62.47%	63.33%	60.93%	**62.77%**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	—	85.99%	**81.37%**
45–64 Years	—	—	93.42%	**87.84%**
65+ Years	—	—	91.92%	**87.52%**
Total	—	—	88.86%	**83.84%**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.32%	86.20%	84.43%*	**86.20%**
HbA1c Control (<8.0%)	44.04%	49.46%	39.08%*	**47.91%**

Performance Measures	HEDIS 2014 Rate (CY2013)	HEDIS 2015 Rate (CY2014)	HEDIS 2016 Rate (CY2015)	NCQA Quality Compass 50th Percentile for HEDIS 2015[1]
Eye Exam (Retinal) Performed	55.05%	53.64%	49.47%*	**54.74%**
Medical Attention for Nephropathy	—	—	89.62%*	**81.75%**
Blood Pressure Control (<140/90 mm Hg)	50.76%	61.86%	50.99%*	**62.23%**
Controlling High Blood Pressure				
Controlling High Blood Pressure	52.34%	59.47%	51.35%	**57.53%**
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	—	59.77%	
Medication Compliance 75%—Total	—	—	33.39%	**29.60%**
Medical Assistance With Smoking and Tobacco Use Cessation				
Advising Smokers and Tobacco Users to Quit	—	—	84.75%	**76.74%**
Discussing Cessation Medications	—	—	50.00%	**46.70%**
Discussing Cessation Strategies	—	—	40.47%	**42.50%**
Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.53%	51.29%	68.89%	**50.51%**
Effective Continuation Phase Treatment	36.82%	35.89%	54.87%	**34.02%**
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	—	54.78%	**40.79%**
Continuation and Maintenance Phase	—	—	66.33%	**50.61%**
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	56.77%	66.44%	64.75%	**66.64%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–5 Years	—	—	NA	
6–11 Years	—	—	65.98%	
12–17 Years	—	—	63.23%	
Total	—	—	64.12%	

[1] NCQA Quality Compass 50th percentile for HEDIS 2015 values are provided for informational purposes.

[2] A lower rate indicates better performance for this measure.

— Indicates that HEDIS 2016 was the first required year of measure reporting; therefore, rates are not presented for historical years (i.e., HEDIS 2014 and HEDIS 2015).

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

^ HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. As a result, the HEDIS 2014 rate was not compared to the NCQA Quality Compass national Medicaid HMO 50th percentile for HEDIS 2013. Caution should be exercised when comparing HEDIS 2014 (or later) rates to prior years.

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

NC indicates that the comparisons to the national Medicaid 50th percentile were not appropriate.

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Indicates when comparisons to the national Medicaid 50th percentile were made, but exact values cannot be published.

VA Premier's Children's Preventive Care performance met or exceeded the national Medicaid 50th percentiles for three of five measure indicators with benchmarks in 2016. VA Premier' s performance consistently met or exceeded the national Medicaid 50th percentiles for the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits* measure indicators from 2014 to 2016. Although VA Premier's *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* performance was a demonstrated strength in 2016, the prior year's result was 0.00%, which is the highest possible performance for this measure indicator; therefore, HSAG recommends that VA Premier investigate potential reasons for this decline in performance. Further, VA Premier's rate for *Childhood Immunization Status—Combination 3* met or exceeded the national Medicaid 50th percentile in 2015 and 2016.

For the Women's Health domain, rates for one of the four measure indicators, *Cervical Cancer Screening*, met or exceeded the national Medicaid 50th percentiles in 2016. Although the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators met or exceeded the national Medicaid 50th percentile in 2015, both rates slightly declined in 2016 and fell below the national Medicaid 50th percentile. Further, although the rate for *Breast Cancer Screening* remained stable from 2014 to 2016, the rate in 2016 fell below the national Medicaid 50th percentile by almost 6 percentage points, indicating an opportunity for improvement.

For the Access to Care domain, VA Premier met or exceeded the national Medicaid 50th percentile for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, indicating an area of strength.

As part of the Care for Chronic Conditions domain, VA Premier's rates met or exceeded the national Medicaid 50th percentiles for five of the 11 measures with benchmarks in 2016, including *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, both *Medication Management for People With Asthma* indicators, and two of the three *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators. Two of the *Comprehensive Diabetes Care* measure indicators, *HbA1c Control* and *Blood Pressure Control (<140/90 mm Hg)*, rates declined in performance from 2015 to 2016 by 10.38 and 10.87 percentage points, respectively, and fell below the national Medicaid 50th percentile. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. Further, VA Premier's rate for *Controlling High Blood Pressure* in 2015 was at or above the national Medicaid 50th percentile; however, the rate in 2016 declined by approximately 8 percentage points and fell below the national Medicaid 50th percentile, indicating an opportunity for improvement.

For the Behavioral Health domain, reportable rates for seven of the 9 measures met or exceeded the national Medicaid 50th percentile in 2016, including both *Antidepressant Medication Management* measure indicators, both *Follow-Up Care for Children Prescribed ADHD Medication* measure indicators, and three *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicators with reportable rates. VA Premier's rates consistently met or exceeded the national Medicaid 50th percentile for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* from 2014 to 2016. Further, the

rates in 2016 for the *Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators increased by approximately 18 and 19 percentage points from 2015, indicating an area of strength for VA Premier. Further, the rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phases* in 2016 exceeded the national Medicaid 50th percentiles by approximately 14 and 16 percentage points, respectively.

MCO Comparative and Virginia Aggregate HEDIS Measure Results

Table 5-7 displays, by MCO, the HEDIS measure results compared to the national Medicaid 50th percentiles for HEDIS 2015 and the Virginia aggregate, which represents the average of all six MCOs' rates weighted by the eligible population.[5-3] Yellow-shaded boxes indicate MCO rates that were at or above the national Medicaid 50th percentiles. Rates scoring above the Virginia aggregates are represented in green font. Certain measures are not appropriate for comparisons to benchmarks (i.e., *Well-Child Visits in the First 15 Months of Life—One, Two, Three, Four,* and *Five Well-Child Visits* indicators) as rates for these measure indicators are descriptive and not related to performance; therefore, Virginia aggregate rates for these measure indicators were not calculated and are denoted with "NC."

Table 5-7—MCO Comparative and Virginia Aggregate HEDIS 2016 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	43.87%	**59.49%**	50.23%	**58.04%**	44.44%	45.70%	**50.67%**
Childhood Immunization Status							
Combination 3	67.45%	**89.79%**	69.91%	67.80%	72.69%	72.19%	**78.13%**
Well-Child Visits in the First 15 Months of Life							
No Well-Child Visits[1]	1.98%	**0.50%**	0.97%	1.04%	1.37%	**0.44%**	**0.82%**
One Well-Child Visit	0.74%	1.50%	0.97%	1.04%	0.55%	1.32%	**NC**
Two Well-Child Visits	2.97%	1.50%	0.97%	0.00%	3.01%	2.21%	**NC**
Three Well-Child Visits	6.44%	3.51%	3.88%	2.08%	2.46%	3.75%	**NC**
Four Well-Child Visits	6.68%	6.27%	9.22%	16.67%	7.92%	8.83%	**NC**
Five Well-Child Visits	20.05%	14.29%	25.73%	34.38%	16.94%	15.45%	**NC**
Six or More Well-Child Visits	61.14%	**72.43%**	58.25%	44.79%	67.76%	67.99%	**68.18%**
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%	**75.24%**	**76.90%**	**74.76%**	**74.17%**	70.42%	**73.84%**

[5-3] For the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, the Virginia aggregate rates were not weighted because the MCOs' eligible population sizes were not available.

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Women's Health							
Breast Cancer Screening							
Breast Cancer Screening	**53.60%**	51.19%	48.41%	NA	**54.92%**	52.44%	**52.50%**
Cervical Cancer Screening							
Cervical Cancer Screening	**64.16%**	**64.68%**	55.94%	**80.17%**	**65.80%**	61.92%	**63.79%**
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	**87.63%**	**89.74%**	63.87%	**90.26%**	81.71%	80.13%	**83.56%**
Postpartum Care	**65.98%**	**66.20%**	45.45%	**89.14%**	59.03%	60.93%	**62.04%**
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
20–44 Years	81.41%	**84.40%**	78.75%	**87.42%**	83.74%	**85.99%**	**84.21%**
45–64 Years	91.01%	92.20%	90.27%	90.16%	91.96%	**93.42%**	**92.30%**
65+ Years	90.39%	91.12%	89.63%	78.26%	**92.76%**	**91.92%**	**91.24%**
Total	85.08%	**87.21%**	83.84%	**87.23%**	86.67%	**88.86%**	**87.21%**
Care for Chronic Conditions							
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing[*]	83.92%	81.48%	**87.86%**	**97.18%**	**89.35%**	84.43%	**84.85%**
HbA1c Control (<8.0%)[*]	**48.46%**	**53.70%**	39.96%	**77.46%**	**52.55%**	39.08%	**47.85%**
Eye Exam (Retinal) Performed[*]	**53.19%**	47.92%	42.16%	**88.73%**	**48.84%**	**49.47%**	**48.75%**
Medical Attention for Nephropathy[*]	**91.25%**	**90.28%**	90.07%	**97.18%**	**90.74%**	89.62%	**90.26%**
Blood Pressure Control (<140/90 mm Hg)[*]	**58.39%**	**60.42%**	51.43%	**78.87%**	**56.71%**	50.99%	**56.04%**
Controlling High Blood Pressure							
Controlling High Blood Pressure	**59.08%**	**57.94%**	49.11%	**75.56%**	51.39%	51.35%	**54.01%**
Medication Management for People With Asthma							
Medication Compliance 50%—Total	54.44%	50.36%	49.22%	NA	**54.80%**	**59.77%**	**54.56%**
Medication Compliance 75%—Total	27.96%	25.92%	22.49%	NA	**31.45%**	**33.39%**	**29.65%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	79.31%	78.81%	74.91%	NA	**80.69%**	**84.75%**	**79.69%**
Discussing Cessation Medications	**52.25%**	47.01%	48.39%	NA	46.42%	**50.00%**	**48.81%**

Performance Measures	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Virginia Aggregate
Discussing Cessation Strategies	**42.61%**	39.41%	36.82%	NA	**44.38%**	40.47%	**40.74%**
Behavioral Health							
Antidepressant Medication Management							
Effective Acute Phase Treatment	50.94%	47.24%	52.63%	NA	48.80%	**68.89%**	**54.94%**
Effective Continuation Phase Treatment	33.49%	33.63%	35.20%	NA	35.40%	**54.87%**	**40.81%**
Follow-up Care for Children Prescribed ADHD Medication							
Initiation Phase	30.68%	40.66%	**54.98%**	NA	38.77%	**54.78%**	**44.11%**
Continuation and Maintenance Phase	43.24%	51.54%	**70.59%**	NA	47.76%	**66.33%**	**56.36%**
Follow-Up After Hospitalization for Mental Illness							
30-Day Follow-Up	56.98%	**61.46%**	59.45%	**77.78%**	53.58%	**64.75%**	**60.22%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
1–5 Years	NA	NA	NA	NA	**66.67%**	NA	**54.22%**
6–11 Years	44.44%	43.28%	NA	NA	44.58%	**65.98%**	**50.46%**
12–17 Years	38.89%	41.57%	**66.00%**	NA	50.57%	**63.23%**	**51.33%**
Total	41.35%	42.36%	**62.20%**	NA	49.11%	**64.12%**	**51.10%**

[1] A lower rate indicates better performance for this measure.

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

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

NC indicates that the comparisons to the Virginia aggregate were not appropriate.

***Note:** MCO measure rates scoring above the Virginia aggregate are represented in green.*

Indicates that the rate was at or above the corresponding national Medicaid 50th percentile (e.g., HEDIS 2016 Rate [CY2015] was at or above the 2015 national Medicaid 50th percentile).

Among the six MCOs, Anthem performed best on measures in the Children's Preventive Care domain as performance on all five performance measure indicators met or exceeded the national Medicaid 50th percentiles and the Virginia aggregate rates. Further, Anthem's rate for *Childhood Immunization Status—Combination 3* performed approximately 17 percentage points above the next highest performing MCO's rate. On the other hand, Aetna only met or exceeded the national Medicaid 50th percentiles for two measure indicators and all of Aetna's rates fell below the Virginia aggregate rates, suggesting opportunities for improvement. Of note, Kaiser Permanente's rate for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was approximately 13 percentage points below the next lowest performing MCO's rate for this measure indicator, demonstrating an opportunity for improvement for Kaiser Permanente.

Within the Women's Health domain, Aetna, Anthem, and Kaiser Permanente performed best as all three MCOs met or exceeded the national Medicaid 50th percentiles and the Virginia aggregate rates for three measure indicators. Kaiser Permanente's rate for *Prenatal and Postpartum Care—Postpartum Care* performed approximately 23 percentage points above the next highest performing MCO's rate for this measure indicator, demonstrating an area of strength. Conversely, INTotal demonstrated the most opportunities for improvement as all of INTotal's rates fell below the national Medicaid 50th percentiles and the Virginia aggregate rates. Further, all MCOs with reportable rates for the *Breast Cancer Screening* measure fell below the national Medicaid 50th percentile.

Among the six MCOs, Aetna, Anthem, Optima, and VA Premier met or exceeded the national Medicaid 50th percentiles for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators, demonstrating an area of strength in the Access to Care domain. Further, VA Premier was the only MCO to also perform above the Virginia aggregate rate for all four measure indicators. INTotal's rate for the *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* measure indicator and Kaiser Permanente's rate for the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* measure indicator fell below the national Medicaid 50th percentiles.

For the Care for Chronic Conditions domain, Aetna's and Optima's rates for seven of the 11 measure indicators were at or above the national Medicaid 50th percentile and at least seven rates were at or above the Virginia aggregate rate. Similarly, Kaiser Permanente met or exceeded the national Medicaid 50th percentiles and the Virginia aggregate rates for six measure indicators with reportable rates. Notably, all six MCOs met or exceeded the national Medicaid 50th percentile for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator. Further, only Kaiser Permanente's rate met or exceeded the national Medicaid 50th percentile for *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)*. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure indicators, caution should be used when comparing HEDIS 2016 rates to benchmarks derived from the previous year's results. Notably, Kaiser Permanente's reportable rates performed approximately 36 and 16 percentage points above the next highest performing MCO's rates for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator and *Controlling High Blood Pressure* measure, respectively. Conversely, INTotal demonstrated the most opportunity for improvement with only three measure indicators performing at or above the national Medicaid 50th percentiles.

Among the six MCOs, VA Premier demonstrated the best performance in the Behavioral Health domain with seven of eight measure indicators with reportable rates meeting or exceeding the national Medicaid 50th percentiles and the Virginia aggregate rates. INTotal also demonstrated positive performance, with six of seven measure indicators with reportable rates meeting or exceeding the national Medicaid 50th percentiles. Further, VA Premier's rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* were approximately 16 and 19 percentage points, respectively, above the next highest performing MCO with reportable rates for these measure indicators, demonstrating an area of strength. Similarly, INTotal's and VA Premier's rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* were more than 14 percentage points above the next highest performing MCO with reportable rates for these measure indicators. Notably, only Kaiser Permanente met or exceeded the

national Medicaid 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator, demonstrating opportunities for improvement for the remaining five MCOs. Further, Kaiser Permanente's rate for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator was approximately 13 percentage points above the next highest performing MCO's rate. Aetna and Anthem demonstrated the most opportunity for improvement within this domain as both MCOs' rates met or exceeded the national Medicaid 50th percentiles for only one of the eight measure indicators reported by the MCOs.

Performance Measure Validation Findings

Summary of PMV Process

Validation of performance measures is one of three mandatory EQR activities required by the Balanced Budget Act of 1997 (BBA) described at 42 CFR §438.358(b)(2). The purpose of PMV is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to which performance measures calculated by the MCOs follow state specifications and reporting requirements.

To meet PMV requirements, DMAS contracted with HSAG to conduct the PMV for the six MCOs, validating the data collection and reporting processes used to calculate the performance measure rates. HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures. HSAG validated a set of performance measures identified by DMAS that were calculated and reported by the MCOs for their Medicaid and FAMIS populations. HSAG conducted the validation in accordance with CMS' PMV protocol cited above.

HSAG focused on data used for calculating and reporting the performance measures for CY 2016 (January 1, 2015–December 31, 2015) for the HEDIS measures.

This section provides conclusions as to the strengths and areas of opportunity related to the quality, timeliness, and access to care provided by the Commonwealth of Virginia MCOs. Appendix A contains a full description of the methodology HSAG used to validate performance measures.

MCO Comparative HEDIS Measure Results

For the HEDIS measures validated by HSAG, no differences in measure performance for any MCO were identified. Please refer to Table 5-7 for each MCO's specific performance on *Controlling High Blood Pressure* and *Adults' Access to Preventive/Ambulatory Health Services*.

Pediatric Quality Measure Results

HSAG calculated the *NQF #2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics* (*APM*) performance measure rate for the measurement period of calendar year 2015. The measure steward is NCQA; and in accordance with HEDIS technical measure specifications, *APM* measures the percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing.[5-4] Measure rates are presented as percentages. Table 5-8 presents *APM* performance measure rates for Virginia stratified by geographic region, age group, gender, and race category.

Table 5-8—*APM* Measure Results

Rate Stratifications	Results (CY 2015)
Virginia Total Rate	
Virginia Total Rate	28.08%
Rates by Region	
Central Virginia	20.87%
Far Southwest Virginia	33.74%
Halifax	25.99%
Northern Virginia	25.94%
Lower Southwest Virginia	33.80%
Tidewater	29.34%
Upper Southwest Virginia	28.57%
Rates by Age Group	
1–5 Years	23.46%
6–11 Years	24.40%
12–17 Years	30.55%
Rates by Gender	
Male	27.11%
Female	29.81%
Rates by Race Category	
White	29.93%
Black/African American	25.55%
Asian	—
Southeast Asian/Pacific Islander	—
Hispanic	32.10%
More than one race/Other/Unknown	21.43%

— *Rate was not presented given that the numerator was composed of fewer than 11 cases.*

[5-4] National Committee for Quality Assurance. Healthcare Effectiveness Data and Information Set 2016, Volume 2, Technical Specifications.

Rates indicated that as age increased the percentage of child members having two or more antipsychotic prescriptions and metabolic testing increased for Medicaid managed care members. In addition, when evaluating child Medicaid managed care members in Virginia, it was determined that a higher percentage of females and individuals of Hispanic race had two or more antipsychotic prescriptions and had metabolic testing.

Conclusions

- Upon evaluation of the MCOs' HEDIS 2016 performance measure results, four of the six MCOs reported positive performance in the Children's Preventive Care domain. Specifically, for at least four MCOs, performance was at or above the national Medicaid 50th percentile for the *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure indicators. Further, for the four MCOs that performed at or above the national Medicaid 50th percentile in 2016 for the measures listed, performance for all three rates was relatively consistent from 2014 to 2016, with no MCO rates changing by more than 8 percentage points.
- Five of the six MCOs demonstrated positive performance in the Women's Health domain, with rates that met or exceeded the national Medicaid 50th percentile for *Cervical Cancer Screening*. Conversely, five of the six MCOs with reportable rates for the *Breast Cancer Screening* measure rates fell below the national Medicaid 50th percentile, indicating an opportunity for improvement. Further, for MCOs with reportable rates from 2014 to 2016 for the *Breast Cancer Screening* measure, performance consistently fell below the national Medicaid 50th percentiles across all three years.
- Four of the six MCOs demonstrated positive performance in the Access to Care domain, with rates that met or exceeded the national Medicaid 50th percentile for all four *Adults' Access to Preventive/Ambulatory Health Services* measure indicators.
- Within the Care for Chronic Conditions domain, various levels of performance were observed across all MCOs. All six MCOs reported positive results for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator, and four MCOs reported positive results for the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*. Conversely, five of the six MCOs rates fell below the national Medicaid 50th percentiles for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators, indicating opportunities for improvement. Further, only one MCO consistently exceeded the national Medicaid 50th percentiles from 2014 to 2016 for the *Comprehensive Diabetes Care—HbA1c Testing* and *HbA1c Control (<8.0%)* measure indicators. However, due to changes in the technical specifications for the *Comprehensive Diabetes Care* measure, exercise caution when trending and benchmarking rates for these measure indicators between 2016 and prior years. Three of the five MCOs with reportable rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicator met or exceeded the national Medicaid 50th percentile; however, only two of the five MCOs with reportable rates for the *Management for People With Asthma—Medication*

Compliance 75% measure indicator met or exceeded the national Medicaid 50th percentile, demonstrating an opportunity for improvement. The remaining MCO did not have reportable rates for these measure indicators; therefore, performance was not compared to national Medicaid percentiles. Similarly, four of the five MCOs with reportable rates for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Strategies* measure indicators met or exceeded the national Medicaid 50th percentile; however, only two of the five MCOs with reportable rates met or exceeded the national Medicaid 50th percentile for the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies* measure indicator, indicating an opportunity for improvement. The remaining MCO did not have reportable rates for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators.

- Measures in the Behavioral Health domain showed the greatest opportunity for improvement for most MCOs. Specifically, five of the six MCOs' rates fell below the national Medicaid 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* measure indicator in 2016. Further, performance for three MCOs consistently fell below the national Medicaid 50th percentile from 2014 to 2016, suggesting an opportunity for improvement. Rates for three of the five MCOs with reportable rates were below the national Medicaid 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator. One MCO did not have a reportable rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator; therefore, performance was not compared to national Medicaid percentile. Similarly, three of the four MCOs with reportable rates for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—6–11 Years* measure indicator fell below the national Medicaid 50th percentile. Two MCOs did not have reportable rates for this measure indicator; therefore, performance was not compared to national Medicaid percentiles. Three of the five MCOs with reportable rates for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—12–17 Years* and *Total* measure indicators fell below the national Medicaid 50th percentile, demonstrating an opportunity for improvement. One MCO did not have a reportable rate for these measure indicators; therefore, performance was not compared to national Medicaid percentiles. In this domain, three of the five MCOs with reportable rates for both A*ntidepressant Medication Management* measure indicators and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* performed at or above the national Medicaid 50th percentile, demonstrating an area of strength. The remaining MCO did not have a reportable rate for this measure indicator; therefore, performance was not compared to national Medicaid percentiles.

Recommendations

- HSAG continues to recommend that DMAS hold MCOs accountable for key HEDIS measure rates and assess performance at or above the national Medicaid 50th percentile. In future years, HSAG recommends that DMAS examine the option of raising the benchmark at which MCOs' HEDIS measure rates are evaluated if overall performance across MCOs shows marked improvement.

- Given the variation in MCO HEDIS rates within each domain, HSAG recommends that DMAS implement incentives for targeting key performance measures in order to facilitate performance improvement. DMAS may want to focus on performance measures related to chronic conditions (e.g., diabetes or hypertension).
- HSAG recommends that MCOs focus on key HEDIS measures, using small-scale, rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives. Over time, these interventions and initiatives should be monitored for successful performance improvement strategies.

6. Performance Improvement Projects

Introduction

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 PIPs is one of three mandatory EQR activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. As described in the CFR at 42 §438.240(b)(1), the Commonwealth of Virginia's (DMAS requires that contracted Medicaid MCOs conduct PIPs in accordance with 42 CFR §438.240[d]). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction.

One mandatory EQR activity under the BBA requires DMAS to validate PIPs. To meet this validation requirement, DMAS contracted with HSAG, as the EQRO. The BBA requires HSAG to assess each MCO's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" (42 CFR §438.364[a][2]).

HSAG, as Virginia's EQRO, validated the PIPs through an independent review process. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. In order for such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[6-1]

HSAG's validation of PIPs includes the following two key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of PDSA cycles, sustainability, and spreading successful

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

change. This component evaluates how well the MCO executed its quality improvement activities and whether the desired aim was achieved and sustained.

The goal of HSAG's PIP validation is to ensure that the MCO and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP.

Rapid-Cycle Approach

HSAG, along with some of its contracted states, has identified that while MCOs have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs have achieved real and sustained improvement. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to health care quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of health care by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement.

Because PIPs must meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within health care settings, a new approach was needed.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of PIPs using this new framework will be approximately 18 months, depending on the project and any challenges that may arise.

To improve outcomes, HSAG's rapid-cycle PIP process incorporates small-scale intervention testing, using PDSA cycles. For the rapid-cycle PIP framework, HSAG developed five modules with an accompanying companion guide:

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

- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is outlined and the data collection methodology is described. The data for the SMART Aim will be displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, the quality improvement activities that can impact the SMART Aim are identified. Through the use of process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a series of PDSA cycles.
- **Module 5—PIP Conclusions:** Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the MCO with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability and to assess the level of confidence in the reported findings.

Performance Improvement Project (PIP) Topics and Training

In 2016, the MCOs transitioned to conducting one DMAS-selected PIP topic focused on diabetes care using HSAG's rapid-cycle improvement model. The approach incorporates quality improvement science tools and places emphasis on improving outcomes using rapid-cycle methods to pilot small changes and subsequently spreading effective strategies to a larger population once that larger population is identified through testing results. Using data, each MCO narrowed the DMAS-selected PIP topic of diabetes care to an area in need of improvement (e.g., retinal eye exams for members assigned to a specific provider).

In April 2016, HSAG provided a high-level overview training to the MCOs on the rapid-cycle PIP process. HSAG provided more specific training on the Module 1 and Module 2 submission requirements in June 2016. Following, in October 2016, HSAG provided training on the Module 3 submission requirements. In addition, at the request of MCOs HSAG provides one-on-one technical assistance to answer questions and provide additional guidance on PIP methodology, the rapid-cycle process, and clarification on any feedback or recommendations HSAG has provided to the MCO after review of its submission for validation. In 2017, HSAG will train the MCOs on the Module 4 and Module 5 PIP submission requirements.

Aetna

For validation year 2016, Aetna Better Health of Virginia **(**Aetna) submitted one DMAS-mandated PIP topic for validation: *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes*. The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. 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. Aetna set a goal to increase each provider's rate 20 percentage points by December 31, 2017.

For the 2016 validation of Aetna's PIP, HSAG identified opportunities for improvement that included:

- Providing comparative data for additional providers and numerators for the baseline rates.
- Correcting the SMART Aim baseline rate to match the HEDIS 2016 rate.
- Updating the goals once the correct baseline rates are in the SMART Aim.
- Revising the key driver diagram.
- Correcting the SMART Aim numerator and denominator statement.
- Completing an accurate run chart.

After receiving technical assistance from HSAG, Aetna revised its modules and resubmitted them for validation. Aetna addressed HSAG's concerns in the Module 1 original submission; however, the number of eligible members for the narrowed focus providers did not match the original submission. For Module 2, Aetna corrected all areas for improvement; however, the run chart x-axis was not labeled correctly.

Table 6-1 depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016. An additional resubmission was required. Modules 3 through 5 have not yet been submitted.

Table 6-1—Status of the *Increasing Diabetic Retinal Exam Screenings Among Members Diagnosed with Diabetes* PIP

Module	Status
1. PIP Initiation	Achieved three of four validation criteria/resubmission required.
2. SMART Aim Data Collection	Achieved four of five validation criteria/resubmission required.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP validation report, Aetna's PIP was in the resubmission review process. HSAG had recommended the following prior to resubmission:

- (Module 1) The MCO should explain changes to the narrowed focus provider data.
- (Module 2) The MCO should include all monthly dates on the x-axis of the run chart.

Anthem

For validation year 2016, Anthem HealthKeepers Plus **(**Anthem) submitted one DMAS-mandated PIP topic for validation: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*. The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. 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. Anthem set a goal to increase the rate from 27.67 percent to 32.00 percent by December 31, 2017.

For the 2016 validation of Anthem's PIP, HSAG identified opportunities for improvement that included:

- Correcting the baseline measurement period.
- Correcting the SMART Aim end date.
- Reporting the Global Aim and key drivers accurately in the key driver diagram.
- Providing additional details about the data collection process that include having a continuous enrollment criterion and a 12-month rolling measurement methodology.
- Including a data collection tool for the medical record data collection.
- Depicting the SMART Aim run chart accurately.

After receiving technical assistance from HSAG, Anthem revised its modules and resubmitted them for validation. Anthem addressed HSAG's concerns in Module 1; however, the Global Aim was still too specific, and one of the key drivers needed to be corrected. For Module 2, Anthem corrected all areas for improvement identified by HSAG in the original submission.

Table 6-2 depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016. An additional resubmission of Module 1 was required. Modules 3 through 5 have not yet been submitted.

Table 6-2—Status of the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* PIP

Module	Status
1. PIP Initiation	Achieved three of four validation criteria/resubmission required.
2. SMART Aim Data Collection	Achieved all five validation criteria.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP validation report, Anthem's PIP Module 1 was in the resubmission review process. HSAG had recommended the following prior to resubmission:

- Anthem should revise the Global Aim to reflect an overarching outcome to which the PIP is contributing and correct the first key driver in the key driver diagram.

INTotal

For validation year 2016**,** INTotal Health (INTotal) submitted one DMAS-mandated PIP topic for validation: *Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members).* The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. 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 three primary care providers. INTotal set a goal to increase the rate 5 percentage points to 47.16 percent by December 31, 2017.

For the 2016 validation of INTotal's PIP, HSAG identified opportunities for improvement that included:

- Correcting the baseline measurement period.
- Providing the baseline rates for the narrowed focus providers.
- Having an adequate number of eligible population in the narrowed focus for the PIP.
- Including an executive sponsor in the PIP team.
- Correcting the SMART Aim end date.
- Stating the SMART Aim correctly.
- Reporting claims completeness within 30 days.
- Providing additional details about the data collection process that include having a 12-month rolling measurement methodology.
- Depicting the SMART Aim run chart accurately.

