



Commonwealth of Virginia
Department of Medical Assistance Services

2010 Annual Technical Report



Delmarva Foundation

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2010 Annual Technical Report

Executive Summary

Introduction

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

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

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

In addition, the BBA requires an annual technical report (ATR) that assesses the quality of care delivered to eligible enrollees through the MCOs. This report, as specified in CFR 438.358, consists of an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that an MCO or their contractors, furnish to recipients enrolled in managed care.

Summary of Findings

Operational Systems Review (OSR)

The 2010 review evaluated the progress in those operational standards identified as opportunities for improvement during the 2008 comprehensive OSR and in the interim review conducted in 2009. Various elements of improvement were identified along with those needing additional follow-up by each MCO. The next comprehensive review is scheduled for 2011.

Performance Measurement Validation (PMV)

The goal of conducting performance measure validation (PMV) is to evaluate the accuracy of the specific Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures required by DMAS for MCO reporting. Delmarva evaluated the MCO's compliance with HEDIS[®] specifications and the accuracy of their reported performance measures. None of the MCOs encountered any major system issues that affected their ability to accurately calculate and report these measures.

The two measures validated by Delmarva included Childhood Immunization Status and Cholesterol Management for Patients with Cardiovascular Conditions. Although each MCO utilized different systems and procedures for their performance measure reporting, all share the following common strengths:

- The MCOs have well-developed and established systems and processes for HEDIS[®] reporting.
- MCOs implemented feedback and recommendations from previous audits in the 2010 HEDIS reporting period.
- All MCOs developed new and creative outreach approaches that increased compliance and resulted in better HEDIS[®] rates.

HEDIS[®]

Virginia's Medicaid MCO average for HEDIS[®] 2010 met or exceeded the National Medicaid Managed Care Average for the following 14 measures:

- Controlling High Blood Pressure

- Use of Appropriate Medications—Asthma Total (Combined Ages)
- Prenatal and Postpartum Care—Timeliness of Prenatal Care
- Prenatal and Postpartum Care—Postpartum Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Cholesterol Management for Patients With Cardio Vascular Conditions--LDL-C Screening
- Comprehensive Diabetes Care—HbA1c Testing
- Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
- Comprehensive Diabetes Care—HbA1c Control (<8.0%)
- Comprehensive Diabetes Care—LDL-C Screening
- Comprehensive Diabetes Care—LDL-C Control (<100/mg/dL)
- Comprehensive Diabetes Care—Medical Attention for Nephropathy
- Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)
- Antidepressant Medical Management—Effective Continuation Phase Treatment

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

From 2008 to 2009, seven out of the ten measures in the Adult survey compared favorably with the CAHPS® National Medicaid Average. Two measures were below the 2009 national average: Rating of Personal Doctor Overall and How Well Doctors Communicate. Results for the Children with Chronic Conditions measures were fairly constant between 2008 and 2009.

Performance Improvement Projects (PIP)

The Virginia Medicaid MCOs made progress over the three-year measurement period in sustaining improvements in both required PIPs. Four of the five MCOs sustained improvement in the Childhood Immunization Combination 2 PIP while three MCOs sustained improvement in the PIP to improve Well-Child Visits in the First 15 Months of Life. Two MCOs demonstrated sustained improvement in both PIPs.

Quality Highlights

- DMAS requires the Medicaid MCOs to be National Committee for Quality Assurance (NCQA) accredited. Four of the five MCOs are nationally ranked according to the *America's Best Health Plans* for 2009-2010, with three MCOs ranked in the top 35 Medicaid health plans.

- Participation in the MCO collaborative has been successfully coordinated by DMAS as a forum for sharing of “best practices.” All five MCOs have quality initiatives to target identified needs of their enrollee populations and to initiate efforts that improve quality.
- Virginia’s Medicaid MCO average for HEDIS® 2010 met or exceeded the National Medicaid Managed Care Average for 14 measures. The MCOs sustained improvement for eleven of their performance measures from 2007 to 2009.
- The *Improving Birth Outcomes* study evaluated the Family Access to Medical Insurance, FAMIS, MOMS (a CHIP Title XXI waiver program), and Medicaid for Pregnant Women (a Medicaid Title XIX program). The percentage of pregnant women in managed care now exceeds 71 percent. The percentage of women receiving adequate prenatal care improved from 2007 to 2009 when compared to the HEDIS® National Medicaid Managed Care Averages.
- Overall Low Birth Weight rates for infants born to women in a managed care organization were the most favorable when compared to both FFS and Primary Care Case Management (PCCM) and with the national benchmarks from 2007 to 2009.
- The rate of infants born prematurely (before 37 completed weeks of pregnancy) in the FAMIS MOMS and Medicaid for Pregnant Women programs was less (less is better) than the national rates for all three study years.

Conclusion

Virginia’s Medicaid MCOs are effectively and collaboratively addressing quality, timeliness, and access to care in their managed care populations. The efforts made to improve quality by DMAS and the MCOs are highly commendable and show continual and consistent improvement. The specific recommendations for both DMAS and the MCOs are outlined in this 2010 ATR report.

This represents an opportunity to build on a solid and organized framework to sustain and improve quality indicators in the future. DMAS should consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates. Recommendations include implementing statewide interventions and collaboration with strategic partners, such as the Virginia Vaccines for Children (VVFC) program. DMAS has the capability to accurately evaluate indicator trends over time and to serve as the catalyst to impact change for improvement.

2010 Annual Technical Report

Introduction

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

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

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

- **Quality**, as it pertains to external quality review, is defined as “the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its enrollees (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.” (Centers for Medicare & Medicaid Services [CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D- Quality Assessment and Performance Improvement*, [June 2002]).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is “the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services.” (2006 *Standards and Guidelines for the Accreditation of Managed Care Organizations*).

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

DMAS is responsible for the operational oversight of health care services provided through two delivery systems: managed care and fee-for-service (FFS). Through its managed care delivery system, health care services are received by eligible enrollees through contracted MCOs. The program was designed to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. The five MCOs contracted with DMAS are:

- AMERIGROUP Community Care (Amerigroup)
- HealthKeepers, Inc. (formally Anthem HMOs)
- Optima Family Care (OFC)
- Southern Health Services, Inc. (CareNet)
- Virginia Premier Health Plan, Inc. (Va Premier)

EQRO Activities

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

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

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

- The 2010 evaluation conducted by DMAS as follow-up to the 2008 comprehensive MCO operational systems reviews (OSRs).
- The 2010 Healthcare Effectiveness Data and Information Set (HEDIS[®])¹ consisting of the two measures selected by DMAS for validation. Each MCO also reports 14 additional measures that aggregate their HEDIS[®] results and include both CHIP and Medicaid enrollees.
- The 2010 Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) 4.0H member satisfaction survey results for Children with Chronic Conditions (CCC), and for Adult Medicaid-HMO.
- 2010 MCO performance improvement projects (PIPs) validations for two DMAS selected projects.

