Commonwealth of Virginia Department of Medical Assistance Services

2020 External Quality Review Technical Report—Commonwealth Coordinated Care Plus

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1. Executive Summary

Overview of 2020 External Quality Review

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Commonwealth of Virginia, Department of Medical Assistance Services (DMAS), contracted with Health Services Advisory Group, Inc. (HSAG), to perform the assessment and produce this annual report.

DMAS contracted with HSAG, its external quality review organization (EQRO) to conduct external quality review (EQR) activities completed during the period of January 1, 2020, through December 31, 2020 (calendar year [CY] 2020). HSAG used the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services' (CMS') December 2018 update of its External Quality Review Toolkit for States when preparing this report.[1-1]

DMAS administers the CCC Plus program which includes the Virginia Medicaid program and the Family Access to Medical Insurance Security (FAMIS) program, the Commonwealth's Children's Health Insurance Program (CHIP). DMAS contracted with six privately owned MCEs, hereafter referred to as MCOs, to deliver physical and behavioral health services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2020 include Aetna Better Health of Virginia (Aetna); HealthKeepers, Inc. (HealthKeepers); Magellan Complete Care of Virginia (Magellan); Optima Health (Optima); UnitedHealthcare of the Mid-Atlantic, Inc. (United); and Virginia Premier Health Plan, Inc. (VA Premier).

Scope of External Quality Review (EQR) Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-2, 1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCOs they contract with for services, and help MCOs improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher-performing

[1-1] The Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR Protocols, December 2018. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: June 27, 2019.

[1-2] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 26, 2020.

[1-3] U.S. 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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Jan 13, 2020.

healthcare delivery systems for their Medicaid and CHIP members. For the CY 2020 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-1 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCO. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-1—EQR Activities

Activity	Description	CMS Protocol
Validation of Rapid-Cycle Performance Improvement Projects (PIPs)	This activity assesses whether the performance measures (PMs) calculated by an MCO are accurate based on the measure specifications and State reporting requirements.	*Protocol 1:* Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the PMs calculated by an MCO are accurate based on the measure specifications and State reporting requirements.	*Protocol 2:* Validation of Performance Measures
Compliance with Medicaid and CHIP Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated state-specific requirements, when applicable.	*Protocol 3*: Review of Compliance with Medicaid and CHIP Managed Care Regulations
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-4] Analysis	This activity assesses member experience with an MCO and its providers and the quality of care members receive.	*Protocol 6:* Administration or Validation of Quality of Care Surveys
Consumer Decision Support Tools	This activity provides information to help eligible members choose a Medicaid Medallion MCO. The tool shows how well the different MCOs provide care and services in various performance areas.	*Protocol 10:* Assist with Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs)

Aggregating and Analyzing Statewide Data

For each MCO, HSAG analyzed the results obtained from each EQR activity. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness

[1-4] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and the overall statewide CCC Plus program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in Sections 4 through 9 of this report.

Virginia Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from CY 2020 to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members. For each MCO reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCOs' performance, which can be found in Sections 5 through 9 of this report. The overall findings and conclusions for all MCOs were also compared and analyzed to develop overarching conclusions and recommendations for the Virginia managed care program. Table 1-2 highlights substantive findings and actionable state-specific recommendations, when applicable, for DMAS to further promote its goals and objectives in its quality strategy. Refer to Sections 4–9 for more details.

Table 1-2—Virginia Managed Care Program Substantive Findings

Program Strengths
• Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as five of the MCOs met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services* measure. Additionally, three of the MCOs met or exceeded the 50th percentile related to the *Use of Imaging Studies for Low Back Pain* measure, and at least three MCOs met or exceeded the 50th percentile for two of the four measures related to *Children and Adolescents' Access to Primacy Care Practitioners*. Of note, HealthKeepers and VA Premier demonstrated the highest performance within the Access and Preventive Care domain, meeting or exceeding the 50th percentile for six of the 10 (60.0 percent) and five of the 10 (50.0 percent) measure rates in this domain, respectively. Results indicate that members are able to access care and services for preventive and well services. • The MCOs demonstrated strength within the Behavioral Health domain related to the use of medication to treat mental health conditions, as all six MCOs met or exceeded the 50th percentile for at least two of the three measure rates related to medication management (*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and both *Antidepressant Medication Management* indicators), Moreover, four of the MCOs met or exceeded the 50th percentile for all three measures. Follow-up care for behavioral health conditions represented an improvement from last year, as all six MCOs met or exceeded the 50th percentile for at least two of the six measure rates (*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* indicators, *Follow-Up After Emergency Department Visits for Mental Illness* indicators, and *Follow-Up After Hospitalization for Mental Illness* indicators), Moreover, three of the MCOs met or exceeded the 50th percentile for four of the six (66.7 percent) measure rates. Of note, while all six MCOs met or exceeded the 50th percentile for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total* indicator, only one MCO met or exceeded the 50th percentile for the *Engagement of*

Program Strengths
AOD—Total—Total indicator. Within the Behavioral Health domain, Magellan and Optima demonstrated the highest performance, meeting or exceeding the 50th percentile for seven of the 13 (53.8 percent) and nine of the 13 (69.2 percent) measure rates, respectively. Program results indicated the MCOs implemented a member-centric approach to behavioral healthcare and services, reducing the need to access behavioral healthcare through an emergency room (ER) or in an inpatient setting. These results also indicated that the MCOs had strong foundations in place to provide medically necessary, quality, timely, and accessible healthcare services to their members. • Within the Taking Care of Children domain, MCO performance was the highest for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates, as four and three MCO rates, respectively, met or exceeded the 50th percentile. Results indicate that members have an understanding of some preventive health schedules and the evidence-based guidelines for children receiving antipsychotic medications. Results from PMV indicated that children and young adults enrolled in the CCC Plus program were able to access care at least annually for preventive and well visits, as necessary, to stay healthy and reduce unnecessary ER utilization. • MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with all three of the reportable measure indicator rates meeting or exceeding the 50th percentile. United had the highest performance, with nine of the 14 (64.3 percent) measure rates compared to benchmarks meeting or exceeding the 50th percentile and 12 of the 14 (85.7 percent) measure rates exceeding the Virginia aggregate. The MCOs demonstrated strength within the Opioids domain related to the use of opioids, as three MCOs met or exceeded the 50th percentile for at least two of the three measure rates related to opioid use (*Use of Opioids From Multiple Providers*), with two of the MCOs, HealthKeepers and VA Premier, meeting or exceeding the 50th percentile for all three measures that were compared to national benchmarks. The results indicate that MCOs and their contracted providers are focusing attention on smoking cessation assistance* for members and are likely sharing resources to support members' efforts to quit. Results also indicate that the MCOs and providers are following evidence-based practices related to prescribing opioids and reducing adverse outcomes from over-prescribing. Implementing effective initiatives for chronic diseases had the potential to greatly impact the services and overall health outcomes of CCC Plus members. **Note: Smoking cessation is not a covered service for Medicaid except for pregnant women and the Medicaid Expansion population.* • In 2020, the CCC Plus MCOs successfully achieved all Module 3 validation criteria for the DMAS-specified PIP topics. The MCOs identified potential interventions and were in the process of testing interventions for the PIPs at the time of this report. The MCOs reported challenges related to coronavirus disease 2019 (COVID-19) in their intervention progress updates including that interventions were delayed due to the pandemic. To address this challenge, the PIPs were extended through May 31, 2021. • In 2020, the CCC Plus MCOs demonstrated strength in the adult CAHPS survey in *Getting Care Quickly* (three MCOs scored statistically significantly higher than the 2020 National Committee for Quality Assurance [NCQA] adult Medicaid national average). In addition, the CCC Plus MCOs

Program Strengths
showed strength in the adult survey in *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* (three MCOs scored statistically significantly higher than the 2020 NCQA adult Medicaid national average or the three MCOs scored statistically significantly higher in 2020 than 2019 for at least one measure). The results indicate member satisfaction with access to and timeliness of care and service delivery. MCOs have an opportunity to further improve members' experience with care and service access, quality, and timeliness by focusing efforts on the accuracy of information included in the provider directory. • The CCC Plus MCOs demonstrated strength in the child CAHPS survey in *Getting Care Quickly* (two MCOs scored statistically significantly higher than the 2020 NCQA child Medicaid national average). In addition, the CCC Plus MCOs showed strength in the child survey in *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service* (two MCOs scored statistically significantly higher than the 2020 NCQA child Medicaid national average and scored statistically significantly higher in 2020 than 2019 for at least one measure). The results indicate member satisfaction with access to and timeliness of care and service delivery. MCOs will improve members' experience with care and service access, quality, and timeliness by focusing efforts on the accuracy of information included in the provider directory.

Program Weaknesses
• Within the Access and Preventive Care domain, cancer screenings for women represents an area for opportunity Virginia-wide, as all reportable rates for the MCOs fell below the 50th percentile for both the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Of note, all six MCOs were more than 15 percentage points below the 50th percentile for the *Cervical Cancer Screening* measure, which is a slight improvement from the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] 2019 measure rates. Magellan and United demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for nine of the 10 (90.0 percent) measure rates within the domain. The lack of participation by members in recommended screenings may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner. • Within the Behavioral Health domain, for two measures (*Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics),* none of the MCOs met or exceeded the 50th percentile, reflecting an area of improvement. Results indicate that members are not following up on recommended care and services needed to manage their health conditions. This may be due to a lack of understanding of care recommendations. • Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to *Childhood Immunization Status, Immunizations for Adolescents, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Well-Child Visits in the First 15 Months of Life* measure rates as none of the MCOs' rates for these measures met or exceeded the 50th percentile. Magellan demonstrated the lowest performance as it was the only MCO to fall below the 50th percentile and Virginia aggregate for all measure rates in this

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

Program Weaknesses
domain. The results indicate an opportunity for the MCOs to increase utilization of well-child visits and receipt of immunizations according to recommended schedules. Results may indicate an opportunity to improve health literacy of members. • For the Living With Illness domain, MCO performance was the weakest related to respiratory conditions, as only two MCOs met or exceeded the 50th percentile for both the *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD [Chronic Obstructive Pulmonary Disease] Exacerbation* measures. MCO performance was low for *Comprehensive Diabetes Care*, particularly for the *HbA1c Testing, Eye Exam (Retinal) Performed* and *Blood Pressure Control (<140/90 mm Hg)* indicators for which no MCO rates met or exceeded the 50th percentile. Optima demonstrated the lowest performance among the MCOs in the Living With Illness domain as it only met or exceeded the 50th percentile for three of the 14 (21.4 percent) measure rates. Members are not consistently obtaining the services they need to maintain optimal health. Performance results suggests that although members are able to access their PCP to manage their chronic conditions, they are not consistently managing their condition. Appropriate asthma, diabetes, and high blood pressure management are critical to reduce risks from complications and prolong the life of DMAS members. • As the CCC Plus MCOs continue to test interventions until the PIPs' SMART (Specific, Measurable, Attainable, Relevant, and Time-bound) Aim end date and prepare to submit the final Module 4s and Module 5s for validation, HSAG recommends that the MCOs should: − Continue to monitor and report any impact COVID-19 has had on the MCO's PIPs. − Address all the feedback and recommendations that HSAG provided in the Module 4 plan pre-validation reviews and Module 4 intervention progress check-ins. After reviewing the feedback and/or recommendations, the MCO should contact HSAG with any questions. − Follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO has questions about the approved methodology, it should review the approved Module 2 submission form and contact HSAG. − Identify and test innovative, actionable changes for the PIPs. If the interventions are not effective, the MCOs should make rapid modifications to the interventions and continue collecting data. If the MCO needs to identify additional potential interventions for the PIP, it should review its process map and failure modes and effects analysis (FMEA) completed in Module 3 to design changes to address gaps and high-priority failures in the process. − Continually monitor the monthly SMART Aim measure and intervention effectiveness measure data. If the outcomes are not improving over time, the MCO should adjust intervention testing. − Attend the Module 4 and Module 5 webinar training that HSAG will schedule prior to the submission of Module 4 and Module 5 for validation. − Request PIP technical assistance from HSAG as often as needed • Overall, the CCC Plus MCOs should focus on maintaining and improving members' experiences of care as the MCO survey results indicated opportunities for improvement in *Rating of Health Plan* and *Rating of All Health Care* for the child population when compared to the 2020 NCQA child Medicaid national averages. In addition, MCO efforts should also focus on improving survey response rates. An area of weakness identified for the child population was that three MCOs

Program Weaknesses
scored statistically significantly lower than the 2020 NCQA child Medicaid national averages for *Rating of Health Plan* and *Rating of All Health Care*.

Program Recommendations	
Recommendation	**Associated 2020–2022 Quality Strategy Goal and/or Objective**
HSAG recommends that the MCOs identify the barriers members are experiencing in receiving care for chronic conditions, such as comprehensive diabetes care, controlling high blood pressure, smoking cessation, and asthma. HSAG recommends that the MCOs identify best practices that have demonstrated success in improving the management of chronic conditions. To improve the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending, HSAG recommends that DMAS consider requiring MCOs to conduct a root cause analysis or focused review that targets the most prevalent diagnosed chronic condition of the MCO's membership.	**Aim 4:** Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions
HSAG recommends that DMAS work with the MCOs to focus interventions—such as assistance with scheduling, transportation to appointments, and the completion of reminder calls—on removing barriers to women's healthcare including completing the breast cancer screening and cervical cancer screening appointments.	**Aim 4:** Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members
HSAG recommends that the MCOs conduct a focus group or use other methods to receive direct information from members on their experience with access to care during their interactions with the healthcare system. Once MCOs gain an understanding of the member's experience, HSAG recommends that the MCOs implement appropriate interventions to improve the member's experience when contacting the health plan and when receiving services from their personal doctor.	**Aim 1:** Enhanced Member Care Experience **Goal 1.1**: Increase Member Engagement and Outreach

2. Introduction to the Annual Technical Report

Methodology for Aggregating and Analyzing EQR Activity Results

For each MCO, HSAG analyzed the results obtained from each EQR activity conducted between January 1, 2020, through December 31, 2020. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each MCO independently and the overall statewide CCC Plus program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in Section 4 of this report.

Scope of External Quality Review (EQR) Activities

At the request of DMAS, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities are briefly described below. Refer to Appendix A—Technical Methods of Data Collection and Analysis—MCOs for a detailed description of each activity's methodology.

Mandatory Activities

Validation of Performance Improvement Projects—The MCOs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2020 validation cycle. The results from the CY 2020 PIP validation are presented in this report.

Validation of Performance Measures—The purpose of PMV is to assess the accuracy of PMs reported by the MCOs and to determine the extent to which these measures follow State specifications and reporting requirements.

DMAS contracted with HSAG to conduct the PMV for each MCO, validating the data collection and reporting processes used to calculate the PM rates. DMAS identified a set of PMs that the MCOs are required to calculate and report. Measures are required to be reported following the specifications provided by DMAS. DMAS identified the measurement period as January 1, 2019, through December 31, 2019.

Review of Compliance with Medicaid and CHIP Managed Care Regulations—HSAG conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2020, HSAG did not conduct MCO compliance review activities for the CCC Plus program.

Validation of Network Adequacy—With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and

certification of MCO, PIHP, and PAHP networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports (MLTSS) programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric), obstetricians/gynecologists, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. DMAS has implemented network standards in its contracts with the MCOs.

Optional Activities

Consumer Decision Support Tool—HSAG develops Virginia's Consumer Decision Support Tool (i.e., Quality Rating System) to improve healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the CCC Plus program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.

Performance Withhold Program (PWP)—HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2020 PWP will use HEDIS and non-HEDIS measures.

Quality Strategy Update—During 2020, DMAS contracted with its EQRO to update the Virginia Quality Strategy. The purpose of the update is to include changes to the Medicaid program including the evolution of CCC to CCC Plus and Medallion 3.0 to Medallion 4.0. The Quality Strategy updates incorporate programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes, and improved health and wellness.

ARTS Measure Specification Development—HSAG identifies, when available, PMs from existing measure sets or develops PMs for the Addiction and Recovery Treatment Services (ARTS) program.

Organizational Structure of Report

Section 1—Executive Summary

This section of the report presents a summary of the EQR activities. The section also includes high-level findings and conclusions regarding the performance of each MCO.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the scope of the EQR activities and provides a brief description of each section's content.

Section 3—Overview of Virginia's CCC Plus Managed Care Program

This section of the report presents a brief description of the Commonwealth of Virginia's managed care program, services, regions, and populations. This section also presents a brief description of Virginia's quality initiatives.

Section 4—MCO Comparative Information

This section presents methodologically appropriate, comparative information about all MCOs by activity and consistent with the guidance provided in the CMS EQR Protocols. Commonwealth-specific recommendations are also included if applicable. This section includes recommendations for improvements to the quality of healthcare services furnished by the MCOs, including how the Commonwealth can target goals and objectives in the Quality Strategy to better support improvement in the quality of, timeliness of, and access to healthcare services furnished to members.

Section 5—Validation of Performance Improvement Projects

This section presents MCO-specific results and conclusions of the validation of PIP activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 6—Validation of Performance Measures

This section presents MCO-specific results and conclusions of the validation of PMs activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Section 7—Review of Compliance With Medicaid and CHIP Managed Care Regulations

This section presents MCO-specific results and conclusions of the compliance with standards review activity. DMAS conducts Compliance with Standards Monitoring reviews using a three-year cycle. During 2020 the Commonwealth of Virginia monitored the MCOs implementation of contract requirements and the MCOs' corrective action plans (CAPs) from prior years' compliance reviews.

Section 8—Member Experience of Care Survey

This section presents MCO-specific results and conclusions of the member experience of care surveys activity. It includes the following:

- Overview
- Objectives
- MCO-specific results including strengths and recommendations for improvement in the quality of, timeliness of, and access to healthcare services furnished to members
- Assessment of how effectively the MCO addressed the recommendations for quality improvement made by the EQR the prior year
- Conclusions and recommendations

Appendix A—Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- Validation of PIPs Methodology
- Validation of PMs Methodology
- CAHPS Survey Methodology
- Consumer Decision Support Tool Methodology
- PWP Methodology
- ARTS Performance Measure Specification Development Methodology

Appendix B—Quality Strategy Status Assessment

This section of the report presents an assessment of the Commonwealth's progress in achieving the metrics included in the Quality Strategy. Appendix B tracks the aggregate annual results of contractual performance metrics that align with the PMs included in the Quality Strategy to measure improvement.

Appendix C—MCO Quality Strategy Quality Initiatives

This section of the report presents self-reported quality initiatives implemented by the MCOs to achieve the goals and objectives outlined in the Virginia 2017–2019 Quality Strategy.

Appendix D—2020–2022 Quality Strategy Aims, Goals, Objectives, and Metrics

This section of the report presents the Virginia 2020–2022 Quality Strategy aims, goals, objectives, and metrics table.

3. Overview of Virginia's Managed Care Program

Medicaid Managed Care in the Commonwealth of Virginia

The Department of Medical Assistance Services

DMAS is the Commonwealth of Virginia's single State agency that administers all Medicaid and FAMIS health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models. As of December 2019, approximately 89 percent of Medicaid enrollees received their benefits through the managed care model, and approximately 11 percent of enrollees participated in Medicaid through the FFS model. In 2019, the managed Medicaid populations in Virginia were organized into two programs: Medallion 4.0 and CCC Plus. Table 3-1 displays the DMAS annual enrollment by program.

Table 3-1—CY 2020 Average Annual Program Enrollment

Program	State Fiscal Year (SFY) 2020 Enrollment as of 7/1/2020
Medallion 4.0	1,219,432
CCC Plus	257,607

DMAS contracted with six privately owned MCOs to deliver physical health and behavioral health services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2020 are displayed in Table 3-2.

Table 3-2—MCOs in Virginia

MCO	Profile Description	MCO National Committee for Quality Assurance (NCQA) Accreditation Status
Aetna	Aetna is the Medicaid/FAMIS Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited* through 4/2/2021
HealthKeepers	HealthKeepers 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 healthcare company, headquartered in Indianapolis, Indiana.	Accredited* through 3/5/2021
Magellan	Magellan is a Medicaid/FAMIS Plus program offered by Magellan Health, Inc., conducting business in Virginia since 1972, headquartered in Scottsdale, Arizona.	Accredited* through 6/29/2023
Optima	Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara,	Accredited* through 4/26/2021

MCO	Profile Description	MCO National Committee for Quality Assurance (NCQA) Accreditation Status
	Optima is a not-for-profit healthcare organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia.	
United	United is part of the UnitedHealth Group family of companies, headquartered in Minneapolis, Minnesota. United provides Medicaid managed care and nationally serves more than 6.6 million low-income and medically fragile people, including Dual-Eligible Special Needs Plans (D-SNPs) across 30 states plus Washington, D.C.	Accredited* through 6/22/2023 Long-Term Services and Supports Distinction through 6/22/2023
VA Premier	VA Premier is a local, not-for-profit MCO owned by the Virginia Commonwealth University (VCU) Medical Center, headquartered in Richmond, Virginia.	Commendable** Accreditation through 7/8/2022

*Accredited: The NCQA has awarded an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement.[3-1]

**Commendable: The NCQA has awarded an accreditation status of Commendable for service and clinical quality that meet NCQA's rigorous requirements for consumer protection and quality improvement.

Commonwealth Coordinated Care Plus Program

The CCC Plus program's focus is to improve the quality of, access to, and efficiency of healthcare and services and supports for individuals residing in facilities and in home and community-based settings. The CCC Plus program approaches care delivery through a person-centered program design in which all members receive care coordination services to ensure they receive needed services. Individuals receiving LTSS through nursing facilities and the Elderly or Disabled with Consumer Direction (EDCD) waiver are also eligible to participate in the CCC Plus managed care program. The CCC Plus care coordinators coordinate the care for Virginia's Medicaid Title XIX and Title XXI members enrolled in both Medicare and CCC Plus.

On June 7, 2018, Virginia's Governor, Ralph Northam, signed the State budget, which included expanded eligibility under Medicaid for qualified Virginia adults. Medicaid expansion coverage began on January 1, 2019, and is administered through a comprehensive system of care. Medicaid expansion provides coverage for eligible individuals, including adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the federal poverty level, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability).

The CCC Plus program is an integrated delivery model that includes physical, behavioral health, and substance use disorder (SUD) services and LTSS. The CCC Plus program incentivizes community

[3-1] The National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: Mar 10, 2020.

living and promotes innovation and value-based payment strategies. The CCC Plus program priorities are displayed in Table 3-3.

Table 3-3—CCC Plus Priorities

Priorities	Priorities
Integrated care delivery model	Full continuum of care
Person-centered care planning	Interdisciplinary care teams
Unified (Medicare/Medicaid) processes, when possible	

COVID-19 Response

The COVID-19 pandemic is an ongoing pandemic of coronavirus disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The pandemic became a public health emergency in January 2020 and a was declared a pandemic in March 2020. The first confirmed case in Virginia was declared on March 7, 2020. Governor Northam declared a State of Emergency in the Commonwealth of Virginia on March 12, 2020.

On March 23, 2020, Governor Northam issued Executive Order Fifty-Three closing schools in all 123 Virginia school districts for the remainder of the 2019–2020 school year. The Virginia Department of Education categorizes the operating statuses of the school districts into five categories (Table 3-4):

Table 3-4—Department of Education Operational Categories

Category	Description
In-Person	4+ days of in-person instruction for all students
Partial in-Person	4+ days per week in-person for some students; hybrid or remote for all students
All Hybrid	All students with some in-person and some remote learning, but neither type hitting the 4 days/week threshold
Partial Hybrid	Some students hybrid, none hitting the 4 days/week threshold; all other students fully remote
Fully Remote	Learning is remote for the vast majority of students, while some students may have in-person learning available to them.

As of December 14, 2020, the fall 2020 semester Virginia School Division education operational status was as follows:

- Nine were operating in-person
- Thirty-five were operating partial-in-person
- Twenty-six were operating hybrid
- Ten were operating partial hybrid
- Fifty-two were operating fully remove

The pandemic also had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. Families deferred going to the doctor's office for routine, non-emergency care. On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and non-physician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care; preventive care; telehealth visits; and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) screens and treatments.[3-2]

DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other home- and community-based services. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 3-5 describes some of the flexibilities allowed during the pandemic.[3-3]

Table 3-5—LTSS COVID-19 Flexibilities

Flexibility
Allow providers and MCOs the option to conduct evaluations, assessments, and person-centered planning meetings telephonically or through video-conferencing in lieu of face-to-face meetings.
Allow an electronic method of service delivery (e.g., telephonic/video-conferencing) to be provided remotely in the home setting for case management and monthly for services in the DD waivers as well as care coordination provided in the CCC Plus waiver.
Allow In-home Support services to be delivered via an electronic method or telehealth (i.e., telephonic/video-conferencing) service delivery.
Allow Group Day Services to continue to be provided by and reimbursed to the authorized Day Support provider when provided in residential settings.
Allow Community Engagement (CE)/Community Coaching (CC) to be provided through telephonic/video-conferencing for individuals who have the technological resources and ability to participate with remote CE/CC staff via virtual platforms (e.g., Zoom, UberConference, etc.).
Allow Therapeutic Consultation activities that do not require direct intervention by the behaviorist to be conducted through telephonic/video-conferencing methods.
Allow legally responsible individuals (parents of children under age 18 and spouses) to provide personal care/personal assistance services for reimbursement.

During CY 2020, Virginia experienced a significant impact from the COVID-19 pandemic. Healthcare demand sometimes exceeded and stretched healthcare supply. In response to COVID-19, MCO care coordinators increased their outreach to members ensuring access to services using telehealth medicine, suspending copays, and automatically extending service authorizations and use of out-of-network providers when necessary. CCC Plus MCO care coordinators sent food kits, each containing 21 meals, to members in need of food; provided masks to members; and provided outreach to

[3-2] Georgetown University Health Policy Institute, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: https://ccf.georgetown.edu/2020/07/27/redirecting-medicaid-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/. Accessed on: Mar 15, 2021.

[3-3] Virginia Department of Medical Assistance Services. Medicaid Memo, 8/11/2020. Available at: https://dbhds.virginia.gov/assets/doc/EI/81020-HCBS-Flexibilities-Extension-Final.pdf. Accessed on: Mar 15, 2021.

members who have filled a buprenorphine prescription in the last 45 days and who were missing a refill or set to need a refill in the next 10 days.

In removing face-to-face contact with members due to COVID-19, the challenge was to find alternate means to assess the member without relying on self-reports or information from others. To avoid disconnection with members, MCO care coordinators developed other means of communication such as telephone and telehealth to address members' concerns and meet their needs. The DMAS Care Management Unit used the care coordination mailbox and training webinars to provide frequent, current information pertaining to COVID-19. These COVID-19 webinar sessions had some of the highest attendance records, each with over 600 attendees and all MCOs being represented. The MCOs stated that this frequent communication has been beneficial to them in order to carry out their care coordination roles and responsibilities. Members and their families reported that, despite challenges, they are communicating well telephonically and by email with their MCO care coordinators through the pandemic and its effects.

CCC Plus care coordinators also developed an after-hours process to assist COVID-19 positive or exposed members with nonemergent transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments were not missed. In addition, CCC Plus care coordinators initiated an intense outreach process to support discharge planning and post-acute care for all members who were pending or confirmed COVID-19 positive. To assist members with their pharmaceutical needs during the pandemic, MCO care coordinators temporarily paused new pharmacy lock-ins for the patient utilization and safety program (PUMS) members and conducted outreach calls to high-risk members not using the mail order pharmacy benefit to ensure that members received their medications on time.

Care Coordination

DMAS has expanded care coordination to all geographic areas, populations, and services within the managed care environment and in FFS. DMAS is in the process of developing a new modularized technology called Medicaid Enterprise System (MES) to align the Agency's Information Technology Road Map with CMS' Medicaid Information Technology Architecture (MITA) layers. One of the MES modules is a dynamic care management solution (CRMS), the first phase of which was implemented in July 2020 that will facilitate care coordination activities for all Medicaid enrollees. CRMS collects and facilitates the secure exchange of member-centric data, through data collection, data sharing, and performance management. CRMS will securely capture the member's health summary, improving the quality and safety of care, reducing unnecessary and redundant patient testing, aiding MCOs with proactive care planning, and reducing costs.

Since July 2020, over 80 inbound and outbound interfaces have been established and DMAS has received millions of records with dates from the beginning of the CCC Plus and Medallion 4.0 programs. This data exchange is the first step toward implementing a comprehensive care management solution that DMAS considers to be critical for supporting continuity of care when a member transitions across MCOs and programs.

Care coordination is the centerpiece of the CCC Plus program. Every member is impacted in some way by care coordination. Each CCC Plus member is assigned an MCO-dedicated care coordinator who works with the member and the member's provider(s) to ensure timely access to appropriate, high-quality care. The CCC Plus model of care uses person-centered care coordination for all members

which involves using methods to identify, assess, and stratify certain populations; the model also uses comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement to ensure competent care through seamless transitions between levels of care and care settings.

Training, Support, and Oversight of Care Coordination

The value of care coordination continues to increase for the most vulnerable members in the CCC Plus program. The MCO care coordinators are engaged and continue to fulfill the mission of the CCC Plus model of care. DMAS' Care Management Unit continues to oversee care coordination through the MCOs and offers the following ongoing efforts and resources for training and support to care coordinators.

- Dedicated care coordination email boxes monitored by the DMAS Care Management Unit staff for MCO care coordinators to send questions related to certain specialized program processes.
- Weekly training webinars offered to care coordinators and MCOs to address needs identified as well as announcements regarding agency initiatives or policy changes.
- Consultation and direct assistance offered for problem solving around complex cases. There has been an increase in direct communication exchanges with care coordinator supervisors and managers on improving integrated care and collaboration with members, caregivers, and providers.
- DMAS nurses led joint visits with MCO care coordinators and any members receiving private duty nursing services. Visits have allowed for direct observation, fostered partnership, and open dialogue regarding appropriate utilization and best practices.
- DMAS Care Management Unit staff participated in workgroups in collaboration with other departments and agencies to identify ways to improve care coordination in areas of specialized services such as early intervention and private duty nursing, as well as covering disease management topics.
- The DMAS Care Management Unit observed progress with members maximizing enhanced benefits by using their care coordinators to obtain services such as dental and vision services as well as environmental modifications.

Supports Intensity Scale (SIS)

The Supports Intensity Scale (SIS) is a nationally recognized assessment tool that measures the intensity of support required for a person with a developmental disability in their personal, work-related, and social activities. Based on the results of a SIS assessment, individuals in the Commonwealth's Developmental Disabilities (DD) waivers are assigned to one of seven support levels, generally least to most support.

In 2009, Virginia began using the SIS in the CCC Plus person-centered planning process. The Department of Behavioral Health and Developmental Services (DBHDS) uses the SIS to inform the person-centered plan for most individuals in the DD waivers, as well as to determine an individual's required level of support. For specific waiver services, there is a tiered provider reimbursement structure that aligns with an individual's support level (e.g., higher reimbursement for services provided to individuals in need of a greater level of support—the determination of support is called a "support level" and the determination of reimbursement is called a "tier").

A comparison of data regarding individuals' support needs levels and related reimbursement tiers shows a high degree of consistency across the past four years. A formal study conducted in 2018 affirmed individuals' stability in levels across time.

Addiction and Recovery Treatment Services (ARTS)

In 2017, DMAS implemented the ARTS benefit and carved-in all services into the managed care contracts, currently CCC Plus and Medallion 4.0. The ARTS benefit focuses on treatment and recovery services for substance use disorder (SUD), including opioid use disorder (OUD), alcohol use disorder (AUD), and related conditions from SUD. The ARTS benefit expanded coverage of many addiction treatment and recovery services for Medicaid and CHIP members, including medications for opioid use disorder (MOUD) treatment, outpatient treatment, short-term residential treatment, and inpatient withdrawal management services. Outcomes are measured through reductions in SUD, OUD, and AUD ED utilization; reductions in inpatient admissions; increases in the number and type of healthcare practitioners providing SUD treatment and recovery services and a decrease in opioid prescriptions. The ARTS benefit is a fully integrated physical and behavioral health continuum of care.

DMAS contracted with Virginia Commonwealth University (VCU) to conduct the 1115 Three-Year Synthesis report of the ARTS benefit. The following ARTS benefit information and findings were reported by VCU from the ARTS Waiver evaluation. On January 1, 2019, Virginia expanded Medicaid enrolling nearly 460,000 members. Of those, approximately 35,000 have received ARTS services. Since the 2020 COVID-19 pandemic began, approximately 91,000 Virginians enrolled in Medicaid, with 40,000 eligible due to Medicaid expansion. An evaluation conducted by the VCU found that of the top 10 telehealth visit diagnoses, number two was for OUD.

DMAS provided a September 2020 report titled, *The Addiction and Recovery Treatment Services (ARTS) Program at Three Years: What Have We Learned?* The report was prepared by the DMAS ARTS Evaluation Team, Department of Health Behavior and Policy, and the VCU School of Medicine. The report included the following findings:[3-4]

- Overall, the number of buprenorphine waivered prescribers in Virginia has more than doubled, from 500 in 2016 to 1,133 in 2019, a 127 percent increase.[3-5]
- Geographic coverage of the State also increased between 2016 and 2019, from 71 counties that had at least one buprenorphine prescriber in 2016 (53 percent) to 91 counties with at least one prescriber in 2019 (68 percent of counties).
- About half of the increase in waivered prescribers between 2016 and 2019 reflects 278 nurse practitioners and physician assistants who received waivers following the passage of the federal Comprehensive Addiction and Recovery Act (CARA) of 2016.
- The Board of Medicine amended the law to allow nurse practitioners with five or more years of experience to apply to practice independently from a supervising physician, further increasing the supply of buprenorphine-waivered prescribers in Virginia.

[3-4] ARTS Evaluation Team, Department of Health Behavior and Policy, Virginia Commonwealth University School of Medicine. *The Addiction and Recovery Treatment Services (ARTS) Program at Three Years: What Have We Learned?* Draft Report; Sept 2020.

[3-5] Saunders, Britton, Cunningham et al., Medicaid participation among Buprenorphine waivered prescribers, cited in ARTS Evaluation Team, Department of Health Behavior and Policy, Virginia Commonwealth University School of Medicine. *The Addiction and Recovery Treatment Services (ARTS) Program at Three Years: What Have We Learned?* Draft Report; Sept 2020.

- The total prescribing capacity has increased further as physicians may now apply to treat up to 275 patients at a time, in contrast to previous limits of up to 30 or 100 patients in 2016. Thus, the total prescribing capacity based on patient limits has increased by 173 percent, from 27,950 patients in 2016 to 76,165 patients in 2019.