INTotal revised its modules and resubmitted them for validation. INTotal addressed some of HSAG's concerns in the Module 1 resubmission; however, some corrections were still needed. For Module 2, INTotal did not address opportunities for improvement regarding claims completeness, the data collection methodology, and SMART Aim run chart. The MCO received technical assistance from HSAG prior to resubmitting the modules for a second time.

Table 6-3 depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016. An additional resubmission was required. Modules 3 through 5 have not yet been submitted.

Table 6-3—Status of the *Let's Check Our Eyes! (An INTotal project to improve completion of retinal eye exams for diabetic members)* PIP

Module	Status
1. PIP Initiation	Achieved two of four validation criteria/resubmission required.
2. SMART Aim Data Collection	Achieved two of five validation criteria/resubmission required.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual validation report, INTotal's PIP was in the resubmission review process. HSAG had recommended that the MCO do the following in the resubmission:

- (Module 1) Provide the SMART Aim goal for each of the four narrowed focus providers.
- (Module 1) State the SMART Aim accurately.
- (Module 2) Indicate the percentage of claims completeness within 30 days.
- (Module 2) Correct the data collection methodology.
- (Module 2) Track the four SMART Aim goals and results on four run charts.

Kaiser Permanente

For validation year 2016, Kaiser Permanente submitted one DMAS-mandated PIP topic for validation: *Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes*. The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. 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.

For the 2016 validation of Kaiser Permanente's PIP, HSAG identified opportunities for improvement that included:

- Selecting a narrowed focus for the PIP.
- Correcting the SMART Aim end date.
- Correcting the SMART Aim measure.
- Providing additional details about the data collection process.
- Depicting the SMART Aim run chart accurately.

After receiving technical assistance from HSAG, Kaiser Permanente revised its modules and resubmitted them for validation. Kaiser Permanente addressed all opportunities for improvement in the resubmissions and passed both Module 1 and Module 2.

Table 6-4 depicts the status of the PIP at the time of the MCO's annual PIP validation report in November 2016. Modules 3 through 5 have not yet been submitted.

Table 6-4—Status of *the Improving the Eye Exam (Retinal Screening) Rate for Virginia Medicaid Adults with Diabetes* PIP

Module	Status
1. PIP Initiation	Achieved all four validation criteria.
2. SMART Aim Data Collection	Achieved all four applicable validation criteria.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

Kaiser Permanente passed Module 1 and Module 2 with the first resubmission. HSAG had recommended that Kaiser Permanente refer to the PIP Companion Guide regarding the Module 3 submission requirements and request technical assistance from HSAG if needed.

Optima

For validation year 2016, Optima Family Care **(**Optima) submitted one DMAS-mandated PIP topic for validation: *Diabetic Retinal Exam Compliance Rate*. The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to increase eye exams for diabetic members ages 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 10 percentage points to 48 percent by December 31, 2017.

For the 2016 validation of Optima's PIP, HSAG identified opportunities for improvement that included:

- Correcting the baseline measurement period.
- Correcting the SMART Aim end date and SMART Aim statement.
- Including only evidence-based strategies (active interventions) in the key driver diagram.
- Correcting the denominator statement.
- Providing additional details about the data collection process that include having a 12-month rolling measurement methodology.
- Depicting the SMART Aim run chart accurately.

Optima revised its modules and resubmitted them for validation. Optima addressed all of HSAG's concerns in Module 1; however, for Module 2, HSAG requested clarification from Optima regarding whether its rate calculation methodology was cumulative or a rolling 12-month measurement.

Table 6-5 depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016. Modules 3 through 5 have not yet been submitted.

Table 6-5—Status of the *Diabetic Retinal Exam Compliance Rate* PIP

Module	Status
1. PIP Initiation	Achieved all four validation criteria.
2. SMART Aim Data Collection	Achieved four of five validation criteria/resubmission required.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual PIP validation report, Optima's PIP Module 2 was in the resubmission review process. HSAG had recommended the following prior to resubmission:

- The MCO should provide more details on the rate calculation methodology.

VA Premier

For validation year 2016, Virginia Premier Health Plan, Inc. (VA Premier) submitted one DMAS-mandated PIP topic for validation: *Comprehensive Diabetes Care: Eye Exams*. The PIP topic addressed CMS' requirements related to quality outcomes—specifically, access to care and services. 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 five federally qualified health centers (FQHCs). VA Premier set a goal to increase the rate to 54.74 percent by December 31, 2017.

For the 2016 validation of VA Premier's PIP, HSAG identified opportunities for improvement that included:

- Correcting the baseline measurement period and baseline rate.
- Including the narrowed focus providers in the SMART Aim statement.
- Providing documentation of claims completeness within 30 days.
- Correcting the SMART Aim numerator and denominator statement.
- Providing additional details about the data collection process that include clarification about the 12-month rolling measurement methodology.
- Completing an accurate SMART Aim run chart.

After receiving technical assistance from HSAG, VA Premier revised its modules and resubmitted them for validation. VA Premier addressed most of HSAG's concerns in Module 1; however, the baseline rates for the narrowed focus providers appeared incorrect. For Module 2, VA Premier did not provide either documentation of claims data completeness or the data collection interval, and the SMART Aim run chart axes were not labeled accurately.

Table 6-6 depicts the status of the PIP for Module 1 and Module 2 at the time of the MCO's annual PIP validation report in November 2016. Modules 3 through 5 have not yet been submitted.

Table 6-6—Status of the *Comprehensive Diabetes Care: Eye Exams* PIP

Module	Status
1. PIP Initiation	Achieved three of four validation criteria/resubmission required.
2. SMART Aim Data Collection	Achieved one of four applicable validation criteria/resubmission required.
3. Intervention Determination	Scheduled to be submitted in December 2016.
4. Plan-Do-Study-Act	Scheduled to be submitted in March 2017.
5. PIP Conclusions	Scheduled to be submitted in February 2018.

At the time of the annual validation report, VA Premier's PIP was in the resubmission review process. HSAG had recommended that the MCO do the following in the resubmission:

- (Module 1) Correct the baseline rates for the narrowed focus providers.
- (Module 2) Provide documentation of claims data completeness within 30 days.
- (Module 2) Document the data collection interval.
- (Module 2) Label the SMART Aim run chart axes accurately.

Conclusions

For the 2016 annual validation, all MCOs completed and submitted Module 1 and Module 2 (PIP Initiation and SMART Aim Data Collection) to HSAG for review and feedback. Each MCO must successfully achieve HSAG's Module 1 and Module 2 review criteria before progressing to Module 3. At the time of the 2016 annual MCO PIP validation reports, all MCOs except one were still in process of making revisions to pass Module 1 and/or Module 2. At the time of this annual technical report, HSAG had determined that the PIPs were methodologically sound projects and all MCOs had successfully passed Module 1 and Module 2, progressing to Module 3. The MCOs will not have PIP SMART Aim measure outcome results until progressing to Module 4 and Module 5.

Recommendations

HSAG recommends that MCOs refer to HSAG's PIP Companion Guide when completing the rapid-cycle PIP modules and request technical assistance from HSAG as needed.

Improving Birth Outcomes Through Adequate Prenatal Care

Objectives

HSAG worked with DMAS to develop a birth outcomes focused study to provide quantitative information about prenatal care and associated birth outcomes among women with singleton births during calendar year 2014 paid by Title XIX or Title XXI, which included the Medicaid, FAMIS, and FAMIS MOMS programs. The Contract Year 2015–2016 Task F.1 Birth Outcomes Focused Study addressed 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 complete study methodology is available in Appendix D.

Study Design

The study used 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 2014. All linked records were classified into either the study population or the comparison group based on the timing and length of Medicaid enrollment.

- The study population includes women continuously enrolled in the Medicaid for Pregnant Women (MPW), the FAMIS MOMS (FM), or an "Other Medicaid" (OM) program for a minimum of 43 days prior to, and including, the date of delivery.
- The comparison group includes women covered by one of the three Medicaid program groups on the date of delivery but without prior continuous enrollment.

Additionally, births among Virginia Medicaid or FAMIS MOMS recipients were assigned to one of three Medicaid program categories (i.e., MPW, FM, or OM) and two service delivery systems (managed care or FFS).

Five study indicators were calculated for all study-eligible members:

- 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 PCP in the 30 days following birth
- Percentage of newborns who had at least one ED visit in the 30 days following birth

Results for each study indicator were stratified by study and comparison groups, program, benefit program and delivery system, and demographic categories (e.g., maternal age, maternal race/ethnicity). For comparative purposes, the most recent national data available from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), National Vital Statistics System (NVSS) were used to identify national averages for selected study indicators.

Description of Data Collection

HSAG used Medicaid recipient, claims, and encounter data files supplied by DMAS to identify members eligible for the study and submitted this list to VDH. VDH used probabilistic and deterministic data linkage techniques to match HSAG's list of potential study members to birth registry records. VDH returned a data file to HSAG containing the information from HSAG's original list and all birth registry data fields for matching members.

HSAG identified study-eligible members (i.e., women with births paid by Virginia Medicaid) from all probabilistically linked or deterministically linked birth registry records and used birth registry records and Medicaid claims and encounters data files to calculate study indicators and identify stratification categories.

Summary of Findings

Overall, 33,634 births among Virginia Medicaid or FAMIS MOMS recipients were paid by Title XIX or Title XXI during CY 2014. Of these, 81.6 percent of births (n=27,438) were attributed to the study population (i.e., babies born to women continuously enrolled in Medicaid for at least 43 days prior to delivery), and 18.4 percent (n=6,196) were attributed to the comparison group (i.e., babies born to women enrolled in Medicaid or FAMIS MOMS at the time of delivery who but did not meet the 43-day continuous enrollment requirement). Of the 33,634 total births, 557 multiple gestation births were excluded from study indicator calculations.

Table 7-1 presents the distribution of all births by study population, Medicaid program, and Medicaid delivery system. Detailed information on maternal demographic characteristics by study population and Medicaid characteristics are presented in the 2015–16 Prenatal Care and Birth Outcomes Focused Study report.

Table 7-1—Distribution of Births by Population and Medicaid Characteristics, CY 2014

Medicaid Characteristics	Study Population		Comparison Group		Total
	n	%	n	%	n
Total	**27,438**	**100.0%**	**6,196**	**100.0%**	**33,634**
Medicaid Program					
FAMIS MOMS	830	3.0%	29	0.5%	859
Medicaid for Pregnant Women	20,872	76.1%	5,128	82.8%	26,000
Other Medicaid	5,736	20.9%	1,039	16.8%	6,775
Medicaid Delivery System					
Fee-For-Service	4,982	18.2%	5,368	86.6%	10,350
Managed Care	22,456	81.8%	828	13.4%	23,284

Births to women in the study population fared better than those in the comparison group for the *Births With Early and Adequate Prenatal Care* and *Newborns With ≥1 ED Visit in the 30 Days Following Birth* indicators. Table 7-2 presents the study indicator results by study and comparison population.

Table 7-2—Overall CY 2014 Study Findings by Indicator and Study Population

Study Indicator	National Benchmark[1]	Study Population		Comparison Population		Statistically Significant Difference (Yes/No)
		n	%	n	%	
Births With Early and Adequate Prenatal Care	77.0%	20,493	76.7%	4,141	70.5%	Yes
Preterm Births (<37 Weeks Gestation)	7.7%	2,403	8.9%	543	8.9%	No
Newborns With Low Birth Weight (<2,500g)	6.2%	2,266	8.4%	476	7.8%	No
Newborns With ≥2 PCP Visits in the 30 Days Following Birth	N/A	6,138	23.2%	1,912	32.2%	Yes
Newborns With ≥1 ED Visit in the 30 Days Following Birth	N/A	1,910	7.2%	676	11.4%	Yes

[1] The national benchmark for *Births With Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmark for *Preterm Births* was identified from NVSS final data for 2014. The national benchmark for *Newborns With Low Birth Weight* was identified from NVSS final data for 2014. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.

Similar to the results in Table 7-2, birth outcomes among women enrolled in managed care were generally better than the results exhibited in births among women in FFS. With the exception of the *Newborns With ≥2 PCP Visits in the 30 Days Following Birth* indicator, births to women enrolled in managed care fared better than those in FFS. Table 7-3 illustrates the study indicator results for all study births by delivery system (i.e., managed care versus FFS).

Table 7-3—Overall CY 2014 Study Findings by Indicator and Service Delivery System

Study Indicator	National Benchmark[1]	Managed Care		Fee-For-Service	
		n	%	n	%
Births With Early and Adequate Prenatal Care	77.0%	17,566	77.3%	7,068	71.8%
Preterm Births (<37 Weeks Gestation)	7.7%	1,952	8.5%	994	9.8%
Newborns With Low Birth Weight (<2,500g)	6.2%	1,900	8.3%	842	8.3%
Newborns With ≥2 PCP Visits in the 30 Days Following Birth	N/A	4,479	19.9%	3,571	36.3%
Newborns With ≥1 ED Visit in the 30 Days Following Birth	N/A	1,439	6.4%	1,147	11.7%

[1] The national benchmark for *Births With Early and Adequate Prenatal Care* is the Healthy People 2020 goal. The national benchmark for *Preterm Births* was identified from NVSS final data for 2014. The national benchmark for *Newborns With Low Birth Weight* was identified from NVSS final data for 2014. Due to the study-specific nature of the remaining indicators, national benchmarks are not available for comparison.

Conclusions

In general, findings across the five study indicators showed encouraging results for Virginia Medicaid members. Although the Virginia Medicaid rates were less favorable than national benchmark values for singleton births, the findings suggest that CY 2014 births to Virginia Medicaid women were associated with early and adequate prenatal care and generally favorable outcomes (i.e., low rates for preterm births and low birth weight newborns). Overall, more women in the study population received early and adequate prenatal care compared to the comparison group. Conversely, infants born to women who met continuous enrollment criteria were less likely to have received at least two ambulatory care visits (i.e., office visits) with a PCP-type provider during the first 30 days of life, compared to infants born to women in the comparison group.

Study indicator rates for singleton births to women in managed care were better than rates among women in FFS for three indicators (*Births With Early and Adequate Prenatal Care*, *Preterm Births*, and *Newborns With ≥1 ED Visit in the 30 Days Following Birth*). More infants born to women in FFS received at least one PCP visit during their first 30 days of life, compared to infants born to women enrolled in an MCO. Additionally, while there were no differences in the rate of low birth weight (<2,500 grams) singleton infants between the two service delivery systems, there was a lower percentage of very low birth weight (<1,500 grams) births to women in managed care compared to women receiving services on an FFS basis.

Recommendations

HSAG's recommendations based on the study findings are listed below; text of the recommendations has not been altered from the 2015–16 Prenatal Care and Birth Outcomes Focused Study report. Based on the findings outlined in this report, HSAG recommends the following:

- DMAS should continue to monitor, trend, and evaluate prenatal care and birth outcomes among Medicaid members. Moreover, using the detailed results presented in the appendices of this report, DMAS should evaluate the potential impact of key demographics (i.e., maternal age, race/ethnicity, citizenship status, and region of residence) on prenatal care and birth outcomes. Areas where notable differences are identified can then be targeted for follow-up analyses (e.g., focus groups, provider surveys, etc.). Additionally, DMAS should regularly evaluate the study indicators used to monitor birth outcomes. For example, DMAS should consider assessing maternal gravidity (i.e., the number of prior pregnancies) as well as maternal history of preterm deliveries as potential determinants for birth outcomes in future focused studies.
- DMAS should work with the MCOs to identify and evaluate specific interventions and outreach programs implemented to improve prenatal care and birth outcomes. Recommendations from the previous Birth Outcomes Study suggested that the MCOs conduct root cause analyses to identify disparities and determine specific barriers to positive perinatal outcomes among the MCOs' prenatal populations. Using the MCO Quality Collaborative as an existing forum for discussion, DMAS could work with the MCOs to share findings from their root cause analyses as well as successful strategies for improving birth outcomes within specific sociodemographic populations. Through collaboration, DMAS could identify best practices among the MCOs and work to implement these strategies statewide and across applicable Medicaid populations.
- The MCOs, in collaboration with DMAS, should conduct supplemental analyses at the provider level to determine the impact of provider office policies and procedures on prenatal care and birth outcomes. Evaluating performance on key study indicators at the provider level will allow the MCOs and DMAS to identify high- and low-performing practices. These providers could then be targeted for surveys or focus groups to assess factors contributing to their performance. The information gathered from these activities would provide the basis for programs and interventions designed to improve member experience and birth outcomes.
- DMAS and the MCOs should work with birthing hospitals and providers to ensure that discharge materials include information that emphasizes the importance of primary care for newborns. This information should include materials that highlight recommendations for post-hospital well-care visits with a primary care physician within the first 30 days of delivery. If possible, MCOs should ensure an infant is assigned a PCP prior to discharge and when possible ensure and/or facilitate scheduling each infant's first well-care visit prior to discharge.
- In communications with birthing hospitals and providers, DMAS and the MCOs should emphasize communicating to parents the importance of notifying the local Virginia DSS or Cover Virginia immediately upon delivery to ensure timely Medicaid enrollment for newborns so as to prevent service delays during the neonatal period. Additionally, birthing hospitals should continue to use the Electronic Reporting of Deemed Newborns system available through the DMAS Web Provider Portal to expedite the enrollment of infants born to women covered by Medicaid or CHIP at the time of the infant's birth.
- Additionally, DMAS and the MCOs should promote the use of 24-hour nursing lines to help inform and educate new parents and educate families about available resources prior to newborns' hospital discharge. Such resources can provide decision support to families who may otherwise seek ED care for nonemergent or preventable conditions.

Improving the Health of Children in Foster Care

Objectives

DMAS contracted with HSAG to conduct a focused study to provide quantitative information about children and adolescents in foster care receiving medical services through Medicaid MCOs. The Improving the Health of Children in Foster Care Focused Study sought to determine the extent to which children in foster care received the expected preventive and therapeutic medical care in the first year of managed care service delivery.

The study examined services received by children in foster care and younger than 18 years of age from July 1, 2014, through June 30, 2015 (i.e., the first full year of statewide managed care service delivery for these members). The study occurred during Contract Year 1 and Contract Year 2, with DMAS approving the study methodology and medical record procurement materials during Contract Year 1 and the remaining study tasks occurring during Contract Year 2. The complete study methodology is available in Appendix E.

Study Design

The study included foster children younger than 18 years of age as of July 1, 2014, enrolled in Virginia Medicaid for any length of time from July 1, 2014, through June 30, 2015. Results for study indicators assessing quality of care or utilization of care were limited to children enrolled in managed care service delivery with any MCO or a combination of MCOs during the study period with enrollment gaps totaling no more than 45 days from administrative claims and encounters data (i.e., continuous enrollment criteria).

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

- *Characteristics of Medicaid Members in Foster Care:* Five indicators in this category provided information on age, sex, race/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 continuously enrolled foster children received expected well-child visits and expected immunizations, and utilized primary care providers (PCPs) and dental services.
- *Behavioral Health:* Six indicators in this category provided information on continuously enrolled foster children, with specific indicators addressing utilization of antipsychotic medications (three indicators), children's receipt of follow-up care following hospitalization for mental illness, and the prevalence of children prescribed antidepressant medications or medications for attention deficit hyperactivity disorder (ADHD).

Study indicators for preventive care and behavioral health were generally based upon HEDIS 2015 Technical Specifications with modifications to accommodate the length of managed care service delivery among foster children.

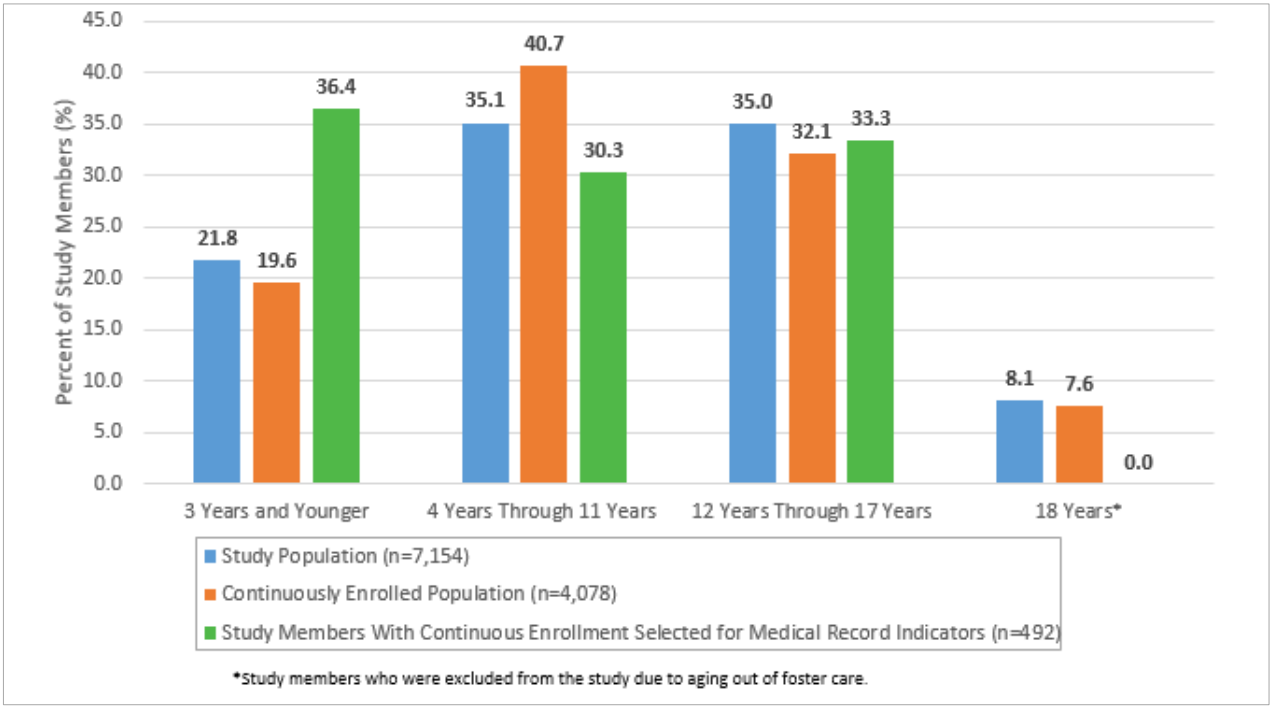
Description of Data Collection

HSAG used Medicaid recipient, claims, and encounter data files supplied by DMAS to identify the study population and calculate study indicators based on administrative data. HSAG also calculated two study indicators using information abstracted from a statistically valid sample of medical records from study members meeting continuous enrollment criteria. For the 492 randomly selected, continuously enrolled study members, HSAG worked directly with PCP-type providers to locate and collect medical records for well-care visits and immunizations. HSAG's clinical review staff abstracted information from the medical records using an electronic data collection instrument specific to the study indicators for the well-child and immunization measures.

Summary of Findings

Overall, 7,154 children in foster care were included in the study population, and 4,078 of these members met the study's continuous enrollment criteria. Figure 7-1 presents the distribution of study members by age category and population subgroup (i.e., overall study members, continuously enrolled study members, and study members sampled for inclusion in medical record indicators).

Figure 7-1 Distribution of Study Members by Age Category as of June 30,2015, and by Study Population Subgroup



No substantial differences existed in the demographic characteristics of members eligible for the study compared to continuously enrolled members, though minor differences were identified related to the distribution of children by age category and region of residence.

Study indicator results among continuously enrolled members are presented in Table 7-4, and detailed study indicator findings by members' demographic characteristics are presented elsewhere in the report.

Table 7-4—Overall Results for Study Indicators Related to Quality and Utilization of Care

Study Indicator by Domain	Denominator	Numerator	Rate (%)
Preventive Care			
Expected Well-Child Visits	492	203	41.3%
Members With At Least One Well-Child Visit in the First Six Months of the Study Period	492	182	37.0%
Members With Zero Well-Child Visits	492	218	44.3%
Expected Immunizations	492	54	11.0%
Access to Primary Care Providers	3,756	3,461	92.1%
Members With at Least One Visit in the First Six Months of the Study Period	3,756	2,979	79.3%
Members With Zero Visits to PCP-Type Providers	3,756	295	7.9%
Annual Dental Visit	3,279	2,873	87.6%

Study Indicator by Domain	Denominator	Numerator	Rate (%)
Behavioral Health			
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	378	7	1.9%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	121	104	86.0%
Overall Use of Psychosocial Care for Children and Adolescents on Antipsychotics	89	87	97.8%
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days	151	66	43.7%
Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days	151	112	74.2%
Prevalence of Antidepressant Medication	2,524	645	25.6%
Prevalence of Children Prescribed ADHD Medication	2,524	1,084	42.9%

The following key findings were identified among the study indicators:

- Despite generally positive preventive care findings from administrative data, medical record documentation supporting expected well-child visits and immunizations was limited, with less than half of the sampled children having medical record documentation which reflected the expected number of well-child visits for their ages.
- Only a small percentage of sampled children had medical record documentation showing all expected immunizations for their ages, and 30.5 percent (n=150) of sampled children had no medical record evidence of immunizations.
  - No sampled children ages 12 through 17 years met the criteria for all expected immunizations, and this age group had the highest percentage of cases with no documented immunizations.
  - Children younger than three years of age had the greatest proportion of cases with expected immunizations and the lowest number of cases with no immunizations.
- A high rate of continuously enrolled foster children received at least one dental visit during the study period, and rate differences were not identified based on members' sex.
  - The Halifax/Lynchburg region had the lowest rate of continuously enrolled foster children with at least one dental visit during the study period, and this region's rate was more than 10 percentage points lower than the region with the next lowest rate.
- Females, especially those 12 years and older, were more likely than males to have received at least one prescription antidepressant medication during the measurement period.
- Males were more likely than females to have been prescribed an attention deficit disorder (ADD)/ADHD medication or receive a newly prescribed ADD/ADHD medication during the measurement period.

Conclusions

During the first year under statewide managed care service delivery, foster children continuously enrolled with one or more MCO(s) generally received expected preventive medical care. Most continuously enrolled foster children had at least one visit with a PCP-type provider and at least one dental visit during the study period. Despite generally positive preventive care findings from administrative data, medical record documentation supporting expected well-child visits and immunizations was limited. In addition to limitations associated with medical record procurement, findings related to low immunization rates may be related to immunization requirements for school attendance in the Commonwealth of Virginia.

Results from behavioral health study indicators showed that foster children continuously enrolled with one or more MCO(s) received therapeutic behavioral health services during their first year under managed care service delivery. Results related to utilization of psychosocial care among children receiving antipsychotic medications indicated that nearly all foster children on antipsychotic medications receive psychosocial care, either as a first-line therapy or within 90 days of receiving a new prescription for an antipsychotic medication. Additionally, fewer than 4 percent of continuously enrolled foster children were hospitalized with a mental illness, and nearly three-quarters of these children received follow-up care with a mental health provider within 30 days of hospital discharge. Females were more likely to have a hospitalization for a behavioral health diagnosis and more likely to have been prescribed an antidepressant during the study period.

Comparative data or other benchmarks were not available to contextualize CY 2015–2016 study indicator results. However, DMAS has contracted HSAG to conduct the Foster Care Focused Study during CY 2016–2017 using the CY 2015–2016 methodology. Available in August 2017, results for the upcoming study will include comparisons of quality and utilization indicator results between study periods.

Recommendations

HSAG's recommendations based on the study findings are listed below; text of the recommendations has not been altered from the 2015–2016 Foster Care Focused Study Report.

- DMAS should work with the Virginia Department of Social Services (DSS) to review the findings of this study with respect to policies and procedures affecting foster children. In cases where study findings suggest that policies or procedures may present a barrier to recommended health care use by children in foster care, DMAS and DSS should collaborate to modify the policy and/or procedure.
- Only 57.0 percent of children in foster care at any time during the study period were continuously enrolled in managed care, and DMAS should consider further evaluation of these continuously enrolled foster children to assess the impact of children's length of time in foster care on expected health care service utilization and quality of care.

- As immunization records were unavailable for nearly one-third of children in foster care, DMAS should collaborate with VDH and DSS to develop a process for monitoring immunization compliance among children in foster care, including communication with the MCOs regarding children, especially adolescents, potentially in need of critical immunizations required for school attendance.
- Given the large percentage of children in foster care with access to a PCP-type provider, DMAS and the MCOs should assess provider networks to identify providers or practices in which physical and behavioral health services are co-located or highly coordinated. As foster children are more likely to require behavioral health services than other children served by Medicaid, DMAS and the MCOs can assess the extent to which co-located or highly coordinated physical and behavioral health practices offer children in foster care better clinical outcomes and greater satisfaction with care than practices unable to offer such service coordination.
- DMAS should conduct data mining activities using claims and encounter data to identify the PCP, dental, behavioral health, and medical specialty providers most commonly serving children in foster care. Based on the data mining results, DMAS should collaborate with DSS and the MCOs to conduct focus groups with these providers to determine the specific challenges associated with serving children in foster care, including details on the processes required to pursue complete medical histories and immunization records and to refer children for behavioral health or specialty services and the extent to which PCP-type providers are able to fulfill the care coordination role recommended for foster children by the American Academy of Pediatrics (AAP) and peer-reviewed literature.
  - Similarly, DMAS and DSS should collaborate to conduct focus groups with the guardians of children in foster care to identify specific challenges in pursuing and coordinating physical and behavioral health care for the children in their care.