In addition, Delmarva evaluated other quality-related aspects of the state's managed care delivery system in order to provide a comprehensive assessment of the overall program. Additional data included the State Managed Care Quality Strategy, focused clinical studies (FCS), and the MCO's best and emerging practices for improving quality of care and service.

¹ HEDIS was developed and is maintained by the NCQA and is the most widely used set of performance measures in the managed care industry

DMAS Quality Strategy

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

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

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

DMAS has established quality requirements for contracted MCOs that exceed the minimum EQR requirements set forth by CMS for all states. Contracted Medicaid MCOs are required by DMAS to achieve and maintain NCQA accreditation. This achievement is recognized among industry leaders, consumers, purchasers, and providers as the MCO's commitment to continuous quality improvement. In 2010, four of the five MCOs achieved an accreditation status of excellent, the highest attainable level. One MCO is currently accredited as a new health plan while pursuing the next accreditation level.

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

Because the MCOs comply with the HEDIS[®] technical specifications, DMAS has deemed a number of the PIP validation elements. Although the comprehensive OSR performed in 2008 did not permit deeming, the next Operational Systems Review (OSR) is scheduled for 2011 and will include partial deeming for those elements that duplicate NCQA accreditation requirements.

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

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

Results from the Improving Birth Outcomes study found that the percentage of pregnant women in managed care now exceeds 71 percent. The overwhelming majority (92.8 percent) of pregnant women were enrolled in the Medicaid for Pregnant Women program while 7.2 percent were enrolled in the FAMIS MOMS program.

The combined rates for FAMIS MOMS (a CHIP Title XXI waiver program) and Medicaid for Pregnant Women (a Medicaid Title XIX program) receiving adequate prenatal cares are more favorable as compared with the HEDIS® National Medicaid Managed Care Averages for all three time periods, 2007 to 2009. Also, the Overall Low Birth Weight rates for infants born to women in a managed care organization were the most favorable when compared to FFS and Primary Care Case Management (PCCM) during the same three year period.

The Child Health study was conducted to assess whether the children enrolled in FAMIS, FAMIS Plus, or Medicaid Expansion programs had the health care services appropriate for their age groups during 2010.

State Quality Initiatives

MCO Collaborative

The contracted MCOs are required to participate in the DMAS quality collaborative. The quarterly meetings of DMAS with the MCOs function as a forum to share “best practices” and to transfer knowledge on how to improve specific quality measures. One example of the output from this initiative was the sharing of MCO “best practices” regarding performance improvement projects, quality improvement initiatives, and targeted interventions.

Best and Emerging Practices for Improving Quality of Care and Service

The MCOs presented a peer-nominated best practice at the DMAS annual best practice session. The selected topics represented exceptional HEDIS[®] scores for 2010.

Virginia Premier Health Plan, Inc. evaluated their population by percentage of members 18 years of age and older who were diagnosed with a new episode of depression, treated with antidepressant and remained on an antidepressant medication treatment. Va Premier developed an antidepressant medication management program to include:

- Behavioral health screening and assessment
- Change of Pharmacy Benefit Manager with enhanced data analysis
- Post-partum depression program for outreach and case management
- Behavioral health home visits within 3 days of hospital discharge/care coordination

The program evaluation documented improvement by an increase in the number of plan enrollees who were initially treated and who remained on antidepressant medication. Program results documented an increase of more than 20 percentage points over the last three years.

CareNet developed a Chronic Obstructive Pulmonary Disease (COPD) program coordinated by an RN Case Manager using national clinical guidelines. Members were stratified according to risk for health complications and co-occurring conditions were also addressed. Educational literature was available to all members in the case management program. The percentage of enrollees in the program who were prescribed appropriate medications exceeded the 2010 Medicaid national average rates for pharmacotherapy management of COPD exacerbation.

HealthKeepers, Inc. implemented a multi-faceted intensive educational program to increase the rates of well child visits and recommended immunizations for children ages 15 months and 2 years. Based on analysis, a public transportation intervention targeted identified populations. Bilingual posters on buses alerted parents to the need for these preventive services. Outreach services assisted parents with making appointments and in securing transportation. The MCO's physicians were provided with a financial incentive for increasing childhood immunization rates. Well child visits increased by 9.5 percent during the remeasurement period.

Optima Family Care targeted quality improvement efforts toward follow-up at 7 and 30 days after mental health hospitalizations. The areas of focus were effective case management and a *Bridge Program*. In the *Bridge Program*, contracted behavioral health providers see hospitalized members at high-volume treating facilities during the inpatient stay and on the day of discharge to facilitate transition from inpatient to outpatient care. Improvement results have been sustained

for follow-up at both 7 and 30 days following hospitalization. Optima's HEDIS[®] rates outperformed the national averages in both categories.

Amerigroup implemented several effective strategies to improve the percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year. Enhanced use of IT capabilities identified recommended preventive service schedules as well as a supplemental documentation source. A comprehensive outreach initiative provided targeted information to both the member/parent and their providers. Sustained improvement produced HEDIS[®] rates that exceeded the national averages from 2007-2009.

Operational Systems Review (OSR)

The CMS EQR guidelines require a comprehensive OSR to be conducted at least once every three years. The OSR includes an extensive desk review of MCO documentation and an onsite review that includes staff interviews and an observation of MCO operations. For the 2010 OSR, a non-mandatory follow-up review was conducted by DMAS to evaluate progress in various systems elements and/or to assess several areas of quality improvement since the 2008 comprehensive OSRs. All MCOs provided explanation and evidence of progress made in all areas that were not fully met in the 2008 comprehensive OSR and in the interim review conducted in 2009. Specific improvements that were identified among the MCOs included the following:

- Process improvements for enrolling newborns into the health plan.
- Policy revisions to monitor compliance with the CMS Program Integrity Audit Corrective Action Plans (CAPs).
- Periodically monitor and validate that billed services were actually received by enrollees.
- Provider outreach and incentive payment programs were used for improving HEDIS[®] results.