Medicaid Outcomes Distributed Research Network (MODRN) Common Data Model

The following are the results of the MODRN Common Data Model comparison of the 2016 Virginia ARTS benefit results to the 2018 program results:

- The percentage of Medicaid members with OUD who initiated and engaged with treatment increased from 6.8 percent in 2016 to 26.4 percent in 2018.[3-6] The results suggest an almost four-fold increase in access to OUD treatment following ARTS implementation.
- Among members with any diagnosis of SUD, treatment rates increased from 24 percent in the year prior to ARTS to 49 percent in the two years following ARTS implementation.
- Treatment rates for OUD increased from 46 percent to 64 percent.
- Treatment rates for AUD increased from 15 percent to 44 percent.
- Among members with OUD diagnoses, the percentage receiving MOUD treatment increased from 36 percent before ARTS to 49 percent.[3-7]
- SUD treatment rates among pregnant individuals in the 12 months prior to delivery increased from 30 percent in the first half of 2017 to 40 percent in the second half of 2018.[3-8]
- OUD treatment rates among pregnant individuals increased from 58 percent in the first half of 2017 to 76 percent in the second half of 2018.[3-9]
- Between 2015–16 and 2017–18 (overlapping the time of ARTS implementation), the percentage of Virginians with SUD who reported receiving SUD treatment nearly tripled, from 5.5 percent in 2015–16 to 14.1 percent in 2017–18.[3-10]
- Among those receiving buprenorphine treatment, the percentage receiving psychotherapy or counseling increased from 37 percent before ARTS to 73 percent in the second year of ARTS.
- More than 75 percent of buprenorphine users had a urine drug screen in the second year of ARTS, compared to 35 percent before ARTS.

[3-6] Cunningham PJ, Woodcock C, Clark M, et al. Virginia Commonwealth University, The Hilltop Institute, University of Maryland, Baltimore County (UMBC), University of Pittsburgh. Expanding Access to Addiction Treatment Services through Section 1115 Waivers for Substance Use Disorders: Experiences from Virginia and Maryland. April 2020. Available at: https://www.academyhealth.org/sites/default/files/expandingaccesstoaddictiontreatmentthrough1115waivers_april2020.pdf. Accessed on: Jan 15, 2021.

[3-7] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report: ARTS Access and Utilization During the Second Year (April 2018–March 2019). February 2020. Available at: https://www.dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Jan 15, 2021.

[3-8] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report: Diagnosis and Treatment of Substance Use Disorders among Pregnant Women Covered by Medicaid. May 2020. Available at: https://www.dmas.virginia.gov/files/links/5330/Diagnosis%20and%20Treatment%20of%20Substance%20Use%20Disorders%20Among%20Pregnant%20Women%20Covered%20by%20Medicaid.pdf. Accessed on: Jan 15, 2021.

[3-9] Ibid.

[3-10] Substance Abuse and Mental Health Data Archive. Restricted-use Data Analysis System Online Analysis Tool (original analysis from the National Survey of Drug Use and Health). Available at: https://rdas.samhsa.gov/#/. Accessed on: Jan 15, 2021.

- The use of case management or care coordination services to assist with other health or social needs increased from 4 percent before ARTS to 46 percent in the second year of ARTS.

The percentage of Medicaid members with OUD who initiated and engaged with treatment increased almost four-fold following the implementation of ARTS benefit.

ARTS Three-Year Outcomes

In the two years since ARTS implementation, there were improvements in behavioral healthcare and substance use disorder treatment resulting in the following:

Emergency Department Utilization:

- SUD-related ED visits per 100 members with a SUD decreased from 56 in the year prior to ARTS to 52 in the two years following ARTS implementation, a 7.1 percent decrease.[3-11]
- OUD-related ED visits decreased by 32.3 percent, from 31 visits per 100 members with OUD prior to ARTS to 21 visits in the second year of the ARTS benefit.
- The likelihood of having an ED visit decreased by 9.4 percentage points (a 21.1 percent relative decrease) among members with OUD, compared to 0.9 percentage points among beneficiaries with no SUD.[3-12]

Inpatient Utilization

- SUD-related inpatient admission decreased from 31 percent prior to ARTS to 26 percent in the second year after ARTS.[3-13]
- OUD-related inpatient stays decreased from 23 percent in the year prior to ARTS to 16 percent in the second year after ARTS.[3-14]

In the two years since the implementation of the ARTS benefit, the likelihood of having an ED visit ***decreased*** *by 9.4 percentage points (a 21.1 percent relative decrease) among members with OUD.*

[3-11] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report: ARTS Access and Utilization During the Second Year (April 2018–March 2019). February 2020. Available at: https://www.dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Jan 15, 2021.

[3-12] Barnes A, Cunningham PJ, Saxe-Walker L, et al. Hospital Use Declines After Implementation Of Virginia Medicaid's Addiction And Recovery Treatment Services. *Health Affairs.* 2020;39(2).

[3-13] Virginia Commonwealth University, Department of Health Behavior and Policy. Evaluation Report: ARTS Access and Utilization During the Second Year (April 2018–March 2019). February 2020. Available at: https://www.dmas.virginia.gov/files/links/5218/ARTS%202%20year%20report.Feb2020%20FINAL.pdf. Accessed on: Jan 15, 2021.

[3-14] Ibid.

ARTS Member Experience Survey

During 2020, VCU also conducted a member experience survey of 1,097 Medicaid recipients who had an OUD and received either Preferred Office-Based Opioid treatment (OBOT), opioid treatment program (OTP), American Society of Addiction Medicine Level 1 (ASAM 1) treatment, or no treatment. Table 3-6 displays the sample frame included in the member experience survey.

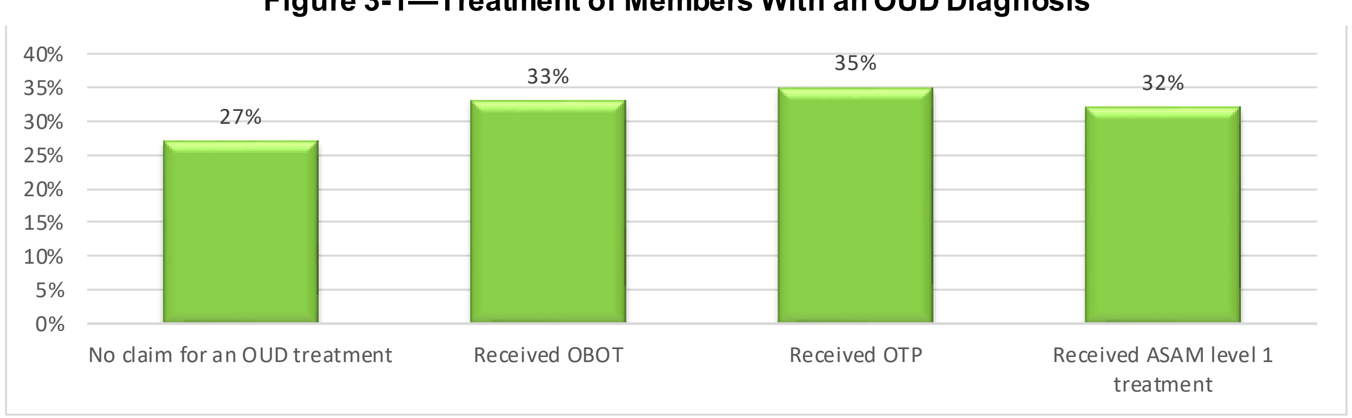
Table 3-6—Member Experience Survey Sample Frame

Sample	Sample Definition
Preferred OBOT	Members with two or more claims for Preferred OBOT treatment since July 1, 2019 (and no OBOT claims in the three months prior, regardless of whether the claim included OUD)
OTP	Members with two or more claims for OTP visits since July 1, 2019 (and no OTP visit claims in the three months prior, regardless of whether the claims included OUD, and no Preferred OBOT claims)
ASAM 1	Members with two or more claims for ASAM level 1 treatment since July 1, 2019 (and no ASAM level 1 claims in the three months prior, regardless of whether the claim included OUD, and no Preferred OBOT or OTP claims)
Untreated	Members who had received an OUD diagnosis but had no Preferred OBOT, OTP, or ASAM Level 1 claims (untreated)

The VCU ARTS member experience survey had a 22.8 percent total response rate. The majority of respondents were under the age of 55 (74 percent); female (58 percent); non-Hispanic White (76 percent); had at least a high school education (88 percent); or were not currently working (either unemployed, retired, a student, or a homemaker (76 percent). Half of the participants reported being in good or better health and using two or more substances in the past year. Nearly one-fifth of the respondents reported an overnight jail stay, and more than a third reported unstable or no housing.

Figure 3-1 displays information regarding treatment utilization of the 1,097 survey respondents with an OUD diagnosis.

Figure 3-1—Treatment of Members With an OUD Diagnosis



The member experience survey also reviewed member characteristics regarding health disparities. The results found that race/ethnicity, marital status, education, psychological distress, and justice

involvement were not significantly associated with receiving any treatment. Table 3-7 displays the findings related to health disparity categories.

Table 3-7—Members With an OUD Diagnosis Experience Survey Disparity Category Responses

Age	Race/Ethnicity	Sex	Employment Status	Housing Status	Justice Involved	Health Status
Those in OUD treatment tended to be working age adults	Non-Hispanic Whites made up a bigger share of the ASAM Level 1 and Preferred OBOT treatment group than OTP group	Males were more likely to be in OTP	Those who were employed were more likely to be in ASAM 1	Those with stable housing were more likely to be in ASAM Level 1	Those with a night in jail/prison in the past year were most likely to be in ASAM Level 1	Those in better health tended to receive treatment in ASAM Level 1
Older adults were much less likely to be treated	Non-Hispanic African Americans made up a bigger share of the OTP treatment group than the ASAM Level 1 and Preferred OBOT treatment groups	Females were more likely to be untreated	Those who were unemployed were in OTP	Those in unstable housing were more likely in Preferred OBOT/OTP		Those in worse psychological distress were more likely to be treated in Preferred OBOTs
	African Americans were more likely to receive treatment from a Preferred OBOT than ASAM Level 1 care compared to non-Hispanic Whites		Those who were out of the labor force were untreated	Those who were homeless were more likely to be in OTP		Members using three or more substances in the past year were more likely to be in treatment than those using one or fewer substances

Figure 3-2 displays information regarding the survey respondents' perceptions of OUD treatment.

Figure 3-2—Members' Perceptions of OUD Treatment

Item	Percent
Stopped treatment against advice of provider	16%
Treatment was usually or always explained and easy to understand	85%
Usually or always felt involved in treatment	85%
Provided information on different types of treatment	73%
Able to refuse a specific type of treatment	72%

Table 3-8 displays the findings related to member perceptions of OUD treatment based on the member experience survey adjusted associations of members' survey responses of their perceptions of OUD treatment, type of OUD treatment received, and member characteristics.

Table 3-8—Perceptions of OUD Treatment According to Member Characteristics

Race/Ethnicity	Sex	Employment Status	Education Level	Health Status
Non-Hispanic African Americans were less likely than non-Hispanic Whites to report feeling able to refuse treatment ($p < 0.05$)	Males were more likely than females to report feeling they could refuse substance use treatment ($p < 0.05$)	Respondents who were not currently employed were less likely than their employed counterparts to report feeling able to refuse treatment ($p < 0.05$)	Compared to non-high school graduates, high school graduates were more likely to report they were given information on different treatment options ($p < 0.05$)	Psychological distress was associated with lower overall perceptions of treatment on the perceptions of treatment scale created (i.e., explain so can understand, shown respect, felt safe, and felt involved) and an increased likelihood of reporting not receiving information on substance use disorder treatment options, stopping treatment against the advice of a doctor or counselor, and having an unmet need ($p < 0.05$ each) Use of three or more substances in the past year was also associated with an increased likelihood of stopping treatment, having an unmet need, and lower overall perceptions of treatment ($p < 0.05$ each)

Figure 3-3 displays information regarding the utilization of OUD treatment.

Figure 3-3—Utilization of OUD Treatment

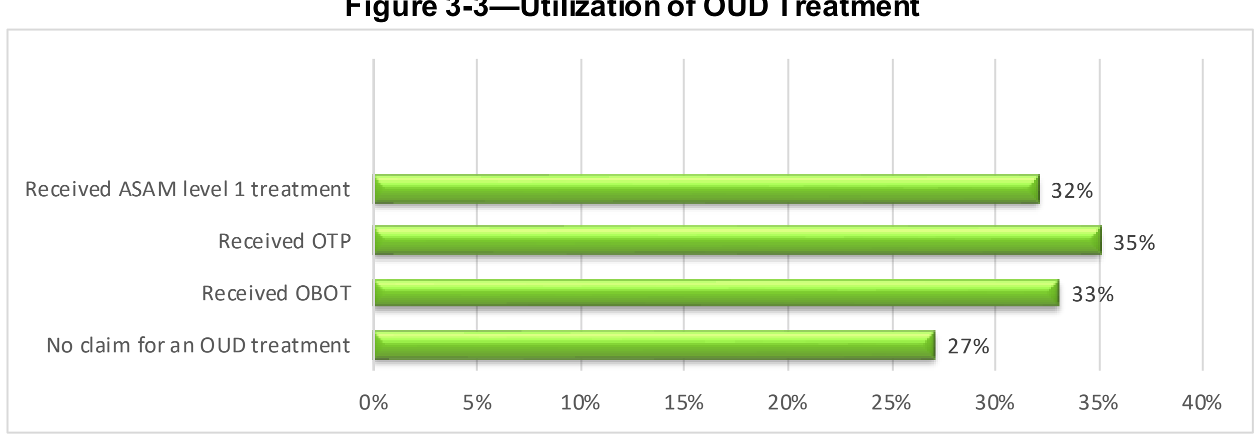


Table 3-9 displays the findings related to member perceptions of OUD treatment based on the member experience survey adjusted associations of members' survey responses regarding the impact of treatment, type of OUD treatment received, and member characteristics:

Table 3-9—Treatment Impact of Members With an OUD Diagnosis

Education Level	Housing Status	Justice Involved	Health Status
Survey respondents with at least some college education reported more positive overall impact from treatment than members with less than a high school education ($p < 0.05$).	Survey participants reporting use of three or more substances in the past year were less likely to report that their housing situation improved due to treatment ($p < 0.05$) Survey participants who were homeless or had unstable housing reported less improvement in their employment situation as a result of receiving treatment ($p < 0.05$ each)	Survey participants who stayed at least one night in a prison or jail in the past year were more likely to report improvement in their housing situation resulting from receiving treatment ($p < 0.05$)	Better health and less psychological distress were positively associated by survey respondents with overall impact as well as specific improvement in employment and housing ($p < 0.05$ each)

Virginia 2017–2019 Quality Strategy

In accordance with 42 CFR §438.340, the DMAS implemented a 2017–2019 written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCOs to Virginia Medicaid and Virginia CHIP members under the Virginia Managed Care Program. This strategy was in place through September 30, 2020.

DMAS Mission and Values

DMAS is committed to upholding its core mission and values. Table 3-10 displays DMAS' values while operating its mission to the Commonwealth.

Table 3-10—DMAS Values

DMAS Values	
Service	*We are committed to serving all who are touched by our system with caring, integrity, and respect.*
Collaboration	*We value professional, respectful cooperation to achieve common goals. Everyone's input is welcome.*

DMAS Values	
Trust	*We are continuously building a culture that is honest, supportive, and fosters integrity.*
Adaptability	*We work together to anticipate and embrace change to meet Virginia's healthcare needs.*
Problem solving	*We promote problem-solving processes and respond to challenges with a forward-thinking approach.*

Quality Strategy Purpose

Consistent with its mission, the purpose of DMAS' Quality Strategy is to:

- Establish a comprehensive quality improvement (QI) system that is consistent with the National Quality Strategy and CMS Triple Aim to enhance member care experiences, promote effective patient care, achieve smarter spending, and improve population health.
- Provide a proactive framework for DMAS to implement a coordinated and comprehensive approach to drive quality throughout the Virginia Medicaid and CHIP systems.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Virginia Medicaid and CHIP members have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practices and make healthcare more affordable for individuals, families, and the State government.
- Improve member satisfaction with care and services.

Quality Strategy Goals and Objectives

Table 3-11 displays DMAS's 2017 Quality Strategy quality dashboard.

Table 3-11—DMAS' 2017 Quality Strategy Quality Dashboard

Health Aims	Goals	Measure Examples
Aim 1: Build a Wellness Focused, Integrated System of Care	**Goal 1:** Strengthen access to primary care network	**Measure 1.1:** HEDIS *Adults' Access to Primary Care Preventive and Ambulatory Health Services*
		Measure 1.2: HEDIS *Children and Adolescents' Access to Primary Care*
	Goal 2: Decrease inappropriate utilization and total cost of care	**Objective 2.1:** All-Cause PQI Admission Rate
		Objective 2.2: CMS/NQF #1768 *All-Cause Readmissions*
		Objective 2.3: HEDIS *Ambulatory Care—Emergency Department Visits*
		Objective 2.4: *Per Capita Healthcare Expenditures* (future measure)

Health Aims	Goals	Measure Examples
	Goal 3: Emphasize member experience of care	**Objective 3.1:** CAHPS/HEDIS/NQF #0006: *Member Rating of Health Plan*
	Goal 4: Integration of behavioral, oral and physical health	**Objective 4.1:** CMS/HEDIS/NQF/#0004: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates)
		Objective 4.2: CMS/NQF #1664 SUB-3 *Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge* and SUB 3a *Alcohol and Other Drug Use Disorder Treatment at Discharge*
		Objective 4.3: HEDIS/NQF #0576 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*
		Objective 4.4: CMS/NQF #2605 *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence*
		Objective 4.5: CMS *Transition of Members Between SUD LOCs, Hospitals, NF, and the Community*
	Goal 5: Encourage appropriate management of prescription medications	**Objective 5.1:** *Use of High-Risk Medications in the Elderly*
		Objective 5.2: NCQA *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
		Objective 5.3: HEDIS *Follow-Up Care for Children Prescribed ADHD Medication—Initiation and Continuation/Maintenance Phases*
		Objective 5.4: HEDIS *Antidepressant Medication Management—Effective Acute Phase Treatment Effective Continuation Phase Treatment*
		Objective 5.5: PQA *Use of Opioids at High Dosage in Persons Without Cancer*
		Objective 5.6: PQA *Use of Opioids from Multiple Providers in Persons Without Cancer*
		Objective 5.7: PQA *Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer*
Aim 2: Focus on Screening and Prevention	**Goal 6:** Cancers are prevented or diagnosed at the earliest stage possible	**Objective 6.1:** HEDIS/NQF #2372 *Breast Cancer Screening Rate*
		Objective 6.2: NQF #0034 *Colorectal Cancer Screening*
		Objective 6.3: HEDIS/NQF #0032 *Cervical Cancer Screening*
	Goal 7: Prevention of nicotine dependency	**Objective 7.1:** AMA PCPI/NQF #0027 *Tobacco Use—Screening and Cessation*
	Goal 8: Virginians protected against vaccine-preventable diseases	**Objective 8.1:** HEDIS *Childhood Immunization Status (Combination 10)*
		Objective 8.2: HEDIS *Immunizations for Adolescents*
		Objective 8.3: HEDIS *Pneumococcal Vaccination Status for Older Adults*
		Objective 8.4: HEDIS *Flu Vaccination*
	Goal 9: Support consistency of recommended pediatric screenings	**Objective 9.1:** CMS/HEDIS *Annual Preventive Dental Visits*
		Objective 9.2: HEDIS *Well-Child Visits in the First 15 Months of Life*

Health Aims	Goals	Measure Examples
		Objective 9.3: HEDIS *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
		Objective 9.4: HEDIS *Adolescent Well-Care Visits (12–21 Years)*
		Objective 9.5: OHSU *Developmental Screening in the First Three Years of Life*
Aim 3: Achieve Healthier Pregnancies and Healthier Babies	**Goal 10:** Virginians plan their pregnancies	**Objective 10.1:** NQF 2902/OPA *Contraceptive Care—Postpartum Women Ages 15–44*
		Objective 10.2: HEDIS *Postpartum Care Visit*
	Goal 11: Improved pre-term birth rate	**Objective 11.1:** *Early Elective Deliveries Rate*
		Objective 11.2: HEDIS *Timeliness of Prenatal Care*
		Objective 11.3: *Frequency of Ongoing Prenatal Care*
		Objective 11.4: CMS/CDC/PQI *Percent of Live Births <2500 Grams*
Aim 4: Maximize Wellbeing Across the Lifespan	**Goal 12:** Effective management of chronic respiratory disease	**Objective 12.1:** PQI 14 *Asthma Admission Rate (Ages 2–17)*
		Objective 12.2: PQI 15 *Asthma in Younger Adults Admission Rate*
		Objective 12.3: CMS/PQI 05/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 13: Comprehensive management of diabetes	**Objective 13.1:** HEDIS *Comprehensive Diabetes Care*
		Objective 13.1: PWI 01/NQF #0272 PQI *Diabetes Short-term Complication Admission Rate*
	Goal 14: Effective management of cardiovascular disease	**Objective 14.1:** HEDIS/NQF #0018 *Controlling High Blood Pressure*
	Goal 15: Ensure quality of life for members with intensive healthcare needs	**Objective 15.1:** JLARC *Nursing Facility Diversion Number and Percent of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home and Community-Based Services (HCBS) Over Institutional Placement*
		Objective 15.2: *Quality of Life and Member Satisfaction Survey* CMS-Specific
		Objective 15.3: *Assessments and Reassessments*
		Objective 15.4: *Plan of Care and POC Revisions*
		Objective 15.5: *Documentation of Care Goals*
		Objective 15.6: JLARC *Transition of Members Between Community Well, LTSS, and Nursing Facility—Services and Successful Retention in Lower Care Settings*
		Objective 15.7: JLARC *Nursing Facility Residents Hospitalization and Readmission Rate*
		Objective 15.8: *Fall Risk Management Intervention/Managing Fall Risk*
	Goal 16: Provide support for end of life	**Objective 16.1:** *Percent Enrollees with Advanced Directives*

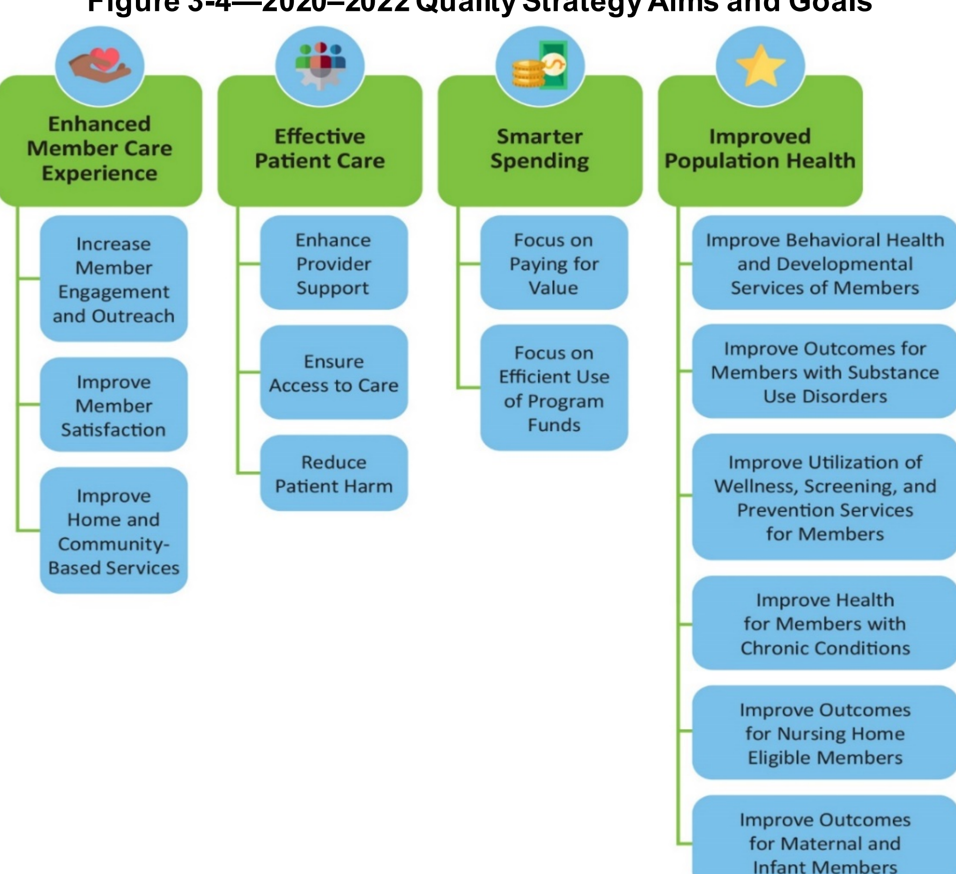
Note: Each objective has targeted metrics to measure progress, as well as outlined interventions to advance the objectives.

Virginia's 2020–2022 Quality Strategy

In 2020, DMAS worked with its EQRO, HSAG, to develop the fourth edition of its comprehensive Medicaid Quality Strategy in accordance with 42 CFR §438.340. DMAS' objectives are to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Virginia Medicaid managed care and FFS programs. The Quality Strategy updates incorporate programmatic changes such as DMAS' focus on care and service integration, a patient-centered approach to care, paying for quality and positive member outcomes; and improved health and wellness. DMAS submitted the fourth edition to CMS and implemented the new Quality Strategy on October 1, 2020. DMAS' Quality Strategy provides the framework to accomplish its overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care along with supporting the provision of quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP recipients.

Beginning on October 1, 2020, Virginia's 2020–2022 Quality Strategy was implemented and is DMAS' guide to achieving Virginia's mission, vision, values, goals, and objectives. DMAS is committed to upholding its core mission and values which have been consistent across all versions of the DMAS Quality Strategy. Figure 3-4 displays the Virginia 2020–2022 Quality Strategy aims and goals. Appendix D contains DMAS's 2020–2022 Quality Strategy aims, goals, objectives, and metrics.

Figure 3-4—2020–2022 Quality Strategy Aims and Goals



Quality Initiatives

The DMAS considers its Quality Strategy to be its roadmap for the future. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The DMAS Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable. The DMAS conducts oversight of MCOs to promote accountability and transparency for improving health outcomes.

Table 3-12 displays a sample of the initiatives DMAS implemented or continued during CY 2020 that support DMAS' efforts toward achieving the 2017–2019 Virginia Quality Strategy's goals and objectives.

Table 3-12—DMAS Quality Initiatives Driving Improvement

Virginia Quality Strategy Aim and Goal	DMAS Quality Initiative
Aim: Achieve Healthier Pregnancies and Healthier Babies **Goal:** Virginians plan their pregnancies **Performance Measures:** • *Contraceptive Care—Postpartum Women Ages 15–44 years* • *Postpartum Care Visit* **Goal:** Improved pre-term birth rate **Performance Measures:** • *Early Elective Deliveries Rate* • *Timeliness of Prenatal Care* • *Frequency of Ongoing Prenatal Care* • *Percent of Live Births <2,500 Grams*	DMAS and its contracted MCOs have undertaken a variety of initiatives aimed at improving quality outcomes in maternal health, a primary goal of the DMAS Quality Strategy. **Baby Steps Virginia:** The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders, including contracted MCOs, to improve maternity outcomes. These efforts have focused on eliminating racial disparities in maternal mortality by 2025, a key goal of Governor Ralph Northam and his administration. The program has five key subgroups all with the aim to promote health equity and quality maternity outcomes: • Eligibility and enrollment • Outreach and information • Community connections • Services and policies • Oversight. During 2020 teams have addressed a variety of topics all with the goal of advancing the holistic well-being of Medicaid and CHIP members including: • Medicaid member outreach • Social media campaign − Newborn screening education − Women, Infants and Children (WIC) enrollment and services − MCO maternity care coordination − Breast feeding awareness − Flu vaccine access

Virginia Quality Strategy Aim and Goal	DMAS Quality Initiative
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Performance Measure:** • *Adolescent Well-Care Visits* **Goal:** Focus on Screening and Prevention **Performance Measure:** • *Childhood Immunization Status* **Aim: Maximize Wellbeing Across the Lifespan** **Goal:** Effective management of chronic respiratory disease **Performance Measure:** • *Asthma Admission Rate (per 100,000 Member Months)* **Goal:** Effective management of chronic respiratory disease **Performance Measure:** • *Comprehensive Diabetes Care* **Aim: Build a Wellness Focused, Integrated System of Care** **Goal:** Integration of behavioral, oral, and physical health **Performance Measure:** • *Follow-Up After Emergency Department (ED) Visit for Mental Illness* **Aim: Achieve Healthier Pregnancies and Healthier Babies** **Goal:** Virginians plan their pregnancies **Performance Measure:** • *Prenatal and Postpartum Care*	**Performance Withhold Program:** As part of an effort to align with DMAS' value-based purchasing (VBP) initiatives, the Medallion 4.0 program implemented a performance withhold program (PWP). This program allows MCOs to earn back a 1 percent quality withhold, or a portion thereof. DMAS determined specific criteria and established methodologies for the performance incentive program.
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Performance Measures:** • *Annual Preventive Dental Visits* • *Well-Child Visits in the First 15 Months of Life* • *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Live* • *Adolescent Well-Care Visits (12-21 Years)*	**Foster Care Focus Study:** DMAS is committed to improving the quality and timeliness of care for children in foster care. The Commonwealth of Virginia Department of Social Services informs and requires foster parents to ensure that their foster children receive regular primary care and dental visits. DMAS conducts a study of the healthcare utilization among children in foster care compared to children not in foster care who were enrolled in Virginia Medicaid MCOs. The study seeks to demonstrate that foster children have higher rates of healthcare utilization than comparable non-foster children for primary care and dental measures.
Aim: Achieve Healthier Pregnancies and Healthier Babies	**Birth Outcomes Study:** DMAS conducts an annual study of Medicaid and CHIP prenatal care and associated birth

Virginia Quality Strategy Aim and Goal	DMAS Quality Initiative
Goal: Improved pre-term birth rate **Performance Measures:** • *Early Elective Deliveries Rate* • *Timeliness of Prenatal Care* • *Frequency of Ongoing Prenatal Care* • *Percent of Live Births <2,500 Grams*	outcomes. The purpose of the study is to determine the extent that women receive early and adequate prenatal care, and the clinical outcomes that are associated with the Medicaid-paid births.
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Emphasize member experience of care **Performance Measure:** • *CAHPS Member Rating of Health Plan*	**Medicaid Advisory Committee:** The DMAS director established the Medicaid Member Advisory Committee (MAC). This committee provides a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The committee is made up entirely of Medicaid-enrolled individuals or an authorized representative of a member. The director of DMAS also designates a DMAS staff member to serve on the committee. The committee members examine and provide input on the impact of DMAS services and programs. The purpose of the committee is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS director improve the overall experience for all Virginia Medicaid applicants and members. Committee members serve for at least one year. The MAC meetings are scheduled quarterly and are open to the public and include a public comment period during each meeting.
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral, and physical health **Performance Measure:** • *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* • *Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB Alcohol and Other Drug Use Disorder Treatment at Discharge* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* • *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence* • *Transition of Members Between SUD LOCs [Levels of Care], Hospitals, NF [Nursing Facilities], and the Community* • *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*	**ARTS Training and Technical Assistance:** • DMAS facilitated over 96 web-based SUD SUPPORT 1010 webinar trainings and technical assistance sessions during 2020 reaching over 4,180 individuals. • DMAS facilitated a Hepatitis C training in collaboration with the Virginia Department of Health, University of Virginia School of Medicine, and University of California San Francisco (UCSF) National Clinician Consultation Center on September 8, 2020. The topics of the webinar included Virginia Medicaid policy updates, Virginia Hepatitis C rates, current treatment rates, Hepatitis C treatment guidelines, interrupted treatment dosage, and clinician resources for treatment. 178 practitioners participated in the training. • DMAS facilitated a webinar on "How to set up a Preferred Office-Based Opioid Treatment Program" on September 23, 2020. The topics of the webinar covered the reasons to invest in this model, how to stand up this model, and DMAS' requirements for reimbursement. 47 practitioners participated. • DMAS facilitated two trainings presented by Dr. Rae-Anne Dougan and Dr. Jeremy Walden from Dougan

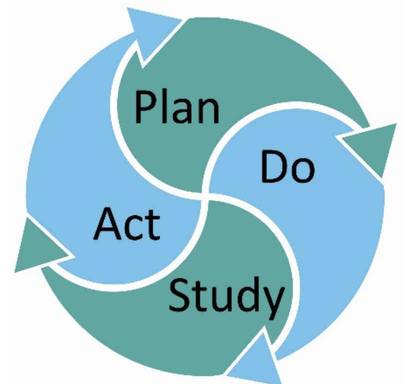
Virginia Quality Strategy Aim and Goal	DMAS Quality Initiative
• *Use of Opioids at High Dosage in Persons Without Cancer* • *Use of Opioids from Multiple Providers in Persons Without Cancer*	and Walden Wellness, PLLC. The training sessions provided education for healthcare providers and organizations on understanding race-based trauma and incorporating cultural humility in clinical practice. The two trainings had a total of 1,300 attendees. **Presentations:** • A presentation on ARTS was conducted at the Member Advisory Committee meeting (October 2020). • How to become an OBOT presentation • VCU Project ECHO COVID-19 Flexibilities and Care Coordination (June 2020) • Monthly behavioral health stakeholder calls • Governor's Opioid Commission meeting (September 2020) • ARTS update for Virginia Hospital and Healthcare Association (March 2020) • Monthly SUPPORT Act grant stakeholder presentations: (March – April 2020) • National Association for State Health Policy—SUD and telehealth flexibilities (August 2020) • National Governor's Association—Ensuring access to harm reduction services during COVID-19 (August 2020) **Workgroups and Grant Participation:** • DMAS staff participated in the GA workgroup HB1157 for improvement of maternal and infant health outcomes. • DMAS continued its NASHP MCH PIP Grant focused on increasing SBIRT within health systems. • DMAS participated in the George Mason University Screening, Brief Intervention and Referral to Treatment (SBIRT) Policy Steering Committee to promote screening for pregnant and parenting individuals.

The MCOs' ongoing quality assessment and performance improvement programs objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

Appendix C provides examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia Quality Strategy's goals and objectives.

Best and Emerging Practices

The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Virginia Medicaid and CHIP members. The DMAS Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable. The DMAS conducts oversight of MCOs to promote accountability and transparency for improving health outcomes.



Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DMAS encourages the MCOs to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a Plan-Do-Study-Act (PDSA) cycle, to determine if the benefit of the intervention outweighs the effort and cost. The DMAS also actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured. Table 3-13 identifies DMAS' identified best and emerging practices.