Health and Acute Care Program

Objectives

HSAG worked with DMAS to develop a Contract Year 2015–2016 focused study to provide quantitative information about the demographic composition, clinical profile, and medical and pharmaceutical utilization trends among HCBS waiver members enrolled in Medicaid Medallion 3.0 under one of five waiver programs[7-1] unified under the HAP beginning on December 1, 2014.[7-2] (This unification of HAP included members enrolled in Virginia Medicaid Medallion Managed Care and then enrolled in a waiver with members that were enrolled in an EDCD waiver and then eligible for Virginia Medicaid Medallion

[7-1] Waiver programs included Elderly or Disabled with Consumer Direction (EDCD), Day Support (DS), Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS), and Alzheimer's Assisted Living (AAL).

[7-2] The precursor to HAP began in 2007 with the transition to managed care for members enrolled in Virginia Medicaid Managed Care and then enrolled in one of the above identified HCBS waivers.

Managed Care.) The HAP Focused Study addressed the following question: *To what extent did the managed care members with home- and community-based waivers enrolled in Medallion 3.0 use medical and pharmacy services during the first year of managed care coverage?*

The complete study methodology is available in Appendix F.

Study Design

This study used administrative data to assemble a member-level analytic dataset examining clinical services received by HAP members during two measurement periods. The pre-HAP period (analysis Phase I included those members enrolled in Virginia Medicaid Medallion Managed Care and then enrolled in a waiver) evaluated services from December 1, 2013, though November 30, 2014; and the post-HAP period (analysis Phase II included those members enrolled in either Virginia Medicaid Medallion Managed Care and then enrolled in a waiver or enrolled in the EDCD waiver and met criteria for enrollment into Virginia Medicaid Medallion Managed Care) evaluated services from December 1, 2014, through November 30, 2015 (i.e., the first full year of statewide managed care for this unified program). Each year (i.e., December 1 through November 30) was considered a distinct measurement period, and results for each study indicator were calculated for each member in the study population for each measurement period.

A total of 20 study indicators were developed across three domains:

- Demographic (seven measures)
- Clinical (three measures)
- Utilization (divided between medical and pharmacy-related metrics)
  - Medical (five measures)
  - Pharmacy (five measures)

Description of Data Collection

HSAG used monthly Medicaid enrollment files supplied by DMAS and extracted on the first day of each month in the study period to identify members enrolled in HAP as of December 1, 2014. The eligibility of HAP members identified in the December 1, 2014, enrollment file was based on enrollment records at a point in time and did not capture eligibility segments or, consequently, continuous enrollment.

In addition to administrative and encounter data, DMAS provided HSAG with dental encounter data from the Medicaid dental benefits manager (DBM), DentaQuest, and behavioral health encounter data from Magellan.

Summary of Findings

As of December 1, 2014, 7,624 members enrolled in Medallion 3.0 managed care with waivers for HCBS were eligible for the rebranded HAP program (i.e., HAP members); and 7,341 of these members were included in Phase II analyses. A total of 283 members were excluded from Phase II analyses as a result of death during the study period.[7-3] Table 7-5 displays the numbers and percentages of study members by waiver program for Phase I and Phase II as well as the percentage of Phase II members who maintained the same waiver program as during Phase I.

Table 7-5—Distribution of Waiver Program Enrollment for Phase I and Phase II

HAP Waiver Program	Phase I		Phase II[1]		Percent of Phase II Members With Same Waiver Across Phases[2]
	Number	Percent	Number	Percent	
Day Support (DS)	40	0.5	37	0.5	**100.0**
Elderly or Disabled with Consumer Directed (EDCD)	6,779	88.9	5,612	76.4	**86.3**
Intellectual Disability (ID)	755	9.9	742	10.1	**92.5**
Individual and Family and Developmental Disabilities Support (IFDDS)	48	0.6	51	0.7	**91.7**
Alzheimer's Assisted Living (AAL)	2	0.0	1	0.0	**100.0**
No HAP Eligible Waiver	—	—	659	9.0	—
No Medicaid	—	—	239	3.3	—
Total	**7,624**	**100.0**	**7,341**	**100.0**	**87.0**

Note: Due to rounding, the sum of the percentages in each column may not equal 100 percent.

[1] Study members who died during Phase I or Phase II have been necessarily excluded from the Phase II analyses.

[2] The percentage consists of the number of study members with the specified waiver in Phase II who were also identified in Phase I divided by the total number of Phase II study members enrolled in the specified waiver program.

The distribution of members among waiver programs was similar during both phases, with most members attributed to the EDCD waiver. Members included in Phase II analyses tended to remain in the same waiver program in which they were enrolled during Phase I.

The HAP population was diverse, though members' demographic profiles differed within individual waiver programs. Study members ranged in age, with children comprising more than one-third of the overall study population during each phase. Among the overall study population, gender was equally represented, non-Hispanic blacks constituted the largest racial/ethnic group of study members, and most study members resided in the Central region during both phases.

[7-3] Twenty-six HAP members had DMAS-confirmed dates of death occurring between December 1, 2013, and November 30, 2014; and 257 HAP members had DMAS-confirmed dates of death occurring between December 1, 2014, and November 30, 2015.

During Phase I, most HAP study members were consistently enrolled with the same MCO; and a similar finding was observed among study members during Phase II. Stability in members' service delivery type (i.e., managed care or FFS) increased from Phase I to Phase II, with a much smaller proportion of study members having gaps in Medicaid coverage and smaller proportions transitioning between managed care and FFS during each measurement period. Table 7-6 shows the number and percentage of study members in each service delivery configuration during Phase I and Phase II.

Table 7-6—Distribution of Study Members by MCO Attribution Status for Phase I and Phase II

Service Delivery Type	Phase I		Phase II	
	Number	Percent	Number	Percent
Never with an MCO	2,500	**32.8**	—	—
Not enrolled in Medicaid as of December 1, 2013[1]	*221*	***2.9***	—	—
Enrolled under fee-for-services (FFS) as of December 1, 2013[1,2]	*2,263*	***29.7***	—	—
Enrolled in limited service delivery as of December 1, 2013[1]	*16*	***0.2***	—	—
With the same MCO	4,084	**53.6**	5,851	**79.7**
With different MCOs	67	**0.9**	253	**3.4**
With FFS and the same MCO	932	**12.2**	508	**6.9**
With FFS and multiple MCOs	41	**0.5**	90	**1.2**
Combination of FFS, one or more MCO(s), and gap in Medicaid enrollment[3]	—	—	639	**8.7**
Total	**7,624**	**100.0**	**7,341**	**100.0**

Note: Due to rounding, the sum of the percentages in each column may not equal 100 percent.

[1] The italicized rows are subcategories of the "Never with an MCO" category.

[2] Members in this group were enrolled in Medicaid under a FFS delivery system as of December 1, 2013. Some members had Medicaid enrollment gaps during the Phase I measurement period.

[3] Members in this group were enrolled in a Medicaid MCO program as of December 1, 2014. Over the remaining 11 months of Phase II, members' coverage transitioned to the FFS delivery system, and some members had Medicaid enrollment gaps.

The number of study members with diabetes, CAD, and mental health diagnoses remained stable from Phase I to Phase II. Disease detection was relatively high across phases for diabetes and mental health diagnoses, while a larger percentage of study members with CAD during Phase II were not detected as having CAD during Phase I. Table 7-7 displays the number and percentage of study members with selected clinical indicators for Phase I and Phase II as well as the percentage of Phase II members who maintained the same clinical indicator as identified during Phase I.

Table 7-7—Distribution of Study Members With Clinical Indicators for Phase I and II

Clinical Indicator	Phase I		Phase II		Phase II Members Detected in Both Phases1
	Number	Percent	Number	Percent	Percent
Diabetes	1,437	18.8	1,320	18.0	89.3
Coronary Artery Disease	746	9.8	641	8.7	64.1
Mental Health	5,191	68.1	5,021	68.4	86.3
Total Unique Members With Clinical Indicators[2]	**5,842**	**76.6**	**5,620**	**76.6**	**79.9**

[1] The percentage consists of the number of study members with disease in Phase II who were also identified in Phase I, divided by the total number of Phase II study members with disease.

[2] Study members may have diagnoses indicating more than one clinical condition.

Medical utilization trends demonstrated an overall decrease from Phase I to Phase II, and the transition to managed care for HAP members corresponded with decreased utilization rates for ambulatory care, ED, and LTC utilization. The decrease in study members using LTC services was notable, as HAP members are required to use at least one LTC service every 30 days while enrolled in the HCBS waiver. Table 7-8 displays the number and percentage of study members using selected medical services during Phase I and Phase II.

Table 7-8—Distribution of Study Members With Utilization of Medical Services for Phase I and II

Medical Utilization Service Categories	Phase I		Phase II	
	Number	Percent	Number	Percent
No Services	33	0.4	75	1.0
Ambulatory Care Services	7,263	95.3	6,904	94.0
Ambulatory Care Services With PCP-Type Provider	*7,023*	*92.1*	*6,635*	*90.4*
Dental Services	2,446	32.1	2,379	32.4
Emergency Department (ED) Services	3,886	51.0	3,530	48.1
Long-Term Care (LTC) Services	7,167	94.0	6,649	90.6

Overall pharmacy utilization trends decreased from Phase I to Phase II, with the most notable decreases observed in the proportions of members receiving antibiotics and opiates. Decreased utilization rates were observed across drug categories in terms of the total number of prescriptions filled, the average number of prescriptions per member, and the members' range of prescriptions received. Additionally, decreases were observed in total prescriptions per member among study members in the top 10 percent of users for Phase I for each drug indicator assessed in the study. Table 7-9 displays the number and percentage of members for each pharmacy utilization study indicator during Phase I and Phase II.

Table 7-9—Distribution of Study Members With Utilization of Pharmaceutical Services for Phase I and II

Pharmacy Utilization Service Categories	Phase I		Phase II	
	Number of Members	Percent of Members	Number of Members	Percent of Members
No Medication	561	7.4	738	10.1
Any Medication	7,063	92.6	6,603	89.9
ADD/ADHD Medications	1,444	18.9	1,341	18.3
Antibiotic Medications	4,337	56.9	3,691	50.3
Antipsychotic Medications	1,611	21.1	1,482	20.2
Opiate Medications	2,617	34.3	2,068	28.2

In 2016 some of the Home and Community-Based waivers changed names and the HAP waivers are listed below for referencing as applicable:

- Elderly or Disabled with Consumer Directed (EDCD) (no changes)
- Intellectual Disability (ID) (changed to Community Living (CL))
- Individual and Family Developmental Disabilities Support (IFDDS) (changed to Family and Individual Support (FIS))
- Day Support (DS) (changed to Building Independence (BI))
- Alzheimer's Assisted Living (AAL) (no changes)

Conclusions

This study assessed the extent to which HAP members used medical and pharmacy services during the first year in the HAP program. The study design allowed comparison of service utilization prior to and after the transition by assessing utilization trends in the year prior to the December 1, 2014 (i.e., HAP program rebranding), in comparison to utilization trends observed in the year following the rebranding.

Continuous enrollment in managed care among HAP members increased between Phase I and Phase II. However, many study members did not receive continuous coverage from a single MCO; and MCO and/or Medicaid enrollment for many study members lapsed during Phase II. The lack of stability in continuous coverage could negatively impact the effectiveness of care coordination and disease management gained through managed care.

A primary aim of this study was the assessment of medical and pharmacy service utilization after a transition to managed care. Study indicators for medical utilization services demonstrated minimal decreases in utilization of ambulatory, dental, ED, and LTC services from Phase I to Phase II. Benefits and services covered by the MCOs may have impacted the utilization rate of specific indicators such as dental services. In addition, study indicators for pharmacy utilization demonstrated decreases from Phase I to Phase II for all drugs, especially antibiotics and opiates. Finally, fewer study members had at least one LTC service during Phase II, and a smaller proportion of study members received at least one

LTC service every 30 days in alignment with the LTC service provision standard for members in the HAP waiver program. Note that LTC services are provided outside of managed care coverage, and HAP members' transition to managed care service delivery may not impact members' compliance with HAP standards for LTC service utilization.

Recommendations

HSAG's recommendations based on the study findings are listed below; text of the recommendations has not been altered from the 2015–2016 Health and Acute Care Program Focused Study Report.

Beginning July 1, 2017, members with HAP-based waivers will be included in the transition, by region, to DMAS' Commonwealth Coordinated Care Plus (CCC Plus) program. Consequently, recommendations were framed to address analytic insights gained from the HAP population's initial transition to managed care that can be continued with the transition to the CCC Plus program. Based on the findings outlined in this report, HSAG recommended the following:

- DMAS should continue to monitor, trend, and evaluate study indicator rates among the HAP waiver population as members are transitioned into the CCC Plus program. Specifically, continued analysis of the medical and pharmacy utilization rates will enrich the longitudinal understanding of the needs of the HAP waiver population and the effectiveness of the program.
  - While the identification of those individuals with mental health issues remained stable over both phases, identification of those beneficiaries with diabetes or CAD was not consistent between Phase I and Phase II when, as of December 1, 2014, these beneficiaries were enrolled with an MCO. To ensure continuity of care among HAP members with chronic health conditions (and in the future all subpopulations integrated into the CCC Plus program), MCOs should establish additional monitoring to identify HAP members with chronic conditions as well as collect and assess data on the utilization rates of preventive care services, participation in care coordination, and health outcomes.
- As appropriate, ambulatory care may reduce the need for inpatient hospitalizations and emergency care. Understanding which clinical conditions were most frequently associated with inpatient admissions and outpatient services for the study population would allow DMAS to more thoroughly assess the impact of managed care on preventable hospitalizations.
  - DMAS should consider assessing the nature of members' ED visits using New York University's Center for Health and Public Service Research algorithm for classifying ED visits based on the degree to which visits required emergent care.[7-4]
  - Similarly, DMAS should expand monitoring of ambulatory care-sensitive conditions among HAP members, including hypertension and asthma, to ensure that the transition of this population to managed care under the MLTSS program increases utilization of preventive care and/or disease management services, thereby reducing unnecessary hospital admissions and preventable ED visits.

[7-4] NYU Wagner. Available at: http://wagner.nyu.edu/faculty/billings/nyued-background. Accessed on: August 3, 2016.

  - Further investigation into drug utilization patterns for study members with chronic illnesses was outside the scope of this study; DMAS should consider conducting such analyses to gain further insight into the impact of managed care on pharmacy utilization.

- For HAP members with more than one year of continuous managed care enrollment, DMAS should conduct longitudinal analyses of member satisfaction after their transition into the MLTSS program. In combination with the recommended program monitoring analyses to assess HAP members' service utilization, a survey would provide a comprehensive picture of HAP members' satisfaction with their experience of care.
- DMAS should work with MCOs to catalog existing and planned care coordination and/or case management efforts for HAP members as well as any evaluations designed to monitor these programs with the transition of applicable members into the CCC Plus program. DMAS may use the member-level study results (i.e., the analytic dataset) produced as a complement to this report to identify specific subpopulations for targeted quality improvement activities.

8. Encounter Data Validation

Objectives of EDV Study

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DMAS contracted with HSAG to conduct an EDV study for the contract year 2015–2016. The goals of the EDV study were to evaluate the overall quality (i.e., completeness, accuracy, and timeliness) of the encounter data submitted by its contracted MCOs and to assist DMAS in developing policies and procedures surrounding the collection, monitoring, and ongoing improvement of encounter data.

Methods of Data Collection and Analysis

Data collection activities for this EDV study were conducted using the approved scope of work and focused on the following three activities:

- Encounter data protocol review through monthly technical assistance conference calls with DMAS and a desk review of existing documents from DMAS.
- Administrative analysis using encounter data with dates of service between July 1, 2013, and December 31, 2014 and extracted from DMAS' MMIS in or before June 2015.
- Final report production, which included a list of recommendations for DMAS to improve the encounter data monitoring/reporting strategies based on results from the preceding two activities and a review of the new EDQ process.

Refer to Appendix G for the approved scope of work and a more detailed methodology for each activity.

Summary of Findings

Encounter Data Protocol Review Results

Through monthly conference calls with key stakeholders from DMAS, HSAG reviewed and discussed existing protocols and procedures for the encounter data processing on the EDI server and MMIS, encounter data testing, and the integration between encounter data and member/provider data. Below are the main findings:

- DMAS has developed the *MCTM* to assist existing and prospective MCOs with the encounter data submission, testing, and monitoring processes; the document is continually updated for improvements.

- DMAS is able to identify original, void, adjustment, and denied encounters and subsequently determine the final adjudicated records when corrections are made by providers or MCOs.
- DMAS provides standard response files and EDQ monitoring reports to the MCOs to inform them of issues with the submitted encounters, and the *MCTM* advises the MCOs to review and correct the issues as appropriate.
- For new MCOs and existing MCOs with any event that will impact the submission and/or content of the encounter data, DMAS requires that the MCO complete a thorough testing plan to test different scenarios (i.e., different encounter type, different encounter adjudication status, and the MCO's subcontractors).
- The member and provider information in the encounter data are well integrated with the member and provider data in the MMIS, and DMAS has processes in place to ensure that both are complete and accurate.
- DMAS staff have a thorough understanding of encounter data processes, have recognized the system limitations or existing issues, and are actively working to resolve any issues or improve current processes.

While areas for improvement are included in Table 8-1; overall, DMAS demonstrates strengths in processing the encounter data from the MCOs and is in the process of improving its encounter monitoring program.

Administrative Analysis Results

For the administrative analysis, HSAG evaluated the monthly volume, timeliness, and element completeness and accuracy for the encounters with dates of service between July 1, 2013, and December 31, 2014, and in the DMAS monthly data extracts from June 2015 or before.

Encounter Volume

Encounter volume was assessed by HSAG in two focus areas: assessing monthly submission volume at the encounter record level and assessing the visit/service counts by service month. Although the distribution generally conformed to a bell or trapezoid-shaped curve for the encounter volume by submission month, certain months deviated from the general shape. However, the visit/service counts by service month or the monthly visit/service counts per 1,000 member months for inpatient, outpatient facility, practitioner, and pharmacy data were relatively stable over time. This observation indicates that these encounter data are relatively complete, although the submission pattern for the MCOs was not very consistent over time. Personal care, laboratory, and transportation encounter types demonstrated less steady monthly visit/service volume over time, which should be investigated further to ensure data completeness.

Encounter Timeliness

Two study indicators were used to evaluate the timeliness of encounter data submission. One indicator evaluates the lag days between MCO payment dates and MCO submission dates to DMAS. The other indicator is based on the lag days between date of service and date processed by DMAS into the MMIS. The first indicator was hindered by the proportion of records (by encounter type) with missing MCO payment dates. Five of the seven encounter types consistently recorded MCO payment dates with percent present rates ranging from 91.7 percent to 100 percent (laboratory, transportation, practitioner, and pharmacy and personal care respectively, from lowest to highest). Inpatient and outpatient facility encounters had the lowest proportion of records with MCO payment dates (58.3 percent and 49.8 percent, respectively), greatly impeding the ability to generalize timeliness results for these encounter types.

Only one (pharmacy encounters) of the seven encounter types had a proportion of original encounters in compliance with DMAS' standard of 95.0 percent of encounters submitted within 60 calendar days of MCO payment. The remaining encounter types generally failed to meet this timeliness standard. Although inpatient and outpatient facility encounters presented fairly close proportions of records within this time frame (both 92.4 percent), the remaining encounter types submitted between 50.0 percent and 80.4 percent of encounters within 60 days of MCO payment dates. Note that only 58.3 percent and 49.8 percent of inpatient and outpatient facility encounters, respectively, reported MCO payment dates and were therefore included in the evaluation.

Although a standard does exist for encounter submission following MCO payment dates, currently no standard exists for the time frame in which an encounter should be processed into the State's MMIS system from the dates of service due to MMIS system limitations. However, this timeliness metric is important since it shows how soon DMAS can use the encounter data in the MMIS for activities such as performance measure calculation and utilization statistics. Beginning from dates of service, pharmacy data are accepted into the MMIS fastest overall, and transportation and personal care visits/services are entered into the MMIS slowest. In order to obtain 90 percent of the visits/services for utilization statistics, DMAS has to wait just over one month for pharmacy services, about four months for laboratory visits, five months for inpatient and outpatient facility services, six months for personal care and practitioner visits, and eight months for transportation services after the dates of services.

Data Element Completeness and Accuracy

Percent present and percent valid were evaluated for key data elements for each encounter type. Data element completeness (e.g., percent present) varied by specific data element in contrast to variation across encounter types. Below are some examples.

- Primary diagnosis code completeness ranged from 80.1 percent (transportation) to 100 percent across encounter types (at least 98.9 percent for four of the five encounter types for which primary diagnosis code was assessed).
- Servicing provider taxonomy code percent present results were at least 93.4 percent across all encounter types, while revenue and type of bill codes were present for all encounters for which they were assessed.

- Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes were always present in the encounter types for 837 professional transactions for submission. However, for outpatient facility encounters, the statewide rate was 63.0 percent and the percent present for the MCOs varied considerably—from 46.1 percent (Anthem) to 82.0 percent (Optima).
- Drug-related data elements such as NDC and drug units were consistently present in low amounts, as expected, across non-pharmacy encounter types (outpatient facility and practitioner). Nearly all NDCs and drug units were present in the pharmacy data submitted to DMAS in the National Council for Prescription Drug Programs (NCPDP) format.
- HCPCS/NDC combinations, representative of physician-administered drugs, were moderately present throughout outpatient facility and practitioner encounters (percent present rates of 61.9 and 50.8 percent, respectively).

Data element validity was relatively high for all data elements, with all elements having validity rates of at least 93.0 percent, excluding HCPCS/NDC combinations. This indicates that information processed into the MMIS for the key data elements is relatively complete and accurate. The missing and invalid values, if any, were generally isolated to a few MCOs or some specific values. The evaluation for the HCPCS/NDC combinations is for informational purposes and may assist DMAS in guiding MCOs as to NDC submission specifics (e.g., for certain HCPCS codes, correct combination for HCPCS/NDCs).

For the type of bill codes, the distribution among the MCOs was similar except for Kaiser Permanente, which had the highest percentage of inpatient hospital encounters and the lowest percentage of outpatient facility encounters. For the physician-administered drugs, providers across MCOs submitted the HCPCS quantity and NDC quantity quite differently. DMAS should discuss this issue with the MCOs and brainstorm ways of helping providers submit values for these data elements correctly and consistently.

Encounter Monitoring/Reporting Strategies

For the new EDQ process that began on July 1, 2015, HSAG reviewed the technical specifications for the critical issues and emerging issues and the first three EDQ reports sent to the MCOs. In general, the issues DMAS selected are encounter-specific and associated with contract standards, pharmacy rebates, or particular issues of concern for DMAS. While some error codes are well-defined, others may require further clarification so that MCOs may investigate error codes more effectively. After the EDQ process passes the initial implementation phase, DMAS may want both to stratify the results further by encounter type and to encourage the MCOs to investigate the top ESC values in the Emerging Issues list monthly, although DMAS has not started tracking.

While the EDQ process monitors many aspects of encounter data quality for the data in the MMIS, DMAS should consider including additional monitoring metrics to ensure that the MCOs are submitting complete data to DMAS promptly (i.e., visit/service count by service month, MCO payments by service month, practitioner services by place of service (POS) category, percentage of duplicate encounters by submission month, and timeliness metrics based on service dates).

Conclusions and Recommendations

Based on the findings of the study, HSAG provided in the final EDV report recommendations for DMAS to assist in improving encounter data quality. Table 8-1 displays these recommendations and the corresponding responses received from DMAS on November 18, 2016. Overall, DMAS has taken action or plans to take action to improve its encounter data quality and enhance its encounter monitoring program.

Table 8-1—DMAS Response to HSAG Recommendations

#	HSAG Recommendation	DMAS Response
1.	DMAS will soon manage the EDI translation rather than Xerox doing so; therefore, DMAS should take this opportunity to address the historical challenges/barriers related to the EDI process—so that the new process is more transparent and customizable and offers more encounter monitoring features.	We now receive daily EDI reports showing transaction counts and EDI compliance results for each MCO. Implementation of the new Encounter Processing Solution (EPS) will upgrade our EDI compliance check to a standard Strategic National Implementation Process (SNIP) level 1–4. Additional EDI edits from levels 5–7 may be used as well. EDI reporting will also be enhanced.
2.	DMAS should set up time-limited, goal-driven meetings between DMAS and appropriate staff from the MCOs to explore targeted issues. The meeting environment should be collaborative and educational—e.g., DMAS could offer educational seminars or brown bag discussions and highly recommend that data staff from MCOs attend so as to further understand encounter data processing at DMAS.	DMAS has not held routine encounter meetings with the MCOs due to the lack of staff (only one encounter staff member). DMAS recently received preliminary approval for an additional encounter full-time employee. Additional staff will allow DMAS the ability to conduct meetings, starting with educational/training seminars for the MCOs concerning the new EPS implementation.
3.	The MCOs in Virginia do not currently know how other MCOs are performing. DMAS should consider making the data/results available to the MCOs. While DMAS may not need to make any judgment (i.e., compliance action) on these data, doing so could serve as a powerful tool in getting the MCOs to focus on the changes needed.	This recommendation is currently under consideration for the Medallion 4.0 program implementation.
4.	DMAS should consider a few suggestions from Section 3 (“Encounter Data Protocol Review Results”) to improve the completeness of the provider information in the encounter data for either short or long term.	DMAS has made improvements in the current provider process by prioritizing the entry of the providers into the system. Providers with large volumes of encounters have a higher priority (e.g., in-state, PCP, pediatricians, hospital, obstetricians, etc.) for data entry into the MMIS. Per new CMS regulations, the EPS/Medicaid Enterprise System (MES) implementation

#	HSAG Recommendation	DMAS Response
		will fully automate collection of provider data from the MCOs and integrate this data for encounter processing.
5.	DMAS should investigate the reason(s) why the monthly visit/service counts for personal care, laboratory, and transportation encounter types were not consistent over time.	DMAS anticipates enhanced reporting across MCOs and closer routine analysis of MCO differences once the new EPS implementation is complete.
6.	DMAS should continue to use Critical Issue 1.5.3.1 Lag Days to enforce the contract standard—submit 95 percent of all encounters within sixty calendar days of the claim payment date. In addition, DMAS should consider adding timeliness standards based on dates of service so that DMAS may use the encounter data for utilization statistics in a timely manner.	DMAS has continued to enforce the Lag Day standard for payment date. A new timeliness EDQ edit has been implemented that will flag encounters that have a date of service beyond three years. The new EPS/MES system will collect MCO Claim Receipt Date and MCO Adjudication Date in addition to MCO Payment Date. These new dates will allow for various "timeliness" measurements.
7.	DMAS should add HCPCS quantities to the monthly SAS data extracts for the outpatient facility encounters.	There is only one units' field on the revenue/HCPCS line for outpatient facility claims. DMAS is capturing this field in our SAS data (REVVUNIT) in the ancillary files.
8.	For physician-administered drugs, DMAS should set up guidelines for when an NDC must be submitted, what the expected NDC for each HCPCS code is, and how to bill the quantities for HCPCS codes and NDCs.	Based on the results of a recent OIG audit, DMAS has developed detailed physician-administered drug edits. The new edits have been published in the *MCTM* on December 1, 2016.
9.	For servicing provider taxonomy codes, the percent present results from Coventry were 87.3 percent, 84.9 percent, 75.9 percent, and 12.9 percent for the outpatient facility, inpatient, laboratory, and practitioner encounters, respectively. DMAS should discuss this issue with Coventry to determine the cause.	DMAS did address this with Coventry (now Aetna). They did attempt to mandate the submission of the taxonomy from the rendering providers. However, they experienced a strong pushback from the provider community and they were unable to implement this change.
10.	For CPT/HCPCS codes in the outpatient facility encounters, the percent valid from Optima was 86.7 percent due to an invalid value of "XXXXX." DMAS may want to discuss this issue with Optima to understand the root cause.	An EDQ edit was created and implemented on the Critical Issues list on September 1, 2016.
11.	For transportation encounters, the percent present rate for the primary diagnosis code was 21.3 percent for VA Premier. DMAS should work with VA Premier to investigate this issue.	VA Premier is the only Medallion MCO that does not subcontract transportation services. VA Premier does not populate diagnosis

#	HSAG Recommendation	DMAS Response
		codes for their internally-provided transportation services.
12.	DMAS should publish and maintain an online document containing the detailed specification for each ESC value in the Critical and Emerging Issues lists.	Detailed specifications for each EDQ are published in the *MCTM* (PDF format) and uploaded to the DMAS website on a monthly basis.
13.	For future EDQ reports, DMAS should consider: 1. Presenting results by both counts and percentages, if applicable. 2. Stratifying results by file type (e.g., 837I, 837P, and NCPDP). 3. Adding error codes related to MCO paid amount. 4. Recommending that MCOs voluntarily investigate the top ESC values monthly and communicate with DMAS the issues identified and actions taken.	1. Current EDQ reports display counts and provide a detailed list of each encounter in error. 2. This was an intentional decision. Previous Medallion encounter error reporting did stratify by file type, but we found that this added "noise" to the reports and created confusion for the MCOs. Based on that experience, one of our goals with EDQ was to simplify the presentation of error reporting for the MCOs. 3. DMAS has created a new edit for MCO paid amount. 4. DMAS does not use ESC codes because they are not valid. The MCOs are instructed to utilize the EDQ edits exclusively, and they are held accountable for every EDQ edit that occurs (via the compliance monitoring process).
14.	DMAS should consider the additional monitoring metrics proposed in the "Encounter Monitoring/Reporting Strategies" section in order to monitor and improve encounter data completeness and timeliness.	All of the proposed edits are under consideration for inclusion in the new EPS. The EPS edits are driven by a rules engine and will be easily configurable.