Even though each MCO had achieved exemplary performance in delivering services to its managed care members, DMAS recognized additional opportunities for improvement. The following are examples of recommendations that were given to one or more of the MCOs:

- Enhance newborn enrollment process by use of the form 213 into the process flow sheets.
- Revise Fraud and Abuse policies to effectively monitor "disclosure of ownership and control interest" in the provider credentialing and recredentialing process, to include monitoring requirements required to document compliance.

- Establish internal quality metrics to identify and trend occurrences and adherence to required timelines for validating services billed were actually received.

Performance Measurement Validation (PMV)

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

Since all five MCOs in the managed care program are NCQA accredited, there are requirements for each MCO to calculate and submit performance rates for HEDIS[®] measures used by NCQA for public reporting and benchmarking. DMAS also requires the MCOs to report on specific HEDIS[®] measures. The goal in conducting performance measure validation (PMV) is to evaluate the accuracy of the measures and to determine the extent to which the MCO followed specifications for calculating and reporting the measures.

Delmarva's Certified HEDIS[®] Compliance Auditors (CHCA) utilized methods consistent with NCQA's *HEDIS[®] Compliance Audit Standards, Policies and Procedures (Volume 5)* to assess each MCO's performance measures data collection and reporting processes for conformity with NCQA's *HEDIS[®] 2010 Technical Specifications (Volume 2)*.

The Delmarva validation team conducted an onsite visit to each MCO to evaluate any potential issues identified and to observe the systems used by the MCO to collect and produce HEDIS[®] data. The methodology is consistent with the CMS protocol for conducting Medicaid External Quality Review Activities, Validating Performance Measures.

The 2010 PMVs were conducted by Delmarva during onsite visits with each MCO. Two HEDIS[®] measures were selected by DMAS for validation by Delmarva: Childhood Immunization Status and Cholesterol Management for Patients with Cardiovascular Conditions. All MCOs submitted the two measures according to the HEDIS[®] 2010 Technical Specifications. Although each MCO utilized different systems and procedures for their performance measure reporting, they share the following common strengths:

- Experience and knowledgeable HEDIS[®] reporting staff are present in the MCOs.

- The MCOs have well-developed and established systems and processes for HEDIS[®] reporting.
- When problems were identified, each MCO staff exhibited the ability to quickly put a solution into action.
- One MCO moved to certified HEDIS software.
- MCOs implemented feedback and recommendations from previous audits in the 2010 HEDIS reporting period.
- All MCOs developed new and creative outreach approaches that increased compliance and resulted in better HEDIS[®] rates.

As a result of the validation process, a key recommendation for the MCOs is to remain vigilant about leveraging Electronic Health Records (EHR) in their provider networks. EHR will increase efficiency in data collection for calculating HEDIS[®] rates.

HEDIS[®]

HEDIS[®] is the nationally recognized tool for monitoring the quality of care in health plans. These indicators are considered the “gold standard” in the industry and are used by many of America’s health plans to measure performance on identified dimensions of health care and services. DMAS identified 14 HEDIS[®] measures that best reflect the performance of the contracted managed care organizations. Each MCO provided DMAS with their HEDIS[®] scores for these 14 measures.

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

HEDIS[®] data are presented in the following tables for each measure for all Virginia Medicaid MCOs for 2007, 2008 and 2009. These rates are compared with HEDIS[®] National Medicaid Managed Care Averages for the corresponding time periods. Calendar year 2008 is reported as HEDIS[®] 2009 and calendar year 2009 is reported as HEDIS[®] 2010. Also displayed are the HEDIS[®] National Medicaid Managed Care 90th percentile rates for each measure.

Table 1 displays the aggregate results for the MCOs.

Table 1. Comparison of the Virginia Medicaid MCO scores and National Medicaid Managed Care Averages for HEDIS 2010 (CY 2009) to HEDIS 2009 (CY 2008) and HEDIS 2008 (CY 2007)

HEDIS Measure	Virginia Medicaid MCO Average (CY 2007)	Virginia Medicaid MCO Average (CY 2008)	Virginia Medicaid MCO Average (CY 2009)	HEDIS 2008 (CY 2007) National Medicaid Managed Care Average*	HEDIS 2009 (CY 2008) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care 90 th Percentile*
Adolescent Well-Care Visit	41.8%	42.1%	44.5%	41.9%	45.9%	47.7%	63.2%
Antidepressant Medical Management-Acute Phase Tx	^	34.5%	49.5%	42.8%	48.2%	49.7%	58.4%
Antidepressant Medical Management-Continuation Phase Tx	^	21.3%	33.6%	27.4%	31.8%	33.0%	43.3%
Childhood Immunization Status Combination 2	^	75.1%	71.5%	72.2%	73.7%	74.3%	85.6%
Childhood Immunization Status Combination 3	64.8%	69.0%	66.2%	65.4%	67.6%	69.4%	82.0%
Breast Cancer Screening	48.1%	46.5%	46.2%	49.8%	50.8%	52.4%	63.8%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Screening	77.6%	59.3%	82.3%	76.3%	79.6%	80.7%	88.8%
Cholesterol Management for Patients With Cardiovascular Conditions-LDL-C Control <100 mg/DL	44.6%	32.5%	36.7%	38.2%	40.1%	41.2%	54.4%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2007)	Virginia Medicaid MCO Average (CY 2008)	Virginia Medicaid MCO Average (CY 2009)	HEDIS 2008 (CY 2007) National Medicaid Managed Care Average*	HEDIS 2009 (CY 2008) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care 90 th Percentile*
Controlling High Blood Pressure	^	56.2%	60.5%	53.5%	55.8%	55.2%	67.2%
Comprehensive Diabetes Care–HbA1c Testing	76.7%	79.2%	81.0%	77.3%	80.5%	80.6%	90.3%
Comprehensive Diabetes Care–Poor HbA1c Control >9% <i>(lower rate is better)</i>	49.9%	45.2%	42.7%	48.0%	44.8%	44.9%	27.7%
Comprehensive Diabetes Care–HbA1c Control <7% [■]	^	16.9%	13.3%	^	*	33.9%	44.5%
Comprehensive Diabetes Care–HbA1c Control <8% [■]	^	42.2%	47.4%	^	*	45.7%	58.8%
Comprehensive Diabetes Care–Eye (Retinal) Exams	40.9%	46.4%	48.3%	49.8%	52.8%	52.7%	70.1%
Comprehensive Diabetes Care–Lipid Profile LDL-C Screening	70.0%	73.5%	74.7%	70.8%	74.1%	74.2%	84.0%
Comprehensive Diabetes Care–LDL-C Control (<100 mg /dL)	32.2%	31.7%	39.6%	31.3%	33.8%	33.5%	45.5%
Comprehensive Diabetes Care–Medical Attention to Nephropathy	70.5%	75.6%	77.9%	74.3%	76.6%	76.9%	86.2%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2007)	Virginia Medicaid MCO Average (CY 2008)	Virginia Medicaid MCO Average (CY 2009)	HEDIS 2008 (CY 2007) National Medicaid Managed Care Average*	HEDIS 2009 (CY 2008) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care 90 th Percentile*
Comprehensive Diabetes Care– Blood Pressure Control (<130/80mm Hg)	30.5%	34.75%	31.4%	29.6%	30.7%	32.2%	44.4%
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	54.3%	53.1%	61.1%	55.6%	56.9%	59.8%	73.4%
Follow-Up After Hospitalization for Mental Illness– 7 Days	^	34.2%	36.0%	42.5%	42.6%	42.9%	64.3%
Follow-Up After Hospitalization for Mental Illness– 30 Days	^	44.7%	54.6%	61.0%	61.7%	60.2%	83.6%
Lead Screening in Children	^	51.9%	56.6%	^	66.7%	66.4%	88.4%
Pharmacotherapy Management of COPD Exacerbation– Bronchodilator	^	60.0%	64.4%	^	78.2%	80.2%	90.0%
Pharmacotherapy Management of COPD Exacerbation– Systemic Corticosteroid	^	48.6%	50.5%	^	61.7%	61.4%	76.2%
Use of Appropriate Medications– Asthma Age 5-9 (CY 2009 Age 5-11) [®]	^	93.6%	91.8%	89.3%	92.0%	91.8%	95.5%