Table 3-13—DMAS' Best and Emerging Practices

Best and Emerging Practices
Stakeholder Collaboration: DMAS collaborated with stakeholders on a variety of projects supporting pregnant and parenting people. Collaboration was geared toward furthering maternity program quality outcomes and engagement with a variety of partners such as the Virginia Department of Health (VDH), the Virginia Department of Social Services (VDSS), the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Hospital and Healthcare Association (VHHA), and the Virginia Neonatal Perinatal Collaborative (VNPC).
DOULA Benefit Study: DMAS and VDH worked closely with State stakeholders to both study requirements to operationalize a doula Medicaid benefit and to execute a streamlined statewide doula certification process overseen by VDH. To realize these goals, both agencies actively collaborated with the Office of the Secretary of Health and Human Services along with community members such as doula groups, VHHA, DMAS MCOs, the VNPC, and other key statewide advocacy groups supporting families. The final report was scheduled for release in December 2020.
Prenatal and Parenting Substance Use and Misuse Initiatives: DMAS worked to promote quality outcomes in services for pregnant and parenting people experiencing substance use and misuse. The DMAS ARTS team partnered with VDH to facilitate a provider training needed to obtain a waiver to prescribe buprenorphine. Forty-three providers utilized this training across the State including obstetrical/gynecological providers, a target group for the series. In 2019, Virginia was one of eight states selected to participate in the National Academy for State Health Policy (NASHP) Maternal and Child Health (MCH) Policy Innovations Program Policy Academy. Through this project, DMAS and VDH partnered with VDSS and the Virginia DBHDS on a statewide collaborative effort to improve

Best and Emerging Practices
Screening, Brief Intervention, and Referral to Treatment (SBIRT) services for pregnant and parenting people via two health system pilot sites. **Policies, Procedures, and Trainings:** DMAS developed ARTS policies, procedures, and training programs focused on: • How to set up an OBOT training. • Guidance on urine drug testing. • Telehealth best practices for SUD treatment trainings.

Table 3-14 identifies the MCOs' self-reported best and emerging practices.

Table 3-14—MCOs' Best and Emerging Practices

MCO	Best and Emerging Practices
Aetna	Launch of Next Best Action Campaigns: Aetna's Next Best Action ("NBA") Program includes a set of analytically driven, member-facing, multi-channel campaigns that focus on personalized, contextualized engagement with members. The corporate-sponsored initiative is designed to help members change their behavior, improve their overall health, and achieve their ambitions. With each NBA, members receive personalized alerts that help them improve their health. For 2020, the NBAs include quality improvement campaigns that target maternity and infant care, flu vaccines, medication adherence, and avoidable ED visits. Pharmacy Hospital Readmission Reduction Program: Aetna's Pharmacy Hospital Readmission Reduction Program is a clinical program that focuses on coordinating care between providers, care managers, and clinical pharmacists when members are discharged from inpatient episodes. Pharmacy technicians utilize the Inpatient Census Report within Aetna Systems to identify eligible members recently discharged from inpatient episodes that meet State criteria. The MCO tracks pharmacy interventions related to post-discharge medication reconciliation, including issues identified through outreach to members and providers. Members included in the report must have an eligible diagnosis, an assigned care manager, and take four or more chronic medications. Behavioral Health High Utilizer Round Pilot Program: Aetna's Behavioral Health High Utilizer Round Program includes representatives from pharmacy, utilization management, behavioral health, care management, and external colleagues focused exclusively on each member's holistic needs. The team continues to round weekly until the member achieves a level of stability in the community. The focus consists of integrating behavioral and physical health along with case management and addressing social determinants of health (SDoH), such as unstable housing, food insecurity, and unemployment that cause overutilization of costly behavioral health inpatient stays. The MCO's pilot program initiated with a private BH [behavioral health] provider to refer Aetna members immediately upon discharge from an inpatient hospitalization with outpatient crisis stabilization services to prevent re-hospitalization and promote engagement in outpatient behavioral health services. Aetna is also actively exploring partnerships with transitional housing agencies, the Department

MCO	Best and Emerging Practices
	of Behavioral Health and Developmental Services (DBHDS), and the Richmond Redevelopment and Housing Authority.
HealthKeepers	Stepping-Stones Program: HealthKeepers recognizes that barriers in communication, knowledge of, and access to available community resources impact the member's quality of life. Members need support from community-based organizations (CBOs) in addition to their health insurance plan. HealthKeepers wants to be the link that supports both the CBO partners and members, and to bridge the communication gap. HealthKeepers supports CBOs by identifying a CBO need and working to provide supportive funding for things such as a little library for an employment agency, funds to purchase meals for a food bank, computers for a housing agency, or blankets and pillows for an emergency shelter. CBOs utilize the funds the best way for their organization and partner with HealthKeepers to share HEDIS information, utilize Aunt Bertha, and refer members for assistance as needed. The CBO follows up with the MCO to share how the support helped. Aunt Bertha (The Community Resource Link) connects anyone in need to free and reduced-cost programs in their local area. They provide free tools and free support to CBOs to manage programs, respond to requests for services, and track/report on outcomes.
Magellan	Sickle Cell Program: Magellan initiated a collaborative management approach with one of its largest health centers in the central region for mutual members living with Sickle Cell Disease. As part of this Sickle Cell collaboration, the health system multidisciplinary care team [members] who work with their mutual members at the clinic, along with the health plan's multidisciplinary staff to include members such as the care coordinator staff, pharmacy director, ARTS care coordinator, recovery support navigators, and Magellan medical directors would meet monthly to discuss members for whom there was a concern either due to the inability of the care coordinator to reach the member, increased ED or inpatient utilization, etc. The team would develop a collaborative approach on how to best assist these members to better manage their condition and live their most vibrant lives. This initiative was so successful, it has since been replicated by other MCO's. Clinic Day: Magellan partners with community providers by holding clinic day events for our members. The Clinic Day offers a fun way to encourage members to: • Obtain the health services they need. • Improve health outcomes. • Improve HEDIS score/close care gaps. • Improve member/provider experience. Magellan's approach includes identification of members in need of care, offering healthcare access to members by connecting them with PCPs and health education. All of these activities contributed to improved overall health outcome and experience. Magellan partners with providers by scheduling member appointments, arranges transportation service, and performs reminder calls. As a result, we reduce administrative burden on provider office staff, decrease no-show rates, and improve member/provider experience.

MCO	Best and Emerging Practices
	The improvement of members' access to providers and encouraging engagement with members are two areas that Magellan continually innovates. In 2020, Due to the COVID 19 pandemic, Magellan worked with providers to initiate and expand the telehealth option to Clinic Day. This allowed members options to attend the event virtually and receive the same quality of services safely at their home.
Optima	Best practices: • BioIQ FIT program. • Quarterly outreach baby showers (currently virtual). • Quarterly outreach member advisory forums (currently virtual). • Care coordination technician outreach. • Dedicated team (CipherHealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc. • Member care gap dashboard shared with provider office partners. • Care management/care coordination care gap dashboard to assist in identifying and closing care gaps when engaging with members. • Quality management reviews of LTSS providers on a quarterly basis. • Behavioral health member engagement program to improve follow-up visits with providers after ED visits. • Long-term care nursing facility discharge rounds with provider to assist care coordination safely transitioning member from nursing facility to community setting. • Partners in Pregnancy (PIP) program. • Performance withhold program monthly tracking grid. • Multidisciplinary team approach to improvement in quality measures, meeting on a monthly basis. • Vendor/partners in care: Emmi, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group (IEG). Emerging practices: • At-home diabetes screening program. • In-home assessments (telehealth during COVID). • Collaboration with vendor to increase pre- and postnatal member engagement, address care gap closures, and coaching support in collaboration with the MCO's care team.
United	Accelerated payment: During the COVID-19 national public health emergency, UnitedHealthcare supported PCPs and FQHCs [federally qualified health centers] through accelerating funds aligned with the Community Plan Primary Care Professional Incentive Program, including adding a capacity building pathways component to the program for provider investment in one of the following areas: • Telemedicine and digital engagement

MCO	Best and Emerging Practices
	• Novel care strategies • Transitions of care • Collaboration with community organizations • Addressing social needs Health inequalities: UnitedHealthcare is focused on reducing health inequalities. To that end, a cross-functional program fosters a holistic approach in reducing health disparities and enhancing the end-to-end consumer experience. Actions include 1) staff education; 2) provider education; 3) analysis of data outcomes looking for variation by age, gender, ethnicity, and geography to determine appropriate population specific interventions; and 4) creation of action plans to address any identified disparities.
VA Premier	Quality NCQA Internal Auditing Team: The corporate, centralized team manages every NCQA program and associated activities for all lines of business. A best practice model has resulted as evidenced by achieving 100 percent on every standard and 100 percent on file audits: • Credentialing & recredentialing • Denials • Case management • Service authorizations • Grievances (internal) • Appeals • Pharmacy These accomplishments were achieved by ensuring zero turnover, consistent interpretation of standards, ongoing organizational training, and a standardized quarterly auditing program with trended outcomes. Quality Management Reviews (QMRs): VA Premier's MLTSS quality improvement team has been recognized, by DMAS, as having "Best Practices" for waiver audit reviews, highlighting the approach, detailed information, and home visit documentation. **Member Outreach & Maternity Program:** This program is identified as a best practice, by organizational program department leaders, for the utilization of a one touchpoint approach during member engagement. Gift card incentives are awarded for program engagement, screening, education, timely prenatal/postpartum visits, and maternity follow-up care. Comprehensive screenings and referrals to the High-Risk OB Care Management Team are performed for high-risk maternity members. Comprehensive postpartum outreach and screening of all births are conducted, including family planning engagement, WIC enrollment, depression screening, pediatrician engagement, and continued enrollment in Medicaid. SDoH screening of members is completed with the initial prenatal assessment to address needs and secure resources. As a result of this program, the low-birth-weight rate decreased from 2.2 percent (FY 2019) to 1.8 percent (FY 2020). Quality Satisfaction Committee (QSC): The QSC is a subcommittee of the Quality Improvement Committee (QIC) which meets on a bimonthly basis ensuring there is

MCO	Best and Emerging Practices
	a coordination of activities, reduction/elimination in duplication of efforts, and streamlined activities related to member and provider experiences. This includes representatives from operational departments with a direct impact on accreditation, member healthcare outcomes, and member and practitioner/provider experiences. There is oversight of organizational surveys to ensure the health plan is meeting regulatory timelines for completion and submission. There are assigned quality assurance coordinators (QACs) working with departments to conduct barrier analyses to identify areas to improve experiences with the health plan or healthcare providers. Also, the QACs with the departments develop strategic interventions to positively affect member and provider experience rates that fall below the benchmark. Outcomes are monitored and tracked over time and reported to the committee. These outcomes are shared with members and providers at least annually. As a result of the QSC, VA Premier has achieved a 4.0 for two consecutive years on the CAHPS Satisfaction Survey. Social Determinants of Health: VA Premier members may be affected by many factors related to SDoH to include, but not limited to, employment, food security, housing stability, education, connection to social supports, health and healthcare, and other environmental factors. VA Premier is dedicated to ensuring our membership is assessed and provided the appropriate referrals and access to address all SDoH needs. In 2020, VA Premier developed an SDoH department to provide a greater focus on this pertinent area of healthcare delivery. In 2021, VA Premier will be updating its clinical documentation system to house member SDoH data in one centralized location. This will allow for greater data aggregation leading to even more targeted community partnerships, referrals, and closed-loop information for comprehensive member care.

Annual Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the 2017–2020 Quality Strategy, HSAG developed the Quality Strategy Status Assessment, as shown in Appendix B. The Quality Strategy Status Assessment lists each of the goals and the objectives used to measure achievement of those goals.

Table 3-15 shows the number of RY 2020 PM rates for which the MCOs scored better than the Virginia aggregate rate and the number or PM rates for which the MCOs performed lower than the Virginia aggregate rate. Please see Section 4 for specific performance measure rates.

Table 3-15—CY 2020 Summary of Performance Measure Results of the CCC Plus MCOs[1,2]

	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Number of RY 2020 Rates Scoring Better Than the Virginia Aggregate	24	33	15	28	29	20

	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Number of RY 2020 Rates Scoring at or Above the HEDIS 50th Percentile	17	23	14	18	18	19

[1] *Certain behavioral health services were provided by a third party, Magellan Behavioral Health of Virginia, during all or a portion of HEDIS 2019.*
[2] *The number of measures by MCO may not be equal because for some MCO measures, the denominator was too small to report a valid rate.*

4. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the CCC Plus program.

Definitions

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

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement.[4-1]

Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care organizations successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).[4-2]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[4-3] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the

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

MCO—e.g., processing appeals and providing timely care. In the final 2016 Federal Managed Care Regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206(a) and at 42 CFR §438.68(b), requiring states to develop both time and distance standards for network adequacy.

MCO Comparative and Statewide Aggregate PIP Results

Performance Improvement Project Highlights

Figure 4-1—PIP Strengths and Weaknesses

Strengths	• The CCC Plus MCOs successfully achieved all Module 3 validation criteria for the DMAS-specified PIP topics.
Weaknesses	• The MCOs reported challenges related to COVID-19 in their intervention progress updates, including that interventions were delayed due to the pandemic. To address this challenge, the PIP were extended.

The MCOs achieved all the Module 3 validation criteria to identify potential interventions and were in the process of testing interventions for the PIPs at the time of this report. There were no SMART Aim measure outcomes yet to report. The SMART Aim and Module 4 and Module 5 validation results will be reported in the next annual technical report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: In 2020, the CCC Plus MCOs successfully achieved all Module 3 validation criteria for the DMAS-specified PIP topics. The MCOs identified potential interventions and were in the process of testing interventions for the PIPs at the time of this report. The MCOs reported challenges related to COVID-19 in their intervention progress updates, including that interventions were delayed due to the pandemic. To address this challenge, the PIPs were extended. The new SMART Aim end date for all the PIPs (previously December 31, 2020) is May 31, 2021. The CCC Plus MCOs will continue to test interventions through May 31, 2021, and will report SMART Aim outcomes for each PIP in July 2021.

Weaknesses

Weakness: Based on the status of the PIPs, there were no specific identified weaknesses.

Recommendation: As the CCC Plus MCOs continue to test interventions until the PIP's SMART Aim end date and prepare to submit the final Module 4s and Module 5s for validation, HSAG recommends that the MCOs:

- Continue to monitor and report any impact COVID-19 has had on the MCO's PIPs.
- Address all the feedback and recommendations that HSAG provided in the Module 4 plan pre-validation reviews and Module 4 intervention progress check-ins. After reviewing the feedback and/or recommendations, the MCO should contact HSAG with any questions.
- Follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO has questions about the approved methodology, it should review the approved Module 2 submission form and contact HSAG.
- Identify and test innovative, actionable changes for the PIPs. If the interventions are not effective, the MCOs should make rapid modifications to the interventions and continue collecting data. If the MCO needs to identify additional potential interventions for the PIP, it should review its process map and FMEA completed in Module 3 to design changes to address gaps and high-priority failures in the process.
- Continually monitor the monthly SMART Aim measure and intervention effectiveness measure data. If the outcomes are not improving over time, the MCO should adjust intervention testing.
- Attend the Module 4 and Module 5 webinar training that HSAG will schedule prior to the submission of these modules for validation.
- Request PIP technical assistance from HSAG as often as needed.

MCO Comparative and Statewide Aggregate Performance Measure Validation (PMV) Results

To evaluate the MCOs' managed care performance in Virginia, DMAS used a subset of HEDIS and non-HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of MCO populations. To evaluate the accuracy of reported PM data, HSAG conducted, on a subset of PMs and all quality withhold measures, non-HEDIS PMV for the measurement period of January 1, 2019, through December 31, 2019.

Performance Measure Validation Highlights

Table 4-1—Performance Measure Strengths and Weaknesses

Domain	Strengths	Weaknesses
Access to Care	Five of the MCOs met or exceeded the 50th percentile for the *Adults' Access to*	All reportable MCO rates fell below the 50th percentile for both the *Breast Cancer*

Domain	Strengths	Weaknesses
	Preventive/ Ambulatory Health Services measure.	*Screening* and *Cervical Cancer Screening* measures. All six MCOs were more than 15 percentage points below the 50th percentile for the *Cervical Cancer Screening* measure.
	Three of the MCOs met or exceeded the 50th percentile for the *Use of Imaging Studies for Low Back Pain* measure.	
	At least three MCOs met or exceeded the 50th percentile for two of the four measures related to the *Children and Adolescents' Access to Primacy Care Practitioners* measure.	
Access and Preventive Care	HealthKeepers and VA Premier demonstrated the highest performance within the Access and Preventive Care domain, meeting or exceeding the 50th percentile for six of the 10 (60.0 percent) and five of the 10 (50.0 percent) measure rates in this domain, respectively.	Magellan and United demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for nine of the 10 (90.0 percent) measure rates within the domain.
Medication Management	All six MCOs met or exceeded the 50th percentile for at least two of the three measure rates related to medication management (*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and both *Antidepressant Medication Management* indicators).	
Behavioral Health	All six MCOs met or exceeded the 50th percentile for at least two of the six measure rates (*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* indicators, *Follow-Up After Emergency Department Visits for Mental Illness* indicators, and *Follow-Up After Hospitalization for Mental Illness* indicators).	Within the Behavioral Health domain, for two measures (*Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics),* none of the MCOs met or exceeded the 50th percentile, reflecting an area for improvement.
	All six MCOs met or exceeded the 50th percentile for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total* indicator.	
	Within the Behavioral Health domain, Magellan and Optima demonstrated the highest performance, meeting or exceeding the 50th percentile for seven	

Domain	Strengths	Weaknesses
	of the 13 (53.8 percent) and nine of the 13 (69.2 percent) measure rates, respectively.	
Taking Care of Children	MCO performance was the highest for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates, as four and three MCO rates, respectively, met or exceeded the 50th percentile.	Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to *Childhood Immunization Status*, *Immunizations for Adolescents*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Well-Child Visits in the First 15 Months of Life* measure rates, as none of the MCOs' rates for these measures met or exceeded the 50th percentile. Magellan demonstrated the lowest performance, as it was the only MCO to fall below the 50th percentile and Virginia aggregate for all measure rates in this domain.
Living With Illness	MCO performance within the Living With Illness domain was the highest for *Medical Assistance With Smoking and Tobacco Use Cessation*, with all MCOs meeting or exceeding the 50th percentile for all three reportable measure indicator rates.	For the Living With Illness domain, MCO performance was the weakest related to respiratory conditions, as only two MCOs met or exceeded the 50th percentile for both the *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation* measures.
	United had the highest performance in the Living with Illness domain, with nine of the 14 (64.3 percent) measure rates meeting or exceeding the 50th percentile and 12 of the 14 (85.7 percent) measure rates exceeding the Virginia aggregate.	MCO performance was low for *Comprehensive Diabetes Care*, particularly for the *HbA1c Testing, Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* indicators, for which no MCO rates met or exceeded the 50th percentile.
	Two of the MCOs, HealthKeepers and VA Premier, met or exceeded the 50th percentile for all three measures in the Use of Opioids domain that were compared to national benchmarks.	Optima demonstrated the lowest performance among the MCOs in the Living With Illness domain as it only met or exceeded the 50th percentile for three of the 14 (21.4 percent) measure rates.

To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit.[4-4] Each MCO contracted with an NCQA-licensed organization (LO) to conduct the HEDIS audit. Additionally, HSAG reviewed the MCOs' final audit reports (FARs), information systems (IS) compliance tools, and the Interactive Data Submission System (IDSS) files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the

[4-4] HEDIS Compliance Audit™ is a trademark of the NCQA.

applicable IS standards and the HEDIS reporting requirements for the key CCC Plus Medicaid measures for HEDIS 2020.

HSAG's PMV activities included validation of the following measures:

- *Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence*
- *Follow-Up After ED Visit for Mental Illness*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*
- *Comprehensive Diabetes Care (excluding HbA1c Control < 7.0%)*
- *Heart Failure Admission Rate (Per 100,000 Member Months)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment*

HSAG contracted with Aqurate Health Data Management, Inc. (Aqurate) for assistance with the validation of the PMs above. Using the validation methodology and protocols described in Appendix A. HSAG validated results for each PM. The CMS PMV protocol identifies two possible validation designations for PMs: *Report* (R)—measure data were compliant with DMAS specifications, and the data were valid as reported; or *Do Not Report (DNR)*—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 4-2, with all rates validated as reportable.

Table 4-2—HSAG MCO Performance Measure Validation Results

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence						
7-Day Follow-Up—Total	16.67%	13.59%	11.24%	14.01%	9.86%	9.30%
30-Day Follow-Up—Total	25.27%	20.19%	17.27%	19.51%	13.27%	14.88%
Follow-Up After Emergency Department Visit for Mental Illness						
7-Day Follow-Up—Total	42.76%	43.97%	47.48%	45.49%	39.61%	44.47%
30-Day Follow-Up—Total	62.76%	62.76%	63.21%	62.01%	57.46%	61.65%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate						
40-64 Years	128.00	124.51	71.52	171.55	130.28	178.23
65+ Years	104.68	98.66	0.00	197.64	139.39	166.63
Total	123.41	112.39	64.56	174.77	133.28	176.21
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	87.10%	85.40%	86.13%	84.67%	88.40%	83.94%
*HbA1c Poor Control (>9.0%)**	50.36%	50.12%	57.66%	57.18%	37.80%	53.04%
HbA1c Control (<8.0%)	42.34%	42.09%	37.71%	35.28%	54.60%	40.39%
Eye Exam (Retinal) Performed	48.18%	55.47%	35.77%	55.96%	57.80%	52.31%
Medical Attention for Nephropathy	89.29%	86.86%	90.75%	81.75%	90.20%	85.16%

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Blood Pressure Control (<140/90 mm Hg)	46.23%	43.31%	42.82%	51.34%	56.80%	45.50%
Heart Failure Admission Rate						
18–64 Years	143.72	97.30	66.65	84.21	105.55	97.49
65+ Years	233.14	179.49	112.98	254.11	274.35	240.71
Total	155.93	127.00	69.36	97.48	144.69	115.39
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment						
Initiation of AOD—Total—Total	48.57%	48.98%	42.74%	47.29%	51.53%	45.97%
Engagement of AOD—Total—Total	10.08%	11.81%	17.34%	10.14%	11.32%	13.05%

** For this indicator, a lower rate indicates better performance.*
***This rate is under review by HSAG and has not been finalized.*

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

Data Integration—HSAG validated the data integration process used by the MCOs, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. HSAG determined that the data integration processes for the MCOs were acceptable.

Data Control—HSAG validated the MCO's organizational infrastructure which included that the structure supported all necessary information systems and that the MCO's quality assurance practices and backup procedures were sound to ensure timely and accurate processing of data and provided data protection in the event of a disaster. HSAG determined that the data control processes in place were acceptable.

Performance Measure Documentation—HSAG conducted MCO staff interviews and reviewed all MCO-provided audit documentation, which included the completed roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of PM calculations, and other related documentation. HSAG determined that the documentation of PM generation by the MCOs was acceptable.

MCO Comparative and Statewide Aggregate HEDIS Results

One DMAS Quality Strategy objective was to use HEDIS data whenever possible to measure each MCO's performance with specific indices regarding quality of, access to, and timeliness of care. As part of the EQR annual technical report, HSAG performed a comparison of rates between MCOs and the Virginia weighted aggregate.

Table 4-3 displays, by MCO, the HEDIS 2020 measure rate results compared to the HEDIS 50th percentiles and the Virginia aggregate, which represents the average of all six MCOs' measure rates weighted by the eligible population. Gray-shaded boxes indicate MCO PM rates that were at or above

the 50th percentile. Rates indicating better performance than the Virginia aggregate rates are represented in burgundy font.

Table 4-3—MCO Comparative and Virginia Aggregate HEDIS 2020 Measure Results

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Access and Preventive Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	88.22%	**92.71%**	80.32%	90.32%	89.62%	**91.08%**	**90.51%**
Adult BMI Assessment							
Adult BMI Assessment	**79.81%**	76.89%	72.02%	**81.15%**	**84.91%**	77.62%	**78.81%**
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]							
Total	33.33%	**68.72%**	34.58%	**60.60%**	**60.35%**	56.51%	**59.65%**
Breast Cancer Screening							
Breast Cancer Screening	49.88%	48.44%	47.37%	**53.10%**	**53.55%**	49.65%	**50.24%**
Cervical Cancer Screening[2]							
Cervical Cancer Screening	**44.04%**	**44.04%**	30.17%	40.15%	40.63%	40.15%	**41.14%**
Children and Adolescents' Access to Primary Care Practitioners[2]							
12–24 Months	NA	**97.48%**	NA	**97.18%**	NA	**98.39%**	**96.68%**
25 Months–6 Years	91.58%	**92.93%**	77.84%	**92.80%**	81.08%	**96.40%**	**92.31%**
7–11 Years	90.24%	**95.58%**	83.08%	90.48%	85.46%	**97.61%**	**92.78%**
12–19 Years	84.85%	**91.32%**	74.68%	87.01%	72.98%	**95.66%**	**87.69%**
Use of Imaging Studies for Low Back Pain							
Use of Imaging Studies for Low Back Pain	69.50%	**73.28%**	**72.96%**	**74.01%**	71.37%	70.04%	**72.07%**
Behavioral Health							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia							
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	**69.61%**	**68.21%**	**71.05%**	66.76%	63.43%	**69.76%**	**68.06%**
Antidepressant Medication Management							
Effective Acute Phase Treatment	51.47%	51.82%	**60.67%**	53.55%	**67.39%**	**67.52%**	**59.31%**
Effective Continuation Phase Treatment	38.99%	39.19%	**47.78%**	40.74%	**53.86%**	**54.66%**	**46.43%**

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia							
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	**73.12%**	NA	**74.47%**	55.26%	71.67%	**71.94%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence							
7-Day Follow-Up—Total	**16.67%**	**13.59%**	11.24%	**14.01%**	9.86%	9.30%	**12.22%**
30-Day Follow-Up—Total	**25.27%**	**20.19%**	17.27%	**19.51%**	13.27%	14.88%	**18.06%**
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Total	42.76%	43.97%	**47.48%**	**45.49%**	39.61%	**44.47%**	**44.05%**
30-Day Follow-Up—Total	**62.76%**	**62.76%**	**63.21%**	**62.01%**	57.46%	61.65%	**61.73%**
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Total	30.56%	**32.25%**	18.69%	**34.09%**	**31.03%**	**32.31%**	**30.60%**
30-Day Follow-Up—Total	**56.67%**	**56.96%**	39.89%	**60.54%**	**55.83%**	**56.52%**	**55.23%**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment							
Initiation of AOD—Total—Total	**48.57%**	**48.98%**	42.74%	47.29%	**51.53%**	45.97%	**47.85%**
Engagement of AOD—Total—Total	10.08%	11.81%	**17.34%**	10.14%	11.32%	**13.05%**	**11.92%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]							
Total	NA	43.97%	**54.55%**	**56.76%**	NA	48.98%	**50.81%**
Taking Care of Children							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	45.01%	**55.72%**	33.58%	43.80%	37.47%	**46.47%**	**46.38%**
Childhood Immunization Status							
Combination 3	**63.33%**	**64.23%**	NA	57.43%	NA	**70.31%**	**62.15%**
Immunizations for Adolescents							
Combination 1 (Meningococcal; Tetanus, Diphtheria Toxoids and Acellular Pertussis [Tdap])	**68.48%**	**66.42%**	46.21%	57.80%	61.47%	**72.46%**	**64.09%**
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	**29.70%**	**26.28%**	20.45%	24.57%	24.77%	**27.27%**	**25.90%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics							

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Blood Glucose Testing—Total[1]	**56.46%**	46.81%	41.89%	48.82%	49.57%	**57.26%**	**50.55%**
Cholesterol Testing—Total[1]	**40.14%**	32.62%	31.08%	**38.76%**	**37.39%**	**42.06%**	**37.17%**
Blood Glucose and Cholesterol Testing—Total	**36.73%**	30.78%	29.05%	**37.04%**	**35.65%**	**40.20%**	**35.23%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile—Total	**64.72%**	56.93%	59.85%	**63.75%**	**68.61%**	58.39%	**60.33%**
Counseling for Nutrition—Total	52.55%	50.85%	51.58%	**60.10%**	**57.42%**	52.31%	**53.80%**
Counseling for Physical Activity—Total	**46.23%**	43.55%	42.82%	**46.96%**	**50.61%**	44.28%	**45.09%**
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	NA	36.73%	NA	**51.61%**	NA	NA	**39.12%**
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	**77.11%**	**77.86%**	60.54%	**77.32%**	62.72%	71.29%	**74.43%**
Living With Illness							
Asthma Medication Ratio							
Total	56.84%	**68.68%**	58.53%	61.97%	**64.65%**	60.90%	**62.79%**
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing	**87.10%**	85.40%	**86.13%**	84.67%	**88.40%**	83.94%	**85.42%**
*HbA1c Poor Control (>9.0%)**	**50.36%**	**50.12%**	57.66%	57.18%	**37.80%**	53.04%	**51.02%**
HbA1c Control (<8.0%)	**42.34%**	**42.09%**	37.71%	35.28%	**54.60%**	40.39%	**41.72%**
Eye Exam (Retinal) Performed	48.18%	**55.47%**	35.77%	**55.96%**	**57.80%**	52.31%	**53.80%**
Medical Attention for Nephropathy	**89.29%**	**86.86%**	**90.75%**	81.75%	**90.20%**	85.16%	**86.17%**
Blood Pressure Control (<140/90 mm Hg)	46.23%	43.31%	42.82%	**51.34%**	**56.80%**	45.50%	**47.25%**
Controlling High Blood Pressure							
Controlling High Blood Pressure	**53.28%**	40.39%	42.09%	**55.33%**	**65.45%**	47.93%	**49.24%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications							
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.12%	**84.50%**	80.57%	78.12%	**84.78%**	**87.13%**	**83.17%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	82.33%	**88.83%**	79.61%	**87.59%**	**85.00%**	82.06%	**84.24%**

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Discussing Cessation Medications	56.48%	**60.49%**	**62.99%**	58.10%	**61.93%**	**61.99%**	**60.33%**
Discussing Cessation Strategies	47.16%	47.57%	50.00%	50.00%	49.16%	**60.00%**	**50.65%**
Pharmacotherapy Management of COPD Exacerbation							
Systemic Corticosteroid	**89.18%**	33.46%	**74.43%**	**52.08%**	**50.22%**	48.48%	**49.19%**
Bronchodilator	**95.39%**	43.16%	**89.31%**	**61.61%**	57.58%	56.95%	**58.14%**
Use of Opioids							
Use of Opioids at High Dosage[1]							
Use of Opioids at High Dosage	10.01%	7.75%	**4.55%**	**6.81%**	**6.15%**	7.40%	**7.36%**
Use of Opioids From Multiple Providers							
*Multiple Prescribers**	23.67%	**20.13%**	24.07%	26.27%	23.47%	**20.34%**	**22.22%**
*Multiple Pharmacies**	20.37%	**4.79%**	**7.22%**	7.61%	**4.85%**	**5.86%**	**7.36%**
*Multiple Prescribers and Multiple Pharmacies**	6.52%	**2.82%**	5.56%	4.40%	**2.86%**	**3.44%**	**3.81%**
Utilization							
Ambulatory Care—Total							
*Emergency Department (ED) Visits—Total**	108.98	**87.27**	105.91	95.39	**80.75**	98.98	**93.33**
Identification of Alcohol and Other Drug Services[3]							
Total—Any Service—Total	14.64%	11.06%	17.20%	12.91%	12.87%	13.89%	**12.94%**
Inpatient Utilization—General Hospital/Acute Care—Total[3]							
Total Discharges per 1,000 Member Months (Total Inpatient)	17.99	17.96	14.98	25.28	16.76	24.34	**20.46**
Total Average Length of Stay (Total Inpatient)	7.02	6.27	7.32	6.11	6.74	6.08	**6.33**
Total Discharges per 1,000 Member Months (Medicine)	11.99	12.23	10.01	18.16	11.55	17.20	**14.24**
Total Average Length of Stay (Medicine)	5.38	5.28	5.92	5.37	5.86	4.94	**5.31**
Total Discharges per 1,000 Member Months (Surgery)	5.39	5.43	4.39	6.58	4.89	6.65	**5.79**
Total Average Length of Stay (Surgery)	11.03	8.66	11.01	8.34	9.03	9.20	**9.04**
Total Discharges per 1,000 Member Months (Maternity)	0.73	0.47	0.64	0.75	0.52	0.69	**0.62**
Total Average Length of Stay (Maternity)	3.68	3.30	3.40	3.77	3.92	3.73	**3.63**
Mental Health Utilization—Total[3]							

Performance Measures	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Any Services—Total	32.05%	24.41%	38.66%	29.67%	24.99%	29.15%	**28.00%**
Plan All-Cause Readmissions[1]							
Observed Readmissions	12.36%	6.18%	12.40%	10.87%	10.33%	10.88%	**9.65%**
O/E Ratio Total	1.01	0.51	1.19	0.89	0.81	0.92	**0.80**

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered with caution.
[3]Rates for utilization measures do not indicate better or worse performance and are displayed for information only. Therefore, comparisons to the 50th percentiles and Virginia aggregates were not performed.
NA indicates that the MCO followed the specifications, but the denominator was too small to report a valid rate.
***Note:** MCO measure rates indicating better performance than the Virginia aggregate are represented in burgundy.*
Indicates that the HEDIS 2020 rate was at or above the 50th percentile.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as five of the MCOs met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services* measure. Additionally, three of the MCOs met or exceeded the 50th percentile related to the *Use of Imaging Studies for Low Back Pain* measure, and at least three MCOs met or exceeded the 50th percentile for two of the four measures related to the *Children and Adolescents' Access to Primacy Care Practitioners* measure. Of note, HealthKeepers and VA Premier demonstrated the highest performance within the Access and Preventive Care domain, meeting or exceeding the 50th percentile for six of the 10 (60.0 percent) and five of the 10 (50.0 percent) measure rates in this domain, respectively.

Strength: The MCOs demonstrated strength within the Behavioral Health domain related to the use of medication to treat mental health conditions, as all six MCOs met or exceeded the 50th percentile for at least two of the three measure rates related to medication management (*Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and both *Antidepressant Medication Management* indicators). Moreover, four of the MCOs met or exceeded the 50th percentile for all three measures. Follow-up care for behavioral health conditions represented an improvement from last year, as all six MCOs met or exceeded the 50th percentile for at least two of the six measure rates (*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* indicators, *Follow-Up After Emergency Department Visits for Mental Illness* indicators, and *Follow-Up After Hospitalization for Mental Illness* indicators). Moreover, three of the MCOs met or exceeded the 50th percentile for four of the six (66.7 percent) measure rates. Of note, while all six MCOs met or exceeded the 50th percentile for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of AOD—Total—Total* indicator, only one MCO met or exceeded the 50th percentile for the *Engagement of AOD—Total—*

Total indicator. Within the Behavioral Health domain, Magellan and Optima demonstrated the highest performance, meeting or exceeding the 50th percentile for seven of the 13 (53.8 percent) and nine of the 13 (69.2 percent) measure rates, respectively.