9. Consumer Survey of Quality of Care

Introduction

This section of the report includes a summary assessment of the FAMIS program and MCOs' strengths and opportunities for improvement derived from the results of CAHPS survey activities. Also included are HSAG's conclusions and general recommendations for improving on the CAHPS survey measure domains. The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

The CAHPS surveys ask members and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting data.

DMAS contracted with HSAG to administer and report the results of the CAHPS survey for the statewide FAMIS program. Aetna, Anthem, INTotal, Kaiser Permanente, Optima, and VA Premier were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf for Medicaid managed care. The MCOs' CAHPS results were forwarded to HSAG for purposes of inclusion in this report. Within this section, the statewide FAMIS program's results are presented, followed by those of the Medallion 3.0 MCOs. The Medallion 3.0 CAHPS results are presented for the statewide aggregate and each MCO for the adult and child Medicaid managed care populations, respectively.

FAMIS CAHPS

Methods of Data Collection and Analysis

For the FAMIS program, 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 Children with Chronic Conditions measurement set. In accordance with CMS' Children's Health Insurance Program Reauthorization Act (CHIPRA) CAHPS reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members receiving health care services through FFS or managed care, representative of the entire population of children covered by Virginia's Title XXI program (i.e., CHIP members in FFS or managed care).

A mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of nonrespondents to the mailed surveys) was used for the FAMIS program. Parents or caretakers of child members completed the surveys between the time period of March to June 2016 and had the option to complete the survey in English or Spanish.

The CAHPS 5.0 Child Medicaid Health Plan Survey (with the Children with Chronic Conditions measurement set) administered to FAMIS members includes a set of 83 standardized items that assess patient perspectives on care. The survey questions were categorized into 14 measures of satisfaction.[9-1] These measures included four global ratings, five composite measures, and five Children with Chronic Conditions composites and items.[9-2] 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). The Children with Chronic Conditions composite and item measures are derived from sets of questions and individual questions that address aspects of care for children with chronic conditions.

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 composite scores and individual items, 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 and items 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 and question summary rate for the individual item scores.

For the FAMIS program, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, the FAMIS program's scores were compared to 2015 NCQA CAHPS child Medicaid national averages, where applicable.[9-3] A measure was noted when the measure's rate was at least 5 percentage points higher or lower than the NCQA national average.

Description of Data Obtained

The CAHPS survey asks members to report on and 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 survey response rate is the total number of completed surveys divided by the number of all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: questions 3, 30, 45, 49, and 54, as specified by NCQA. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: deceased, invalid (did not meet eligible population criteria), or

[9-1] 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, five composite measures, and five Children with Chronic Conditions CAHPS measures.

[9-2] The Children with Chronic Conditions composite and item measures are applicable to the population of children with chronic conditions only; therefore, these measures are not reported for the general child population.

[9-3] Quality Compass 2015 data serve as the source for the 2015 NCQA CAHPS child Medicaid national averages for the general child and children with chronic conditions populations (i.e., general child and children with chronic conditions results).

having a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the CAHPS 5.0 Child Medicaid Health Plan Surveys to the FAMIS program, HSAG provided DMAS with an aggregate report of the general child and children with chronic conditions CAHPS survey results, representing the CAHPS survey results for the statewide FAMIS program in aggregate (i.e., FAMIS program child members enrolled in FFS and managed care combined).

For additional detail on the CAHPS survey methodology, please refer to Appendix H of this report.

FAMIS Program Aggregate Results

In 2016, a total of 3,490 FAMIS members were surveyed and 908 parents/caretakers returned a completed survey on behalf of a child member.[9-4] After ineligible members were excluded, the response rate for the FAMIS program was 26.5 percent. The FAMIS program's response rate was greater than the national child Medicaid response rate reported by NCQA for 2016, which was 23.0 percent.

Table 9-1 shows the 2016 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for each global rating and composite measure, respectively, for the FAMIS program's general child population.

Table 9-1—FAMIS Program General Child CAHPS Results

Measure	2016 Rate
Global Ratings	
Rating of Health Plan	69.5%
Rating of All Health Care	67.0%
Rating of Personal Doctor	75.7%
Rating of Specialist Seen Most Often	69.4%+
Composite Measures	
Getting Needed Care	83.6%
Getting Care Quickly	91.2%
How Well Doctors Communicate	94.1%
Customer Service	88.4%+
Shared Decision Making	71.8%+

+ The program had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national child Medicaid average.

[9-4] The total number of members surveyed, completed surveys, and response rate are based on the responses of parents/caretakers of children in the general child and children with chronic conditions supplemental populations.

Comparison of the FAMIS program's 2016 general child CAHPS results to 2015 NCQA national child Medicaid averages revealed the following summary results:

- The FAMIS program scored at or above the 2015 NCQA national child Medicaid average on six measures*: Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.
- The FAMIS program scored 5 or more percentage points lower than the 2015 NCQA national child Medicaid average on one measure, *Shared Decision Making*, and did not score 5 or more percentage points higher than the 2015 NCQA national child Medicaid average on any measure.

Table 9-2 shows the 2016 question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for each global rating, composite measure, and children with chronic conditions composite and item measures for the FAMIS program's children with chronic conditions population.

Table 9-2—FAMIS Program Children With Chronic Conditions CAHPS Results

Measure	2016 Rate
Global Ratings	
Rating of Health Plan	70.0%
Rating of All Health Care	67.6%
Rating of Personal Doctor	76.6%
Rating of Specialist Seen Most Often	71.2%
Composite Measures	
Getting Needed Care	89.5%
Getting Care Quickly	93.3%
How Well Doctors Communicate	94.8%
Customer Service	87.6%+
Shared Decision Making	84.8%
Children With Chronic Conditions Composites and Items	
Access to Prescription Medicines	90.0%
Access to Specialized Services	78.3%+
Family-Centered Care (FCC): Personal Doctor Knows Child	90.1%
Coordination of Care for Children with Chronic Conditions	74.3%+
FCC: Getting Needed Information	91.8%

+ The program had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national child Medicaid average.

Comparison of the FAMIS program's 2016 children with chronic conditions CAHPS results to 2015 NCQA national child Medicaid averages for children with chronic conditions revealed the following summary results:

- The FAMIS program scored at or above the 2015 NCQA national child Medicaid average for children with chronic conditions on twelve measures*: Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Access to Prescription Medicines*, *Access to Specialized Services*, *FCC: Personal Doctor Knows Child*, and *FCC: Getting Needed Information*.
- The FAMIS program scored 5 or more percentage points higher than the 2015 NCQA national child Medicaid averages for children with chronic conditions on one measure, *Rating of Health Plan*, and did not score 5 or more percentage points lower than the 2015 NCQA national child Medicaid averages for children with chronic conditions on any measures.

Medallion 3.0 CAHPS

Methods of Data Collection and Analysis

For the Medallion 3.0 MCOs, Anthem Health Keepers Plus, 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.[9-5] The mode of CAHPS survey data collection varied slightly among MCOs. Aetna used a standard internet mixed-mode methodology for both its adult and child populations. INTotal and Anthem used an enhanced mixed-mode survey methodology pre-approved by NCQA for its adult and child populations. Optima used a standard Internet mixed-mode methodology of data collection for its adult Medicaid members and a standard mixed-mode methodology for its child Medicaid members. Kaiser Permanente used a standard mixed-mode methodology for both its adult and child populations. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each MCO completed the surveys between the time period of January through May 2016.

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

[9-5] VA Premier administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set to its child Medicaid population, 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 VA Premier represent the CAHPS results for its general child population (i.e., general child CAHPS results).

followed for member selection and survey distribution.[9-6] 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 Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into nine measures of satisfaction.[9-7] 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 statewide aggregate score and each MCO's scores were compared to 2015 NCQA national Medicaid averages, where applicable.[9-8] For purposes of this comparison, a measure was noted when the measure's rate was at least 5 percentage points higher or lower than the 2015 NCQA national average. Additionally, HSAG compared the MCOs' CAHPS survey results to identify those measures for which MCOs scored highest and lowest. The MCO comparisons were performed for each the four CAHPS global ratings and five composite measures.

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 as Not Applicable (NA).

[9-6] Aetna contracted with the Center for the Study of Services (CSS), Anthem contracted with DSS Research, INTotal contracted with MORPACE, and Optima and VA Premier both contracted with SPH Analytics (formerly The Myers Group) to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations.

[9-7] 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.

[9-8] Quality Compass 2015 data serve as the source for the 2015 NCQA CAHPS adult Medicaid and child Medicaid national averages.

Description of Data Obtained

As described above, 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 survey response rate is the total number of completed surveys divided by the number of all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: questions 3, 15, 24, 28, and 35 for adult Medicaid and questions 3, 15, 27, 31, and 36 for child Medicaid, as specified by NCQA. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: deceased, invalid (did not meet eligible population criteria), having a language barrier, or mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the MCOs' survey vendors, and a summary of the final survey dispositions was provided to HSAG in the data (i.e., NCQA Summary Reports) received.

For additional detail on the CAHPS survey methodology, please refer to Appendix H of this report.

Aggregate and Comparative MCO Results

Adult Medicaid CAHPS Results

Table 9-3 presents the 2016 adult Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate.[9-9]

Table 9-3—Comparison of 2016 Adult Medicaid CAHPS Results

	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Statewide Aggregate
Global Ratings							
Rating of Health Plan	58.4%	65.2%	60.3%	57.5%	70.2%	67.8%	66.4%
Rating of All Health Care	52.7%	60.2%	58.5%	59.5%	60.2%	55.8%	58.4%
Rating of Personal Doctor	62.5%	66.2%	69.4%	66.7%	71.5%	69.4%	68.3%
Rating of Specialist Seen Most Often	59.4%	63.1%	73.7%	71.7%	67.9%	69.6%	66.5%
Composite Measures							
Getting Needed Care	81.9%	79.8%	83.0%	80.9%	79.8%	83.8%	81.2%
Getting Care Quickly	87.0%	83.5%	88.1%	81.6%	83.2%	83.4%	83.9%
How Well Doctors Communicate	88.1%	93.1%	92.0%	89.1%	88.6%	89.8%	90.7%
Customer Service	92.6%	87.2%	85.4%	NA	87.4%	86.7%	87.3%
Shared Decision Making	78.3%	80.7%	80.9%	NA	81.9%	84.0%	81.7%

Given fewer than 100 respondents for a measure, this is denoted as Not Applicable (NA) in the table above.
Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national adult Medicaid average.

[9-9] Statewide Aggregate scores were derived by calculating a mean of the combined scores of the six MCOs (i.e., weighted average of the MCOs' top-box rates combined).

Comparison of the statewide aggregate and MCOs' 2016 adult Medicaid CAHPS scores to the 2015 NCQA national adult Medicaid averages revealed the following summary results:

- The statewide aggregate scored 5 or more percentage points higher than the NCQA national adult Medicaid average on two measures: *Rating of Health Plan* and *Rating of All Health Care*. Further, the statewide aggregate did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any measure.
- Aetna scored 5 or more percentage points higher than the NCQA national adult Medicaid average on two measures: *Getting Care Quickly* and *Customer Service,* and scored 5 or more percentage points lower than the NCQA National adult Medicaid average on one measure, *Rating of Specialist Seen Most Often*.
- Anthem scored 5 or more percentage points higher than the NCQA national adult Medicaid average on two measures: *Rating of Health Plan* and *Rating of All Health Care*. Further, Anthem did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any measure.
- INTotal scored 5 or more percentage points higher than the NCQA national adult Medicaid average on three measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often,* and *Getting Care Quickly*. Further, INTotal did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any measure.
- Kaiser Permanente scored 5 or more percentage points higher than the NCQA national adult Medicaid average on two reportable measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often*. Further, Kaiser Permanente did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any reportable measure.
- Optima scored 5 or more percentage points higher than the NCQA national adult Medicaid average on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Further, Optima did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any measure.
- VA Premier scored 5 or more percentage points higher than the NCQA National adult Medicaid average on two measures: *Rating of Health Plan* and *Shared Decision Making*. Further, VA Premier did not score 5 or more percentage points lower than the 2015 NCQA national adult Medicaid average on any measure.

Comparison of the MCOs' 2016 adult Medicaid CAHPS scores revealed the following summary results:

- Aetna scored highest among the six MCOs on one measure, *Customer Service*. However, Aetna also scored lowest among the MCOs on five measures: *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate,* and *Shared Decision Making*.
- Anthem scored highest among the six MCOs on one measure, *How Well Doctors Communicate*, and was even with Optima for the highest score on one additional measure, *Rating of All Health Care*. Conversely, Anthem was even with Optima for lowest score for *Getting Needed Care*.

- INTotal scored highest among the six MCOs on two measures: *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. However, INTotal scored the lowest among the six MCOs on one measure, *Customer Service*.
- Kaiser Permanente scored lowest among the six MCOs on two reportable measures: *Rating of Health Plan* and *Getting Care Quickly*, and did not score highest among the six MCOs on any reportable measure.
- Optima scored highest among the six MCOs on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*, and was even with Anthem for the highest rating for *Rating of All Health Care*. Conversely, Optima was even with Anthem for the lowest score among the MCOs on one measure, *Getting Needed Care*.
- VA Premier scored highest among the MCOs on two measures: *Getting Needed Care* and *Shared Decision Making*, and did not score lowest among the six MCOs on any measure.

Child Medicaid CAHPS Results

Table 9-4 presents 2016 child Medicaid CAHPS top-box scores (i.e., the percentage of top-level responses) for each MCO and the statewide aggregate.[9-10]

Table 9-4—Comparison of 2016 Child Medicaid CAHPS Results

	Aetna	Anthem	INTotal	Kaiser Permanente	Optima	VA Premier	Statewide Aggregate
Global Ratings							
Rating of Health Plan	68.6%	75.5%	77.3%	65.3%	80.1%	68.3%	74.4%
Rating of All Health Care	70.5%	68.3%	68.0%	68.0%	74.5%	69.9%	70.2%
Rating of Personal Doctor	73.5%	77.1%	74.3%	72.5%	77.0%	75.2%	76.2%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	71.5%
Composite Measures							
Getting Needed Care	88.6%	85.8%	87.1%	80.7%	85.2%	83.7%	85.3%
Getting Care Quickly	92.3%	91.2%	89.2%	84.1%	90.1%	89.8%	90.4%
How Well Doctors Communicate	93.8%	92.7%	92.3%	91.5%	94.5%	95.4%	93.8%
Customer Service	NA	84.7%	88.1%	88.3%	NA	NA	86.6%
Shared Decision Making	NA	NA	73.8%	NA	NA	NA	78.4%

Given fewer than 100 respondents for a measure, this is denoted as Not Applicable (NA) in the table above.
Cells highlighted in yellow represent rates that are equal to or greater than the 2015 NCQA national child Medicaid average.

Comparison of the statewide aggregate and MCOs' 2016 child Medicaid CAHPS scores to the 2015 NCQA national child Medicaid averages revealed the following summary results:

- The child Medicaid statewide aggregate score was 5 or more percentage points higher than the NCQA national child Medicaid average on one measure, *Rating of Health Plan*, and did not score 5 or more percentage points lower than the national average on any measure.
- Anthem scored 5 or more percentage points higher than the NCQA national child Medicaid average on one reportable measure, *Rating of Health Plan*, and did not score 5 or more percentage points lower than the national average on any reportable measure.
- INTotal scored 5 or more percentage points higher than the NCQA national child Medicaid average on one reportable measure, *Rating of Health Plan*, and did not score lower than the national average on any reportable measure.
- Optima Health Plan scored 5 or more percentage points higher than the NCQA national child Medicaid average on two reportable measures: *Rating of Health Plan* and *Rating of All Health Care*, and did not score lower than the NCQA national average on any reportable measure.

[9-10] The scores for the statewide aggregate were derived by calculating a mean of the combined scores of the six MCOs (i.e., weighted average of the MCOs' top-box rates combined).

- Three MCOs (Aetna, Kaiser Permanente, and VA Premier) did not score 5 or more percentage points higher or lower than the NCQA national child Medicaid average on any reportable measure.

Comparison of the MCOs' 2016 child Medicaid CAHPS scores revealed the following summary results:

- Aetna scored highest among the six MCOs on two reportable measures: *Getting Needed Care* and *Getting Care Quickly*, and did not score lowest among the MCOs on any reportable measure.
- Anthem scored highest among the six MCOs on one reportable measure, *Rating of Personal Doctor*, and scored lowest on one reportable measure, *Customer Service*.
- INTotal scored lowest among the six MCOs on one reportable measure, *Shared Decision Making* and was even with Kaiser Permanente for the lowest score for *Rating of All Health Care*. Conversely, INTotal did not score highest on any reportable measure.
- Kaiser Permanente scored lowest among the six MCOs on five reportable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*, and was even with INTotal for the lowest score for *Rating of All Health Care*. Conversely, Kaiser Permanente did not score highest on any reportable measure.
- Optima scored highest among the six MCOs on two reportable measures: *Rating of Health Plan* and *Rating of All Health Care*. Further, Optima did not score lowest among the MCOs on any reportable measure.
- VA Premier scored highest among the six MCOs on one reportable measure, *How Well Doctors Communicate*, and did not score lowest among the MCOs on any reportable measure.

Conclusions and Recommendations

FAMIS Program

Based on an evaluation of the FAMIS program's 2016 general child and children with chronic conditions CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on enhancing members' experiences in those areas where CAHPS measure performance was lower than the 2015 NCQA national Medicaid average by 5 percentage points or more, or lower than the NCQA national Medicaid average.

For the population of children with chronic conditions, based on the FAMIS' program 2016 CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on enhancing members' experiences with *Customer Service* and *Coordination of Care for Children with Chronic Conditions*, since these measures scored lower than the NCQA national Medicaid average. For the general child population, based on the FAMIS' program 2016 CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on enhancing members' experiences with *Shared Decision Making* due to the measure scoring 5 percentage points or lower than the NCQA

national Medicaid average. The FAMIS program should evaluate these general recommendations in the context of its own operational and QI activities.

Customer Service

- **Call Centers**—An evaluation of current program call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- **Creating an Effective Customer Service Training Program**—The program could consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.
- **Customer Service Performance Measures**—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

Shared Decision Making

- **Improving Shared Decision Making**—Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. One key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration and understand patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Coordination of Care for Children with Chronic Conditions

- **Family-Centered Medical Home**—Health plans should ensure sufficient pediatric primary and specialty care pediatricians to manage and provide services to children. Health plans should understand and support family-centered care as it is parents and/or caretakers who are responsible for their children's health. It would be beneficial for health plans to integrate oral and mental health care into the delivery system, as some of the most common chronic care conditions children experience are oral and mental health problems. Health plans should have systems in place to provide to primary care practitioners committed to transforming their practices into family-centered medical homes, such as resources for clinical and non-clinical care, technical assistance, and management support.
- **Developing Physician Communication Skills for Patient-Centered Care**—Communication skills are an important component of the patient-centered care approach, offering a positive impact on patient satisfaction, adherence to treatments, and self-management of conditions. Health plans should offer communication skills education to their physicians to better afford effective communication and interaction with parents and/or caretakers of child clients. Physicians should ask questions about parents'/caretakers' concerns, priorities, and values and listen to their answers. Health plans can offer training to physicians in the following fundamental functions of physician-patient communication: fostering healing relationships, exchanging information, responding to patients' emotions, managing uncertainty, making informed decisions, and enabling patient self-management. Training to improve physician communication skills may be offered through in-house programs or through communications programs offered by outside organizations.
- **Enhancing Health Plan Structure**—Health plans can integrate medical, behavioral health, and social services for children. Care coordinators ensure that children receive appropriate services based on their medical, behavioral, and social needs. Care coordinators perform an assessment for each child, assign the child to a PCP, and assign the child to an appropriate risk tier to guide his/her level of care management. The risk tier a child is placed in directs the amount of care coordination, management, and monitoring the child should receive.

Medallion 3.0 CAHPS

Based on an evaluation of the MCOs' 2016 adult and child Medicaid CAHPS survey results, HSAG recommends that the MCOs focus QI initiatives on enhancing members' experiences in those areas where CAHPS measure performance was lower than the 2015 NCQA national Medicaid average by 5 percentage points or more, or lower than the NCQA national Medicaid average. The following is a summary of recommended area(s) for improvement based on these findings.

- Based on an evaluation of Aetna 2016 adult Medicaid CAHPS results, HSAG recommends that the MCO focus QI initiatives on enhancing members' satisfaction with *Rating of Specialist Seen Most Often*. For the child Medicaid population, the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that Anthem focus QI initiatives where measure performance was below the

NCQA national average. For the child Medicaid population, Aetna scored below the NCQA national average on *Rating of Health Plan* and *Rating of Personal Doctor*.

- An evaluation of Anthem's 2016 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that Anthem focus QI initiatives where measure performance was below the NCQA national average. For the adult Medicaid population, Anthem scored below the NCQA national average on *Rating of Specialist Seen Most Often* and *Getting Needed Care*. For the child Medicaid population, Anthem scored below the NCQA national average on *How Well Doctors Communicate* and *Customer Service*.
- An evaluation of INTotal's 2016 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that INTotal focus QI initiatives where measure performance was below the NCQA national average. For the adult Medicaid population, INTotal scored below the NCQA national average on *Customer Service*. For the child Medicaid population, INTotal scored below the NCQA national average on *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- An evaluation of Kaiser Permanente's 2016 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that Kaiser Permanente focus QI initiatives where measure performance was below the NCQA national average. For the adult Medicaid population, Kaiser Permanente scored below the NCQA national average on *Rating of Health Plan* and *How Well Doctors Communicate*. For the child Medicaid population, Kaiser Permanente scored below the NCQA national average on *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- An evaluation of Optima's 2016 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that Optima focus QI initiatives where measure performance was below the NCQA national average. For the adult Medicaid population, Optima scored below the NCQA national average on *Getting Needed Care* and *How Well Doctors Communicate*. For the child Medicaid population, Optima did not score below the NCQA national average on any reportable measure.
- An evaluation of VA Premier's 2016 adult and child Medicaid CAHPS results revealed that the MCO did not score 5 or more percentage points lower than the NCQA national Medicaid average on any of the CAHPS survey measures. Therefore, HSAG recommends that VA Premier focus QI initiatives where measure performance was below the NCQA national average. For the adult Medicaid population, VA Premier scored below the NCQA national average on *How Well Doctors Communicate* and *Customer Service*. For the child Medicaid population, VA Premier scored below the NCQA national average on *Rating of Health Plan* and *Getting Needed Care*.

The following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was lower than

the NCQA national Medicaid average. Each MCO should evaluate these general recommendations in the context of their own operational and QI activities.

Rating of Health Plan

- **Alternatives to One-on-One Visits**—The MCO should engage in efforts that assist providers in examining and improving their systems' capabilities to manage patient demand. As an example, the MCO could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments. Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.
- **Health Plan Operations**—It is important for MCOs to view their organizations each as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when MCO staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Further, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

Rating of All Health Care

- **Access to Care**—The MCO should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The MCO should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols for access to care issues can assist in this process by ensuring issues are handled consistently across all practices. As an example, the MCO could develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.
- **Patient and Family Engagement Advisory Councils**—Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. As such, the MCO should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members, providing new perspectives and serving as resources for feedback on health care processes.

Involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the MCO and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; design of materials or tools that support the provider-patient relationship; and marketing of health care services.

Rating of Personal Doctor

- **Maintain Truth in Scheduling**—The MCO can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. The MCO could provide assistance or instructions to those physicians unfamiliar with this type of assessment. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.
- **Direct Patient Feedback**—The MCO can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. The MCO can assist in this process by developing comment cards that physician office staff can provide to patients following their visit. Asking patients to describe what they liked most, what they liked least, and one thing they would like to see changed about the care they received during their recent office visit can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest.
- **Physician-Patient Communication**—The MCO should encourage physician-patient communication to improve patient satisfaction and outcomes. The health plan can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication techniques, and effectively communicating expectations and goals of health care treatment.
- **Improving Shared Decision Making**—The MCO should encourage skills training in shared decision making for all physicians. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process; ensuring that physicians understand the importance of taking each patient's values into consideration; and understanding patients' preferences and needs.

Rating of Specialist Seen Most Often

- **Planned Visit Management**—The MCO could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system

could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

- **Skills Training for Specialists**—The MCO could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
- **Telemedicine**—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Getting Needed Care

- **Appropriate Health Care Providers**—The MCO should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner.
- **Interactive Workshops**—The MCO should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.
- **"Max-Packing"**—The MCO can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.
- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a web-

based system, can improve the communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

Getting Care Quickly

- **Decrease No-Show Appointments**—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The MCO can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the MCO in determining targeted, potential resolutions.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Open Access Scheduling**—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

How Well Doctors Communicate

- **Communication Tools for Patients**—The MCO can encourage patients to take a more active role in the management of their health care by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options. MCO could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care.

- **Health Literacy**—Often, health information is presented to patients in a way that is too complex and technical, which can result in patients' reluctance to adhere to suggested care and thereby poor health outcomes. To address this issue, the MCO should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information being presented. Further, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' levels of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.
- **Language Barriers**—The MCO could consider hiring interpreters that serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationship among patient, family members, and physician. With an interpreter present to translate, the physician will have a clearer understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Customer Service

- **Call Centers**—An evaluation of current MCO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- **Creating an Effective Customer Service Training Program**—The MCO could consider implementing a training program to meet the needs of its unique work environment. from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The keys to ensuring that employees carry out the skills they learned in training are to not only provide motivation, but to implement a support structure when they are back on the job.
- **Customer Service Performance Measures**—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

10. Best and Emerging Practices for Improving Quality of Care and Service

This section of the report includes the best and emerging practices shared by MCOs. These effective and promising practices were developed to meet the needs of members, improve HEDIS scores, increase member and provider satisfaction, and close member gaps.

Anthem

Clinic Day Program

Anthem partners with its transportation broker (Southeastrans [SET]) to monitor missed appointments and complaints associated with "no-shows." For members who repeatedly no-show to appointments, Anthem works closely with SET to "gold card" them to closely monitor their transportation. Anthem has implemented a Clinic Day program that helps reduce no-shows for providers. The outbound call center and health program representatives assist members with setting up provider appointments which may include any transportation needs the member may have. Benefits of a Clinic Day:

- Improve the quality of life of members, specifically in relation to certain health care needs.
- Bolster member and provider satisfaction.
- Increase HEDIS scores.
- Decrease "no show" rates for providers.

There were 110 Clinic Day events held in CY2016. Anthem's Clinic Day program ensures that members are seeing the appropriate provider. Members are assisted with appointments. For preventive services, members see primary care physicians (PCPs); for eye exams, members see ophthalmologists or optometrists; for female-related care, members see gynecologists. Through Anthem's Clinic Day program, many providers utilize an open access type model, where providers set aside multiple days in which members can schedule appointments. This allows for appointment flexibility.

Electronic Medical Records

Anthem obtained electronic medical record (EMR) access from Virginia Commonwealth University Health Systems and Riverside. EMR access for University of Virginia (UVA) and Sentara is currently pending. EMR access is discussed and requested for every Clinic Day provider.

Telemedicine and Group Visits

Anthem covers telemedicine as a benefit to providers/members. The service/code is used rather infrequently at the moment and used mostly by behavioral health providers. One of Anthem's participating (PAR) providers, University of Virginia Health Systems, is trying to spread the use of telemedicine into more rural parts of the State. VCU Health, in Richmond VA, has a Centering Pregnancy Program in which Anthem members can be seen in a group setting. Quality has partnered with the VCU Centering Pregnancy Team to close care gaps such as cervical cancer screenings and chlamydia.

Electronic Communication

Anthem uses texting for health services to send health alerts to members. The alerts provide education information and reminders about general health and screenings and encourage activities to improve health.

- Screening Reminders
- Health Survey
- Health Education (quizzes)
- Healthy Challenges

Health Education Advisory Committee (HEAC) Member Focus Groups

Anthem ensures communication and an ongoing exchange of information with new and existing members to ensure that members understand their benefits as well as policies and procedures. This has been achieved by conducting HEAC member focus groups, where members are able to communicate any concerns they may encounter. Where opportunities exist, Anthem will follow up and act on the opportunities.

Max-Packing Model

Anthem utilizes the max-packing model by identifying all care gaps for each member prior to each clinic day event. All gaps are provided to the PCP or provider prior to each clinic day event so that all or as many gaps as possible can be closed during that one visit, reducing the need for numerous subsequent visits. Physical gaps in care are shared with the behavioral health team to share with the community service boards (CSBs), upon request. When members are seen at the CSBs, providers close both the physical and the behavioral health care gaps during one visit, reducing the need for numerous subsequent visits.

Aetna Better Health of Virginia

Member and practitioner engagement are key components to improving the quality of care and services for Aetna Better Health of Virginia (VA) members. Each team member within Aetna Better Health of VA is charged with making every member and provider interaction a positive and informative experience.

Member Services

The member services department is often the member's initial point of contact with the health plan. Since this interaction is so important to members, Aetna Better Health of VA, formerly CoventryCares, launched in 2015 a new catch phrase at the end of each member call: "Thank YOU for being the best part of Aetna Better Health of VA!" This slogan was designed to remind members that they are the most important parts of the health plan. The goal is to achieve first-call resolution and improve the quality of the services available to Aetna Better Health of VA members. Beginning this year, member services also addressed any gaps in care for each member that called in to the health plan and assisted the member to make necessary appointments and transportation requests.

Integrated Care Management

Integrated care management also began using the gaps in care tool when meeting with members via phone or in person. Care managers addressed all of the member needs, including HEDIS reminders and addressing barriers to care.

Provider Services

Provider Services conducted multiple provider forums and introduced a new Aetna Better Health of Virginia provider Web portal designed to assist the practitioner to find necessary information in one place. Offices could even find on the portal a list of their members who need HEDIS visits.