HEDIS Measure	Virginia Medicaid MCO Average (CY 2007)	Virginia Medicaid MCO Average (CY 2008)	Virginia Medicaid MCO Average (CY 2009)	HEDIS 2008 (CY 2007) National Medicaid Managed Care Average*	HEDIS 2009 (CY 2008) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care Average*	HEDIS 2010 (CY 2009) National Medicaid Managed Care 90 th Percentile*
Use of Appropriate Medications—Asthma Age 10-17 (CY 2009 Age 12-50) [Ⓞ]	^	92.2%	85.1%	86.9%	89.1%	86.0%	90.7%
Use of Appropriate Medications—Asthma Total (Combined Ages)	91.2%	90.9%	88.7%	86.9%	88.7%	88.6%	92.8%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	84.3%	86.0%	86.4%	81.4%	81.9%	83.3%	92.7%
Prenatal and Postpartum Care—Postpartum Care	63.9%	65.6%	66.3%	58.6%	62.7%	64.1%	74.4%
Well-Child Visits in the First 15 Months of Life (Six or more visits)	56.2%	59.6%	65.2%	53.0%	58.8%	59.4%	76.3%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	68.3%	69.4%	71.2%	65.1%	69.7%	71.6%	82.5%

* HEDIS National Medicaid Average and 90th Percentile-Quality Compass

^ Measure not collected

▣ New measure for 2009-not for public reporting

Ⓞ CY2009 Age parameters have changed from previous years

* Comparative benchmark not available

The Virginia Medicaid MCO average met or exceeded the corresponding HEDIS[®] 2008, 2009 and 2010 National Medicaid Managed Care Average all three years for the following measures:

- Use of Appropriate Medications—Asthma Total (Combined Ages)
- Prenatal and Postpartum Care—Timeliness of Prenatal Care

- Prenatal and Postpartum Care—Postpartum Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life

Since HEDIS[®] 2008, the Virginia Medicaid MCO average improved for the following measures, but fell below the national average:

- Adolescent Well-Care Visit
- Comprehensive Diabetes Care—Poor HbA1c Control >9 percent
- Comprehensive Diabetes Care—Eye (Retinal) Exams
- Comprehensive Diabetes Care—Lipid Profile LDL-C Screening (<100 mg/dL)
- Comprehensive Diabetes Care—HbA1c Testing
- Comprehensive Diabetes Care—HbA1c Poor Control (>9%)
- Comprehensive Diabetes Care—Medical Attention to Nephropathy
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life
- Prenatal and Postpartum Care—Timeliness of Prenatal Care
- Prenatal and Postpartum Care—Postpartum Care

As compared to the HEDIS[®] 2010 National Medicaid Managed Care Average, the Virginia MCO average for 2009 exceeded this benchmark for the following measures:

- Controlling High Blood Pressure
- Use of Appropriate Medications—Asthma Total (Combined Ages)
- Prenatal and Postpartum Care—Timeliness of Prenatal Care
- Prenatal and Postpartum Care—Postpartum Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)
- Cholesterol Management for Patients With Cardio Vascular Conditions--LDL-C Screening
- Comprehensive Diabetes Care—HbA1c Testing
- Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)
- Comprehensive Diabetes Care—HbA1c Control (<8.0%)
- Comprehensive Diabetes Care—LDL-C Screening
- Comprehensive Diabetes Care—LDL-C Control (<100/mg/dL)
- Comprehensive Diabetes Care—Medical Attention for Nephropathy
- Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)
- Antidepressant Medical Management—Effective Continuation Phase Treatment

Overall, the Virginia Medicaid MCOs performance improved in many measures from HEDIS[®] 2009 to HEDIS[®] 2010. The measures in which at least four of the five MCOs obtained scores that exceeded comparative benchmarks are as follows:

- Cholesterol Management for Patients With Cardiovascular Conditions—LDL-Screening
- Controlling High Blood Pressure
- Comprehensive Diabetes Care—LDL-C Screening1
- Use of Appropriate Medications—Asthma Total (Combined Ages)
- Prenatal and Postpartum Care—Timeliness of Prenatal Care
- Prenatal and Postpartum Care—Postpartum Care
- Well-Child Visits in the First 15 Months of Life (Six or more visits)

The Virginia Medicaid MCOs implemented initiatives to continually improve quality and the HEDIS[®] results for their members. The success of the managed care delivery system is dependent on these achievements in order to evaluate the health care services provided to these vulnerable populations. Appendix Table A1-1 details all individual results MCO results for calendar years 2007, 2008 and 2009.

Consumer Assessment of Healthcare Providers and Systems (CAHPS[®])

The CAHPS[®] program develops and utilizes standardized surveys to obtain consumer information about the health services received. While originally designed to help consumers select health plans, the measures have evolved into an important tool in the effort to improve health care quality.