Strength: Within the Taking Care of Children domain, MCO performance was the highest for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates, as four and three MCO rates, respectively, met or exceeded the 50th percentile.

Strength: MCO performance within the Living With Illness domain was the highest for *Medical Assistance With Smoking and Tobacco Use Cessation*, with all MCOs meeting or exceeding the 50th percentile for all three reportable measure indicator rates. United had the highest performance in this domain, with nine of the 14 (64.3 percent) measure rates meeting or exceeding the 50th percentile and 12 of the 14 (85.7 percent) measure rates exceeding the Virginia aggregate. The MCOs demonstrated strength within the Use of Opioids domain, as three MCOs met or exceeded the 50th percentile for at least two of the three measure rates (*Use of Opioids From Multiple Providers*). Moreover, two of the MCOs, HealthKeepers and VA Premier, met or exceeded the 50th percentile for all three measures that were compared to national benchmarks.

Weaknesses

Weakness: Within the Access and Preventive Care domain, cancer screenings for women represents an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for both the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Of note, all six MCOs were more than 15 percentage points below the 50th percentile for the *Cervical Cancer Screening* measure, which is a slight improvement from HEDIS 2019 measure rates. Magellan and United demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for nine of the 10 (90.0 percent) measure rates within the domain.

Why the weakness exists: Members are not completing recommended screenings which may indicate a lack of understanding of healthcare or recommended preventive schedules. Members' lack of participation in screenings may also be a result of a disparity-driven barrier.

Recommendation: HSAG recommends that the MCOs consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended screenings and to make appropriate health decisions. HSAG recommends that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates for a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends that the MCOs implement appropriate interventions to increase the screening rates due to the low rates for both measures.

Weakness: Within the Behavioral Health domain, for two measures (*Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics),* none of the MCOs met or exceeded the 50th percentile, reflecting an area of improvement.

Why the weakness exists: None of the MCOs met or exceeding the HEDIS 50th percentile for two of the behavioral health measures indicates that providers are not following recommended guidelines for follow-up monitoring or using psychosocial care as a first-line protocol for children prescribed antipsychotics.

Recommendation: HSAG recommends that the MCOs develop processes to ensure providers understand and implement recommended care guidelines. HSAG recommends that the MCOs consider if there are disparities within the MCOs' populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a disparity-driven issue**,** HSAG recommends that the MCOs implement appropriate interventions to improve use of evidence-based practices in the provision of behavioral healthcare and services.

Weakness: Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to *Childhood Immunization Status*, *Immunizations for Adolescents*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Well-Child Visits in the First 15 Months of Life* measure rates as none of the MCOs' rates for these measures met or exceeded the 50th percentile. Magellan demonstrated the lowest performance as it was the only MCO to fall below the 50th percentile and Virginia aggregate for all measure rates in this domain.

Why the weakness exists: Child members are not consistently receiving recommended immunizations, well-visits, or screenings according to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or Bright Futures schedules, indicating a possible health literacy or healthcare disparity issue in members understanding the need for preventive and well care for children.

Recommendation: HSAG recommends that the MCOs identify best practices for ensuring children receive all preventive and well-child services according to recommended schedules. HSAG recommends that the MCOs consider conducting a root cause analysis to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions.

Weakness: For the Living With Illness domain, MCO performance was the weakest related to respiratory conditions, as only two MCOs met or exceeded the 50th percentile for both the *Asthma Medication Ratio* and *Pharmacotherapy Management of COPD Exacerbation* measures. MCO performance was low for *Comprehensive Diabetes Care*, particularly for the *HbA1c Testing, Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* indicators, for which no MCO rates met or exceeded the 50th percentile. Optima demonstrated the lowest performance among the MCOs in the Living With Illness domain as it only met or exceeded the 50th percentile for three of the 14 (21.4 percent) measure rates.

Why the weakness exists: Although members with chronic conditions may have access to care, these members are not consistently managing their conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity.

Recommendation: HSAG recommends that the MCOs conduct a root cause analysis to determine why members are not maintaining their chronic health conditions at optimal levels. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions.

Compliance With Standards Monitoring

DMAS conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2020, HSAG did not conduct MCO compliance review activities for the CCC Plus program. During 2020, DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from prior years' compliance reviews.

Compliance With Standards Monitoring Highlights

Figure 4-2—DMAS Compliance With Standards Actions Taken

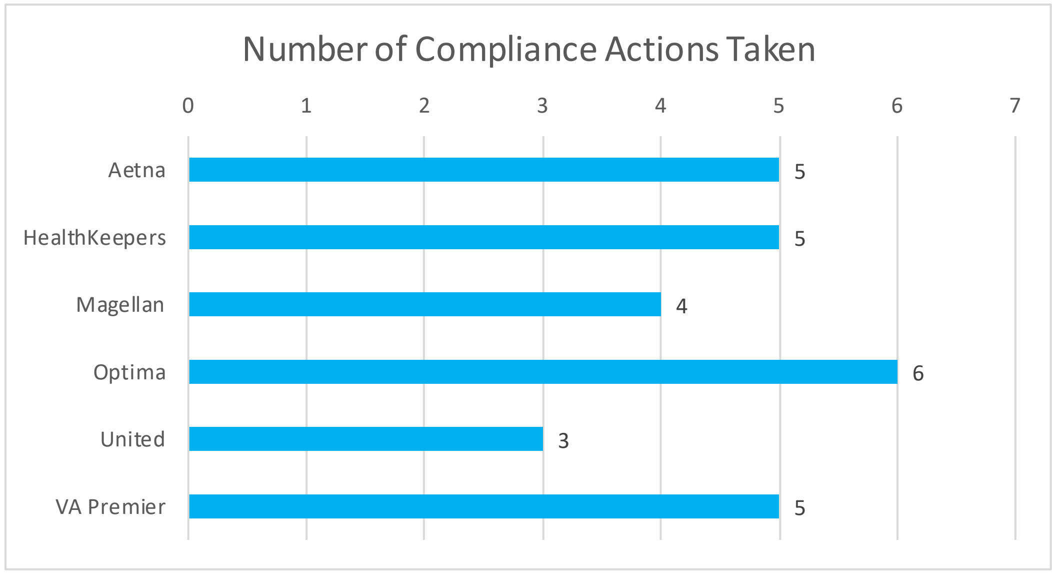


Table 4-4 displays the purpose of compliance actions taken with the MCOs during 2020.

Table 4-4—MCO Compliance Actions Taken

Purpose of Compliance Action	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier
Inappropriate Waiver enrollment	X			X		
Inappropriate occupational therapy service denials	X			X		
Payment cycle data not submitted and certified according to the CCC Plus Encounter Technical Manual	X	X	X	X		X
Delayed portal entry	X					
Failure to load nursing facility rates	X					
Erroneous ambulance claim edits creating inappropriate claim denials/payments		X				
Inappropriate service overage denials		X		X	X	
Care coordination staff ratios		X				
Durable medical equipment payment issues		X				X
Data Quality Scorecard			X			
Care coordination				X		
Untimely reporting/Failure to submit reports				X		X
PCG Public Partnership, LLC (PPL) eligibility file exchange issue					X	
Inaccurately classifying CCC Plus Waiver members as unable to contact					X	
Non-submittal of denied pharmacy claim encounters						X
Non-submittal of cost containment vendor subcontracts for DMAS approval						X
Managed care improvement plan (MIP) for failing to report electronic visit verification data			X			
Corrective action plan (CAP) for untimely adjudication of nursing facility claims for members enrolled in hospice			X			

Statewide Aggregate CAHPS Results

Member Experience Survey Highlights

Figure 4-3—CAHPS Strengths and Weaknesses

CAHPS Strengths

Three of the CCC Plus MCOs scored statistically higher than the 2020 NCQA adult Medicaid national average in the CAHPS adult survey for the *Getting Care Quickly* measure.

The CCC Plus MCOs showed strength in the adult survey for *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*, with three MCOs scoring statistically significantly higher than the 2020 NCQA adult Medicaid national average.

Two MCOs scored statistically higher than the 2020 NCQA child Medicaid national average for the child survey for the *Getting Care Quickly* measure.

The CCC Plus MCOs showed strength in the child survey for *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service* measures, with two MCOs scoring statistically significantly higher than the 2020 NCQA child Medicaid national average.

CAHPS Weaknesses

Three MCOs scored statistically significantly lower than the 2020 NCQA child Medicaid national averages for the *Rating of Health Plan* and *Rating of All Health Care* measures.

Adult Medicaid

Table 4-5 and Table 4-6 present the 2020 top-box scores for each MCO and the CCC Plus Program (i.e., all MCOs combined) compared to the 2019 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2020 CAHPS scores for each MCO and the CCC Plus Program were also compared to the 2020 NCQA adult Medicaid national averages.

Table 4-5—Comparison of 2019 and 2020 Adult Global Top-Box Scores

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2019	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**
CCC Plus Program	61.6%	65.5%▲	55.0%	57.5%	69.6%	72.3%	71.0%	71.6%
Aetna	63.1%	64.8%	55.0%	56.1%	70.4%	73.4%	71.1%	70.8%
HealthKeepers	59.3%	63.2%	53.7%	57.1%	68.5%	72.1%	72.0%	70.2%
Magellan	59.6%	61.3%	56.3%	53.5%	72.5%	70.4%	68.1%	68.6%
Optima	63.4%	68.6%	56.6%	59.5%	69.4%	73.4%	73.5%	70.5%
United	63.5%	66.0%	54.7%	59.3%	64.0%	72.0%▲	70.9%	68.2%
VA Premier	62.3%	67.1%	55.4%	56.8%	73.7%	72.2%	68.3%	77.6%

\+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Table 4-6—Comparison of 2019 and 2020 Adult Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2019	**2020**	**2019**	**2020**	**2019**	**2020**	**2019**	**2020**
CCC Plus Program	86.2%	85.0%	85.9%	85.5%	91.2%	93.6%▲	90.0%	91.3%
Aetna	87.3%	83.8%	83.2%	86.2%	91.5%	92.7%	90.8%	88.2%
HealthKeepers	87.0%	86.9%	88.2%	86.2%	91.5%	94.1%	89.3%	92.4%
Magellan	80.7%	79.0%	79.1%	81.6%	90.1%	91.8%	84.8%	88.9%
Optima	84.6%	85.5%	84.5%	83.5%	92.0%	93.8%	90.4%	91.3%
United	84.6%	80.9%	82.0%	86.5%	90.7%	92.6%	86.0%	88.3%
VA Premier	87.8%	86.2%	87.9%	85.9%	90.7%	94.0%	93.6%	93.4%

\+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: In 2020, the CCC Plus MCOs demonstrated strength in the adult survey for the *Getting Care Quickly* measure (three MCOs scored statistically

significantly higher than the 2020 NCQA adult Medicaid national average). In addition, the CCC Plus MCOs showed strength in the adult survey for *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service* (three MCOs scored statistically significantly higher than the 2020 NCQA adult Medicaid national average or the three MCOs scored statistically significantly higher in 2020 than 2019 for at least one measure.

Weaknesses

Weakness: Overall weaknesses in the adult CAHPS survey were not identified.

Recommendation: Overall, the CCC Plus MCOs should focus on maintaining and improving members' experiences of care as the MCO survey results indicated opportunities for improvement in *Rating of Health Plan* and *Rating of All Health Care* for the adult population when compared to the 2020 NCQA adult Medicaid national averages. In addition, MCO efforts should also focus on improving survey response rates.

Child Medicaid

Table 4-7 and Table 4-8 present the 2020 top-box scores for each MCO and the CCC Plus Program compared to the 2019 child Medicaid CAHPS scores for the global ratings and composite measures. The 2020 CAHPS scores for each MCO and the CCC Plus Program were also compared to the 2020 NCQA child Medicaid national averages.

Table 4-7—Comparison of 2019 and 2020 Child Global Top-Box Scores

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2019	2020	2019	2020	2019	2020	2019	2020
CCC Plus Program	62.3%	63.1%	63.9%	67.1%	75.7%	78.2%	70.5%	73.9%
Aetna	65.4%	69.3%	65.3%	63.9%	71.9%	74.1%	74.3%	75.0%+
HealthKeepers	60.2%	55.4%	65.0%	64.9%	77.2%	75.6%	70.1%	70.0%
Magellan	62.8%+	50.6%	60.3%+	55.7%	71.3%+	75.9%	71.7%+	69.4%+
Optima	65.7%	66.1%	62.9%	67.5%	76.6%	79.0%	71.4%	72.3%
United	52.6%	60.0%	61.1%+	67.6%	73.5%+	74.8%	66.7%+	83.6%+ ▲
VA Premier	67.1%+	73.0%	63.6%+	74.1%	74.2%+	84.2%	70.2%+	78.0%+

\+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Table 4-8—Comparison of 2019 and 2020 Child Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2019	2020	2019	2020	2019	2020	2019	2020
CCC Plus Program	86.3%	87.9%	92.5%	93.0%	94.0%	95.5%	83.1%	87.7%▲
Aetna	86.1%	89.9%	92.3%	89.4%	94.3%	93.1%	92.6%+	83.7%+
HealthKeepers	85.4%	86.1%	92.2%	94.4%	92.8%	95.9%▲	79.3%	88.2%▲
Magellan	88.4%+	83.4%+	87.8%+	86.2%+	92.9%+	93.8%	85.1%+	82.3%+
Optima	85.6%	87.6%	91.9%	93.1%	94.5%	94.4%	89.5%	88.6%
United	81.3%+	86.4%+	87.2%+	92.2%+	96.5%+	94.7%+	82.2%+	92.6%+
VA Premier	90.2%+	91.4%	97.3%+	95.2%+	96.4%+	97.7%	83.8%+	88.0%+

\+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
▲ *Statistically significantly higher in 2020 than in 2019.*
▼ *Statistically significantly lower in 2020 than in 2019.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The CCC Plus MCOs demonstrated strength in the child survey for the *Getting Care Quickly* measure (two MCOs scored statistically significantly higher than the 2020 NCQA child Medicaid national average). In addition, the CCC Plus MCOs showed strength in the child survey for *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service* measures (two MCOs scored statistically significantly higher than the 2020 NCQA child Medicaid national average and scored statistically significantly higher in 2020 than 2019 for at least one measure).

Weaknesses

Weakness: Three MCOs scored statistically significantly lower than the 2020 NCQA child Medicaid national averages for the *Rating of Health Plan* and *Rating of All Health Care* measures, indicating an area of weakness for the child population.

Why the weakness exists: Based on the child survey results, overall, MCO members indicated that they are not satisfied with their health plan or their healthcare. This may indicate that they are experiencing access to care issues, have a lack of understanding of how to access care and services, or there may be disparity issues related to care and service delivery.

Recommendation: Overall, the CCC Plus MCOs should focus on maintaining and improving members' experiences of care as the MCO survey results

indicated opportunities for improvement in *Rating of Health Plan* and *Rating of All Health Care* measures for the child population when compared to the 2020 NCQA child Medicaid national averages. In addition, MCO efforts should also focus on improving survey response rates.

Other Surveys Conducted

DMAS also conducts the following member experience surveys:

Member and Attendant Satisfaction with Fiscal/ Employer Agent Services: These annual surveys assess the performance of vendors who act as fiscal agents to manage consumer-directed healthcare services for the CCC Plus Waiver members.

Intellectual and Developmental Disability (ID/D) Quality Assurance Surveys: MCOs conduct quarterly member surveys to assess the performance of transportation providers for ID/D Waiver members.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

DMAS contracted with HSAG in 2020 to produce a consumer decision support tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the CCC Plus MCOs. The CCC Plus Consumer Decision Support Tool demonstrates how the Virginia Medicaid CCC Plus MCOs compare to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 4-9. Please refer to Appendix A for the detailed methodology used for this tool.

Table 4-9—Consumer Decision Support Tool Results—Performance Levels

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

Table 4-10 displays the CCC Plus 2020 Consumer Decision Support Tool results for each MCO.

Table 4-10—2020 Consumer Decision Support Tool Results

MCO	Overall Rating*	Doctors' Communication	Access and Preventive Care	Behavioral Health	Medication Management
Aetna	★★★	★★	★★★	★★★★	★★★
HealthKeepers	★★★	★★★	★★★★	★★★	★★
Magellan	★	★★	★	★★★	★★★
Optima	★★★★★	★★★★	★★★★★	★★★★	★
United	★★★	★★★	★★★	★	★★★
VA Premier	★★★★★	★★★★	★★★	★★★	★★★★★

*The Overall Rating category includes all measures from the other categories as well as CAHPS *Rating of All Health Care*, *Rating of Health Plan*, *Rating of Personal Doctor*, and *How Well Doctors Communicate* measures.

Strengths, Weaknesses, and Recommendations

For 2020, VA Premier demonstrated the strongest performance by achieving the Highest Performance level for the *Overall Rating* category and never falling below the Average Performance level for the remaining four categories. Optima also demonstrated strong performance, achieving the Highest Performance level for the *Overall Rating* and *Access and Preventive Care* categories. Magellan demonstrated the lowest performance by achieving the Lowest Performance level for the Overall Rating and *Access and Preventive Care* categories and never once performing above the Average Performance level.

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of MCO, PIHP, and PAHP networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for MLTSS programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types for the provider type to be subject to such time and distance standards:

- Primary care (adult and pediatric)
- Obstetricians/gynecologists
- Behavioral health
- Specialist (adult and pediatric)
- Hospital
- Pharmacy
- Pediatric dental
- Additional provider types when they promote the objectives of the Medicaid program

DMAS established time and distance standards and additional network capacity requirements in its contracts with the MCOs. DMAS receives monthly MCO network files and conducts internal analyses to determine network adequacy and compliance with contract network requirements. DMAS is prepared to move forward with the mandatory EQRO network adequacy review once the CMS protocol is finalized.

On November 13, 2020, CMS updated the Managed Care Rule to address state concerns and ensure that states have the most effective and accurate standards for their programs. CMS revised the provider-specific network adequacy standards by replacing time and distance standards with a more flexible requirement of a quantitative minimum access standard for specified healthcare providers and LTSS providers. The new requirements include, but are not limited to:

- Minimum provider-to-enrollee ratios.
- Maximum travel time or distance to providers.
- Minimum percentage of contracted providers that are accepting new patients.
- Maximum wait times for an appointment.
- Hours of operation requirements (for example, extended evening or weekend hours).
- Or a combination of these quantitative measures.

In addition, the November 13, 2020, Managed Care Rule changes confirm that states have the authority to define "specialist" in whatever way they deem most appropriate for their programs. And finally, CMS removed the requirement for states to establish standards for additional provider types.

Performance Withhold Program

In 2020, HSAG worked with DMAS to develop and implement a scoring mechanism for the CCC Plus Performance Withhold Program (PWP). Due to the impacts of the COVID-19 pandemic on MCOs' ability to collect and report data, as well as DMAS' ability to appropriately evaluate performance levels and improvement, DMAS determined that SFY 2021, which assesses CY 2020 performance measure data, will be a pay-for-reporting year for the PWP. For the CY 2019 PWP, the CCC Plus MCOs could earn all or a portion of their 1 percent quality withhold based on sufficiently reporting the required measure rates for four NCQA HEDIS measures and two CMS' Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures. The CY 2019 PWP was based on whether the MCO reported valid HEDIS 2020 (i.e., CY 2019) measure rates to NCQA in the required reporting method (i.e., hybrid for *Comprehensive Diabetes Care* and administrative for the remaining measures) and whether the MCO received a "*Reportable (R)*" or "*Small Denominator (NA)*" audit designation for all HEDIS measures and CMS Adult Core Set measures. All MCOs met the requirements to earn back their entire 1 percent quality withhold for the CY 2019 PWP. For detailed information related to the PWP, please see the *CCC Plus Performance Withhold Methodology (Updated for COVID-19)* on DMAS' website.[4-5]

[4-5] Health Services Advisory Group, Inc. *Revised CY 2019 and SFY 2021 CCC Plus Performance Withhold Program Methodology*. Available at: https://www.dmas.virginia.gov/files/links/5502/Revised%20CY%202019%20and%20SFY%202021%20CCC%20Plus%20Performance%20Withhold%20Program%20Methodology.pdf. Accessed on: Jan 20, 2021.

5. Validation of Performance Improvement Projects

This section presents HSAG's findings and conclusions from the EQR validation of PIPs conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs have addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objective

As part of the State's Quality Strategy, each CCC Plus MCO is required to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[5-1] Additionally, HSAG's PIP process facilitates frequent communication with the CCC Plus MCOs. HSAG provides written feedback after each module is validated and provides technical assistance for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while CCC Plus MCOs test interventions.

DMAS requires the CCC Plus MCOs to conduct two PIPs annually. The topics continued in 2020 were:

- *Follow-Up After Hospital Discharge*
- *Ambulatory Care—Emergency Department Visits*

The topics selected by DMAS addressed CMS requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

For each PIP topic, the CCC Plus MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the CCC Plus MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?

[5-1] U.S. 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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Jan 21, 2020.

- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

Approach to PIP Validation

In 2020, HSAG obtained the data needed to conduct the PIP validation from the CCC Plus MCOs' module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The CCC Plus MCOs submitted each module according to the approved timeline. After the initial validation of each module, the CCC Plus MCOs received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the CCC Plus MCO progressed to the next phase of the PIP process.

The goal of HSAG's PIP validation is to ensure that DMAS and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities the CCC Plus MCO conducted during the PIP. HSAG's scoring methodology evaluates whether the CCC Plus MCO executed a methodologically sound improvement project and confirmed that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the CCC Plus MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the CCC Plus MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the CCC Plus MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Training and Implementation

HSAG trained the CCC Plus MCOs on the PIP module submission and validation requirements prior to the submission due dates. HSAG's rapid-cycle PIP validation process facilitates frequent communication with the CCC Plus MCOs. HSAG provides technical assistance throughout the process. At the onset, HSAG provides feedback to ensure that PIPs are well-designed. CCC Plus MCOs also have opportunities for mid-course corrections. In addition to the PIP module training webinars that HSAG provides, the CCC Plus MCOs may seek ongoing technical assistance.

PIP Validation Status

In 2020, all CCC Plus MCOs achieved the Module 3 validation criteria and progressed to testing interventions. HSAG will report the PIP SMART Aim outcomes and validation findings for Module 4 and Module 5 in the next annual EQR report.

Recommendations

The CCC Plus MCOs should evaluate whether interventions have an impact on the SMART Aim results and determine whether changes need to be made. If an intervention is not effective, CCC Plus MCOs should start new interventions and monitor for effectiveness. Interventions should be tested for the PIP through the SMART Aim end date. If CCC Plus MCOs have any questions or need technical assistance with their PIPs, they should reach out to HSAG.

Validation Findings

Aetna

In 2020, Aetna submitted the following topics for validation: *Ambulatory Care—Emergency Department Visits* and *Follow–Up After Discharge*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-1 displays the SMART Aim for each PIP.

Table 5-1—SMART Aim Statements: Aetna

Ambulatory Care—Emergency Department Visits	
SMART Aim Statement	By 5/31/2021, decrease the percentage of African American members in the Central VA region (ZIP Code 23223) who had one ambulatory visit and two or more emergency department (ED) visits from 47.3% to 43.7%.
Follow–Up After Discharge	
SMART Aim Statement	By 5/31/2021, increase the percentage of members ages 45–64 years in the Central VA region who had a post-hospitalization follow-up visit with a PCP [primary care physician] or specialist within 30 days of discharge from 29.4% to 36.98%.

For each PIP, Aetna completed a process map and a failure modes and effects analysis (FMEA) to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-2 and Table 5-3 summarize the potential interventions Aetna identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 5-2—Intervention Determination Summary for the *Ambulatory Care—Emergency Department Visits* PIP

Failure Modes	Potential Interventions
Transportation no-show.	Collaborate with transportation vendor to improve staffing during high-volume hours.
Members do not understand the importance of utilizing their PCP for managing chronic conditions.	Member newsletter article. Telephonic outreach to members.
Member does not schedule appointment.	Perform telephonic outreach to assist members with scheduling primary care appointments.

Table 5-3—Intervention Determination Summary for the *Follow-Up After Discharge* PIP

Failure Modes	Potential Interventions
Transportation issues prevent members from scheduling appointments.	Telephonic outreach to members/education about transportation assistance and accommodations that are available.
Members do not feel the need for follow-up.	Telephonic outreach to members/education about the importance of following up with a PCP or specialist within 30 days.
Members do not know who is calling/do not answer call from case manager.	Update outbound call logic to include MCO, department, and/or case manager name.

Aetna had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. Aetna provided the first Module 4 progress updates for both PIPs in July 2020.

For the *Ambulatory Care—Emergency Department Visits* PIP, Aetna submitted Module 4 progress updates for three interventions—Transportation Access Improvement, Member Newsletter Article, and Telephonic Outreach; however, it indicated that the transportation intervention would not be tested because data showed transportation was not an issue as the MCO had previously thought. For the *Follow-Up After Discharge* PIP, Aetna submitted Module 4 progress updates for three interventions—Transportation Access Improvement, Educational Letter, and Updates to Outbound Call Logic. At the time of the updates, Aetna did not have data to report.

Regarding challenges related to COVID-19, in its Module 4 intervention testing progress updates for the CCC Plus PIPs, Aetna did not report specific challenges as a result of the COVID-19 pandemic.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to Aetna during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

Recommendation: For the CCC Plus PIPs, HSAG recommends that Aetna:

- Provide the correct intervention description in the Module 4 plan.
- Include all the details in the intervention process steps.
- Update the Module 5 Intervention Determination Table with interventions that were not in Module 3.
- Define the intervention effectiveness measure accurately.
- Clarify that the intervention is focused specifically on the narrowed focus of the PIP.
- **S**pecify whether claims lag would impact receiving the intervention results.
- Provide the data in the SMART Aim measure run chart correctly.
- Address the Module 4 pre-validation review feedback for the intervention effectiveness measure.

Assessment of Follow-Up on Prior Recommendations

Table 5-4 includes HSAG's recommendations for improvement and Aetna's actions taken.

Table 5-4—PIP Recommendations and Aetna's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**Aetna's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommended that Aetna should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed.	• Attended all module-specific trainings. • Identified and tested innovative, actionable changes for each PIP. • Monitored the outcomes and made rapid adjustments as necessary. • Requested PIP technical assistance from HSAG as needed.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. Specific efforts for each recommendation were not provided.	

HealthKeepers

In 2020, HealthKeepers submitted the following topics for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-5 displays the SMART Aim for each PIP.

Table 5-5—SMART Aim Statements: HealthKeepers

Ambulatory Care—Emergency Department Visits	
SMART Aim Statement	By 5/31/2021, decrease the percentage of members who have an emergency department (ED) visit among the Riverside Regional Medical Center—Brentwood population from 21.77% to 16.24%.
Follow-Up After Discharge	
SMART Aim Statement	By 5/31/2021, increase the percentage of members among the Riverside Regional Medical Center—Brentwood practice who have a follow-up visit within 30 days of discharge from 62.82% to 75%.

For each PIP, HealthKeepers completed a process map and a FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-6 and Table 5-7 summarize the potential interventions HealthKeepers identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 5-6—Intervention Determination Summary for the *Ambulatory Care—Emergency Department Visits* PIP

Failure Modes	Potential Interventions
Member unaware that the care coordinator assists.	• Member education at the time of Health Risk Assessment (HRA) regarding care coordination services. • Provider education regarding available care coordination services/monthly provider orientation. • Member education provided by PCP regarding available care coordination services. • Distribute flyers to members at appointments.
Member does not attend PCP appointment/lack of transportation.	• Member education at the time of HRA regarding care coordination services. • Provider education regarding available care coordination services/monthly provider orientation. • Member education provided by PCP regarding available care coordination services. • Distribute flyers to members at appointments.
Members go to ED without contacting their PCP first.	• Member education on appropriate level of care for ED.

Failure Modes	Potential Interventions
	• “Call us first” campaign—buttons worn by PCP staff to prompt discussions with members to call PCP before going to the ED. • Member education regarding PCP availability after hours. • Member education regarding MCO’s 24-hour Nurse Line. • Notification sent to the care coordinator for follow-up if member contacts the Nurse Line.

Table 5-7—Intervention Determination Summary for the *Follow-Up After Discharge* PIP

Failure Modes	Potential Interventions
Member not seen by PCP for follow-up/no appointment.	• Care coordinator calls member—offers appointment scheduling assistance and identifies barriers to keeping the appointment. • Care coordinator calls member—promotes self-management/engages member to schedule appointment. • Care coordinator reaches out to PCP/explains member was recently discharged and needs appointment. • Care coordinator utilizes “Patient Insights” within the Collective Medical Tool for high ED utilizers (>10 [ED visits] within six months) which may include the following provided to the discharging facility: care coordinator/number; 24-hour Nurse Line; transportation vendor/number; PCP/number; dialysis center/number; date/time member goes to dialysis; specialists; and recommendations (e.g., “Encourage patient to call PCP”).
Transportation scheduled but member does not attend the appointment.	• PCP contacts members who did not attend appointment to reschedule and identify barriers to keeping the appointment. • Care coordinator calls member—promotes self-management/engages member to schedule appointment. • PCP and care coordinators collaborate regarding member barriers and ways to align the plan of care. • Care coordinator utilizes “Patient Insights” within the Collective Medical Tool for high ED utilizers (>10 [ED visits] within six months) which may include the following provided to the discharging facility: care coordinator/number; 24-hour Nurse Line; transportation vendor/number; PCP/number; dialysis center/number; date/time member goes to dialysis; specialists; and recommendations (e.g., “Encourage patient to call PCP”).
Member not seen by PCP for follow-up/no transportation.	• PCP contacts member to ensure transportation to the appointment was scheduled.

Failure Modes	Potential Interventions
	• Care coordinator calls member—promotes self-management/engages member to schedule appointment. • Care coordinator utilizes "Patient Insights" within the Collective Medical Tool for high ED utilizers (>10 [ED visits] within six months) which may include the following provided to the discharging facility: care coordinator/number; 24-hour Nurse Line; transportation vendor/number; PCP/number; dialysis center/number; date/time member goes to dialysis; specialists; and recommendations (e.g., "Encourage patient to call PCP").
Transportation not scheduled.	• Care coordinator schedules transportation for the member. • Care coordinator utilizes "Patient Insights" within the Collective Medical Tool for high ED utilizers (>10 [ED visits] within six months) which may include the following provided to the discharging facility: care coordinator/number; 24-hour Nurse Line; transportation vendor/number; PCP/number; dialysis center/number; date/time member goes to dialysis; specialists; and recommendations (e.g., "Encourage patient to call PCP").

HealthKeepers had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. HealthKeepers provided the first Module 4 progress updates for both PIPs in June 2020.

For the *Ambulatory Care—Emergency Department Visits* PIP, HealthKeepers submitted a Module 4 progress update for the "Call Us First Campaign" intervention. For the *Follow-Up After Discharge* PIP, HealthKeepers submitted a Module 4 progress update for an "Improving the Frequency of Patient Insights and Member Engagement" intervention. At the time of the updates, HealthKeepers did not have intervention evaluation data to report.

HealthKeepers reported in its Module 4 progress updates that the COVID-19 pandemic was a challenge for the CCC Plus PIPs; however, it didn't provide specific reasons.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to HealthKeepers during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

Recommendation: For the CCC Plus PIPs, HSAG recommends that HealthKeepers:

- Include the key driver and failure mode the intervention is expected to address/impact.
- Include all the details in the intervention process steps.

- Define the intervention effectiveness measure accurately.
- Provide a data collection plan for the intervention effectiveness measure.
- Address how the results of the intervention are hypothesized to impact the SMART Aim (explain the theory of change).
- Target with intervention testing a population large enough to impact the SMART Aim.

Assessment of Follow-Up on Prior Recommendations

Table 5-8 includes HSAG's recommendations for improvement and HealthKeepers' actions taken.

Table 5-8—PIP Recommendations and HealthKeepers' Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**HealthKeepers' Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommended that HealthKeepers should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed.	• Attended all module-specific trainings. • Continued to attend the module-specific trainings. • Identified and tested innovative, actionable changes for the PIP. • Initially started and due to challenges was not able to be completed. • Modified interventions for this outcome. • Continually monitored the outcomes and made rapid adjustments, as needed. • Moved from our initial intervention to modified interventions. • Requested PIP technical assistance from HSAG as often as needed. • Continue to request assistance as needed.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

Magellan

In 2020, Magellan submitted the following topics for validation: *Reduce Emergency Department Visits* and *Increasing Follow-up Visits After Discharge*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-9 displays the SMART Aim for each PIP.

Table 5-9—SMART Aim Statements: Magellan

Reduce Emergency Department Visits	
SMART Aim Statement	By 5/31/2021, reduce the percentage of members assigned to Dr. Diggs, Dr. Patel, and Dr. Bhowmik as a PCP [primary care physician] who have >5 emergency department (ED) visits in 90 days from 14.1% to 9.1%.
Increasing Follow-up Visits After Discharge	
SMART Aim Statement	By 5/31/2021, increase the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days in the Central region from 43.69% to 50.0%.

For each PIP, Magellan completed a process map and a FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-10 and Table 5-11 summarize the potential interventions Magellan identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 5-10—Intervention Determination Summary for the *Reduce Emergency Department Visits* PIP

Failure Modes	Potential Interventions
Member contact information is not current/correct.	Monthly claims review—close monitoring to check if members had any recent visits with a provider. MCO obtains member contact information from the provider.
Provider does not have accurate member contact information.	Continue partnership with provider. Develop a communication plan to obtain accurate member contact information.
ED care coordinator is not able to develop a timely care plan.	Partnership with provider relation team—work with provider to develop a care plan while member attends follow-up appointment.

Table 5-11—Intervention Determination Summary for the *Increasing Follow–up Visits After Discharge* PIP

Failure Modes	Potential Interventions
Member not able to go to follow-up appointment.	Care transition coordinator provides reminder calls to members, identifies needs, and provides resources.
Care transition coordinator unable to monitor member.	Partnership with provider—provider outreaches members to schedule a follow-up appointment.
Care transition coordinator receives inpatient notification but is unable to outreach the member while inpatient.	Telephonic outreach to member and hospital to schedule 30-day follow-up visit. Obtain accurate member contact information from the hospital for follow-up monitoring.