Outreach

Outreach re-introduced the Ted E. Bear Club for kids. This program engages children ages 0 through 10 with a birthday club and surprises for members who are up to date on their well exams and immunizations. It also offers health and wellness education material geared toward children in a kid-friendly format (Ted E. Bear coloring books and bookmarks) and an online partnership with KidsHealth.

Quality Management

Quality Management staff members visited over 170 practitioner offices this year. The team spent time with office staff talking about HEDIS tips, opportunities to conduct well care during sick visits, closing gaps in care, and removing barriers to well care. Aetna Better Health of VA also partnered with practices to make sure they knew about the incentives offered so that they could support and encourage Aetna Better Health of VA's efforts to engage the members they also attempted to reach via phone.

INTotal

In 2016, INTotal implemented a number of quality practices to improve the health and well-being of members and to strengthen the collaboration with providers and community partners. Below are several initiatives that INTotal began in 2016 and will continue to expand and grow in 2017.

Appeals and Grievances

In an effort to provide quicker response time to members on an appeal decision, the additional support from the Quality of Care (QOC) staff has been instrumental in reducing the wait time for appeal completion. INTotal had a drop in average turnaround time (TAT) for appeal review when including the additional nursing support in the third quarter of 2016.

2016 Average TAT for Appeal Review		
	# of Appeals	Average TAT (days)
Quarter 1	546	22.85
Quarter 2	399	28.02
Quarter 3	356	19.62

Communication to members regarding how to initiate a grievance with the Appeals and Grievances (A&G) department was included in the Q2 member newsletter, which resulted in an increased volume of reported grievances. The increased volume of grievances led to a higher number of member communications and interactions, which afforded the A&G staff the opportunity to provide additional education directly to members regarding coverage, how to provide the right identification when making and arriving at appointments (to avoid inappropriate bills) and how to look for a participating, in-network provider.

2016 Total Number of Grievances	
Quarter 1	190
Quarter 2	159
Quarter 3	252

Behavioral Health Home

INTotal case managers contact hospital discharge planners of members who are hospitalized for psychiatric reasons immediately following notification of the hospitalization. This helps to coordinate follow-up care for the member and meet the 30-day follow-up appointment measure. Additionally, members who meet the State requirements for the Behavioral Health Home (BHH) pilot are followed by a case manager and enrolled, at a minimum, in care coordination. Case managers involved with members enrolled in the BHH pilot establish relationships with the member's providers to coordinate care among primary care physicians and behavioral health providers. A goal for 2016 is to increase the number of visits by INTotal case managers to members while those members are hospitalized for psychiatric reasons so as to establish relationships with the members and to become more involved in care coordination.

7-Day and 30-Day Follow-Up Appointments for Behavioral Health (BH) Members

Following the best practice of ensuring follow-up care within 7 days of discharge from a psychiatric admission, INTotal assigned a case manager to each member while the member was still inpatient. The goals included reducing avoidable readmissions, facilitating member engagement, and assisting the member with making the follow-up appointment. Additionally, INTotal case managers partnered with the inpatient discharge planners to ensure that follow-up appointments were made while the member was in the hospital. Once the INTotal case managers were aware of the appointment, efforts were made (telephone calls, accompanying member to the appointment) to ensure that the member arrived to the scheduled appointment.

Pediatric Practice Behavioral Health Home Model

INTotal partnered with a pediatric practice to provide additional behavioral health services for pediatric members with behavioral health diagnoses. A psychiatrist provided services at the practice for up to four hours a week. Additionally, the pediatricians, psychiatrist, and social workers at the practice, along with case management staff from INTotal, met monthly to conduct rounds of selected members with behavioral health diagnoses. All staff worked together to develop care plans and to make referrals to community resources.

Emergency Room (ER) and 24-Hour Nurse Line Real Time Data

INTotal, through its parent partnership with Inova Health System was able to secure access to real time emergency room (ER) data for INTotal members receiving ED services at eight Northern Virginia hospitals. A spreadsheet was delivered electronically each morning and allowed for real time intervention, coordination, and follow-up for members who had sought care in an emergency setting within the past 24 hours. Members cases were reviewed daily and stratified by case management staff for outreach. Outreach occurred within 24 through 48 hours after the emergency room visit. Populations

targeted for outreach included high-risk pregnant members not previously identified, high utilizers of care, and members requiring medical follow-up and coordination with new providers (e.g., orthopedics). The goals of outreach for this population included timely intervention, customer service support (e.g., assistance with prescriptions not on formulary, locating providers), better use of in-network providers, and education on the utilization of the correct care setting.

In addition to the daily ED reports, INTotal received a daily report from the 24-hour nurse line identifying members that called in, their questions or concerns, and any advice or instructions provided by the clinical staff. These reports were individualized by each member and provided a thorough and detailed summary of each call. Case management staff reviewed and returned member calls within the next business day to discuss member experiences, to offer continued support, and to determine whether or not members followed up on the nurse's recommendations. The daily nurse line report has led to additional member outreach and increased referrals for both Disease Management and Case Management.

Utilization Management

INTotal's Utilization Management (UM) department has evaluated services that require authorization and determined that some services that require authorization may impede the member's ability to get needed services timely. As a result, the authorization requirements for all breast pumps and outpatient hysterectomies have been removed. This initiative was identified through the analysis of appeals data and reviewing the key findings of INTotal's Adult and Children CAHPS survey results. The UM department continues to work with the provider network and provider relations to assist with educating practitioners on prior authorization requirements and the importance of submitting complete information at the time of requesting service. The UM department continues to educate providers about allowed timeframes for making UM decisions.

Case Management

The Maternal and Child Health program offered community-based education for its members that included child birth education, child care education, breastfeeding education, and coordination of care services. The behavioral health program offered a care management program based in a large provider office serving members of the pediatric population in Northern Virginia. Supporting INTotal members with an on-site child psychiatry as well as care coordination model of care has improved communication between providers. The neonatal intensive care unit (NICU) care management program connected all NICU members and parents with care managers for ongoing coordination of care. A care manager is assigned upon member admission to the NICU and continues to work with the member and the member's parents through discharge. This improved post-hospitalization support has encouraged the parents to develop relationships with INTotal's care managers.

Outreach

INTotal launched two initiatives in 2016 with a focus on engagement and benefit education. The Hello, We Have Been Trying to Reach You initiative took place at a community event offered to members and potential members. Participants were asked to voluntarily provide their contact information. The plan used this information to validate member information provided on the state 834, and then INTotal documented the alternative contact information in the case management system. This activity supported INTotal's ability to reach a greater percentage of members through ongoing engagement and access to care. This initiative was implemented in January 2016 and to date has yielded the following outcome: from January 2016 through October 2016, in the Northern VA pilot, 1,471 individuals were engaged during community events, of which 579 were INTotal members. Of the 579 members, 71 percent had a change in or different demographics (phone and/or address) than that presented on the current state 834.

The Managed Medicaid With INTotal Health: Know Your Benefit initiative involves a YouTube video which presents benefit information about prenatal, dental, and transportation services available to members. These services are in addition to value-added services such as registration to a local Boys and Girls Club and school physicals. INTotal received great feedback from both community partners and members about this initiative.

Kaiser Permanente

Health Education

Regional health education offers telephonic wellness coaching for five lifestyle topics including weight management, healthy eating, tobacco cessation, stress management, and physical activity. Members may schedule 20-minute phone appointments and unlimited follow-up appointments.

Comprehensive Perinatal Program

Kaiser Permanente Mid-Atlantic States' Comprehensive Perinatal Program has three interrelated components surrounding the goal of helping mothers have healthy pregnancies and deliver full-term, healthy babies.

- **Early Start**: This perinatal substance abuse intervention program educates women about the risks of substance abuse, including tobacco use, in pregnancy. Women are universally screened in early pregnancy via urine toxicology and questionnaire. If the screen is positive, a best practice alert notifies the provider that the member is appropriate for outreach by the Kaiser Permanente Early Start specialist.
- **High-risk perinatal case management**: Through responses on the prenatal questionnaire, pregnant women experiencing domestic violence, unstable housing, food insecurity, transportation barriers, or

unemployment trigger a best practice alert to notify the provider that the member is considered high-risk and to be contacted by telephone by a case manager.

- **Perinatal service center**: Nurses identify members at risk for diabetes, hypertension, or pre-term delivery and provide education, care coordination, and close monitoring through frequent phone contact.
- **Newborn Care Center and Lactation Support**: Kaiser Permanente's Newborn Care Centers provide, at one to three days' post hospital discharge, newborn physical assessments and feeding evaluations for all healthy mothers/babies. The goals of the program are to ensure a smooth transition from hospital to home as well as provide lactation support to any member who requests it. International Board Certified Lactation Consultants run the Newborn Care Centers and offer services seven days a week. No charge exists for these appointments.

Flu Vaccination Program

Program Philosophy

Kaiser Permanente's 2016-2017 Flu Vaccination Program is focused on ensuring that all patients of Kaiser Permanente, including Medicaid and the State Children's Health Insurance Program, have the ability to receive a vaccination, at no additional cost, as part of our preventive and integrated care model. Patients are strongly encouraged to come to any of our Medical Office Buildings to receive a flu shot. No appointments necessary and some of our centers are open 24 hours. Flu shots are also available year round; however, during peak months, flu clinics are set up in the lobby of each medical building.

Access to Immunization

From September through December, flu clinics were opened and highly visible in every medical office building to aid in the access and ease for members. Kaiser Permanente implemented a large advertising campaign this year to assist in communicating this value-added benefit to members. Continuing flu season 2016 into 2017, providers will continue to see member walk-ins for a flu shot at all Kaiser Permanente locations.

Program Outreach and Results

Along with open access, healthcare teams have the ability to track immunizations, allowing providers to know real time if a patient has been immunized. This is part of the proactive care model, ensuring staff are asking every patient at every encounter to get a flu shot. Additionally, staff routinely use secure email to reach out to patients who have not been immunized.

Pediatric Care Delivery

Health Assessments and Prevention Screening

Kaiser Permanente offers an integrated approach to members. Kaiser Permanente is dedicated to prevention and screening for the youngest members.

Kaiser Permanente staff members use health questionnaires at every health assessment as a screening tool for development, nutrition, and anticipatory guidance. In addition, all members are screened for developmental delay with Ages and Stages questionnaires at ages 9, 18, 24, and 30 months.

Members are also screened for autism at 9, 18, and 24 months using the Modified Checklist for Autism in Toddlers (MCHAT). This approach allows for early identification and intervention for any fine and gross motor developmental delays, speech delays, or autistic behaviors.

Program Outreach

Kaiser Permanente proactively contacts members for preventive care. One of the major initiatives is outreach for routine health assessments and immunizations. Kaiser Permanente's integrated health care system captures and monitors when members are due for a physical or immunization.

Kaiser Permanente also participates with the Virginia Immunization System to ensure accurate information is obtained for members.

Kaiser Permanente partnered with the Bright Smiles program to ensure that all of the providers and health plan staff were trained on the Fluoride Training program.

Case Management

Kaiser Permanente uses a comprehensive case management strategy to assist high-risk and special needs members through our integrated care delivery system. Upon enrollment, members identified as having special needs are triaged through case management and receive targeted outreach to meet milestones in various care regimens. Additionally, Kaiser Permanente case management surveys these members for social determinants of health that may impact their lives negatively. The questionnaire posed to members includes food, transportation, housing, and financial concerns; and the case manager assists in connecting the member to appropriate community resources. Members are also asked about their living conditions in terms of safety and caregiving to ensure that they are properly equipped to address everyday life as well as their health needs.

Optima

Member Outreach

Optima Family Care has fully implemented a new cloud-based workflow management system called Symphony™. The Symphony software allows staff to proactively manage patient outreach and assessments. It also creates electronic tracking of all member outreach encounters, allowing for more seamless reporting. Enhancements include:

- Implementation of "hard stops" on assessments to require completion of all questions prior to saving the document.
- Formatting changes (the order or wording of questions) to improve the flow of conversation when the assessment is completed telephonically.
- The identification of members within same households to better group outreach activities.

In addition, Program Managers are working closely with outreach staff to assist with the validation of member demographic information (to assist in finding correct location and telephone numbers). This has allowed for better completion of member assessments for the aged, blind, disabled, foster care, early intervention, and HAP members.

Targeted Health Initiatives

- Optima Family Care has developed programs/mailings to specifically target preventive care.
- Targeted outreach phone calls are made to members due for well-child and/or adolescent care visits as well as for prenatal care appointments.
- Pop-up notification occurs in the eligibility system. When a Member Service Representative or Case Manager is on the phone with a member and accesses the eligibility on a member, a "pop-up" will let them know if the member is in need of specific preventive health care such as immunizations, well-child visits, mammograms, or cervical cancer screening. The representative can then discuss the importance of the services with the member.
- Immunizations and well-child visits reminders:
  - Calendar sent to all households with a child under the age of six.
  - Age-appropriate birthday cards for preventive care are sent to adults, and three childhood, age-appropriate cards are also sent (annually).
  - Immunization reminder postcards are sent to members at 6, 12, and 18 months of age.
- Cervical cancer postcards are sent to female members who have not had a screening by age 22 or during the previous year.
- Mammography reminder mailings are sent to non-compliant members.

- Partners in Pregnancy mailings are sent at early pregnancy, 7 months, and 38 weeks. Enclosures include a pregnancy handbook, childhood immunization magnet, fleers on depression, and information on prenatal care and the Partners in Pregnancy program.

Lifeline and Voxiva

Optima Family Care continued use of lifeline and digital health messaging programs (Voxiva) has increased the number of mobile phones to their members. This has allowed for better access and communication with members. The text message-based program is designed to educate and support members; encourage them to follow recommended guidelines for preventive care, immunizations, and screenings; and inform them of health plan services and benefits.

Controlling Blood Pressure

Case management follows members with a diagnosis of high blood pressure to verify compliance with medications and follow-up visits to their physicians. Optima Family Care added tips to the Member Service telephone line regarding cardiac/heart disease. Information was added to the Member Outreach calendar that is distributed each year.

Quality Improvement Information

Packets were distributed to pediatricians and other PCPs as well as to behavioral health and OB/GYN providers. The packets addressed HEDIS measures and their corresponding Screening, Test, or Care Needed definitions. Quality improvement continued to identify non-compliant members, and letters were sent to the corresponding physicians.

VA Premier

Atypical Antipsychotics Program

Children and adolescents prescribed antipsychotics are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, and some metabolic effects. Although there is no research on the long-term effects of multiple concurrent antipsychotics on children's health, the increased side effect burdens of certain antipsychotic medications for youth, such as weight gain and metabolic disturbances, have implications for future physical health, including concerns such as obesity and diabetes. Both the efficacy and side effects of antipsychotic medications vary by age.

The Atypical Antipsychotics program began in September 2015. Several American Academy of Child and Adolescent Psychiatry (AACAP) practice parameters (including for treatment of schizophrenia and

bipolar disorder and for the use of psychotropic medication and atypical antipsychotics) recommend careful monitoring of side effects. The Canadian Alliance for Monitoring Safety and Effectiveness of Antipsychotics in Children recently published evidence-based guidelines for metabolic and neurological monitoring of children prescribed atypical antipsychotics.

Through a collaborative process between Case Management and Pharmacy, the Atypical Antipsychotic program promotes care coordination between medical and behavioral health providers. Pharmacy receives monthly reports that identify members between ages 7 and12 and with a claim for an antipsychotic medication who have not had a well-child PCP visit within the previous 12 months. The Pharmacy Department then mails care coordination letters to both the BH and PCPs. The monthly report is also consumed by the MMIS, which automatically opens cases for all affected members and triggers outreach for the Case Management Team. Both members and providers are called in an effort to arrange primary care well-child visits and coordinate communication between primary medical and behavioral care.

Interventions for the Program include:

- Pharmacy mails care coordination letter to the identified member's PCP and BH practitioner advising that there is no record of a well-child visit in the previous 12 months.
- A Case Management episode is automatically opened in the MMIS, triggering outreach by a Case Manager. Case Management contacts each member to complete a health risk assessment and to coordinate a well-child checkup.

Since its implementation, approximately 24 percent of identified members have completed well-child visits with PCPs.

Practitioner Golden Globe Award

VA Premier values quality and safety first, especially when coordinating and managing care for members. The Practitioner Golden Globe Award (PGA) program was established to recognize, promote, enhance, and salute excellence in the VA Premier practitioner network. Criteria for recognition includes receipt of an award and/or special designation in one's field; appointment to a health-related local, state, or national committee; or attainment of any NCQA recognition awards (Diabetes Physician Recognition Program, the Heart/Stroke Physician Recognition Program, or the Physician Practice Connection designation). Also recognized are physicians who have instituted targeted health improvement programs in their practices to address the health care needs of a specific patient group. A practitioner can self-nominate or be nominated by a member or a colleague.

The PGA program meets the intent of NCQA standard QI 1, which requires that health plans maintain a QI infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members. This PGA program specifically addresses patient safety improvement. Also, this is a way of engaging the providers and recognizing their value to the health plan.

One award recipient is selected per fiscal year based upon the following criteria: Practitioner must have an unrestricted, current, and valid license; be in good standing with VA Premier; have had no founded grievances or quality issues within the last 12 months; and have no legal issues. Practitioners are encouraged to proudly display the award in their office. Members, colleagues, and the public may access information about this program and the award recipients via member and provider newsletters and the VA Premier website: www.vapremier.com.

Provider Quality Toolkit

VA Premier is aware that physician engagement is key to impacting the care of members. VA Premier considers physicians partners, not customers. A known strategy to engage providers is to "engage" them by using data and tools to be successful. VA Premier tries to use data sensibly through ongoing monitoring of the practice's data with Care Gap Reports outlining members paneled to their practices and the identified gaps. The quality staff sets up visits to discuss the care gaps and educate practitioners.

During the visit, a quality toolkit is provided to the practice to reinforce educational efforts by the staff. These provider toolkits have been well received. The contents of the toolkit consist of the following:

- HEDIS Quick-Reference Billing Codes
- PCP Change-Request Form
- Care Management Request Form
- Consumer Assessment of Healthcare Providers and Systems
- HEDIS Hybrid Measures Overview
- Provider Measure Overview
- Immunization Schedules for Person Ages 0–18 Years
- Well Care: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Exam Forms and Anticipatory Guidance
- Well-Child and Adolescent Well Care Visits Guide
- Diabetes Mellitus Patient Checklist
- Body Mass Index (BMI) for Age Percentiles 2–20 Years: Boys
- Body Mass Index (BMI) for Age Percentiles 2–20 Years: Girls
- Body Mass Index (BMI) Table: Adults
- Virginia Guidelines for Childhood Lead Poisoning Testing
- Virginia Immunization Information System (VIIS)
- Vaccines for Children (VFC) Program Information
- Healthy Heartbeats Brochure
- Postpartum Fliers
- Member Safety Program Flier

11. Assessment of MCO Follow-Up on Prior Year Recommendations

Introduction

Below are the MCO quality improvement activities implemented per recommendations stated in the 2015 EQR technical report.

NCQA HEDIS Compliance Audit, Performance Measure Validation, and Rate Review EQR 2015 Recommendations

- To ensure timely and accurate mapping, generation of medical record review lists, and submission of quality-checked documentation to HEDIS auditors, HSAG recommended that additional steps be included in quality control activities to ensure that documentation and processes are completed effectively.
- For the MCO that could not report Board certification rates, if this measure is required in the future, the MCO should identify processes to improve the provider certification data.
- HSAG recommends that DMAS continue to hold MCOs accountable for key HEDIS measure set rates and assess performance at or above the Quality Compass 50th percentiles. In future years, HSAG recommends that DMAS examine the option of raising the benchmark at which MCOs' HEDIS measure rates are evaluated if overall performance across MCOs shows marked improvement.
- Given the variation in MCO HEDIS rates within each measure set, HSAG recommends that DMAS facilitate sharing of successful improvement interventions for HEDIS measure rates between MCOs (e.g., engage high-performing MCOs to collect strategies for improving prenatal and postpartum care provided to pregnant members, increasing access to optometrists, and achieving adequate blood pressure control for members with diabetes; and share those strategies with low-performing MCOs as appropriate).
- HSAG recommends that MCOs focus on key HEDIS measures, using small-scale, rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives.

MCO Responses

Following are MCO responses, which have been primarily included as presented to HSAG.

Aetna Better Health of Virginia, Formerly CoventryCares of Virginia

Aetna has its own goals and internal benchmarks and is tracking for the 75th and 90th percentiles for key HEDIS measures. Aetna suggests and agrees to share successful improvement interventions for HEDIS measure rates at the summer Medicaid Managed Care Quality Collaborative meeting and

perhaps work on a common initiative that all MCOs would promote together. Aetna is in the process of learning small-scale and rapid-cycle intervention testing to assess effectiveness and facilitate spread of successful initiatives for the Diabetes PIP. Lessons learned will be applied to additional HEDIS measures in 2017.

Anthem

Anthem has policies in place to insure that quality control and processes are completed effectively. Anthem reported the Board Certification rates for the recent HEDIS project via the credentialing and re-credentialing process. Anthem key HEDIS measure set rates have reached the Quality Compass 50th percentiles and the Anthem goal is the 75th percentile in HEDIS 2017. For the *Timeliness of Prenatal Care* measure, HEDIS 2015 rates (CY2014) were at the 50th percentile. For HEDIS 2016 (CY2015), Anthem increased rates to the 75th percentile. HEDIS Best Practices by the MCOs are shared at the DMAS Medicaid Managed Care Quality Collaborative meetings. In 2014, Anthem presented a best practice initiative at the DMAS Quality Collaborative meeting. Currently, Anthem is going through its first cycle of a rapid- cycle PIP for Diabetic Retinal Eye Exams.

INTotal

In 2016, INTotal was able to increase the staffing support for HEDIS. INTotal hired a HEDIS Manager to coordinate all HEDIS activities at the plan and designated a data analyst specifically for HEDIS and CAHPS. INTotal also used the expertise of a HEDIS consultant to assess the strategic plan and to help structure activities around the most impactful areas of improvement. To increase the number of supplemental data sources, INTotal is partnering with Inova's electronic medical record vendor, EPIC, to obtain data feeds, which further support the care that was provided at all of the Inova hospitals and ambulatory care settings.

By the end of 2016, INTotal will launch a new provider software solution that will allow for enhanced reporting, a robust provider directory, and an integrated credentialing system. In the process of customizing and launching this system, all provider data have been reviewed and updated. Automated calls are made to members, which provide information and support on a variety of health topics (e.g., immunizations, ED follow-up) and disease-specific education (asthma, diabetes, blood pressure). Welcome packets to new members include INTotal's preventive care guidelines along with an immunization schedule. Customer service representatives in the call center are able to identify member care gaps, address gaps in care with the member in real time, and assist the member with connecting to a specific provider or INTotal's service or staff member.

Members continue to receive incentives for their prenatal and postpartum care. INTotal has educational offerings in a variety of modalities: paper letters and mailings, phone calls, online tools, and personalized interactive assessments. A coding guide was created and disseminated to providers INTotal has developed close community partnerships to help members navigate care across the continuum. Case management programs were expanded in 2016 to include case manager assignment for all members hospitalized with behavioral health needs, case manager assignment for all members that are high-risk for re-hospitalization, and case manager assignment for all members in any high-risk category.

INTotal continues monthly campaigns to increase member awareness about the importance of preventive care, such as reminder calls and mailing for mammograms, diabetic retinal eye exams, and cervical cancer screenings.

Kaiser Permanente

Kaiser Permanente was not included in the review, having not submitted 2014 HEDIS rates to NCQA because it was not a contracted MCO with DMAS until 2013.

Optima

Based on review of HEDIS 2015 rates, Optima Health reviewed their current work groups' structures and developed two internal work groups to address HEDIS measures. One work group, HEDIS Improvement, focuses on initiatives and implementation; the second work group, HEDIS Weekly Workgroup, focuses on how data are captured and reported.

The HEDIS Improvement Workgroup was expanded to include additional departments to focus on improving rates not meeting the 50th percentile of Quality Compass. The work group meets to review, discuss, develop, and implement initiatives. The measures identified for improvement were measures that declined from HEDIS 2015.

The HEDIS Weekly Workgroup meets weekly to review all HEDIS updates, Inovalon updates, and any rate changes. This group includes multiple departments and staff. The group reviews rates that are declining in order to determine causes. If determined to be a performance issue, the issue is referred to the HEDIS Improvement Workgroup for further review. If a data issue exists, the group will work to verify that data are being captured and reported accurately and make changes and improvements where necessary. This group also looks at other data sources that could be used to capture HEDIS measures.

The Analytics Department conducted a detailed analysis of HEDIS 2015 data to determine the cause of the decreased rates. Once these measures, *Follow-Up After Hospitalization*, *Prenatal Care*, and *Postpartum Care*, were identified, processes were developed to improve data transmission into the HEDIS Inovalon tool. This allows for the appropriate capture of data, thus allowing the transmissions and reporting to fully represent the visits completed. In reviewing the data for *Prenatal Care* and *Postpartum Care*, the group discovered that not all pre-authorization documentation/codes from the Care Manager system were being transmitted into the Inovalon tool. IT developed and implemented a process to capture and transmit the codes to Inovalon.

VA Premier

VA Premier has built quality checks into the medical record review process. The process is outlined from abstraction to data entry in the HEDIS Record of Administration, Data Management, and Processes (Roadmap). The medical record list is generated out of the HEDIS software for auditor selection. Once the records are selected, the documentation to substantiate compliance is provided to the auditor for review. There is a built-in quality check of the records prior to submission to the auditor to insure

accuracy and compliance. All medical record reviews by the HEDIS auditors have passed without deficiencies.

VA Premier's goals are to achieve the National 50th percentile on HEDIS measures with a stretch goal toward 75th percentile and to increase member compliance.

VA Premier has implemented the following active interventions to impact rates:

- Gaps in care—Member Services refers calls from diabetic members to Disease Management to encourage appointments for eye exams and screenings.
- Member alert system for member service representatives identifies members with gaps in care and refers to Case Management or Disease Management.
- Member Outreach full press (system-generated member alerts) locates members, who have been identified as having gaps in care, to schedule appointments.

Performance Improvement Projects EQR 2015 Recommendations

The PIPs were methodologically sound; however, the Outcomes stage represented an opportunity for improvement for all MCOs. The Outcomes stage is the culmination of the previous two stages of the PIP. When improved PIP outcomes are not achieved, MCOs must revisit steps in the Implementation stage, including the identification of barriers through causal/barrier analysis and the subsequent selection of effective improvement strategies to address those barriers.

In addition, an MCO's choice of interventions, combination of intervention types, sequence, and timing of interventions are essential to the PIP's overall success. Active interventions (e.g., system changes, direct member and/or provider contact, events, incentives) should be selected rather than passive changes (e.g., newsletters, postcard mailings, interactive voice response [IVR] calls, website updates). Passive interventions can be difficult to evaluate because it is unclear whether or not the member or provider was reached and/or whether or not the change had any impact on the study indicator result.

MCOs should also regularly evaluate interventions to ensure that they are having the desired effects. A concurrent review of data is encouraged. HSAG recommends rapid-cycle testing of interventions on a small scale using a quality improvement method such as PDSA. Interventions deemed effective when tested on a small scale should be considered and evaluated for larger-scale testing. If the evaluation of interventions and/or review of data indicates that interventions are not having a desired effect, the MCOs should revisit causal/barrier analysis; verify that the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

HSAG recommends that the MCOs:

- Conduct causal/barrier analysis using quality improvement tools (e.g., a key driver diagram, fishbone diagram, or process mapping) for each PIP topic at least annually and ensure that the

quality improvement tools completed focus specifically on barriers to improving the study indicator results for the PIP topic.

- Drill down to determine why the members and providers are "not compliant." Those answers are the barriers.
- Prioritize barriers for all PIPs based on results of data analysis and/or other quality improvement processes.
- Implement active interventions to address the highest-priority barriers.
- Logically link all interventions with barriers identified as a result of causal/barrier analysis.
- Have an evaluation plan to measure the effectiveness of each intervention.
- Review interim intervention evaluation results, and make modifications to interventions as necessary.
- Be cognizant of the timing of interventions. Interventions implemented too late in the measurement period will not have enough time to impact the results. Each remeasurement period should have active interventions in place throughout the entire measurement period.
- Evaluate whether or not additional system and/or process barriers impede improvement, and identify evidence-based interventions that can be implemented to address discovered barriers.
- Consider testing more changes on a small scale using rapid-cycle quality improvement tools such as PDSA.

In 2016, the MCOs transitioned to conducting one DMAS-selected PIP topic focused on diabetes care using the HSAG rapid-cycle improvement model (Refer to Section 6—Performance Improvement Projects).

MCO Responses

Aetna Better Health of Virginia, Formerly CoventryCares of Virginia

Aetna, along with the other Commonwealth of Virginia MCOs, is currently learning and completing the first three modules for a new rapid-cycle PIP approach under the direction of HSAG. All PIP recommendations have been incorporated into the new process.

Anthem

Anthem's rapid cycle PIP topic for 2016 is Comprehensive Diabetes Care-Eye Exam (Retinal) Performed. Anthem completed Module 1 and Module 2 and submitted them to HSAG in October 2016. Module 1 and Module 2 are now fully compliant per HSAG. Anthem is currently working on Module 3, which is due to the State on December 2, 2016.

INTotal

INTotal did not identify any improvement activities under this recommendation related to the 2015 PIP recommendations.

Kaiser Permanente

Kaiser Permanente was not required to conduct PIPs in 2015.