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

The specific domains of quality measured by CAHPS[®] surveys for Children with Chronic Conditions (CCC), and the Adult Medicaid populations include the following:

- Rating of Health Plan
- Rating of Health Care

- Rating of Personal Doctor
- Rating of Specialist
- Customer Service
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Shared Decision Making

Table 2 displays the aggregate average results of the Virginia MCO's CAHPS[®] Adult Population Survey for 2007 through 2009 as compared with the 2007- 2009 CAHPS[®] National Medicaid Averages and the 2009 90th percentile. There are no CAHPS[®] National benchmarks for the 4.0H Child Survey with CCC due to small CCC numbers that are not currently suitable for public reporting and comparison. The CAHPS[®] 2008 data reflects calendar year 2008, CAHPS[®] 2009 data was reported in calendar year 2009 and CAHPS[®] 2010 is based on data reported for calendar year 2008.

Table 2. Comparison of the Virginia MCO average scores and National Medicaid Averages for CAHPS® 2008 (CY 2007) through CAHPS® 2010 (CY 2009)

Measure	Virginia MCO Avg (CY2007) ◇	Virginia MCO Avg (CY 2008)	Virginia MCO Avg (CY 2009)	CAHPS® (CY 2007) National Medicaid Average*	CAHPS® (CY 2008) National Medicaid Average*	CAHPS® (CY 2009) National Medicaid Average*	CAHPS® (CY 2009) National Medicaid 90th Percentile*
CAHPS – Adult Population							
Rating of Health Plan Overall	75%	77.2%	74.8%	70.6%	72.8%	70.7%	79.3%
Rating of Health Care Overall	70%	69.7%	67.4%	67.1%	68.2%	67.4%	74.4%
Rating of Personal Doctor Overall	76%	77.9%	75.1%	75.7%	76.2%	75.6%	80.9%
Rating of Specialist Overall	75%	81.3%	78.4%	75.5%	76.4%	76.4%	81.7%
Customer Service Composite	84%	82.9%	84.0%	78.9%	80.1%	79.5%	86.3 %
Getting Needed Care Composite	76%	77.2%	76.7%	75.2%	75.7%	75.1%	82.0%
Getting Care Quickly Composite	79%	80.5%	80.3%	80.2%	80.1%	79.5%	84.6%
How Well Doctors Communicate Composite	85%	86.7%	86.1%	86.7%	87.2%	87.0%	90.4%
Shared Decision Making Composite	58%	61.9%	63.4%	58.1%	58.6%	59.6%	65.2%
Advised to Quit Smoking by a Doctor or Other Health Provider	–	67.7%	72.7%	-	-	-	-
CAHPS – Child CCC							
Rating of Health Plan Overall	-	78.2%	81.3%	79.7%	81.0%	-	-
Rating of Health Care Overall	-	74.7%	78.0%	81.9%	79.0%	-	-
Rating of Personal Doctor Overall	-	81.4%	83.4%	82.5%	84.0%	-	-
Rating of Specialist Overall	-	79.7%	81.8%	80.4%	83.0%	-	-
Customer Service Composite	-	86.1%	81.4%	NA	-	-	-
Getting Needed Care Composite	-	80.8%	81.7%	NA	-	-	-
Getting Care Quickly Composite	-	88.4%	88.8%	NA	-	-	-

Measure	Virginia MCO Avg (CY2007) ◆	Virginia MCO Avg (CY 2008)	Virginia MCO Avg (CY 2009)	CAHPS® (CY 2007) National Medicaid Average*	CAHPS® (CY 2008) National Medicaid Average*	CAHPS® (CY 2009) National Medicaid Average*	CAHPS® (CY 2009) National Medicaid 90th Percentile*
How Well Doctors Communicate Composite	-	91.6%	91.6%	89.7%	91.0%	-	-
Shared Decision Making Composite	-	70.9%	69.0%	NA	-	-	-

◆ Results for this measure were taken from the 2008 Annual Technical Report for the Commonwealth of Virginia, Division of Medical Assistance Services in January 2009 by MPRO and was only available as a whole number

® Consumer Assessment of Healthcare Providers and Systems

* CAHPS National Medicaid Average and 90th Percentile-Quality Compass

- No comparative benchmarks available

NA Denominator was too small to report a valid rate

From 2008 to 2009, seven out of the ten measures in the Adult category of the CAHPS® survey Virginia MCO averages compared favorably with the CAHPS® National Medicaid Average. Two measures were below the 2009 national average: *Rating of Personal Doctor Overall* and *How Well Doctors Communicate*. Seven measures decreased between 2008 and 2009. The results for the Children with Chronic Conditions measures were fairly constant between 2008 and 2009.

Performance Improvement Projects (PIPs)

PIPs are used to assess the health plan’s focus on improving quality, access, and timeliness of care and services. DMAS’ annual contract with each MCO requires that PIPs be designed to achieve significant and sustainable improvement in clinical and non-clinical areas. The projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIPs must include measuring performance using objective quality indicators, implementing system interventions to achieve improvement in quality, evaluating the effectiveness of the interventions, and planning and initiating activities for increasing or sustaining improvement.

Delmarva uses the CMS protocol *Validating Performance Improvement Projects—A Protocol for Use in Conducting Medicaid External Quality Review Activities* as a guideline in PIP review activities. This protocol assists Delmarva in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and whether it provides DMAS with a validation that the MCO’s improvement projects are methodical and effective.

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

Under the direction of DMAS, MCOs were required to perform PIPs on Well-Child Visits and Childhood Immunizations. DMAS selected this topic for the third consecutive year based on its relevance to the MCO population. For these projects, DMAS requires MCOs to base the PIPs on the following two HEDIS[®] measures:

➤ *Well-Child Visits in the First 15 Months of Life (W15)*

The W15 measure is the percentage of members who turned 15 months old during the measurement year 2009 and who had six or more well-child visits since birth.

➤ *Childhood Immunization Status—Combination 2 (CIS-2)*

The CIS-2 measure is the percentage of children who turned 24 months old during the measurement year 2009 and received four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); two H influenza type B (Hib); three hepatitis B; and one chicken pox (VZV) vaccination on or before the child's second birthday.

The following is an overview of the MCOs' PIPs for reporting year 2010, based on measurement year 2009. Four of the five MCOs sustained improvement in the *Combination 2* PIP. Three MCOs sustained improvement in the *Well-Child Visits* PIP and two MCOs sustained improvement in both PIPs. The progress made by the MCOs over the three-year measurement period since baseline was commendable.