Magellan had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. Magellan provided the first Module 4 PIP progress updates in July 2020 and August 2020.

For the *Reduce Emergency Department Visits* PIP, Magellan submitted a Module 4 progress update for monthly claims checks to obtain current member contact information. For the *Increasing Follow-up Visits After Discharge* PIP, Magellan submitted a Module 4 progress update for a member outreach intervention.

In its Module 4 intervention testing progress updates, Magellan did not report any challenges specifically related to the COVID-19 pandemic for the CCC Plus PIPs.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to Magellan during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

Recommendation: For the CCC Plus PIPs, HSAG recommends that Magellan:

- Include the key driver the intervention is expected to address/impact.
- Address how claims lag may impact the intervention.
- Provide more details of the step-by-step data collection process.
- Include all the details in the intervention process steps.
- Define the intervention effectiveness measure accurately.
- Provide the data in the SMART Aim measure run chart correctly.

Assessment of Follow-Up on Prior Recommendations

Table 5-12 includes HSAG's recommendations for improvement and Magellan's actions taken.

Table 5-12—PIP Recommendations and Magellan's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**Magellan's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommended that Magellan should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed.	• Magellan has been fully compliant with all PIP activities and will continue to work together with HSAG. • Attended all PIP module trainings. • Identified and tested innovative, actionable changes for the PIP. • Continually monitored the outcomes and made rapid adjustments.

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**Magellan's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
	• Reached out to HSAG for any PIP technical assistance as often as needed.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. Specific efforts for each recommendation were not provided.	

Optima

In 2020, Optima submitted the following topics for validation: *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD [Chronic Obstructive Pulmonary Disease], Asthma, Bronchitis, or Emphysema* and *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members.* The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-13 displays the SMART Aim for each PIP.

Table 5-13—SMART Aim Statements: Optima

Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD [Chronic Obstructive Pulmonary Disease], Asthma, Bronchitis, or Emphysema	
SMART Aim Statement	By 5/31/2021, decrease the rate of emergency department (ED) visits among adult Tidewater regional members with COPD, asthma, bronchitis, or emphysema from 1.90 to 1.71.
Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members	
SMART Aim Statement	By 5/31/2021, increase 30-day ambulatory follow-up visits with a practitioner among members who reside in the Tidewater region and have a hospital discharge from 68.57% to 75.43%.

For each PIP, Optima completed a process map and a FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-14 and Table 5-15 summarize the potential interventions Optima identified to address high priority subprocesses and failure modes determined in Module 3.

Table 5-14—Intervention Determination Summary for the *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* PIP

Failure Modes	Potential Interventions
Care coordinator does not: • Assess member's understanding of discharge instructions, diagnosis, and/or medications.	Develop a template that addresses diagnoses, medications, discharge instructions, and ED alternatives for care coordinators to use when following up with members after an ED discharge.

Failure Modes	Potential Interventions
• Confirm that provider follow-up appointment has been scheduled. • Educate member about ED alternatives.	
Not all members are called/provided education about ED alternatives.	Implement Friday "check-in" calls to members in the Tidewater Region with a primary diagnosis of COPD, asthma, bronchitis, or emphysema. Assess current status, provide education and ED alternatives.
Members who could benefit from integrated care manager services may be missed/overlooked.	• Ensure care coordinator follows up with the member after each ED visit to identify needs and provide resources. • Develop a template that addresses diagnoses, medications, discharge instructions, and ED alternatives for care coordinators to use when following up with members after an ED discharge.

Table 5-15—Intervention Determination Summary for the *Improving Compliance in 30-Day Ambulatory Follow–Up Appointments for Tidewater Regional Members* PIP

Failure Modes	Potential Interventions
Care coordinator is unaware that member was discharged.	• Global access to facility patient medical records. • "Symphony notifications" for inpatient discharges. • Write access in Epic to add care coordinator to hospital care team for ease of communication. • Collaboration with Premanage to identify barriers to timely reporting of member status.
Care coordinator does not assess for provider visit within 30 days of discharge.	• Write access in Epic to add care coordinator to care team for communication from facilities. • Develop tool for member post-discharge follow-up telephone call to include provider appointment verification/scheduling and evaluation of member needs.
Not all patients are scheduled for a follow-up appointment before discharge.	• Write access in Epic to add care coordinator to hospital care team for ease of communication. • List of care coordinator assignments provided to hospital care teams. • Develop tool for member post-discharge follow-up telephone call to include provider appointment verification/scheduling and evaluation of member needs.

Optima had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. Optima provided the first Module 4 progress updates for both PIPs in July 2020.

For the *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* PIP, Optima submitted a Module 4 progress update for scripted post-ED discharge telephone calls. Although intervention testing began in March 2020, Optima did not yet have intervention effectiveness results to report because it was waiting for claims to determine decreased ED utilization following initiation of the intervention.

For the *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members* PIP, Optima submitted a Module 4 progress update for scripted post-inpatient discharge telephone calls. Optima also began testing this intervention in March 2020; however, the MCO did not yet have intervention effectiveness results to report in the update because it was waiting for claims for completed follow-up appointments within 30 days of discharge after the scripted post-discharge telephone calls began.

For its *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* PIP, Optima reported the following specific challenges as a result of the COVID-19 pandemic:

- Stay-at-home order recommended by the Virginia Governor on March 24, 2020; mandated starting March 30, 2020—in effect until June 10, 2020.
- Tidewater remained in Phase 2 of reopening as of June 30, 2020. This could have limited/affected members' willingness and ability to utilize services other than the ED.
- It was unclear whether the outreach program successfully decreased ED utilization or if it was affected by concerns with COVID-19.

Optima also reported the stay-at-home order and Tidewater reopening challenges for its *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members* PIP. In addition, specific to this PIP, providers may have scaled back the availability of appointments based on need and acuity to limit exposure to COVID-19.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to Optima during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

For the CCC Plus PIPs, HSAG recommends that Optima:

- Include all the details in the intervention process steps.
- Update the Module 5 Intervention Determination Table with interventions that were not in Module 3.
- Define the intervention effectiveness measure accurately.
- Provide a complete data collection and data analysis plan for the intervention evaluation.
- Define the SMART Aim measurement periods following the rolling 12-month methodology.
- Investigate whether there is another way to collect intervention data in real time to avoid claims lag.

Assessment of Follow-Up on Prior Recommendations

Table 5-16 includes HSAG's recommendations for improvement and Optima's actions taken.

Table 5-16—PIP Recommendations and Optima's Response

Prior Year Recommendations *From the CY 2019 EQR Technical Report for PIPs*	**Optima's Response** *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
HSAG recommended that Optima should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed.	Technical assistance from HSAG requested and meetings were scheduled: • 10/4/2019 • 1/27/2020 • 5/26/2020
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. Specific efforts for the recommendations to attend training, identify and test changes, and monitor outcomes were not provided.	

United

In 2020, United submitted the following topics for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-17 displays the SMART Aim for each PIP.

Table 5-17—SMART Aim Statements: United

Ambulatory Care—Emergency Department Visits	
SMART Aim Statement	By 5/31/2021, decrease nonemergent emergency department (ED) visits among the Elderly or Disabled with Consumer Direction (EDCD) waiver population from 198.20 to 188.29 per 1,000 members.
Follow-Up After Discharge	
SMART Aim Statement	By 5/31/2021, increase the percentage of members in the Tidewater and Roanoke regions that have a follow-up visit within 30 days of discharge from 54.13% to 58.23%.

For each PIP, United completed a process map and a FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-18 and Table 5-19 summarize the potential interventions United identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 5-18—Intervention Determination Summary for the *Ambulatory Care—Emergency Department Visits* PIP

Failure Modes	Potential Interventions
Family member/caregiver does not know how to advise member on medical conditions—lack of knowledge regarding how to respond to the medical needs of the member, preventive care, and what constitutes an emergency.	• Develop an educational flyer to advise members, caregivers, and care attendants on when to seek medical care from a PCP or urgent care instead of the ED. • Develop a methodology for documenting/tracking review of the flyer with the member and caregiver/care attendant. Build out the documentation system to capture and report activity. • Tie education into the development of an emergency preparedness plan in the service plan. • Develop and implement a process for MCO staff to contact members following a discharge from an ED visit for nonemergent reasons. Review alternatives to ED care, identify needs and resources, and ensure appropriate follow-up care has been scheduled. • Implement a data collection strategy focused on post-ED visits. Identify reasons why members sought nonemergent medical care from the ED.
Service plan does not address appropriate steps to take when seeking medical care/member is not familiar with the service plan.	• Develop updated service plan document. Include a new section on emergency preparedness specific to each member: 1) who to reach out to for nonemergent medical needs, 2) appropriate resources for members—PCP and urgent care, and 3) back-up caregiver for personal care services. • Develop materials for care coordination training. Implement new service plan.
Nurse Line advice is not followed because member refuses or is unable (e.g., no supplies or medications at home).	• Review and analyze the Nurse Line process for care coordination notification after member or caregiver contact has occurred. • Develop a follow-up process in response to Nurse Line notifications. Ensure member has received the appropriate level of medical care.

Table 5-19—Intervention Determination Summary for the *Follow-Up After Discharge* PIP

Failure Modes	Potential Interventions
No confirmation of member's post-discharge appointment/member not assisted with scheduling an appointment.	Develop and implement a care coordination process for hospitalized members that includes 1) discharge planning or interfacing with vendor; and 2) ensuring post-hospital assessments are completed, initiating or confirming the member has a scheduled follow-up appointment.
Access to member while inpatient or immediately after	• Assess barriers to access members at in-network hospitals. Identify needs and partner with health provider systems in

Failure Modes	Potential Interventions
discharge/not notified of hospitalization.	Tidewater and/or Roanoke to gain access to hospitalized members during their admission. • Enhance relationship with health system discharge planners—educate on role of health coaches, develop and implement strategies to improve transitions, and plan for follow-up care.
Access to member status when followed by vendor health coach.	Assess and redesign the partnership with the vendor managing discharge planning to determine the effectiveness of the health coach process. Address any enhancements needed.

United had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. United provided the first Module 4 progress updates for both PIPs in June 2020.

For the *Ambulatory Care—Emergency Department Visits* PIP, United submitted a Module 4 progress update for an educational flyer and member follow-up calls post-ED visit. For the *Follow-Up After Discharge* PIP, United submitted a Module 4 progress update for vendor oversight of post-hospital assessment completion and a discharge follow-up process standard operating procedure. At the time of the updates, United did not have data to report.

United reported challenges related to COVID-19 in its Module 4 intervention testing progress updates. For the *Ambulatory Care—Emergency Department Visits* PIP, United reported the following challenges as a result of the pandemic:

- Mailings were postponed by DMAS which impacted getting the flyers to members.
- Face-to-face interventions were suspended; therefore, telephonic methods were used.
- Care coordinators were assigned additional tasks to support COVID-19 efforts.

For the *Follow-Up After Discharge* PIP, United reported the following challenges as a result of the COVID-19 pandemic:

- Face-to-face interventions were suspended including the vendor health coach home visits; only telephonic methods were used to complete post-hospital contacts.
- Clinical staff members were assigned additional member outreach tasks to support COVID-19 efforts, delaying development of the discharge process and subsequent staff training.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to United during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

Recommendation: For the CCC Plus PIPs, HSAG recommends that United:

- Include all the details in the intervention process steps—the step-by-step process for the intervention.

- Test a new change for the PIP.
- Review monthly data for intervention effectiveness.
- Examine how claims lag may impact the intervention evaluation results.
- Ensure the targeted regions would impact a population large enough to impact the SMART Aim.
- Consider tracking how many members were reached face-to-face and telephonically.
- Define the intervention effectiveness measure completely.

Assessment of Follow-Up on Prior Recommendations

Table 5-20 includes HSAG's recommendations for improvement and United's actions taken.

Table 5-20—PIP Recommendations and United's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**United's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommended that United should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed.	• Attended all trainings provided by HSAG for PIPs. • Identified and adapted interventions that will produce actionable changes and build on the success of the PIPs. • Tested the adapted intervention through further PDSA cycles. • Evaluated and monitored outcomes using defined testing measures to ensure meaningful and actionable testing results for the PIP interventions. • Reached out to HSAG for help and clarification and received technical assistance and recommendations from HSAG, as needed.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

VA Premier

In 2020, VA Premier submitted the following topics for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge.* The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 5-21 displays the SMART Aim for each PIP.

Table 5-21—SMART Aim Statements: VA Premier

Ambulatory Care—Emergency Department Visits	
SMART Aim Statement	By 5/31/2021, decrease the rate of emergency department (ED) visits among members 20–44 years old from 127.04 to 112.68.
Follow-Up After Discharge	
SMART Aim Statement	By 5/31/2021, increase follow-up visits within 30 days of discharge for hospitalized members ages 18–64 years from 70% to 75%.

For each PIP, VA Premier completed a process map and a FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 5-22 and Table 5-23 summarize the potential interventions VA Premier identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 5-22—Intervention Determination Summary for the *Ambulatory Care—Emergency Department Visits* PIP

Failure Modes	Potential Interventions
Inappropriate utilization of emergency care.	• Implement an intensive care coordination program for high ED utilizers. • ED utilization member education campaign. • Companywide education campaign.
Member not identified as a high ED utilizer with intervention by care coordinator.	• Create and implement ED utilization reports for members. • Standardization of care coordination for high ED utilizers. • Develop utilization assessment tool with protocol for directing members to seek the appropriate level of care.
Care coordinator does not receive notification of ED encounter/untimely ED encounter alerts.	• Partner with Collective Medical to develop and implement accurate ED encounter reporting. • Create a streamlined care coordination notification process.
Timely transportation cannot be scheduled.	• Implement alternative scheduling requirements for identified ED high utilizers who have transportation identified as a barrier.

Table 5-23—Intervention Determination Summary for the *Follow-Up After Discharge* PIP

Failure Modes	Potential Interventions
Limited query capabilities and report requires extensive manual manipulation to be useful (Collective Medical).	• Partner with Collective Medical to develop and implement accurate admission reporting. • Create a streamlined notification process.
Limited reporting capability in new case management	• Partner with clinical applications team to use reporting function in JIVA.

Failure Modes	Potential Interventions
system (JIVA).	• Training for reporting function in JIVA. • Implementation of care coordinator use of JIVA reports.
Large caseload prevents timely follow-up.	• Utilization of existing support roles (i.e., member care specialist, regional transition coordinator). • Create visibly urgent notifications in JIVA.
Member hospitalized at a facility that does not participate in the collaborative care management system (Collective Medical).	• Create and use claims data-based reports. • Develop a process—admissions or case management at the facility contacts care coordinators for high-rate inpatient admissions and ED utilization. • Request participation in Collective Medical reporting.

VA Premier had progressed to intervention testing using PDSA during the 2020 validation year. Part of the PIP intervention testing process is providing Module 4 progress updates to HSAG for review. VA Premier provided the first Module 4 progress updates for both PIPs in July 2020.

For the *Ambulatory Care—Emergency Department Visits* PIP, VA Premier submitted a Module 4 progress update for an intervention to partner with Collective Medical to more efficiently use existing reporting capabilities and/or implement new reporting functions. For the *Follow-Up After Discharge* PIP, VA Premier submitted a Module 4 progress update for improving accuracy of notifications from Collective Medical and care coordination follow-up.

Regarding challenges related to the COVID-19 pandemic, in its Module 4 intervention testing progress updates VA Premier reported for the *Ambulatory Care—Emergency Department Visits* PIP that members were not initially visiting the ED as frequently, which skewed the results and demonstrated a decline in the data. For the *Follow-Up After Discharge* PIP, VA Premier reported challenges with coordination efforts. Specifically, provider appointments were limited and coding to capture virtual visits required a modification in tracking.

Strengths, Weaknesses, and Recommendations

At the time of this report, there were no SMART Aim measure results to report. HSAG provides feedback and recommendations to VA Premier during the PIP module validation process, Module 4 plan pre-validation reviews, and Module 4 intervention progress check-ins.

Recommendations

Recommendation: For the CCC Plus PIPs, HSAG recommends that VA Premier:

- Include the approved SMART Aim in Module 4.
- Include SMART Aim measurement periods following the rolling 12-month methodology.
- Provide the approved SMART Aim run chart template from Module 2, updated with the SMART Aim measure results to date.
- Report the intervention effectiveness measure results accurately.

- Report the results for the narrowed focus only in the final PIP SMART Aim run chart.
- Allow enough time for all claims to be submitted for intervention evaluation, considering claims lag.
- Include all the details in the intervention process steps.
- Define the intervention effectiveness measure accurately.
- Specify whether claims lag would impact receiving the intervention results. Use real-time data for intervention evaluation, if possible.
- Provide the data in the SMART Aim measure correctly.

Assessment of Follow-Up on Prior Recommendations

Table 5-24 includes HSAG's recommendations for improvement and VA Premier's actions taken.

Table 5-24—PIP Recommendations and VA Premier's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**VA Premier's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommended that VA Premier should: • Attend all module-specific trainings. • Identify and test innovative, actionable changes for the PIP. • Continually monitor the outcomes and make rapid adjustments, as needed. • Request PIP technical assistance from HSAG as often as needed	VA Premier had two MLTSS Rapid-Cycle Performance Improvement Projects (PIPs) underway: one clinical and one nonclinical. Clinical PIP: *Ambulatory Care—ED Visits* Nonclinical PIP: *Follow-Up After Discharge* • Feedback was received prior to testing. • Continually monitored interventions for effectiveness and updates. • Addressed and incorporated validation recommendations in subsequent submissions. • Coordinated training for key individuals involved in the PIPs process in CY 2020 to ensure understanding of the PIP rapid cycle process. • Outcomes are continually monitored, and adjustments are made for improvement, when needed. • In efforts to improve success of the PIPs, technical assistance is requested as needed.

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for PIPs***	**VA Premier's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
	• Identification and testing of innovative, actionable changes remains in progress and will be documented appropriately. • VA Premier's key PIP individuals will attend all module-specific trainings.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

6. Validation of Performance Measures

Overview

This section presents HSAG's findings and conclusions from the PMV EQR activities conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

DMAS uses HEDIS, CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. HSAG conducts NCQA HEDIS Compliance Audits of the MCOs annually and reports the HEDIS results to DMAS as well as to NCQA. HSAG also conducts annual PMV of certain measures such as the CMS Core Measure Sets, MLTSS measures, and measures pertaining to behavioral health and developmental disability programs. As part of the EQR annual technical report, the EQRO trends each MCO's rates over time and also performs a comparison of the MCOs' rates and a comparison of each MCO's rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring.

HSAG validated PM results for each MCO. HSAG validated the data integration, data control, and PM documentation during the PMV process.

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

In Section 4, Table 4-3 displays, by MCO, the HEDIS 2020 measure rates which were used as the basis for the strengths and weaknesses described in the following MCO-specific evaluations.

MCO-Specific HEDIS Measure Results

Aetna

Aetna's HEDIS auditor found that the MCO was fully compliant with all information systems standards and determined that Aetna submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that Aetna followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Aetna's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Aetna's eligibility system or processes.
- *Provider Data:* The MCO's mapping of native provider specialties to HEDIS provider types was reviewed. It was noted that the MCO's HEDIS auditor approved the mapping of clinic and urgent care facilities to PCPs. Aetna explained that these mappings were accepted by the HEDIS auditor because Aetna was able to demonstrate that the majority of all practitioners at these facilities were PCPs. HSAG identified no other concerns with Aetna's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Aetna's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Aetna's supplemental data systems and processes other than the failure to include the Signify supplemental data source in Aetna's Roadmap submission.
- *Data Integration:* HSAG identified no concerns with Aetna's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Strength: Within the Access and Preventive Care domain, Aetna met or exceeded the 75th percentile for *Adults' Access to Preventive/Ambulatory Health Services—Total and Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years,* indicating that children, young adults, and adults were able to access a PCP at least annually for preventive services and appropriate treatment as necessary to stay healthy and reduce unnecessary ER utilization.
	Strength: Aetna's performance within the Behavioral Health domain identified two measures met or exceeded the 75th percentile including *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total—Total.* The strong performance in the behavioral health measures indicates that Aetna established strong access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.
	Strength: Aetna's performance within the Living With Illness domain identified two measures meeting or exceeding the 75th percentile including *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit,* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* measure indicators. The MCO's performance in the smoking cessation and pharmacotherapy management of COPD exacerbation condition measures indicates that Aetna's providers have established processes to assist members in quitting tobacco use.

The results also indicate that providers are following evidence-based guidelines for management of COPD-diagnosed members.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for Aetna:

- *Adult BMI Assessment*
- *Ambulatory Care—ED Visits—Total*
- *Asthma Medication Ratio—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total*
- *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

Why the weakness exists: Across all domains, Aetna members are not accessing and completing timely well-visits, screenings, or behavioral health services, or receiving recommended care for chronic conditions. The lack of member participation in recommended care and services may be a result of a disparity-driven barrier, a lack of understanding of care recommendations for optimal health, or the ability to access care and services in a timely manner.

Recommendation: HSAG recommends that Aetna conduct a root cause analysis to determine why members are not consistently accessing and completing well-child visits, childhood immunizations, cancer screenings, behavioral health services, and care and services for chronic conditions. HSAG recommends that Aetna analyze its data and consider if there are disparities within their populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that Aetna implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members and that may result in unnecessary use of the ED and inpatient settings.

Assessment of Follow-Up on Prior Recommendations

Table 6-1 includes HSAG's recommendations for improvement and Aetna's actions taken.

Table 6-1—Prior Recommendations and Aetna's Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**Aetna's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG recommends that Aetna work closely with Athena and Aetna's HEDIS auditor to ensure the source of each record in the supplemental data set is clearly identified so Aetna can ensure this data source is compliant with audit guidelines.	• Worked closely with Athena and our auditor Advent. • Completed primary source verification on Athena by our HEDIS auditor. • Pulled records from Athena to verify that they were accurate; this is part of the formal audit from Advent.
The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Aetna (i.e., fell below the 25th percentile): • *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* • *Cervical Cancer Screening* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Adolescent Well-Care Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Asthma Medication Ratio—Total* • *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	• Engaged in several initiatives to close gaps in care for our members, including outreach calls to members and ongoing initiatives. • Established internal cross-functional workgroups that collaborate to develop new programs and also look for opportunities to improve established programs to improve outcomes for its members.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. Specific initiatives and programs to improve the measure rates were not provided.	

HealthKeepers

HealthKeepers' HEDIS auditor found that the MCO was fully compliant with all information systems standards and determined that HealthKeepers submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that HealthKeepers followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with HealthKeepers' claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with HealthKeepers' eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with HealthKeepers' provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with HealthKeepers' medical record review processes.
- *Supplemental Data:* It was determined during the audit process that the Continuity of Care Document provided to the MCO by Care Evolution was used for PSV. Although Care Evolution performed quality assurance to ensure that data from each individual source are correctly reflected in the CCD, HSAG recommends that the plan use the legal health record for verification in the future. All documentation related to supplemental data, including procedures, data file layouts, and impact reports, was reviewed and found to meet specifications. HSAG identified no other concerns with HealthKeepers' supplemental data systems and processes other than the failure to use the actual legal health record for PSV on supplemental data provided by Care Evolution.
- *Data Integration:* HSAG identified no concerns with HealthKeepers' procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strength: Within the Access and Preventive Care domain, HealthKeepers ranked at or above the 75th percentile for these measure indicators: *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years,* and *7–11 Years;* and *Adults' Access to Preventive/Ambulatory Health Services—Total.* These rankings indicate that children, young adults, and adults were able to access a PCP at least annually for preventive services and appropriate treatment, as necessary, to stay healthy and reduce unnecessary ER utilization.

Strength: Within the Living With Illness domain, HealthKeepers ranked at or above the 75th percentile for these measure indicators: *Asthma Medication Ratio—Total; Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications;* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications*. The strong performance in the Living With Illness measures related to asthma medication, diabetes screening for

members using antipsychotic medications, and medical assistance with tobacco use indicates that HealthKeepers has established successful processes related to screening for diabetes based on medication usage and medication management and availability.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for HealthKeepers:

- *Adult BMI Assessment*
- *Ambulatory Care—ED Visits—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Why the weakness exists: HealthKeepers' rates for several measure indicators in the Taking Care of Children, Utilization, Access and Preventive Care, Living With Illness, and Behavioral Health domains falling below the HEDIS 2020 25th percentile suggests a lack of access to care or an understanding of recommended or needed care, or that a disparity may exist in access and availability of care. HealthKeepers members are not consistently seeking well and preventive care or managing their behavioral or chronic conditions according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, screening and monitoring visits, or physical activity.

Recommendation: HSAG recommends that HealthKeepers conduct a root cause analysis to determine why members are not consistently following evidence-based care guidelines or receiving recommended screenings, care, or services. HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that HealthKeepers implement

appropriate evidence-based interventions to improve the receipt of diagnosis-specific monitoring visits, well and preventive care, and evidence-based care and services that impact the health of its members and to reduce unnecessary ED use and inpatient utilization.

Assessment of Follow-Up on Prior Recommendations

Table 6-2 includes HSAG's recommendations for improvement and HealthKeepers' actions taken.

Table 6-2—Prior Recommendations and HealthKeepers' Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**HealthKeepers' Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG recommends that HealthKeepers work closely with Care Evolution and HealthKeepers' HEDIS auditor to ensure the source of each record in the supplemental data file is clearly identified so HealthKeepers can ensure this data source is compliant with audit guidelines.	• Continued to work with Care Evolution and our HEDIS auditor to ensure the source of each record in the supplemental data set is clearly identified to ensure this data source is compliant with audit guidelines.
The following HEDIS 2019 measure rates were determined to be opportunities for improvement for HealthKeepers (i.e., fell below the 25th percentile): • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*	• Annually analyzed HEDIS measure rates against national benchmarks and State performance goals to identify opportunities to improve clinical care and service. • Conducted quantitative and qualitative analyses to evaluate the effectiveness of activities in achieving HealthKeepers' clinical and service performance goals. • Took into account, among other things, potential barriers to achieving desired outcomes and interventions or recommended strategies. • Aggregated data to track and trend over time for identification of optimal and suboptimal plan performance. • Recognized the decline in performance with the *Breast Cancer Screening*, *Cervical Cancer Screening*, *Comprehensive Diabetes*, and *Pharmacotherapy Management of COPD* measures and took steps to improve performance. • Implemented the critical performance steering committee and workgroups to

Prior Year Recommendations *From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)*	HealthKeepers' Response (*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)
	implement interventions and monitored performance. • Offered member incentives for completing breast cancer screening or cervical cancer screening. • Provided outreach via telephone to members with scheduled appointments. • Focused outreach via text messaging • Started social media campaigns via Facebook and Instagram. • Created HEDIS alerts in Member 360 and Care Compass. • Implemented the Mammies and Massages program partnering with regional mammography providers and a local massage school to give 10-minute massages to women who attend Clinic Day and complete breast cancer screening (on hold due to COVID-19). • Collaborated with the American Cancer Society (ACS). • Implemented the standing order initiative for breast cancer screenings. • Conducted a Fitbit raffle for members on gap in care report who complete a breast cancer screening. Drawing will be held in October 2021. • Prepared an administrative refresh of HEDIS data monthly. • Provided continuous HEDIS training for case managers/care coordinators. • Used the gap-in-care report to address gaps in care with members. • Educated providers via HEDIS desktop reference guide, Category II HEDIS coding bulletin, and HEDIS coding booklets. • Collaborated with Kroger's The Little Clinic and CVS Minute Clinic—members will be directed to these clinics for needed screenings for A1c, blood pressure, nephropathy, and diabetic retinal exams

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**HealthKeepers' Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
	• Collaborated with eye vendor to close gaps in care related to diabetic retinal eye exams. • Pharmacy utilized a specific retrospective Drug Utilization Review program that specifically addresses COPD. A provider fax is sent to prescribers of members with a gap following discharge.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

Magellan

Magellan's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Magellan submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that Magellan followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Magellan's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Magellan's eligibility system and processes.
- *Provider Data:* HSAG identified no concerns with Magellan's practitioner data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Magellan's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Magellan's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Magellan's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Living With Illness domain, Magellan displayed strong performance in the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measures, which exceeded the 75th percentile. The high level of performance in providing medical assistance with smoking and tobacco use cessation and pharmacotherapy management for COPD indicates that Magellan ensures that providers follow evidence-based clinical guidelines, are being encouraged to participate in smoking cessation and to complete recommended care and services thereby reducing adverse member outcomes and unnecessary ER utilization.

Strength: Within the Behavioral Health domain, Magellan ranked at or above the 75th percentile for these measures: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.* The strong performance in the behavioral health measures indicates that Magellan has improved member access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for Magellan:

- *Adolescent Well-Care Visits*
- *Adult BMI Assessment*
- *Ambulatory Care—ED Visits—Total*
- *Asthma Medication Ratio—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years,* and *12–19 Years*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Use of Opioids From Multiple Providers—Multiple Prescribers and Multiple Pharmacies*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Why the weakness exists: Magellan's PM rates for several measures across several domains falling below the HEDIS 2020 25th percentile suggests a lack of access and use of well and preventive care, behavioral health services, and chronic disease management. Magellan's members are not consistently scheduling or completing follow-up on recommended care or services or scheduling evidence-based care and services. With low performance across several domains, healthcare disparities may exist and members may not have a comprehensive understanding of their healthcare needs or benefits. Magellan members may need the tools and support to consistently manage their healthcare conditions according to evidence-based guidelines and preventive health schedules.

Recommendation: HSAG recommends that Magellan conduct a root cause analysis or focus groups to identify the reasons why members are not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions. HSAG recommends that Magellan analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of root causes, HSAG recommends that Magellan implement appropriate evidence-based interventions to improve access to, and timeliness of care and services across low-scoring healthcare domains.

Assessment of Follow-Up on Prior Recommendations

Table 6-3 includes HSAG's recommendations for improvement and Magellan's actions taken.

Table 6-3—Prior Recommendations and Magellan's Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**Magellan's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG recommends that, for future reporting, Magellan review provider specialty mapping to ensure the mappings are compliant with NCQA provider specialty guidelines.	• Acknowledged the need to adjust annually the provider specialty mapping to conform to NCQA's HEDIS updates and does so. • Sought validation by its HEDIS auditor prior to rate finalization.
The following HEDIS 2019 measure rates were determined to be opportunities for improvement for Magellan (i.e., fell below the 25th percentile):	Acknowledged that the listed measures were opportunities for improvement and strived annually to make improvements in these rates. All of these measures' rates improved from the

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**Magellan's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
• *Cervical Cancer Screening* • *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* • *Adolescent Well-Care Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* • *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*	prior year. Across the 13 measures listed, there was a combined average rate improvement of 4 percentage points. There were eight that improved, two with less than a percentage point change, and three that declined.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report.	

Optima

Optima's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Optima submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that Optima followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with Optima's claims system or processes.

- *Enrollment Data:* HSAG identified no concerns with Optima's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Optima's practitioner data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Optima's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with Optima's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Optima's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Access and Preventive Care domain, Optima met or exceeded the 75th percentile for these measures: *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months and 25 Months–6 Years.* Optima's performance indicates that adults, children, and young adults are able to access a PCP at least annually for preventive services and appropriate treatment as necessary to stay healthy and reduce unnecessary ER utilization.

Strength: Within the Behavioral Health domain, Optima displayed strong performance, with the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total—Total* measure meeting or exceeding the 75th percentile. The strong performance in the behavioral health measure indicates that Virginia and the MCOs have improved access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Strength: Within the Living With Illness domain, Optima displayed strong performance for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* measure, which exceeded the 75th percentile. The strong performance in the smoking cessation measure indicates that the MCO has established successful processes to connect members to the resources needed to quit tobacco use.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for Optima:

- *Adolescent Well-Care Visits*
- *Adult BMI Assessment*
- *Ambulatory Care—ED Visits—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*

- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Immunizations for Adolescent—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD—Total—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Why the weakness exists: Optima's PM rates in the Taking Care of Children, Access and Preventive Care, Behavioral Health, Use of Opioids, and Living With Illness domains falling below the HEDIS 2020 25th percentile suggests a lack of access to preventive care, screenings, behavioral healthcare, and care for chronic conditions. Optima's members are not consistently scheduling well visits or receiving immunizations according to the recommended schedules. Chronic care PM results indicate that members may not understand care recommendations or follow up on evidence-based care and services. With low performance across several domains, healthcare disparities may exist or members may not have a comprehensive understanding of their healthcare needs or benefits. Optima members may need the tools and support to consistently manage their healthcare conditions according to evidence-based guidelines and preventive health schedules.

Recommendation: HSAG recommends that Optima conduct a root cause analysis or focus group to determine why members are not receiving well visits, immunizations, and screenings according to recommended schedules. HSAG also recommends that Optima conduct similar processes and analyses of data to better understand barriers members experience in receiving behavioral healthcare and care for chronic conditions. HSAG recommends that Optima consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that Optima implement appropriate interventions to improve access to, and timeliness of well visits, screenings, behavioral healthcare, and recommended services for members diagnosed with a chronic condition.

Assessment of Follow-Up on Prior Recommendations

Table 6-4 includes HSAG's recommendations for improvement and Optima's actions taken.

Table 6-4—Prior Recommendations and Optima's Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**Optima's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG PMV auditors indicated that Optima's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. Optima's systems appear to support accurate PM production.	Optima continued current practices to ensure this process continued to be successful in reporting of measures.
• *Adult BMI Assessment* • *Cervical Cancer Screening* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* • *Adolescent Well-Care Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)* • *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator and Systemic Corticosteroid*	• Sent birthday card reminder to health plan members 18–85 years old of preventive health screenings. • Sent postcard reminder to noncompliant women 21+ years old on cervical cancer screening (sent during birthday month). • Sent list of noncompliant women for birthday month to physicians monthly. • Sent letter to providers of members with cervical care gap every month. • Reviewed clinical guidelines and updated every two years and as needed. • Notified providers of updated clinical guidelines via newsletter and provider site. • Articles in the member newsletter. • Utilized PreManage reports to identify members who fall into denominator of measure. • Engaged members to follow up with provider. • Assisted members with follow-up visit reminder, scheduling, transportation needs, etc., pre- and post-appointment. • Used adolescent well-child visit incentive program. • Utilized EmmiManager for educational videos. • Used care gap reports to identify members with gaps. • Conducted diabetic eye exam campaign with IEG annually Aug–Sept. • Implemented Emmi engage video email campaign Jun–Nov 2020.