Optima

Optima Health developed a rapid-cycle PIP process for Improving Diabetic Eye Exams for Medicaid members identified in zip codes where eye exams appear to be low. Optima Health submitted this rapid-cycle PIP to HSAG for Module 1 and Module 2.

VA Premier

Based upon guidance and direction from the EQRO, VA Premier is in the process of implementing a focus on CDC eye exams using rapid-cycle quality improvement testing. The health plan selected five federally qualified health centers (FQHCs) to increase eye exam rates. An interdisciplinary team was formed to implement the rapid-cycle process, which will include testing interventions on a small scale. Active interventions were selected to positively impact the measures. Monthly surveillance of the measure and the intervention will be conducted to gauge if the intervention is having the desired effect. Interventions will be reviewed; and if the desired effect is not attained, a causal/barrier analysis will be conducted; and the intervention will be revised or discontinued, or new interventions will be implemented. Drill down of data will occur to identify barriers that may impact increasing the measure. Interim evaluations of results will be conducted to make any necessary adjustments. Based upon success of the interventions, implementation will be spread on a larger scale.

Consumer Survey of Quality of Care EQR 2015 Recommendations

FAMIS Program

DMAS contracted with HSAG to administer and report the results of the CAHPS survey for the statewide FAMIS program. Anthem, Coventry, INTotal, Optima, and VA Premier were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf for Medicaid managed care. Based on an evaluation of the FAMIS program's 2015 general child CAHPS survey results, HSAG recommends that the FAMIS program focus QI initiatives on enhancing members' experiences with Getting Care Quickly. The following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas where CAHPS measure performance was lower than the NCQA national child Medicaid average by 5 percentage points or more.

MCO Responses

Aetna Better Health of Virginia, Formerly CoventryCares of Virginia

FAMIS Program Response

Rating of Health Plan

Aetna is embracing the telemedicine technology and working with VCU Health System to offer this solution to members. The Dynamo® Gaps in Care tool was developed as a process improvement initiative to help guide consistent messaging across different departments wherein staff members may have an opportunity to speak with a member. Anyone in Member Services, Utilization Management, or Quality Management, who is speaking with a member, can utilize the Gaps in Care reports. These reports tell who needs wellness visits or who might be missing preventive screenings in 2016. Each team is also empowered to assist the members with making appointments and addressing the barriers to care.

At Aetna, quality improvement initiatives are communicated at every level, beginning with the CEO and CMO and extending to each of their respective direct reports and teams. Aetna feels that quality is everyone's job and that the responsibility to engage and empower members belongs to each staff member. QI initiatives are shared at various plan-level committees with participating provider involvement. Quality data are available to practitioners to assist them with identifying members in need of care. Interventions are implemented using a rapid-cycle monitoring approach and adjusted quickly if found ineffective.

Getting Care Quickly

Aetna staff members encourage practices to notify them when members have missed appointments. Their team conducts outreach to the members to identify reasons for no-show appointments. Aetna asks members at the Member Advisory Committee meetings about barriers to care and what they can do to help them get the care they need. Aetna staff heard at a recent Member Advisory Committee that members were not aware of the transportation benefit. Aetna increased advertising of this benefit and always asks if the member needs help with transportation when assisting with scheduling appointments.

Aetna is leading the way in designing the next generation's approach to information exchange and population health management software, CareUnify. The primary purpose of CareUnify is to create a collaborative information platform to digitally share and aggregate actionable data across systems and organizations with the purpose of promoting effective and efficient care coordination— especially for high-risk individuals with complex health care needs.

Customer Service

Aetna's Member Services Manager conducts an evaluation of the prior day's call volumes daily. A report of the prior day's calls shows the number of calls that come in to the center in 30-minute increments. The report includes numbers of calls offered, answered, and abandoned. Additionally, it

shows how long it took for the calls to be answered in that 30-minute period. The analysis of these data allows for changes to be made to staffing based on findings for specific periods of the day.

Each of Aetna's call center representatives completes a four-week intensive training plan. This training consists of three parts:

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

The telephone skills training includes cultural competency and soft skill phone etiquette. Additional behavioral health training is conducted to enable staff to recognize when clinical support is needed.

Aetna's call center representatives are monitored monthly to ensure that they are handling calls correctly. Each time representatives are monitored, they receive feedback from the team lead or manager based on the findings of each call. Aetna is dedicated to making sure that call center staff members provide all the required information to callers, with the best possible outcomes.

Member Services staff members report call center data to the state monthly, including total calls offered and received, total calls abandoned by percentage, average speed to answer, and average talk time. Performance goals are established for each of the preceding elements. In addition to the required reporting statistics, the Member Services manager conducts a monthly analysis of call types, average calls per day, average time to abandon, and percentage of calls answered in 30 seconds or less. By analyzing call data, Member Services is able to appropriately staff the call center with trained individuals to ensure that all required and expected call metrics are met. Aetna consistently meets health plan metrics with local Member Services agents since the time that CoventryCares of Virginia migrated to Aetna in April 2016.

Medallion 3.0 CAHPS Recommendations

Based on an evaluation of Coventry's 2015 adult Medicaid CAHPS results, HSAG recommends that the MCO focus QI initiatives on enhancing members' satisfaction with *Rating of Specialist Seen Most Often.* For the child Medicaid population, HSAG recommends that Coventry[11-1] focus QI initiatives on *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*.

Aetna Responses

Rating of Health Plan

Aetna is implementing the same processes for the Medallion 3.0 CAHPS recommendations as implemented for the FAMIS program for this area of improvement as cited previously.

[11-1] Aetna acquired Coventry Health Care of Virginia in 2013.The name change to Aetna was effective April 1, 2016.

Aetna is embracing the telemedicine technology and working with VCU Health System to offer this solution to members. The Dynamo® Gaps in Care tool was developed as a process improvement initiative to help guide consistent messaging across different departments wherein staff members may have an opportunity to speak with a member. Anyone in Member Services, Utilization Management, or Quality Management, who is speaking with a member, can utilize the Gaps in Care reports. These reports tell who needs wellness visits or who might be missing preventive screenings in 2016. Each team is also empowered to assist the members with making appointments and addressing the barriers to care.

At Aetna, quality improvement initiatives are communicated at every level, beginning with the CEO and CMO and extending to each of their respective direct reports and teams. Aetna feels that quality is everyone's job and that the responsibility to engage and empower members belongs to each staff member. QI initiatives are shared at various plan-level committees with participating provider involvement. Quality data are available to practitioners to assist them with identifying members in need of care. Interventions are implemented using a rapid-cycle monitoring approach and adjusted quickly if found ineffective.

Rating of All Health Care

Quarterly Geo Access reports indicate that Aetna has adequate numbers of participating practitioners across their service area. When members are unable to obtain the care they need, the Clinical Health Services team assists and authorizes out-of-network care as necessary for the member. Aetna also educates members at least annually about developing medical home-type relationships with their PCPs for urgent care and the option of urgent care centers if their PCP is not available for non- life-threatening illnesses.

Aetna has instituted Member Advisory Committees across the State this year. Aetna invite members and their support persons to participate. Topics addressed this year have included wellness and benefit education, website review, transportation, and HEDIS.

Aetna looks forward to larger and more robust meetings throughout 2017 wherein they hope to further engage members and families in program development and member focus groups. Feedback from these types of encounters is valuable as they continually evaluate programs for opportunities to improve.

Rating of Specialist Seen Most Often

This year, Aetna is focusing on the relationship between the PCP and the specialist to understand if effective communication exists between the two. Aetna also wrote newsletter articles to educate members on how to prepare for a practitioner visit and tips for a successful visit. Records for members with chronic conditions may be flagged for case management intervention and monitoring, which would include appropriate follow-up with the specialist. To date, Aetna interventions have been member focused; however, Aetna will take HSAG's recommendations under advisement for 2017.

The Aetna provider newsletter is a solid vehicle to address specialists' skills training for specialists and cultural competency awareness. Aetna is also revising the Aetna website and provider portal to provide more effective communication and education, which would be beneficial to participating specialists.

Customer Service

Aetna's Member Services Manager conducts an evaluation of the prior day's call volumes daily. A report of the prior day's calls shows the number of calls that come in to the center in 30-minute increments. The report includes numbers of calls offered, answered, and abandoned. Additionally, it shows how long it took for the calls to be answered in that 30-minute period. The analysis of these data allows for changes to be made to staffing based on findings for specific periods of the day.

Each of Aetna's call center representatives completes a four-week intensive training plan. This training consists of three parts:

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

The telephone skills training includes cultural competency and soft skill phone etiquette. Additional behavioral health training is conducted to enable staff to recognize when clinical support is needed.

Aetna's call center representatives are monitored monthly to ensure that they are handling calls correctly. Each time representatives are monitored, they receive feedback from the team lead or manager based on the findings of each call. Aetna is dedicated to making sure that call center staff members provide all the required information to callers, with the best possible outcomes.

Member Services staff members report call center data to the state monthly, including total calls offered and received, total calls abandoned by percentage, average speed to answer, and average talk time. Performance goals are established for each of the preceding elements. In addition to the required reporting statistics, the Member Services manager conducts a monthly analysis of call types, average calls per day, average time to abandon, and percentage of calls answered in 30 seconds or less. By analyzing call data, Member Services is able to appropriately staff the call center with trained individuals to ensure that all required and expected call metrics are met. Aetna consistently meets health plan metrics with local Member Services agents since the time that CoventryCares of Virginia migrated to Aetna in April 2016.

Anthem

FAMIS Program Response

Rating of Health Plan

Anthem covers telemedicine as a benefit to providers/members. The service/code is used rather infrequently at the moment and used mostly by behavioral health providers. One of Anthem's participating (par) providers, University of Virginia Health Systems, is attempting the expansion of telemedicine into more rural parts of Virginia. Anthem supports telemedicine by reimbursing HCPCS code, Q3014, telehealth originating site facility fee.

VCU Health, in Richmond VA, has a Centering Pregnancy Program in which Anthem members can be seen in a group setting. Anthem has partnered with the VCU Centering Pregnancy Team to close care gaps such as cervical cancer screenings and chlamydia.

Anthem continually monitors the health care economic landscape for opportunities to improve microsystem performance. Two broad programs implemented in the prior year include the Plan's highly successful Behavioral Health home initiative in Central VA, the statewide value-based payment (VBP) program, and the provider quality incentive program (PQIP), which reinforces and rewards high-volume PCP practices for providing high quality and efficient health care in their respective geographic microsystems.

From strictly a provider-contracting and provider-relations standpoint, Anthem promotes quality improvement initiatives through its VBP programs and the tools that support those programs. The two VBP programs currently being implemented in the Virginia market are: the PQIP, a Category 3 VBP program for larger PCPs that allows them to earn shared savings payouts at no risk if they meet certain quality and cost targets; and Physician Access & Quality Care Program (PAQCP), which is a Category 3 VBP program for smaller PCP's that pays providers an annual per member per month (PMPM) incentive for meeting certain quality and utilization measures.

Getting Care Quickly

Currently, Anthem partners with its transportation broker (Southeastrans) to monitor missed appointments and complaints associated with "no-shows". For members who repeatedly no-show to appointments, Anthem works closely with SET to "gold card" them to closely monitor their transportation.

Anthem has implemented a Clinic Day program that helps to reduce no-shows for providers. The outbound call center and health program representatives assist members with setting up provider appointments which may include any transportation needs the member may have. Benefits of a Clinic Day:

- Improve the quality of life of members, specifically in relation to certain health care needs.

- Bolster member and provider satisfaction.
- Increase HEDIS scores.
- Decrease "no show" rates for providers.

Anthem uses texting for health services to send health alerts to members. The alerts provide education information and reminders about general health and screenings and encourage activities to improve health.

- Screening Reminders
- Health Survey
- Health Education (quizzes)
- Healthy Challenges

As noted previously, telemedicine services are also an option. Through the Clinic Day program, many providers use an open access type model. For Clinic Day events, providers set aside multiple days in which members may schedule. This allows for appointment flexibility. Anthem has contracted with urgent care centers which also allow for same-day appointments.

Anthem contracts with providers require that those providers be accessible to members within 24hours, if needed. Anthem is currently conducting a survey of providers to determine appointment availability with providers. Also, Anthem has a robust network of providers across all disciplines and constantly monitors to ensure that there are sufficient numbers of providers to support membership.

Currently, Anthem conducts an Access and Availability Survey that assesses wait times. Where there are opportunities, Anthem follows up. Anthem has well-defined member grievance procedures in place to track and receive complaints from members related to access and availability. The provider relations team conducts site visits as needed at providers' offices. Anthem also conducts surveys with members to better understand perceived and actual wait times at providers' offices.

Customer Service

Anthem's Customer Service team analyzes call patterns and conducts member surveys regularly to determine if current call center hours are sufficient to meet the members' needs. For certain member needs such as grievances, mechanisms are in place for members to leave messages after hours. Anthem has an after-hours nurse line that assists members with their needs 24 hours per day, seven days a week.

Beginning with new hire training, Customer Service representatives receive extensive education. Key parts of this education include:

- Unique attributes of the various markets served.
- Systems, workflows, and processes.
- Effective communication techniques.

- Handling difficult and escalated calls.

Anthem's training curriculum encompasses several educational strategies that accommodate different learning styles, including written materials, interactive class discussions, and computer-based tutorials that enable Customer Service representatives to build the skills necessary to deliver professional and knowledgeable assistance and services to customers. Anthem uses a post-training survey for continuous improvement to the new hire training program. Feedback from the management team is gathered to help identify potential gaps in the new and ongoing training programs. As part of their ongoing training and support, Customer Service representatives receive coaching and supervision which support the consistent application of these principles when serving customers. Anthem's management team uses a variety of incentives and motivation techniques to help keep a strong focus on the service provided to customers.

The National Call Center (NCC) has established customer service standards that are tracked and reviewed ongoing. These standards include, but are not limited to the following:

- Post call surveys
- Quality
- Service levels

Modifications are made as necessary to ensure that standards are at or above industry standards. Outcomes are shared with members and providers via the member and provider newsletters and/or portals.

Medallion 3.0 CAHPS Recommendations

An evaluation of Anthem's 2015 adult and child Medicaid CAHPS results revealed that Anthem did not score 5 or more percentage points lower than the NCQA national Medicaid average on any CAHPS survey measure. Therefore, HSAG recommends that Anthem focus QI initiatives where measure performance was below the NCQA national average. For the child Medicaid population, Anthem scored below the NCQA national average on *Rating of All Health Care* and *Getting Care Quickly*.

Anthem's Response

Anthem's corporate CAHPS work group is a venue for sharing of best practices within the company; Anthem Virginia Medicaid partnered with Anthem California Medicaid to share best practices and initiatives are implemented where possible. Anthem is also encouraging member participation in the CAHPS survey via the Web and providing the NCC with talking points. Anthem has also implemented the member CAHPS flier to educate the members on the importance of the survey. The Provider CAHPS Flier is going through the approval process currently. Member satisfaction and opportunities from the member satisfaction survey are also shared and discussed at Health Education Advisory Committee meetings, which consist primarily of members. The member satisfaction survey is reviewed; and where opportunities arise, Anthem works to resolve them.

Rating of All Health Care

Anthem has well-defined member grievance procedures in place to track member complaints. The provider relations team will follow up with providers' offices, if needed, regarding any perceived or actual obstacles to receiving care. Anthem also conducts surveys with members to better understand perceived and actual obstacles to care with providers' offices. Also, Anthem currently has a robust network of providers across all disciplines and constantly monitors to ensure sufficient provider numbers to support the membership.

Anthem includes a section in the primary, specialist, and group contracts and cited below that supports a provider's right to communicate freely with his/her patients. This helps to prevent any hindrances a patient may encounter while seeking care.

Patient Medical Options and Medical Management Decisions

As required by Virginia Code Section 38.2-3407.10 K., Facility shall freely communicate with Covered Individuals regarding the individual treatment options available to them, including alternative medications. Medical management decisions by Facility must be based on sound clinical judgments and the appropriateness of care and services. Nothing in this Agreement is intended to require Facility to deny or withhold Covered Services to Covered Individuals that Facility knows to be Medically Necessary and appropriate.

Anthem ensures communication and an ongoing exchange of information with new and existing members to ensure that members understand their benefits as well as policies and procedures. This has been achieved by conducting Health Education Advisory Committee (HEAC) member focus groups. The total participation for 2016 has resulted in 26 members and 9 non-members having attended the HEAC meetings. This yields a total of 35 (members and non-members) who have attended the HEAC meetings. Where opportunities present, Anthem has and will continue to follow up and act.

Rating of Personal Doctor

Anthem is currently conducting a survey of providers to determine appointment availability with providers. Also, Anthem currently has a robust network of providers across all disciplines and constantly monitors to ensure sufficient provider numbers to support the membership. Finally, Anthem has well-defined member grievance procedures in place to track member complaints. The provider relations team follows up with providers' offices, if needed, regarding any perceived or actual obstacles to receiving care.

Anthem conducts HEAC member focus groups wherein members may communicate any concerns they may encounter. Where opportunities exist, Anthem follows up and acts. A survey is provided to each member at all Clinic Day events. In 2017, an additional one to three questions will be added that will relate to the member's experience.

Physician-patient communication is encouraged via provider contracts, member and provider newsletters, the provider manual, the member handbook, and the member and provider Web portals.

Anthem conducts member and provider satisfaction surveys to better understand perceived and actual communication barriers. Where opportunities present, Anthem works to implement interventions and solutions. Anthem is committed to working with network physicians to make members' health care experiences positive.

Anthem's Multicultural Health Programs team, in collaboration with Training Systems Design, developed a new online experience for providers – "Moving Toward Equity in Asthma Care." Anthem has a provider training document specific to helping the providers meet the cultural, value, and linguistic needs of members. The training is posted online. The provider relations team will do site visits and conduct trainings, as needed, at providers' offices. The Quality Department will conduct Clinic Day trainings with providers prior to hosting Clinic Day events. The Quality Department also conducts HEDIS trainings on measures upon request.

Rating of Specialist Seen Most Often

The Provider Care Management Solutions (PCMS) database allows providers access to view which specialists members have seen. The database identifies members' chronic conditions from claims data to alert the PCP and allows the PCP to take necessary action to provide appropriate care for the member. Additionally, the system provides a view of member medications and dosages.

Getting Care Quickly

Educational health literacy information is provided at every Health Education Advisory Committee (HEAC) member focus group and every Clinic Day event. Five HEAC meetings and more than 110 Clinic Day events were held in CY2016. Over 1,400 members were educated at Clinic Day events in CY2016. Anthem's Clinic Day program ensures that members are seeing the appropriate provider. Members are assisted with appointments. For preventive services, they see PCPs (e.g., pediatricians). For eye exams, members see ophthalmologists or optometrists. For female-related care, members see gynecologists. Anthem has a quality of care process in place that ensures an in-depth review of quality of care issues; the issues are thoroughly investigated, and a medical director is engaged, as needed. An ongoing monitoring process exists for all quality of care issues. Members are matched to providers with high quality ratings, both upon request and when members fail to select providers.

Anthem utilizes the max-packing model by identifying all care gaps for each member prior to each clinic day event. All gaps are provided to the PCP or provider prior to each clinic day event so that all or as many gaps as possible can be closed during that one visit, reducing the need for numerous subsequent visits. Physical gaps in care are shared with the behavioral health team to share with the Community Service Boards (CSBs), upon request. So, when members are seen at the CSBs, providers close both the physical and the behavioral health care gaps during one visit, reducing the need for numerous subsequent visits.

Anthem has streamlined its referral process by eliminating the need for a referral for a member to see a participating specialist. Anthem has a provider lookup tool on the website for members to use to find a specialist as needed. Members may also call the NCC for help finding a specialist.

How Well Doctors Communicate

Anthem's Provider Relations Department is in the process of distributing ER brochures to all practices to help educate members about when to go to the ER versus contacting their PCPs. Anthem's member materials are designed to be easily understood by members. All member materials, including member letters/notices and health promotion/health tip information, are designed to meet the DMAS readability requirements of Flesch-Kincaid readability scores of 40 or better (at or below 12th grade reading level). Internally, Anthem tried to adhere to a stricter standard of keeping member materials at no higher than a 6th or 7th grade reading level. Anthem uses Fry and Flesch-Kincaid Readability to determine grade levels to make sure that readers can understand presented content. Grade leveling is done by breaking up long sentences into multiple, shorter ones. Anthem uses simpler words with fewer syllables (can't vs. cannot) and bullet points instead of paragraphs. In order to make documents more understandable for members, Anthem embeds definitions of terms where readers need them, includes informative headings so that information stands out, groups information in meaningful chunks, and uses graphics to emphasize key points. In addition, Anthem understands there exist cultural sensitivities for how providers communicate with members. Anthem has developed a cultural competency toolkit related to members, which may assist in providers' communications with members.

Anthem has not hired fulltime staff interpreters to work in provider offices. However, Anthem does have interpreter services available to members in provider's offices. Members, members' representatives, and providers may call the Anthem NCC (phone number listed on the member's ID card) to request face-o-face, on-site interpreter services. Requests for interpreter services may be submitted up to one month in advance. Anthem seeks requests for interpreter services for routine doctor visits 5 days in advance and for acute care services, 24 hours in advance. Cancellation of the member's need for translation services is requested 24 hours in advance where possible.

Customer Service

Call arrival patterns are monitored ongoing to ensure that hours of operation meet the needs of members. Anthem has multiple call centers across the country, with each having unique hours of operation. Anthem also operates in a virtual environment, meaning that market (State) calls can be taken at multiple locations, reducing potential wait time. In 2015, Anthem's NCC answered more than 5.5 million calls from members all across their health plan affiliates, with an abandonment rate of less than 1 percent. Anthem makes it easy for members to get the help they need. After hours, Anthem provides access to the nurse advice line and IVR services. Anthem conducts random automated phone surveys within 24 to 72 hours after customer contact. The survey is related to the member's experience, with specific questions about help and information. The survey also provides insight that allows Anthem to identify opportunities for improvement and implement actions to resolve any issues.

INTotal

Both INTotal adult and child CAHPS scores increased in 2016, but numerous opportunities for improvement still exist. In 2016, INTotal conducted an access to care survey for both providers and members to better understand their knowledge, perceptions, and concerns about INTotal's network. The

survey provided INTotal with greater insight about access to specialty care, referral patterns to specific specialties, and how members access and use the open network. In conjunction with this activity, INTotal developed and disseminated materials that promoted the specialist network and encouraged PCPs to develop new referral patterns that aligned with the network.

INTotal completed an in-depth analysis of appeals and grievances to determine the existence of service gaps for members, inaccessible specialists, or distance constraints related to seeing a needed specialist. INTotal evaluated the usefulness of the tools available to members to find needed care and analyzed the trends and patterns related to regional availability, distance availability, and wait times for appointments. INTotal also improved its communication tools related to medical necessity denials to ensure that both members and providers understood the processes for reviews and for appeals.

Kaiser Permanente

Kaiser Permanente did not conduct a CAHPS survey in 2015.

Optima

Optima identified no improvement activities under this recommendation related to the Consumer Survey of Quality of Care.

Virginia Premier

Medallion 3.0 CAHPS Recommendations:

Based on an evaluation of VA Premier's 2015 adult Medicaid CAHPS survey results, HSAG recommends that the MCO focus QI initiatives on enhancing members' satisfaction with *Rating of All Health Care* and *How Well Doctors Communicate*. For the child Medicaid population, HSAG recommends that VA Premier focus QI initiatives on *Rating of All Health Care*, *Rating of Personal Doctor*, and *Getting Needed Care*.

Virginia Premier's Response

Rating of All Health Care

VA Premier assesses its provider network to insure adequacy and access to care, including demographically aligning members with providers. In an effort to continually expand the network and improve outcomes for members, VA Premier has implemented a reimbursement structure for providers which is designed to increase access to care and health outcomes. The Member Advisory Committee (MAC) was re-engineered to include a member representative to participate in the Quality Forum to discuss issues or concerns of members, which encompasses providing feedback or recommendations on health plan processes.

VA Premier will continue as a member-centric organization by engaging members in plan processes, developing and implementing new strategies to gain greater and more diverse participation at the

Member Advisory Committee meetings across all regions. VA Premier conducts a MAC meeting survey at the end of each meeting. VPHP engages members by evaluating recommendations provided by the survey. VA Premier also encourages non-English-speaking members to attend MAC meetings and provides interpretation services and translated documents to those who attend and require them.

How Well Doctors Communicate

According to the Agency for Healthcare Research and Quality (AHRQ), patient engagement in outpatient safety involves two related concepts: first, educating patients about their illnesses and medications using methods that require patients to demonstrate understanding (such as "teach-back"); and second, empowering patients and caregivers to act as safety "double-checks" by providing access to advice and test results and encouraging patients to ask questions about their care. Success has been achieved in this area for patients taking high-risk medications, even in patients with low health literacy at baseline.

VA Premier provides its members with tools to assist with communicating with their physicians to include a set of questions related to surgery and medications. Interpreter services are available for members and practitioners to further enhance communication.

Rating of Personal Doctor

VA Premier conducts site visits and assesses wait times for appointments to insure that adequate time is scheduled for appointments. The 2016 CAHPS Adult Survey resulted in an increase of 3.9 percentage points in the composite score for the Health Promotion and Education satisfaction area over the benchmark. The percentage of respondents that indicated that they had a conversation with their health care providers related to shared decision making signified 8.0 percentage points over the benchmark.

VA Premier strengthened provider communications through faster and more thorough follow-up to physician questions; providing education on standards, rules, and regulations; conducting more office visits and office training sessions; increasing consistency in information given to providers and patients; standardizing staff training; and improving web-based resources, including providing answers to questions frequently asked via providers, online training, and streamlined online referral services.

Getting Needed Care

VA Premier promotes health education and preventive health care with members through their wellness program. The Health and Wellness program is for members of all ages. It works with the Disease Management and Care Management teams to promote healthy living. The program helps members find ways in their everyday life to meet their wellness goals. As part of Health and Wellness, VA Premier offers Living Healthy programs. Each Living Healthy program includes a one-on-one phone consultation with a health educator. These educators give members information, tools, and resources to meet their needs. Below are examples of some Living Healthy programs.

- Eat Smart: Learn about food labels, portion control, and meals that lower your cholesterol and blood pressure. We'll provide recipes, food logs, mailings, and classes.

- Go Smoke-Free: We offer Nicotine Replacement Therapy (NRT), and we'll send mailings with tips and tools to help you quit smoking. We also promote Quit Now Virginia, which offers free phone counseling and tools for all ages.
- We Like to Move It Move It: We can get you moving with suggestions on physical activities and exercises to improve wellbeing.
- Women of Wellness (WOW): This program is for women of all ages who want to improve their overall health. We'll give advice, a health-check passport, a smart living calendar, and more.
- A Monthly National Health Observances Calendar is used to provide education to members at events, baby showers, Member Advisory Committee meetings, and health events.

Educate providers on coordinating care to meet the patient's need during one visit. For example, if a member presents for a sick visit, a well-child visit could be documented by addressing the subcomponents of a well-child visit.

VA Premier's strategy will be Outcomes focused and when improvement is not achieved, a causal/barrier analysis will be conducted and the subsequent selection of effective improvement strategies will be developed to address the identified barriers. Interventions will be evaluated regularly to insure the desired impact on measures.

Appendix A. Performance Measure Validation Methodology

Overview

The Virginia Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the Commonwealth of Virginia. DMAS refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). DMAS contracts with six privately owned managed care organizations (MCOs) to deliver services to members enrolled in its Medicaid and CHIP programs. The six MCOs are Anthem HealthKeepers Plus; Aetna Better Health of Virginia; INTotal Health; Kaiser Permanente; Optima Family Care; and Virginia Premier Health Plan, Inc.

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (MCOs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described at Code of Federal Regulations (CFR) at 42 CFR 438.358(b)(2). The purpose of performance measure validation (PMV) is to assess the accuracy of performance measure rates reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. According to the EQR protocol[A-1] developed by CMS, 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).

To meet the PMV requirements, DMAS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct the PMV for each MCO, validating the data collection and reporting processes used for the calculation of the performance measure rates. HSAG has contracted with Aqurate Health Data Management, Inc. (Aqurate), to assist in conducting the validation of performance measures.

Annually, DMAS identifies a set of performance measures that the MCOs are required to calculate and report. Two measures were selected from HEDIS, developed by the National Committee for Quality Assurance (NCQA), and two measures were developed by DMAS. The measurement period identified by DMAS is measurement year (MY) 2015 for HEDIS measures and State fiscal year (SFY) 2016 (July 1, 2015, through June 30, 2016) for the non-HEDIS measures. Table A-2 lists the selected performance measures, the method required for data collection, and the specifications that the MCOs were required to use.

[A-1] *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.

Objectives

The primary objectives of HSAG's PMV process are to:

- Evaluate the accuracy of the performance measure data reported by the MCOs.
- Determine the extent to which the performance measures calculated by the MCOs or DMAS (or on behalf of the MCOs or DMAS) follow the DMAS' reporting requirements.

Description of Validation Activities

HSAG will focus on data used for calculating and reporting the performance measures for MY 2015 (January 1, 2015, through December 31, 2015) for the HEDIS measures and SFY 2016 (July 1, 2015, through June 30, 2016) for the non-HEDIS measures. HSAG will use several validation strategies to achieve the validation objectives.

The validation activities described below will be used in combination as appropriate for the type of measures evaluated (HEDIS or non-HEDIS).

The validation of the foster care assessment measure will be focused on ensuring that the MCO has appropriate systems and processes in place to identify new members requiring an assessment and to conduct assessments as well as appropriate methods of tracking and counting completed assessments and reporting data to DMAS based on guidelines in the Medallion 3.0 contract. The validation of data for timeliness of claims processing will be a combination of source code review, review of supporting documentation, and primary source verification to confirm that the processes used to report data to DMAS are appropriate.