All MCOs *met* validation requirements for at least eight of the 10 steps on both projects while two MCOs *met* all 10 validation steps for one PIP. All other indicators were *partially met* with the exception of one MCO with one indicator *not met* in each PIP for the 2010 reporting period. The primary reasons for validation steps to receive a *partially met* score were as follows:

- Interventions were passive and either not modified or not targeted to address the study question.
- If the MCO was not successful in achieving improvement and/or scored poorly on the indicator, there was insufficient explanation of evaluation and follow-up activities.
- Outreach activities had limited impact if interventions replicated prior educational efforts versus those that were new and targeted strategies that allowed for one-to-one contact with the member or provider.
- Data collection methodologies also had an impact on results and should be incorporated into specific interventions and evaluations.

Receiving a score of *not met* on a validation step was due to the following reasons:

- The indicator rate declined or decreased during a measurement period.
- Many passive interventions were continued instead of implementing robust strategies that targeted specific barriers.
- Sustained improvement was not evident during the measurement period.

Delmarva's recommendations to improve the PIP process and outcomes included more targeted interventions that are based on barrier analyses to identify gaps in lower performing indicators or processes. MCOs should continue to share and adopt "best practices" from both local peers and national resources. An intervention that promotes one-to-one contact or outreach with members and providers can be effective for sub-groups needing improvement. Finally, developing strategies to strive for more significant improvement (i.e., statistically significant rate increases) and targeting the HEDIS[®] National Medicaid Managed Care 90th Percentile as a stretch goal over the average should be considered.

Recommendations for DMAS

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

- The MCO collaborative should continue to be coordinated by DMAS to encourage cooperation and improvement efforts to influence the quality of care provided to recipients enrolled in managed care.
- MCOs with HEDIS[®] results that are that meet or exceed the National Medicaid Managed Care 90th percentile rate, should be encouraged to share "best practice" strategies.

- DMAS should consider increasing the performance measure goals to target the HEDIS® National Medicaid Managed Care 90th percentile rates.
- For most measures in the Adult category of the CAHPS® survey Virginia MCO results compared favorably with the CAHPS® National Medicaid Average in all three years between 2007 and 2009. Seven measures decreased between 2008 and 2009.

Recommendations for the Virginia MCOs

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

- MCOs should remain vigilant about leveraging Electronic Health Records (EHR) in their provider networks to increase efficiency in data collection for HEDIS®.
- MCOs with the best HEDIS® results compared with the National Medicaid Managed Care 90th percentile rates, should continue to share successful intervention strategies.
- MCOs should conduct a root-cause or barrier analyses for those HEDIS® measures not meeting the HEDIS® National Medicaid Managed Care Average.
- *How Well Doctors Communicate* is the Adult CAHPS® survey question that compares unfavorably with the National Medicaid Average in both 2007 and 2008. The MCOs should incorporate improvement efforts that target this physician education component as part of ongoing PIP activities.
- PIP interventions need to reflect gap analyses that identify specific barriers and are targeted to improve the results of population sub-groups.
- All MCOs should implement specific recommendations identified for improvement from all EQR activities.

Conclusions for DMAS

- All Virginia MCOs are required to be NCQA accredited. Four of the five MCOs are nationally ranked according to the *America's Best Health Plans* for 2009-2010, with three MCOs in the top 35 Medicaid health plans. DMAS should continue this requirement.

Conclusions for the Virginia MCOs

- Well-developed, in-house HEDIS® reporting processes were enhanced by the MCOs with the MCO collaborative is an effective forum for sharing of local and national “best practices” that increase effectiveness in both PIP initiatives and HEDIS® results use of targeted interventions to increase their performance measure rates.
- The MCO collaborative is an effective forum for sharing of local and national “best practices” that increase effectiveness in both PIP initiatives and HEDIS® results.

Appendix

Table A1-1 MCO Rates (CY 2007 – CY 2009)□

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPHP HEDIS 2008 (CY2007)	VPHP HEDIS 2009 (CY 2008)	VPHP HEDIS 2010 (CY 2009)
Effectiveness of Care															
Antidepressant Medical Management– Acute Phase Tx	^	NA	51.3%	^	37.9%	42.3%	^	50.0%	43.6%	^	36.1%	45.1%	^	48.6%	65.4%
Antidepressant Medical Management– Continuation Phase Tx	^	NA	35.9%	^	23.9%	27.2%	^	27.9%	24.8%	^	20.0%	29.31%	^	34.8%	50.8%
Childhood Immunization Status Combination 2	63% ♦	86.8%	77.7%	73% ♦	78.9%	75.7%	64% ♦	61.3%	60.4%	76% ♦	74.0%	68.2%	74 % ♦	74.7%	75.4%
Childhood Immunization Status Combination 3	55.6%	80.4%	73.5%	66.4%	71.8%	71.1%	56.7%	56.0%	55.1%	68.6%	68.3%	62.3%	68.6%	68.4%	69.3%
Breast Cancer Screening	46.3%	46.4%	45.7%	44.6%	45.6%	47.6%	40.3%	43.9%	41.3%	50.0%	48.9%	48.9%	45.6%	47.8%	47.6%

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPHH HEDIS 2008 (CY2007)	VPHH HEDIS 2009 (CY 2008)	VPHH HEDIS 2010 (CY 2009)
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Screening	NA	NA	90.5%	80.0%	75.6%	80.0%	75.0%	59.5%	80.4%	76.0%	79.9%	78.2%	79.5%	81.5%	82.2%
Cholesterol Management for Patients With Cardiovascular Conditions– LDL-C Control <100 mg/DL	NA	NA	41.9%	50.8%	42.3%	47.8%	37.5%	31.0%	39.3%	39.4%	40.9%	38.9%	50.6%	48.4%	57.4%
Controlling High Blood Pressure	^	53.5%	66.4%	^	64.0%	66.4%	^	51.2%	54.1%	^	54.0%	55.5%	^	58.4%	63.0%
Comprehensive Diabetes Care– HbA1c Testing	69.4%	82.4%	84.5%	74.9%	76.3%	79.1%	77.6%	74.1%	75.0%	83.8%	83.0%	83.1%	77.6%	80.1%	83.4%
Comprehensive Diabetes Care– Poor HbA1c Control >9% (lower rate is better)	67.7%	50.0%	44.2%	42.5%	37.8%	39.3%	51.8%	53.6%	49.2%	37.9%	39.4%	43.9%	49.4%	45.1%	36.7%
Comprehensive Diabetes Care– HbA1c Control <7% [■]	^	NR	NR	^	NR	NR	^	37.2%	29.3%	^	NR	NR	^	47.5%	37.4%