Prior Year Recommendations *From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)*	**Optima's Response** (*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)
	• Used Tableau dashboard care gap identification. • Completed EmmiManager CCS Training—July 2020 • Used Prealize data in workflow. • Started diabetic eye exam incentive program—October 2019 • Improved and enhanced Sentara diabetes class communication with Sentara providers and Optima members about the Sentara diabetes classes offered that do not require a provider referral. This includes updating the website and engaging Sentara hospitals and providers. • Notified members of program eligibility requirements on Optima Health website, benefit flyer, and email. • Provided members reminders to complete diabetic screenings (laboratory test, diabetic eye exam, diabetic neuropathy). • Encouraged members to take medications as prescribed. • Offered Optima disease management services. • Encouraged members to take medications as prescribed.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

United

United's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that United submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that United followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters:* HSAG identified no concerns with United's claims system or processes.

- *Enrollment Data:* HSAG identified no concerns with United's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with United's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with United's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with United's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with United's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Living With Illness domain, United displayed strong performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medication* measures, which met or exceeded the 75th percentile. This level of performance for these measures indicates that providers serving members with a behavioral health diagnosis taking antipsychotic medications are following evidence-based screenings and clinical guidelines and encouraging members to complete recommended care and services thereby reducing adverse member outcomes and unnecessary ER utilization. The results also indicate that members are receiving services and supports necessary to quit tobacco use.

Strength: Within the Access and Preventive Care Domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, which met or exceeded the 75th percentile. This level of performance in providing access to care for adults indicates that United is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged to complete recommended care and services thereby reducing adverse member outcomes and unnecessary ER utilization.

Strength: Within the Behavioral Health domain, United ranked at or above the 75th percentile for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment and Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total—Total* measures. The strong performance in these measures indicates that United has improved access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Weaknesses

Weakness: HSAG identified that State reporting requirements continue to be a challenge due to the timing as well as the communication flow of the organization.

Recommendation: HSAG recommends that United continue to evaluate its processes and communication flow to identify opportunities for further improvement in meeting State reporting requirements.

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for United:

- *Adolescent Well-Care Visits*
- *Ambulatory Care—ED Visits—Total*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, 7–11 Years,* and *12–19 Years*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Why the weakness exists: Several of United's PM rates in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below the HEDIS 2020 25th percentile suggests a lack of access or understanding of the need for preventive care, screenings, behavioral healthcare, and care for chronic conditions. United's members are not consistently scheduling well visits or cancer screenings; adults and children are not accessing care or services according to evidence-based recommendations; and members with a behavioral health diagnosis or chronic conditions are not consistently following evidence-based, diagnosis-specific care and recommendations. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. United members may need the tools and support to consistently manage their healthcare conditions according to evidence-based guidelines and preventive health schedules.

Recommendation: HSAG recommends that United conduct a root cause analysis or focus group(s) to determine why members are not consistently receiving well care, screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules or evidence-based guidelines. HSAG also recommends that United conduct data analyses to better understand barriers members may experience in receiving care for chronic conditions. HSAG recommends that United consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that United implement appropriate interventions to improve access to and timeliness of preventive visits, screenings, and recommended services for members diagnosed with a chronic condition.

Assessment of Follow-Up on Prior Recommendations

Table 6-5 includes HSAG's recommendations for improvement and United's actions taken.

Table 6-5—Prior Recommendations and United's Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**United's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG recommends that United work closely with its vendors and their HEDIS auditor to ensure the data sources are compliant with audit guidelines to be considered as standard supplemental data sources.	HSAG identified no concerns with United's supplemental data systems and processes, and United continues to work with our HEDIS auditor to ensure data sources are compliant for supplemental data.
The following HEDIS 2019 measure rates were determined to be opportunities for improvement for United (i.e., fell below the 25th percentile): • *Adult BMI* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total* • *Adolescent Well-Care Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* • *Asthma Medication Ratio—Total* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*	• Completed annual reminders for preventive care visits which include BMI assessment. • Conducted women's health email campaign to encourage members' cervical and breast cancer health screenings. • Included screening information in member newsletters. • Sent parents reminders each year in their child's birthday month to encourage preventive care, including messaging about wellness visits and potential vaccinations needs. • Completed behavioral health and/or medical care coordinators' outreach to members on discharge to assist with appointment scheduling and transportation assistance, as needed. • Encouraged telehealth visits for follow-up care. • Ensured members scheduled a follow-up appointment after an emergency department visit or hospitalization for a mental health condition. • Utilized motivational interviewing when working with members to address barriers, particularly those that could impede receiving follow-up care.

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**United's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
• *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*	• Implemented Member Rewards program to incentivize members when they complete a well-care visit. • Used live agent outreach to assist parents or member with appointment scheduling and arranging transportation, as needed. • Sent parents reminders each year in their child's birthday month to encourage preventive care, including messaging about wellness visits and potential vaccinations needs. • Provided messaging to pediatricians about documentation of assessments and counseling. • Care coordinators educated members and parents on appropriate medication management including ways to incorporate inhalers into daily routine. • Developed and used a member self-management plan to prevent and control asthma attacks, including reduction of asthma triggers. • Implemented provider incentive program to help close gaps in care. Reports delivered to physicians monthly that provided data on noncompliant members for patient outreach. • Used Member Rewards program to incentivize members when they completed a diabetic A1c blood sugar (HbA1c) test or eye exam. • Offered in-home retinal eye exam to members. • Case management outreached to members for education on the disease and appropriate screenings/testing. • Completed more frequent complex case management outreach to high-risk members with multiple chronic conditions.

Prior Year Recommendations *From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)*	**United's Response** (*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)
	• Used complex care management for members with COPD. • Developed and used a self-management plan with actions to take based on daily symptoms. Includes appropriate use and timing of quick relief inhalers and oral steroids and when to seek medical attention.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

VA Premier

VA Premier's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that VA Premier submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG determined that VA Premier followed the measure specifications and produced reportable rates for all measures in the scope of the validation of PMs. Additionally, HSAG found the following based on its PMV:

- *Medical Service Data (Claims/Encounters:* HSAG identified no concerns with VA Premier's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with VA Premier's eligibility system or processes.
- *Provider Data:* The MCO's mapping of native provider specialties to HEDIS provider types was reviewed. It was noted that the MCO's HEDIS auditor approved the mapping of multiple physician specialties to PCP. The mapping of the Occupational Therapy for Low Vision specialty to a vision care provider was also approved. During the audit, VA Premier staff confirmed that specialists were not considered to be PCPs. The auditor requested that VA Premier provide member-level detail for all members who met administrative numerator compliance for *Adolescent Well-Care Visits (AWC)* and *Comprehensive Diabetes Care (CDC)—Eye Exam (Retinal) Performed* indicator. Provider specialties associated with numerator-compliant services were analyzed and found to meet HEDIS technical specifications for both measures. Therefore, the erroneous mapping did not affect PM rates. VA Premier will correct the provider specialty mapping before calculating future PM rates. HSAG identified no other concerns with VA Premier's practitioner data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with VA Premier's medical record review processes.
- *Supplemental Data:* HSAG identified no concerns with VA Premier's supplemental data systems and processes.

- *Data Integration:* HSAG identified no concerns with VA Premier's procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Within the Access and Preventive Care domain, VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years,* and *12–19 Years* measures, all meeting or exceeding the 75th percentile. The high level of performance in providing access to care for children and adults indicates that VA Premier is ensuring that providers follow recommended preventive and well-care schedules thereby reducing adverse member outcomes and unnecessary ER utilization.

Strength: Within the Behavioral Health domain, VA Premier ranked at or above the 75th percentile for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia and Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment measures.*

The strong performance in these behavioral health measures indicates that VA Premier has improved access to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

Strength: Within the Living With Illness domain, VA Premier displayed strong performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* measures, which met or exceeded the 75th percentile. The level of performance in providing diabetes screening for people with behavioral health diagnosis and smoking cessation care indicates that VA Premier is ensuring that providers follow evidence-based clinical guidelines and that members are being encouraged and provided support to quit tobacco use.

Weaknesses

Weakness: HSAG identified that VA Premier had some challenges in its use and the accuracy of supplemental data sources, such as electronic medical record data from provider offices. VA Premier also had some challenges with ensuring value set code mapping was reviewed and updated appropriately. HSAG also identified that VA Premier has an opportunity to explore potential data sources to impact the electronic clinical data systems (ECDS) measures and enable future reporting. The MCO did not consistently map provider specialties to HEDIS provider types according to NCQA guidelines.

Why the weakness exists: New data sources require the development and implementation of processes to ensure the accuracy and completion of the data received from the data source.

Recommendation: HSAG recommends that VA Premier implement processes to continue to conduct PSV of a sample of data from each provider office that provides supplemental data through electronic medical record feeds and to review and update any value set code mapping that is implemented, as needed. HSAG also recommends VA Premier explore potential data sources to impact the ECDS measures and enable future reporting, as VA Premier did not report these measures. HSAG recommends that VA Premier ensure that the mapping of provider specialties to HEDIS provider types is compliant with NCQA guidelines.

Weakness: The following HEDIS 2020 measure rates fell below the HEDIS 2020 25th percentile and were determined to be opportunities for improvement for VA Premier:

- *Adult BMI Assessment*
- *Ambulatory Care—ED Visits—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*

Why the weakness exists: Several of VA Premier's PM rates in the Access and Preventive Care, Living With Illness, Behavioral Health, and Taking Care of Children domains falling below the HEDIS 2020 25th percentile suggests members may not have adequate access to well and preventive care, screenings, behavioral healthcare, and care for chronic conditions. VA Premier's members are not consistently scheduling well visits or cancer screenings; adults are not accessing care or services according to evidence-based chronic care recommendations; and members with a behavioral health diagnosis are not receiving appropriate follow-up after prescribing. With low performance across several domains, healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. VA Premier members may need the tools to consistently manage their healthcare conditions according to evidence-based guidelines and preventive health schedules.

Recommendation: HSAG recommends that VA Premier conduct root cause or data analysis or conduct focus group(s) to determine why members are not consistently receiving well visits, preventive screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules. HSAG recommends that VA Premier consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that VA Premier implement appropriate interventions to improve access to and timeliness of well and preventive visits and screenings and recommended services for members diagnosed with a behavioral health or chronic condition, and follow-up assistance to ensure services are scheduled and received.

Assessment of Follow-Up on Prior Recommendations

Table 6-6 includes HSAG's recommendations for improvement and VA Premier's actions taken.

Table 6-6—Prior Recommendations and VA Premier's Actions

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**VA Premier's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
HSAG PMV auditors indicated that VA Premier's measure data were compliant with HEDIS and DMAS specifications and that the data, as reported, were valid. VA Premier's systems appear to support accurate PM production.	• VA Premier's Quality Measures Improvement Committee, which reports to the Quality Improvement Committee, met on a quarterly basis to monitor, track, and trend HEDIS data. • The Quality Leadership and Data Teams, who met monthly, continued to monitor and track HEDIS measures based on technical specifications to ensure ongoing compliancy.
The following HEDIS 2019 measure rates were determined to be opportunities for improvement for VA Premier (i.e., fell below the 25th percentile): • *Adult BMI Assessment* • *Cervical Cancer Screening* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Adolescent Well-Care Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—*	• Generated a measures dashboard as a means of ongoing monitoring and will continue to track and trend the success of each measure and adjust interventions, when needed. • Developed a dedicated quality measures improvement committee. This committee included representatives from each operational area within the organization. This committee's sole function was to discuss measure improvement opportunities which included monitoring, tracking, and trending of rates month-over-

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**VA Premier's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*	month and year-over-year. Measures were assigned to a business owner and interventions were tracked within an interventions grid and reviewed monthly for any updates or changes. • Conducted wellness events through VA Premier's population health program. • Used interactive voice response and live telephonic calls. • Implemented text messaging campaign. • Used enhanced care coordination program. • Behavioral health chronic care coordinators worked with the enhanced care coordination program that required targeted case managers employed with Community Service Boards to conduct seven-day follow-up with members discharged from acute facilities. • Behavioral health inpatient reviewers sent a letter to the member's PCP notifying them [the PCP] of the inpatient admission and scheduled follow-up appointments. • Completed behavioral Health recommendations to regional transition care. • Used coordinators/case manager and transition care coordinator on discharge planning to support a member's behavioral health needs. • Conducted chronic care management program outreach. • Conducted assessments to coordinate care services for the member. • Encouraged members to have spirometry testing to officially diagnose chronic obstructive pulmonary disease (COPD). • Conducted COPD assessments to coordinate care services for the member. • Mailed educational materials to members.

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for Validation of Performance Measures—NCQA HEDIS Compliance Audit (Medicaid)***	**VA Premier's Response** **(*Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting*)**
	• Encouraged members to take the pneumonia vaccine to prevent future exacerbations.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

7. Review of Compliance With Medicaid and CHIP Managed Care Regulations

During 2020, HSAG did not conduct MCO operational and systems review activities for the CCC Plus program. During 2020, DMAS monitored the MCOs' implementation of federal and State requirements and corrective action plans from prior years' compliance reviews.

8. Member Experience of Care Survey

Overview

This section presents HSAG's MCO-specific results and conclusions of the member experience of care surveys conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively the MCOs has addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

The CAHPS surveys were conducted for Virginia's CCC Plus managed Medicaid population to obtain information on the levels of satisfaction of adult and child Medicaid members. For the CCC Plus MCOs (Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier), the technical method of data collection was conducted through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCOs.

MCO-Specific Results

Aetna

Table 8-1 and Table 8-2 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for Aetna were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-1—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: Aetna

	2019	2020
Global Ratings		
Rating of Health Plan	63.1%	64.8%
Rating of All Health Care	55.0%	56.1%
Rating of Personal Doctor	70.4%	73.4%
Rating of Specialist Seen Most Often	71.1%	70.8%
Composite Measures		
Getting Needed Care	87.3%	83.8%
Getting Care Quickly	83.2%	86.2%

	2019	2020
How Well Doctors Communicate	91.5%	92.7%
Customer Service	90.8%	88.2%

Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Aetna's 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Aetna scored statistically significantly higher than the 2020 NCQA adult Medicaid national average on one measure, *Getting Care Quickly*.

Weaknesses

Weakness: Aetna did not score statistically significantly higher in 2020 than in 2019 on any measure.

Why the weakness exists: Based on the adult survey results, Aetna did not achieve statistically significant improvement in survey rates other than for the measure *Getting Care Quickly*. The results indicate an opportunity for Aetna to focus on overall activities that will improve the member experience of care.

Recommendation: HSAG recommends that Aetna focus evidence-based quality improvement efforts on activities and interventions that have an overall impact on improving member experience and satisfaction of care.

Table 8-2—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: Aetna

	2019	2020
Global Ratings		
Rating of Health Plan	65.4%	69.3%
Rating of All Health Care	65.3%	63.9%
Rating of Personal Doctor	71.9%	74.1%
Rating of Specialist Seen Most Often	74.3%	75.0%+
Composite Measures		
Getting Needed Care	86.1%	89.9%
Getting Care Quickly	92.3%	89.4%
How Well Doctors Communicate	94.3%	93.1%

	2019	2020
Customer Service	92.6%+	83.7%+

+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Aetna's 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: There were no identified strengths for Aetna.

Weaknesses

Weakness: Aetna scored statistically significantly lower than the 2020 NCQA child Medicaid national average on one measure, *Rating of All Health Care*. Aetna did not score statistically significantly higher in 2020 than in 2019 on any measure.

Why the weakness exists: Based on the child survey results, Aetna members indicated a lack of satisfaction with *Rating of All Health Care.* The results may indicate that members are experiencing access to care issues or have a lack of understanding of how to access care and services.

Recommendation: HSAG recommends that Aetna focus quality improvement efforts on the measure that exhibited a statistically significant lower score than the 2020 NCQA Medicaid national average (i.e., *Rating of All Health Care* for the child Medicaid population*)*. HSAG recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as an area of low performance. HSAG also recommends that Aetna focus initiatives on raising member satisfaction regarding overall healthcare and continue to monitor the measures to ensure there are no significant decreases in scores over time.

Assessment of Follow-Up on Prior Recommendations

Table 8-3 includes HSAG's recommendations for improvement and Aetna's actions taken.

Table 8-3—CAHPS Survey Recommendations and Aetna's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for CAHPS***	**Aetna's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommends that Aetna continue to monitor the measures to ensure there are no significant decreases in rates over time.	• Continued to monitor CAHPS composite measures per HSAG recommendations.

Prior Year Recommendations *From the CY 2019 EQR Technical Report for CAHPS*	Aetna's Response *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendation in the prior year's annual technical report. The MCO did not provide specific initiatives or actions implemented for monitoring the measures.	

HealthKeepers

Table 8-4 and Table 8-5 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for HealthKeepers were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-4—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: HealthKeepers

	2019	2020
Global Ratings		
Rating of Health Plan	59.3%	63.2%
Rating of All Health Care	53.7%	57.1%
Rating of Personal Doctor	68.5%	72.1%
Rating of Specialist Seen Most Often	72.0%	70.2%
Composite Measures		
Getting Needed Care	87.0%	86.9%
Getting Care Quickly	88.2%	86.2%
How Well Doctors Communicate	91.5%	94.1%
Customer Service	89.3%	92.4%

Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: HealthKeepers scored statistically significantly higher than the 2020 NCQA adult Medicaid national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Weaknesses

Weakness: HealthKeepers did not score statistically significantly higher in 2020 than in 2019 on any measure.

Why the weakness exists: Based on the adult survey results, HealthKeepers did not achieve statistically significant improvement in survey rates other than for the measures *Getting Needed Care* and *Getting Care Quickly*. The results indicate an opportunity for HealthKeepers to focus on quality improvement activities that will improve the members' experience with care.

Recommendation: HSAG recommends that HealthKeepers focus evidence-based quality improvement efforts on activities and interventions that have an overall impact on improving members' experience and satisfaction with healthcare services.

Table 8-5—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: HealthKeepers

	2019	2020
Global Ratings		
Rating of Health Plan	60.2%	55.4%
Rating of All Health Care	65.0%	64.9%
Rating of Personal Doctor	77.2%	75.6%
Rating of Specialist Seen Most Often	70.1%	70.0%
Composite Measures		
Getting Needed Care	85.4%	86.1%
Getting Care Quickly	92.2%	94.4%
How Well Doctors Communicate	92.8%	95.9%▲
Customer Service	79.3%	88.2%▲

▲ Statistically significantly higher in 2020 than in 2019.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: HealthKeepers scored statistically significantly higher than the 2020 NCQA child Medicaid national average on one measure, *Getting Care Quickly*.

Weaknesses

Weakness: HealthKeepers scored statistically significantly lower than the 2020 NCQA child Medicaid national average on two measures: *Rating of Health* Plan and *Rating of All Health Care*. HealthKeepers scored statistically significantly higher in 2020 than in 2019 on two measures: *How Well Doctors Communicate* and *Customer Service*. measure.

Why the weakness exists: Quality improvement efforts focused on the members' experience with care and services did not result in an improvement in their experience with Health**K**eepers' customer service or in communicating with their doctors.

Recommendation: HSAG recommends that HealthKeepers focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages (i.e., *Rating of Health Plan* and *Rating of All Health Care* for the child Medicaid population). HSAG also recommends that HealthKeepers conduct a root cause analysis of study indicators that have been identified as areas of low performance. HSAG recommends that HealthKeepers focus best practice quality improvement initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases.es over time.

Assessment of Follow-Up on Prior Recommendations

Table 8-6 includes HSAG's recommendations for improvement and HealthKeepers' actions taken.

Table 8-6—CAHPS Survey Recommendations and HealthKeepers' Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for CAHPS***	**HealthKeepers' Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommends that HealthKeepers focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. HealthKeepers could conduct a root cause analysis of study indicators that have been identified as areas of low performance.	• Took steps to focus quality improvement efforts on measures that declined or fell below the 50th percentile. • Formed the CAHPS workgroup, consisting of associates across the health plan to review the results of the surveys and conduct root-cause analysis studies to identify key drivers and barriers. • Determined priorities and took specific actions for improvement. • Presented the results of the analysis to the Quality Management Committee for discussion and approval. • Implemented interventions/improvements to address the decline in scores.

Prior Year Recommendations *From the CY 2019 EQR Technical Report for CAHPS*	**HealthKeepers' Response** *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
	• Held annual internal CAHPS awareness training for all associates. • Educated providers about CAHPS via newsletter and provider portal. • Gave providers the opportunity to earn CME [continuing medical education] credits by taking a Provider CAHPS awareness training geared to understanding "What Matters Most." • Educated members about CAHPS via Member Advisory Committee meetings, SMS/IVR [short message service/interactive voice response] and social media campaigns. • Reviewed data collected for member complaints, appeals, prior authorization denials, quality of care concerns, and voice of the customer reports to assess the member experience.
HSAG recommends that HealthKeepers continue to monitor the measures to ensure there are no significant decreases in rates over time.	• Continued to focus quality improvement efforts on measures to ensure that there are no significant decreases in rates over time. • Continued to conduct root-cause analysis studies to identify key drivers and barriers. • Determined priorities and took specific actions for improvement.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

Magellan

Table 8-7 and Table 8-8 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for Magellan were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-7—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: Magellan

	2019	2020
Global Ratings		
Rating of Health Plan	59.6%	61.3%
Rating of All Health Care	56.3%	53.5%
Rating of Personal Doctor	72.5%	70.4%
Rating of Specialist Seen Most Often	68.1%	68.6%
Composite Measures		
Getting Needed Care	80.7%	79.0%
Getting Care Quickly	79.1%	81.6%
How Well Doctors Communicate	90.1%	91.8%
Customer Service	84.8%	88.9%

Strengths, Weaknesses, and Recommendations

Magellan's 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Strengths

Strength: Magellan did not have any identified strengths.

Weaknesses

Weakness: Magellan did not have any identified weaknesses.

Table 8-8—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: Magellan

	2019	2020
Global Ratings		
Rating of Health Plan	62.8%+	50.6%
Rating of All Health Care	60.3%+	55.7%
Rating of Personal Doctor	71.3%+	75.9%
Rating of Specialist Seen Most Often	71.7%+	69.4%+
Composite Measures		
Getting Needed Care	88.4%+	83.4%+
Getting Care Quickly	87.8%+	86.2%+

	2019	2020
How Well Doctors Communicate	92.9%+	93.8%
Customer Service	85.1%+	82.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Magellan's 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Magellan did not have any identified strengths.

Weaknesses

Weakness: Magellan scored statistically significantly lower than the 2020 NCQA child Medicaid national average on two measures: *Rating of Health Plan* and *Rating of All Health Care*. Magellan did not score statistically significantly higher or lower in 2020 than in 2019 on any measure

Why the weakness exists: Based on the results of the child CAHPS survey, not all members are satisfied with the MCO or the provision of healthcare. This may be due to accessibility issues or a lack of members' understanding of how to access care and services.

Recommendation: HSAG recommends that Magellan focus evidence-based quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages (i.e., *Rating of Health Plan* and *Rating of All Health Care* for the child Medicaid population). HSAG recommends that Magellan conduct a root cause analysis of study indicators that have been identified as areas of low performance. HSAG recommends that Magellan focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time. HSAG recommends that Magellan focus on increasing response rates to the CAHPS survey for its child population so that there are greater than 100 respondents for each measure.

Assessment of Follow-Up on Prior Recommendations

Table 8-9 includes HSAG's recommendations for improvement and Magellan's actions taken.

Table 8-9—CAHPS Survey Recommendations and Magellan's Response

Prior Year Recommendations *From the CY 2019 EQR Technical Report for CAHPS*	**Magellan's Response** *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
HSAG recommends that Magellan continue to monitor the measures to ensure there are no significant decreases in rates over time.	• COVID-19 had a significant negative impact on response rates to the 2020 survey and may also have a similar impact on the 2021 survey. • Planned to monitor the measure rates and implement interventions to increase the rates over time.
HSAG recommends that Magellan focus on increasing response rates to the CAHPS survey for its child population so there are greater than 100 respondents for each measure.	• COVID-19 had a significant negative impact on response rates to the 2020 survey and may also have a similar impact on the 2021 survey. • Planned additional interventions to encourage a higher response rate to the 2021 survey.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. The MCO did not provide specific initiatives or actions implemented for monitoring the measures and rates.	

Optima

Table 8-10 and Table 8-11 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for Optima were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-10—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: Optima

	2019	**2020**
Global Ratings		
Rating of Health Plan	63.4%	68.6%
Rating of All Health Care	56.6%	59.5%
Rating of Personal Doctor	69.4%	73.4%
Rating of Specialist Seen Most Often	73.5%	70.5%
Composite Measures		
Getting Needed Care	84.6%	85.5%
Getting Care Quickly	84.5%	83.5%

	2019	2020
How Well Doctors Communicate	92.0%	93.8%
Customer Service	90.4%	91.3%

Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Optima's 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Optima scored statistically significantly higher than the 2020 NCQA adult Medicaid national average on one measure, *Rating of Health Plan*.

Weaknesses

Weakness: Optima did not score statistically significantly higher or lower in 2020 than in 2019 on any measure.

Why the weakness exists: Quality improvement efforts focused on the members' experience with care and services did not result in survey response rate improvement.

Recommendation: HSAG recommends that Optima focus quality improvement efforts on improving overall members' experience with care and services.

Table 8-11—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: Optima

	2019	2020
Global Ratings		
Rating of Health Plan	65.7%	66.1%
Rating of All Health Care	62.9%	67.5%
Rating of Personal Doctor	76.6%	79.0%
Rating of Specialist Seen Most Often	71.4%	72.3%
Composite Measures		
Getting Needed Care	85.6%	87.6%
Getting Care Quickly	91.9%	93.1%
How Well Doctors Communicate	94.5%	94.4%
Customer Service	89.5%	88.6%

Strengths, Weaknesses, and Recommendations

Optima's 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Strengths	**Strength:** Optima did not have any identified strengths.
Weaknesses	**Recommendation:** HSAG recommends that Optima continue to monitor the measure results to ensure there are no significant decreases in scores over time.

Assessment of Follow-Up on Prior Recommendations

Table 8-12 includes HSAG's recommendations for improvement and Optima's actions taken.

Table 8-12—CAHPS Survey Recommendations and Optima's Response

Prior Year Recommendations *From the CY 2019 EQR Technical Report for CAHPS*	**Optima's Response** *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
HSAG recommends that Optima focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. Optima could conduct a root cause analysis of study indicators that have been identified as areas of low performance.	• Commenced action planning meetings to address low performance measures.
HSAG recommends that Optima continue to monitor the measures to ensure there are no significant decreases in rates over time.	• Continued to monitor measures on a monthly basis and implemented action plans to address any significant decreases as needed.
HSAG Assessment: HSAG has determined that the MCO has not addressed the recommendations in the prior year's annual technical report. The MCO did not provide specific initiatives or actions implemented for monitoring the measures and rates.	

United

Table 8-13 and Table 8-14 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for United were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-13—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: United

	2019	2020
Global Ratings		
Rating of Health Plan	63.5%	66.0%
Rating of All Health Care	54.7%	59.3%
Rating of Personal Doctor	64.0%	72.0%▲
Rating of Specialist Seen Most Often	70.9%	68.2%
Composite Measures		
Getting Needed Care	84.6%	80.9%
Getting Care Quickly	82.0%	86.5%
How Well Doctors Communicate	90.7%	92.6%
Customer Service	86.0%	88.3%

▲ Statistically significantly higher in 2020 than in 2019.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: United scored statistically significantly higher than the 2020 NCQA adult Medicaid national average on one measure, *Getting Care Quickly*. United scored statistically significantly higher in 2020 than in 2019 on one measure, *Rating of Personal Doctor*.

Weaknesses

Weakness: There were no identified weaknesses for United.

Table 8-14—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: United

	2019	2020
Global Ratings		
Rating of Health Plan	52.6%	60.0%
Rating of All Health Care	61.1%+	67.6%
Rating of Personal Doctor	73.5%+	74.8%
Rating of Specialist Seen Most Often	66.7%+	83.6%+▲

	2019	2020
Composite Measures		
Getting Needed Care	81.3%+	86.4%+
Getting Care Quickly	87.2%+	92.2%+
How Well Doctors Communicate	96.5%+	94.7%+
Customer Service	82.2%+	92.6%+

+ *Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.*
▲ *Statistically significantly higher in 2020 than in 2019.*
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: United scored statistically significantly higher than the 2020 NCQA child Medicaid national average on one measure, *Rating of Specialist Seen Most Often*. Conversely, United scored statistically significantly lower than the 2020 NCQA child Medicaid national average on one measure, *Rating of Health Plan*.

United scored statistically significantly higher in 2020 than in 2019 on one measure, *Rating of Specialist Seen Most Often*.

Weaknesses

Weakness: United scored statistically significantly lower than the 2020 Medicaid national average on the *Rating of Health Plan* measure for the child Medicaid population.

Why the weakness exists: Members' rating of the health plan may reflect their experience with customer service, access and availability of care and services, or other factors that are associated with their overall experience in receiving care or services through the MCO.

Recommendation: HSAG recommends that United focus evidence-based quality improvement efforts on the measure that scored statistically significantly lower than the 2020 Medicaid national average (i.e., *Rating of Health Plan* for the child Medicaid population). HSAG recommends that United conduct a root cause analysis of the study indicator that has been identified as an area of low performance. HSAG recommends that United focus best practice initiatives on raising the statistically significantly lower score and continue to monitor the measure results to ensure there are no significant decreases in scores over time. HSAG recommends that United focus on increasing response rates to the CAHPS survey for its child population so that there are greater than 100 respondents for each measure.

Assessment of Follow-Up on Prior Recommendations

Table 8-15 includes HSAG's recommendations for improvement and United's actions taken.

Table 8-15—CAHPS Survey Recommendations and United's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for CAHPS***	**United's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
HSAG recommends that United focus quality improvement efforts on measure scores that were statistically significantly lower than the NCQA Medicaid national averages. United could conduct a root cause analysis of study indicators that have been identified as areas of low performance.	• Presented CAHPS results in the Quality Management Committee meeting to identify indicators that showed low performance. • Looked at four surveys, Medallion and CCC Plus adult and child, and identified the areas as opportunities from two main topics: 1. Healthcare overall − Identified for improvement from all surveys. 2. Physician/member communication − Doctor listened carefully − Doctor spent enough time − Doctor showed respect • Identified as top opportunities for Medallion adult and child, and CCC Plus adult surveys. The CCC Plus child survey showed these as strengths. To address healthcare overall: • Supported members through enhanced benefits for greater access to care. • Used care coordination to assist members with navigating in the health system. To address physician/member communication: • Published a list of tips to remind providers to use simple choices in words and information depth to affect the quality of one-to-one communication between the patient and physician. • Published articles for members on how to prepare for their physician office visit to get the most out of the interaction.

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for CAHPS***	**United's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***
	• Advised members they could change their PCP to ensure they had one that could meet their needs, especially for language and cultural preferences.
HSAG recommends that United continue to monitor the measures to ensure there are no significant decreases in rates over time.	• Continued to monitor rates over time for potential decreases.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

VA Premier

Table 8-16 and Table 8-17 present the 2020 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. The 2020 CAHPS scores for VA Premier were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-16—Comparison of 2019 and 2020 Adult Medicaid CAHPS Results: VA Premier

	2019	2020
Global Ratings		
Rating of Health Plan	62.3%	67.1%
Rating of All Health Care	55.4%	56.8%
Rating of Personal Doctor	73.7%	72.2%
Rating of Specialist Seen Most Often	68.3%	77.6%
Composite Measures		
Getting Needed Care	87.8%	86.2%
Getting Care Quickly	87.9%	85.9%
How Well Doctors Communicate	90.7%	94.0%
Customer Service	93.6%	93.4%

Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

VA Premier's 2019 and 2020 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: VA Premier scored statistically significantly higher than the 2020 NCQA adult Medicaid national average on two measures: *Rating of Specialist Seen Most Often* and *Customer Service*.

Weaknesses

Weakness: VA Premier did not score statistically significantly higher or lower in 2020 than in 2019 on any measure.

Why the weakness exists: VA Premier's quality improvement efforts focused on the members' experience with care and services did not result in survey response rate improvement.

Recommendation: HSAG recommends that VA Premier focus evidence-based quality improvement efforts on improving overall member experience with care and services.

Table 8-17—Comparison of 2019 and 2020 Child Medicaid CAHPS Results: VA Premier

	2019	2020
Global Ratings		
Rating of Health Plan	67.1%+	73.0%
Rating of All Health Care	63.6%+	74.1%
Rating of Personal Doctor	74.2%+	84.2%
Rating of Specialist Seen Most Often	70.2%+	78.0%+
Composite Measures		
Getting Needed Care	90.2%+	91.4%
Getting Care Quickly	97.3%+	95.2%+
How Well Doctors Communicate	96.4%+	97.7%
Customer Service	83.8%+	88.0%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

VA Premier's 2019 and 2020 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: VA Premier scored statistically significantly higher than the 2020 NCQA child Medicaid national average on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

Weaknesses	**Weakness:** VA Premier did not score statistically significantly higher or lower in 2020 than in 2019 on any measure. VA Premier experienced a low response rate with less than 100 respondents for some measures. **Why the weakness exists:** The MCO's quality improvement efforts focused on the members' experience with care and services did not result in survey response rate improvement. **Recommendation:** HSAG recommends that VA Premier focus evidence-based quality improvement efforts on improving overall members' experience with care and services. HSAG recommends that VA Premier continue to monitor the measure results to ensure that there are no significant decreases in scores over time. HSAG recommends that VA Premier focus on best practices for increasing response rates to the CAHPS survey for its child population so that there are greater than 100 respondents for each measure.

Assessment of Follow-Up on Prior Recommendations

Table 8-18 includes HSAG's recommendations for improvement and VA Premier's actions taken.

Table 8-18—CAHPS Survey Recommendations and VA Premier's Response

Prior Year Recommendations ***From the CY 2019 EQR Technical Report for CAHPS***	**VA Premier's Response** ***(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)***

HSAG recommends that VA Premier continue to monitor the measures to ensure there are no significant decreases in rates over time.	• Continued to monitor measures to early detect statistically significant decreases in rates over time.
	• Conducted a mid-year "off-cycle" Medicaid (Adult) CAHPS Simulation to assess areas of opportunity for improvement and continually monitor progress.
	• Previously identified measures with the greatest opportunity:
	    – Medallion 4.0 Child: *Coordination of Care* (7.3% decrease compared to 2019)
	    – Medallion 4.0 Adult: *Getting Care Quickly* (12.9% decrease compared to 2019)
	• Included QI [quality improvement] interventions to improve measures.
	• Performed Clinical Practice Guideline Record Reviews.