Pre-On-Site Activities

HSAG will conduct the validation activities as outlined in the CMS PMV protocol. HSAG will prepare a document request letter for the MCOs outlining the steps in the PMV process. The document request letter will include a request for source code for each performance measure; a completed HEDIS 2016 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.

The document request letter will also provide guidance to the MCOs that when there are questions in the ISCAT that are also covered in the Roadmap submission MCOs may reference the Roadmap by providing details about the section or document title and page number from the Roadmap in lieu of a response. In addition, HSAG will forward a letter that includes requested documentation needed to complete the medical record review validation (MRRV) process. HSAG will provide an introductory overview of the performance validation process to the MCOs before the document request packet is sent.

Approximately two weeks prior to the on-site visit, HSAG will provide MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG will also conduct a pre-on-site conference call with the MCOs to discuss on-site logistics and expectations, important deadlines, and any outstanding questions.

HSAG will assist DMAS to calculate a rate for the *Assessment of Foster Care Children* measure. This rate will be calculated based on data received by HSAG from DMAS. The data provided by DMAS will be a combination of self-reported completed foster care assessment counts as reported by the MCOs and eligibility data maintained by DMAS.

Based on the scope of the validation, HSAG will assemble a validation team having the full complement of skills required for validating the specific performance measures and conducting the PMV for each MCO. The team will be composed of a lead auditor and several team members.

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 HSAG will review and how HSAG analyzed these data:

- **NCQA's HEDIS 2016 Roadmap:** The MCO will complete and submit the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG will use responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** The MCOs will complete and submit an ISCAT for HSAG's review of the required DMAS-developed measures. HSAG will use responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation:** The MCOs will be responsible for completing the medical records review section within the Roadmap. In addition, HSAG will request that the MCOs submit the following documentation for review: medical record hybrid tools and instructions, training materials for medical record review staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. HSAG will conduct over-read of 30 records from the hybrid sample. HSAG will follow NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and will then use the MRRV results to determine if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for performance measures:** MCOs that calculate the performance measures using source code will be required to submit source code for each performance measure being validated. HSAG will complete line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG will identify any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs that do not use source code will be required to submit documentation describing the steps taken for performance measure calculation.

- **Supporting documentation:** HSAG will request documentation that provides 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 will review all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

During the on-site visit, HSAG will collect additional information to compile PMV findings using several methods including interviews, system demonstration, review of data output files, observation of data processing, and review of data reports. The on-site strategies will include:

- **Opening meetings**—Include introductions of the validation team and key MCO staff involved in the calculation or reporting of the performance measures. The purpose of the PMV, required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation**—This session is designed to be interactive with key MCO staff so that the validation team obtains a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and can evaluate the degree of compliance with written documentation. HSAG will conduct interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures are used and followed in daily practice.
- **Evaluation of enrollment, eligibility, foster care risk assessment and claims systems and processes—**The evaluation includes 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 will include confirming systems and processes in place to identify completed foster care assessments.

  HSAG will conduct interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff may include 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. HSAG will use these interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures—**This session will include a review of the information systems and evaluation of processes used to collect, calculate, and report the performance measures—including accurate numerator and denominator identification and algorithmic compliance (which will evaluate whether or not rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  HSAG will perform additional validation using primary source verification (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. Using this technique, HSAG will assess the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG will select cases across measures to verify that the MCOs have system documentation that support 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 are detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error; and as a result no additional cases related to that issue may be 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**—At the end of each on-site visit, HSAG will summarize preliminary findings and revisit the documentation requirements for any post-on-site activities.

Post On-Site Activities

After the on-site visit, HSAG will review any final performance measure rates submitted by the MCOs to DMAS and follow up with each MCO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issue identified from the rate review will be communicated to the MCO as a corrective action as soon as possible so that the rate can be revised before the PMV report is issued.

HSAG will prepare a PMV report for each MCO, documenting the validation findings. Based on all validation activities, HSAG will determine the validation result for each performance measure listed in Table A-2. The CMS PMV Protocol identifies possible validation results for performance measures, defined in the Table A-1.

Table A-1—Validation Results and Definitions for Performance Measures

Report (R)	Measure was compliant with the specifications, and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which the MCO rate was 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 five 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 corrective action that cannot be implemented in time will be noted in the MCO's PMV report under "Recommendations." If the corrective action is closely related to accurate rate reporting, HSAG may render a particular measure "NR."

Performance Measures List for SFY 2016

The following table lists the performance measures selected by DMAS, the method (i.e., hybrid or administrative) required for data collection, and the specifications that the MCOs are required to use.

Table A-2—2016 Performance Measures Selected by DMAS for Validation

Performance Measure	Specifications	Methodology
Assessment of Foster Care Children	DMAS	Hybrid*
Timeliness of Claims Payment	DMAS	Admin
Controlling High Blood Pressure (CBP)	HEDIS	Hybrid
Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	Admin

* Hybrid refers to a review of both the administrative data system as well as foster care assessments contained in the MCOs' care/case management systems.

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 2013, 2014, and 2015 measures evaluated for the MCOs.[B-1]

Table B-1—NCQA Quality Compass 50th Percentile Values

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2013	NCQA Quality Compass 50th Percentile for HEDIS 2014	NCQA Quality Compass 50th Percentile for HEDIS 2015
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	48.18%	48.51%	49.15%
Childhood Immunization Status			
Combination 3	72.88%	72.33%	71.53%
Well-Child Visits in the First 15 Months of Life			
No Well-Child Visits[1]	1.22%	1.46%	1.65%
Six or More Well-Child Visits	65.16%	62.86%	59.76%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.26%	71.76%	72.02%
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	51.32%	57.37%*	58.34%
Cervical Cancer Screening			
Cervical Cancer Screening	—	—	61.05%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	85.88%	84.30%	85.19%
Postpartum Care	63.99%	62.84%	62.77%
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	—	—	81.37%
45–64 Years	—	—	87.84%
65+ Years	—	—	87.52%

[B-1] Although comparisons to benchmarks were made for *Medication Management for People With Asthma—Medication Compliance 50%* and all four *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotic* measure indicators, these benchmarks are not displayed.

Performance Measures	NCQA Quality Compass 50th Percentile for HEDIS 2013	NCQA Quality Compass 50th Percentile for HEDIS 2014	NCQA Quality Compass 50th Percentile for HEDIS 2015
Total	—	—	83.84%
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	83.16%	83.88%	86.20%
HbA1c Control (<8.0%)	48.57%	46.43%	47.91%
Eye Exam (Retinal) Performed	54.31%	54.14%	54.74%
Medical Attention for Nephropathy	—	—	81.75%
Blood Pressure Control (<140/90 mm Hg)	61.03%	61.31%	62.23%
Controlling High Blood Pressure			
Controlling High Blood Pressure	56.20%	56.46%	57.53%
Medication Management for People With Asthma			
Medication Compliance 75%—Total	—	—	29.60%
Medical Assistance With Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit	—	—	76.74%
Discussing Cessation Medications	—	—	46.70%
Discussing Cessation Strategies	—	—	42.50%
Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	51.47%	49.66%	50.51%
Effective Continuation Phase Treatment	35.26%	33.93%	34.02%
Follow-up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	—	40.79%
Continuation and Maintenance Phase	—	—	50.61%
Follow-Up After Hospitalization for Mental Illness			
30-Day Follow-Up	65.85%	64.63%	66.64%

[1] A lower rate indicates better performance for this measure.

[*] HEDIS significantly modified the specifications for this measure beginning with HEDIS 2014. Caution should be exercised when comparing 2014 (or later) 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 in HEDIS 2016; therefore, national Medicaid 50th percentiles are not displayed.

Appendix C. Performance Improvement Projects—Rapid-Cycle Approach

A Redesigned Approach

HSAG has redesigned its approach for validating performance improvement projects (PIPs) to place greater emphasis on improving both health care outcomes and processes through the integration of quality improvement science. This approach guides MCOs through a process for conducting PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCOs will have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale. HSAG has developed a series of five modules to guide the MCOs through this new process as they conduct PIP activities. HSAG will provide technical assistance throughout the process with frequent contact and feedback to ensure that projects are well-designed at the onset and provide opportunities for mid-course corrections.

Quality Improvement Framework

HSAG's quality improvement framework represents a modified version of IHI's QI Model for Improvement. Key concepts include the formation of a team; setting aims; establishing measures; selecting, testing, and implementing interventions; and spreading changes. The IHI's QI model focuses on accelerating improvement without replacing change models that different organizations may already be using. The core component of the model includes testing changes on a small scale using PDSA cycles and applying rapid-cycle learning and evaluation that informs the project theory during the course of the improvement project.

HSAG selected this framework as it allows MCOs broad flexibility, builds on proven quality concepts, and provides a systematic technique to approach an improvement activity.

HSAG's quality improvement framework for PIPs is detailed in the following modules:

- PIP Initiation
- SMART Aim Data Collection
- Intervention Determination
- Plan-Do-Study-Act
- PIP Conclusions

Each of the five modules provides instructions to be used by the MCOs in completing the corresponding Module Submission Form.

Appendix D. Prenatal Care and Birth Outcomes Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a focused study that will provide quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. The Contract Year 2015-2016 Task F.1 Birth Outcomes Focused Study will 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?*

Study Design

Measurement Period

The study will include all singleton births paid by Virginia Medicaid during calendar year (CY) 2014. Results for CY 2012 and CY 2013 will be taken from previously published reports and included in the current study for trending purposes.

Eligible Population

The eligible population will consist of all live births paid by Virginia Medicaid during the measurement period, regardless of whether the births occurred in Virginia. The birth registry contains records of live births; other pregnancy outcomes will not be included in this study. To examine outcomes among all Medicaid-paid births in light of expected services, births will be grouped into a study population and a comparison group based upon the timing and length of Medicaid enrollment. Specifically, the study population will include women continuously enrolled in the FAMIS MOMS, the Medicaid for Pregnant Women, or an "Other Medicaid" program for a minimum of 43 days prior to, and including, the date of delivery. The "Other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or the Medicaid for Pregnant Women categories. The comparison group will include women enrolled in one of the three Medicaid program groups defined above on the date of delivery, but without prior continuous enrollment. HSAG will conduct tests for statistical significance between CY 2014 results for the study and comparison populations, as directed by DMAS.

Data Collection

Using Medicaid recipient, claims, and encounter data files supplied by DMAS, HSAG will identify members eligible for the study. HSAG will assemble a list of members eligible for the study and submit this list to VDH. VDH will use probabilistic data linking to match HSAG's list of members eligible for the study to birth registry records. In addition to the probabilistic data linkage, VDH will match HSAG's list of study-eligible members to birth registry records using social security numbers. This deterministic data linkage aligns with prior years' study methodology and will be used by HSAG to validate the data linkage. VDH will return a data file to HSAG containing the information from HSAG's original list and all birth registry data fields for matching members for each of the data linkage processes. HSAG will identify study-eligible members as all probabilistically linked or deterministically linked birth registry records. A three-month data run-out period will be allowed between the end of the measurement period and data extraction; data extraction will begin no earlier than April 1, 2015.

Indicators

Study indicators are limited to singleton births, defined using the Plurality field in the birth registry. Since multiple gestation births are subject to different clinical guidelines, results for multiple births will be limited to demographic summaries (e.g., maternal age, Medicaid program, neonatal characteristics) and used for informational purposes only. Table D-1 illustrates the study indicators included in the study as well as the numerator and denominator definitions. Please note that calculation of the measures is contingent upon the availability of timely, complete, and accurate data.

Table D-1—Study Indicators

Indicator	Denominator	Numerator
1. Percentage of births with early and adequate prenatal care.	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent. Note: Secondary analyses will be completed to determine the number of singleton, live births with a Kotelchuck Index score greater than or equal to 110 percent (i.e., "Adequate Plus"). This information will be used for informational purposes only.
2. Percentage of births by gestational estimate.[1]	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: 1. Preterm: Less than 37 weeks a. Extremely preterm: <28 weeks

Indicator	Denominator	Numerator
		b. Very preterm: 28 through 31 weeks c. Moderate preterm: 32 through 33 weeks d. Late preterm: 34 through 36 weeks 2. Term: 37 weeks through 41 weeks (may be reported weekly) a. Early Term: 37 weeks though 38 weeks b. Full Term: 39 weeks through 40 weeks c. Late Term: 41 weeks 3. Post Term: 42 weeks and beyond
3. Percentage of newborns with low birth weight.	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: 1. Overall low birth weight: less than 2,500 grams a. Moderately low birth weight: 1,500 grams through 2,499 grams b. Very low birth weight: less than 1,500 grams
4. Percentage of newborns receiving at least two visits with a primary care provider (PCP) in the 30 days following birth.[2] Note: Supplemental analyses will identify the percentage of newborns receiving 1) zero visits in the 30 days following birth, and 2) one visit in the 30 days following birth.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Based on the availability and reliability of a birth registry indicator for a newborn's neonatal intensive care unit (NICU) stay, these births may be excluded from the measure.	Number of singleton, live births where the newborn received at least two office visits in the 30 days following birth with any PCP-type provider.[3] Visits must occur on separate days and do not have to be with the same provider. **PCPs** = Pediatricians, family practice physicians, general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. **Office Visits** = Identified from claims/encounter data with any of the following procedure and/or diagnosis codes for office or other outpatient services, home services, preventive medicine, or general medical examination: CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345,

Indicator	Denominator	Numerator
		99347-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429 HCPCS: G0438, G0439 ICD-9-CM: V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9
5. Percentage of newborns who had at least one emergency department (ED) visit in the 30 days following birth. Note: Supplemental analyses will identify the range in the number of ED visits reported within the 30-day period. Pending review of the data, supplemental analysis may be included to report on the reasons for ED visits.	Number of singleton, live births paid by Virginia Medicaid during the measurement period. Note: Based on the availability and reliability of a birth registry indicator for a newborn's NICU stay, these births may be excluded from the measure.	Number of singleton, live births where the newborn had at least one ED visit in the 30-day period following birth.[4] ED visits will be considered unique by facility, date of service, and member. **ED Visit** = Identified from claims/encounter data with any of the following procedure or revenue codes for emergency department visits: CPT: 99281-99285 CPT: 10040-69979 AND Place of Service = "23" (Emergency Room – Hospital) Revenue: 045x, 0981

[1] Estimated gestational age will be based upon the *Clinical Estimate of Gestation* (CEG) provided on the birth certificate. In the event this estimate is not available, HSAG will attempt to calculate gestation using the date of the *Last Menstrual Period* (LMP) indicated on the birth certificate. Birth certification records missing both CEG and LMP values will be captured in a "missing gestational age" category, or they will be dropped based on the number identified cases.

[2] An alternate approach to identification of visits with PCP-type providers may be proposed by HSAG after assessing potential limitations to provider type identification in Medicaid data.

[3] Based on the *Virginia EPSDT Periodicity Chart* published online by Virginia DMAS at http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf [Accessed on April 1, 2015], infants are expected to have at least two visits with a PCP-type provider in the first 30 days of life.

[4] ED visits associated with the infant's birth and resulting hospital stay will be excluded, as will ED visits associated with transfers between acute inpatient facilities.

Additionally, unless otherwise specified, all measure results will be stratified by the key demographic categories listed in Table D-2.

Table D-2—Demographic Categories

Demographic Category	Category Values
Medicaid Program	FAMIS MOMS (Eligibility category TBD) Medicaid for Pregnant Women (Eligibility category TBD) An "other Medicaid" category will include births paid by Medicaid that do not fall within the FAMIS MOMS or Medicaid for Pregnant Women program categories.
Medicaid Delivery System	Fee-for-Service (FFS)

Demographic Category	Category Values
	Managed Care
Maternal Region of Residence Note: Maternal region of residence will be defined based on members' county of residence using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).	Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater
Race/Ethnicity Note: Race/ethnicity will be defined based on members' non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the HISPANIC category.	White African American Asian Hispanic Other
Maternal Age[1]	15 years and younger 16 years through 17 years 18 years through 20 years 21 years through 24 years 25 years through 29 years 30 years through 34 years 35 years through 39 years 40 years through 44 years 45 years and older
Maternal Immigration Status	U.S. Citizen (Citizenship Status = "C", "N") Documented immigrant (Citizenship Status = "E", "I", "P", "R") Undocumented immigrant (Citizenship Status = "A") Other (Citizenship Status = "V")

[1] Maternal age categories will be aggregated into four groups for graphic presentation: 18 years and younger, 18 years through 21 years, 22 years through 34 years, and 35 years and older.

Deliverable

HSAG will present the findings of this focused study in a data report. The data report will primarily consist of tables and graphs with some text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based upon the report. HSAG will also provide a copy of the analysis dataset in a format to be determined by DMAS (e.g., SAS dataset, pipe-delimited text file, etc.).

Appendix E. Foster Care Focused Study Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a focused study that will provide quantitative and qualitative information about foster care children receiving medical services through Medicaid managed care plans (MCPs). The Contract Year 2 Task F.2 Foster Care Focused Study will address the following question: *To what extent did children in foster care receive the expected preventive and therapeutic medical care in the first year of managed care service delivery?*

Study Design

Measurement Period

The study will examine services received by foster care children from July 1, 2014, though June 30, 2015 (i.e., the first full year of statewide managed care service delivery for these members).

Eligible Population

The eligible population will consist of all Medicaid children under 18 years of age as of July 1, 2014, identified by DMAS as enrolled in Medicaid under the aid category for children in foster care (Aid Category "76").

Since this population was newly enrolled into managed care service delivery, HSAG will identify all children enrolled in the foster care aid category at any point during the measurement period. HSAG will provide information on trends in managed care enrollment among all children in foster care. However, quality and utilization measures within this study will be limited to children enrolled in managed care with any MCP or combination of MCPs from July 1, 2014, through June 30, 2015, with one or more gaps in enrollment totaling no more than 45 days.

Data Collection

Administrative Data

As select study indicators will benefit from supplemental data, immunization registry data may be extracted by the Virginia Department of Health (VDH) and submitted to HSAG. Once received, HSAG will use probabilistic data linkage methods to associate the immunization data with Medicaid members

eligible for this study. To conduct the probabilistic matching and subsequent analyses, HSAG will extract the member information needed for the study from the data they have already received from DMAS. In addition, DMAS will supply HSAG with dental encounter data from the Medicaid Dental Benefit Manager (DBM), DentaQuest and behavioral health encounter data from Magellan. A three-month data run-out period will be allowed between the end of the measurement period and data extraction; data extraction will begin no earlier than October 1, 2015.

Medical Record Data

HSAG will calculate the hybrid study indicators based on information abstracted from a statistically valid sample of medical records. Due to the overlapping nature of the study topics, data abstracted from a single sample of medical records will be used to calculate both hybrid study indicators. HSAG will identify 492 children[E-1] eligible for inclusion in the study population using a random sample stratified equally across three age groups based on the child's age at the end of the measurement period (children younger than three years, children ages three through 11 years, and adolescents ages 12 through 17 years). This sample size is based on a 95.0 percent confidence level and a margin of error less than 4.8 percent.

To ensure the greatest likelihood of medical record procurement, HSAG will pursue medical records for each sampled case through up to two avenues ("chases"): (1) the primary care provider (PCP) assigned to the child, and (2) the PCP-type provider who provided the child's most recent well-check. HSAG will use administrative data to identify the provider(s) for each of these chases for each sampled case. After sample cases are selected, HSAG will work directly with providers to locate and collect the medical records. HSAG will compile a list containing those sampled cases in which a well-check visit is not identified from the administrative data for DMAS' consideration and potential follow-up.

Concurrent with medical record procurement efforts, HSAG will develop an electronic data collection instrument specific to the study indicators for the well-child and immunization measures (refer to the *Indicators* section). Upon receipt of the medical records, HSAG will abstract the information from the records. To ensure accuracy of the abstracted data, clinical review staff will undergo training prior to record abstraction, and inter-rate reliability (IRR) testing will be conducted upon conclusion of training. Each reviewer must score 95 percent before beginning "live" abstraction. Following the initial IRR, HSAG will conduct ongoing Rater-To-Standard (RTS) reliability testing throughout the duration of the record review process. Each clinical reviewer must maintain a 95 percent accuracy score throughout the study. Following medical record abstraction, a set of standard edits will be run against the abstracted data as a final validity check, including a review of the frequency distributions, valid range checks, and logical field-to-field comparisons.

[E-1] The sample of 492 children is consistent with 411 cases plus a 20 percent oversample to address potential exclusions (e.g., cases in which the medical record shows that the member did not meet the denominator criteria).

Indicators

The unit of analysis for this study will be Medicaid members. Table E-1 illustrates the study indicators included in the study as well as the numerator and denominator definitions. Please note that calculation of the measures is contingent upon the availability of timely, complete, and accurate data.

While many measures are based on HEDIS 2015 technical specifications, modifications have been made based upon the study population's length of time in managed care. For consistency with other quality initiatives, clinical and billing codes noted in the HEDIS 2015 value sets will be used, and applicable HEDIS 2015 value sets are named in the study indicator descriptions.

Table E-1—Study Indicators

Indicator	Denominator	Numerator
Characteristics of Medicaid Members in Foster Care[E-2]		
1. **Age**—An administrative measure describing the number of children by age category.	Category Values: Year of Age (e.g., 1 year, 2 years, 3 years, etc.) Note: Age categories will be aggregated into three groups for graphic presentation: 3 years and younger, 4 years through 11 years, 12 years through 17 years (under 18 years of age).	Descriptive Measure - Not Applicable
2. **Sex**—An administrative measure describing the number of children by sex (gender).	Category Values: Female Male Other	Descriptive Measure - Not Applicable
3. **Race/Ethnicity—**An administrative measure describing the number of children by race/ethnicity.	Category Values: White African American Asian Hispanic Other Note: Race/ethnicity will be defined based on members' non-Hispanic race (i.e., White, non-Hispanic) classification with Hispanic members of any race being reported in the Hispanic category. Race/ethnicities in the Other category may be reported	Descriptive Measure - Not Applicable

[E-2] Indicators in this category will be provided for informational purposes only and will not be subject to continuous enrollment criteria.

Indicator	Denominator	Numerator
	independently if the denominator is greater than 30.	
4. **Region of Residence—**An administrative measure describing the number of children by the region of residence as of June 30, 2015.	Category Values: Central Charlottesville Far Southwest Halifax/Lynchburg Northern/Winchester Roanoke/Alleghany Tidewater Note: Region of residence will be defined based on members' county of residence as of June 30, 2015 using the Virginia Department of Social Services Regional Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).	Descriptive Measure - Not Applicable
5. **Percentage of Children Moving Between Regions—** An administrative measure of the number of children who resided in more than one region during the measurement period. Note: Supplemental analysis will identify the range in the number regions reported within the measurement period.	Members in the study population.	Number of members in the study population with more than one region of residence.
Preventive Care		
1. **Expected Well-Child Visits**—A medical record review measure assessing whether children have received the expected number of well-child visits for their age, based upon the Virginia EPSDT periodicity schedule.[E-3] This measure combines elements of the HEDIS 2015 W15, W34, and AWC measures.	Members sampled from the study population divided into three groups based on the members' age at the end of the measurement period: • Children younger than 3 years as of June 30, 2015 • Children ages 3 years through 11 years as of June 30, 2015 • Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age)	The number of sampled members receiving the expected number of well-child visits in the measurement period for their age, based on the Virginia EPSDT periodicity schedule. A complete well-child visit will be determined by the presence of the following items in the member's medical record: • Health history • Mental development history/assessment

[E-3] Virginia DMAS. *Virginia EPSDT Periodicity Chart.* Available at: http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-epsdt_poi2.pdf. Accessed on February 25, 2015.

Indicator	Denominator	Numerator
Note: Supplemental analyses will identify the percentage of sampled members receiving 1) zero visits in the review period, and 2) at least one visit in the first six months of the review period.	Note: This indicator uses the same sample and denominator as the **Expected Immunizations** indicator.	• Physical development history/assessment • Physical exam • Age appropriate anticipatory guidance Note: Further information pertaining to members' immunization status will be assessed in the **Expected Immunizations** indicator.
2. **Expected Immunizations**—A medical record review measure assessing whether children are up-to-date on immunizations expected for their age. This measure combines elements of the HEDIS 2015 CIS, IMA, and HPV measures.	Members sampled from the study population divided into three groups based on the members' age at the of the measurement period: • Children younger than 3 years as of June 30, 2015 • Children ages 3 years through 11 years as of June 30, 2015 • Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age) Note: This indicator uses the same sample and denominator as the **Expected Well-Child Visits** indicator.	The number of sampled members up to date on their immunizations as of their most recent well-check.[E-4] As a subindicator, HSAG will consider whether sampled members not up to date with their immunizations have evidence of an immunization make-up schedule in effect. Note: In the event medical records show that an immunization is contraindicated, that immunization will not be counted toward the member's overall immunization status.
3. **Access to Primary Care Providers**—An administrative measure based on the HEDIS 2015 CAP measure, assessing the percentage of children older than 12 months and under 18 years of age who had a visit with a PCP. Note: Supplemental analyses will identify the percentage of sampled members receiving 1) zero visits in the review period, and 2) at least one visit in the first six months of the review period.	Members in the study population divided into four groups: • Children ages 12 months through 24 months as of June 30, 2015 • Children ages 25 months through 6 years as of June 30, 2015 • Children ages 7 years through 11 years as of June 30, 2015 • Adolescents ages 12 years through 17 years as of June 30, 2015 (i.e., under 18 years of age)	Members in the study population who had at least one visit with a PCP (HEDIS 2015 *Ambulatory Visits* Value Set) during the measurement period.

[E-4] Expected immunizations will be determined based on the child's age at the visit as compared to the American Committee on Immunization Practices (ACIP) listed in the Virginia EPSDT periodicity schedule. Immunizations that may be provided at any point within an age range will only be required for numerator compliance if the member has completed the age range. For example, the second dose of the Measles, Mumps, Rubella (MMR) vaccine may be administered between four and six years of age and the presence or absence of this vaccine in relation to this study indicator will only be considered among children seven years and older.

Indicator	Denominator	Numerator
4. **Annual Dental Visit**—An administrative measure based on the HEDIS 2015 ADV measure, assessing the percentage of children older than three years who had a visit with a dentist.	Members in the study population at least three years of age as of the beginning of the measurement period.	Members in the study population at least three years of age as of the beginning of the measurement period who had at least one dental visit (HEDIS 2015 *Dental Visits* Value Set) with a dental practitioner during the measurement period.
Behavioral Health		
1. **Use of Multiple Concurrent Antipsychotics in Children and Adolescents**—An administrative measure based on the HEDIS 2015 APC measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who were on two or more concurrent antipsychotic medications. A lower rate indicates better performance. Note: HEDIS 2015 Technical Specifications for the APC measure will be used to calculate this study indicator with modifications only to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology.	Children older than 1 year of age and under 18 years of age as of June 30, 2015, with 90 days of continuous antipsychotic medication treatment during the measurement period.	Children older than 1 year and under 18 years of age as of June 30, 2015, with 90 days of continuous antipsychotic medication treatment during the measurement period and two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement period.
2. **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics**—An administrative measure based on the HEDIS 2015 APP measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Note: HEDIS 2015 Technical Specifications for the APP measure will be used to calculate this study	Children older than 1 year and under 18 years of age as of June 30, 2015, who had a new prescription for an antipsychotic medication between November 1, 2014, and May 30, 2015. Note: Members for whom first-line antipsychotic medications may be clinically appropriate are excluded from this measure. These exclusions will be applied as described in the HEDIS 2015 Technical Specifications for the APP measure.	Children in the denominator with documentation of psychosocial care (HEDIS 2015 *Psychosocial Care* Value Set) in the 121-day period from 90 days before the date of their earliest new prescription for an antipsychotic medication during the measurement period through 30 days after the date of their earliest new prescription for an antipsychotic medication.

Indicator	Denominator	Numerator
indicator with modifications to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology and utilization under managed care service delivery.		
3. **Overall Use Psychosocial Care for Children and Adolescents on Antipsychotics**—An administrative measure inspired by the HEDIS 2015 APP measure, assessing the percentage of children and adolescents older than 1 year and under 18 years of age who had documentation of psychosocial care in the ninety days following a new prescription for an antipsychotic medication.	Children older than 1 year and under 18 years of age as of June 30, 2015, who had a new prescription for an antipsychotic medication between July 1, 2014, and March 31, 2015.	Children in the denominator with documentation of psychosocial care (HEDIS 2015 Psychosocial Care Value Set) in the 90-day period from the day after the date of their earliest new prescription for an antipsychotic medication during the measurement period through 90 days after the date of their earliest new prescription for an antipsychotic medication.
4. **Follow-Up After Hospitalization for Mental Illness**—An administrative measure based on the HEDIS 2015 FUH measure, assessing the percentage of discharges for children six years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Rates will be reported for the percentage of discharges for which the child received follow-up within 30 days of discharge, and within 7 days of discharge. Note: HEDIS 2015 Technical Specifications for the FUH measure will be used to calculate this study indicator with modifications only to accommodate continuous enrollment as described in the *Eligible Population* section of this methodology.	Children older than 6 years and under 18 years of age as of the date of hospital discharge for treatment of selected mental illness diagnoses (HEDIS 2015 *Mental Illness* Value Set).	Children older than 6 years and under 18 years of age as of the date of hospital discharge for treatment of selected mental illness diagnoses (HEDIS 2015 *Mental Illness* Value Set) who had an outpatient visit, and intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days and 30 days of discharge (two rates reported).