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPHH HEDIS 2008 (CY2007)	VPHH HEDIS 2009 (CY 2008)	VPHH HEDIS 2010 (CY 2009)
Comprehensive Diabetes Care–HbA1c Control <8% ■	^	39.7%	49.5%	^	54.0%	40.8%	^	24.4%	42.5%	^	52.8%	51.6%	^	39.9%	52.4%
Comprehensive Diabetes Care–Eye (Retinal) Exams	30.7%	45.6%	48.9%	51.1%	59.8%	55.9%	39.9%	36.0%	41.4%	43.2%	42.1%	43.9%	39.7%	48.4%	51.5%
Comprehensive Diabetes Care–Lipid Profile LDL-C Screening	64.5%	83.8%	83.2%	68.3%	71.7%	74.3%	71.3%	67.7%	67.2%	73.2%	71.8%	73.5%	72.5%	72.6%	75.4%
Comprehensive Diabetes Care–LDL-C Control (<100 mg /dL)	16.1%	27.9%	38.4%	32.5%	33.4%	38.8%	27.1%	23.3%	30.8%	42.6%	37.7%	37.6%	42.6%	36.3%	52.6%
Comprehensive Diabetes Care–Medical Attention to Nephropathy	59.7%	73.5%	77.6%	76.1%	78.5%	81.6%	67.7%	71.8%	74.7%	77.6%	79.6%	79.8%	71.3%	74.8%	75.7%
Comprehensive Diabetes Care–Blood Pressure Control (<130/80mm Hg)	25.8%	26.5%	36.7%	32.9%	35.4%	34.7%	28.4%	25.9%	25.3%	31.6%	55.5%	28.6%	33.8%	30.5%	31.8%

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPHH HEDIS 2008 (CY2007)	VPHH HEDIS 2009 (CY 2008)	VPHH HEDIS 2010 (CY 2009)
Comprehensive Diabetes Care– Blood Pressure Control (<140/90mm Hg)	41.9%	64.7%	68.2%	61.8%	62.5%	66.4%	52.2%	53.9%	53.6%	60.5%	23.8%	53.3%	55.2%	60.8%	64.1%
Follow-Up After Hospitalization for Mental Illness– 7 Days	^	NA	16.3%	^	33.0%	36.2%	^	29.3%	51.4%	^	72.6%	61.6%	^	36.0%	31.0%
Follow-Up After Hospitalization for Mental Illness– 30 Days	^	NA	40.7%	^	59.3%	62.5%	^	50.3%	34.8%	^	54.2%	78.2%	^	59.9%	56.9%
Lead Screening in Children	^	56.5%	60.4%	^	40.5%	50.0%	^	52.3%	57.6%	^	54.6%	59.1%	^	55.5%	55.7%
Pharmacotherapy Management of COPD Exacerbation– Bronchodilator	^	NA	NA	^	80.6%	72.8%	^	62.2%	84.2%	^	79.3%	85.8%	^	78.0%	79.2%
Pharmacotherapy Management of COPD Exacerbation– Systemic Corticosteroid	^	NA	NA	^	67.4%	62.5%	^	54.1%	73.7%	^	71.3%	68.0%	^	50.3%	48.1%

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPH HEDIS 2008 (CY2007)	VPH HEDIS 2009 (CY 2008)	VPH HEDIS 2010 (CY 2009)
Use of Appropriate Medications– Asthma Age 5-9 (CY 2009 Age 5-11) [⊙]	^	94.1%	95.9%	^	91.4%	86.1%	^	94.8%	93.0%	^	94.0%	91.3%	^	94.0%	92.9%
Use of Appropriate Medications– Asthma Age 10-17 (CY 2009 Age 12-50) [⊙]	^	91.9%	87.2%	^	92.2%	78.5%	^	91.4%	85.8%	^	93.0%	86.6%	^	92.3%	87.5%
Use of Appropriate Medications– Asthma Total (Combined Ages) [⊙]	92% [♦]	92.6%	92.3%	92% [♦]	90.2%	82.6%	92% [♦]	89.4%	89.6%	89% [♦]	91.2%	88.9%	92% [♦]	91.3%	90.0%
Access and Availability of Care															
Prenatal and Postpartum Care– Timeliness of Prenatal Care	77.0%	85.8%	86.6%	88.8%	89.0%	87.3%	84.3%	85.0%	88.7%	88.2%	84.7%	79.8%	83.2%	85.4%	89.5%
Prenatal and Postpartum Care– Postpartum Care	64.4%	62.6%	63.9%	66.4%	70.3%	65.5%	59.1%	62.7%	67.3%	67.5%	68.2%	64.3%	62.0%	64.2%	70.3%
Use of Services															
Adolescent Well-Care Visit	42.6%	43.9%	47.2%	46.1%	45.1%	40.7%	36.2%	35.7%	46.8 %	39.2%	41.1%	40.8%	45.1%	44.5%	46.7%
Well-Child Visits in the First 15 Months of Life Six or more visits	47.5%	61.1%	64.1%	59.7%	56.5%	66.0%	46.6%	36.8%	48.9%	61.7%	61.7%	70.4%	65.5%	82.0%	76.6%

Measure	AMG HEDIS 2008 (CY 2007)	AMG HEDIS 2009 (CY 2008)	AMG HEDIS 2010 (CY 2009)	Anthem HMOs HEDIS 2008 (CY 2007)	Anthem HMOs HEDIS 2009 (CY 2008)	Anthem HMOs HEDIS 2010 (CY 2009)	CareNet /SHS HEDIS 2008 (CY 2007)	CareNet /SHS HEDIS 2009 (CY 2008)	CareNet /SHS HEDIS 2010 (CY 2009)	Optima HEDIS 2008 (CY 2007)	Optima HEDIS 2009 (CY 2008)	Optima HEDIS 2010 (CY 2009)	VPH HEDIS 2008 (CY2007)	VPH HEDIS 2009 (CY 2008)	VPH HEDIS 2010 (CY 2009)
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	73.6%	72.2%	77.2%	70.7%	70.0%	71.2%	62.7%	64.4%	65.3%	65.2%	70.0%	70.8%	69.1%	70.3%	71.3%

□ Comparative rates for Virginia MCOs and HEDIS 2010-Quality Compass can be found on Table 1

NA The denominator was too small to report a valid rate.

NR The measure was calculated but the rate was materially biased, or the rate was not chosen to be reported.