Prior Year Recommendations *From the CY 2019 EQR Technical Report for CAHPS*	**VA Premier's Response** *(Note—The narrative within the MCO's Response section was provided by the MCO and has not been altered by HSAG except for minor formatting)*
	• Ensured timely referrals to Care Coordination/Case Management. • Analyzed and investigated QI opportunities among measures or composites for key drivers. • Formed a Quality Satisfaction Committee (QSC) composed of key stakeholders from all functional/operational areas. • Reviewed survey scores and discussed, documented, and tracked improvement implementation strategies. • Met bimonthly to discuss opportunities for improvement.
HSAG recommends that VA Premier focus on increasing response rates to the CAHPS survey for its child population so that there are greater than 100 respondents for each measure.	• Implemented CAHPS Survey Response Rate interventions: − Increased notifications to members informing them of upcoming CAHPS survey via email and/or text notification. − Conducted oversampling. − Ensured questions are in easy-to-understand language.
HSAG Assessment: HSAG has determined that the MCO has addressed the recommendations in the prior year's annual technical report.	

Appendix A. Technical Methods of Data Collection and Analysis—MCOs

This section of the report presents the approved technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs. It includes:

- Rapid-Cycle PIP Validation Approach
- Validation of Performance Measure Methodology
- CAHPS Survey Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

Rapid-Cycle PIP Validation Approach

HSAG's PIP approach guides CCC Plus plans through a process using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. Performing small tests of change should require fewer resources and allow more flexibility for adjustments throughout the improvement process. By piloting on a smaller scale, CCC Plus plans have an opportunity to determine the effectiveness of changes prior to expanding successful interventions. HSAG developed a series of five modules that CCC Plus plans complete as they progress through the PIP.

Module 1—PIP Initiation

The objective of this module is to ask and answer the first fundamental question of the Model for Improvement: "What are we trying to improve?" In Module 1, CCC Plus plans outline the project's framework. The framework includes the topic rationale, data supporting the need to improve the selected topic, members who make up the PIP team, and the key driver diagram that defines the aim, factors that influence achievement of the aim, and interventions that can lead to the desired improvement.

Module 2—SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim Data Collection

The objective for this module is to ask and answer the second fundamental question of the Model for Improvement: "How will we know that a change is an improvement?" In Module 2, CCC Plus plans define how and when it will be known that improvement is happening. CCC Plus plans define the SMART Aim measure, data collection methodology, data collection plan, and develop a SMART Aim measure run chart.

Module 3—Intervention Determination

The objective for this module is to ask and answer the third fundamental question of the Model for Improvement: "What changes can we make that will result in improvement?" In Module 3, CCC Plus plans identify potential interventions that can impact the SMART Aim using quality improvement activities. The MCO's PIP team employs a step-by-step process that uses process mapping and failure modes effect analysis (FMEA) to determine interventions that may be tested using Plan-Do-Study-Act (PDSA).

Module 4—PDSA

In Module 4, CCC Plus plans test interventions that have the potential to impact the SMART Aim using PDSA cycles. CCC Plus plans document details about the change and an evaluation plan. Based on testing, CCC Plus plans analyze the data and summarize results. CCC Plus plans subsequently determine what needs to be done with the intervention based on what was learned from the test (i.e., adopt, adapt, abandon, continue testing). CCC Plus plans complete a Module 4 submission form for each intervention that it tests for the PIP.

Module 5—PIP Conclusions

In Module 5, CCC Plus plans summarize key findings, comparison of successful and unsuccessful interventions, and outcomes. CCC Plus plans synthesize all data collected, information gathered, and lessons learned to document the impact of the PIP and to consider how any demonstrated improvement can be shared and used as a foundation for further improvement going forward. CCC Plus plans submit the PIP's final key driver diagram, SMART Aim run chart with mapped interventions, and FMEA. Additionally, the MCO will update Module 3's intervention determination table if it selected an intervention to test in Module 4 that was not identified in Module 3.

PIP Validation Overview

HSAG's methodology for validating PIPs is a consistent, structured process that uses standardized scoring. HSAG validates PIPs annually to the point of progression using criteria that it developed to align with CMS PIP validation protocols and rapid-cycle improvement principles. The validation process determines if DMAS and other key stakeholders can have confidence in the CCC Plus plans' reported PIP results.

HSAG provides DMAS and the CCC Plus plans with a PIP Validation Tool for each submitted module that consists of validation criteria necessary for successful completion of a valid PIP. HSAG scores the criteria as *Achieved* or *Not Achieved* and provides detailed written feedback and recommendations. HSAG provides general comments for achieved criteria when enhanced documentation would demonstrate a stronger application of the PIP requirements. HSAG also provides annual MCO-specific PIP Validation Reports that include the validation findings and recommendations for improvement.

Validation of Performance Measure Validation Methodology

Overview

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. Title 42 of the Code of Federal Regulations (CFR) §438.350(a) requires states that contract with MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or primary care case management (PCCM) entities to have a qualified EQRO perform an annual external quality review (EQR) that includes validation of contracted entity performance measures (42 CFR §438.358(b)(1)(ii)). HSAG, in conjunction with Aqurate Health Data Management, Inc. (Aqurate), conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the performance measure rates by the MCOs in accordance with the Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019*.

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). The Medallion 4.0 program provides services to the Medicaid and FAMIS populations. The Commonwealth Coordinated Care Plus (CCC Plus) program is an integrated managed care delivery model that includes medical services, nursing, personal care, and behavioral (mental) health services. DMAS contracted with six privately owned MCOs to provide services to members enrolled in the Medallion 4.0 and CCC Plus programs for calendar year (CY) 2019. DMAS identified a set of performance measures that the MCOs are required to calculate and report.

The purpose of the PMV is to assess the accuracy of performance measures reported by the Medallion 4.0 and CCC Plus MCOs and to determine the extent to which performance measures reported by the MCOs follow State specifications and reporting requirements. Table A-1 displays the Medallion 4.0 and CCC Plus MCOs that were included in the PMV.

Table A-1—CY 2019 Medallion 4.0 and CCC Plus MCOs

MCO Name
Aetna Better Health of Virginia
HealthKeepers, Inc.
Magellan Complete Care of Virginia
Optima Health
UnitedHealthcare of the Mid-Atlantic, Inc.
Virginia Premier Health Plan, Inc.

Objectives

The primary objectives of the PMV process are to evaluate the accuracy of the performance measure data collected by the MCO and determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each

performance measure. A measure-specific review was performed on a subset of CCC MCO performance measures, all part of quality withhold measures, to evaluate the accuracy of reported performance measure data. PMV results provided DMAS additional information for MCO quality withhold payments.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities for MCOs, HSAG obtained a list of the performance measures that were selected by DMAS for validation.

HSAG then prepared a document request letter that was submitted to the MCOs outlining the steps in the PMV process. The document request letter included a request for source code/software programming or process steps used to generate the performance measure data element values for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, a timetable for completion, and instructions for submission. HSAG responded to any audit-related questions received directly from the MCOs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided MCOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with MCOs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from MCOs.

Based on the scope of the validation, HSAG assembled a validation team based on the full complement of skills required for validating the specific performance measures and conducting the PMV for each MCO. The team was 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 reviewed and how HSAG analyzed these data:

- Roadmap and ISCAT—The MCOs submitted a Roadmap for HSAG's review that was to be completed as part of the NCQA HEDIS audit process. HSAG completed a thorough review of the Roadmap, which includes MCO operational and organizational structure; data systems and data reporting structure and processes; and additional information related to HEDIS audit standards. Additionally, the MCOs completed and submit an ISCAT for HSAG's review of the performance measures. The ISCAT supplemented the information included in the Roadmap and address data collection and reporting specifics of non-HEDIS measures. HSAG used responses from the Roadmap and 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 for the measures reported using the hybrid method. In addition, HSAG will request that the MCOs submit the following documentation for review: medical record abstraction tools and instructions, training materials for medical record review staff members, and

policies and procedures outlining the processes for monitoring the accuracy of the abstractions performed by the review staff members. HSAG will conduct over-read of 30 records from the hybrid sample for each performance measure. HSAG will follow NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and will determine if the findings impact the audit results for any performance measure rate.

- Source code (programming language) for performance measures—The MCOs that calculate the performance measures using internally developed source code will be required to submit source code for each performance measure being validated. HSAG will complete a 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. If the MCOs outsourced programming for HEDIS measure production to an outside vendor, the MCOs will be required to submit the vendor's NCQA measure certification reports.
- 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, measure certification reports, 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 that identify numerator and denominator compliance, observation of data processing, and review of data reports. The on-site will be combined for the Medallion 4.0 and CCC Plus programs. The on-site strategies will include:

- **Opening meetings**—These 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 if written policies and procedures are used and followed in daily practice.
- **Evaluation of enrollment, eligibility, 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. HSAG will conduct interviews with key staff familiar with the processing, monitoring, reporting, and calculation 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 generation of the performance measures. 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 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 data output files. PSV is a review technique used to confirm that the information from the primary source matches the data output file 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 supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors 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, discuss follow-up items, 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 that must be addressed as soon as possible so that the rate can be revised before the PMV report is issued.

HSAG will prepare a separate PMV report for Medallion 4.0 and CCC Plus for each MCO, documenting the validation findings. Based on all validation activities, HSAG will determine the validation result for each performance measure. The CMS PMV protocol identifies possible validation results for performance measures, defined in Table A-2 below.

Table A-2—Validation Results and Definitions for Performance Measures

Designation	Description
Reportable (R)	Measure was compliant with State specifications.
Do Not Report (DNR)	MCO rate was materially biased and should not be reported.

According to the CMS EQR PMV 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 errors detected within each audit element. It is possible for an audit element to receive a validation result of DNR when the impact of even a single 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 "Reportable" (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 DNR.

Performance Measure List for SFY 2020

The following table lists the performance measures selected by DMAS, the method (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs are required to use.

Table A-3—Performance Measure List for SFY 2020

Performance Measure	Specifications	Method*
CCC Plus		
Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS 2020	Admin
Follow-up after Emergency Department Visit for Mental Illness	HEDIS 2020	Admin
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)***	ADULT CORE SET	Admin
Comprehensive Diabetes Care (excluding HbA1c control < 7.0%)	HEDIS 2020	Hybrid
*Heart Failure Admission Rate (PQI08-AD)***	ADULT CORE SET	Admin
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	HEDIS 2020	Admin
Medallion 4.0		
Adolescent Well-Care Visits	HEDIS 2020	Hybrid
*Asthma Admission Rate (Per 100,000 Member Months)***	AHRQ PDI	Admin
Childhood Immunization Status—Combo 3	HEDIS 2020	Hybrid
Comprehensive Diabetes Care (excluding HbA1c control < 7.0%)	HEDIS 2020	Hybrid
Follow-Up After Emergency Department Visit for Mental Illness	HEDIS 2020	Admin
Prenatal and Postpartum Care	HEDIS 2020	Hybrid

* The administrative (admin) reporting method refers to the review of transactional data (e.g., claims data) for the eligible population. The hybrid reporting method refers to the review of transactional data and medical records/electronic medical records for a sample of the eligible population.

** These non HEDIS measures are included in the Performance Withhold Program (PWP)

CAHPS Survey Methodology

The primary objective of the Adult and Child CAHPS surveys was to effectively and efficiently obtain information on the levels of experience of adult and child Medicaid members enrolled in Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier with their MCO and healthcare.

Technical Methods of Data Collection and Analysis

MCO CAHPS

For the CCC Plus MCOs, the technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.0H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[A-1] The mode of CAHPS survey data collection varied slightly among the MCOs. Magellan, Optima, United, and VA Premier used an enhanced mixed-mode survey methodology that was pre-approved by NCQA for both their adult and child populations. Aetna and HealthKeepers used a mail only methodology for their adult and child populations. In addition, Aetna and Optima included the option for adult and child members to complete the survey via internet. Following NCQA's standard HEDIS timeline, adult members and parents/caretakers of child members enrolled in each of the MCOs completed the surveys between the time period of January to May 2020.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[A-2] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.0H Surveys include a set of standardized items (40 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey, 41 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions [CCC] measurement set, and 76 items for the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all healthcare, personal doctor, and specialist. The

[A-1] Aetna, HealthKeepers, Magellan, Optima, and United administered the CAHPS 5.0H Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set to their child Medicaid populations, while VA Premier administered the CAHPS 5.0H Child Survey without the CCC measurement set. For purposes of this report, the child Medicaid CAHPS results presented for Aetna, HealthKeepers, Magellan, Optima, and United represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[A-2] Aetna and HealthKeepers contracted with the Center for the Study of Services (CSS); and Magellan, Optima, United, and VA Premier contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

composite measures 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 experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response or top-box score. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were “Never,” “Sometimes,” “Usually,” or “Always. A top-box response or top-box score for the composite measures was defined as a response of “Usually/Always.”

The 2020 CAHPS scores for each MCO and the statewide aggregate were compared to the 2020 NCQA Medicaid national averages.[A-3] Statistically significant differences are noted with colors. A cell was highlighted in orange if the MCO score was statistically significantly higher than the national average. However, if the MCO score was statistically significantly lower than the national average, then a cell was highlighted in gray.

It is important to note that NCQA requires a minimum of 100 respondents in order to report the CAHPS item as a valid survey result. If the NCQA minimum reporting threshold of 100 respondents was not met, the CAHPS score was denoted with a cross (+). Caution should be exercised when interpreting results for those measures with fewer than 100 respondents.

Description of the Data Obtained/Time Period

The CAHPS survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2020 for the CCC Plus MCOs.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.0H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of “completed” if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement, a survey was assigned a disposition code of “completed” if at least three of the following five questions were answered: 3, 10, 22, 26, and 31. For the CAHPS 5.0H Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of “completed” if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

[A-3] Quality Compass 2020 data serve as the source for the 2020 NCQA CAHPS adult Medicaid and child Medicaid national averages.

CCC Plus Consumer Decision Support Tool Methodology

Project Overview

DMAS contracted with HSAG to analyze 2020 HEDIS results, including 2020 CAHPS data from six Virginia MCOs serving the CCC Plus population for presentation in the 2020 CCC Plus Consumer Decision Support Tool. The CCC Plus Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

For this activity, HSAG received the MCOs' CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2020. The *HEDIS 2020 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2020 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

Reporting Categories

The CCC Plus Consumer Decision Support Tool reporting categories and descriptions of the measures they contain are:

- **Overall Rating:** Includes all HEDIS and CAHPS measures included in the 2020 Consumer Decision Support Tool analysis. This category also includes adult, general child, and children with chronic conditions CAHPS measures on consumer perceptions of the overall rating of the MCO and their overall health care.
- **Doctors' Communication:** Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions about how well their doctors communicate, and overall ratings of personal doctors and specialists seen most often. This category also includes a children with chronic conditions CAHPS composite related to family centered care. In addition, this category includes an adult CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care:** Includes adult and general child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. Additionally, a children with chronic conditions CAHPS question summary rate related to prescription medications is also included. This category includes HEDIS measures that assess adults' and children's access to care. This category also includes HEDIS measures that assess how well MCOs perform related to breast cancer screenings, as well as appropriate treatment for acute bronchitis/bronchiolitis and low back pain.
- **Behavioral Health:** Includes HEDIS measures that assess how often members receive appropriate care and follow-up services for mental illness and alcohol and other drug (AOD) use disorder or dependence. This category also includes HEDIS measures that assess the use of psychosocial care as a first-line treatment for children and adolescents on antipsychotics as well as cardiovascular monitoring for members with schizophrenia.

- **Medication Management:** Includes HEDIS measures related medication management for respiratory and behavioral health conditions.

Measures Used In Analysis

DMAS, in collaboration with HSAG, chose measures for this year's CCC Plus Consumer Decision Support Tool based on a number of factors. In an effort to align with the Performance Withhold Program (PWP), the HEDIS measures evaluated as part of the PWP will be included in this analysis, as well as many measures required by the CCC Plus Technical Manual for reporting.[A-4] Per NCQA specifications, the CAHPS 5.0H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.0H Child Survey with Children with Chronic Conditions item set was used for the child population.

Table A-4 lists the 46 measure indicators, 20 CAHPS and 26 HEDIS, and their associated weights.[A-5] Weights will be applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally in the derivation of the final results. Please see section VI for more detail on comparing MCO performance.

Table A-4—MCO CCC Plus Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Category: Overall Rating[6]	
General Child Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
General Child Medicaid—Rating of Health Care (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Health Care (CAHPS Global Rating)	1
Adult Medicaid—Rating of Health Care (CAHPS Global Rating)	1

[A-4] Virginia Department of Medical Assistance Services. *CCC Plus Technical Manual*. Version 2.6.

[A-5] Due to the impact of Coronavirus Disease 2019 (COVID-19) on the MCOs' abilities to collect medical record data, all hybrid measures have been removed from the 2020 Consumer Decision Support Tool analysis. Additionally, the *Rating of Specialist Seen Most Often* (Child CAHPS); *How Well Doctors Communicate* (CAHPS Children with Chronic Conditions); *Getting Needed Care* (CAHPS Children with Chronic Conditions); *Getting Care Quickly* (Child CAHPS); *Coordination of Care for Children with Chronic Conditions* (CAHPS Children with Chronic Conditions Question Summary Rates); *Access to Specialized Services* (CAHPS Children with Chronic Conditions); and the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* measures have been removed from the 2020 Consumer Decision Support Tool analysis due to half the MCOs or more having Not Applicable (NA) or Not Reported (NR) designations. The *Family Centered Care: Getting Needed Information* (CAHPS Children with Chronic Conditions) measure was removed due to the measure having no variation in performance across the MCOs.

[A-6] To calculate the Overall Rating category, all 46 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.

Measures	Measure Weight
Category: Doctors' Communication	
General Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
General Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Family Centered Care: Personal Doctor Who Knows Child (CAHPS Composite)	1
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3
Discussing Cessation Strategies	1/3
Category: Access and Preventive Care	
General Child Medicaid—Getting Needed Care (CAHPS Composite)	1
Adult Medicaid—Getting Needed Care (CAHPS Composite)	1
Adult Medicaid—Getting Care Quickly (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Access to Prescription Medicines (CAHPS Question Summary Rates)	1
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	1/3
45–64 Years	1/3
65+ Years	1/3
Children and Adolescents' Access to Primary Care Practitioners	
25 Months–6 Years	1/3
7–11 Years	1/3
12–19 Years	1/3
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	
3 Months–17 Years	1/3
18–64 Years	1/3
65+ Years	1/3
Use of Imaging Studies for Low Back Pain	1

Measures	Measure Weight
Breast Cancer Screening	1
Category: Behavioral Health	
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1
Initiation and Engagement of AOD Dependence Treatment	
Initiation of AOD Treatment—Total	1/2
Engagement of AOD Treatment—Total	1/2
Follow-Up After Emergency Department (ED) Visit for AOD Dependence—30-Day Follow-Up—Total	1
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	1
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1
Category: Medication Management	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	1
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1
Asthma Medication Ratio—Total[A-7]	1
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	1
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	1/2
Bronchodilator	1/2

Missing Values

In general, HEDIS and CAHPS data contain three classes of missing values:

[A-7] The *Asthma Medication Ratio—Total* measure was used in the 2020 CCC Plus Consumer Decision Support Tool instead of the *Medication Management for People With Asthma* measure, given that all MCOs reported the *Asthma Medication Ratio—Total* measure for HEDIS 2020 and because the *Medication Management for People With Asthma* measure is no longer endorsed by the National Quality Forum (NQF).

- *Not Reported (NR)*—MCOs chose not to submit data, even though it was possible for them to do so.
- *Biased Rate (BR)*—MCOs' measure rates were determined to be materially biased in a HEDIS Compliance Audit.
- *Not Applicable (NA)*—MCOs were unable to provide a sufficient amount of data (e.g., too few members met the eligibility criteria for a measure).

In developing scores and ratings for the reporting categories, HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned the minimum rate.
- Rates with a *BR* designation were assigned the minimum rate.
- Rates with an *NA* designation were assigned the average value.

For measures with an *NA* audit result, HSAG used the mean of non-missing observations across all MCOs. For measures with an *NR* or *BR* audit result, HSAG used the minimum value of the non-missing observations across all MCOs. This minimized the disadvantage for MCOs that were willing but unable to report data and ensured that MCOs did not gain advantage from intentionally failing to report complete and accurate data. If half of the plans or more had an *NR, BR,* or *NA* for any measure, then the measure was excluded from the analysis.

For MCOs with *NR, BR,* and *NA* audit results, HSAG used the average variance of the non-missing observations across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.

Additionally, HSAG replaced missing values where an MCO reported data for at least 50 percent of the indicators in a reporting category. If an MCO was missing more than 50 percent of the measures that comprised a reporting category, HSAG gave the MCO a designation of "Insufficient Data" for that category.

Comparing MCO Performance

HSAG computed five summary scores for each MCO, as well as the summary mean values for the MCOs as a group. Each score was a standardized score where higher values represented more favorable performance. Summary scores for the five reporting categories (Overall Rating, Doctors' Communication, Access and Preventive Care, Behavioral Health, and Medication Management) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always," "9/10," and "Yes," where applicable) to a 1 for each individual question, as described in *HEDIS 2020 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.

2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS measures was calculated as follows:

$$\frac{p_k(1-p_k)}{n_k-1}$$

where: p_k = MCO k score
n_k = number of members in the measure sample for MCO k

For general CAHPS global rating measures and question summary rates, the variance was calculated as follows:

$$\frac{1}{n}\frac{\sum_{i=1}^{n}(x_i-\overline{x})^2}{n\ -1}$$

where: x_i = response of member i
$\overline{x}$ = the mean score for MCO k
n = number of responses in MCO k

For general CAHPS composite measures, the variance was calculated as follows:

$$\frac{N}{N-1}\sum_{i=1}^{N}\left(\sum_{j=1}^{m}\frac{1}{m}\frac{(x_{ij}-\overline{x}_j)}{n_j}\right)^2$$

where: j = 1,…,m questions in the composite measure
i = 1,….,n_j members responding to question j
x_{ij} = response of member i to question j
$\overline{x}_j$ = MCO mean for question j
N = members responding to at least one question in the composite

3. For MCOs with *NA* and *NR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.

4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.

5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category rating.

6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.

7. For each MCO *k*, HSAG calculated the category variance, CV_k, as: $CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$

where: j = 1,…,m HEDIS or CAHPS measures in the summary

V_j = variance for measure j

c_j = group standard deviation for measure j

w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MCO summary measure scores. The difference score, d_k, was calculated as d_k = MCO k score – group mean.

9. For each MCO *k*, HSAG calculated the variance of the difference scores, $Var(d_k)$, as:

$$Var(d_k) = \frac{P(P-2)}{P^2} CV_k + \frac{1}{P^2} \sum_{k=1}^{P} CV_k$$

where: P = total number of MCOs

CV_k = category variance for MCO *k*

10. The statistical significance of each difference was determined by computing a confidence interval (CI). A 95 percent CI and 68 percent CI were calculated around each difference score to identify plans that were significantly higher than or significantly lower than the mean. Plans with differences significantly above or below zero at the 95 percent confidence level received the top (Highest Performance) and bottom (Lowest Performance) designations, respectively. Plans with differences significantly above or below zero at the 68 percent confidence level, but not at the 95 percent confidence level, received High Performance and Low Performance designations, respectively. A plan was significantly above zero if the lower limit of the CI was greater than zero; and was significantly below zero if the upper limit of the CI was below zero. Plans that do not fall either above or below zero at the 68 percent confidence level received the middle designation (Average Performance). For a given measure, the formulas for calculating the CIs were:

95% CI = $d_k \pm 1.96\sqrt{Var(d_k)}$

68% CI = $d_k \pm \sqrt{Var(d_k)}$

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance across MCOs and presents data in a manner that emphasizes meaningful differences between MCOs. The CCC Plus Consumer Decision Support Tool displays results for each MCO as follows:

Table A-5—2020 CCC Plus Consumer Decision Support Tool–Performance Ratings

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

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

CCC Plus Performance Withhold Program Methodology

Project Overview

DMAS contracted with HSAG, as its EQRO, to establish, implement, and maintain a scoring mechanism, for the managed care Performance Withhold Program (PWP). For the PWP, CCC Plus MCOs' performance is evaluated on four NCQA HEDIS measures and two of CMS' Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures. HSAG is responsible for collecting MCOs' audited HEDIS measure rates and the CMS Adult Core Set measure rates from DMAS. HSAG will validate the two CMS Adult Core Set measures in accordance with *External Quality Review (EQR) Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019.[A-8] HSAG will derive PWP scores for each measure and calculate the portion of the 1 percent quality withhold earned back for each MCO.

The following sections provide the PWP calculation methodology for calendar year (CY) 2019 and State Fiscal Year (SFY) 2021. Due to the impacts of the Coronavirus Disease 2019 (COVID-19) pandemic on MCOs' abilities to collect and report data, as well as DMAS' ability to appropriately evaluate performance levels and improvement, DMAS has determined that both CY 2019 and SFY 2021 will be pay-for-reporting years for the PWP; therefore, the MCOs are eligible to earn back all or a portion of their quality withhold based solely on their ability to sufficiently report the required measure rates. DMAS and HSAG will assess the methodology for SFY 2022 once additional information becomes available.

[A-8] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)* 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jun 1, 2020.

Performance Measures

DMAS selected the following HEDIS measures and CMS Adult Core Set measures for the CY 2019 PWP, as indicated in Table A-6.

Table A-6—CY 2019 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Behavioral Health		
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	HEDIS	Administrative
Chronic Conditions		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	HEDIS	Hybrid
Comprehensive Diabetes Care—Medical Attention for Nephropathy	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	HEDIS	Hybrid
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative

DMAS selected the following HEDIS measures and CMS Adult Core Set measures for the SFY 2021 PWP, as indicated in Table A-7. Due to measure specification changes made by NCQA after the start of the SFY 2021 measurement period, DMAS must make conforming changes to both the SFY 2021 PWP measures (Table A-7) and corresponding measure weights (Table A-4). These adjustments address NCQA's decision to retire the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator.

Table A-7—SFY 2021 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Behavioral Health		
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	HEDIS	Administrative
Chronic Conditions		
Comprehensive Diabetes Care—HbA1c Testing	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	HEDIS	Hybrid
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative

Performance Period

The CY 2019 PWP assesses CY 2019 performance measure data (i.e., the performance measures will be calculated following HEDIS 2020 and CMS federal fiscal year [FFY] 2020 Adult Core Set specifications that use a CY 2019 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in CY 2019 (i.e., the 1 percent of capitation payments withheld from January 1, 2019 through December 31, 2019). The SFY 2021 PWP assesses CY 2020 performance measure data (i.e., the performance measures will be calculated following the HEDIS measurement year [MY] 2020 and CMS FFY 2021 Adult Core Set specifications that use a CY 2020 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld from an 18-month period from January 1, 2020, through June 30, 2021. This one-time withhold window spanning 18 months is necessary to align the PWP program with the movement of the CCC Plus contract from a CY to SFY schedule. Subsequent withholding periods will cover the 12 months of the SFY.

Data Collection

The HEDIS Interactive Data Submission System (IDSS) files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS measure rates will be provided to HSAG by the MCOs. Starting with the CY 2019 PWP, DMAS will contract with HSAG, as their EQRO, to validate the two CMS Adult Core Set measures (two measure indicators) in accordance with *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Following the performance measure validation, HSAG will provide the true, audited rates for the two CMS Adult Core Set measures (two measure indicators) to DMAS.

PWP Calculation

The following sections provide a detailed description of the PWP scoring and quality withhold funds model for the CY 2019 PWP and SFY 2021 PWP. With receipt of audited HEDIS measure rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back. Table A-8 provides the HEDIS and non-HEDIS audit designations that will be eligible or ineligible to receive points in the PWP.

Table A-8—HEDIS and Non-HEDIS Audit Designations

HEDIS Audit Designation	Non-HEDIS Audit Designation
Eligible for Points in CCC Plus PWP Analysis	
Reportable (R)	Reportable (R)
Small Denominator (NA)	
Ineligible for Points CCC Plus PWP Analysis	
Biased Rate (BR)	Do Not Report (DNR)
Not Required (NQ)	Not Applicable (NA)
No Benefit (NB)	No Benefit (NR)
Not Reported (NR)	
Unaudited (UN)	

As indicated in Table A-8, only measure rates with a "*Reportable* (*R*)" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) or "*Small Denominator (NA)*" (HEDIS rates only) audit result (i.e., the plan followed the specifications but the denominator was too small to report a valid rate) will be included in the PWP calculation. Measure rates with the following audit results will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure):

- "*Biased Rate (BR)*" audit result for HEDIS measures or "*Do Not Report (DNR)*" audit result for non-HEDIS measures (i.e., the calculated rate was materially biased)
- "*Not Required (NQ)*" audit result for HEDIS measures or "*Not Applicable (NA)*" audit result for non-HEDIS measures (i.e., the plan was not required to report the measure)
- "*No Benefit (NB)*" audit result for HEDIS measures or "*No Benefit (NR)*" for non-HEDIS measures (i.e., the measure was not reported because the plan did not offer the required benefit)

- "*Not Reported (NR)*" audit result for HEDIS measures (i.e., the plan chose not to report the measure)
- "*Unaudited (UN)"* audit result for HEDIS measures (i.e., the measure was not audited)

CY 2019 PWP

As indicated above, scoring for the CY 2019 PWP will be based on whether the MCO reported valid HEDIS 2020 measure rates to NCQA in the required reporting method as indicated in Table A-7 (i.e., hybrid for *Comprehensive Diabetes Care* and administrative for the remaining measures) and whether the MCO received an allowable audit designation as indicated in Table A-8. For example, if the MCO receives a "*Reportable* (*R*)" audit designation for the applicable HEDIS measures and CMS Adult Core Set measures, then the MCO will earn back their entire quality withhold. However, if the MCO received any of the ineligible audit designations outlined in Table A-8 then the MCO will not earn back the portion of their quality withhold attributed to that measure (e.g., if the MCO receives a "*Biased Rate* (*BR*)" audit designation for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* HEDIS measure, then the MCO would not receive the 7.5 percent of withheld funds associated with that measure). Table A-9 shows the percentage of withhold associated with each performance measure indicator.

Table A-9—CY 2019 PWP Measure Weights

Indicator	Measure Weight
Behavioral Health	
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	10%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	7.5%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	7.5%
Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	3.33%*
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	3.33%*
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	3.33%*
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	3.33%*
Comprehensive Diabetes Care—Medical Attention for Nephropathy	3.33%*
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	3.33%*
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	15%
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	15%

**The Comprehensive Diabetes Care (CDC) measure has a total weight of 20 percent; therefore, each indicator has a weight of 3.33 percent (i.e., 20 percent divided by 6). Please note, the 3.33 percent listed in the table is a rounded value.*

SFY 2021 PWP

The SFY 2021 PWP will be based on the same pay-for-reporting methodology described above for the CY 2019 PWP and will use the MCO's audited HEDIS MY 2020 and validated CMS FFY 2021 Adult Core Set performance measure data. Table A-10 shows the percentage of withhold associated with each performance measure indicator.

Table A-10—SFY 2021 PWP Measure Weights

Indicator	Measure Weight
Behavioral Health	
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	10%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	7.5%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	7.5%
Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	4%*
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	4%*
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	4%*
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	4%*
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	4%*
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	15%
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	15%

**The Comprehensive Diabetes Care (CDC) measure has a total weight of 20 percent; therefore, each indicator has a weight of 4 percent (i.e., 20 percent divided by 5).*

Appendix B. 2017–2019 Quality Strategy Status Assessment

Table B-1 provides DMAS's progress on achieving the 2017–2019 Quality Strategy Goals. The table identifies the goals, measures, baseline rate, and the aggregate 2019 remeasurement rate. The reported 2016 baseline rates and the 2019 aggregate remeasurement rates are not comparable due to programmatic and population changes.