Indicator	Denominator	Numerator
5. Prevalence of Antidepressant Medication—An administrative measure inspired by the HEDIS 2015 AMM measure, assessing the percentage of children on antidepressant medications during the measurement period.	Children older than 6 years and under 18 years of age as of June 30, 2015.	Children older than 6 years and under 18 years of age as of June 30, 2015 who had at least one prescription for an antidepressant medication during the measurement period. Note: Secondary analyses will be completed to determine the number of children younger than 6 years who received a prescription for an antidepressant medication during the study period, as antidepressants are not FDA-approved for use in children younger than 6 years.
6. Prevalence of Children Prescribed ADHD Medication—An administrative measure inspired by the HEDIS 2015 ADD measure, assessing the percentage of children on ADHD medication during the measurement period.	Children older than 6 years and under 18 years of age as of June 30, 2015.	Children older than 6 years and under 18 years of age as of June 30, 2015 who had at least one prescription for an ADHD medication during the measurement period. Note: Secondary analyses will be completed to determine the number of numerator cases in which the child received a newly prescribed ADHD medication between November 1, 2014, and June 30, 2015 (i.e., the child did not have any new or refilled ADHD medications during the 120 days prior to their earliest ADHD prescription).

Deliverable

HSAG will present the findings of this focused study in a data report. The data report will primarily consist of tables and graphs with some text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based upon the report.

Appendix F. Health and Acute Care Program Methodology

Purpose

The Virginia Department of Medical Assistance Services (DMAS) has contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a focused study that will provide quantitative information about the clinical profile of Medicaid Medallion 3.0 members in the Health and Acute Care Program (HAP). Beginning on December 1, 2014, the service delivery system for members covered by one of five waiver programs[F-1] were unified under managed care in the HAP.

The Contract Year 2 Task F.3 HAP Focused Study will address the following question: *To what extent did HAP members in this combined waiver population use medical and pharmacy services during the first year of managed care coverage?*

Study Design

Measurement Period

The study will examine clinical services received by Medicaid members of the HAP during two measurement periods. The pre-HAP period (analysis Phase I—members enrolled in Virginia Medicaid Medallion Managed Care and then enrolled in a long term care waiver) will evaluate services from December 1, 2013, though November 30, 2014; and the post-HAP period (analysis Phase II—members enrolled in Virginia Medicaid Medallion Managed Care and then enrolled in a long term care waiver with members enrolled in EDCD and then enrolled in Virginia Medicaid Medallion Managed Care) will evaluate services from December 1, 2014, through November 30, 2015 (i.e., the first full year of HAP rebranding statewide managed care for this program). Analyses will consider each year (i.e., December 1 through November 30) as a distinct measurement period.

Eligible Population

The eligible population will consist of all Medicaid members enrolled in the HAP as of December 1, 2014. DMAS will provide HSAG with a monthly enrollment file for each month in the study period, extracted on the first day of the month. HAP members will be identified within the monthly enrollment file as having a value of "HAP" in the WAIVER data field.

[F-1] In addition to members in the Elderly or Disabled with Consumer Direction (EDCD) waiver, the following Home and Community-Based Services (HCBS) waiver programs are included in HAP: Day Support (DS), Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS), and Alzheimer's Assisted Living (AAL).

The eligibility of HAP members identified in the December 1, 2014, enrollment file is based on enrollment records at a point in time and does not capture eligibility segments, or consequently, continuous enrollment. As such, HSAG will use eligibility data received from DMAS to assess continuous enrollment and enrollment patterns of members in the study population throughout the measurement period.

Data Collection

In addition to administrative claims and encounter data, DMAS will supply HSAG with dental encounter data from the Medicaid Dental Benefit Manager (DBM), DentaQuest, and behavioral health encounter data from Magellan. A four-month data run-out period will be allowed between the end of the measurement period and data extraction. Data extraction for Phase II analyses will begin no earlier than April 1, 2016. DMAS has already provided HSAG with data for Phase I analyses in the course of other External Quality Review activities.

Analysis

The unit of analysis for this study will be Medicaid members. Due to the exploratory nature of these analyses, HSAG will first establish an analytic dataset containing a member-level profile of members' demographic, clinical, and utilization characteristics (i.e., study metrics). This information will then be aggregated statewide (i.e., at the level of the HAP) and by individual waiver program for each of the two time periods under considerations (i.e., December 1, 2013, through November 30, 2014 for Phase I, and December 1, 2014, through November 30, 2015 for Phase II). HSAG will compare the aggregated statewide and program-level results over time. Table F-1 presents the study metrics HSAG will assemble for each member in the study population. Please note that calculation of the study metrics is contingent upon the availability of timely, complete, and accurate data.

Indicators

For consistency with other quality initiatives, clinical and billing codes noted in the HEDIS 2016 technical specifications and value sets will be used when possible.[F-2] Table F-1 lists the proposed study metrics, including a brief description of each measure, category values, and notes regarding the measure. Metrics are grouped into three domains: demographic, clinical, and utilization; the utilization domain is divided between medical and pharmacy-related metrics.

[F-2] HEDIS 2016 value sets will be used because the measurement period includes the October 1, 2015, transition date for ICD-10-CM diagnosis codes, and these codes are not reflected in value sets prior to HEDIS 2016.

Table F-1—Study Metrics

Metric	Description
Demographic Profile	
1. Age	Member's age as of December 1, 2014 Category Values: Numeric age in years (e.g., 1, 2, 3, etc.) Member's age will be aggregated into four categories for graphic presentation: 17 years and younger, 18 years through 34 years, 35 years through 64 years, and 65 years and older.
2. Sex	Member's sex (gender) Category Values: Female, Male, Other
3. Race/Ethnicity	Member's race/ethnicity Category Values: White, African American, Asian, Hispanic, Other Race/ethnicity will be defined based on the member's non-Hispanic race (i.e., White, non-Hispanic) classification; *Hispanic* members of any race will be reported in the Hispanic category. Race/ethnicities in the *Other* category may be reported independently if the denominator is greater than 30 members.
4. Region of Residence	Member's region of residence; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Central, Charlottesville, Far Southwest, Halifax/Lynchburg, Northern/Winchester, Roanoke/Alleghany, Tidewater, Out of State Region of residence will be defined based on a member's county of residence as of December 1, 2014, using the Virginia Managed Care Regions Map and Federal Information Processing Standards (FIPS) codes defined in Appendix A of the External Quality Review Organization (EQRO) Request for Proposal (RFP).
5. Managed Care Plan	A member's managed care plan; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Anthem, Coventry, INTotal, Kaiser Permanente, Optima, VA Premier, Fee-For-Service (FFS) Note: MajestaCare will be a valid category value for members as of 12/1/2013 only.
6. Change in Managed Care Plan	A binary indicator (i.e., Yes or No) noting whether the member changed managed care plans during the measurement period for each study phase.
7. Waiver Program	A member's waiver program; metrics established as of 12/1/2013, 12/1/2014, and 11/30/2015. Category Values: Day Support, Elderly or Disabled With Consumer Direction (EDCD), Individuals with Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS), Alzheimer's, No Waiver
Clinical Profile	
1. Diabetes	A binary indicator (i.e., Yes or No) noting whether the member had a diagnosis of diabetes at any time during the measurement period for each study phase.

Metric	Description
	Diabetes will be identified based on diagnosis and procedure codes from claims/encounter data using the following HEDIS-like specifications: • Members who met any of the following criteria during the measurement period: – At least two outpatient visits (*Outpatient* Value Set), observation visits (*Observation* Value Set), Emergency Department (ED) visits (*ED* Value Set) or non-acute inpatient encounters (*Non-acute Inpatient* Value Set) on different dates of service, with a diagnosis of diabetes (*Diabetes* Value Set). Visit type need not be the same for the two visits. – At least one acute inpatient encounter (*Acute Inpatient* Value Set) with a diagnosis of diabetes (*Diabetes* Value Set). – Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement period (NDC Table CDC-A).
2. Coronary Artery Disease (CAD)	A binary indicator (i.e., Yes or No) noting whether the member had a diagnosis of coronary artery disease (CAD) during the measurement period for each study phase. CAD will be identified as claim/encounter data with a diagnosis of ICD-9-CM 414.x, 410.xx, or 429.9, where ".xx" indicates any specific code subordinate to the overall category. Corresponding ICD-10-CM codes for Phase II data analyses will be identified by HSAG and submitted for DMAS approval prior to initiation of the Phase II analyses.
3. Mental Health Diagnosis	A binary indicator (i.e., Yes or No) noting whether the member had a mental health diagnosis at any time during the measurement period for each study phase. A mental health diagnosis will be identified from diagnoses on claim/encounter data using the HEDIS *Mental Health Diagnosis* Value Set.
Medical Utilization	
1. Ambulatory Care Visits	The number of unique ambulatory care visits attributed to the member during the measurement period for each study phase. An ambulatory care visit will be identified from claim/encounter data using the HEDIS *Ambulatory Visit* Value Set or the *Other Ambulatory Visits* Value Set. Ambulatory care visits occurring on the same date of service with the same provider will be counted as a single visit.
2. Ambulatory Care Visits with a PCP-Type Provider*	The number of unique ambulatory care visits with a PCP-type provider attributed to the member during the measurement period for each study phase. An ambulatory care visit will be identified from claim/encounter data using the HEDIS *Ambulatory Visit* Value Set or the *Other Ambulatory Visits* Value Set. Ambulatory care visits occurring on the same date of service with the same provider will be counted as a single visit.
3. Dental Visits	A binary indicator (i.e., Yes or No) noting whether or not the member had a dental visit with a dental practitioner during the measurement period for each study phase. A dental visit will be identified from encounter data using the HEDIS *Dental Visits* Value Set. Dental procedures occurring on the same date of service with the same provider will be counted as a single visit.

Metric	Description
4. Emergency Department (ED) Visits	The number of unique ED visits attributed to the member during the measurement period for each study phase. ED visits resulting in an inpatient encounter or for the purposes of receiving mental health or chemical dependency services will be excluded. An ED visit will be identified as claims/encounter data with a value from the HEDIS *ED* Value Set or a value from each of the *ED Procedure Code* Value Set and *ED POS* Value Set. ED visits occurring on the same date of service with the same provider will be counted as a single visit.
5. Long-Term Care (LTC) Service Days	The number of unique days in which the members received LTC services for each study phase. LTC services will be identified from claim/encounter data using the list of Long-Term Services and Supports (LTSS) Waiver Service Codes supplied by DMAS (Table F-2).
Pharmacy Utilization**	
1. Prescriptions	The number of unique prescriptions attributed to the member during the measurement period for each study phase.
2. Prescriptions for ADD/ADHD Medications	The number of unique prescriptions for ADD/ADHD medications attributed to the member during the measurement period for each study phase. Prescription ADD/ADHD medications will be identified using HEDIS NDC Table ADD-A.
3. Prescriptions for Antibiotics	The number of unique prescriptions for antibiotics attributed to the member during the measurement period for each study phase. Prescription antibiotics will be identified using HEDIS NDC Table ABX-A.
4. Prescriptions for Antipsychotics	The number of unique prescriptions for antipsychotic medications attributed to the member during the measurement period for each study phase. Prescription antipsychotics will be identified using HEDIS NDC Table SSD-D or the HEDIS *Long-Acting Injections* Value Set.
5. Prescriptions for Opiates	The number of unique prescriptions for natural or synthetic opiates attributed to the member during the measurement period for each study phase. Prescription opiates will be identified from the Medi-Span pharmacy database as drugs with a generic product identifier beginning with “65”, "431010", "439950", "439951", "439952", "439953", or "439954".

* Based on direction from DMAS, HSAG may add up to two Medical Utilization metrics similar to the *Ambulatory Care Visits with a PCP-Type Provider* metric. These metrics will focus on ambulatory visits with specific specialty provider types (e.g., cardiologists or endocrinologists).

** For all pharmacy utilization measures, HSAG will identify unique prescriptions by de-duplicating paid prescription drug claims/encounters by Member, Date of Service, National Drug Code (NDC), and Billing Provider (Pharmacy). HSAG may recommend alternate criteria based upon consideration of the data.

Table F-2 lists the LTSS Waiver Service Codes supplied by DMAS for use in identifying members with LTC services.

Table F-2—Long-Term Services and Supports Procedure Codes by Waiver

LTSS Waiver Services Code Description	Code	Modifier	HAP Waiver Program and Code				
			Alzheimer's (T)	EDCD (9)	Day Support/ Building Independence (BI) (S)	IFDDS/Family and Individual Supports (FIS) (R)	ID/Community Living (CL) (Y)
Adult Day Health Care	S5102			X			
Adult Day Health Care (per trip)	A0120			X			
Assisted Living per diem	T2031		X				
Assistive Technology Only	T1999			X		X	X
Assistive Technology, Maintenance Costs Only	T1999	U5		X		X	X
Case Management (State Plan)	T1017	U3					X
CD - Companion Services	S5136					X	X
Companion Services	S5135					X	X
Congregate Nursing/LPN	T1001	U1					
Congregate Nursing/RN	T1000	U1					
Congregate Residential Support	97535						X
Congregate Residential - Exceptional Supports	97535	U1					X
Consumer Directed Personal Assistance/Attendant Care	S5126			X		X	X
Consumer-Directed Respite Services	S5150			X		X	X
Crisis Stabilization - Intervention	H2011					X	X
Crisis Stabilization - Supervision	H0040					X	X
Day Support, High Intensity	97537	U1			X	X	X
Day Support, Regular Intensity	97537				X	X	X
Environmental Modification, Maintenance Costs Only	99199	U4		X		X	X
Environmental Modifications Only	S5165			X		X	X
Family Care Giver Training	S5111					X	
In-Home Residential Support	H2014					X	X
PERS Installation	S5160			X		X	X
PERS Installation and Medication Monitoring	S5160	U1		X		X	X
PERS Medication Monitoring	S5185			X		X	X
PERS Monitoring	S5161			X		X	X
PERS Nursing Services/LPN	H2021	TE		X		X	X
PERS Nursing Services/RN	H2021	TD		X		X	X
Personal Care	T1019			X		X	X
Pre-vocational Services, High Intensity	H2025	U1			X	X	X
Pre-vocational Services, Regular Intensity	H2025				X	X	X
Respite Care	T1005			X		X	X
Respite Care LPN	S9125	TE		X			
Service Facilitation Consumer Training Visit	S5109			X		X	X
Service Facilitation Initial Comprehensive Visit	H2000			X		X	X
Service Facilitation Management Training Hours	S5116			X		X	X
Service Facilitation Reassessment Visit	T1028			X		X	X

LTSS Waiver Services Code Description	Code	Modifier	HAP Waiver Program and Code				
			Alzheimer's (T)	EDCD (9)	Day Support/ Building Independence (BI) (S)	IFDDS/Family and Individual Supports (FIS) (R)	ID/Community Living (CL) (Y)
Service Facilitation Routine Visit	99509			X		X	X
Skilled Nursing Services/LPN	T1003					X	X
Skilled Nursing Services/RN	T1002					X	X
Sponsored Residential	T2033						X
Sponsored Residential - Exceptional Supports	T2033	U1					X
Support Coordination (per month) (State Plan)	T2023					X	
Supported Employment, Enclave/Work Crew	H2024				X	X	X
Supported Employment, Individual	H2023				X	X	X
Therapeutic Consultation	97139					X	X
Transition Coordination	H2015			X			
Transition Services	T2038			X		X	X

Deliverable

HSAG will present the findings of this focused study in two phases, including a data brief and a data report. The data brief will include results from the first phase of analysis and will primarily consist of tables and graphs with minimal text discussing the results presented in the tables and graphs. The data report will include results from both phases of analysis, including comparisons of results across the two measurement periods. The data report will primarily consist of tables and graphs with minimal text discussing the results presented in the tables and graphs. A corresponding PowerPoint slide deck will be produced based upon the data report. HSAG will also provide a copy of the analytic dataset in a format to be determined by DMAS (e.g., SAS dataset, pipe-delimited text file, etc.).

Appendix G. Encounter Data Validation Methodology/Scope of Work

Overview

Accurate and complete encounter data are critical to assessing quality, monitoring program integrity, and making financial decisions. Therefore, DMAS requires its contracted MCOs to submit high-quality encounter data. For contract year 2015–2016, DMAS contracted with HSAG to conduct an EDV study. The goals of the EDV study were to assist DMAS in developing policies and procedures surrounding the collection, monitoring, and ongoing improvement of encounter data and to evaluate the overall quality (i.e., accuracy and completeness) of the encounter data submitted by its contracted MCOs.

HSAG conducted the following key activities:

- **Task 1—Encounter Data Protocol Review**: Reviewed and discussed the existing protocols and procedures for the submission, collection, processing, management, and monitoring of encounter data, including the recommendation of process enhancements. Identified gaps in current encounter data quality programs and targeted priority areas for review and improvement. This activity was conducted via monthly conference calls with key stakeholders from DMAS and its vendors. Supplemental data collection instruments (e.g., questionnaires) were used to facilitate HSAG's review and subsequent discussions.
- **Task 2—Technical Assistance (TA) Related to Monitoring/Reporting Strategies**: Drawing on information obtained from the monthly conference calls, baseline encounter data quality results, and the MCO-specific EDQ reports from the new EDQ process, HSAG assisted DMAS staff in (1) improving/updating existing critical issues in the *MCTM*, (2) evaluating emerging issues in the *MCTM* and updating/promoting some emerging issues to critical issues, and (3) identifying existing data quality deficits and recommending areas/mechanisms for improvement.
- **Task 3—Assessment of Encounter Data Accuracy, Completeness, and Timeliness**: The analysis of encounter data completeness, accuracy, and timeliness involved the calculation of evaluation metrics at the file and/or field level using the most recent encounter data extracted from DMAS' MMIS. These evaluations supplemented DMAS' ongoing EDQ program reporting by expanding its analysis in order to (1) investigate findings from monitoring reports and (2) further assist with the development of encounter data standards suitable for Virginia's Medallion 3.0 program.

Methodology

Prior to the initiation of the encounter data quality project, HSAG worked with DMAS to define and finalize the project scope and methodology. HSAG understands that in order to make results and information relevant to DMAS' needs, the project must be rooted in Virginia's Medicaid environment.

A detailed approach for each task is outlined in the following pages, addressing each key project milestone.

Task 1: Encounter Data Protocol Review

HSAG coordinated and conducted monthly conference calls with key stakeholders from DMAS, including its vendors[G-1] as appropriate, to discuss the topics in Table G-1. The conference calls consisted of two one-hour sessions or one two-hour session as needed monthly. In order to facilitate the calls, HSAG did the following before each conference call:

- Informed DMAS of the discussion topic and set up the conference call with key stakeholders ten business days before the call.
- Submitted a document request to DMAS for existing documents related to the discussion topic ten business days before the conference call. The requested documents included but were not limited to data submission requirements, data dictionaries, process flow charts, data system diagrams, encounter system edits, encounter data monitoring reports, work group meeting minutes, and communication documents. The requested documentation pieces were in the forms of work/PDF document, PowerPoint presentation, diagrams, or flow charts.
- Reviewed the document from DMAS for the conference topic and submitted a list of questions for discussion three business days before the call.

Each call was targeted to a specific area or process; therefore, HSAG worked with DMAS to identify the appropriate staff needed to attend each call to ensure the most effective use of staff time. Following each call, HSAG distributed the meeting minutes and action items to the attendees for documentation and for purposes of tracking action items and subsequent follow-up. Table G-1 outlines the topics discussed each month.

Table G-1—Topics for Conference Calls with DMAS

Month	Topic
June 2015	• Overview of current encounter data flow from the MCOs to the MMIS in DMAS and the upcoming changes for the transition to a new EDI environment. • Determine how DMAS is using/will use encounter data to address short- and long-term needs (e.g., encounter reporting, performance measure calculations, and performance improvement projects).
July 2015	• Data submission processing procedures and personnel between the MCOs and Fiscal Agent (FA).
August 2015	• Discuss *MCTM* and system edits.

[G-1] DMAS planned to take over the EDI server approximately December 2015, replacing the vendor, Xerox. Therefore, Xerox did not attend the conference calls; DMAS answered the questions addressed to Xerox in the questionnaire.

Month	Topic
September 2015	• Data submission processing procedures and personnel between the FA and MMIS.
October 2015	• Data exchange policies and procedures within MMIS. • Integrate encounter data with provider, member, eligibility, and enrollment data.

Task 2: TA Related to Monitoring/Reporting Strategies

DMAS developed a new EDQ process that was implemented on July 1, 2015. In the new EDQ process, two categories of issues were identified and reported to the MCOs: critical issues and emerging issues. HSAG reviewed the EDQ reports to the MCOs and assisted DMAS in (1) improving and updating three critical issues in the *MCTM*, (2) evaluating eight emerging issues in the *MCTM*, and (3) updating/promoting some emerging issues to critical issues.

In addition to the new EDQ process, HSAG synthesized the information gained from the conference calls (Task 1) and the administrative analyses (Task 3) to develop actionable recommendations that DMAS may consider when developing future encounter data activities. Recommendations focused on developing an encounter data program capable of governing the encounter data submission and processing processes and monitoring the overall quality of encounter data.

Task 3: Assessment of Encounter Data Accuracy, Completeness, and Timeliness

Task 3 involved HSAG's performance of an administrative analysis to assist DMAS with setting up the encounter data standards for future MCO contracts. Table G-2 lists the encounter data metrics HSAG proposed for inclusion in the baseline assessment. The results for these metrics are presented at the MCO and statewide levels.

Table G-2—Encounter Data Metrics

Metric Type	Metric Description	Purpose
File-level	• Monthly encounter data volume by claim type. • Encounters per 1,000 members per month (PMPM) by claim type.	Evaluate encounter data completeness.
File-level	• Percentage of encounters accepted into the MMIS within 60 days, 90 days, and such from the MCO payment date by claim type. • Percentage of encounters submitted to DMAS within 60 days, 90 days, and such from the MCO payment date by claim type.	Evaluate encounter data timeliness.

Metric Type	Metric Description	Purpose
Field-level	• Percent present and percent with valid values for selected key data elements in Appendix H. • Assist DMAS in evaluating whether values in the data element *Units* are reported consistently across the MCOs for the pharmacy data.	Evaluate encounter data completeness and accuracy.

To conduct the administrative analysis, HSAG worked with DMAS to request and receive extracts from its MMIS. Specifically, HSAG required encounter data for dates of service between July 1, 2013, and December 31, 2014, as well as member eligibility/enrollment data. Table G-3 contains the key parameters that define the required data for this activity.

Table G-3—Criteria for Encounter Data Extraction

Data Element	Data Parameter
Claim Type	Inpatient Hospital Facility, Outpatient Facility*, Personal Care, Practitioner, Pharmacy, Laboratory, Transportation
MCO	Anthem HealthKeepers Plus (Anthem), CoventryCares of Virginia (Coventry), INTotal Health (INTotal), Kaiser Permanente, MajestaCare[G-2], Optima Family Care (Optima), Virginia Premier Health Plan, Inc. (VA Premier)
Member	Enrolled in Medicaid or Family Access to Medical Insurance Security (FAMIS)
End Date of Service	July 1, 2013 ≤ End Date of Service ≤ December 31, 2014
As of Date for Monthly Extract Files from DMAS	On or before June 2015
File Format	SAS® [G-3] datasets
*Due to lack of clear definition about home health encounters, these encounters were included in the outpatient facility encounters for the analysis.	

Deliverable

Prior to drafting the final deliverable, HSAG submitted a formatted report outline to DMAS for review and approval. The draft report included key findings and recommendations from all three tasks. To streamline the reporting process, HSAG produced one aggregate report for DMAS with MCO-specific results in an appendix. The MCO-specific appendix provided the results from Task 3 for a specific MCO and the statewide results, and could be distributed to each MCO for further investigation. Based on the findings and experience working with other states, HSAG provided recommendations that are specific and actionable. HSAG incorporated DMAS' feedback and delivered the final report on January 29, 2016.

[G-2] The contract with MajestaCare was terminated effective December 1, 2014; therefore, HSAG did not include an appendix for MajestaCare in the report. However, HSAG did include MajestaCare encounters in its analysis, where appropriate, to generate statewide results and/or to help evaluate encounter volume change among the MCOs.

[G-3] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

Appendix H. Methodology for CAHPS Survey Validation

Introduction and Description of the Activity

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in the FAMIS program, Aetna Better Health of Virginia, Anthem Health Keepers Plus, INTotal, Kaiser Permanente, Optima, and VA Premier with their MCO and health care experiences.

FAMIS CAHPS

Technical Methods of Data Collection and Analysis, Including Validation Protocol

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 Children with Chronic Conditions 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., 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, 2015. 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 2016. 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 for 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.[H-1]

For the FAMIS program, the survey questions were categorized into 14 measures of satisfaction.[H-2] These measures included four global ratings, five composite measures, and five Children with Chronic Conditions (CCC) composite measures and items.[H-3] 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"). The CCC composite measures and items assess various aspects of care relevant to the population of children with chronic conditions (e.g., "Access to Specialized Services" and "Family-Centered Care [FCC]: Personal Doctor Who Knows Child").

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 the CCC composite measures and items, the percentage of respondents who chose a positive response was calculated. Questions' response choices for the CAHPS CCC composite measures and items fell into one of two categories: 1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response was defined as a response of "Usually/Always" for the *Access to Specialized Services*, *Access to Prescription Medicines*, and *Family-Centered Care (FCC): Getting Needed Information* composited, and "Yes" for the *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* items. The percentage of top-box responses is referred to as a global proportion for the composite scores and a question summary rate for the individual item measures.

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 less than 100

[H-1] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

[H-2] 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, five composite measures, and five Children with Chronic Conditions CAHPS measures.

[H-3] The Children with Chronic Conditions composite and item measures are applicable to the population of children with chronic conditions only; therefore, these measures are not reported for the general child population.

respondents. CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Additionally, the FAMIS program's general child and CCC populations' survey findings were compared to 20154 NCQA CAHPS child Medicaid national averages, where applicable. [H-4] A measure was noted when the measure's rate was 5 percentage points higher or lower than the NCQA national average.

Description of Data Obtained

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 March to June 2016 using a mixed-mode methodology designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by the number of all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 30, 45, 49, and 54. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: deceased, invalid (did not meet the eligible population criteria), or having a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the FAMIS CAHPS surveys, HSAG provided DMAS with an aggregate report of the general child and children with chronic conditions 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 Section 9 of this report.

Medallion 3.0 CAHPS

Technical Methods of Data Collection and Analysis, including Validation Protocol

For the Medallion 3.0 CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey and CAHPS 5.0H Child Medicaid Health Plan Survey to adult and child Medicaid members, respectively, enrolled in Aetna Better Health of Virginia (Aetna), Anthem Health Keepers Plus (Anthem), INTotal, Kaiser Permanente, Optima, and VA Premier. Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2015; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2015.

Each MCO was responsible for contracting with their own NCQA-certified survey vendor to conduct CAHPS surveys of their adult and child Medicaid populations, on their behalf, including survey analysis and reporting of CAHPS results. Aetna contracted with the Center for the Study of Services (CSS), Anthem and Kaiser contracted with DSS Research, INTotal contracted with MORPACE, and Optima

[H-4] The source for the 2015 NCQA national child Medicaid averages for the general child population and children with chronic conditions population is Quality Compass® 2015 data.

and VA Premier both contracted with SPH Analytics (formerly The Myers Group) to conduct the CAHPS survey administration and analysis and reporting of survey results for their respective adult and child Medicaid populations. To support the reliability and validity of the findings, NCQA's standardized sampling and data collection procedures were followed to select members and distribute surveys. 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 submitted to NCQA via NCQA's Interactive Data Submission System (IDSS) and aggregated into a database for analysis. Each MCO provided HSAG with their NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report of NCQA-calculated CAHPS survey results) for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the children with chronic conditions measurement set) that assess members' perspectives on care.[H-5] The survey questions were categorized into nine measures of satisfaction.[H-6] These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their health plan, all health care, personal doctor, and specialists. 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. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "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 each MCO, the 2016 adult and child CAHPS scores were compared to 2015 NCQA national adult and child Medicaid averages, respectively. In addition to the MCOs' scores, HSAG provided a statewide aggregate rate calculated as the average (i.e., mean) of the MCOs' scores combined for each CAHPS survey measure and compared the statewide aggregate to the 2015 NCQA national Medicaid average.[H-7]

[H-5] VA Premier administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set to its child Medicaid population, 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 VA Premier represent the CAHPS results for its general child population only based on parents'/caretakers' responses of child members selected as part of the general child sample (i.e., general child CAHPS results) and do not include CAHPS survey measure results captured through the Children with Chronic Conditions measurement set of questions.

[H-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. Therefore, reported results are limited to the four global ratings and five composite measures.

[H-7] The source for the 2015 NCQA national adult and child Medicaid averages is Quality Compass® 2015 data.

For purposes of this comparison, a measure was noted when the measure's rate was at least 5 percentage points higher or lower than the 2015 NCQA national average.

Additionally, HSAG performed a comparison of the MCOs' CAHPS survey results to one another to identify those measures where MCOs scored highest and lowest. The MCO comparisons were performed for each the four CAHPS global ratings and five composite measures. 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 as Not Applicable (NA).

Description of Data Obtained

As described above, 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 MCOs' CAHPS surveys would have been administered between the time periods of January through May 2016. While the MCOs' methodologies for data collection varied; each MCO would have selected their mode for data collection to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by the number of all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: questions 3, 15, 24, 28, and 35 for adult Medicaid and questions 3, 15, 27, 31, and 36 for child Medicaid, as specified by NCQA. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: deceased, invalid (did not meet the eligible population criteria), having a language barrier, or mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the MCOs' survey vendors, and a summary of the final survey dispositions was provided to HSAG in the data (i.e., NCQA Summary Reports) received.