⊙ CY2009 Age parameters have changed from previous years

^ Measure not collected

♦ From Virginia Medicaid Managed Care Performance Report, December 2008; rates available in whole numbers

▣ New measure for 2009-not for public reporting

Table A1-2 MCO CAHPS® (CY 2007 – CY 2009) □

Measure	AMG CAHPS 2008 (CY2007) ❖	AMG CAHPS 2009 (CY2008)	AMG CAHPS 2010 (CY2009)	Anthem HMOs CAHPS 2008 (CY2007) ❖	Anthem HMOs CAHPS 2009 (CY2008)	Anthem HMOs CAHPS 2010 (CY2009)	CareNet /SHS CAHPS 2008 (CY2007) ❖	CareNet /SHS CAHPS 2009 (CY2008)	CareNet /SHS CAHPS 2010 (CY2009)	OFC CAHPS 2008 (CY2007) ❖	OFC CAHPS 2009 (CY2008)	OFC CAHPS 2010 (CY2009)	VPH CAHPS 2008 (CY2007) ❖	VPH CAHPS 2009 (CY2008)	VPH CAHPS 2010 (CY2009)
CAHPS – Adult Population															
Rating of Health Plan Overall	64%	67.3%	64.6%	78%	81.2%	76.3%	76%	78.2%	78.7%	80%	82.1%	80.4%	79%	77.4%	74.0%
Rating of Health Care Overall	65%	65.9%	63.1%	73%	70.9%	67.8%	73%	68.8%	69.5%	68%	74.8%	72.7%	72%	68.1%	64.2%
Rating of Personal Doctor Overall	66%	69.7%	70.3%	78%	83.1%	76.6%	78%	79.2%	73.6%	79%	81.5%	80.9%	78%	75.7%	73.9%
Rating of Specialist Overall	73%	NA	76.6%	73%	79.4%	85.0%	78%	75.0%	73.9%	83%	85.5%	81.6%	70%	85.5%	74.9%

Measure	AMG CAHPS 2008 (CY2007) ❖	AMG CAHPS 2009 (CY2008)	AMG CAHPS 2010 (CY2009)	Anthem HMOs CAHPS 2008 (CY2007) ❖	Anthem HMOs CAHPS 2009 (CY2008)	Anthem HMOs CAHPS 2010 (CY2009)	CareNet /SHS CAHPS 2008 (CY2007) ❖	CareNet /SHS CAHPS 2009 (CY2008)	CareNet /SHS CAHPS 2010 (CY2009)	OFC CAHPS 2008 (CY2007) ❖	OFC CAHPS 2009 (CY2008)	OFC CAHPS 2010 (CY2009)	VPHS CAHPS 2008 (CY2007) ❖	VPHS CAHPS 2009 (CY2008)	VPHS CAHPS 2010 (CY2009)
Customer Service Composite	79%	77.0%	77.3%	87%	88.3%	86.4%	83%	81.0%	88.3%	85%	84.1%	NA	86%	84.1%	NA
Getting Needed Care Composite	62%	67.6%	69.1%	77%	80.5%	80.5%	78%	77.0%	78.9%	84%	82.0%	78.7%	78%	78.8%	76.5%
Getting Care Quickly Composite	69%	74.5%	69.8%	81%	80.8%	82.9%	81%	77.7%	83.3%	83%	87.0%	81.8%	81%	82.5%	83.5%
How Well Doctors Communicate Composite	79%	82.3%	81.5%	88%	89.2%	87.9%	86%	86.5%	84.5%	88%	90.4%	89.6%	86%	85.2%	86.9%
Shared Decision Making Composite	49%	NA	59.4%	60%	58.9%	63.0%	54%	64.0%	65.1%	65%	60.8%	66.7%	63%	63.8%	62.7%
Advised to Quit Smoking by a Doctor or Other Health Provider	-	66.4%	73.6%	-	69.1%	73.3%	-	66.3%	69.9%	-	69.6%	70.0%	-	67.2%	76.8%
CAHPS – Child CCC															
Rating of Health Plan Overall	^	76.6%	77.8%	^	86.3%	87.2%	^	84.1%	79.3%	^	75.3%	84.6%	^	68.9%	77.6%
Rating of Health Care Overall	^	79.3%	73.4%	^	84.7%	77.9%	^	79.8%	80.9%	^	64.3%	78.1%	^	65.6%	79.7%
Rating of Personal Doctor Overall	^	78.1%	77.0%	^	88.2%	85.0%	^	86.9%	83.5%	^	76.8%	86.4%	^	76.8%	85.3%
Rating of Specialist Overall	^	NA	NA	^	80.6%	78.2%	^	88.2%	79.9%	^	74.8%	85.2%	^	75.1%	84.2%

Measure	AMG CAHPS 2008 (CY2007) ❖	AMG CAHPS 2009 (CY2008)	AMG CAHPS 2010 (CY2009)	Anthem HMOs CAHPS 2008 (CY2007) ❖	Anthem HMOs CAHPS 2009 (CY2008)	Anthem HMOs CAHPS 2010 (CY2009)	CareNet /SHS CAHPS 2008 (CY2007) ❖	CareNet /SHS CAHPS 2009 (CY2008)	CareNet /SHS CAHPS 2010 (CY2009)	OFC CAHPS 2008 (CY2007) ❖	OFC CAHPS 2009 (CY2008)	OFC CAHPS 2010 (CY2009)	VPHS CAHPS 2008 (CY2007) ❖	VPHS CAHPS 2009 (CY2008)	VPHS CAHPS 2010 (CY2009)
Customer Service Composite	^	NA	NA	^	88.9%	NA	^	84.2%	85.0%	^	85.0%	85.8%	^	86.3%	73.3%
Getting Needed Care Composite	^	72.6%	NA	^	85.0%	84.0%	^	79.6%	78.7%	^	81.8%	83.9%	^	85.1%	80.3%
Getting Care Quickly Composite	^	78.5%	80.4%	^	90.5%	89.3%	^	91.0%	91.6%	^	90.6%	91.3%	^	91.3%	91.2%
How Well Doctors Communicate Composite	^	85.6%	90.1%	^	92.7%	91.7%	^	92.2%	91.1%	^	93.2%	82.5%	^	94.2%	92.6%
Shared Decision Making Composite	^	NA	NA	^	70.0%	69.4%	^	67.8%	72.1%	^	73.0%	67.2%	^	72.6%	67.3%

□ Comparative rates for Virginia MCOs and HEDIS 2010-Quality Compass can be found on Table 2

❖ From Virginia Medicaid Managed Care Performance Report, December 2008; rates available in whole numbers

- No comparative benchmarks available

^ Measure not collected

NA Denominator too small to calculate a reliable rate