Table B-1—Virginia Medicaid 2017–2019 Quality Strategy Status Assessment

Aim: Build a Wellness Focused, Integrated System of Care			
Goal	**Measure**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Strengthen access to primary care network	HEDIS: *Adults' Access to Primary Care (Prevention/Ambulatory Health Services)*	86.48%	83.70%
	HEDIS: *Children and Adolescents' Access to Primary Care*	12–24 Months: 97.70% 25 Months–6 Years: 92.25% 7–11 Years: 94.30% 90.78% 12–19 Years: 91.16%	12–24 Months: 95.51% 25 Months–6 Years: 89.94% 7–11 Years: 92.59% 90.78% 12–19 Years: 90.78%
Decrease inappropriate utilization and total cost of care	*All-cause PQI Admission Rate*	NR	NR
	CMS/National Quality Form (NQF) #1768: *Plan All-Cause Readmissions*	NR	NR
	HEDIS: *Ambulatory Care—Emergency Department Visits*	64.19%	69.28%
	Per Capita Healthcare Expenditures (future measure)	NR	NR
Emphasize member experience of care	CAHPS/HEDIS/NQF #0006: *Member Rating of Health Plan*	78.37%	76.57%

Aim: Build a Wellness Focused, Integrated System of Care			
Goal	**Measure**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Integration of behavioral, oral, and physical health	CMS/HEDIS/NQF #0004: *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates)	Initiation Total: ND Engagement Total: ND	Initiation Total: 43.73% Engagement Total: 13.25%
	CMS/NQF #1664: *SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge*	NR	NR
	HEDIS/NQF #0576: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*	38.95%	30.29%
	CMS/NQF #2605: *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence*	NR	The measure was updated to separate mental illness and alcohol and other drugs (AOD) between 2016 and 2019
	CMS: *Transition of Members Between SUD LOCs, hospitals, NF, and the Community*	NR	NR
Encourage appropriate management of prescription medications	*Use of High-Risk Medications in the Elderly*	NR	NR
	NCQA: *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*	2.66%	2.53%
	HEDIS: *Follow-up Care for Children Prescribed ADHD Medication—Initiation and Continuation/Maintenance Phases*	Initiation Phase: 43.97% Continuation and Maintenance Phase: 55.89%	Initiation Phase: 46.25% Continuation and Maintenance Phase: 61.44%
	HEDIS: *Antidepressant Medication Management—Effective Acute Phase Treatment, Effective Continuation Phase Treatment*	Effective Acute Phase Treatment: 53.70%	Effective Acute Phase Treatment: 53.40% Effective Continuation Phase: 37.51%

Aim: Build a Wellness Focused, Integrated System of Care			
Goal	**Measure**	**2016 Baseline Rate**	**2019 Aggregate Rate**
		Effective Continuation Phase: 38.52%	
	PQA: *Use of Opioids at High Dosage in Persons Without Cancer*	NR	NR
	PQA: *Use of Opioids from Multiple Providers in Persons Without Cancer*	NR	NR
	PQA: *Use of Opioids at High Dosage and From Multiple Providers in Persons Without Cancer*	NR	NR

Aim: Focus on Screening and Prevention			
Goal	**Examples of Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Cancers are prevented or diagnosed at the earliest stage possible	HEDIS/NQF #2372: *Breast Cancer Screening*	52.11%	51.43%
	NQF #0034: *Colorectal Cancer Screening*	NR	NR
	HEDIS/NQF #0032: *Cervical Cancer Screening*	65.44%	56.36%
Prevention of nicotine dependency	AMA-PCPI/NQF #0027: *Tobacco Use—Screening and Cessation*	NR	Discussing Cessation Medications: 48.65% Discussing Cessation Strategies: 42.89%
Virginians protected against vaccine-preventable diseases	HEDIS: *Childhood Immunization Status (Combo 10)*	Combo 10: 40.54%	Combo 10: 36.55%
	HEDIS: *Immunizations for Adolescents*	Meningococcal: 59.67% Tdap/Td: 88.93%	Meningococcal: 65.28% Tdap/Td: 90.22%
	HEDIS: *Pneumococcal Vaccination Status for Older Adults*	NR	NR
	HEDIS: *Flu Vaccinations*	Adult: 43.92%	Adult: 48.71%

Aim: Focus on Screening and Prevention			
Goal	**Examples of Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
		Child: 56.33%	Child: 52.55%
Support consistency of recommended pediatric screenings	CMS/HEDIS: *Annual Preventive Dental Visits*	ND	ND
	HEDIS: *Well-Child Visits, First 15 Months of Life*	62.06%	63.56%
	HEDIS: *Well-Child Visits in Third, Fourth, Fifth, and Sixth Years of Life*	74.13%	74.88%
	HEDIS: *Adolescent Well-Care Visits (12–21 years)*	50.30%	51.55%
	OHSU: *Developmental Screening in the First 3 Years of Life*	NR	NR

Aim: Achieve Healthier Pregnancies and Healthier Births			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Virginians plan their pregnancies	NQF 2902/OPA: *Contraceptive Care—Postpartum Women Ages 15–44*	NR	NR
	HEDIS: *Postpartum Care Visit*	64.45%	61.84%
Improved pre-term birth rate	*Early Elective Deliveries Rate*	NR	NR
	HEDIS: *Timeliness of Prenatal Care*	82.22%	80.09%
	HEDIS: *Frequency of Ongoing Prenatal Care*	<20%: 28.52% 21–40%: 12.13% 41–60%: 74% 61–80%: 12.08% ≥81%: 38.53%	Retired HEDIS measure
	CMS/CDC/PQI: *Percent of Live Births <2,500 Grams*	NR	NR

Aim: Maximize Wellbeing Across the Lifespan			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
Effective management of chronic respiratory disease	PQI 14: *Asthma Admission Rate (Ages 2–17)*	NR	NR
	PQI 15: *Asthma in Younger Adults Admission Rate*	NR	NR
	CMS/PQI 05/NQF #0275: *COPD and Asthma in Older Adults Admission Rate* (two measures)	NR	NR
Comprehensive management of diabetes	HEDIS: *Comprehensive Diabetes Care*	Hemoglobin A1c (HbA1c) Testing: 87.37% HbA1c Poor Control (>9.0%): 40.76% HbA1c Control (<8.0%): 51.87% Eye Exam (Retinal) Performed: 55.05% Medical Attention for Nephropathy: 91.52% Blood Pressure Control (<140/90 mm Hg): 59.47%	Hemoglobin A1c (HbA1c) Testing: 86.33% HbA1c Poor Control (>9.0%): 50.94% HbA1c Control (<8.0%): 41.47 Eye Exam (Retinal) Performed: 45.48% Medical Attention for Nephropathy: 88.15% Blood Pressure Control (<140/90 mm Hg): 50.44%
	PQI 01/NQF #0272: *PQI Diabetes Short-Term Complication Admission Rate*	NR	NR
Effective management of cardiovascular disease	HEDIS/NQF #0018: *Controlling High Blood Pressure*	57.40%	55.61%
Ensure quality of life for members with intensive healthcare needs	JLARC: *Nursing Facility Diversion—# and % of New Members Meeting Nursing Facility Level of Care Criteria Who Opt for Home & Community Based Services (HCBS) Over Institutional Placement*	NR	NR

Aim: Maximize Wellbeing Across the Lifespan			
Goal	**Measures**	**2016 Baseline Rate**	**2019 Aggregate Rate**
	Quality of Life and Member Satisfaction Survey CMS-Specific	NR	NR
	Assessments and Reassessments	NR	NR
	Plan of Care and POC Revisions	NR	NR
	Documentation of Care Goals	NR	NR
	JLARC: *Transition of Members Between Community Well, LTSS and Nursing Facility—Services and Successful Retention in Lower Care Settings*	NR	NR
	JLARC: *Nursing Facility Residents Hospitalization and Readmission Rate*	NR	NR
	Fall Risk Management: Intervention/Managing Fall Risk	NR	NR
Provide support for End of Life	*% Enrollees with Advance Directives*	NR	NR

NR: Rates not reported.

ND: Not a covered benefit.

Appendix C. MCO Quality Strategy Quality Initiatives

Table C-1 through Table C-6 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia Quality Strategy's goals and objectives.

Aetna

Table C-1—Aetna's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Strengthen access to primary care network	Members will be sent approximately 1-3 messages each month. If a member is in multiple measure campaigns the messages will be staggered. • Short message service (SMS)	(AAP) Adults' Access to Preventive/Ambulatory Health Services (Total)
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings	Members will be sent approximately 1-3 messages each month. If a member is in multiple measure campaigns, the messages will be staggered. • SMS	(W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings	Members will be sent approximately 1-3 messages each month. If a member is in multiple measure campaigns, the messages will be staggered. • SMS	(AWC) Adolescent Well-Care Visits
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Effective management of cardiovascular disease	Members will be sent approximately 1-3 messages each month. If a member is in multiple measure campaigns, the messages will be staggered. • Short message service (SMS)	(CBP) Controlling High Blood Pressure
Aim: Build a Wellness Focused, Integrated System of Care	Promote health behavior changes and choices with one or more past visits to the emergency room for avoidable reasons. • Direct mail	(AMB) Ambulatory Care

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal: Decrease inappropriate utilization and total cost of care	• Text messaging • Interactive voice response (IVR) • Microsite	
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Flyer co-branded with the American Cancer Society to discuss the benefits of quitting smoking/tobacco cessation and the risks of smoking during pregnancy. • Flyer	(PPC) Prenatal and Postpartum Care
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health	Improve collaboration and support between utilization management (UM), case management (CM), and behavioral health (BH) departments in working with members.	(FUH) Follow-Up After Hosp For Mental Illness
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Effective management of cardiovascular disease	1. Coordinate monthly over the counter (OTC) benefit to allow members to obtain blood pressure cuff and coordinate 90-day supply of hypertension (HTN) medications. 2. Education on monitoring of blood pressure at home, recording, and frequency of checking blood pressure. 3. Educate member on blood pressure target goals, know when to call, and teach members to "Know Your Numbers". 4.Coordinate follow up with primary care provider as necessary to assist with blood pressure control. • Health risk assessments • Development of the individualized care plan • Ongoing coordination of interdisciplinary care team activities. • Hypertension assessment (in Dynamo)	(CBP) Controlling High Blood Pressure

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	• Condition management in care plan (in Dynamo) • KRAMES educational materials utilized	
Aim: Focus on Screening and Prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible	Colonoscopy postcard sent to age appropriate members informing them of colorectal screenings and the different options for screening. • Mailing	(COL) Colorectal Cancer Screening
Aim: Focus on Screening and Prevention **Goal:** Virginians protected against vaccine-preventable diseases	Printed message on prescription bag.	(CIS) Childhood Immunization Status (IMA) Immunizations for Adolescents (PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-64
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive management of diabetes	Incentive for members that complete a yearly wellness and diabetes exam. • Flyer	(CDC) Comprehensive Diabetes Care
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care	Call made to member with one outpatient visit and two or more emergency department visits. • Live call	(AMB) Ambulatory Care
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Flyer outlining unsafe habits during pregnancy. • Flyer	(PPC) Prenatal and Postpartum Care
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Call to identified pregnant members to provide education and encourage first trimester prenatal care to reduce risk of preterm or low birth weight births.	(PPC) Prenatal and Postpartum Care

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	• Live call	
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Goal:** Virginian's protected against vaccine-preventable diseases	Mailer sent to members (parents), as a reminder for well child visits with PCP and to keep up to date with immunizations. Monthly mailing based on child's birthday and gaps in care. • Mailing	(ADV) Annual Dental Visit (11-14 Yrs.) (AWC) Adolescent Well-Care Visits (CIS) Childhood Immunization Status (IMA) Immunizations for Adolescents (LSC) Lead Screening in Children (W15) Well-Child Visits in the first 15 Months of Life (6 or more visits) (W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Aim: Focus on Screening and Prevention **Goal:** Virginians protected against vaccine-preventable diseases	Flu card reminder sent to head of household. • Mailing	(PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-65
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care **Goal:** Integration of behavioral, oral and physical health	Letter mailed to identified members providing education of importance of engaging in follow up appointment within 30 days after hospital discharge. • Mailing	(PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits (IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Build a Wellness Focused, Integrated System of Care	Outbound caller identification (ID) is updated to identify case management calls to members.	(PCR) Plan All-Cause Readmission Rate

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal: Decrease inappropriate utilization and total cost of care **Goal:** Integration of behavioral, oral and physical health	Member received education from case manager regarding the importance of engaging in a 30-day post-discharge follow up visit with a PCP or specialist and is provided with assistance with scheduling the appointment if needed. • Live call	(EDU) Ambulatory Care – Emergency Department Visits (IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health	Integrative round with utilization management, behavioral health, case management, medical management, pharmacy, Plan Sponsor Services (PSS) representation to focus on stabilizing one member at a time who is a high utilizer of behavioral health inpatient hospitalizations. • Call with member	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up *Indirectly aligns to various HEDIS metrics to close gaps in care*.
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health	Ensure that discharging physicians prescribe psychiatric medications that are on formulary, thereby avoiding delays and lack of continuity with medications. • Fax	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care	Clinical program focused on coordinating care between providers, case managers and clinical pharmacists as members are discharged from the hospital. • Outreach call	(PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Incentive for members completing all prenatal appointments and post-partum check-up. • Pamphlet	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care
Aim: Achieve Healthier Pregnancies and Healthier Births	Provider incentive for identifying pregnant members and providing members with prenatal/postpartum care. • Assessment	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goals: Improved pre-term birth rates		
Aim: Focus on Screening and Prevention **Goal:** Virginians protected against vaccine-preventable diseases	Recorded messages for members reminding them to get their free flu shot. • Message recording	(PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-64
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive management of diabetes	Q2: Letter sent to members with last date of service for needed tests and diabetes educational booklet. Q3: Reminder sent to members to have their diabetic retinal eye exam. Q4: Reminder card sent to members that have not completed diabetic HEDIS screenings. • Mailing	(CDC) Comprehensive Diabetes Care
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Goal:** Virginian's protected against vaccine-preventable diseases	Program that promotes parents to have their child's well child check-up which includes physical exam, immunizations, and growth and development screening. Incentive includes: $10 Walmart gift card, teddy bear, crayons/coloring book, bookmark • Flyer; mailing	(W15) Well-Child Visits in the first 15 Months of Life (6 or more visits) (W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (WCV) Adolescent Well-Care Visits
Aim: Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Goal:** Virginian's protected against vaccine-preventable diseases	Revised Ted E Bear MD program; promotes parents to have their child's well child check-up which includes a physical exam, immunizations, and growth and development screening. Each child receives an enrollment gift (based on age) and a Walmart gift upon completion of well child check-up (gift cards varies based on age group). • Flyer, mailing	(W15) Well-Child Visits in the first 15 Months of Life (6 or more visits) (W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (WCV) Adolescent Well-Care Visits (CIS) Childhood Immunization Status (IMA) Immunizations for Adolescents

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
		(PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-64
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Obstetrical packet mailed to member's last seen obstetrician/gynecologist (OB/GYN); provides OB/GYB with billable codes to use for smoking cessation counseling, along with a flow chart on navigating through smoking cessation conversation and patient self-evaluation. • Mailing	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care
Aim: Achieve Healthier Pregnancies and Healthier Births **Goals:** Improved pre-term birth rates	Calls made to identified pregnant smokers to inform members of available resources and options to engage in smoking cessation. • Live call	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health	Provides benchmark of how many members are in treatment. Reports from Pre-Manage are reviewed weekly for recent emergency department admissions for drug or alcohol (ETOH) overdose. These members are outreached by the behavioral health department to assure safety and encourage engagement in outpatient substance use disorder services. • Live Call	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Focus on Screening and Prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible	Preventive reminder encourages women to receive an annual well woman exam and includes two unique cards. The card for ages 21-39 years focuses on cervical cancer screening. The card for ages	(BCS) Breast Cancer Screening (CCS) Cervical Cancer Screening (COL) Colorectal Cancer Screening

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	40-74 years focuses on both cervical and breast cancer screenings. • Mailing	
Aim: Focus on Screening and Prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible	Incentive for members that complete their Papanicolaou test (pap) and mammogram. • Flyer	(BCS) Breast Cancer Screening (CCS) Cervical Cancer Screening (COL) Colorectal Cancer Screening
Aim: Focus on Screening and Prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible **Goal:** Virginians protected against vaccine-preventable diseases **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive management of diabetes	Program that incentivizes members for completing various screenings and yearly wellness exams. • Flyer	(BCS) Breast Cancer Screening (CCS) Cervical Cancer Screening (COL) Colorectal Cancer Screening (CDC) Comprehensive Diabetes Care
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive management of diabetes **Goal:** Effective management of cardiovascular disease	Tool used to determine patient is exhibiting behavior that indicates that they aren't adherent to medications. Target six medical conditions (diabetes, heart health (hypertension, congestive heart failure and coronary artery disease), and psychosis medications). Analyze what are drivers for nonadherence. • IVR • Disease management newsletter • Some cohorts will receive SMS and IVR and other cohorts will receive the mailer.	(CDC) Comprehensive Diabetes Care (CBP) Controlling High Blood Pressure

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care	Reduce 30-day readmissions for members who have been recently discharged from an acute inpatient hospital stay for a subset of conditions through increased follow-up. Reduce readmission by 3-5%. • SMS • IVR • Direct mail • Live Call	(PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits

HealthKeepers

Table C-2—HealthKeepers' Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	HealthKeepers has focused targeted metrics in place to measure progress as well as interventions in place that are in line with the Virginia Quality Strategy including enhance the member care experience; effective patient care; smarter spending; and improve population health.	

Magellan

Table C-3—Magellan's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	Magellan established in-home assessments using the vendor Inovalon to help capture and ensure the proper clinical profile of its membership. These in-person or telehealth assessments help the MCO to	

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
	better understand the clinical profile of each member to ensure they are offering relevant services in supporting our members in the best possible way.	
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health **Goal:** Strengthen access to primary care network **Goal:** Decrease inappropriate utilization and total cost of care **Goal:** Encourage appropriate management of prescription medications **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Effective management of chronic respiratory disease **Goal:** Comprehensive management of diabetes **Goal**: Effective management of cardiovascular disease **Aim:** Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Goal:** Virginian's plan their pregnancies	HEDIS intervention is organized by four workgroups: behavioral health, pharmacy, chronic conditions, and women and children. Magellan is working with internal teams, network providers, and vendors to monitor and continue improvement of measure outcomes by identifying members with gaps in care and assisting members to receive health services they need.	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up (AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services) (PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits Use of Multiple Concurrent Antipsychotics in Children and Adolescents (ADD) Follow-up Care for Children Prescribed ADHD Medications – Initiation and Continuation/Maintenance Phase (OHD) Use of Opioids at High Dosage in Persons Without Cancer (AMM) Antidepressant Medication Management – Effective Acute Phase Treatment and Continuation/Maintenance Phases (PQI15) Asthma Admission Rate

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Goal: Improved pre-term birth rate **Goal:** Virginian's protected against vaccine-preventable diseases		(CDC) Comprehensive Diabetes Care (CBP) Controlling High Blood Pressure (PDENT) Annual Preventive Dental Visits (W15) Well-Child Visits First 15 Months of Life (W34) Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life (AWC) Adolescent Well-Care Visits (12-21 Years) (PPC) Post-Partum Care Visit (PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care (LBW) Percent of Live Births <2,500 Grams (CIS) Childhood Immunization Status (IMA) Immunizations for Adolescents (PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-64
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Strengthen access to primary care network	Magellan ensures all members receive transportation needed to health care services. Even during the COVID-19 pandemic, all members, even members diagnosed with	(AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services) Children and Adolescents' Access to Primary Care

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
	COVID-19, receive the same quality transportation services.	
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	Member engagement begins with member outreach. Successful outreach is critical to Magellan's members' overall health outcomes. Magellan uses Lexis Nexis to obtain the most current member contact information to boost successful member outreach and engagement.	
Aim: Build a Wellness Focused Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care	Magellan established a process to identify factors such as network, age, and other relevant membership cohorts that impact low-acuity non-emergent emergency room visits, hospital readmission, and potential preventable hospital admission rates and implement interventions to improve the rates.	(PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health	Magellan's integrated care pilot program was developed and implemented in partnership with a Community Services Board (CSB) to improve healthcare quality and cost outcomes for members with behavioral health, substance use, and physical health comorbidities.	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	Magellan offers services that are not generally covered through Medicaid fee-for-service. Magellan members have access to the following benefits: • Dental • Vision • Bicycle helmets • Over-the-counter products • Complete care counts member incentive program • Smart phone	

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
	• On to Better Health Behavioral Health Resources • Clickotine program to quit smoking • Environmental modifications • Community connections • Post discharge meals • Personal care attendant support • Transition of care for children in foster care and for adults • Caring for care givers program	
Aim: Achieve Healthier Pregnancies and Healthier Births **Goal:** Improved pre-term birth rate	Early identification of pregnancy is critical to prenatal care for members and their unborn children. To improve early identification and health outcomes for maternal and infant members, Magellan designed a pregnancy notification form for members and providers. Upon confirmation of a positive pregnancy, the form can be completed by members or providers. This form allows the Magellan pregnancy care team to coordinate prenatal visits and provide support to pregnant members.	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavioral, oral and physical health **Goal:** Strengthen access to primary care network	Magellan sends out personalized text messages with health tips and reminders based on the member's age and specific risk factors to our members. Text message campaign topics are diabetes, maternal health, pediatric health, individual preventive health, and COVID-19.	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up (AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services)

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Goal: Decrease inappropriate utilization and total cost of care **Goal:** Encourage appropriate management of prescription medications **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Effective management of chronic respiratory disease **Goal:** Comprehensive management of diabetes **Goal**: Effective management of cardiovascular disease **Aim:** Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings **Goal:** Virginian's plan their pregnancies **Goal:** Improved pre-term birth rate **Goal:** Virginian's protected against vaccine-preventable diseases		Children and Adolescents' Access to Primary Care (PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits Use of Multiple Concurrent Antipsychotics in Children and Adolescents (ADD) Follow-up Care for Children Prescribed ADHD Medications – Initiation and Continuation/Maintenance Phase (OHD) Use of Opioids at High Dosage in Persons Without Cancer (PQI15) Asthma Admission Rate (CDC) Comprehensive Diabetes Care (CBP) Controlling High Blood Pressure (PDENT) Annual Preventive Dental Visits (W15) Well-Child Visits First 15 Months of Life (W34) Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life (AWC) Adolescent Well-Care Visits (12-21 Years) (PPC) Post-Partum Care Visit (PPC) Timeliness of Prenatal Care

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
		(PPC) Frequency of Ongoing Prenatal Care (LBW) Percent of Live Births <2,500 Grams (CIS) Childhood Immunization Status (IMA) Immunizations for Adolescents (PNU) Pneumococcal Vaccination Status for Older Adults (FVA) Flu Vaccinations for Adults Ages 18-64

Optima

Table C-4—Optima's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Aim: Build a Wellness Focused, Integrated System of Care **Goal 1.2:** Emphasize member experience of care *The quality initiatives may impact other Quality Strategy aims and goals.*	• Outreach baby showers • Outreach member advisory forums (virtual currently) • Care coordination technician member outreach • Continued and increased outreach to members through the vendor EMMI for IVR calls and educational videos as well as live calls by the population care team • Member portal through BioIQ so members can have immediate access to their fecal immunochemical test (FIT) results	CAHPS Member Rating of Health Plan

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Care coordinators work with members to close gaps in care by utilizing gaps in care reports • Use of PreManage/Collective Medical reports to identify members with high utilization of ED and inpatient admissions to improve access to most appropriate levels of care/services • Dedicated team (CipherHealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc. • Implementation of in-home testing and assessments for members through Matrix in-home assessment (IHA)	
Aim: Build a Wellness Focused, Integrated System of Care **Goal :** Emphasize member experience of care	• Annual care coordination program satisfaction surveys and develop action plan • Customer service training for care coordinators • Implemented a member portal through BioIQ so members can have immediate access to their FIT results • CAHPS action planning to improve measures	CAHPS Member Rating of Health Plan
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive diabetes management **Aim:** Focus on Screening and Prevention	• Provide at-home testing for diabetes care • Continued services and improvement to provide at-home testing for colorectal cancer screening • Implementation of in-home testing and assessments for	(CDC) Comprehensive Diabetes Care (BCS) Breast Cancer Screening (COL) Colorectal Screening

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal: Cancers are diagnosed at the earliest stage possible **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Ensure quality of life for members with intensive healthcare needs	members through Matrix IHA	(CCS) Cervical Cancer Screening Assessments and Reassessments
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	• Member care gap dashboard shared with provider office partners • Provider education meetings • Provider portal enhancements • Relationships with clearinghouses that allows for better electronic data interchangeability for claims processing • COVID-19 mitigation meetings held with pediatricians in June, July and August from the Children's Hospital King's Daughters (CHKD), Sentara Medical Group and Sentara Quality Care Network to discuss vaccine counseling, well-visits, patient communication, visit coding, telehealth, providers-sharing of best practices with each other.	
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive diabetes management **Aim:** Focus on Screening and Prevention	• Provider network access evaluation • Provide at-home testing for diabetes care • Continued services and improvement to provide at-home testing for colorectal cancer screening	(CDC) Comprehensive Diabetes Care (BCS) Breast Cancer Screening (COL) Colorectal Screening (BCS) Cervical Cancer Screening

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal: Cancers are diagnosed at the earliest stage possible **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Ensure quality of life for members with intensive healthcare needs	• In-home assessments (telehealth during COVID) • Hospital and ED post-discharge follow-up calls to members to assist with scheduling appointment with PCP, MDLive or specialists as needed • Personal care authorization end dates were extended 60 days during COVID • Members were not removed from the Waiver during COVID • Respiratory related durable medical equipment (DME) and supplies did not require an authorization during COVID • Members who were hospitalized did not require a screening to be placed in a nursing facility during COVID • Home health and hospice did not require an authorization during COVID • Out of network policy relaxed during COVID	Assessments and Reassessments
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	• Critical incident process and reporting • Mandatory Adult Protective Service/Child Protective Service (APS/CPS) reporting policy	
A direct link to the aims and goals in the 2017-2019 Virginia Quality Strategy could not be determined.	• Quality management reviews (QMRs) of LTSS providers • Value-based arrangement discussions and agreements with providers	
Aim: Build a Wellness Focused, Integrated System of Care	• Mental health skill building Initiative to identify members making progress from the service and actively transition members	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal: Integration of behavior, oral and physical health **Goal:** Decrease inappropriate utilization and total cost of care	who are not benefiting from the service to a more appropriate service • Use of PreManage/Collective Medical reports to identify members with high utilization of emergency department and inpatient admissions to improve access to most appropriate levels of care/services • Updating contracts and payment structures for DME providers	(FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up (PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavior, oral and physical health	• The behavioral health program with MDLIVE and the BH team • Use of PreManage reports to identify members with BH ED visit utilization to improve follow-up appointment compliance and access to most appropriate levels of care/services	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Integration of behavior, oral and physical health	• Optima behavioral health team outreach to assist with scheduling treatment services	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Comprehensive diabetes management **Goal:** Ensure quality of life for members with intensive healthcare needs **Aim:** Focus on Screening and Prevention	• Continued colorectal cancer screening program (FIT) • Engagement of members with the mobile van for mammograms • Diabetic eye exam incentive program • Diabetic eye exam PopCare campaign • Care coordinators work with members to close gaps in care by utilizing gaps in care reports	(CDC) Comprehensive Diabetes Care Assessments and Reassessments (BCS) Breast Cancer Screening (COL) Colorectal Screening (CCS) Cervical Cancer Screening

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal: Cancers are diagnosed at the earliest stage possible **Aim:** Build a Wellness Focused, Integrated System of Care **Goal:** Decrease inappropriate utilization and total cost of care	• Use of PreManage/ Collective Medical reports to identify members with high utilization of emergency department and inpatient admissions to improve access to most appropriate levels of care/services • Dedicated team (CipherHealth) to conduct hospital and emergency department post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc. • Implementation of in-home testing and assessments for members through Matrix IHA	(PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Ensure quality of life for members with intensive healthcare needs	• Complex case management services by the clinical team • Clinical care services team utilization of Prealize Predictive Analytics for member engagement into care coordination/case management services • Implementation of in-home testing and assessments for members through Matrix IHA with referrals to Optima case management teams if needed	Assessments and Reassessments
Aim: Maximize Wellbeing Across the Lifespan **Goal:** Ensure quality of life for members with intensive healthcare needs	• Care coordinators attend nursing facility Minimum Data Set (MDS) meetings, identify and transition eligible members back to community • Long-term care nursing facility discharge rounds with provider to assist care coordinator in safely	Assessments and Reassessments (TRC) Transition of Members Between Community Well, LTSS and Nursing Facility – Services and Successful Retention in Lower Care Settings

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	transitioning member from a nursing facility to community setting • Critical incidents submitted to quality improvement for care concern investigations	
Aim: Achieve Healthier Pregnancies and Healthier Births **Goal:** Improved pre-term birth rate	• Outreach baby showers • Prenatal and postpartum incentive program • Referrals to Partners in Pregnancy case management program • Case manager to assist in scheduling prenatal/postpartum visits, managing chronic conditions, providing care coordination and case management as well as providing support and education during the prenatal and postpartum period • Continued and increased outreach to members through the vendor EMMI for educational videos as well as live calls by the partners in pregnancy team	(PPC) Timeliness of Prenatal Care (PPC) Frequency of Ongoing Prenatal Care (LBW) Percent of Live Births <2,500 Grams

United

Table C-5—United's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Emphasize member experience of care	UnitedHealthcare (Medallion and CCC Plus) has quality integrated into all facets of the health plan in order to provide quality services to members, ensure they have appropriate access to care and to improve health outcomes.	CAHPS Member Rating of Health Plan (IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
Goal: Integration of behavioral, oral and physical health **Goal:** Decrease inappropriate utilization and total cost of care **Goal:** Strengthen access to primary care network **Aim:** Maximize Wellbeing Across the Lifespan **Goal:** Ensure quality of life for members with intensive healthcare needs **Aim:** Focus on Screening and Prevention **Goal:** Support consistency of recommended pediatric screenings	To meet the goals and objectives in the Virginia Quality Strategy, UnitedHealthcare monitors rates for multiple quality measures, including those on the DMAS Quality Strategy Quality Dashboard. Initiatives UnitedHealthcare has implemented to meet the Quality Strategy include, but were not limited to: *Enhanced Member Care Experience:* Within the health plan, care coordination integrates physical and behavioral health, and incorporates medical management (pharmacy services) in the members' care management plans. These care plans focus on member goals for positive health outcomes and aim to improve appropriate use of services and reduce inappropriate utilization. UnitedHealthcare also coordinates member access to HCBS services and monitors provider and member satisfaction with those services. *Effective Patient Care:* UnitedHealthcare maintains network adequacy, so members have appropriate access to care. We ensure we are meeting DMAS network adequacy standards. We ensure providers have the most current information on benefits and resources to support the members. UnitedHealthcare partners with providers for member support such as 1)	(FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up (PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits (AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services) Children and Adolescents' Access to Primary Care Assessments and Reassessments (PDENT) Annual Preventive Dental Visits (W15) Well-Child Visits First 15 Months of Life (W34) Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life (AWC) Adolescent Well-Care Visits (12-21 Years)

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	providing PCPs with data on members with gaps in care, 2) identifying emergency department visits through the emergency department Care Coordination (EDCC) interface and working with emergency departments on adequate discharge plans and follow-up appointments, 3) coordinating transportation to appointments, and 4) partnering with Federally Qualified Health Centers (FQHCs) for member care and support of community events. *Smarter Spending:* UnitedHealthcare continually monitors to ensure we are operating as efficiently and effectively as possible. There is also focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits. UnitedHealthcare initiated a Community Plan Primary Care Provider Incentive Program which is a value-based incentive program with the goal of compensating primary care providers for performance for key member outcome measures. UnitedHealthcare assists in the identification of members who need preventive services so primary care providers can appropriately outreach and schedule appointments with these members. *Improved Population Health:*	

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	Through a variety of methodologies UnitedHealthcare provides member education and outreach, with appropriate focus on special populations. Many of these outreach programs are outlined in the performance measure validation section on HEDIS measure activities. UnitedHealthcare is continually reviewing metrics to identify where outreach is most needed. In addition, UnitedHealthcare has supported and encouraged the use of telemedicine through the pandemic to assist members with continued access to care. The purpose of all these activities is to improve the overall health of United's members.	

VA Premier

Table C-6—VA Premier's Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Aim: Build a Wellness Focused, Integrated System of Care **Goal:** Emphasize member experience of care **Goal:** Decrease inappropriate utilization and total cost of care	Corporate quality and safety strategy: Quadruple Aim • Population Health – improving population health with value-based care • Patient/member engagement – improving patient care and engagement	CAHPS Member Rating of Health Plan (PCR) Plan All-Cause Readmission Rate (EDU) Ambulatory Care – Emergency Department Visits

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Goals: Integration of behavioral, oral and physical health	• Cost reduction – reducing total cost of care while improving quality • Provider engagement – Improving provider engagement across the continuum of care The MCO strives to meet the needs of underserved and vulnerable populations, in Virginia, by delivering quality-driven, culturally sensitive, and financially viable healthcare to all members. The quality improvement program has an ongoing commitment to promote excellence in healthcare, enhance personal wellness, continuously improve member experiences and outcomes, and provide access to care in a safe and cost-effective manner. The MCO initiatives are aimed at achieving goals and objectives aligned with Virginia Premier's quality strategy: Quadruple Aim (adopted in 2019) and designed to inspire healthy living through innovation, strategic partnerships, and industry-leading healthcare across the continuum of care. Initiatives developed and implemented by the MCO to meet goals and objectives in the Virginia Quality Strategy include, but are not limited to, the following: • Quality improvement program • Quality improvement committee (QIC) structure and governance	(IET) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (FUH) Follow-Up After Hospitalization for Mental Illness, 7-Day Follow-Up

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
	• HEDIS performance monitoring and targeted improvement plan • Population health program to include year-long engagement with members to close care gaps • Medical outreach/health education • Value-based purchasing • Member safety initiatives • Member/provider satisfaction surveys • Member/provider outreach/engagement • Cultural competency and healthcare disparities analyses and evaluations • Culturally and linguistically appropriate services (CLAS) competency provider training • Utilization management program • Patient utilization management and safety (PUMS) program • Behavioral health/ARTS benefit • Reducing readmissions • Reducing emergency department utilization • Case management program • Chronic care management program • Maternity health/disparities • Social determinants of health (SDOH) The various initiatives span a multitude of areas as all departments ultimately contribute to quality outcomes for the MCO's members and providers.	

Appendix D. 2020–2022 Quality Strategy Aims, Goals, Objectives, and Metrics

Appendix D provides DMAS's 2020–2022 Quality Strategy aims, goals, objectives, and quality measures.

Table D-1—DMAS' 2020 Quality Strategy Goals and Objectives

AIM	Goal	Objective	Measure Name	Metric specifications
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	Increase Timely Access to Care	**Metric 1.2.1:** Getting Care Quickly Q6	CMS Adult Core Set: CPA-AD
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings	CMS Adult Core Set: CPA-AD
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD
	Goal 1.3: Improve Home and Community-Based Services	Ensure Patient-Centered Care and Services	**Metric 1.3.1:** Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	Quality Management Review (QMR)
		Ensure Access to Care	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	Quality Management Review (QMR)
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	Maintain Provider Engagement	**Metric 2.1.1:** Rating of Personal Doctor	CMS Adult Core Set: CPA-AD
		Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD
	Goal 2.2: Ensure Access to Care	Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	Decrease Potentially Preventable Admissions	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions	VBP Reporting Team
		Decrease Emergency Department Visits	**Metric 3.1.2:** Frequency of Emergency Department Visits	VBP Reporting Team

AIM	Goal	Objective	Measure Name	Metric specifications
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team
		Decrease Emergency Department Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS
	Goal 3.2: Focus on Efficient Use of Program Funds	Ensure High-Value Appropriate Care	**Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total	Finance Team Reporting
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	Increase Follow-Up Visits After Hospitalization for Mental Illness	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness	CMS Adult Core Set: FUH-AD
		Increase Follow-Up Visits After Emergency Department Visit for Mental Illness	**Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness	CMS Adult Core Set: FUM-AD
		Increase Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	**Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	CMS Child Core Set: ADD-CH
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT
		Increase Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CMS Child Core Set: APP-CH
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	Increase Identification of Alcohol and Other Drug Services	**Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services	NCQA HEDIS IAD
		Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CMS Adult Core Set: FUA-AD

AIM	Goal	Objective	Measure Name	Metric specifications
		Decrease Use of Opioids at High Dosage in Persons Without Cancer	**Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer	CMS Adult Core Set: OHD-AD
		Increase Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	CMS Adult Core Set: IET-AD
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	Increase Percentage of Eligibles who Receive Preventive Dental Services	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services	CMS Child Core Set: PDENT-CH
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH
	Goal 4.4: Improve Health for Members with Chronic Conditions	Decrease Heart Failure Admission Rate	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate	CMS Adult Core Set PQI08-AD
		Decrease Asthma Admission Rate	**Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17)	AHRQ Quality Indicators PDI 14
		Decrease COPD and Asthma in Older Adults' Admission Rate	**Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate	CMS Adult Core Set PQI05-AD
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set HPC-AD
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD
	Goal 4.5: Improve Outcomes for Nursing Home	Decrease Use of High-Risk Medications in Older Adults (Elderly)	**Metric 4.5.1:** Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS DAE

AIM	Goal	Objective	Measure Name	Metric specifications
	Eligible Members			
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	Increase Postpartum Care	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care	CMS Adult Core Set PPC-AD
		Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH
		Decrease Low Birth Weight Babies	**Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams	CMS Child Core Set LBW-CH
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH