Commonwealth of Virginia Department of Medical Assistance Services

2021 External Quality Review Technical Report—Commonwealth Coordinated Care Plus

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Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
Adult Core Set	CMS Core Set of Adult Health Care Quality Measures for Medicaid
AHRQ	Agency for Healthcare Research and Quality
ARTS	Addiction and Recovery Treatment Services
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BBA	Balanced Budget Act of 1997
BH	Behavioral Health
BMI	Body Mass Index
BR	Biased Rate
CAHPS®,[1]	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CC	Community Coaching
CCC Plus	Commonwealth Coordinated Care Plus
CE	Community Engagement
Child Core Set	CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
CHIP	Children's Health Insurance Program
CMHRS	Community Mental Health Rehabilitative Services
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CRMS	Care Management Solution
CY	Calendar Year
D-SNP	Dual-Eligible Special Needs Plan
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disability
DMAS	Department of Medical Assistance Services
DME	Durable Medical Equipment
ED	Emergency Department
EDCD	Elderly or Disabled With Consumer Direction
EDV	Encounter Data Validation
EPS	Encounter Processing Solution
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review

[1] CAHPS® is a registered trademark of AHRQ.

EQRO.....External Quality Review Organization
FAMIS.....Family Access to Medical Insurance Security
FAR.....Final Audit Report
FFS.....Fee-for-Service
FFY.....Federal Fiscal Year
FMEA.....Failure Mode and Effects Analysis
FPL.....Federal Poverty Level
HCBS.....Home and Community-Based Services
HCPCS.....Healthcare Common Procedure Coding System
HEDIS®,[2].....Healthcare Effectiveness Data and Information Set
HHS.....United States Department of Health and Human Services
HIPAA.....Health Insurance Portability and Accountability Act of 1996
HMO.....Health Maintenance Organization
HSAG.....Health Services Advisory Group, Inc.
I/DD.....Intellectual and Developmental Disability
IACCT.....Independent Assessment Certification and Coordination Team
ICT.....Intensive Community Treatment
ID.....Identification
IDSS.....Interactive Data Submission System
IIH.....Intensive In-Home Services
IS.....Information Systems
ISP.....Individual Service Plan
LO.....Licensed Organization
LOB.....Line of Business
LTSS.....Long-Term Services and Supports
MCE.....Managed Care Entity
MCO.....Managed Care Organization
MES.....Medicaid Enterprise System
MHSS.....Mental Health Skill-Building Services
MITA.....Medicaid Information Technology Architecture
MLTSS.....Managed Long-Term Services and Supports
MMIS.....Medicaid Management Information System
MODRN.....Medicaid Outcomes Distributed Research Network
MOUD.....Medications for Opioid Use Disorder
MRRV.....Medical Record Review Validation
MUE.....Medically Unlikely Edit
MY.....Measurement Year

[2] HEDIS® is a registered trademark of NCQA.

NCQA ..... National Committee for Quality Assurance
NDC ..... National Drug Code
NF ..... Nursing Facility
NPI ..... National Provider Identifier
NR ..... Not Reported
O/E ..... Observed/Expected
OB/GYN ..... Obstetrics and Gynecology
OBOT ..... Office-Based Opioid Treatment
OSR ..... Operational Systems Review
OTP ..... Opioid Treatment Program
OUD ..... Opioid Use Disorder
PAHP ..... Prepaid Ambulatory Health Plan
PASRR ..... Preadmission Screening and Resident Review
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDSA ..... Plan-Do-Study-Act
PHE ..... Public Health Emergency
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMV ..... Performance Measure Validation
PRTF ..... Psychiatric Residential Treatment Facility
PSR ..... Psychosocial Rehabilitation
PTP ..... Procedure-to-Procedure
PWP ..... Performance Withhold Program
QAPI ..... Quality Assessment and Performance Improvement
QI ..... Quality Improvement
QS ..... Quality Strategy
SARS-CoV-2 ..... Severe Acute Respiratory Syndrome Coronavirus 2
SBIRT ..... Screening, Brief Intervention, and Referral to Treatment
SFY ..... State Fiscal Year
SHCN ..... Special Health Care Needs
SIS ..... Supports Intensity Scale
SMART ..... Specific, Measurable, Attainable, Relevant, Time-bound
SNF ..... Skilled Nursing Facility
SUD ..... Substance Use Disorder
T-MSIS ..... Transformed Medicaid Statistical Information System
TDT ..... Therapeutic Day Treatment
TGH ..... Therapeutic Group Home

TPL	Third Party Liability
VA	Virginia
VCU	Virginia Commonwealth University
VDH	Virginia Department of Health
VDSS	Virginia Department of Social Services
VHHA	Virginia Hospital & Healthcare Association
VNPC	Virginia Neonatal Perinatal Collaborative
WIC	Women, Infants and Children

1. Executive Summary

Overview of 2021 External Quality Review

Per 42 CFR §438.364, states are required to use an EQRO to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid MCOs, in accordance with the CFR, were aggregated and analyzed. HSAG used the HHS CMS' December 2018 update of its EQR Toolkit for States when preparing this report.[1-1]

To meet this requirement, the Commonwealth of Virginia, DMAS, contracted with HSAG, as its EQRO, to perform the assessment and produce this report for EQR activities conducted during the period of January 1, 2021, through December 31, 2021 (CY 2021). In addition, this report draws conclusions about the quality of, timeliness of, and access to healthcare services that the contracted MCOs provide.

DMAS administers the CCC Plus program, which includes the Virginia Medicaid program and the FAMIS program, the Commonwealth's CHIP. DMAS contracted with six privately owned MCOs to deliver physical and behavioral health services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2021 are displayed in Table 1-1.

Table 1-1—Medicaid CCC Plus MCOs in Virginia

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

Scope of External Quality Review 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 CMS. 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 the Commonwealth's efforts to

[1-1] 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: Nov 29, 2021.

purchase high-value care and to achieve higher performing healthcare delivery systems for its Medicaid and CHIP members.

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2021 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2021, through December 31, 2021. From these analyses, HSAG derived conclusions and made recommendations about the quality of, access to, and timeliness of care and services provided by each DMAS MCO and the overall statewide CCC Plus program. A comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO are found in the results of each activity in sections 4 through 8 of this report and Section 9—Summary of MCO-Specific Strengths and Weaknesses. Detailed information about each activity's methodology is provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities		
Validation of Rapid-Cycle PIPs	The purpose of PIP validation is to validate PIPs that have the potential to affect and improve member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provided detailed information about the PIPs related to the steps completed and validated by HSAG for the 2021 validation cycle.	*Protocol 1.* Validation of Performance Improvement Projects
PMV	HSAG conducts the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these measures follow State specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the PM rates. DMAS identified and selected the specifications for a set of PMs that the MCOs were required to calculate and report for the measurement period of January 1, 2020, through December 31, 2020.	*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. HSAG conducted full compliance reviews (called OSRs) that included all federal and state-specific requirements for the review period of July 1, 2020, through June 30, 2021.	*Protocol 3*. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Activity	Description	CMS EQR Protocol
Validation of Network Adequacy	The network adequacy validation activity validates MCO network adequacy using DMAS' network standards in its contracts with the MCOs. DMAS established time and distance standards for the following network provider types: primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types that promote the objectives of the Medicaid program.	*Protocol 4.* Validation of Network Adequacy *(Pending Final Protocol)*
Optional Activities		
EDV	HSAG conducts EDV, which includes an IS review/assessment of DMAS' and the MCOs' IS and processes to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. HSAG also completes an administrative profile, which is an analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. This activity evaluates the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters.	*Protocol 5.* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
CAHPS	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
ARTS Measurement Specification Development and Maintenance	HSAG identifies, when available, PMs from existing measure sets or develops PMs for the ARTS program.	*Protocol 7.* Calculation of Additional Performance Measures
Consumer Decision Support Tool	This activity provides information to help eligible members choose a Medicaid CCC Plus MCO. The tool shows how well the different MCOs provide care and services in various performance areas. 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.	*Protocol 10.* Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans

Activity	Description	CMS EQR Protocol
PWP	HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2021 PWP used HEDIS and non-HEDIS measures.	
QS Update	HSAG works with DMAS to update and maintain the Virginia 2020–2022 QS. QS maintenance incorporates 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. HSAG reviews the QS to ensure the most current Managed Care Rule and CMS Medicaid and CHIP Managed Care QS Toolkit requirements are met.	Medicaid and CHIP Managed Care QS Toolkit

Virginia Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the MCOs' performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members as required in 42 CFR §438.364. The overall findings and conclusions regarding quality, timeliness, and access for all MCOs were also compared and analyzed to develop overarching conclusions and recommendations for the Virginia managed care program. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 1-3 provides the overall strengths and weaknesses of the CCC Plus program that were identified as a result of the EQR activities. Refer to Section 3 for a summary of each activity.

Methodology: HSAG follows a three-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality of, timeliness of, and access to care furnished by each MCO, as well as the program overall.

Step 1: HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about the overall quality of, timeliness of, and access to care and services furnished by the MCO.

Step 3: HSAG identifies any patterns and commonalities that exist across the program to draw conclusions about the quality of, timeliness of, and access to care for the program.

Table 1-3—Overall CCC Plus Program Conclusions: Quality, Access, and Timeliness

EQRO Results	
Domain	**Conclusion**
Quality	**Strengths:** Overall, MCOs are providing quality care for members diagnosed with a mental/behavioral health condition. All six MCOs met or exceeded the NCQA 50th percentile in four of the HEDIS behavioral health measures. Compliance reviews of the MCOs supported a strong implementation of the ARTS benefit, with few grievances or appeals filed with the MCOs indicating member access to needed behavioral and SUD treatment and services. **Strength:** Overall, MCO members are satisfied with the quality of care provided through their MCOs. MCO members rated their health plan, the specialist seen most often, and the ability to get needed care higher in 2021 than in 2020. The member experience results were supported by improved PM rates in the Living With Illness domain, including measures focused on discussing and advising members to quit smoking and tobacco use and providing medical assistance with smoking cessation. Further evidence was found in the quality of care provided in respiratory care with pharmacotherapy management of COPD exacerbation and asthma medication ratios exceeding the NCQA 50th percentile. **Weaknesses:** Although members with chronic conditions may have access to care, they are not always able to manage conditions, such as diabetes, according to evidence-based guidelines through the appropriate use of medications, diet and nutrition, or physical activity. A factor that may have contributed to low performance in the management of chronic conditions is the temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. **Weakness:** Preventive care for children, including immunizations and nutrition and physical activity counseling, also showed opportunities to improve quality of care. For adults, performance rates for early diagnosis through screening for breast and cervical cancer fell below the NCQA 50th percentile, indicating the MCOs have opportunities to improve the quality of care.
Access	**Strengths:** The MCOs implemented interventions to increase utilization of EPSDT services, using multiple modalities to ensure that members were informed of covered services and how to access services. The MCOs also implemented processes to provide and inform members and providers of direct access to women's health services, out-of-network services, and second opinions. **Strengths:** Overall, the MCOs evaluated and monitored the quality of, appropriateness of, and access to care for members with SHCN, ensuring that members had physical access, reasonable accommodations, and accessible equipment for members with disabilities. **Strengths:** Adult and child members are able to access a PCP to receive routine and preventive care. Overall, access to care was also evident as the MCOs' interventions have resulted in children and adolescents accessing well-care visits and oral health care, and receiving most screenings according to the

EQRO Results	
Domain	**Conclusion**
	EPSDT or Bright Futures schedules. Overall, member experience survey results also showed high performance in *Getting Needed Care* and *Getting Care Quickly*, indicating that members experienced having access to care and services when needed. **Weaknesses:** The Access and Preventive Care domain was identified as a weakness for the MCOs, with breast cancer screening and cervical cancer screening falling below the NCQA 50th percentile. Members may have had difficulties finding access to care or this weakness may be a result of disparities in the population served. Members may also have had concerns with accessing preventive and early diagnosis services during the COVID-19 PHE, resulting in delays or missed screenings.
Timeliness	**Strengths:** Overall, the MCOs eased requirements and expanded access points during the COVID-19 PHE, including expanded use of telemedicine and services. The MCOs also eased processes to ensure claims edits were not triggered for emergency service claims. Members were able to access a PCP timely and receive appropriate treatment as necessary to stay healthy and reduce unnecessary ED utilization. **Weaknesses:** Overall, MCO members experienced issues in receiving timely follow-up care and services such as cardiovascular disease monitoring, follow-up on alcohol and drug abuse dependence after an ED visit, and initiation and engagement of alcohol and drug abuse treatment. Similar to the access to care weakness, overall timeliness of early diagnosis of breast cancer screening and cervical cancer screening may have contributed to these rates falling below the NCQA 50th percentile. Members may have had concerns with timely accessing preventive and early diagnosis services during the COVID-19 PHE, resulting in delays or missed screenings.

Quality Strategy Recommendations for the Virginia Managed Care Program

The Virginia 2020–2022 QS is designed to improve the health outcomes of its Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and CHIP members served by the Virginia Medicaid managed care programs. DMAS' QS provides the framework to accomplish DMAS' overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Virginia Medicaid and CHIP system. In consideration of the goals of the QS and the comparative review of findings for all activities, HSAG's Virginia-specific recommendations for QI that target the identified goals within the Virginia 2020–2022 QS are included in Table 1-4.

Table 1-4—Quality Strategy Recommendations For the Virginia Medicaid Managed Care Program

Program Recommendations	
Recommendation	**Associated Virginia 2020–2022 QS Goal and/or Objective**
To improve program-wide performance in support of Goal 4.2 and improve members' receipt of follow-up services, HSAG recommends the following: • Require the MCOs to identify healthcare disparities within the behavioral health follow-up PM data to focus QI efforts on a disparate population. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	**Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders **Objective:** Increase Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
To improve program-wide performance in support of Goal 4.3 and mitigate the barriers members experience related to access to care, HSAG recommends the following: • Require the MCOs to identify access-related PMs, such as *Child and Adolescent Well-Care Visits*, that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population.	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Objective:** Increase Child and Adolescent Well-Care Visits
To improve program-wide performance in support of Goal 4.4 and improve members' receipt of recommended care and services for better management of chronic conditions, HSAG recommends the following: • Require the MCOs to identify chronic health-related PMs that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile and focus QI efforts on identifying the cause and implementing interventions to improve access to care. • Require the MCOs to identify healthcare disparities within the chronic health PM data to focus QI efforts on a disparate population.	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure

2. 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, managed care and FFS. As of December 2021, approximately 89.5 percent of Medicaid enrollees received their benefits through the managed care model, and approximately 10.5 percent of enrollees participated in Medicaid through the FFS model. In 2021, the managed Medicaid managed care populations in Virginia were organized into two programs: Medallion 4.0 and CCC Plus. Table 2-1 displays the DMAS annual enrollment by program.

Table 2-1—CY 2021 Average Annual Program Enrollment

Program	SFY 2021 Enrollment as of 09/15/21
Medallion 4.0	1,413,408
CCC Plus	272,818

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 2021 are displayed in Table 2-2.

Table 2-2—MCOs in Virginia

MCO	Profile Description	MCO NCQA Accreditation Status
Aetna	Aetna Better Health of Virginia is the Medicaid/FAMIS Plus program offered by Aetna, a multistate healthcare benefits company headquartered in Hartford, Connecticut.	Accredited* through 04/01/24 LTSS Distinction through 04/01/24
HealthKeepers	HealthKeepers is a Virginia 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 03/09/24 LTSS Distinction through 03/09/24
Magellan	Magellan is a Medicaid/FAMIS Plus program offered by Magellan Health, Inc.,	Accredited* through 06/29/23 LTSS Distinction through 06/30/23

MCO	Profile Description	MCO NCQA Accreditation Status
	conducting business in Virginia since 1972. Magellan is headquartered in Scottsdale, Arizona.	
Optima	Optima is the Medicaid managed care product offered by Optima Health. A subsidiary of Sentara, Optima is a not-for-profit healthcare organization serving Virginia and northeastern North Carolina, headquartered in Norfolk, Virginia.	Accredited* through 04/01/24 LTSS Distinction through 04/01/24
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 D-SNPs across 30 states plus Washington, D.C.	Accredited* through 06/22/23 LTSS Distinction through 06/22/23
VA Premier	VA Premier, founded in 1995, is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Virginia, and VCU Health Systems, based in Richmond, Virginia.	Commendable** Accreditation through 07/08/22 LTSS Distinction through 07/08/22

*Accredited: 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 QI.[2-1]

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

MCO CCC Plus Enrollment Characteristics

Figure 2-1 through Figure 2-4 display the CCC Plus program enrollment characteristics. Table 2-3 through Table 2-7 display the MCO and CCC Plus program overall enrollment characteristics.

[2-1] 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: Nov 19, 2021.

Figure 2-1—CCC Plus Program CY 2021 Eligibility Categories

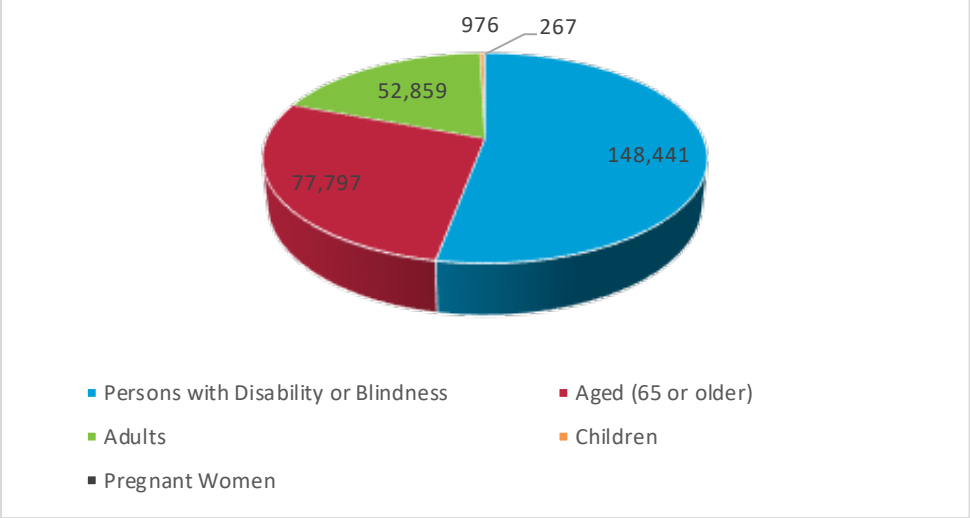


Table 2-3—CCC Plus Program CY 2021 MCO Eligibility Categories

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Eligibility							
Overall Total	43,213	79,666	27,247	45,846	35,072	49,296	280,340
Persons With Disability or Blindness	22,531	40,733	13,280	26,200	16,217	29,480	148,441
Aged (65 or older)	12,369	22,929	7,655	9,907	12,862	12,075	77,797
Adults	8,200	15,565	6,225	9,512	5,891	7,466	52,859
Children	73	388	44	186	52	233	976
Pregnant Women	40	51	43	41	50	42	267

Figure 2-2—CCC Plus Program CY 2021 Categories by Race

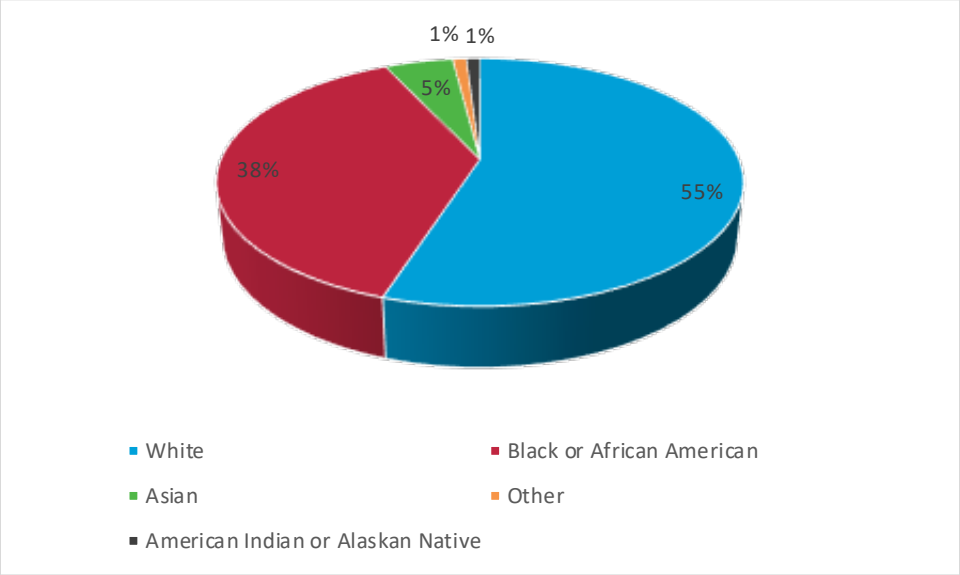


Table 2-4—CCC Plus Program CY 2021 MCO Categories by Race

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Race							
White	56%	54%	53%	49%	56%	63%	55%
Black or African American	37%	37%	41%	46%	36%	33%	38%
Asian	5%	7%	3%	3%	6%	2%	5%
Other	1%	1%	2%	1%	1%	1%	1%
Native Hawaiian or Other Pacific Islander	0%	0%	0%	0%	0%	0%	0%
American Indian or Alaskan Native	0%	1%	0%	1%	1%	0%	1%

Table 2-5—CCC Plus Program CY 2021 MCO Categories by Ethnicity

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Ethnicity							
Non-Hispanic	99%	98%	99%	98%	98%	99%	99%
Hispanic	1%	2%	1%	2%	2%	1%	1%

Figure 2-3—CCC Plus Program CY 2021 Percentage by Gender

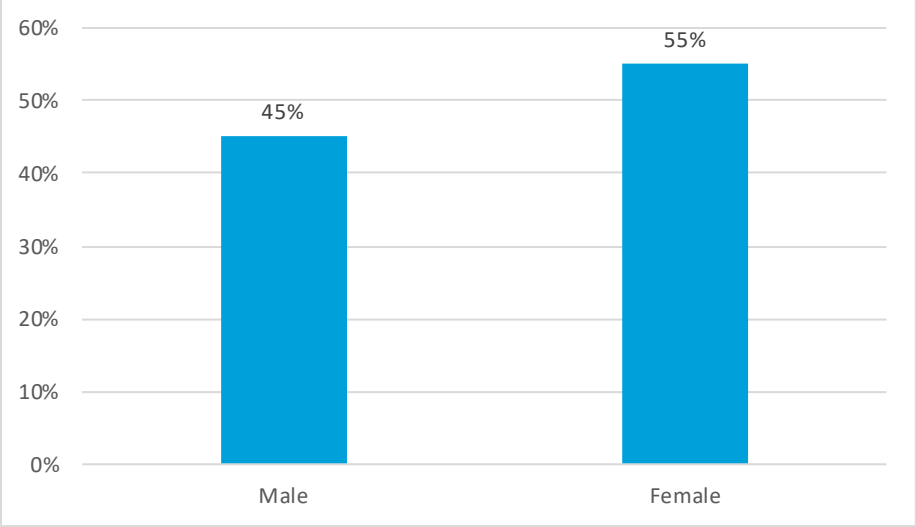


Table 2-6—CCC Plus Program CY 2021 MCO Percentage by Gender

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Gender							
Male	44%	44%	49%	46%	45%	45%	45%
Female	56%	56%	51%	54%	55%	55%	55%

Figure 2-4—CCC Plus Program CY 2021 Enrollment by Age Group

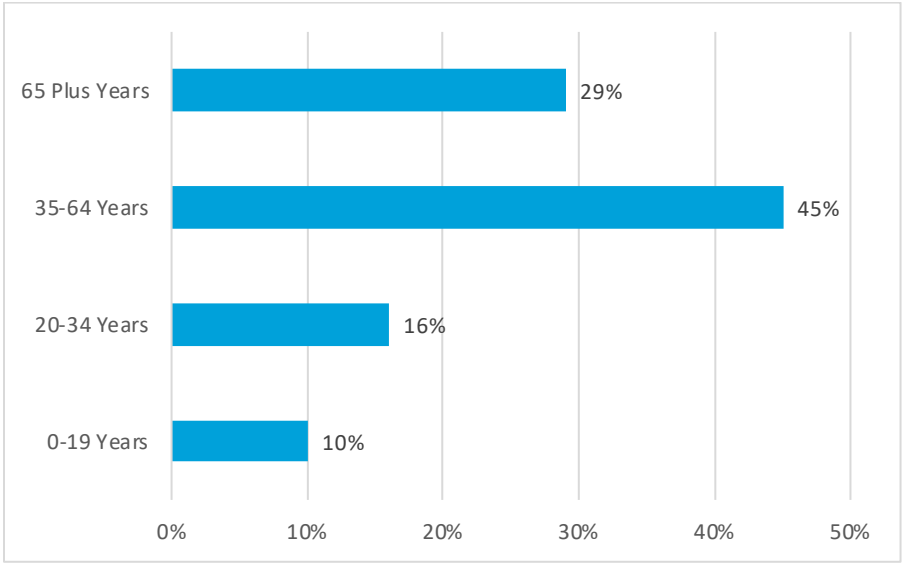


Table 2-7—CCC Plus Program CY 2021 MCO Enrollment by Age Group

Category	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	All
Age Groups							
0–19 Years	7%	12%	8%	13%	6%	13%	10%
20–34 Years	15%	16%	17%	17%	13%	15%	16%
35–64 Years	47%	42%	46%	47%	42%	47%	45%
65 Plus Years	30%	30%	29%	23%	38%	26%	29%

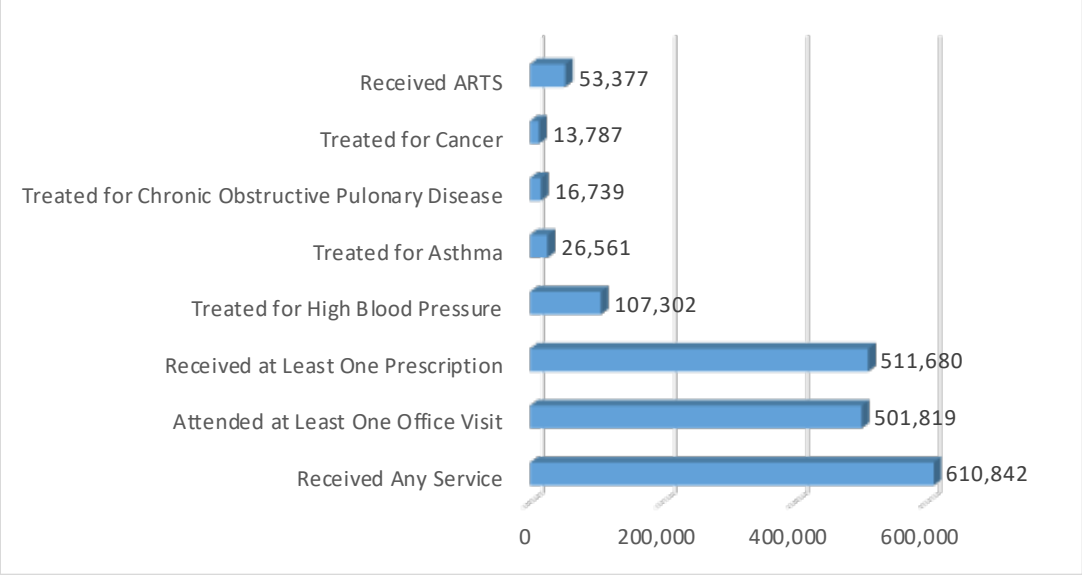
Data from 09/15/21 Enrollment Data at https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/.

CCC 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 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.

Medicaid expansion coverage began in Virginia 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 FPL, 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). As of September 15, 2021, 584,631 adults were newly enrolled in Medicaid as a result of Virginia's Medicaid expansion. Of those, 147,182 were also parents. Males accounted for 46 percent of the Medicaid expansion population and 54 percent were female. Figure 2-5 displays services received by Medicaid expansion members since January 2019. Enrollment and service data were obtained from the September 15, 2021 Medicaid Expansion data at: https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment. All other data in Figure 2-5 and Figure 2-6 were obtained from the September 15, 2021 enrollment data at: https://www.dmas.virginia.gov/data/medicaid-expansion-access.

Figure 2-5—Medicaid Expansion Service Provision

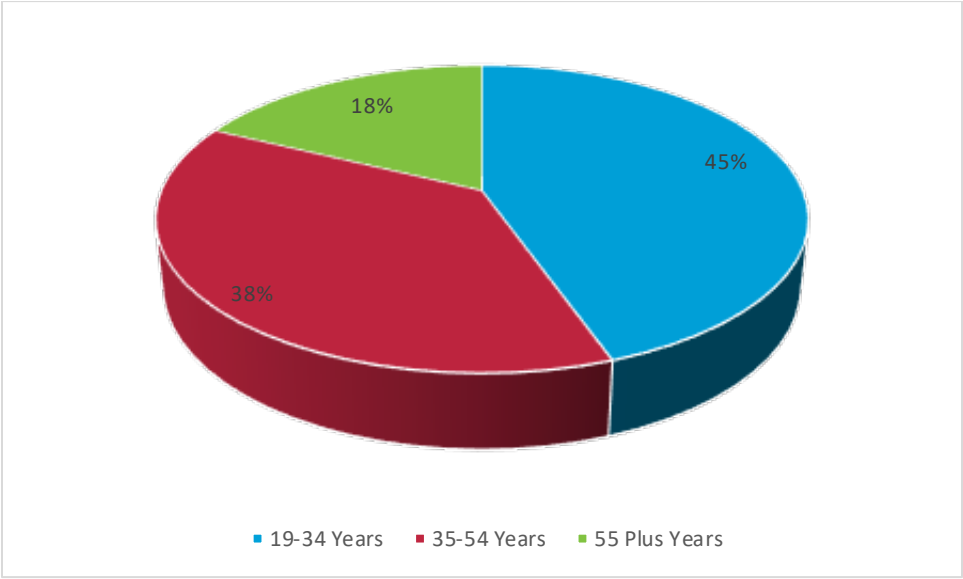


Notes:

- *The number of members enrolled through Medicaid Expansion is a point-in-time measurement as of 9/15/21.*
- *The number of members who received a service is cumulative and includes members enrolled through Medicaid Expansion at any time from 1/1/19–9/15/21 and identified through paid claims submitted to DMAS.*

Figure 2-6 displays the number of Medicaid expansion members by age category.

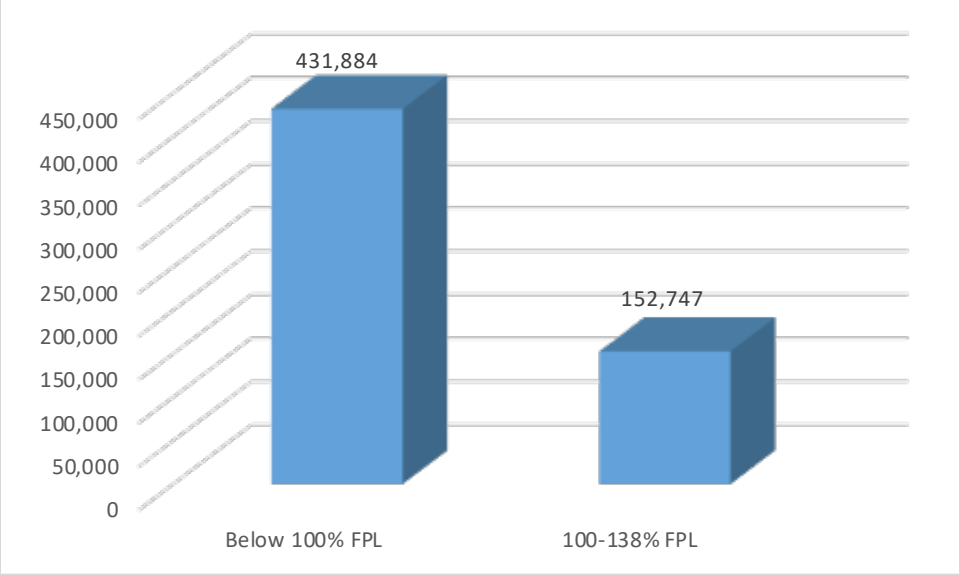
Figure 2-6—Medicaid Expansion Number of Members by Age Category



Note: The number of members enrolled through Medicaid Expansion is a point-in-time measurement as of 9/15/21.

The number of Medicaid expansion members below 100 percent of the FPL and the number of members between 100 percent and 138 percent of the FPL are displayed in Figure 2-7.

Figure 2-7—Medicaid Expansion Members by FPL Category



Note: The number of members enrolled through Medicaid Expansion is a point-in-time measurement as of 9/15/21.

The CCC Plus program is an integrated delivery model that includes physical, behavioral health, and SUD services and LTSS. The CCC Plus program incentivizes community living and promotes innovation and value-based payment strategies. The CCC Plus program priorities are displayed in Table 2-8.

Table 2-8—CCC Plus 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 PHE had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. Families also deferred going to the doctor's office for routine, nonemergency care.

The ongoing COVID-19 pandemic, caused by SARS-CoV-2, became a PHE in January 2020 and was declared a pandemic in March 2020. The Commonwealth's PHE declaration expired on June 30, 2021.[2-2] Governor Northam approved $25 million to support COVID-19-related expenses for Day

[2-2] Department of Medical Assistance Services. Medicaid Memo: COVID Flexibilities Update—Expiration of State PHE on 6/30/2021. Available at: https://www.dmas.virginia.gov/media/3590/covid-flexibilities-update-for-june-30-2021.pdf. Accessed on: Nov 19, 2021.

Support providers to cover expenses from August 1, 2020, through December 31, 2021.[2-3] Services that qualify for payment include: Group Day Support, Group Day Support Customized, Community Engagement, Community Coaching Customized, and Community Coaching.

During 2021 DMAS continued flexibilities for care and services for members receiving LTSS through June 30, 2021. Upon the expiration of the Commonwealth's PHE, DMAS began to unwind certain flexibilities and allowed providers to transition back to pre-COVID operations for a period of 60 days (August 29, 2021) in order to allow providers appropriate time to revert to normal procedures and policy requirements. As of July 1, 2021, DMAS resumed PASRR Level I and Level II assessments, and the requirement for a new certificate of medical need for DME equipment.

DMAS 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 2-9 describes some of the flexibilities and waivers allowed during the PHE that continued throughout 2021.[2-4]

Table 2-9—COVID-19 Flexibilities and Waivers[2-5]

Support for Medicaid Members—Access to Services
No pre-approvals were required for many critical medical services and devices, and some existing approvals were automatically extended. Some rehabilitative services were permitted to be provided via telehealth.
Access to Appeals and State Fair Hearings
Deadlines were extended for members and applicants to file Medicaid appeals.
Appeals were processed as long as the Medicaid member or applicant gave appropriate verbal authorization of legal representation even if the paperwork for the appointment of representation was incomplete.
ARTS
OTPs administered medication as take-home dosages, up to a 28-day supply.
Member's home served as the originating site for prescription of buprenorphine.
Behavioral Health Services
TDT, IIH, MHSS, ICT, and PSR: • The service authorization request for new services used to track which members were continuing to receive these services, assessed the appropriateness of the services being delivered via different active, telehealth modes of treatment, and to determine if this was an appropriate service to meet the member's needs. • Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP

[2-3] Department of Medical Assistance Services. Guidance to Agencies – COVID Day Support Payments. February 2021 UPDATE: Reporting Deadline Extended. Available at: https://www.dmas.virginia.gov/media/3013/updated-day-support-provider-relief-faqs-pdf.pdf. Accessed on: Dec 2, 2021.

[2-4] Department of Medical Assistance Services. Medicaid Memo: Developmental Disabilities (DD) and Commonwealth Coordinated Care (CCC) Plus Waivers: Provider Flexibilities Related to COVID-19, 08/11/20. Available at: https://dbhds.virginia.gov/assets/doc/EI/81020-HCBS-Flexibilities-Extension-Final.pdf. Accessed on: Nov 29, 2021.

[2-5] Department of Medical Assistance Services. COVID-19 Response. Virginia Medicaid is increasing access to care in response to COVID-19. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Dec 2, 2021.

were updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19, as well as any newly identified problem. Documentation of this review was added to the individual's medical record as evidenced by the dated signatures of the qualified or licensed professional.
For youth participating in both TDT and IIH, TDT were not used in person in the home as this was considered a duplication of services. TDT was allowed to be provided through telehealth to youth receiving IIH (in person or via telehealth) as long as services were not duplicated and ensured treatment efficacy.
During the PHE, TDT, IIH, MHSS, ICT and PSR: Providers billed for one unit on days when a billable service was provided, even if time spent in billable activities did not reach the time requirements to bill a service unit. Providers billed for a maximum of one unit per day if any of the following applied: • The provider was only providing services through telephonic communications. If only providing services through telephonic communications, the provider billed a maximum of one unit per member per day, regardless of the amount of time of the phone call(s). • The provider was delivering services through telephonic communications, telehealth, or face to face and did not reach a full unit of time spent in billable activities. • The provider was delivering services through any combination of telephonic communications, telehealth, and in-person services and did not reach a full unit of time spent in billable activities.
Behavioral Therapy (H2033)—Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual to COVID-19, and any newly identified problem. Documentation of this review added to the individual's medical record as evidenced by the dated signatures of the licensed behavioral health provider.
Behavioral Therapy (H2033)—One service unit equaled 15 minutes. Effective June 11, 2020, behavioral therapy providers did not have a one-unit limit per day for audio-only communications.
Crisis Stabilization/Crisis Intervention Services—The appropriateness of a crisis response using telehealth (including telephonic) evaluated by the clinician and a determination made by the clinician responding to the crisis. Any therapeutic interventions including therapy, assessments, care coordination, team meetings, and treatment planning could occur via telehealth. Face-to-face service requirements continued to be waived, documentation justified the rationale for the service through a different model of care. The goals, objectives, and strategies of the ISP, updated to reflect any change or changes in the individual's progress and treatment needs, including changes impacting the individual related to COVID-19 and any newly identified problem and documented according to the requirements in the CMHRS provider manual.
IACCT—IACCT assessments could occur via telehealth or telephone communication.
Psychiatric Inpatient, Facility Based Crisis Stabilization, PRTF, and TGH Levels of Care: • The requirement for service authorization remained in place. • Therapy, assessments, case management, team meetings, and treatment planning could occur via telehealth. • The plan of care updated to include any change in service delivery as well as any change in goals, objectives, and strategies, including impacts on the individual due to COVID-19.

Pharmacy
Drugs dispensed for 90 days subject to a 75 percent refill "too-soon" edit. Patients only received a subsequent 90-day supply of drugs after 75 percent of the prescription had been used (approximately day 68).
The agency made exceptions to their published Preferred Drug List if drug shortages occurred.
Suspended all drug co-payments for Medicaid and FAMIS members.
Support for Medicaid Providers—Streamlined Enrollment and Screening
Provider enrollment requirements were streamlined.
Site visits, application fees, and certain background checks were waived to temporarily enroll providers in the Medicaid program.
Deadlines for revalidations of providers were postponed.
Out-of-state providers were permitted to be reimbursed for services to Medicaid members.
Telehealth policies—waiver of penalties for HIPAA non-compliance and other privacy requirements.
Facilities fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applied to facility-based providers only.
Electronic signatures accepted for visits that were conducted through telehealth.
Waivers
Members who received less than one service per month not discharged from an HCBS waiver.
Any member with a significant change requesting an increase in support due to changes in medical condition and/or changes in natural supports must have an in-person visit.
Legally responsible individuals (parents of children under age 18 and spouses) provided personal care/personal assistance services for reimbursement.
Personal care, respite, and companion aides hired by an agency permitted to provide services prior to receiving the standard 40-hour training.
CE/CC provided through telephonic/video conferencing for individuals who had the technological resources and ability to participate with remote CE/CC staff via virtual platforms.
In-home support services delivered via an electronic method or telehealth.
Group day services provided through video conferencing for individuals who had the technological resources and ability to participate with remote group day staff members via virtual platforms.
Residential providers permitted to not comply with the HCBS settings requirement at 42 CFR §441.301(c)(4)(vi)(D) that individuals were able to have visitors of their choosing at any time.
Nursing Facilities
Waived the requirements at 42 CFR §483.35(d) (with the exception of 42 CFR §483.35[d][1][i]), which required that an SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under 42 CFR §483.35(d).

Source accessed on 9/27/21: https://dmas.virginia.gov/media/3594/active-flexibilities-07-01-2021.pdf

Medicaid Enterprise System

DMAS is in the process of developing a new modularized technology called MES to align the Agency's Information Technology Road Map with CMS' Medicaid MITA layers. The MES is a project that replaces the outdated MMIS with a new, modular solution. MES reassembles Medicaid information management into a modular, flexible, and upgradeable system. This provides DMAS with better information access and control, and supports better information sharing with Medicaid providers, Medicaid members, and sister agencies.

Virginia was early to respond to requirements from CMS to upgrade to new and more flexible technology. MES will support DMAS to provide better and advanced data reporting and fraud detection. The separate MES modules represent each of the complex processes DMAS uses and can be individually updated to meet DMAS' needs without disrupting other modules. Several modules were live and providing benefits to DMAS and stakeholders. Remaining MES modules will transition all legacy MMIS functions, such as member enrollment data, claims adjudication, payment management, and health plan management to the new modular model by April 1, 2022.

One of the MES modules is a dynamic CRMS, the first phase of which was implemented in July 2020, that facilitates 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 the MCOs with proactive care planning, and reducing costs.

Since July 2020, 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

DMAS has expanded care coordination to all geographic areas, populations, and services within the managed care environment.

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 demonstrate its worth with DMAS' most vulnerable members in the CCC Plus program. The DMAS Care Management Unit continued to oversee care coordination provided through the MCOs and provide training and support to the MCO care

coordinators. The following is a list of the ongoing efforts and resources provided for the continued development and success of the care coordinators:

- Participation in integrated care teams for complex cases, which required DMAS' support, assistance, and guidance to ensure members'/families' needs were being heard and met.
- Consultation and direct assistance to the MCOs to discuss challenging cases and problem solving to overcome the barriers within a member's individual case.
- Collaboration with care coordinator supervisors and managers on improving integrated care, along with members', caregivers', and providers' feedback/input.
- Dedicated email boxes for MCO care coordinators to send questions related to certain specialized program processes. The email boxes were also a direct link for care coordinators to request assistance and support regarding a specific case situation.
- Active engagement with care coordinators on what types of training would be beneficial to them in their roles and the specific population they served to ensure they had the tools and resources needed to be effective and knowledgeable in their role.
- Provision of ongoing training webinars to care coordinators and MCO staff members to address needs identified, as well as announcements regarding agency initiatives or policy changes.
- Training webinars were fluid and responsive to immediate and current issues, such as COVID-19 flexibilities and COVID-19 vaccinations.
- Participation in workgroups along with other departments, agencies, and advocates/stakeholders to identify ways to improve care coordination in areas of specialized services and disease management.

The MCO care coordinators were engaged in the training and support provided by the DMAS Care Management Unit and continued to fulfill the mission of the CCC Plus model of care. The DMAS Care Management Unit continually made observations of members maximizing the use of enhanced benefits with the assistance of the MCOs' care coordinators in order to obtain services such as dental and vision services, environmental modifications, and transportation. DMAS also continued to observe the ongoing efforts of the MCOs' care coordinators to know and embrace community resources, in their region and throughout the Commonwealth, for members in areas of need that their MCO did not cover, such as housing and food security.

Supports Intensity Scale

The SIS is a nationally recognized assessment tool that measures the intensity of support required for a person with a DD in their personal, work-related, and social activities. Based on the results of a SIS assessment, individuals in the Commonwealth's 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 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.

ARTS

In 2017, DMAS implemented the ARTS benefit and carved-in all services into the CCC Plus and Medallion 4.0 managed care contracts. The ARTS benefit focuses on treatment and recovery services for SUD, including OUD, 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 OUD 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 provided a July 2021 report titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care 2016-2019*. The report was prepared by the VCU School of Medicine, Health Behavior and Policy. The objective of the report was to examine SUD treatment service utilization, access, and quality of care among Medicaid members through CY 2019, the first year of Medicaid expansion. The report stated that the findings in the report were based on a number of data sources, including Medicaid administrative claims, information on the supply of substance use treatment providers, and a survey of Medicaid members who used ARTS.

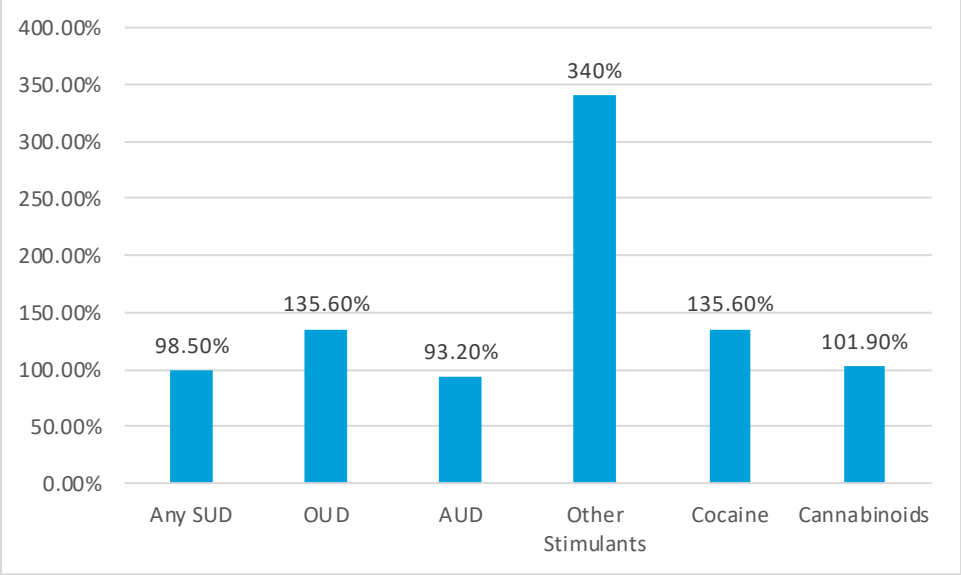
The following ARTS benefit information and findings were reported by VCU from the ARTS waiver evaluation.

- In total, 96,000 Medicaid members had a SUD diagnosis in 2019, including about 42,000 members enrolled through Medicaid expansion. VCU determined that this represents a 62 percent increase in the number of Medicaid members with a SUD diagnosis from 2018 and double the number in 2016.
- There were 46,500 members who used ARTS in 2019, a 79 percent increase from 2018.
- Services that experienced especially large increases included Preferred OBOT, OTPs, care coordination services at OBOT and OTP providers, and SUD residential treatment centers.
- More than 23,000 members received MOUD treatment in 2019, more than double the number receiving MOUD treatment in 2018.
- Nearly 3,500 members with SUD had a stay at a residential treatment center in 2019, 3.3 times the number of members with residential stays in 2018. The percentage of members with SUD who had a stay at a residential treatment center in 2019 (3.6 percent) doubled from 2018 (1.8 percent).

The report indicated that the supply of addiction treatment providers continued to increase in 2019. There were 1,133 practitioners in Virginia in 2019 that had federal authorization to prescribe buprenorphine, including 278 nurse practitioners and physician assistants. However, only 40 percent of those prescribers treated any Medicaid patients in 2019. In addition, nearly 4,900 outpatient practitioners of all types billed for ARTS in 2019, which was a 31 percent increase from 2018. The number of Preferred OBOT providers increased from 38 sites at the beginning of the ARTS benefit in 2017 to 153 sites by September 2020.

The report stated that diagnosed prevalence of other SUD among Medicaid members increased between 2016 and 2019. In particular, prevalence of SUD related to methamphetamine use (identified as "other stimulants" in the following figure) more than tripled from 2,169 members in 2016 to 9,544 members in 2019. However, opioids remained responsible for the vast majority of fatal overdoses. The prevalence of SUD are shown in Figure 2-8.

Figure 2-8—Diagnosed Prevalence of SUD

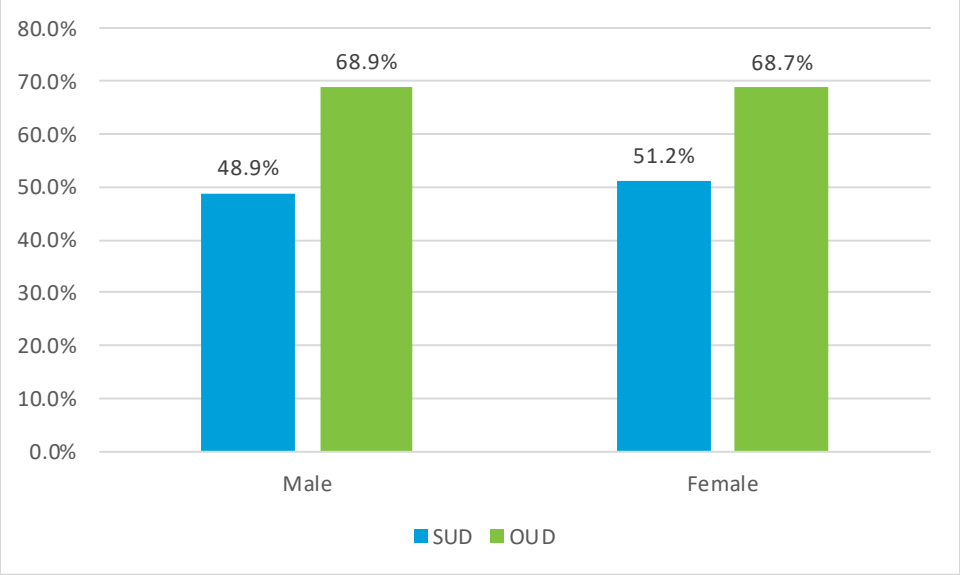


Note: "Other Stimulants" refers primarily to methamphetamines.

Characteristics of Members Receiving ARTS Benefit

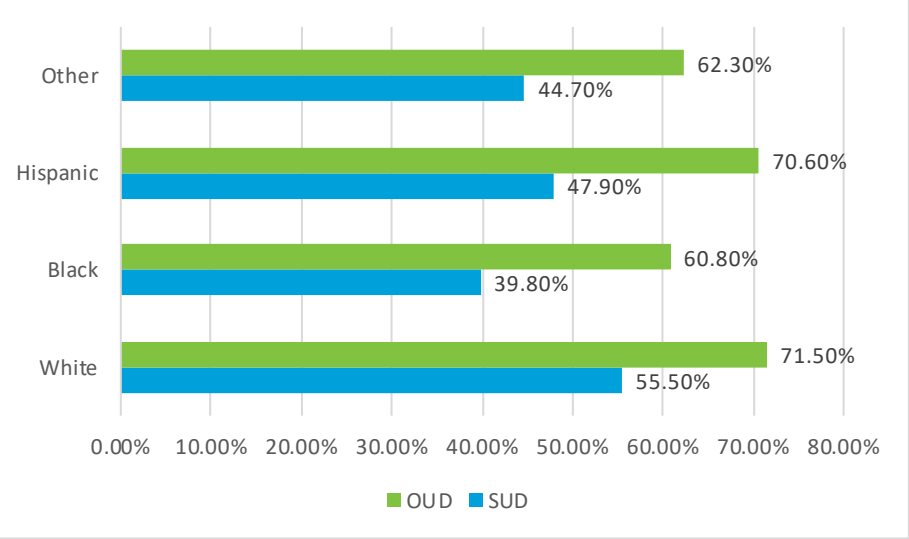
Members with a diagnosed SUD of any type represented 5.4 percent of the 1.78 million people in Virginia who were enrolled in Medicaid at some point in 2019. Figure 2-9 shows the prevalence, by gender, of members treated for SUD and OUD. Males were treated for an OUD at a higher rate than females. Females were treated for a SUD at a higher rate than males.

Figure 2-9—2019 Treatment Rates for SUD and OUD by Gender



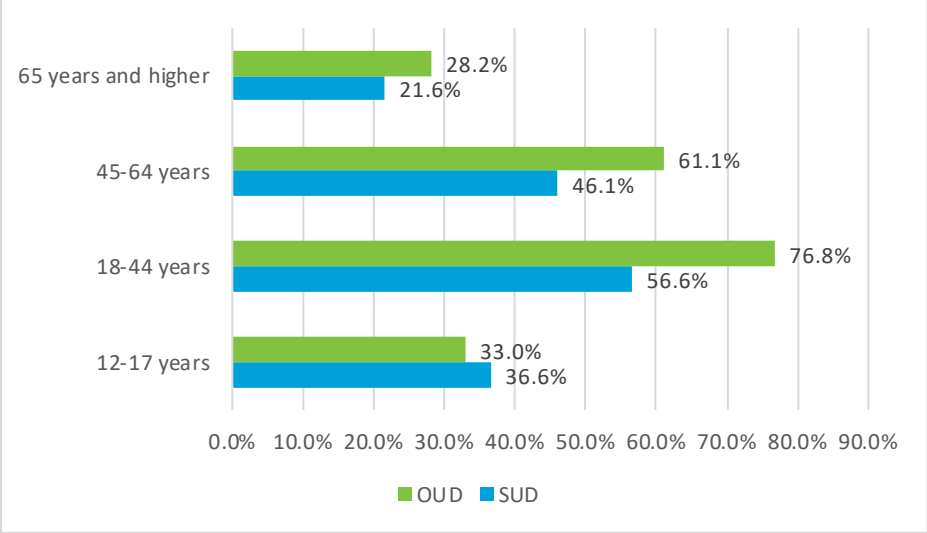
In reviewing the results published in the report, the prevalence of diagnosed SUD is lower among members identifying as Black (4.8 percent) and Hispanic (1.1 percent) compared to White members (6.3 percent). SUD and OUD treatment rates by race/ethnicity are depicted in Figure 2-10.

Figure 2-10—2019 Treatment Rates for SUD and OUD by Race/Ethnicity



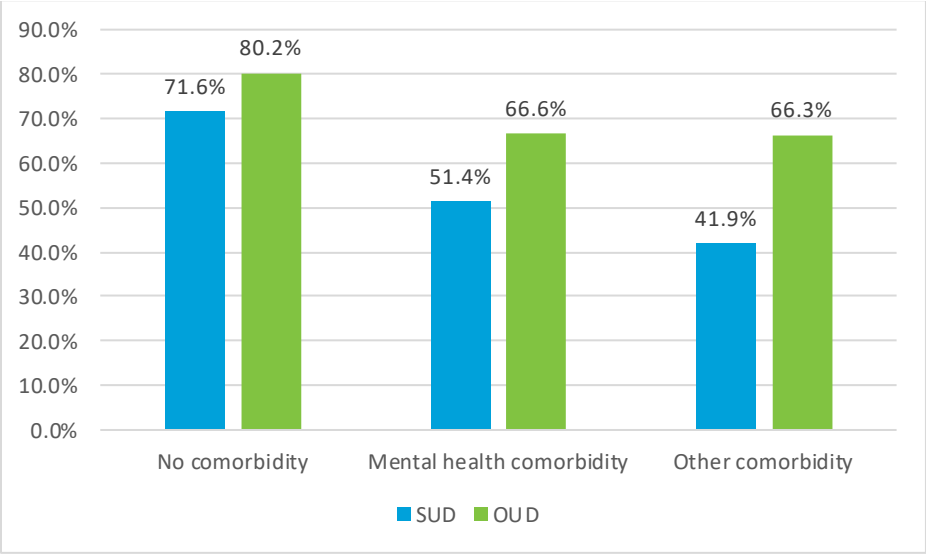
Variances in treatment rates for SUD and OUD were also identified by age group in the report. Members in the 45 to 64 age group had by far the highest diagnosed prevalence compared to other ages. Adolescents (ages 12 to 17) had the lowest diagnosed prevalence. Treatment for SUD and OUD by age are shown in Figure 2-11.

Figure 2-11—Treatment Rates for SUD and OUD by Age



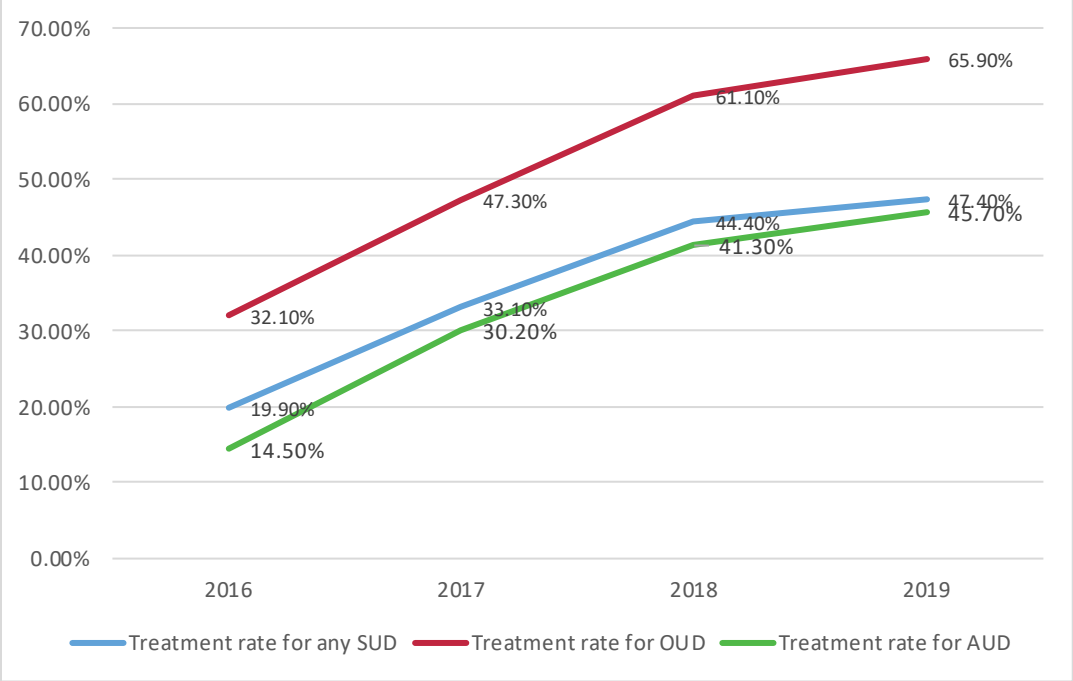
SUDs are often accompanied by other co-occurring physical conditions and mental health disorders. Compared to all Medicaid members, those with SUD are more likely to have other comorbid conditions, including mental health disorders. Figure 2-12 shows the SUD and OUD treatment rates for members with diagnosed comorbidities.

Figure 2-12—Treatment Rates for SUD and OUD by Comorbidity



Treatment rates for any SUD, OUD, and AUD continued to increase each year since the implementation of the ARTS benefit. The changes in treatment rates for SUD among the base Medicaid member, which excludes Medicaid expansion members, are shown in Figure 2-13.

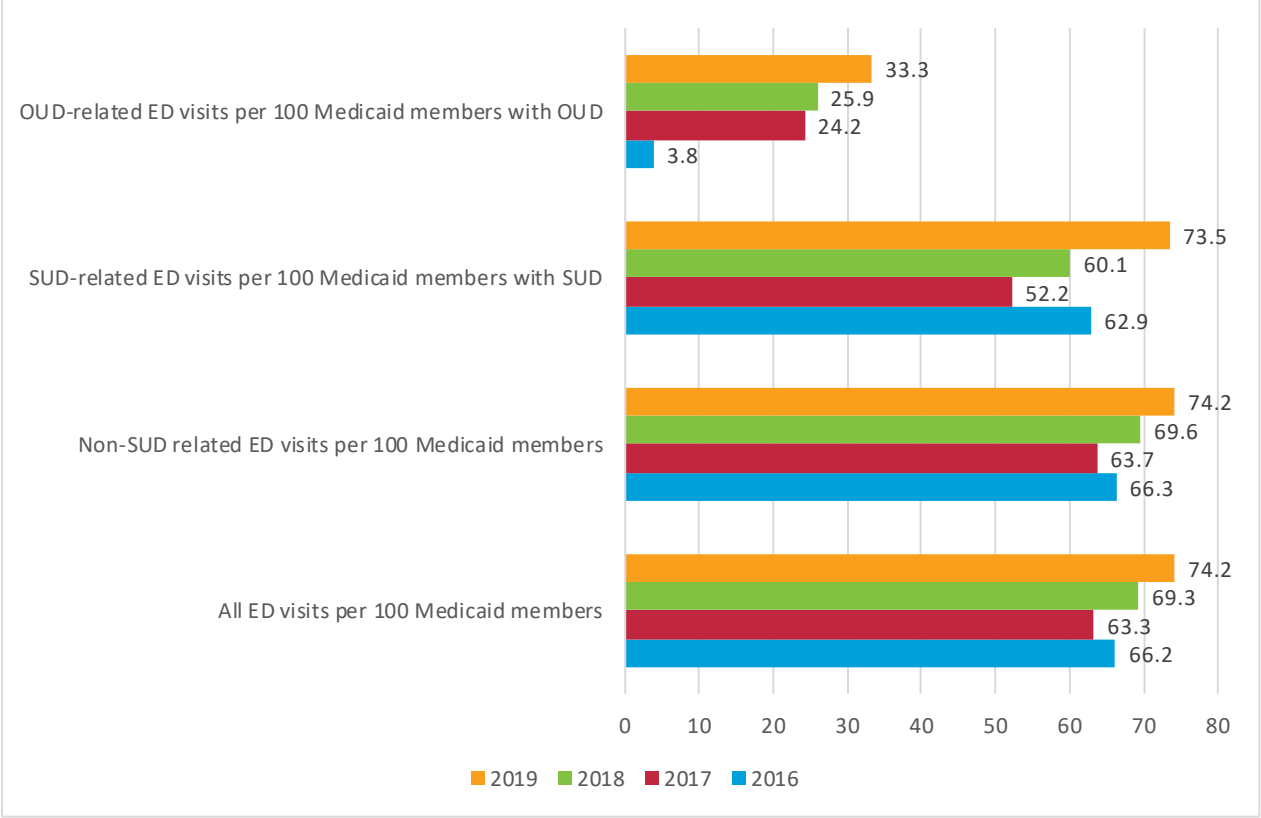
Figure 2-13—Change in Treatment Rates for SUD Among Base Members



Note: Base members exclude members enrolled through Medicaid expansion to maintain comparability with prior years.

The results in the report showed that following 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, compared to 0.9 percentage points among members with no SUD. A similar decline was noted in inpatient hospitalizations. Figure 2-14 shows the ED visits per 100 base Medicaid members.

Figure 2-14—ED Visits Per 100 Base Medicaid Members



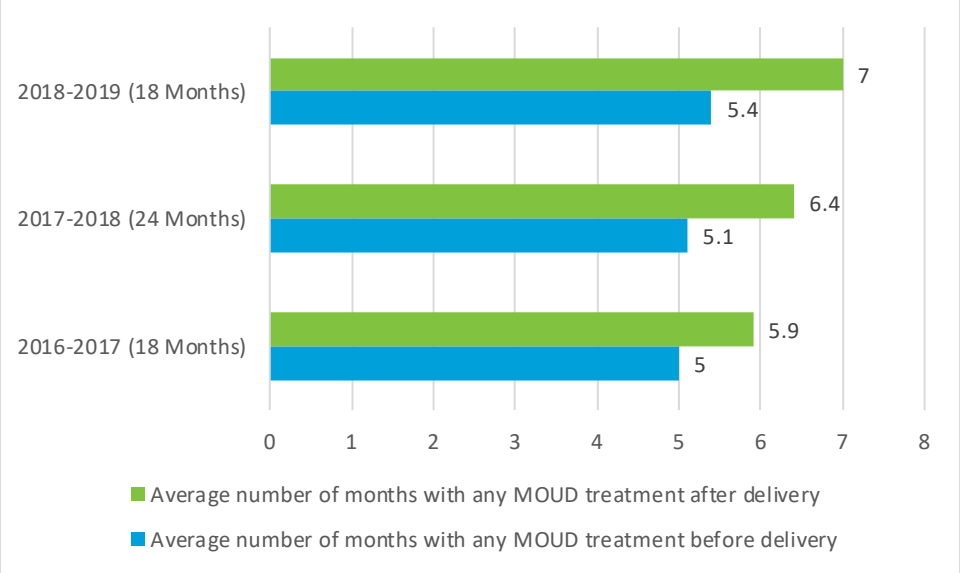
Note: Base members exclude members enrolled through Medicaid expansion to maintain comparability with prior years.

The report also states that use of services in 2019 increased across all ASAM levels of care. In 2019, 46,520 members used a treatment service categorized with an ASAM level of care, a 79 percent increase from 2018, and a 172 percent increase since 2017, the first year of ARTS. Increases in use included:

- SBIRT (ASAM Level 0.5) increased 359 percent from 2017 (2017: 498; 2019: 2,288).
- In 2019, 9,558 members received services through Preferred OBOT or OTPs, which was 15 times the number in 2017 (2017: 630; 2019: 9,558).
- Outpatient services (ASAM Level 1) increased 179 percent from 2017 (2017: 12,208; 2019: 34,077).
- Partial hospitalization and intensive outpatient services (ASAM Level 2) increased 267 percent since 2017 (2017: 1,115; 2019: 4,096).
- Residential treatment services (ASAM Level 3) increased from 1,049 members in 2018 to 3,483 members using residential treatment in 2019.
- More than double the number of members, 9,569, used medically managed inpatient services for SUD in 2019 than in 2018.
- In 2019, 4,048 members received care coordination services at Preferred OBOTs and OTP providers, nearly quadruple the number receiving these services in 2018.

The Virginia ARTS benefit expanded the treatment services available to Medicaid members, including pregnant individuals covered by Medicaid in the prenatal and postpartum period. MOUD treatment rates increased from 52.4 percent in 2016–2017 to 62.1 percent in 2018–2019, while the average number of months with any MOUD in the 12 months prior to delivery increased from 5 months in 2016–2017 to 5.4 months by 2018–2019. MOUD treatment rates were higher in the 12 months after delivery than the 12 months prior to delivery (69.5 percent in 2016–2017 to 74.5 percent in 2018–2019). The number of months of MOUD treatment increased from 5.9 months in 2016–2017 to 7 months by 2018–2019. Diagnosed SUD, OUD, and MOUD treatment rates 12 months before and after childbirth are shown in Figure 2-15.

Figure 2-15—Diagnosed MOUD Treatment Rates Among Individuals in the 12 Months Before and After Childbirth



DMAS shared an article written by WTVR that highlighted a case study with positive outcomes from the ARTS program.[2-6] The case study describes a member's journey battling addiction. After having lost two of her children soon after they were born, the member soon became pregnant with her third child. The little girl growing inside of her was enough motivation for her to get sober. Through the ARTS benefit, the obstetrical and addiction service providers worked to meet the member where she was. Program providers had an understanding of the challenges that pregnant women and postpartum women with an addiction struggle with and work to reduce the challenges. The member successfully delivered a healthy baby girl.

The DMAS member stated "I don't think I ever wanted to get clean like I did that time. Especially when I found out I was pregnant with her. So, she actually saved my life."

[2-6] WTVR. "After losing 2 children during addiction, mother gives birth to miracle baby." Available at: https://www.wtvr.com/news/local-news/after-losing-2-children-during-addiction-mother-gives-birth-to-miracle-baby. Accessed on: Nov 24, 2021.

Comparison of OUD Prevalence and Treatment with States Participating in the Medicaid Outcomes Distributed Research Network

To enhance cross-state comparisons, VCU and DMAS participate in MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment access and quality of care. Table 2-10 displays characteristics of members receiving OUD treatment in Virginia compared to other states participating in MODRN.

Table 2-10—2018 OUD Treatment for Medicaid Members State Comparison

Member Characteristic	Percentage of Members with OUD Diagnosis	
	Virginia	Other MODRN States*
Age Group		
12–20	1.2%	1.5%
21–34	35.1%	41.9%
35–44	28.7%	29.%
45–54	19.3%	16.9%
55–64	15.7%	10.3%
Gender		
Female	66.3%	51.2%
Male	33.7%	48.8%
Race/Ethnicity		
Non-Hispanic White	79.1%	76.2%
Non-Hispanic Black	19.4%	13.8%
Hispanic	0.1%	2.9%
Other/Unknown	1.4%	7.1%
Eligibility Group		
Pregnant	5.1%	5.6%
Youth	1.1%	1.4%
Disabled Adults	41.1%	17.1%
Non-Disabled	52.7%	24.6%
Medicaid Expansion Adults	Not Applicable	51.3%
Living Area		
Urban	69.0%	73.3%
Rural	31.0%	26.4%
Missing Urban/Rural Category	0%	0.2%

*Cross-state comparison data is from the MODRN, a collaboration of state-university partnerships through AcademyHealth established for the purpose of comparing state Medicaid programs on key measures of SUD and OUD treatment (DE, KY, MD, MA, ME, MI, NC, OH, PA, UT, VA, WV, WI).

Member Experience With ARTS Services

The ARTS member survey, adapted from a version of the CAHPS survey, included a number of questions assessing the patient's experience with ARTS treatment services and was designed to assess behavioral treatment providers. The total number of survey respondents included 708 members. Results of the survey indicate that the majority of survey respondents have positive experiences with the treatment they are receiving. Of the survey respondents, 67.5 percent indicated that they were able to see someone as soon as they wanted, if needed. In addition, 83.6 percent of respondents indicated that providers explained things in a way they could understand, 84.5 percent indicated that providers showed respect for what the member had to say, and 90.1 percent indicated that the provider made them feel safe.

Regarding patient involvement in treatment or discontinuation of treatment, 84.8 percent of respondents were involved in treatment as much as they wanted to be, 73.7 percent of respondents indicated that they were provided information about different treatment options, and 72.1 percent of respondents felt able to refuse a specific type of medicine or treatment.

Survey questions also focused on changes to personal and social life related to treatment assessed circumstances after having received treatment. Findings include:

- 82 percent are more confident about not being dependent on drugs or alcohol
- 80 percent are able to deal more effectively with daily problems
- 73 percent are better able to deal with a crisis
- 81 percent are getting along better with their family
- 68 percent perform better in social situations
- 63 percent report that their housing situation has improved
- 43 percent report that their employment situation has improved

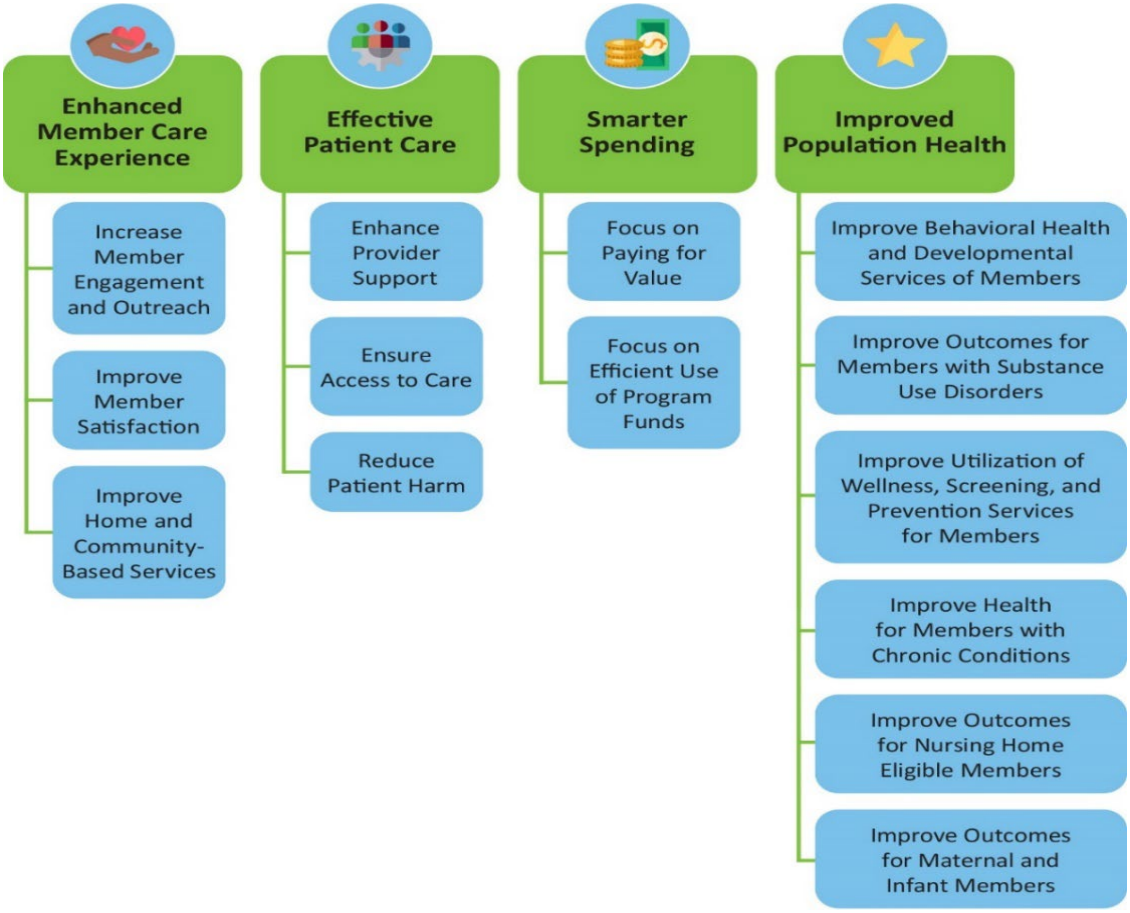
Virginia's 2020–2022 Quality Strategy

In 2021, DMAS worked with its EQRO, HSAG, to review and update the fourth edition of its comprehensive Virginia 2020–2022 QS in accordance with 42 CFR §438.340. The QS updates did not meet the QS' definition of a significant change.

DMAS' QS 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. Virginia's 2020–2022 QS 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 QS 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.

Virginia's 2020–2022 QS 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 Virginia QS. Figure 2-16 displays Virginia's 2020–2022 QS aims and goals. Appendix F contains Virginia's 2020–2022 QS aims, goals, objectives, and metrics.

Figure 2-16—Virginia's 2020–2022 Quality Strategy Aims and Goals



Quality Initiatives

DMAS considers its QS to be its roadmap for the future. The QS 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 Virginia QS strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable. DMAS conducts oversight of the MCOs to promote accountability and transparency for improving health outcomes.

Table 2-11 displays a sample of the initiatives DMAS implemented or continued during CY 2021 that support DMAS' efforts toward achieving the Virginia 2020–2022 QS' goals and objectives.

Table 2-11—DMAS Quality Initiatives Driving Improvement

Virginia 2020–2022 QS Aim and Goal	DMAS Quality Initiative
Aim 4: Improved Population Health	DMAS and its contracted MCOs have undertaken a variety of initiatives aimed at improving quality outcomes in maternal health, a primary goal of the

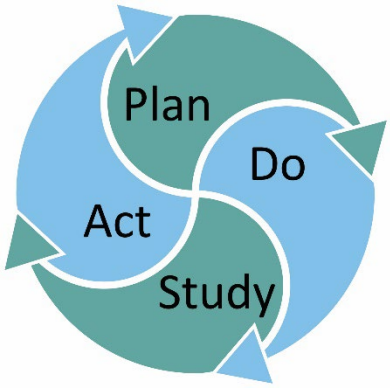
Virginia 2020–2022 QS Aim and Goal	DMAS Quality Initiative
Goal 4.6: Improve Outcomes for Maternal and Infant Members	Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these 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 including eligibility and enrollment, outreach and information, community connections, services and policies, and oversight, all with the aim to promote health equity and quality maternity outcomes. This year, teams have addressed a variety of topics such as Medicaid member outreach including a social media campaign, newborn screening education, WIC enrollment and services, MCO maternity care coordination, breastfeeding awareness, and flu vaccine access, all with the goal of advancing the holistic well-being of Medicaid and CHIP members.

The MCOs' ongoing QAPI 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 D provides examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2020–2022 QS' goals and objectives.

Best and Emerging Practices

The Virginia 2020–2022 QS 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. DMAS conducts oversight of the 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 QI 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 QI initiatives and interventions, using a PDSA cycle, to determine if the benefit of the intervention outweighs the effort and cost. DMAS also actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which MCO performance is measured. Table 2-12 identifies DMAS' best and emerging practices. The MCOs' self-reported best and emerging practices are found in Appendix C.

Table 2-12—DMAS' Best and Emerging Practices

Best and Emerging Practices
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 VDH, VDSS, DBHDS, VHHA, and VNPC. VDH and DMAS worked closely this year with state stakeholders to study requirements to operationalize a doula Medicaid benefit and 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 Resources along with community members such as doula groups, VHHA, DMAS MCOs, VNPC, and other key statewide advocate groups supporting families. The final report is scheduled to be released in December 2020. DMAS also 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 training needed to obtain a waiver to prescribe buprenorphine. Forty-three providers utilized this training across the state including OB/GYN providers, a target group for the series. In 2019, Virginia was one of eight states selected to participate in the National Academy of State Health Policy Maternal and Child Health Policy Innovations Program Policy Academy. Through this project, DMAS and VDH are partnering with VDSS and DBHDS on a statewide, collaborative effort to improve SBIRT services for pregnant and parenting people via two health system pilot sites.

3. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

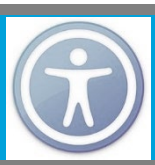
In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the CCC Plus program.

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

as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]



Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[2]

Timeliness

as it pertains to EQR, is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] Ibid.
[3] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

MCO Comparative and Statewide Aggregate PIP Results

PIP Highlights

The CCC Plus MCOs completed their PIPs in 2021 and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to the CCC Plus MCOs in the initial validation tools for Module 4 and Module 5, and the CCC Plus MCOs had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** One PIP received a score of *High confidence*.
	Strength: One PIP received a score of *Confidence*.
	Strength: Two MCOs selected more than one intervention (two) to test for its PIPs.
	Strength: Four interventions were *adopted*.
	Strength: Seven interventions were *adapted*.
Weaknesses	**Weakness:** An MCO selected a passive intervention (mailed member letter) to test for the *Follow-Up After Discharge* PIP. **Why the weakness exists:** The MCO reported that the members were unable to be reached by telephone and that it understood mailed letters are not ideal for PIP interventions. The MCO also reported that it was not successful with getting approval for another intervention to incorporate additional language for the PIP population into a company-wide database. **Recommendation:** The MCOs should identify and test innovative, actionable changes for the PIPs.
	Weakness: Four PIPs received *Reported PIP results were not credible*. **Why the weakness exists**: It appeared that the PIP methodology was not executed as approved based on the documentation the MCO submitted. **Recommendation:** The MCOs should follow the approved methodology for the PIP and report the PIP's data in alignment with the approved methodology. If the MCO needs PIP technical assistance, it should contact HSAG.

MCO Comparative and Statewide Aggregate 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, 2020, through December 31, 2020. Table 3-1 highlights the overall strengths and weaknesses identified by PM domain.

PMV Highlights

Table 3-1—PM Strengths and Weaknesses

Domain	Strengths	Weaknesses
Access and Preventive Care	Five of the MCOs met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.	All reportable MCO rates fell below the 50th percentile for the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Use of Imaging Studies for Low Back Pain* measures.
Behavioral Health	All six MCOs met or exceeded the 50th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators. All six MCOs met or exceeded the 50th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of Alcohol and Other Drug—Total—Total* measure indicators.	All MCO rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total*, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of Alcohol and Other Drug—Total—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators rates, reflecting an area for improvement.
Taking Care of Children	One of the MCOs met or exceeded the 50th percentile for the *Childhood Immunization Status—Combination 3* measure.	All six MCOs have opportunities for improvement related to the *Immunizations for Adolescents*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicator rates, as none of the MCOs' rates for these measures met or exceeded the 50th percentile.
Living With Illness	MCO performance within the Living With Illness domain was the highest for *Medical Assistance With Smoking and Tobacco Use Cessation*, with five of six MCOs meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators and all six	All MCO rates fell below the 50th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Comprehensive Diabetes Care—HbA1c Testing* measures.

Domain	Strengths	Weaknesses
	MCOs meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator.	
	Three of the MCOs met or exceeded the 50th percentile for the *Pharmacotherapy Management of COPD Exacerbation* measure indicator rates. Four MCOs met or exceeded the 50th percentile for the *Asthma Medication Ratio* measure.	Five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators.
Use of Opioids	Three MCOs met or exceeded the 50th percentile for at least two of the three *Use of Opioids From Multiple Providers* measure indicator rates.	Five of the six MCOs' rates fell below the 50th percentile for the *Use of Opioids at High Dosage* measure.

To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit.™,[3-1] Each MCO contracted with an NCQA LO to conduct the HEDIS audit. Additionally, HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key CCC Plus Medicaid measures for HEDIS MY 2020.

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

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

HSAG contracted with ALI Consulting Services, LLC, for assistance with the validation of the PMs listed above. Using the validation methodology and protocols described in Appendix B, HSAG validated results for each PM. The CMS PMV protocol identifies two possible validation designations for PMs: *Reportable (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 3-2, with all rates validated as *Reportable (R)*.

[3-1] HEDIS Compliance Audit™ is a trademark of NCQA.

Table 3-2—HSAG MCO PMV Results

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*						
40–64 Years	65.63	69.74	97.50	109.50	161.49	118.30
65+ Years	50.36	43.78	26.19	127.80	89.83	110.30
Total	61.93	60.93	90.07	111.74	129.41	116.56
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	82.00%	80.05%	77.62%	84.67%	86.86%	74.21%
*HbA1c Poor Control (>9.0%)**	48.91%	46.47%	59.85%	60.10%	34.55%	55.47%
HbA1c Control (<8.0%)	44.28%	43.80%	33.09%	35.52%	53.77%	37.96%
Eye Exam (Retinal) Performed	45.74%	48.66%	40.39%	46.72%	62.77%	47.93%
Blood Pressure Control (<140/90 mm Hg)	51.09%	51.82%	35.77%	43.31%	58.88%	40.39%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence						
7-Day Follow-Up—Total	12.12%	11.76%	9.27%	11.87%	11.15%	11.79%
30-Day Follow-Up—Total	16.36%	21.68%	17.74%	21.11%	17.84%	20.63%
Follow-Up After Emergency Department Visit for Mental Illness						
7-Day Follow-Up—Total	52.94%	49.04%	45.58%	43.58%	46.45%	46.51%
30-Day Follow-Up—Total	69.55%	63.70%	59.52%	60.54%	62.41%	62.79%
Heart Failure Admission Rate (Per 100,000 Member Months)*						
18–64 Years	112.59	85.63	101.66	81.48	150.94	97.70
65+ Years	154.43	122.76	130.94	159.75	318.48	279.84
Total	119.80	94.37	103.54	87.55	207.99	126.76
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment						
Initiation of Alcohol and Other Drug—Total—Total	43.68%	46.82%	51.34%	45.05%	46.42%	46.09%
Engagement of Alcohol and Other Drug—Total—Total	11.32%	12.85%	12.81%	10.03%	13.80%	13.88%

** For this indicator, a lower rate indicates better performance.*

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 each MCO's organizational infrastructure, which included confirming the structure supported all necessary IS 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.

PM 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 the quality of, timeliness of, and access to care. As part of the annual EQR technical report, HSAG performed a comparison of rates between the MCOs and the Virginia weighted aggregate.

Table 3-3 displays, by MCO, the HEDIS MY 2020 measure rate results compared to NCQA's Quality Compass®,[3-2] national Medicaid HMO percentiles for the HEDIS MY 2019 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 3-3—MCO Comparative and Virginia Aggregate HEDIS MY 2020 Measure Results

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Access and Preventive Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	87.05%	**88.70%**	78.26%	**87.46%**	**87.54%**	**87.19%**	**87.12%**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis							
Total	35.84%	**48.26%**	43.28%	**56.98%**	34.66%	**51.25%**	**47.93%**
Breast Cancer Screening[2]							
Breast Cancer Screening	**48.23%**	44.34%	36.63%	**50.21%**	**56.90%**	43.08%	**46.58%**
Cervical Cancer Screening[2]							

[3-2] Quality Compass® is a registered trademark of NCQA.

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Cervical Cancer Screening	**43.07%**	**43.55%**	39.90%	**43.31%**	40.15%	39.66%	**41.86%**
Use of Imaging Studies for Low Back Pain							
Use of Imaging Studies for Low Back Pain	**71.59%**	**72.69%**	70.86%	70.68%	**73.78%**	70.17%	**71.49%**
Behavioral Health							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**71.76%**	68.66%	66.18%	67.44%	68.99%	**73.63%**	**69.50%**
Antidepressant Medication Management							
Effective Acute Phase Treatment	55.96%	57.25%	55.75%	59.53%	**65.93%**	**67.32%**	**61.11%**
Effective Continuation Phase Treatment	44.04%	43.73%	43.60%	45.57%	**54.85%**	**54.52%**	**48.29%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia							
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	**75.36%**	NA	68.75%	**73.33%**	60.32%	**70.97%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence[2]							
7-Day Follow-Up—Total	**12.12%**	**11.76%**	9.27%	**11.87%**	11.15%	**11.79%**	**11.44%**
30-Day Follow-Up—Total	16.36%	**21.68%**	17.74%	**21.11%**	17.84%	**20.63%**	**19.98%**
Follow-Up After Emergency Department Visit for Mental Illness[2]							
7-Day Follow-Up—Total	**52.94%**	**49.04%**	45.58%	43.58%	46.45%	46.51%	**47.03%**
30-Day Follow-Up—Total	**69.55%**	**63.70%**	59.52%	60.54%	62.41%	62.79%	**62.83%**
Follow-Up After Hospitalization for Mental Illness[2]							
7-Day Follow-Up—Total	**35.29%**	**37.42%**	23.60%	**35.21%**	**31.91%**	20.91%	**30.77%**
30-Day Follow-Up—Total	**61.40%**	**62.37%**	45.47%	**61.18%**	**59.74%**	37.86%	**54.12%**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment[2]							

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Initiation of Alcohol and Other Drug—Total—Total	43.68%	**46.82%**	**51.34%**	45.05%	**46.42%**	46.09%	**46.41%**
Engagement of Alcohol and Other Drug—Total—Total	11.32%	**12.85%**	**12.81%**	10.03%	**13.80%**	**13.88%**	**12.51%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	NA	35.64%	**46.15%**	**50.67%**	NA	**46.15%**	**43.71%**
Taking Care of Children							
Child and Adolescent Well-Care Visits[1]							
Total	38.68%	**44.78%**	31.01%	**40.59%**	30.04%	39.21%	**39.86%**
Childhood Immunization Status							
Combination 3	**70.00%**	**75.00%**	NA	61.25%	NA	**68.75%**	**65.58%**
Immunizations for Adolescents							
Combination 1 (Meningococcal; Tetanus, Diphtheria Toxoids and Acellular Pertussis [Tdap])	**67.26%**	**66.67%**	60.17%	**64.60%**	**65.65%**	60.34%	**64.10%**
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	**27.98%**	**28.47%**	25.42%	25.06%	25.19%	23.84%	**26.02%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	**45.00%**	40.83%	35.07%	35.80%	**45.10%**	**46.82%**	**41.33%**
Cholesterol Testing—Total	**30.71%**	26.91%	22.39%	26.40%	26.47%	**33.94%**	**28.59%**
Blood Glucose and Cholesterol Testing—Total	**30.00%**	25.54%	20.90%	24.60%	26.47%	**31.94%**	**27.05%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile—Total[2]	62.77%	**70.07%**	58.88%	61.80%	**65.69%**	55.23%	**62.83%**
Counseling for Nutrition—Total	**56.45%**	**62.77%**	**56.20%**	46.96%	**57.42%**	51.09%	**55.07%**
Counseling for Physical Activity—Total	46.72%	**54.26%**	**48.42%**	37.23%	**52.55%**	43.80%	**46.78%**
Well-Child Visits in the First 30 Months of Life[1]							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	NA	**31.37%**	NA	**35.42%**	NA	27.27%	**30.67%**

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	**91.18%**	69.48%	NA	**79.12%**	NA	70.48%	**71.81%**
Living With Illness							
Asthma Medication Ratio							
Total	62.44%	**68.92%**	54.44%	62.46%	60.25%	62.58%	**63.62%**
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing[2]	**82.00%**	80.05%	77.62%	**84.67%**	**86.86%**	74.21%	**80.34%**
*HbA1c Poor Control (>9.0%)**,2*	**48.91%**	**46.47%**	59.85%	60.10%	**34.55%**	55.47%	**51.42%**
HbA1c Control (<8.0%)[2]	**44.28%**	**43.80%**	33.09%	35.52%	**53.77%**	37.96%	**41.04%**
Eye Exam (Retinal) Performed[2]	45.74%	48.66%	40.39%	46.72%	**62.77%**	47.93%	**48.94%**
Blood Pressure Control (<140/90 mm Hg)[1]	**51.09%**	**51.82%**	35.77%	43.31%	**58.88%**	40.39%	**46.85%**
Controlling High Blood Pressure[1]							
Controlling High Blood Pressure	**55.47%**	**49.64%**	35.52%	44.53%	**55.96%**	45.50%	**48.07%**
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	**77.51%**	**80.27%**	72.79%	70.87%	**78.62%**	**81.48%**	**77.18%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	81.99%	**85.05%**	77.70%	**82.31%**	**83.50%**	81.97%	**82.09%**
Discussing Cessation Medications	54.04%	**65.10%**	**60.67%**	57.04%	**62.00%**	58.01%	**59.48%**
Discussing Cessation Strategies	47.57%	**52.60%**	49.83%	48.73%	**58.29%**	**52.36%**	**51.56%**
Pharmacotherapy Management of COPD Exacerbation							
Systemic Corticosteroid	**79.67%**	56.08%	**76.60%**	49.61%	**75.87%**	51.91%	**59.35%**
Bronchodilator	**93.78%**	67.08%	**85.11%**	63.63%	**84.71%**	60.81%	**70.26%**
Use of Opioids							
Use of Opioids at High Dosage[2]							
Use of Opioids at High Dosage	**6.28%**	**6.31%**	**3.95%**	6.55%	**5.90%**	6.65%	**6.32%**
Use of Opioids From Multiple Providers*2							
Multiple Prescribers	22.38%	**21.78%**	24.47%	24.80%	22.71%	**19.82%**	**21.99%**

Performance Measure	Aetna	Health Keepers	Magellan	Optima	United	VA Premier	Virginia Aggregate
Multiple Pharmacies	7.29%	**2.56%**	3.70%	4.62%	**2.80%**	**3.13%**	**3.67%**
Multiple Prescribers and Multiple Pharmacies	4.48%	**1.80%**	2.99%	3.29%	**1.94%**	**1.97%**	**2.46%**
Utilization							
Ambulatory Care—Total							
*ED Visits—Total**	84.31	**70.40**	85.22	78.65	79.13	78.45	**77.45**
Identification of Alcohol and Other Drug Services[3]							
Total—Any Service—Total	13.61%	12.12%	20.97%	12.14%	14.26%	13.17%	**13.38%**
Inpatient Utilization—General Hospital/Acute Care—Total[3]							
Total Discharges per 1,000 Member Months (Total Inpatient)	14.56	12.99	16.23	21.29	18.32	19.80	**17.47**
Total Average Length of Stay (Total Inpatient)	7.00	7.08	9.72	7.15	6.82	6.61	**7.09**
Total Discharges per 1,000 Member Months (Medicine)	9.65	12.62	10.96	15.15	12.59	13.96	**13.12**
Total Average Length of Stay (Medicine)	5.94	7.09	9.52	6.20	5.87	5.26	**6.31**
Total Discharges per 1,000 Member Months (Surgery)	4.44	0.05	4.77	5.62	5.29	5.49	**3.93**
Total Average Length of Stay (Surgery)	9.72	26.13	10.81	9.97	9.41	10.25	**10.09**
Total Discharges per 1,000 Member Months (Maternity)	0.58	0.43	0.56	0.72	0.62	0.49	**0.55**
Total Average Length of Stay (Maternity)	3.03	3.62	3.54	4.15	2.91	3.12	**3.50**
Mental Health Utilization—Total[3]							
Any Services—Total	28.77%	23.72%	32.69%	27.91%	23.74%	22.40%	**25.34%**
Plan All-Cause Readmissions*							
Observed Readmissions—Total	12.45%	**9.89%**	11.48%	11.81%	12.01%	11.93%	**11.42%**
O/E Ratio—Total	0.97	**0.81**	0.97	0.97	0.97	1.00	**0.94**

** 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 MY 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 MY 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 MY 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—Total* measure.
	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 the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure and the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicator rates. Follow-up care for behavioral health conditions represented strength, as all six MCOs met or exceeded the 50th percentile for both *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators. Moreover, all six MCOs met or exceeded the 50th percentile for three of the six (50.0 percent) measure rates related to follow-up care for behavioral health conditions. Additionally, 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 Alcohol and Other Drug—Total—Total* measure indicator. Within the Behavioral Health domain, HealthKeepers and Optima demonstrated the highest performance, meeting or exceeding the 50th percentile for nine of the 13 (69.2 percent) and eight of the 13 (61.5 percent) measure rates, respectively.
	Strength: MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators and all six MCOs meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator. Additionally, three MCOs met or exceeded the 50th percentile for the *Pharmacotherapy Management of COPD Exacerbation* measure indicator rates and four MCOs met or exceeded the 50th percentile for the *Asthma Medication Ratio* measure. United had the highest performance in this domain, with eight of the 13 (61.5 percent) measure rates meeting or exceeding the 50th percentile and 12 of the 13 (92.3 percent) measure rates exceeding the Virginia aggregate.
	Strength: 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 *Use of Opioids From Multiple Providers* measure indicator rates. Moreover, VA Premier met or exceeded the 50th percentile for three of four (75.0 percent) measure rates 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 the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Use of Imaging Studies for Low Back Pain*

measures. Magellan demonstrated the lowest performance within the Access and Preventive Care domain, falling below the 50th percentile for all five (100 percent) measure rates within the domain.

Why the weakness exists: Members are not completing recommended cancer 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. Additionally, members with low back pain are receiving imaging studies, which may not be an appropriate treatment for low back pain. Factors that may have contributed to low cancer screenings include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

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 and higher usage of imaging studies when not clinically appropriate for a particular race or ethnicity, age group, ZIP Code, etc. HSAG recommends that the MCOs implement appropriate interventions to increase the screening rates and reduce imaging studies due to the low rates for the three measures.

Weakness: Within the Behavioral Health domain, for four measure indicator rates (*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total* measure indicator*, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of Alcohol and Other Drug—Total—Total* measure indicator*,* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure*),* none of the MCOs met or exceeded the 50th percentile, reflecting an area of improvement.

Why the weakness exists: Results for four measure indicator rates in the behavioral health domain indicate that providers may not be 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 root cause issue, HSAG recommends that the MCOs implement appropriate interventions to improve use of evidence-based practices related to behavioral healthcare and services.

Weakness: Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to the *Immunizations for Adolescents*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for*

Children/Adolescents measure indicator rates, as none of the MCOs' rates for these measures met or exceeded the 50th percentile.

Why the weakness exists: Child members are not consistently receiving recommended immunizations, well visits, or testing and screenings according to the 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. Factors that may have contributed to the declines include site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

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 to improve the performance related to the Taking Care of Children domain.

Weakness: Within the Living With Illness domain, all six MCOs have opportunities for improvement related to the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measures rates as none of the MCOs' rates for this measure met or exceeded the 50th percentile. MCO performance was low for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* measure indicator rate for which no MCOs' rates met or exceeded the 50th percentile. Additionally, five of the six MCOs' rates fell below the 50th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed measure* indicators.

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 critical for effective monitoring and treatment. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that the MCOs conduct a root cause analysis or focused study 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 2021, HSAG conducted MCO compliance review activities for the CCC Plus program. DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from the 2021 compliance reviews.

Operational Systems Reviews

Table 3-4 displays the scores for the current three-year period of OSRs conducted in 2021.

Table 3-4—Standards and Scores in the OSR for the Three-Year Period: SFY 2019–SFY 2021

Standard	CFR	Standard Name	Aetna	HealthKeepers	Magellan	Optima	United	VA Premier	Overall Score
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	85.7%	97.6%
II.	438.100 438.224	Enrollee Rights* and Confidentiality	85.7%	100%	100%	100%	100%	100%	97.6%
III.	438.10	Member Information	100%	100%	95.2%	95.2%	100%	90.5%	96.8%
IV.	438.114	Emergency and Poststabilization Services*	100%	100%	100%	100%	100%	100%	100%
V.	438.206 438.207	Assurance of Adequate Capacity and Availability of Services	77.8%	72.2%	77.8%	61.1%	83.3%	50.0%	70.4%
VI.	438.208	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
VII.	438.210	Coverage and Authorization of Services	100%	100%	95.0%	95.0%	100%	100%	98.3%
VIII.	438.214	Provider Selection	100%	100%	100%	100%	100%	100%	100%
IX.	438.230	Subcontractual Relationships and Delegation	75.0%	100%	100%	75.0%	50.0%	75.0%	79.2%
X.	438.236	Practice Guidelines	100%	100%	100%	100%	100%	100%	100%
XI.	438.242	Health Information Systems**	100%	100%	100%	100%	100%	100%	100%
XII.	438.330	Quality Assessment and Performance Improvement	100%	66.7%	100%	83.3%	100%	100%	91.7%
XIII	438.228	Grievance and Appeal Systems	86.2%	82.8%	86.2%	96.6%	93.1%	75.9%	86.8%
XIV.	438.608	Program Integrity	100%	100%	100%	100%	100%	100%	100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services	62.5%	62.5%	62.5%	87.5%	87.5%	62.5%	70.8%
TOTAL SCORE			**92.2%**	**91.0%**	**92.2%**	**92.2%**	**95.2%**	**86.2%**	**91.5%**

* Added in the 2020 Medicaid Managed Care Rule effective December 14, 2020.
** The Health Information Systems standard includes an assessment of each MCO's information system.

Each MCO's total compliance scores ranged from a low of 86.2 percent to a high of 95.2 percent. Additionally, all MCOs achieved full compliance for Standard IV—Emergency and Poststabilization Services, Standard VI—Coordination and Continuity of Care, Standard VIII—Provider Selection, Standard X—Practice Guidelines, Standard XI—Health Information Systems, and Standard XIV—Program Integrity.

The MCOs' lowest-scoring standards were Standard V—Assurance of Adequate Capacity and Availability of Services, Standard IX—Subcontractual Relationships and Delegation, Standard XIII—Grievance and Appeal Systems, and Standard XV—EPSDT Services.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** The MCOs implemented interventions to increase the utilization of EPSDT services. The MCOs used multiple modalities to ensure that members were informed of covered services and how to access services. The MCOs also implemented processes to provide for direct access to women's health services, out-of-network services, and second opinions; and informed members and providers, as applicable.
	Strength: The MCOs evaluated and monitored the quality and appropriateness of care provided to members with SHCN. The MCOs also monitored provider networks to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with disabilities.
	Strength: The MCOs eased requirements and expanded access points during the COVID-19 PHE. The MCOs implemented processes to ensure claims edits were not triggered for emergency service claims.
	Strength: The MCOs implemented comprehensive training processes for care coordination staff members. The MCOs also leveraged a multidisciplinary approach to engage disruptive members in continued care. The MCOs implemented processes to prevent, detect, and remediate critical incidents.
Weaknesses	**Weakness:** The MCOs' network adequacy policies, procedures, and monitoring did not consistently align with federal and Commonwealth requirements. The MCOs did not consistently ensure there were enough providers of each type, in each region, or always differentiate rural versus urban network requirements. The MCOs did not consistently address access standards for LTSS. In addition, the MCO did not ensure that travel time and distance standards were monitored according to the appropriate DMAS travel time and distance standards for each region. The MCOs' subcontractor and delegated entity agreements did not consistently include Virginia-specific requirements. **Why the weakness exists:** The MCOs did not consistently update subcontractor and delegated entity agreements, policies, and procedures to align with the CMS 2020 Medicaid Managed Care Rule updates. The MCOs did not always monitor provider networks against DMAS program-specific requirements for time, distance, and regional requirements.

Recommendation: The MCOs must update subcontractor and delegated entity agreements, policies, and procedures when changes are made in federal or DMAS contract requirements. The MCOs must implement policies, procedures, and processes to monitor networks against federal and DMAS time, distance quantity, and regional requirements at a frequency determined by DMAS.
Weakness: Most MCOs did not consistently meet grievance and appeal timelines or include all member rights in notices to members. The MCOs also did not consistently meet notice of adverse benefit determination timelines or include all required language. In addition, the MCOs did not consistently inform members about the secondary EPSDT review process and that, when denied, services may be available through DMAS. **Why the weakness exists:** The MCOs did not consistently update policies and procedures to address changes in member rights or member information as required in the 2020 Medicaid Managed Care Rule or in the DMAS contract. **Recommendation:** The MCOs must consistently update policies, procedures, processes, and templates used to inform members of their rights and ensure that member communications and notices meet member information requirements.
Weakness: The MCOs did not consistently provide machine-readable formats of their formularies or provider directories on their websites. MCO member notices were not consistently in a format and language that was easily understood by members. **Why the weakness exists:** The MCOs did not consistently update policies and procedures to address changes in member information as required in the 2020 Medicaid Managed Care Rule or the DMAS contract. **Recommendation:** The MCOs must consistently update policies, procedures, processes, and templates to ensure that member communications and notices meet member information requirements and are easily understood by members.

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)
- OB/GYN
- 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 EQR 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. Finally, CMS removed the requirement for states to establish standards for additional provider types.

MCO Comparative and Statewide Aggregate EDV Results

EDV Project Highlights

DMAS contracted with HSAG to conduct an EDV, which consisted of two activities:

1) **IS review** to assess each MCO's technical processes and capabilities.
2) **Administrative profile analysis** to assess the quality, completeness, and timeliness of encounter data submitted to DMAS.

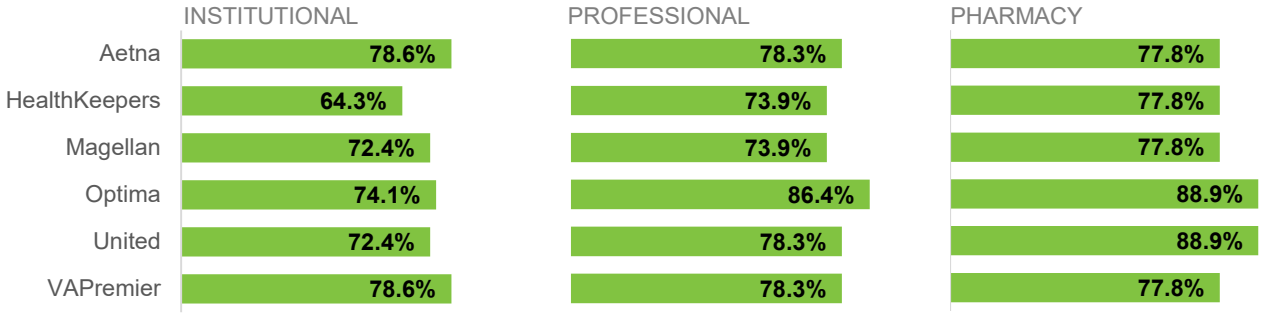
The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

Quality

HSAG assessed the validity of values found across all commonly used data elements and data elements of particular interest to DMAS. HSAG considered rates of valid values of 99 percent to be sufficiently high for no concern. Figure 3-1 shows that across all data elements assessed, Optima met the valid value criteria for over 80 percent of data elements for professional and pharmacy encounters.

Meanwhile, less than 75 percent of data elements for HealthKeepers and Magellan met the valid value criteria of 99 percent for institutional and professional encounters.

Figure 3-1—Percentage of Data Elements Meeting 99 Percent Valid Value Criteria



Detailed data element-level results can be found in Section 7—Encounter Data Validation.

Completeness

Overall, DMAS' encounter data were sufficiently complete to continue supporting analyses such as HEDIS PM calculation. While some gaps in data completeness were identified, these gaps should not preclude DMAS from conducting further analysis. Notable gaps included:

- Large variation across the MCOs when populating the Servicing Provider Taxonomy Code data field for institutional encounters
  - Ranged from 0 percent (Optima) to 99.2 percent (VA Premier)
- Low completeness of header TPL paid amounts for Magellan's institutional encounters

Timeliness

The MCOs are required to submit 96 percent of institutional and professional encounters and 99 percent of pharmacy encounters within 30 days of payment. HSAG assessed this standard, shown in Table 3-5, based on the paid and submission dates populated on the encounters.

Table 3-5—Percentage of Encounters Submitted Within 30 Days of Payment

Plan	Institutional		Professional		Pharmacy	
Statewide	**95.9%**		**95.0%**		**92.0%**	
Aetna	91.5%		81.0%		99.8%	✓
HealthKeepers	96.2%	✓	96.1%	✓	99.9%	✓
Magellan	99.3%	✓	94.7%		99.3%	✓
Optima	99.9%	✓	99.4%	✓	100%	✓
United	97.6%	✓	98.2%	✓	11.0%	
VA Premier	92.1%		99.0%	✓	97.1%	

✓ Met submission standard

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** The IS review revealed Aetna has a comparatively robust internal assessment and reporting of encounter data quality and timeliness.
	Strength: Optima met the valid value criteria of 99 percent for over 80 percent of data elements for professional and pharmacy encounters. HealthKeepers, Magellan, Optima, and United met the 30-day submission standards for two of the three encounter types.
Weaknesses	**Weakness:** The IS review identified that several MCOs (HealthKeepers, Magellan, Optima, and VA Premier) could make improvements to their internal process for monitoring encounter data. **Why the weakness exists:** While the MCOs create regular reports assessing the inbound encounter data, the reports HSAG reviewed focused primarily on a single snapshot of submission timeliness and acceptance rates. **Recommendation:** HSAG recommends that the MCOs consider augmenting existing monitoring reports to include comparisons of existing metrics over time (e.g., week-to-week or month-to-month acceptance rates) and/or summary metrics on encounter data quality and completeness.
	Weakness: Aetna and VA Premier did not meet the 30-day submission standards for two of the three encounter types. **Why the weakness exists**: The IS review and administrative profile analysis did not identify the specific root cause of the weakness. **Recommendation:** HSAG recommends that the MCOs seek to identify the root cause of any delays in submitting encounters to rectify any issues.
	Weakness: Less than 75 percent of data elements for HealthKeepers and Magellan met the valid value criteria of 99 percent for institutional and professional encounters. **Why the weakness exists:** The IS review and administrative profile analysis did not identify the specific root cause of the weakness. **Recommendation:** HSAG recommends that the MCOs incorporate additional logic and referential checks to assess the validity of data elements.

Statewide Aggregate CAHPS Results

Member Experience Survey Highlights

Figure 3-2—CAHPS Strengths and Weaknesses

CAHPS Strengths

The CCC Plus program scored statistically significantly higher than the 2020 NCQA adult Medicaid national averages for six measures. In addition, one MCO scored statistically significantly higher than the 2020 NCQA adult Medicaid national averages for five measures.

HealthKeepers' 2021 top-box score was statistically significantly higher than the 2020 score for the *Rating of Health Plan* measure for the child Medicaid population.

The scores for the *Rating of Specialist Seen Most Often* and *Getting Needed Care* measures were statistically significantly higher than the 2020 NCQA child Medicaid national averages for United and VA Premier, respectively.

CAHPS Weaknesses

The top-box scores for the *Rating of Health Plan*, *Rating of All Health Care*, and *How Well Doctors Communicate* measures for the CCC Plus program were statistically significantly lower than the 2020 NCQA child Medicaid national averages. Furthermore, the scores for *Rating of Health Plan* for five out of six MCOs were statistically significantly lower than the 2020 NCQA child Medicaid national averages.

The 2021 top-box scores for the CCC Plus program were statistically significantly lower than the 2020 child Medicaid scores for the *Getting Care Quickly* and *How Well Doctors Communicate* measures. In addition, the 2021 top-box score for one MCO was statistically significantly lower than the 2020 NCQA child Medicaid score for the *Getting Care Quickly* measure.

Adult Medicaid

Table 3-6 and Table 3-7 present the 2021 top-box scores for each MCO and the CCC Plus program (i.e., all MCOs combined) compared to the 2020 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2021 CAHPS scores for each MCO and the CCC Plus program were also compared to the 2020 NCQA adult Medicaid national averages.

Table 3-6—Comparison of 2020 and 2021 Adult Global Top-Box Scores

	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2020	2021	2020	2021	2020	2021	2020	2021
CCC Plus Program	65.5%	64.7%	57.5%	58.7%	72.3%	71.8%	71.6%	70.0%
Aetna	64.8%	61.5%	56.1%	57.9%	73.4%	71.7%	70.8%	73.1%
HealthKeepers	63.2%	62.4%	57.1%	57.3%	72.1%	69.8%	70.2%	66.0%
Magellan	61.3%	62.4%	53.5%	58.4%	70.4%	71.2%	68.6%	71.1%
Optima	68.6%	67.7%	59.5%	61.2%	73.4%	75.4%	70.5%	74.1%
United	66.0%	63.4%	59.3%	59.9%	72.0%	68.1%	68.2%	65.2%
VA Premier	67.1%	67.3%	56.8%	58.0%	72.2%	72.2%	77.6%	71.0%

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

Table 3-7—Comparison of 2020 and 2021 Adult Composite Top-Box Scores

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2020	2021	2020	2021	2020	2021	2020	2021
CCC Plus Program	85.0%	86.1%	85.5%	85.0%	93.6%	94.2%	91.3%	91.3%
Aetna	83.8%	86.0%	86.2%	84.1%	92.7%	91.8%	88.2%	87.8%
HealthKeepers	86.9%	85.3%	86.2%	84.1%	94.1%	94.2%	92.4%	91.9%
Magellan	79.0%	83.9%	81.6%	79.8%	91.8%	93.7%	88.9%	92.2%
Optima	85.5%	88.6%	83.5%	84.4%	93.8%	96.1%	91.3%	92.8%
United	80.9%	83.8%	86.5%	84.4%	92.6%	93.0%	88.3%	91.5%
VA Premier	86.2%	86.2%	85.9%	88.9%	94.0%	94.1%	93.4%	90.3%

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength: In 2021, the CCC Plus program scored statistically significantly higher than the 2020 NCQA adult Medicaid national averages for *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. Optima's 2021 top-box scores were statistically significantly higher than the 2020 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*,

Getting Needed Care, *How Well Doctors Communicate*, and *Customer Service*. Magellan's and VA Premier's 2021 top-box scores were statistically significantly higher than the 2020 NCQA adult Medicaid national averages for *Customer Service* and *Getting Care Quickly*, respectively.

Weaknesses

Weakness: Overall weaknesses in the adult CAHPS survey were not identified.
Why the weakness exists: NA.
Recommendation: HSAG recommends the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Child Medicaid

Table 3-8 and Table 3-9 present the 2021 top-box scores for each MCO and the CCC Plus program compared to the 2020 child Medicaid CAHPS scores for the global ratings and composite measures. The 2021 CAHPS scores for each MCO and the CCC Plus program were also compared to the 2020 NCQA child Medicaid national averages.

Table 3-8—Comparison of 2020 and 2021 Child Global Top-Box Scores

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2020	***2021***	***2020***	***2021***	***2020***	***2021***	***2020***	***2021***
CCC Plus Program	63.1%	65.4%	67.1%	68.5%	78.2%	79.5%	73.9%	74.8%
Aetna	69.3%	63.7%	63.9%	66.1%	74.1%	75.8%	75.0%+	76.5%
HealthKeepers	55.4%	65.7%▲	64.9%	68.3%	75.6%	79.5%	70.0%	74.1%
Magellan	50.6%	52.4%	55.7%	60.0%+	75.9%	77.6%	69.4%+	54.7%+
Optima	66.1%	66.0%	67.5%	69.8%	79.0%	82.4%	72.3%	79.8%
United	60.0%	62.3%	67.6%	70.2%	74.8%	76.8%	83.6%+	82.3%+
VA Premier	73.0%	69.8%	74.1%	70.4%	84.2%	79.7%	78.0%+	74.2%

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Statistically significantly higher in 2021 than in 2020.
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 3-9—Comparison of 2020 and 2021 Child Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2020	***2021***	***2020***	***2021***	***2020***	***2021***	***2020***	***2021***
CCC Plus Program	87.9%	87.3%	93.0%	89.7%▼	95.5%	93.9%▼	87.7%	89.4%
Aetna	89.9%	88.2%	89.4%	91.2%	93.1%	92.5%	83.7%+	87.5%+

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2020	2021	2020	2021	2020	2021	2020	2021
HealthKeepers	86.1%	85.6%	94.4%	89.0%▼	95.9%	94.1%	88.2%	89.8%
Magellan	83.4%+	81.2%+	86.2%+	90.2%+	93.8%	91.7%+	82.3%+	81.3%+
Optima	87.6%	86.7%	93.1%	86.4%	94.4%	92.9%	88.6%	91.2%+
United	86.4%+	87.7%+	92.2%+	91.2%+	94.7%+	93.7%	92.6%+	87.2%+
VA Premier	91.4%	91.5%	95.2%+	92.5%	97.7%	95.7%	88.0%+	90.8%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Statistically significantly lower in 2021 than in 2020.
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: HealthKeepers' 2021 top-box score was statistically significantly higher than the 2020 score for the *Rating of Health Plan* measure. In addition, the scores for the *Rating of Specialist Seen Most Often* and *Getting Needed Care* measures were statistically significantly higher than the 2020 NCQA child Medicaid national averages for United and VA Premier, respectively.

Weaknesses

Weakness: The top-box scores for the *Rating of Health Plan*, *Rating of All Health Care*, and *How Well Doctors Communicate* measures for the CCC Plus program were statistically significantly lower than the 2020 NCQA child Medicaid national averages. In addition, the 2021 top-box scores for the CCC Plus program were statistically significantly lower than the 2020 scores for the *Getting Care Quickly* and *How Well Doctors Communicate* measures. The 2021 top-box score for HealthKeepers was statistically significantly lower than the 2020 score for the *Getting Care Quickly* measure. The scores for *Rating of Health Plan* for five out of six MCOs were statistically significantly lower than the 2020 NCQA child Medicaid national averages. The top-box scores for the *Rating of All Health Care* and *Rating of Specialist Seen Most Often* measures for Magellan and the *How Well Doctors Communicate* measure for Aetna were statistically significantly lower than the 2020 NCQA child Medicaid national averages.

Why the weakness exists: Based on the child survey results, parents/caretakers of child members indicated that they are not overly satisfied with their child's health plan, healthcare their child received, and communication with their child's doctor. Parents/caretakers of child members are reporting more negative experiences with their ability to quickly access care for their child. This may indicate that they are experiencing access to care issues or have a lack of understanding of how to access care and services. Furthermore,

parents/caretakers of child members in Magellan are reporting more negative experiences with their child's specialists.

Recommendation: HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Other Surveys Conducted

DMAS also conducted 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.

I/DD Quality Assurance Surveys: The MCOs conduct quarterly member surveys to assess the performance of transportation providers for I/DD waiver members.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

DMAS contracted with HSAG in 2021 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 3-10. Please refer to Appendix B for the detailed methodology used for this tool.

Table 3-10—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.

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

Table 3-11 displays the CCC Plus 2021 Consumer Decision Support Tool results for each MCO.

Table 3-11—2021 Consumer Decision Support Tool Results

MCO	Overall Rating*	Doctors' Communication	Access and Preventive Care	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	★★★	★	★★★	★★★	★★★★	★★★★★
HealthKeepers	★★★	★★★	★★★	★★★★	★★★★★	★★★★★
Magellan	★	★★★	★★	★	★★	★
Optima	★★★★	★★★★★	★★★	★★	★★★	★
United	★★★	★★	★★★	★★★	★★	★★★★★
VA Premier	★★★★★	★★★★	★★★★★	★★★★★	★★★	★

**This rating includes all categories, as well as how the member feels about their MCO, their MCO's customer service, and the healthcare they received.*

Strengths, Weaknesses, and Recommendations

Strengths

Strength: For 2021, VA Premier demonstrated the strongest performance by achieving the Highest Performance level for the *Overall Rating*, *Access and Preventive Care*, and *Behavioral Health* categories; High Performance for the *Doctors' Communication* category; and Average Performance for the *Taking Care of Children* category. HealthKeepers also demonstrated strong performance by achieving the Highest Performance level for the *Taking Care of Children* and *Living With Illness* categories and High Performance for the *Behavioral Health* category. Additionally, Optima and Aetna demonstrated strong performance by achieving High or Highest Performance in at least two of the categories, and United achieved Highest Performance in at least one of the categories.

Weaknesses

Weaknesses: Magellan demonstrated the lowest performance by achieving the Lowest Performance level for the *Overall Rating*, *Behavioral Health,* and *Living With Illness* categories and never performing above the Average Performance level.

Performance Withhold Program

In 2021, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the CCC Plus PWP. Due to the impacts of the COVID-19 PHE on the 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 PM data, would be a pay-for-reporting year for the PWP. The SFY 2021 PWP assessed CY 2020 PM data 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 was necessary to align the PWP program with the movement of the CCC Plus contract from a calendar year to state fiscal year schedule. Subsequent withholding periods will cover the 12 months of the state fiscal year. For the SFY 2021 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 Adult Core Set measures. The SFY 2021 PWP was based on whether the MCO reported valid HEDIS MY 2020 (i.e., CY 2020) measure rates to NCQA in the required reporting method (i.e., hybrid for the *Comprehensive Diabetes Care* measure 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 SFY 2021 PWP. For detailed information related to the PWP, please see the *CCC Plus PWP Methodology (Updated for COVID-19)* on DMAS' website.[3-3]

[3-3] Health Services Advisory Group, Inc. *Revised CY 2019 and SFY 2021 CCC Plus Performance Withhold Program Methodology*. Available at: https://www.dmas.virginia.gov/media/2341/revised-cy-2019-and-sfy-2021-ccc-plus-performance-withhold-program-methodology.pdf. Accessed on: Nov 22, 2021.

4. 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 QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

Objective

As part of the Commonwealth's QS, 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 BBA, HSAG, as the Commonwealth'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. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[4-1] 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 2021 were:

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

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?

[4-1] 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: Nov 29, 2021.

- **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 2021, 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 Module 4 and Module 5 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. This process allowed the CCC Plus MCOs an opportunity to address criteria that received a *Not Achieved* score, provide additional SMART Aim and intervention evaluation data, and potentially improve the PIP's confidence level. 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 QI 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 PIP and confirmed that any achieved improvement can be linked to the QI 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 QI 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, QI 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 QI 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. The 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

The CCC Plus MCOs progressed to reporting outcomes for the 2021 annual validation. The Module 4 submissions contained the data for intervention evaluation and the Module 5 submissions contained the SMART Aim measure results. HSAG validated Module 4 and Module 5 in 2021 and assessed whether the goal was achieved and if there was demonstrated improvement in the SMART Aim measure results that could be linked with an intervention tested for the PIP. The PIP validation findings for each CCC Plus MCO are provided below.

Recommendations

The CCC Plus MCOs should ensure understanding of the essential components for conducting PIPs and continue improvement efforts in the PIP topic areas. The CCC Plus MCOs should consider spreading interventions that have been effective. If the CCC Plus MCOs have questions or need technical assistance with their PIPs, they should reach out to HSAG.

Validation Findings

Aetna

In 2021, 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 4-1 displays the SMART Aim and results for each PIP.

Table 4-1—SMART Aim Statements and Results: Aetna

SMART Aim Statement	By May 31, 2021, decrease the percentage of African American CCC+ members in the Central VA Region zip code 23223 who have had one ambulatory visit and two or more ED visits from 47.3% to 43.7%.
Lowest Rate Achieved	1.3%
Confidence Level	*Low confidence*

SMART Aim Statement	By May 31, 2021, increase the percentage of members aged 45–64 years old in the Central VA region who had a post-hospitalization follow up with a PCP or specialist within 30 days of discharge from 29.4% to 36.98%.
Highest Rate Achieved	30.6%
Confidence Level	*Low confidence*

For each PIP, Aetna completed a process map and an 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 targeted interventions. Table 4-2 and Table 4-3 provide the interventions that Aetna selected to test for the PIPs and the MCO's decision for each intervention—adopted (select changes to test on a larger scale or develop plan for sustainability if progressive testing has revealed that the intervention should be implemented across the board), adapted (integrate the results of lessons learned during the study phase into a new test or adapt the test to a new or larger environment/situation), abandoned (discard this change idea and test a different one), or further testing is required.

Table 4-2—Intervention Summary for *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
Member Telephonic Outreach	Abandon

Table 4-3—Intervention Summary for *Follow-Up After Discharge*

Intervention	Intervention Status
Member Educational Letter	Adapt

Aetna completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to Aetna in the initial validation tools for Module 4 and Module 5 and Aetna had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. Aetna made corrections in the resubmissions to address criteria that had received a *Not Achieved* score.

For Aetna's *Ambulatory Care—Emergency Department Visits* PIP, the SMART Aim measure result was lower than the goal (a lower result is better) for the duration of the PIP; however, the MCO indicated that the results were likely due to "extraneous variables." Additionally, Aetna could not determine that the intervention was successful in impacting the SMART Aim. For the *Follow-Up After Discharge* PIP, the SMART Aim result did not meet the goal and was below the baseline after the intervention started.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Aetna removed a member newsletter article from the *Ambulatory Care—Emergency Department Visits* PIP intervention because it is considered a passive change.
	Strength: Aetna recognized that because few members were reached by the member telephonic outreach intervention, it likely had little impact on the SMART Aim.
Weaknesses	**Weaknesses:** Aetna received *Low confidence* for both PIPs. **Why the weakness exists:** For the *Ambulatory Care—Emergency Department Visits* PIP, the MCO could not link improvement to an intervention tested for the PIP. For the *Follow-Up After Discharge* PIP, the SMART Aim result did not meet the goal. **Recommendation:** HSAG recommends that Aetna: • Test more than one intervention per PIP. • Focus on testing active and engaging interventions.

HealthKeepers

In 2021, 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 4-4 displays the SMART Aim and results for each PIP.

Table 4-4—SMART Aim Statements and Results: HealthKeepers

SMART Aim Statement	By May 31, 2021, decrease the percentage of CCC Plus members among the Riverside Regional Medical Center-Brentwood practice who have an ED visit, from 21.77% to 16.24%.
Lowest Rate Achieved	47.3%
Confidence Level	*Reported PIP results were not credible*
SMART Aim Statement	By May 31, 2021, increase the percentage of CCC Plus members among the Riverside Regional Medical Center—Brentwood who have a follow-up visit within 30 days after discharge from the hospital, from 64.82% to 75%.
Highest Rate Achieved	The MCO did not provide the SMART Aim data.
Confidence Level	*Reported PIP results were not credible*

For each PIP, HealthKeepers completed a process map and an 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 targeted interventions. Table 4-5 and Table 4-6 provide the interventions that HealthKeepers selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-5—Intervention Summary for *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
"Call Us First" Campaign at PCP Office	Abandon

Table 4-6—Intervention Summary for *Follow-Up After Discharge*

Intervention	Intervention Status
Managing Transitions by Improving the Frequency of Patient Insights and Member Engagement	Abandon

HealthKeepers completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to HealthKeepers in the initial validation tools for Module 4 and Module 5 and HealthKeepers had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. HealthKeepers did not make all the requested corrections in the resubmissions to address criteria that had received a *Not Achieved* score.

For HealthKeepers' *Ambulatory Care—Emergency Department Visits* PIP, the MCO provided some data; however, the total eligible population was much smaller than the baseline. HealthKeepers did not provide additional data or an explanation for the small denominator sizes in the resubmission. For the *Follow-Up After Discharge* PIP, the MCO did not provide the data for the SMART Aim measure and reported that it abandoned the intervention.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HealthKeepers responded to some of HSAG's PIP validation feedback in the resubmission.

Weaknesses

Weaknesses: HealthKeepers received *Reported PIP results were not credible* for both PIPs.

Why the weakness exists: The MCO did not address all HSAG's PIP validation feedback in the resubmission and did not include all the requested SMART Aim and intervention evaluation data.

Recommendation: HSAG recommends that HealthKeepers:

- Address all feedback and recommendations in a PIP resubmission.
- Design a complete and accurate intervention evaluation plan.
- Provide the required data for the PIP's SMART Aim measure.

- Explain possible reasons for changes in the total population size.
- Provide additional SMART Aim measure data in the resubmission.
- Test more than one intervention per PIP.
- Reach out to HSAG for PIP technical assistance.

Magellan

In 2021, 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 4-7 displays the SMART Aim and results for each PIP.

Table 4-7—SMART Aim Statements and Results: Magellan

SMART Aim Statement	By May 31, 2021, reduce the rate of members who are high utilizers (>5 ED in 90 days) of the emergency department, by 5% points from 14.1% to 9.1%, who are assigned to Dr. Diggs, Dr. Patel, and Dr. Bhowmik as a primary care provider.
Lowest Rate Achieved	10.4%
Confidence Level	*Low confidence*
SMART Aim Statement	By May 31, 2021, increase by 6.31 percentage points the rate of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge in the Central Region from 43.69% to 50.0%.
Highest Rate Achieved	61.1%
Confidence Level	*Low confidence*

For each PIP, Magellan completed a process map and an 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 targeted interventions. Table 4-8 and Table 4-9 provide the interventions that Magellan selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-8—Intervention Summary for *Reduce Emergency Department Visits*

Intervention	Intervention Status
Improve Accurate Member Contact Information by Reviewing Claims	Abandon

Table 4-9—Intervention Summary for *Increasing Follow-Up Visits After Discharge*

Intervention	Intervention Status
Member Telephonic Outreach	Abandon

Magellan completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to Magellan in the initial validation tools for Module 4 and Module 5 and Magellan had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. Magellan made corrections in the resubmissions to address criteria that had received a *Not Achieved* score.

For Magellan's *Reduce Emergency Department Visits* PIP, there was improvement reported in the SMART Aim measure results; however, the goal was not reached. For the *Increasing Follow-Up Visits After Discharge* PIP, the SMART Aim measure result was above the goal for the duration of the PIP. Magellan provided the intervention effectiveness measure data in the resubmission. The MCO indicated that the intervention was not effective at impacting the SMART Aim and could not be linked to the improvement.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Magellan requested technical assistance from HSAG prior to resubmitting the PIPs.

Strength: Magellan provided intervention evaluation data in both PIP resubmissions.

Strength: Magellan provided additional SMART Aim data in the *Reduce Emergency Department Visits* PIP resubmission.

Weaknesses

Weaknesses: Magellan received *Low confidence* for both PIPs.

Why the weakness exists: For the *Reduce Emergency Department Visits* PIP, the SMART Aim goal was not achieved. For the *Increasing Follow-Up Visits After Discharge* PIP, the intervention was not effective at impacting the SMART Aim and could not be linked to the improvement.

Recommendation: HSAG recommends that Magellan:

- Test more than one intervention per PIP.
- Ensure that all data are reported accurately in the PIP submission.

Optima

In 2021, Optima submitted the following topics for validation: *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, 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 4-10 displays the SMART Aim and results for each PIP.

Table 4-10—SMART Aim Statements and Results: Optima

SMART Aim Statement	By May 31, 2021, decrease the rate of ED visits among adult Optima Health Community Care Tidewater regional members with chronic obstructive pulmonary disease (COPD), asthma, bronchitis, or emphysema, by 10% (from 1.90-1.71).
Lowest Rate Achieved	1.70
Confidence Level	*Confidence*
SMART Aim Statement	By May 31, 2021, increase the percentage of 30-day ambulatory follow-ups with a practitioner among Optima Health Community Care members residing in the Tidewater region with a hospital discharge, by 10% (from 68.57% to 75.43%).
Highest Rate Achieved	66.2%
Confidence Level	*Low confidence*

For each PIP, Optima completed a process map and an 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 targeted interventions. Table 4-11 and Table 4-12 provide the interventions that Optima selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-11—Intervention Summary for *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema*

Intervention	Intervention Status
Post-ED Scripted Member Telephonic Outreach (Automated)	Adapt
Post-ED Scripted Member Telephonic Outreach (Care Coordinator)	Adapt

Table 4-12—Intervention Summary for *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members*

Intervention	Intervention Status
Post-Discharge Scripted Member Telephonic Outreach (Automated)	Adapt
Post-Discharge Scripted Member Telephonic Outreach (Care Coordinator)	Adapt

Optima completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested

could be linked to demonstrated improvement. HSAG provided feedback and recommendations to Optima in the initial validation tools for Module 4 and Module 5 and Optima had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. Optima made corrections in the resubmissions to address criteria that had received a *Not Achieved* score.

For Optima's *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* PIP, the MCO provided the SMART Aim data through May 31, 2021, and the results achieved the goal. For the *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members* PIP, the MCO provided SMART Aim data through May 31, 2021; however, the results did not achieve the goal.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Optima provided the SMART Aim data through May 31, 2021, in the PIP resubmissions and achieved the goal for the *Reducing Utilization of the Emergency Department for a Primary Diagnosis of COPD, Asthma, Bronchitis, or Emphysema* PIP.

Strength: Optima planned to adapt interventions to increase effectiveness.

Weaknesses

Weaknesses: Optima received *Low confidence* for the *Improving Compliance in 30-Day Ambulatory Follow-Up Appointments for Tidewater Regional Members* PIP.

Why the weakness exists: The SMART Aim results did not achieve the goal.

Recommendation: HSAG recommends that Optima:

- Ensure that interventions reach the maximum number of eligible members.
- Provide SMART Aim data beyond May 31, 2021, in the resubmissions.

United

In 2021, 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 4-13 displays the SMART Aim and results for each PIP.

Table 4-13—SMART Aim Statements and Results: United

SMART Aim Statement	By May 31, 2021, the Virginia UnitedHealthcare Commonwealth CCC Plus plan will decrease the percentage of non-emergent ED visits among the EDCD waiver population, from 198.20 per 1,000 members to 188.29.
Lowest Rate Achieved	71.62
Confidence Level	*High confidence*

SMART Aim Statement	The Virginia UnitedHealthcare CCC Plus plan will increase the percentage of members in the Tidewater and Roanoke regions that have a follow-up visit within 30 days of discharge from the hospital from 54.13 percent to 58.23 percent by May 31, 2021.
Highest Rate Achieved	60.3%
Confidence Level	*Low confidence*

For each PIP, United completed a process map and an 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 targeted interventions. Table 4-14 and Table 4-15 provide the interventions that United selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-14—Intervention Summary for *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
Educational Flyer	Adopt
Member Follow-Up Post ED Visit	Adopt

Table 4-15—Intervention Summary for *Follow–Up After Discharge*

Intervention	Intervention Status
Vendor Oversight of Post Hospital Assessment Completion	Adopt
Discharge Follow-up Process Implementation in Tidewater and Roanoke Regions	Adopt

United completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to United in the initial validation tools for Module 4 and Module 5 and United had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. United made corrections in the resubmissions to address criteria that had received a *Not Achieved* score.

For United's *Ambulatory Care—Emergency Department Visits* PIP, the MCO provided additional SMART Aim data points for June 2021 and July 2021 in the resubmission. The data demonstrated further improvement and the SMART Aim goal continued to be achieved. The MCO reported that it continued both interventions and provided additional intervention effectiveness data. For the *Follow-Up After Discharge* PIP, United provided additional SMART Aim data points and an update on the interventions in the resubmission. The SMART Aim goal was achieved prior to intervention testing and was not achieved after intervention testing began; therefore, improvement could not be linked to the interventions.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** United tested more than one intervention per PIP.
	Strength: United provided additional SMART Aim and intervention evaluation data in both PIP resubmissions.
	Strength: United increased the score for the *Ambulatory Care—Emergency Department Visits* PIP to *High confidence*.
	Strength: United planned to adopt successful interventions.
Weaknesses	**Weakness:** United received *Low confidence* for the *Follow-Up After Discharge* PIP. **Why the weakness exists:** Improvement could not be linked to the interventions. **Recommendation:** HSAG recommends that United: • Continue efforts to achieve further improvement and spread interventions to other populations as appropriate.

VA Premier

In 2021, 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 4-16 displays the SMART Aim and results for each PIP.

Table 4-16—SMART Aim Statements and Results: VA Premier

SMART Aim Statement	By May 31, 2021, decrease the rate of ED visits among members 20-44 years old from 127.04 to 112.68.
Lowest Rate Achieved	12.9%
Confidence Level	*Reported PIP results were not credible*
SMART Aim Statement	By May 31, 2021, increase the percentage of follow-up within 30 days after discharge among hospitalized members ages 18-64 years old from 70% to 75%.
Highest Rate Achieved	89.0%
Confidence Level	*Reported PIP results were not credible*

For each PIP, VA Premier completed a process map and an 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 targeted interventions. Table 4-17 and Table 4-18 provide the

interventions that VA Premier selected to test for the PIPs and the MCO's decision for each intervention.

Table 4-17—Intervention Summary for *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
Partner With Collective Medical (PreManage) to Utilize Existing Reporting Capabilities and/or Implement New Reporting Functions to Ensure Member ED Visit Notification (within 24 hours)	Adapt

Table 4-18—Intervention Summary for *Follow-Up After Discharge*

Intervention	Intervention Status
Partner With Collective Medical (PreManage) to Utilize Existing Reporting Capabilities and/or Implement New Reporting Functions to Ensure Member ED Visit Notification (within 24 hours)	Adapt

VA Premier completed both PIPs and submitted Module 4 and Module 5 to HSAG for validation. HSAG assessed the SMART Aim measure results for improvement and whether interventions that were tested could be linked to demonstrated improvement. HSAG provided feedback and recommendations to VA Premier in the initial validation tools for Module 4 and Module 5 and VA Premier had an opportunity to resubmit the PIPs with corrections and additional data to potentially improve the 2021 PIP validation scores. VA Premier made some corrections in the resubmissions to address criteria that had received a *Not Achieved* score; however, not all the changes resulted in *Achieved* scores because the revised documentation did not meet the validation criterion.

For VA Premier's *Ambulatory Care—Emergency Department Visits* PIP, the MCO provided the SMART Aim measure numerator and denominator results in the resubmission; however, it appeared that the remeasurement data were not comparable to the baseline. For the *Follow-Up After Discharge* PIP, the MCO also provided SMART Aim measure numerator and denominator results in the resubmission; however, it appeared that the remeasurement data were not comparable to the baseline. The MCO did not provide additional data beyond the SMART Aim end date.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** VA Premier provided some corrections in the resubmissions.
	Strength: VA Premier planned to adapt the interventions to increase effectiveness.
Weaknesses	**Weaknesses:** VA Premier received *Reported PIP results were not credible* for both PIPs.

Why the weakness exists: The MCO did not address all HSAG's feedback in the resubmissions and documented SMART Aim remeasurement data that appeared to be not comparable to the baseline.

Recommendation: HSAG recommends that VA Premier:

- Ensure understanding of the PIP methodology and data reporting requirements.
- Address all feedback and recommendations in PIP resubmissions.

5. 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 QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

DMAS uses HEDIS, Child Core Set, and 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 DD programs. As part of the annual EQR 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 HEDIS data to NCQA as part of performance measurement. 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 3, Table 3-3 displays, by MCO, the HEDIS MY 2020 measure rates that 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 IS 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:* HSAG identified no 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.
- *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 displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The high level of performance in providing access to care for adults indicates that Aetna is ensuring that providers follow recommended preventive or ambulatory care visits, thereby reducing adverse member outcomes and unnecessary ED utilization.
	Strength: Aetna's performance within the Behavioral Health domain identified four measure indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile, including the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia, Antidepressant Medication Management—Effective Continuation Phase Treatment,* and *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicator rates. 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 three measure indicators meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile, including the *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* measure indicators. The MCO's performance in pharmacotherapy management of COPD exacerbation condition measures indicates that Aetna's providers have established evidence-based guidelines for management of COPD-diagnosed members.

Weaknesses

Weakness: The following HEDIS MY 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna:

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Cholesterol Testing—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—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 screenings, 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. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that Aetna conduct a root cause analysis or focused study to determine why members are not consistently accessing and completing preventive 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 its 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 ambulatory services, which can significantly reduce non-urgent ED visits.

HealthKeepers

HealthKeepers' HEDIS auditor found that the MCO was fully compliant with all IS 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:* HSAG identified no concerns with HealthKeepers' supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with HealthKeepers' procedures for data integration and measure production.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Within the Access and Preventive Care domain, HealthKeepers displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, meeting or exceeding NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. The high level of performance in providing access to care for adults indicates that HealthKeepers is ensuring that providers follow recommended preventive or ambulatory care visits, thereby reducing adverse member outcomes and unnecessary ED utilization.
	Strength: Within the Behavioral Health domain, HealthKeepers had two measure indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile: *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Continuation Phase Treatment*. The strong performance in the two behavioral health measure indicators indicate that HealthKeepers established strong access to antipsychotic and antidepressant medications in behavioral healthcare and services.
	Strength: Within the Living With Illness domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for three measure indicators: *Asthma Medication Ratio—Total* 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 and medical assistance with tobacco use indicates that HealthKeepers has established successful processes related to medication and medical assistance for members living with illness.

Strength: Within the Use of Opioids domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* measure indicator. HealthKeepers displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Plan All Cause Readmissions—O/E Ratio—Total* measure indicator. The strong performance related to use of opioids indicates that HealthKeepers is managing the frequency of its members' use of multiple pharmacies for opioid medications.

Weaknesses

Weakness: The following HEDIS MY 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *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: HealthKeepers' rates for several measure indicators in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

Recommendation: HSAG recommends that HealthKeepers conduct a root cause analysis or focused study 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 improve the performance related to these measures.

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 Behavioral Health domain, Magellan ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for two measures: *Antidepressant Medication Management—Effective Continuation Phase Treatment* and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of Alcohol and Other Drug—Total—Total*. Performance on these 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.

Strength: Within the Living With Illness domain, Magellan ranked at or above NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* measure indicator. The strong performance on this measure indicates that Magellan has established successful processes related to medical assistance for members living with illness.

Weaknesses

Weakness: The following HEDIS MY 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Magellan:

- *Asthma Medication Ratio—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *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)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total,* and *Blood Glucose and Cholesterol Testing—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Use of Imaging Studies for Low Back Pain*

- *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*

Why the weakness exists: Magellan's rates for several measures across several domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

Recommendation: HSAG recommends that Magellan conduct a root cause analysis or focused study to identify the reasons why members are not accessing preventive care, behavioral healthcare, and care for chronic conditions. HSAG recommends that Magellan analyze its data and results of any root cause analysis or focused study to identify opportunities to reduce any disparities within the MCOs' 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 the performance related to these low-scoring healthcare domains.

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 NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure. Optima's performance indicates that adults follow recommended preventive or ambulatory care visits, thereby reducing adverse member outcomes and unnecessary ED utilization.

Strength: Within the Behavioral Health domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for two measure indicators: *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.* The strong performance indicates that Optima 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.

Strength: Within the Living With Illness domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* indicators. The strong performance on this measure indicates that Optima has established successful processes related to medical assistance for members living with illness.

Weaknesses

Weakness: The following HEDIS MY 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:

- *Breast Cancer Screening*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Use of Imaging Studies for Low Back Pain*
- *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*

Why the weakness exists: Optima's rates across multiple domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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 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. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

Recommendation: HSAG recommends that Optima conduct a root cause analysis or focused study 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 across all domains of care. HSAG recommends that Optima consider whether 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 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.

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 Access and Preventive Care domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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 ED utilization.
	Strength: Within the Behavioral Health domain, United met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. 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.
	Strength: Within the Living With Illness domain, United displayed strong performance for the three *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance for this measure indicates that members are receiving services and supports necessary to quit smoking and tobacco use.
	Strength: Within the Use of Opioids domain, United met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple Pharmacies* measure indicator. The strong performance related to use of opioids indicates that United is managing the frequency of its members' use of multiple pharmacies for opioid medications.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United:

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Cervical Cancer Screening*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, *Cholesterol Testing—Total*, and *Blood Glucose and Cholesterol Testing—Total*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *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: Several of United's rates in the Access and Preventive Care, Taking Care of Children, and Living With Illness domains falling below the HEDIS MY 2019 25th percentile suggests a lack of access or understanding of the need for preventive care and screenings. United's members are not consistently scheduling cancer screenings; adults and children are not accessing care or services according to evidence-based recommendations; and members with 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. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

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.

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:* HSAG identified no 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* measure, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance in providing access to care for adults indicates that VA Premier 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 ED utilization.
	Strength: Within the Behavioral Health domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. 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 *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* measure indicator,

which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance for this measure indicator indicates that members are receiving services and supports necessary to quit smoking and tobacco use.

Weaknesses

Weakness: The following HEDIS 2020 measure rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

- *Breast Cancer Screening*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *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)*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *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: Several of VA Premier's rates in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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. Screening declines may have coincided with the

rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.

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 its 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 implement appropriate interventions to improve the performance related to these measures.

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

Overview

This section presents HSAG's MCO-specific results and conclusions of the review of compliance with Medicaid and CHIP Managed Care Regulations 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 QI made by HSAG during the previous year.

The OSR standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2020, through June 30, 2021. To conduct the OSR, HSAG followed the guidelines set forth in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[6-1]

Objectives

The compliance review evaluates MCO compliance with federal and Commonwealth requirements. The compliance reviews include all required CMS standards and related DMAS-specific MCO contract requirements.

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 23, 2021.

Deeming

Federal regulations allow DMAS to exempt an MCO from a review of certain administrative functions when the MCO's Medicaid contract has been in effect for at least two consecutive years before the effective date of the exemption, and during those two years the MCO has been subject to EQR and found to be performing acceptably for the quality of, timeliness of, and access to healthcare services it provides to Medicaid beneficiaries. DMAS requires the MCOs to be NCQA accredited, which allows DMAS to leverage or deem certain review findings from a private national accrediting organization that CMS has approved as applying standards at least as stringently as Medicaid under the procedures in 42 CFR §422.158 to meet a portion of the EQR compliance review requirements. DMAS has exercised the deeming option to meet a portion of the EQR OSR requirements. DMAS and HSAG followed the requirements in 42 CFR §438.362, which include obtaining:

- Information from a private, national accrediting organization's review findings. Each year, the Commonwealth must obtain from each MCO the most recent private accreditation review findings reported on the MCO, including:
  - All data, correspondence, and information pertaining to the MCO's private accreditation review.
  - All reports, findings, and other results pertaining to the MCO's most recent private accreditation review.
  - Accreditation review results of the evaluation of compliance with individual accreditation standards, noted deficiencies, CAPs, and summaries of unmet accreditation requirements.
  - All measures of the MCO's performance.
  - The findings and results of all PIPs pertaining to Medicaid members.

HSAG organized the OSR standards by functional area. Table 6-1 specifies the related CMS categories of access, quality, and timeliness for each standard.

Table 6-1—OSR Standard Assigned CMS Categories

Standard	SFY 2020–2021	Access	Quality	Timeliness
Provider Network Management				
V. Adequate Capacity and Availability of Services	✓	✓	✓	✓
VIII. Provider Selection	✓	✓	✓	✓
IX. Subcontractual Relationships and Delegation	✓	✓	✓	✓
Member Services and Experiences				
II. Member Rights and Confidentiality	✓		✓	
III. Member Information	✓		✓	
IV. Emergency and Poststabilization Services	✓	✓	✓	✓
VI. Coordination and Continuity of Care	✓	✓	✓	✓

Standard	SFY 2020–2021	Access	Quality	Timeliness
VII. Coverage and Authorization of Services	✓	✓	✓	✓
XIII. Grievance and Appeal Systems	✓	✓	✓	✓
Managed Care Operations				
I. Enrollment and Disenrollment	✓	✓		✓
X. Practice Guidelines	✓		✓	
XI. Health Information Systems	✓	✓	✓	✓
XII. Quality Assessment and Performance Improvement	✓	✓	✓	✓
XIV. Program Integrity	✓	✓	✓	
XV. EPSDT Services	✓	✓	✓	✓

The MCO OSR results are displayed in the following tables and include the results of the current three-year period of compliance reviews. HSAG also provides a summary of each MCO's strengths, weaknesses, and recommendations, as applicable, for the MCO to meet federal and DMAS requirements.

Aetna

Table 6-2 presents a summary of Aetna's OSR review results.

Table 6-2—Aetna's CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	6	1	85.7%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	18	0	14	4	77.8%
VI	Coordination and Continuity of Care	9	5	4	0	100%
VII	Coverage and Authorization of Services	20	2	18	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	2	1	75.0%
X	Practice Guidelines	3	1	2	0	100%

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	25	4	86.2%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**167**	**13**	**141**	**13**	**92.2%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements **and then dividing by the total number of elements.**
* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, Aetna received *Met* scores for 141 elements and *Not Met* scores for 13 elements. Deeming was also applied to 13 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 92.2 percent. These findings suggest that Aetna developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Aetna.

Strengths

Strength: The MCO was compliant with all:

- Enrollment and Disenrollment requirements
- Member Information requirements
- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Coverage and Authorization of Services requirements
- Provider Selection requirements
- Subcontractual Relationships and Delegation requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Quality Assessment and Performance Improvement requirements
- Program Integrity requirements

Strength: The MCO monitored its provider network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with disabilities. The MCO also implemented processes to maintain and

monitor its provider network related to the cultural, ethnic, racial, and linguistic needs of its members.

Strength: The MCO used oversight and monitoring reports to ensure timely decisions on standard and expedited service requests. The MCO evaluated and monitored the quality and appropriateness of care provided to members with SHCN. The MCO also monitored for overutilization and underutilization on an ongoing basis.

Weaknesses

Weakness: The MCO's network adequacy policies and analysis did not align with federal and Commonwealth requirements for all provider types. The MCO did not include all federal and Commonwealth member rights in its Member Rights and Responsibilities policy.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met.

Weakness: The MCO's appeal policy did not specifically address adverse benefit determinations based on the type or level of service, appropriateness, setting, or effectiveness of a covered benefit. The MCO also did not consistently send grievance resolution letters to members.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. The MCO must ensure that grievance resolution letters are consistently sent to members.

Weakness: The MCO did not consistently inform members that although an EPSDT service was carved out and therefore not covered under the member's managed care health plan, it may be available through DMAS under the Medicaid state plan and provide the appropriate contact information for the member to inquire with DMAS.

Why the weakness exists: The MCO's adverse benefit determination letters to members focused on coverage decisions of benefits provided by the MCO and not all benefits available to the member.

Recommendation: The MCO should consistently inform members that EPSDT benefits not covered by the MCO may be available through DMAS, and how to contact DMAS to receive a benefit determination.

HealthKeepers

Table 6-3 presents a summary of HealthKeepers' OSR review results.

Table 6-3—HealthKeepers' CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	18	0	13	5	72.2%
VI	Coordination and Continuity of Care	9	5	4	0	100%
VII	Coverage and Authorization of Services	20	2	18	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	3	0	100%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	2	2	66.7%
XIII	Grievance and Appeal Systems	29	0	24	5	82.8%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**167**	**14**	**138**	**15**	**91.0%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements and then dividing by the total number of elements.

* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, HealthKeepers received *Met* scores for 138 elements and *Not Met* scores for 15 elements. Deeming was also applied to 14 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 91.0 percent. These findings suggest that HealthKeepers developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to HealthKeepers.

Strengths

Strength: The MCO was compliant with all:

- Enrollment and Disenrollment requirements
- Member Rights and Confidentiality requirements
- Member Information requirements
- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Coverage and Authorization of Services requirements
- Provider Selection requirements
- Subcontractual Relationships and Delegation requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Program Integrity requirements

Strength: The MCO conducted monthly provider meetings to ensure providers were informed of policies and expectations, including those focused on member rights and confidentiality. The MCO also conducted member focus groups that resulted in communication improvements such as a welcome kit to simplify initial materials members receive upon enrollment. The MCO used multiple modalities to ensure that members were informed of covered services and how to access services.

Strength: A denial case file review demonstrated timeliness of authorization decisions. Although the MCO's grievance and appeal policies did not include all federal requirements, the MCO demonstrated through a grievance case file review that it implemented processes that met federal and State requirements.

Strength: The MCO consistently included all DMAS-specific contract requirements in subcontractor and delegated entity agreements. The MCO developed a Virginia-specific Medicaid Exhibit and included it consistently in the subcontractor and delegated entity agreements

Weaknesses

Weakness: The MCO's policies and procedures did not consistently contain all federal requirements regarding capacity and availability of services. The MCO did not ensure that travel time and distance standards were monitored according to the appropriate DMAS travel time and distance standards for each region. The MCO did not consistently monitor access to care according to DMAS' requirement to determine provider compliance or take corrective action when there was a failure to comply with requirements. Provider access standards were not consistent in the MCO's provider manual and network policies. The MCO did not consistently monitor that its network included sufficient family planning providers to ensure

timely access to covered services. The MCO did not clearly define the provider types it included as family planning providers or assess its network for gaps.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and network monitoring.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. The MCO must implement monitoring processes to ensure all federal and Commonwealth network requirements and monitoring requirements are met.

Weakness: The MCO did not have a defined process to identify members with SHCN, monitor the quality and appropriateness of care furnished to members with SHCN, or conduct assessments of the quality and appropriateness of care provided to members with SHCN.

Why the weakness exists: The MCO applied general policies to all populations served, including members with SHCN. Therefore, the MCO was unable to assess the quality and appropriateness of care provided to SHCN members.

Recommendation: The MCO must define and identify members with SHCN. The MCO must develop and implement processes to conduct assessments of the quality and appropriateness of care and services delivered to members with SHCN.

Weakness: The MCO's grievance and appeal policies did not include requiring easily understood format and language requirements. Member notices were not consistently in a format and language that was easily understood by the member. An opportunity exists for the MCO to strengthen grievance resolution notifications to clearly state the resolution so that it is easily understood by the member. The MCO's appeal policy was not updated to include all requirements in the most current 2020 Medicaid Managed Care Rule, including that an oral appeal does not need to be followed with a written and signed request for an appeal; the member's right to dispute an extension of time proposed by the MCO to make an authorization decision; and the member's right to request a State fair hearing.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights.

Weakness: The MCO did not ensure monitoring of CCC Plus members for the use of EPSDT services, including tuberculosis screening/skin testing. The MCO did not have a documented process to educate its members about the risks of childhood obesity and services available to treat members. The MCO had not implemented a process to monitor, track, and evaluate PCP fluoride varnish applications in accordance with the American Academy of Pediatrics guidelines.

Why the weakness exists: The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.

Recommendation: The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services.

Magellan

Table 6-4 presents a summary of Magellan's OSR review results.

Table 6-4—Magellan's CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	20	1	95.2%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	18	0	14	4	77.8%
VI	Coordination and Continuity of Care	9	3	6	0	100%
VII	Coverage and Authorization of Services	20	2	17	1	95.0%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	3	0	100%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	25	4	86.2%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**167**	**11**	**143**	**13**	**92.2%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements and then dividing by the total number of elements.

* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, Magellan received *Met* scores for 143 elements and *Not Met* scores for 13 elements. Deeming was also applied to 11 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 92.2 percent. These findings suggest that Magellan developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Magellan.

Strengths

Strength: The MCO was compliant with all:

- Enrollment and Disenrollment requirements
- Member Rights and Confidentiality requirements
- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Coverage and Authorization of Services requirements
- Provider Selection requirements
- Subcontractual Relationships and Delegation requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Quality Assessment and Performance Improvement requirements
- Program Integrity requirements

Strength: The MCO leveraged a multidisciplinary approach to engage disruptive members in continued care. The MCO promoted the delivery of services in a culturally appropriate manner and ensured access to members with physical and mental disabilities. The MCO also assessed the quality and appropriateness of care provided to members with SHCN. The MCO implemented processes to prevent, detect, and remediate critical incidents.

Strength: The MCO offered two providers per category and two providers per CCC Plus locality within the time and distance standards for all provider types, which exceeded the DMAS requirements. The MCO consistently included all DMAS-specific contract requirements in subcontractor and delegated entity agreements. The MCO developed a Virginia-specific Medicaid Exhibit and included it consistently in the subcontractor and delegated entity agreements. The MCO's provider agreements clearly outlined the MCO's guiding principles and responsibilities and the provider's responsibilities.

Strength: The MCO had consistent processes to ensure grievance and appeal timelines were met. The MCO received few grievances or appeals for the ARTS program.

Strength: The MCO had several programs in place to monitor, track, and implement interventions to improve utilization of EPSDT services. The MCO measured EPSDT services at the provider level and worked with providers to improve utilization of EPSDT services.

Weaknesses

Weakness: The MCO has an opportunity to improve consistency across member information policies and member materials. The MCO did not provide machine-readable formats of its formulary or provider directory on its website.

Why the weakness exists: The MCO did not have processes to ensure that federal and DMAS requirements were consistently included and applied in its policies and procedures. The MCO did not implement 2020 Medicaid Managed Care Rule requirements of ensuring that members have access to machine-readable formats of its formulary and provider directory.

Recommendation: The MCO should consider establishing a review process to ensure that member information policies, procedures, and member materials are consistent and contain all requirements. The MCO should also review member materials to ensure that federal requirements, including easily understood and machine-readable formats, are available to members.

Weakness: The MCO's grievance and appeals policies and procedures did not consistently contain all federal and DMAS requirements. The MCO did not consistently resolve the appeal and provide written notice to the member within the required time frames. In addition, a review of case files identified that the MCO did not consistently meet the time frame to mail the notice of adverse benefit determination to the member.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights.

Weakness: The MCO did not consistently provide the member with a written appeal resolution notice that included all member rights or inform the member how to request continued services, notice that the member may be liable for the cost of the continued benefits if the hearing decision upholds the MCO's adverse benefit determination, and the time frame to request a State fair hearing.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights.

Weakness: The MCO did not ensure members eligible for EPSDT services obtained all the care and services they needed, including medical and behavioral health needs and community-based resources. The MCO did not monitor, track, and evaluate PCP fluoride varnish applications in accordance with American

Academy of Pediatrics guidelines. The MCO did not educate members about the dangers of lead exposure.

Why the weakness exists: The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.

Recommendation: The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services.

Optima

Table 6-5 presents a summary of Optima's OSR review results.

Table 6-5—Optima's CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	20	1	95.2%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	18	0	11	7	61.1%
VI	Coordination and Continuity of Care	9	3	6	0	100%
VII	Coverage and Authorization of Services	20	2	17	1	95.0%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	0	3	1	75.0%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	3	1	83.3%
XIII	Grievance and Appeal Systems	29	0	28	1	96.6%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	7	1	87.5%
Total Compliance Score		**167**	**10**	**144**	**13**	**92.2%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*,
Total Elements: The total number of elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements and then dividing by the total number of elements.
* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, Optima received *Met* scores for 144 elements and *Not Met* scores for 13 elements. Deeming was also applied to 10 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 92.2 percent. These findings suggest that Optima developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Optima.

Strengths

Strength: The MCO was compliant with all:

- Enrollment and Disenrollment requirements
- Member Rights and Confidentiality requirements
- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Provider Selection requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Program Integrity requirements

Strength: The MCO's emergency and poststabilization policies were thorough with clear inclusion of all federal and DMAS requirements.

Strength: The MCO's policies and procedures included the required accessibility standards, informed providers about the access standards, and assessed the network against the requirements. The MCO implemented processes to ensure services to members were delivered in a culturally competent manner.

Strength: The MCO implemented a process to conduct secondary reviews for EPSDT service authorization requests. The MCO implemented processes to monitor, evaluate, and implement interventions to improve utilization of EPSDT services. The MCO implemented processes to monitor PCPs on fluoride varnish applications.

Weaknesses

Weakness: The MCO did not have a provider directory in a machine-readable file format available to members on its website.

Why the weakness exists: The MCO did not implement 2020 Medicaid Managed Care Rule requirements of ensuring that members have access to machine-readable formats of its formulary and provider directory.

Recommendation: The MCO should establish a process to review member materials to ensure that federal requirements, including easily understood language and machine-readable formats, are available to members.

Weakness: The MCO did not include all required provider types listed in the DMAS contract when describing the number of providers offered to members or to assess the network against the appropriate travel time and distance standards required in the contract. The MCO did not consider all required factors when establishing and maintaining its network. The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia-specific requirements. The MCO developed a Medicaid Addendum but did not consistently include it in the subcontractor and delegated entity agreements.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the content of subcontractor and delegated entity agreements.

Recommendation: The MCO must update its policies and procedures to ensure that network requirements outlined in the 2020 Medicaid Managed Care Rule and in the DMAS contract are met. The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements.

Weakness: The MCO did not consistently resolve each appeal and provide written notice of the disposition to the member within the required time frames. A review of a sample of the MCO's denial case files identified that the MCO did not consistently meet timeliness or content requirements in the notice of action to the members.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.

Recommendation: The MCO must develop and implement processes to monitor and ensure that all denial, grievance, and appeal time frames are met.

Weakness: The MCO did not notify members about the secondary review process for EPSDT services upon a prior authorization denial for an EPSDT service. The MCO did not notify members that, when an EPSDT service is denied by the MCO, the service may be available through DMAS or provide DMAS contact information to the member.

Why the weakness exists: The MCO's adverse benefit determination letters to members focused on coverage decisions of MCO covered benefits and not all benefits available to the member.

Recommendation: The MCO should consistently inform members that EPSDT benefits not covered by the MCO may be available through DMAS, and how to contact DMAS to receive a benefit determination.

United

Table 6-6 presents a summary of United's OSR review results.

Table 6-6—United's CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	7	0	100%
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	21	0	100%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	18	0	15	3	83.3%
VI	Coordination and Continuity of Care	9	2	7	0	100%
VII	Coverage and Authorization of Services	20	2	18	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	1	2	50.0%
X	Practice Guidelines	3	1	2	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	2	4	0	100%
XIII	Grievance and Appeal Systems	29	0	27	2	93.1%
XIV	Program Integrity	12	0	12	0	100%
XV	EPSDT Services	8	0	7	1	87.5%
Total Compliance Score		**167**	**10**	**149**	**8**	**95.2%**

***D**=Deemed, **M**=Met, **NM**=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements and then dividing by the total number of elements.

* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, United received *Met* scores for 149 elements and *Not Met* scores for 8 elements. Deeming was also applied to 10 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 95.2 percent. These findings suggest that United developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to United.

Strengths

Strength: The MCO was compliant with all:

- Enrollment and Disenrollment requirements
- Member Rights and Confidentiality requirements
- Member Information requirements
- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Coverage and Authorization of Services requirements
- Provider Selection requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Quality Assessment and Performance Improvement requirements
- Program Integrity requirements

Strength: The MCO monitored its provider network for adequacy and accessibility according to appropriate federal and Commonwealth requirements. The MCO implemented processes to make members and providers aware of network requirements through the provider manual and member handbook. The MCO monitored its provider network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with disabilities.

Strength: The QAPI program was focused on QI and measuring the results of quality initiatives to continue performance improvement. The MCO implemented processes to evaluate the quality and appropriateness of care provided to members with SHCN. The MCO also implemented processes to monitor and evaluate critical incidents.

Strength: The MCO implemented robust compliance procedures that included regular meetings between the compliance officer, executive team, and various departments to maintain and monitor ongoing risk assessments, monitoring activities, and remediation work.

Strength: The MCO implemented interventions to increase utilization of EPSDT services. The MCO implemented processes to inform members and providers of the EPSDT covered services. The MCO implemented adequate processes to educate members about childhood obesity and the dangers of lead exposure. The MCO monitored, tracked, and evaluated PCP fluoride varnish applications. The MCO demonstrated a comprehensive process of a secondary review to ensure that EPSDT requirements were considered and to notify the member of the results of the review.

Weaknesses

Weakness: The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia-specific requirements. The MCO developed a subcontractor agreement, the Virginia Medicaid Regulatory Appendix, but it was not consistently included in the subcontractor and delegated entity agreements.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the subcontractor and delegated entity agreements.

Recommendation: The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements.

Weakness: The MCO's appeals policy stated that, unless the member requested an expedited resolution, an oral appeal must be followed by a written, signed appeal, which was not consistent with federal and Commonwealth requirements.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the content of subcontractor and delegated entity agreements.

Recommendation: The MCO must update its policies and procedures to ensure that grievance and appeal requirements outlined in the 2020 Medicaid Managed Care Rule and in the DMAS contract are met.

Weakness: The MCO did not have an implemented process to provide information about the grievance process, appeal process, and State fair hearing system to all providers, subcontractors, and delegated entities at the time they entered into a contract.

Why the weakness exists: The MCO informed providers of grievance, appeal, and State fair hearing system rights in notice of adverse benefit determination, grievance, and appeal notifications. The MCO did not ensure information on the processes were consistently available to providers upon entering a contractual relationship with the MCO.

Recommendation: The MCO should consider providing information to providers upon signing of a contract with the MCO on the grievance, appeal, and State fair hearing processes in a consistent and standardized method.

VA Premier

Table 6-7 presents a summary of VA Premier's OSR review results.

Table 6-7—VA Premier's CCC Plus OSR Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
I	Enrollment and Disenrollment	7	0	6	1	85.7%

Standard #	Standard Name	Total Elements	Number of Elements			Total Compliance Score
			D	*M*	*NM*	
II	Member Rights and Confidentiality	7	0	7	0	100%
III	Member Information	21	0	19	2	90.5%
IV	Emergency and Poststabilization Services	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	18	0	9	9	50.0%
VI	Coordination and Continuity of Care	9	5	4	0	100%
VII	Coverage and Authorization of Services	20	2	18	0	100%
VIII	Provider Selection	5	2	3	0	100%
IX	Subcontractual Relationships and Delegation	4	1	2	1	75.0%
X	Practice Guidelines	3	3	0	0	100%
XI	Health Information Systems*	6	0	6	0	100%
XII	Quality Assessment and Performance Improvement	6	4	2	0	100%
XIII	Grievance and Appeal Systems	29	0	22	7	75.9%
XIV	Program Integrity	12		12	0	100%
XV	EPSDT Services	8	0	5	3	62.5%
Total Compliance Score		**167**	**17**	**127**	**23**	**86.2%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*,
Total Elements: The total number of elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Deeming*** elements and the ***Met*** elements and then dividing by the total number of elements.
* The Health Information Systems standard includes an assessment of each MCO's information system.

Findings

Of the 167 elements, VA Premier received *Met* scores for 127 elements and *Not Met* scores for 23 elements. Deeming was also applied to 17 elements using scores received from the MCO's NCQA accreditation survey. The MCO received an overall compliance score of 86.2 percent. These findings suggest that VA Premier developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with most of the expectations of the contract.

Strengths, Weaknesses, and Recommendations

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to VA Premier.

Strengths

Strength: The MCO was compliant with all:

- Member Rights and Confidentiality requirements

- Emergency and Poststabilization Services requirements
- Coordination and Continuity of Care requirements
- Coverage and Authorization of Services requirements
- Provider Selection requirements
- Practice Guidelines requirements
- Health Information Systems requirements
- Quality Assessment and Performance Improvement requirements
- Program Integrity requirements

Strength: The MCO had a robust quality monitoring program for its member services staff regarding member rights and confidentiality. The MCO's member services department provided a wide range of services to members via warm transfer processes.

Strength: The MCO implemented processes to ensure members receive culturally competent services. In addition, The MCO implemented processes to provide for direct access to women's health services, out-of-network services, and second opinions; and informed members and providers, as applicable.

Strength: The MCO identified no denials of the ARTS benefit. The MCO identified a limited number of grievances for the ARTS benefit.

Strength: The MCO demonstrated policies and procedures for a comprehensive QAPI program. The MCO implemented processes to ensure members eligible for EPSDT services received appropriate services, including medical and behavioral health services.

Weaknesses

Weakness: The MCO did not provide machine-readable file formats of the formulary and provider directories on its website.

Why the weakness exists: The MCO did not implement 2020 Medicaid Managed Care Rule requirements of ensuring that members have access to machine-readable formats of its formulary and provider directory.

Recommendation: The MCO should establish a process to review member materials to ensure that federal requirements, including easily understood language and machine-readable formats, are available to members.

Weakness: The MCO did not delineate the requirements for the number of providers in each CCC Plus locality or measure the adequacy accordingly in its policies and procedures. The MCO did not have a process to measure the accessibility of the provider network quarterly or follow up with providers on the failure to comply with accessibility standards. The MCO did not have a process to evaluate its network to ensure timely access to family planning services.

Why the weakness exists: The MCO's policies and procedures regarding network adequacy were not updated to reflect the federal and DMAS contract requirements. The MCO also did not have a process to monitor and measure provider network accessibility according to DMAS requirements.

Recommendation: The MCO must update its policies and procedures to reflect federal and DMAS network requirements. The MCO must implement processes to monitor its network to ensure member network accessibility.

Weakness: The MCO did not appropriately apply its appointment access standards to the entire network. The MCO did not have processes to ensure that providers ensured the same hours of operation for its Medicaid members as commercial or FFS members or ensure that the provider network offered care and services 24 hours a day, seven days a week. The MCO did not have a process to follow up with providers to take corrective action when a provider does not meet appointment accessibility standards.

Why the weakness exists: Although the MCO's policies and procedures contained most federal and DMAS requirements regarding access to care and services, the MCO did not have implemented processes to monitor and ensure that requirements are met.

Recommendation: The MCO must develop and implement processes to monitor and track that its appointment standards and access requirements are consistently met.

Weakness: The MCO's subcontractor and delegated entity agreements did not consistently include the DMAS-specific requirements. The MCO's subcontractor and delegated entity agreements did not consistently include the Virginia Medicaid Addendum.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements regarding network requirements and the subcontractor and delegated entity agreements.

Recommendation: The MCO must also ensure that its subcontractor and delegated entity agreements include all DMAS requirements.

Weakness: The MCO's grievance and appeals policies and procedures did not consistently contain all federal and DMAS contract requirements. The MCO's grievance and appeals policies and procedures did not require the member's approval for an authorized representative or provider to act on his or her behalf when filing a grievance or appeal. A review of the MCO's sample appeal case files identified that the MCO did not consistently acknowledge receipt of appeals. The MCO's appeal resolution notices to the member were not consistently sent, and when sent, did not consistently include all member rights.

Why the weakness exists: The MCO did not update all policies and procedures to reflect the 2020 Medicaid Managed Care Rule and DMAS contract requirements that assure member rights are respected.

Recommendation: The MCO must update its policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements are met. Grievance and appeal notices to members must be easily understood and include all member rights. The MCO must also ensure that it consistently provides grievance and appeal notices to the member.

Weakness: The MCO did not sufficiently inform providers about EPSDT services they are required to provide, adequately monitor service provision, and implement interventions to improve member participation in EPSDT services. The MCO did not inform providers about the provision of oral health screenings as part of the EPSDT visit, or track, monitor, and evaluate PCP fluoride varnish applications. The MCO did not conduct member outreach regarding childhood obesity.

Why the weakness exists: The MCO did not have documented and implemented processes that ensured EPSDT age members and providers that service EPSDT age members were aware of EPSDT benefits. The MCO did not have implemented processes to monitor and track members' receipt of EPSDT services.

Recommendation: The MCO should consider developing EPSDT-specific policies and procedures to ensure that members and providers are aware of EPSDT benefits, and to ensure that EPSDT service utilization is tracked, monitored, and action is taken to increase utilization of covered EPSDT services.

DMAS Intermediate Sanctions Applied

During 2021, DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from prior years' compliance reviews.

7. Encounter Data Validation

Overview

This section presents HSAG's MCO-specific results and conclusions of EDV 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. The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

HSAG's EDV study was comprised of two components:

- **IS review** to assess each MCO's technical processes and capabilities.
- **Administrative profile analysis** to assess the quality, completeness, and timeliness of encounter data submitted to DMAS.

Objectives

The MCOs contracted with Virginia DMAS submit encounter data to DMAS. These encounter data are used for a variety of purposes including capitation rate setting, QI, program evaluation, program monitoring, and submission to CMS as T-MSIS extracts. The MCOs that do not meet certain standards relating to the accuracy, completeness, and timeliness of encounter data may face penalties or CAPs.

Statewide Results

Overall, DMAS' encounter data will support continued analyses such as HEDIS PM calculation. Data were largely **complete**, **valid**, and **reliable**. While some gaps and data concerns were identified, this should not preclude DMAS or its contractors from conducting further analysis given adequate assessment of encounters prior to analysis.

General Recommendations

- HSAG identified there was a lack of standardized monitoring by the MCOs to ensure accuracy and completeness of encounter data, and the monitoring ranged in terms of scope and depth. As such, DMAS may consider the following recommendations:
  - Consider requiring all MCOs to add standardized metrics to actively monitor encounter data completeness and accuracy. Some example metrics include reviewing encounter volume by month, investigating high dollar claims, and establishing trends.
  - Require the MCOs' monitoring results to be submitted to DMAS for use in its ongoing data monitoring.
- DMAS may wish to consider conducting validation activities that align with T-MSIS Priority Items to limit potential data quality issues in T-MSIS data extracts routinely submitted to CMS.

- Leverage data quality reporting tools from CMS (such as DQ Atlas and/or Imersis) to align internal encounter data quality monitoring with T-MSIS extracts sent to CMS. Internal data monitoring may be used to quickly identify the root cause of potential problem areas identified from CMS tools.

MCO-Specific Results

Aetna

Table 7-1 shows Aetna met the 30-day submission standard of 99 percent for pharmacy encounters but fell below the standard for institutional and professional encounters.

Table 7-1—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	Aetna	
Professional	96.0%	95.0%	81.0%	
Institutional	96.0%	95.9%	91.5%	
Pharmacy	99.0%	92.0%	99.8%	✔

✔ Met submission standard

Table 7-2 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 78.6 percent
- **Professional**: 78.3 percent
- **Pharmacy**: 77.8 percent

Table 7-2—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	96.9%	✗	98.0%	✗	95.9%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		99.9%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		99.9%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		100%		-	
Rendering Provider NPI	100%		100%		100%	
Attending Provider NPI	98.3%	✗	-		-	
Servicing Provider Taxonomy Code	85.9%	✗	99.3%		-	
Referring Provider NPI	-		96.8%	✗	-	
Prescribing Provider NPI	-		-		98.6%	✗
Primary Diagnosis Codes	100%		100%		-	

Field Name	Institutional		Professional		Pharmacy	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	97.1%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	97.1%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.6%		98.0%	✗	-	
Primary Surgical Procedure Codes	99.7%		-		-	
Secondary Surgical Procedure Codes	99.8%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	100%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	99.6%		99.8%		99.4%	
HCPCS/NDC Combination	69.6%	✗	74.2%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	99.5%		98.0%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	28		23		9	
Percentage of data elements meeting 99% or greater validity	78.6%		78.3%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: The IS review revealed Aetna has a comparatively robust internal assessment and reporting of encounter data quality and timeliness.

Weaknesses

Weakness: Aetna did not meet the timeliness standards for both institutional and professional encounters.

Why the weakness exists: The IS review and administrative profile analysis did not identify the specific root cause of the weakness.

Recommendation: HSAG recommends Aetna identify the root cause of any delays in submitting institutional and professional encounters to rectify any issues.

HealthKeepers

Table 7-3 shows HealthKeepers met the 30-day submission standards for all three types of encounters.

Table 7-3—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	HealthKeepers	
Professional	96.0%	95.0%	96.1%	✔
Institutional	96.0%	95.9%	96.2%	✔
Pharmacy	99.0%	92.0%	99.9%	✔

✔ Met submission standard

Table 7-4 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 64.3 percent
- **Professional**: 73.9 percent
- **Pharmacy**: 77.8 percent

Table 7-4—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	94.3%	✗	97.2%	✗	93.5%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		99.9%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		99.9%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		100%		-	
Rendering Provider NPI	-		100%		100%	
Attending Provider NPI	97.5%	✗	-		-	
Servicing Provider Taxonomy Code	79.5%	✗	70.9%	✗	-	
Referring Provider NPI	95.8%	✗	95.4%	✗	-	
Prescribing Provider NPI	-		-		94.7%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	97.2%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	97.1%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.6%		98.8%	✗	-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	99.9%		-		-	
Revenue Codes	100%		-		-	

Field Name	Institutional		Professional		Pharmacy	
Diagnosis-Related Groups Codes	86.1%	✗	-		-	
Type of Bill Codes	100%		-		-	
NDCs	97.5%	✗	99.8%		99.5%	
HCPCS/NDC Combination	63.9%	✗	78.9%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	88.1%	✗	97.5%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	28		23		9	
Percentage of data elements meeting 99% or greater validity	64.3%		73.9%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: HealthKeepers met the timeliness submission standards for all encounter types.

Weaknesses

Weakness: HealthKeepers did not meet the validity criteria for both institutional and professional encounters.

Why the weakness exists: The IS review and administrative profile analysis did not identify the specific root cause of the weakness.

Recommendation: HSAG recommends HealthKeepers:

- Incorporate additional logic and referential checks to assess the validity of data elements.

Magellan

Table 7-5 shows Magellan met the 30-day submission standards for institutional and pharmacy encounters but fell below the standard for professional encounters.

Table 7-5—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	Magellan	
Professional	96.0%	95.0%	94.7%	
Institutional	96.0%	95.9%	99.3%	✔
Pharmacy	99.0%	92.0%	99.3%	✔

✔ Met submission standard

Table 7-6 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 72.4 percent
- **Professional**: 73.9 percent
- **Pharmacy**: 77.8 percent

Table 7-6—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	95.1%	✗	96.6%	✗	93.9%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	98.7%	✗	99.5%		-	
Rendering Provider NPI	100%		99.6%		99.6%	
Attending Provider NPI	99.5%		-		-	
Servicing Provider Taxonomy Code	98.5%	✗	98.9%	✗	-	
Referring Provider NPI	99.2%		95.1%	✗	-	
Prescribing Provider NPI	-		-		91.2%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	96.2%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	96.1%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.7%		98.2%	✗	-	
Primary Surgical Procedure Codes	99.7%		-		-	
Secondary Surgical Procedure Codes	99.6%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	99.9%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	98.8%	✗	99.8%		99.6%	

Field Name	Institutional		Professional		Pharmacy	
HCPCS/NDC Combination	64.0%	✗	77.4%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	80.5%	✗	98.7%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	29		23		9	
Percentage of data elements meeting 99% or greater validity	72.4%		73.9%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: Magellan met the timeliness submission standards for institutional and pharmacy encounters.

Weaknesses

Weakness: The IS review revealed Magellan could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, Magellan did not meet the validity criteria for both institutional and professional encounters. Lastly, Magellan had virtually no header TPL paid amounts for the first half of 2020 in its institutional encounters.

Why the weakness exists: For the IS review, the existing process relies on vendor-provided summaries and regular internally conducted manual checks on the number of records and files received. For the field validity and header TPL paid amounts, the IS review and administrative profile analysis did not identify the specific root cause of the weakness.

Recommendation: HSAG recommends Magellan:

- Consider augmenting its automated data validation processes to generate regular reports and/or dashboards containing quality and timeliness summary metrics as other MCOs have developed. This may be done in consultation with DMAS to align validation efforts across MCOs.
- Incorporate additional logic and referential checks to assess the validity of data elements.
- Identify the root cause of missing header TPL paid amounts for the first half of 2020 in its institutional encounters to rectify any issues.

Optima

Table 7-7 shows Optima met the 30-day submission standard for all three types of encounters.

Table 7-7—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	Optima	
Professional	96.0%	95.0%	99.4%	✔
Institutional	96.0%	95.9%	99.9%	✔
Pharmacy	99.0%	92.0%	100%	✔

✔ Met submission standard

Table 7-8 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 74.1 percent
- **Professional**: 86.4 percent
- **Pharmacy**: 88.9 percent

Table 7-8—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	95.4%	✗	97.3%	✗	95.2%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		99.7%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		99.7%		-	
Date of Service	-		-		100%	
Billing Provider NPI	99.9%		99.2%		-	
Rendering Provider NPI	-		99.2%		100%	
Attending Provider NPI	99.8%		-		-	
Servicing Provider Taxonomy Code	0.0%	✗	69.1%	✗	-	
Referring Provider NPI	-		-		-	
Prescribing Provider NPI	-		-		100%	
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	97.8%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	97.8%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.7%		99.1%		-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	99.8%		-		-	
Revenue Codes	100%		-		-	

Field Name	Institutional		Professional		Pharmacy	
Diagnosis-Related Groups Codes	99.0%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	96.0%	✗	99.9%		99.5%	
HCPCS/NDC Combination	67.3%	✗	88.7%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	7.6%	✗	99.8%		100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	27		22		9	
Percentage of data elements meeting 99% or greater validity	74.1%		86.4%		88.9%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: Optima met the timeliness submission standard for all encounter types. Furthermore, over 80 percent of data elements assessed met the validity criteria for professional and pharmacy encounters.

Weaknesses

Weakness: The IS review revealed Optima could improve its internal monitoring tools for assessing quality and timeliness of encounter data. Additionally, Optima did not meet the validity criteria for institutional encounters.

Why the weakness exists: The existing weekly process consists of encounter acceptance rates. While Optima produces monthly and quarterly reports, HSAG was not furnished with these reports as part of the IS review. The IS review and administrative profile analysis did not identify the specific root cause of the weakness in validity.

Recommendation: HSAG recommends Optima:

- Consider augmenting its automated data validation processes to contain quality and timeliness summary metrics as other MCOs have developed. This may be done in consultation with DMAS to align validation efforts across MCOs.
- Incorporate additional logic and referential checks to assess validity of data elements for institutional encounters.

United

Table 7-9 shows United met the 30-day submission standard of 96 percent for professional and institutional encounters but fell below the standard for pharmacy encounters. The pharmacy encounter data HSAG analyzed revealed that most contained an invalid submission or payment date by including a submission date to DMAS before the MCO payment date.

Table 7-9—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	United	
Professional	96.0%	95.0%	98.2%	✓
Institutional	96.0%	95.9%	97.6%	✓
Pharmacy	99.0%	92.0%	11.0%	

✓ Met submission standard

Table 7-10 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 72.4 percent
- **Professional**: 78.3 percent
- **Pharmacy**: 88.9 percent

Table 7-10—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	96.3%	✗	97.6%	✗	95.0%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		100%		-	
Rendering Provider NPI	100%		100%		100%	
Attending Provider NPI	99.4%		-		-	
Servicing Provider Taxonomy Code	87.7%	✗	99.8%		-	
Referring Provider NPI	98.3%	✗	97.8%	✗	-	
Prescribing Provider NPI	-		-		100%	
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	93.2%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	93.0%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.8%		98.0%	✗	-	

Field Name	Institutional		Professional		Pharmacy	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	99.9%		-		-	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	99.8%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	98.6%	✗	99.8%		99.7%	
HCPCS/NDC Combination	66.0%	✗	81.2%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	73.5%	✗	83.7%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	29		23		9	
Percentage of data elements meeting 99% or greater validity	72.4%		78.3%		88.9%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: United met the timeliness submission standards for institutional and professional encounters. In addition, over 80 percent of the data elements assessed for pharmacy encounters met the validity criteria.

Weaknesses

Weakness: United did not meet the validity criteria for institutional encounters.
Why the weakness exists: The IS review and administrative profile analysis did not identify the specific root cause of the weakness in meeting the validity criteria.
Recommendation: HSAG recommends United:

- Assess how submission and payment dates are populated on pharmacy encounters to determine the root cause for having submission dates prior to payment.
- Incorporate additional logic and referential checks to assess the validity of data elements for institutional encounters.

VA Premier

Table 7-11 shows VA Premier met the 30-day submission standard of 96 percent for professional encounters but did not meet the standard for institutional and pharmacy encounters.

Table 7-11—Percentage of Encounters Submitted Within 30 Days

Encounter Type	Standard	Statewide	VA Premier	
Professional	96.0%	95.0%	99.0%	✔
Institutional	96.0%	95.9%	92.1%	
Pharmacy	99.0%	92.0%	97.1%	

✔ Met submission standard

Table 7-12 presents the percentage of valid values contained in the encounters for each field noted below. The percentage of data elements that had valid values for at least 99 percent of encounters are presented below by claim type:

- **Institutional**: 78.6 percent
- **Professional**: 78.3 percent
- **Pharmacy**: 77.8 percent

Table 7-12—Percentage of Encounters With Valid Values

Field Name	Institutional		Professional		Pharmacy	
Member ID	97.1%	✗	98.1%	✗	97.4%	✗
Header Service From Date	100%		100%		-	
Header Service To Date	100%		100%		-	
Detail Service From Date	100%		100%		-	
Detail Service To Date	100%		100%		-	
Date of Service	-		-		100%	
Billing Provider NPI	100%		100%		-	
Rendering Provider NPI	-		100%		100%	
Attending Provider NPI	99.6%		-		-	
Servicing Provider Taxonomy Code	95.0%	✗	93.4%	✗	-	
Referring Provider NPI	99.5%		99.1%		-	
Prescribing Provider NPI	-		-		95.6%	✗
Primary Diagnosis Codes	100%		100%		-	
Secondary Diagnosis Codes	100%		100%		-	
CPT/HCPCS Codes	98.1%	✗	100%		-	
CPT/HCPCS Codes with PTP Edits	98.0%	✗	100%		-	
Service Units	100%		100%		-	
Service Units with MUE	99.6%		97.3%	✗	-	
Primary Surgical Procedure Codes	99.9%		-		-	
Secondary Surgical Procedure Codes	99.8%		-		-	

Field Name	Institutional		Professional		Pharmacy	
Revenue Codes	100%		-		-	
Diagnosis-Related Groups Codes	100%		-		-	
Type of Bill Codes	100%		-		-	
NDCs	97.4%	✗	99.9%		99.6%	
HCPCS/NDC Combination	70.9%	✗	83.0%	✗	-	
MCO Received Date	100%		100%		100%	
MCO Paid Date	100%		100%		100%	
Header Paid Amount	100%		100%		100%	
Header TPL Paid Amount	99.2%		97.7%	✗	100%	
Detail Paid Amount	100%		100%		-	
Detail TPL Paid Amount	100%		100%		-	
Number of applicable data elements evaluated for validity	28		23		9	
Percentage of data elements meeting 99% or greater validity	78.6%		78.3%		77.8%	

✗ Did not meet 99 percent valid value criteria

Strengths, Weaknesses, and Recommendations

MCO encounter data were assessed for data quality and timeliness. Based on the analysis, the following strengths and weaknesses were identified.

Strengths

Strength: No strengths were identified from the IS review or administrative profile based on a comparison to other MCOs.

Weaknesses

Weakness: The IS review revealed VA Premier could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, VA Premier did not meet the timeliness standards for both institutional and pharmacy encounters.

Why the weakness exists: The existing weekly process consists of encounter acceptance rates. While VA Premier produces monthly and quarterly reports, HSAG was not furnished with these reports as part of the IS review.

Recommendation: HSAG recommends VA Premier:

- Consider augmenting its automated data validation processes to contain quality and timeliness summary metrics as other MCOs have developed. This may be done in consultation with DMAS to align validation efforts across MCOs.
- Identify the root cause of any delays in submitting institutional and pharmacy encounters to rectify any issues.

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 have addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

Objectives

The CAHPS surveys were conducted for Virginia's CCC Plus Medicaid managed care 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 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H 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 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Aetna's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for Aetna were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-1—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: Aetna

	2020	2021
Global Ratings		
Rating of Health Plan	64.8%	61.5%
Rating of All Health Care	56.1%	57.9%
Rating of Personal Doctor	73.4%	71.7%
Rating of Specialist Seen Most Often	70.8%	73.1%
Composite Measures		
Getting Needed Care	83.8%	86.0%

	2020	2021
Getting Care Quickly	86.2%	84.1%
How Well Doctors Communicate	92.7%	91.8%
Customer Service	88.2%	87.8%

Strengths, Weaknesses, and Recommendations

Aetna's 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths

Strength: Aetna's 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: Aetna's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-2—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: Aetna

	2020	2021
Global Ratings		
Rating of Health Plan	69.3%	63.7%
Rating of All Health Care	63.9%	66.1%
Rating of Personal Doctor	74.1%	75.8%
Rating of Specialist Seen Most Often	75.0%+	76.5%
Composite Measures		
Getting Needed Care	89.9%	88.2%
Getting Care Quickly	89.4%	91.2%
How Well Doctors Communicate	93.1%	92.5%
Customer Service	83.7%+	87.5%+

+ 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 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Aetna's 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: Aetna's 2021 top-box scores were statistically significantly lower than the NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Aetna overall, which may be associated with their perception of the ability to receive care or services and communication with their child's doctor.

Recommendation: HSAG recommends that Aetna conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna 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.

HealthKeepers

Table 8-3 and Table 8-4 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared HealthKeepers' 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for HealthKeepers were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-3—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: HealthKeepers

	2020	2021
Global Ratings		
Rating of Health Plan	63.2%	62.4%
Rating of All Health Care	57.1%	57.3%
Rating of Personal Doctor	72.1%	69.8%
Rating of Specialist Seen Most Often	70.2%	66.0%

	2020	2021
Composite Measures		
Getting Needed Care	86.9%	85.3%
Getting Care Quickly	86.2%	84.1%
How Well Doctors Communicate	94.1%	94.2%
Customer Service	92.4%	91.9%

Strengths, Weaknesses, and Recommendations

HealthKeepers 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths

Strength: HealthKeepers' 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: HealthKeepers' 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-4—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: HealthKeepers

	2020	2021
Global Ratings		
Rating of Health Plan	55.4%	65.7%▲
Rating of All Health Care	64.9%	68.3%
Rating of Personal Doctor	75.6%	79.5%
Rating of Specialist Seen Most Often	70.0%	74.1%
Composite Measures		
Getting Needed Care	86.1%	85.6%
Getting Care Quickly	94.4%	89.0%▼
How Well Doctors Communicate	95.9%	94.1%

	2020	2021
Customer Service	88.2%	89.8%

▲ *Statistically significantly higher in 2021 than in 2020.*
▼ *Statistically significantly lower in 2021 than in 2020.*
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: HealthKeepers' 2021 top-box score was statistically significantly higher than the 2020 top-box score for one measure: *Rating of Health Plan*.

Weaknesses

Weakness: HealthKeepers' top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. In addition, HealthKeepers' 2021 top-box score was statistically significantly lower than the 2020 top-box score for one measure, *Getting Care Quickly.*

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with HealthKeepers overall, which may be associated with their perception of their child's ability to receive access to care or services in a timely manner.

Recommendation: HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.

Magellan

Table 8-5 and Table 8-6 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Magellan's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for Magellan were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-5—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: Magellan

	2020	2021
Global Ratings		
Rating of Health Plan	61.3%	62.4%
Rating of All Health Care	53.5%	58.4%
Rating of Personal Doctor	70.4%	71.2%
Rating of Specialist Seen Most Often	68.6%	71.1%
Composite Measures		
Getting Needed Care	79.0%	83.9%
Getting Care Quickly	81.6%	79.8%
How Well Doctors Communicate	91.8%	93.7%
Customer Service	88.9%	92.2%

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

Strengths, Weaknesses, and Recommendations

Magellan's 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Magellan's 2021 top-box score was statistically significantly higher than the 2020 NQCA adult Medicaid national average for one measure, *Customer Service*.

Weaknesses

Weakness: Magellan's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that Magellan monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-6—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: Magellan

	2020	2021
Global Ratings		
Rating of Health Plan	50.6%	52.4%
Rating of All Health Care	55.7%	60.0%+

	2020	2021
Rating of Personal Doctor	75.9%	77.6%
Rating of Specialist Seen Most Often	69.4%+	54.7%+
Composite Measures		
Getting Needed Care	83.4%+	81.2%+
Getting Care Quickly	86.2%+	90.2%+
How Well Doctors Communicate	93.8%	91.7%+
Customer Service	82.3%+	81.3%+

+ 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 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Magellan's 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: Magellan's 2021 top-box scores were statistically significantly lower than the 2020 NCQA child Medicaid national average on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Magellan or their provision in healthcare overall, which may be associated with their perception of their child's ability to receive care or services from the MCO and from their child's specialist.

Recommendation: HSAG recommends that Magellan conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. 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.

Optima

Table 8-7 and Table 8-8 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared Optima's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for Optima were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-7—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: Optima

	2020	2021
Global Ratings		
Rating of Health Plan	68.6%	67.7%
Rating of All Health Care	59.5%	61.2%
Rating of Personal Doctor	73.4%	75.4%
Rating of Specialist Seen Most Often	70.5%	74.1%
Composite Measures		
Getting Needed Care	85.5%	88.6%
Getting Care Quickly	83.5%	84.4%
How Well Doctors Communicate	93.8%	96.1%
Customer Service	91.3%	92.8%

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

Strengths, Weaknesses, and Recommendations

Optima's 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Optima's 2021 top-box scores were statistically significantly higher than the 2020 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.

Weaknesses

Weakness: Optima's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-8—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: Optima

	2020	2021
Global Ratings		
Rating of Health Plan	66.1%	66.0%
Rating of All Health Care	67.5%	69.8%
Rating of Personal Doctor	79.0%	82.4%
Rating of Specialist Seen Most Often	72.3%	79.8%
Composite Measures		
Getting Needed Care	87.6%	86.7%
Getting Care Quickly	93.1%	86.4%
How Well Doctors Communicate	94.4%	92.9%
Customer Service	88.6%	91.2%+

+ 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

Optima's 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: Optima's 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: Optima's top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Optima overall, which may be associated with their perception of the ability to receive care or services.

Recommendation: HSAG recommends that Optima conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that Optima continue to monitor the measures to ensure significant decreases in scores over time do not occur.

United

Table 8-9 and Table 8-10 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared United's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for United were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-9—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: United

	2020	2021
Global Ratings		
Rating of Health Plan	66.0%	63.4%
Rating of All Health Care	59.3%	59.9%
Rating of Personal Doctor	72.0%	68.1%
Rating of Specialist Seen Most Often	68.2%	65.2%
Composite Measures		
Getting Needed Care	80.9%	83.8%
Getting Care Quickly	86.5%	84.4%
How Well Doctors Communicate	92.6%	93.0%
Customer Service	88.3%	91.5%

Strengths, Weaknesses, and Recommendations

United's 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths

Strength: United's 2021 top-box scores were not statistically significantly higher than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses

Weakness: United's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
Why the weakness exists: NA.
Recommendation: HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-10—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: United

	2020	2021
Global Ratings		
Rating of Health Plan	60.0%	62.3%
Rating of All Health Care	67.6%	70.2%
Rating of Personal Doctor	74.8%	76.8%
Rating of Specialist Seen Most Often	83.6%+	82.3%+
Composite Measures		
Getting Needed Care	86.4%+	87.7%+
Getting Care Quickly	92.2%+	91.2%+
How Well Doctors Communicate	94.7%+	93.7%
Customer Service	92.6%+	87.2%+

+ 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.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: United's 2021 top-box score was statistically significantly higher than the 2020 NCQA child Medicaid national average for one measure, *Rating of Specialist Seen Most Often*.

Weaknesses

Weakness: United's 2021 top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.

Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with United overall, which may be associated with their perception of the ability to receive care or services for their child.

Recommendation: HSAG recommends that United conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not occur.

VA Premier

Table 8-11 and Table 8-12 present the 2020 and 2021 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures, respectively. A trend analysis was performed that compared VA Premier's 2021 CAHPS scores to its corresponding 2020 CAHPS scores. In addition, the 2021 CAHPS scores for VA Premier were compared to the 2020 NCQA adult and child Medicaid national averages.

Table 8-11—Comparison of 2020 and 2021 Adult Medicaid CAHPS Results: VA Premier

	2020	2021
Global Ratings		
Rating of Health Plan	67.1%	67.3%
Rating of All Health Care	56.8%	58.0%
Rating of Personal Doctor	72.2%	72.2%
Rating of Specialist Seen Most Often	77.6%	71.0%
Composite Measures		
Getting Needed Care	86.2%	86.2%
Getting Care Quickly	85.9%	88.9%
How Well Doctors Communicate	94.0%	94.1%
Customer Service	93.4%	90.3%

▲ *Statistically significantly higher in 2021 than in 2020.*
▼ *Statistically significantly lower in 2021 than in 2020.*
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 2020 and 2021 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: VA Premier's 2021 top-box score was statistically significantly higher than the 2020 NCQA adult Medicaid national average for one measure, *Getting Care Quickly*.

Weaknesses

Weakness: VA Premier's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that VA Premier monitor the measures to ensure significant decreases in scores over time do not occur.

Table 8-12—Comparison of 2020 and 2021 Child Medicaid CAHPS Results: VA Premier

	2020	2021
Global Ratings		
Rating of Health Plan	73.0%	69.8%
Rating of All Health Care	74.1%	70.4%
Rating of Personal Doctor	84.2%	79.7%
Rating of Specialist Seen Most Often	78.0%+	74.2%
Composite Measures		
Getting Needed Care	91.4%	91.5%
Getting Care Quickly	95.2%+	92.5%
How Well Doctors Communicate	97.7%	95.7%
Customer Service	88.0%+	90.8%+

+ 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.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2020 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

VA Premier's 2020 and 2021 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths

Strength: VA Premier's 2021 top-box score was statistically significantly higher than the 2020 NCQA child Medicaid national average for one measure, *Getting Needed Care*.

Weaknesses

Weakness: VA Premier's 2021 top-box scores were not statistically significantly lower than the 2020 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.

Why the weakness exists: NA.

Recommendation: HSAG recommends that VA Premier monitor the measures to ensure significant decreases in scores over time do not occur.

9. Summary of MCO-Specific Strengths and Weaknesses

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess each MCO's performance in providing quality, timely, and accessible healthcare services to DMAS Medicaid and CHIP members as required in 42 CFR §438.364. For each MCO reviewed, HSAG provides a summary of its overall key findings related to quality, access, and timeliness based on the MCO's performance, which can be found in sections 4 through 8 of this report. In accordance with 42 CFR §438.364(a)(1), HSAG provides a description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the MCOs. Table 9-1 through Table 9-6 provide MCO-specific strengths and weaknesses identified through the aggregation of the results of EQR activities. MCO specific recommendations are found in sections 4 through 8 of the report.

Methodology: HSAG follows a three-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality of, timeliness of, and access to care furnished by each MCO.

Step 1: HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the MCO for the EQR activity.

Step 2: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions about the overall quality of, timeliness of, and access to care and services furnished by the MCO.

Step 3: HSAG identifies any patterns and commonalities that exist across the program to draw conclusions about the quality of, timeliness of, and access to care for the program.

Aetna

Table 9-1—Overall Conclusions for Aetna: Quality, Access, and Timeliness

EQRO Results for Aetna	
Domain	**Conclusion**
Quality	**Strengths:** Aetna achieved full compliance with 11 standards including Standard XI—Health Information Systems, Standard XXI—Quality Assessment and Performance Improvement, and Standard VII—Coverage and Authorization of Services. Aetna also had a comparatively robust internal assessment and reporting system for encounter data quality and timeliness. These robust systems and processes were evident in Aetna's PM results in the Behavioral Health domain where it met or exceeded the NCQA Quality Compass national Medicaid HMO 75th percentile for four measures. A similar impact was found in the Living With Illness domain where three measure rates exceeded the NCQA HEDIS 75th percentile.

EQRO Results for Aetna	
Domain	**Conclusion**
	Weaknesses: Aetna received statistically lower scores than the NCQA child Medicaid national average for two measures, *Rating of Health Plan* and *How Well Doctors Communicate*, indicating lower member satisfaction. Another factor that may have contributed to the lower satisfaction score was identified during the compliance review where it was found that members were not consistently informed that EPSDT services denied by Aetna as non-covered may be covered by DMAS.
Access	**Strengths:** PM results for access and preventive care showed that adults had access to preventive and ambulatory care, with Aetna achieving a rate in the NCQA Quality Compass national Medicaid HMO 75th percentile. Compliance review results supported access to care with Aetna monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with SHCN. Aetna also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members. **Weaknesses:** Aetna members were not consistently completing timely screenings, receiving recommended care for chronic conditions, or receiving optimal care. The declines in preventive health and care for chronic health conditions may have been a result of the COVID-19 PHE. Aetna also did not align its network adequacy policies with federal and DMAS requirements, which may have also contributed to members' inability to access screening services and care for chronic conditions.
Timeliness	**Strengths:** Possibly as a result of DMAS' implementation of the ARTS benefit, Aetna met or exceeded the NCQA HEDIS MY 2019 Medicaid 75th percentile for some Behavioral Health domain measures including the *Antidepressant Medication Management—Effective Continuation Phase Treatment* and *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* measure indicators, which are dependent on timely receipt of care and services. This indicates that Aetna had effective care management processes to identify and work with members who received services in an ED for mental illness to ensure follow-up care was received. **Weaknesses:** Aetna did not meet timeliness standards for institutional or professional encounters. Aetna also did not consistently meet timeliness requirements for grievance resolution letters to members.

HealthKeepers

Table 9-2—Overall Conclusions for HealthKeepers: Quality, Access, and Timeliness

EQRO Results for HealthKeepers	
Domain	**Conclusion**
Quality	**Strengths:** HealthKeepers conducted monthly provider meetings and regular member focus groups to share updates, information, and policy changes, and to receive input and feedback for improvement. These efforts may have impacted the member experience survey rating for *Customer Service*, which was statistically higher than the 2020 NCQA adult Medicaid national average. **Weaknesses:** Although HealthKeepers scored well for *Customer Service*, the MCO was statistically significantly lower than the 2020 NCQA child Medicaid national average for *Rating of Health Plan*. The results indicate that parents and caretakers of child members have a lower level of satisfaction with HealthKeepers. Also possibly contributing to the lower rating for HealthKeepers in the member experience survey; HealthKeepers did not have a defined process to identify members with SHCN or processes to monitor the quality and appropriateness of care furnished to members with SHCN. A review of member information policies also identified that HealthKeepers did not include requirements for member information to be easily understood, including grievance resolution notices that did not consistently state the member resolution.
Access	**Strengths:** HealthKeepers consistently included all DMAS contract requirements in its subcontractor and delegated entity agreements. **Weaknesses:** Although contract requirements were met, HealthKeepers' performance rates indicated potential access to care issues with early detection screenings, preventive care, recommended care for chronic conditions, and well-care for children falling below the NCQA Quality Compass national Medicaid HMO 25th percentile. The results may also indicate a lack of understanding of recommended or needed care, or that a disparity may exist.
Timeliness	**Strengths:** HealthKeepers demonstrated timeliness of authorization decisions as well as grievance and appeal member notices. **Weaknesses:** HealthKeepers did not have defined processes to ensure members received EPSDT services or to inform members about the risks of childhood obesity, or the need for fluoride varnish and its availability in the PCP's office. HealthKeepers did not meet the timeliness standards or validity criteria for institutional and professional encounters, which may have limited the MCO's ability to identify timely members in need of EPSDT services.

Magellan

Table 9-3—Overall Conclusions for Magellan: Quality, Access, and Timeliness

EQRO Results for Magellan	
Domain	**Conclusion**
Quality	**Strengths:** Magellan promoted the delivery of services in a culturally appropriate manner and ensured access to members with physical and mental disabilities. Magellan also assessed the quality and appropriateness of care provided to members with SHCN. These processes were evident in the performance measurement results in the NCQA HEDIS Living With Illness domain where the *Medical Assistance with Smoking and Tobacco Use Cessation–Discussing Cessation Medications* measure indicator results ranked at or above NCQA's HEDIS MY 2019 Medicaid HMO 75th percentile. The strong performance on this measure indicates that Magellan has established successful processes related to medical assistance for members living with illness. The member experience of care survey showed that Magellan scored statistically significantly higher than the 2020 NCQA adult Medicaid national average for the *Customer Service* measure. This may be a result of how Magellan leveraged a multidisciplinary approach to engage disruptive members in continued care and the processes implemented to prevent, detect, and remediate critical incidents. **Weaknesses:** The member experience survey identified that parents/caretakers of child members have a lower level of satisfaction with Magellan or their provision in healthcare overall, which may be associated with their perception of their child's ability to receive care or services from Magellan and from their child's specialist. Magellan had initiated programs to monitor, track, and implement interventions to improve utilization of EPSDT services. Magellan also measured EPSDT services at the provider level and worked with providers to improve utilization of EPSDT services. These programs may positively impact member experience and help Magellan improve member satisfaction with the MCO and its provision of healthcare overall.
Access	**Strengths:** Performance on behavioral health measures, including those focused on antidepressant medication management and initiating and engaging members in treatment for alcohol or other drug abuse or dependence, 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. In addition, Magellan exceeded the DMAS requirements for the number of and the time and distance standards for each provider category and CCC Plus locality, which was an indication of access to care. **Weaknesses:** Magellan's rates for several PMs across several domains fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile, suggesting a lack of access and use of well and preventive care, behavioral health services, and chronic disease management. Magellan's

EQRO Results for Magellan	
Domain	**Conclusion**
	members are not consistently scheduling or completing follow-up on recommended care or services or scheduling evidence-based care and services. These results align with the compliance review results, which identified that Magellan did not consistently ensure members eligible for EPSDT services obtained all the care and services they needed, including medical and behavioral health needs and referrals to community-based resources. The low performance across several PM domains and the results of Magellan's compliance review indicate that healthcare disparities may exist, and members may not have a comprehensive understanding of their healthcare needs or benefits. Factors that also may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.
Timeliness	**Strengths:** There were no identified overall strengths related to timeliness identified for the MCO. **Weaknesses:** A review of Magellan's compliance identified that the MCO did not consistently resolve appeals and provide written notice to members within the required time frames. In addition, a review of case files identified that Magellan did not consistently meet the time frame to mail notices of adverse benefit determination to members.

Optima

Table 9-4—Overall Conclusions for Optima: Quality, Access, and Timeliness

EQRO Results for Optima	
Domain	**Conclusion**
Quality	**Strengths:** Optima's member experience survey results were statistically significantly higher than the 2020 NCQA adult Medicaid national average for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*. These satisfaction results may relate to the MCO's performance measurement results in the NCQA HEDIS Living With Illness domain; the *Medical Assistance With Smoking and Tobacco Use Cessation–Advising Smokers and Tobacco Users to Quit* measure indicator results ranked at or above NCQA's HEDIS MY 2019 Medicaid HMO 75th percentile. The strong performance on this measure indicates that Optima has established successful processes related to medical assistance for members living with illness. **Weaknesses:** Optima's member experience survey 2021 top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. Based on the survey results, parents/caretakers of child members had a lower level of satisfaction with

EQRO Results for Optima	
Domain	**Conclusion**
	Optima overall, which may be associated with their perception of the ability to receive care or services. The compliance review results in the EPSDT standard also supported the survey results. The compliance review found that Optima did not notify members that, when an EPSDT service is denied by the MCO, the service may be available through DMAS or provide DMAS contact information to the member in order to request approval of the service.
Access	**Strengths:** Optima's member experience survey results were statistically significantly higher than the 2020 NCQA adult Medicaid national average for *Getting Needed Care*. The member experience results align with PM results in the Behavioral Health domain where Optima met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for two measure indicators: *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*. The strong performance indicates that Optima had 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. Member experience survey results for access to care are also reflected in the Access and Preventive Care domain where Optima met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure. Optima's performance indicates that adults follow recommended preventive or ambulatory care visits, thereby reducing adverse member outcomes and unnecessary ED utilization. Compliance review results also showed that Optima focused efforts on access to care with the MCO implementing processes to monitor, evaluate, and implement interventions to improve utilization of EPSDT services. **Weaknesses:** Results of Optima's compliance review identified that Optima did not include all provider types required in the DMAS contract, which may have impacted its assessment of time and distance standards compliance. These deficiencies may have impacted PM results with Optima's rates across multiple domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile. The results suggest a lack of access to preventive care, screenings, behavioral healthcare, and care for chronic conditions. Optima's members were not consistently scheduling well visits or receiving immunizations according to the recommended schedules. Chronic care results indicated 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. Factors that may also have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.

EQRO Results for Optima	
Domain	**Conclusion**
Timeliness	**Strengths:** There were no identified overall strengths related to timeliness identified for the MCO. **Weaknesses:** Optima did not include all DMAS-required provider types or consider all required factors when describing and maintaining the number of providers offered to members or assessing the network against the appropriate travel time and distance standards required in the contract. Optima also did not consistently resolve all appeals and provide written notice of the disposition to the member within the required time frames or consistently meet the content requirements in the notice of action (denial) to members.

United

Table 9-5—Overall Conclusions for United: Quality, Access, and Timeliness

EQRO Results for United	
Domain	**Conclusion**
Quality	**Strengths:** The compliance review results showed that United's QAPI program was focused on QI and measuring the results of quality initiatives to continue performance improvement. United implemented processes to evaluate the quality and appropriateness of care provided to members with SHCN. The MCO also implemented processes to monitor and evaluate critical incidents. These processes may have impacted United's PM results reflecting quality of care in the Living With Illness domain. United displayed strong performance for the three *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance for this measure indicates that members are receiving services and supports necessary to quit smoking and tobacco use. The compliance review also showed that United implemented robust compliance procedures that included regular meetings between the compliance officer, executive team, and various departments to maintain and monitor ongoing risk assessments, monitoring activities, and remediation work. **Weaknesses:** United's member experience survey 2021 top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Rating of Health Plan*. Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with United overall, which may be associated with their perception of the ability to receive care or services for their child.
Access	**Strengths:** United monitored its provider network for adequacy and accessibility according to appropriate federal and Commonwealth requirements. United also monitored its provider network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members with

EQRO Results for United	
Domain	**Conclusion**
	disabilities. These monitoring processes may have resulted in improved access to care as evidenced in the results of the PMs. 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 NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 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 ED utilization. Access to care was also found within the Behavioral Health domain, where United met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators. 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:** Several of United's rates in the Access and Preventive Care, Taking Care of Children, and Living With Illness domains falling below the HEDIS MY 2019 25th percentile suggests a lack of access or understanding of the need for preventive care and screenings. United's members are not consistently scheduling cancer screenings; adults and children are not accessing care or services according to evidence-based recommendations; and members with 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. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to the COVID-19 PHE. The COVID-19 PHE also likely deterred individuals from seeking healthcare services.
Timeliness	**Strengths:** The compliance review identified that United implemented interventions to increase utilization of EPSDT services including processes to inform members and providers of the EPSDT covered services. Outreach included educating members about childhood obesity and the dangers of lead exposure. United's PM results within the Use of Opioids domain aligned with compliance review findings of strong processes to identify, track, and monitor member care. United met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Use of Opioids From Multiple Providers—Multiple*

EQRO Results for United	
Domain	**Conclusion**
	Pharmacies measure indicator. The strong performance related to use of opioids indicates that United is managing the frequency of its members' use of multiple pharmacies for opioid medications. **Weaknesses:** United did not meet the timeliness standards for both institutional and pharmacy encounters. This may have impacted United's identification of members in need of preventive, early diagnosis, and evidence-based care, resulting in lower PM results in some measures.

VA Premier

Table 9-6—Overall Conclusions for VA Premier: Quality, Access, and Timeliness

EQRO Results for VA Premier	
Domain	**Conclusion**
Quality	**Strengths:** PM results showed that within the Living With Illness domain, VA Premier displayed strong performance for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* measure indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance for this measure indicator indicates that members are receiving services and supports necessary to quit smoking and tobacco use. **Weaknesses:** The MCO did not implement the 2020 Medicaid Managed Care Rule requirements of ensuring that members have access to machine-readable formats of its formulary and provider directory.
Access	**Strengths:** Compliance review results showed that VA Premier implemented processes to ensure members received culturally competent services. VA Premier also implemented processes to ensure that members had direct access to women's health services, out-of-network services, and second opinions. These processes may have had a positive impact on PM rates within the Access and Preventive Care domain. VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, which met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile. This level of performance in providing access to care for adults indicates that VA Premier 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 ED utilization. **Weaknesses:** A review of compliance of VA Premier identified that the MCO had not updated its policies and procedures regarding network adequacy or implemented a process to monitor and measure provider network accessibility. These results may have impacted several of VA Premier's rates in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living

EQRO Results for VA Premier	
Domain	**Conclusion**
	With Illness domains, as these rates falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggest 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. Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to the COVID-19 PHE.
Timeliness	**Strengths:** A compliance review of VA Premier demonstrated that VA Premier had appropriate policies and procedures for a comprehensive QAPI program. VA Premier implemented processes to ensure members eligible for EPSDT services received appropriate services, including medical and behavioral health services. The results of PMV indicated that the outreach processes implemented by VA Premier may have had a positive impact on PM results. Within the Behavioral Health domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* measure indicators. The strong performance in these Behavioral Health domain measures indicates that VA Premier has improved access and timeliness to behavioral healthcare, potentially as a result of Virginia's focus on the ARTS benefit, the development of member-centric behavioral healthcare and services, and its outreach and follow-up processes. **Weaknesses:** A compliance review identified that VA Premier did not appropriately apply its appointment access standards to the entire network; have processes to ensure that providers ensured the same hours of operation for its Medicaid members as commercial or FFS members; or ensure that the provider network offered care and services 24 hours a day, seven days a week. VA Premier did not have a process to follow up with providers to take corrective action when a provider did not meet appointment accessibility standards. In addition, VA Premier did not have processes that ensured EPSDT age members and were aware of EPSDT benefits or processes to monitor and track members' receipt of EPSDT services. These compliance review findings may have impacted the timeliness of care and service delivery, resulting in several of VA Premier's rates in the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile.

Appendix A. Technical Report and Regulatory Crosswalk

Table A-1 lists the required and recommended elements for EQR Annual Technical Reports, per 42 CFR §438.364 and recent CMS technical report feedback received by states. The Table identifies the page number where the corresponding information that addresses each element is located in the Virginia EQR Annual Technical Report.

Table A-1—Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30th.	Cover Page
2	All eligible Medicaid and Children's Health Insurance Program (CHIP) Plans are included in the report.	1-1
3a	Required elements are included in the report: Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were **aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.**	1-4 – 1-5
3b	Required elements are included in the report: An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Section 9
3c	Required elements are included in the report: Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP enrollees.	1-6 – 1-7
3d	Recommend improvements to the quality of health care services furnished by each MCP.	Sections 4, 5, 6, 7, and 8
3e	Provides state-level recommendations for performance improvement.	1-7
3f	Ensure methodologically appropriate, comparative information about all MCPs.	Section 3
3f	Assess the degree to which each MCP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	Appendix E
4	Validation of performance improvement projects (PIPs): A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
4a	Validation of performance improvement projects (PIPs): • **Interventions**	Section 4: Tables 4-2, 4-3, 4-5, 4-6,

	Required Elements	Page Number
		4-8, 4-9, 4-11, 4-12, 4-14, 4-15, 4-17, 4-18
4b	Validation of performance improvement projects (PIPs): • **Objectives;**	4-1
4c	Validation of performance improvement projects (PIPs): • **Technical methods of data collection and analysis;**	Appendix B B-1 – B-2
4d	Validation of performance improvement projects (PIPs): • **Description of data obtained; and**	4-3 – 4-14
4e	Validation of performance improvement projects (PIPs): • **Conclusions drawn from the data.**	4-3 – 4-14
5	Validation of performance measures: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	Validation of performance measure validation (PMV): • **Objectives;**	5-1
5b	Validation of performance measure validation (PMV): • **Technical methods of data collection and analysis;**	Appendix B B-4
5c	Validation of performance measure validation (PMV): • **Description of data obtained; and**	3-6
5d	Validation of performance measure validation (PMV): • **Conclusions drawn from the data.**	5-1 – 5-15
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report including information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	Review for compliance: • **Objectives;**	6-1
6b	Review for compliance: • **Technical methods of data collection and analysis;**	Appendix B
6c	Review for compliance: • **Description of data obtained; and**	Appendix B
6d	Review for compliance: • **Conclusions drawn from the data.**	6-3 – 6-21

	Required Elements	Page Number
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	Optional activities: • **Objectives;**	7-1, 8-1
7b	Optional activities: • **Technical methods of data collection and analysis;**	Appendix B
7c	Optional activities: • **Description of data obtained; and**	Appendix B B-16 B-18 – B-23
7d	Optional activities: • **Conclusions drawn from the data.**	7-1 – 7-13; 8-1 – 8-13

Appendix B. 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
- Operational Systems Review Methodology
- Encounter Data Validation Methodology
- CAHPS Survey Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

Rapid-Cycle PIP Validation Approach

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG, as Virginia's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[B-1]

In July 2014, HSAG developed a PIP approach and framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[B-2] The redesigned PIP approach is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework directs MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement.

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on June 8, 2020.

[B-2] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Mar 26, 2019.

project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is approximately 18 months.

There are five modules with an accompanying reference guide for the MCOs to use to document their PIPs. Prior to issuing each module, HSAG provides module-specific training with the MCOs to educate about the documentation requirements and use of specific quality improvement tools for each of the modules. The five modules are defined as:

- Module 1—PIP Initiation: Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and Specific, Measurable, Attainable, Relevant, Time-bound (SMART), and completing a key driver diagram.
- Module 2—SMART Aim Data Collection: In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- Module 3—Intervention Determination: In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- Module 4—PDSA: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- Module 5—PIP Conclusions: In Module 5, the MCO summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

During PIP validation, HSAG determines if criteria for each module are *Achieved*. As the PIP progresses, and at the completion of Module 5, HSAG uses 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 assigns a level of confidence and reports 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 MCO accurately summarized the key findings.
- *Confidence* = The PIP was methodologically sound, the SMART Aim was achieved, and the 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.

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

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 ALI Consulting Services, LLC, 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 CMS publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019.[B-3]

DMAS is responsible for administering the Medicaid program and CHIP in the Commonwealth of Virginia. DMAS refers to its CHIP program as Family Access to Medical Insurance Security (FAMIS). The 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 CCC Plus program for CY 2020. DMAS identified a set of performance measures that the MCOs were required to calculate and report.

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

Table B-1—CY 2020 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 were 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

[B-3] The Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: Apr 14, 2021.

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

Description of Validation Activities

As a result of the Coronavirus disease 2019 (COVID-19) public health emergency, HSAG, in conjunction with DMAS, determined that the PMV on-site component would be conducted as an interactive virtual site visit. Therefore, the term "on-site" is used, as the virtual site visit and on-site activities are the same.

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 submitted an ISCAT for HSAG's review of the performance measures. The ISCAT supplemented the information included in the Roadmap and addresses 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 were responsible for completing the medical records review section within the Roadmap for the measures reported using the hybrid method. In addition, HSAG requested 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 conducted over-read of 16 records from the hybrid sample for each performance measure. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and determined 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 identified 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 were 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 were required to submit the vendor's NCQA measure certification reports.
- Supporting documentation—HSAG requested 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 reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

During the on-site visit, HSAG collected 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 was combined for the Medallion 4.0 and CCC Plus programs. The on-site strategies included:

- **Opening meetings**—These meetings included 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 was 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 conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain if written policies and procedures were 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 conducted 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 used 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 included 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 evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  HSAG performed 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 assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCOs have system documentation 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 were 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 summarized 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 reviewed final performance measure rates submitted by the MCOs to DMAS and followed 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 was communicated to the MCO as a corrective action that must be addressed as soon as possible so that the rate could be revised before the PMV report was issued.

HSAG prepared a separate PMV report for CCC Plus for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS PMV protocol identifies possible validation results for performance measures, defined in Table B-2 below.

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

Designation	Description
Report (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 is 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 2021

Table B-3 lists the performance measures selected by DMAS, the method (i.e., hybrid or admin) required for data collection, and the specifications that the MCOs were required to use.

Table B-3—Performance Measure List for SFY 2021

Performance Measure	Specifications	Method*
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05- AD)	ADULT CORE SET	Admin
Comprehensive Diabetes Care	HEDIS MY 2020	Hybrid
Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	HEDIS MY 2020	Admin
Follow-up After Emergency Department Visit for Mental Illness	HEDIS MY 2020	Admin
Heart Failure Admission Rate (PQI08- AD)	ADULT CORE SET	Admin
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	HEDIS MY 2020	Admin

* 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.

Compliance With Standards Methodology

Requirement

Compliance reviews (Operational Systems Review or OSRs) are a mandatory activity that are used to determine the extent to which Medicaid and CHIP managed care plans (MCPs) are in compliance with federal standards. The U.S. Department of Health & Human Services (HHS) developed standards for managed care plans (MCPs), which are codified at 42 CFR §438 and 42 C.F.R. §457, as revised by the Medicaid and CHIP managed care final rule issued in 2020. Federal regulations require MCPs to undergo a review at least once every three years to determine MCP compliance with federal standards as implemented by the state.

Brief Overview

- HSAG will conduct a full compliance review of the CCC Plus and Medallion 4.0 MCOs beginning in SFY 2021. The review period will be determined by DMAS, however it will most likely be the most recent contract year or calendar year.
- DMAS staff may participate as observers during the OSR or may use the opportunity to review/audit other requirements not included in the OSRs.
- All federal standards will be reviewed and will incorporate Virginia-specific related requirements as requested by the State.
- The OSR will include a virtual review of documents, data, case files and information from the MCOs that they provide that is their evidence of compliance with the requirements.
- The OSR will include an in-person or virtual visit (dependent on the status of the COVID-19 PHE and DMAS guidelines for in-person reviews/audits) where MCO staff are interviewed, systems are reviewed, and observation occurs. Any gaps or areas identified as non-compliant during document review will be discussed during the in-person/virtual visit to allow MCOs the opportunity to provide additional evidence of compliance.
- MCOs will ensure that their subject matter experts are available for the applicable session during the in-person/virtual review.
- Case files will be reviewed for compliance and timeliness such as authorizations, grievance, appeals, and credentialing.
- MCOs will be fully aware of requirements that will be scored as "Not Met" at the conclusion of the on-site/virtual review.
- Draft reports will be submitted to DMAS within 30 days of the conclusion of the on-site/virtual visit.

Document Request Packet

The document request packet is a tool HSAG and the MCO will use to prepare for the upcoming OSR.

The following components are included in this packet:

Section I	Contact Information
Section II	Timeline
Section III	Standards and Review Information
Section IV	Virtual Review Agenda
Appendix I	Standard I—Enrollment and Disenrollment Tool
Appendix II	Standard II—Member Rights and Confidentiality Tool
Appendix III	Standard III—Member Information Tool
Appendix IV	Standard IV—Emergency and Poststabilization Services Tool
Appendix V	Standard V—Adequate Capacity and Availability of Services Tool

Appendix VI	Standard VI—Coordination and Continuity of Care Tool
Appendix VII	Standard VII—Coverage and Authorization of Services Tool
Appendix VIII	Standard VIII—Provider Selection Tool
Appendix IX	Standard IX—Subcontractual Relationships and Delegation Tool
Appendix X	Standard X—Practice Guidelines Tool
Appendix XI	Standard XI—Health Information Systems Tool
Appendix XII	Standard XII—Quality Assessment and Performance Improvement Tool
Appendix XIII	Standard XIII—Grievance and Appeal Systems
Appendix XIV	Standard XIV—Program Integrity Tool
Appendix XV	Standard XV—EPSDT Services

Table B-4—Operations and Systems Review Timeline

Section II—Timeline			
Task Description	**Start Date**	**End Date**	**Responsibility**
Submit to the HSAG SAFE site a Microsoft Excel list of all standard appeal requests for covered/authorization of services during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all expedited appeal requests for covered/authorization of services during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all standard grievances received during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all expedited grievances received during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all service authorizations (including approved and denied requests) during the review period.	No later than July 6, 2021		MCO
Submit to the HSAG SAFE site an Excel list of all delegation or subcontract agreements in effect during the review period.	No later than July 6, 2021		MCO
HSAG provides notification to the MCO of sample cases and agreements selected for review. • A separate sample will be selected by HSAG for each program (Medallion 4.0 and CCC Plus) • For each program a separate sample will be selected by HSAG of the following: 1. Overall cases 2. ARTS cases 3. EPSDT cases	No later than July 9, 2021		HSAG

Section II—Timeline			
Task Description	**Start Date**	**End Date**	**Responsibility**
• Ten sample cases plus an over-sample cases selected by HSAG of the following case types: 1. Standard appeals 2. Expedited appeals 3. Standard grievances 4. Expedited grievances 5. Service authorization denials 6. Subcontractor and delegated entity agreements			
MCO submits selected cases for review to the appropriate folders on the HSAG SAFE site.	No later than July 14, 2021		MCO
Submit to the HSAG SAFE site the MCO evidence of compliance documents for desk review.	No later than July 14, 2021		MCO
Perform virtual review.	To be populated with MCO-specific audit dates	To be populated with MCO-specific audit dates	HSAG/MCO/ DMAS
Review period	July 1, 2020	June 30, 2021	HSAG/MCO/ DMAS

Table B-5—Operations and Systems Review Process Overview

Section III—Standards and Review Information	
General Instructions and Notes	
The MCO will need to designate subject matter expert staff members for each of the review areas during the interview portion of the OSR.	
Standards Covered During the Operational Systems Review (OSR)	
Brief Description	HSAG will review the following standards as part of the OSR: I. Enrollment and Disenrollment (§438.56) II. Member Rights and Confidentiality (§438.10.00§438.100.00; §438.224) III. Member Information (§438.10) IV. Emergency and Poststabilization Services (§438.114) V. Adequate Capacity and Availability of Services (§438.206 and §438.207) VI. Coordination and Continuity of Care (§438.208) VII. Coverage and Authorization of Services (§438.210) VIII. Provider Selection (§438.214) IX. Subcontractual Relationships and Delegation (§438.230) X. Practice Guidelines (§438.236) XI. Health Information Systems (§438.242) XII. Quality Assessment and Performance Improvement (§438.330) XIII. Grievance and Appeal Systems (§438.228) XIV. Program Integrity (§438.608; §438.610) XV. EPSDT Services (1903 of the Social Security Act)

Section III—Standards and Review Information	
Document Request and Evaluation Tool	The Document Request and Evaluation Tool is the OSR tool that HSAG will use to assess the MCO's compliance with the standards being reviewed. The tools are organized according to the CMS 2016 Final Managed Care Rule categories, with the December 2020 updates applied. HSAG will review the MCO's compliance of the policies, procedures, or other written documents with federal and State requirements **and the evidence of implementation of the requirements**. The MCO is the expert at identifying documentation that supports its compliance with federal and Virginia-specific requirements and should submit accordingly. Enter the name of the document that contains evidence of the MCO's compliance directly in the "Evidence as Submitted by the Health Plan" section of the tool. Please be very specific as to which document includes the information (i.e., for policies and procedures, include the policy name/number; for meeting minutes, include which committee and for which meeting date). Also, specify the exact page, section, attachment, etc., that provides evidence of compliance with the requirement. When submitting documents, please do not copy or cut a section or paragraph from one document and paste it into a separate document for submission. Reviewers need to see the entire policy or document to understand the context and the associated information. ***Highlight in yellow in the document submission the applicable information that demonstrates evidence of compliance with the standard.*** Please note that HSAG will review only the document portions highlighted and referenced according to page number, section, or attachment in the "Evidence as Submitted by the Health Plan" section of the tool for each element as evidence of the MCO's compliance with the standard/element. When uploading the referenced documents to the HSAG SAFE site folders, please name the file the same name as listed in the Evidence column. The Document Request and Evaluation Tool is provided in a Microsoft Word format that allows the MCO to enter information directly into the "Evidence as Submitted by the Health Plan" section of the tool. Please note that the preferred font for entering the information is Helvetica, size 11, black. Please do not enter, delete, or change information in any of the other sections of the tool (i.e., Requirements, Findings, Required Actions, and Score). The MCO must post all case/service lists in Excel format to the HSAG SAFE site folders (Operational Systems Review > CCC Plus > File Review > 1 – Universe File and Operational Systems Review > Medallion 4_0 > File Review > 1 – Universe File) no later than July 1, 2021. All requested MCO users have been granted access. Do not submit any documents via email as they may contain protected health information (PHI) or personally identifiable information (PII). Post all referenced documents to the appropriate folder (organized by standard) on the HSAG SAFE site folders site no later than July 1, 2021, and post all selected case files or documentation to the HSAG SAFE site folders no later than July 14, 2021.
Desk Review	
Brief Description	HSAG will conduct a desk review of the submitted documents, complete case file reviews, and conduct virtual interviews and systems demonstrations with MCO staff members to determine the MCO's compliance with federal and State requirements.
Procedure	HSAG will conduct a desk review of the submitted documents prior to the virtual visit. HSAG will then conduct a virtual visit and interview MCO staff members to determine if the MCO is in compliance with the elements of each standard. MCO staff members should be prepared to discuss implementation of the standards during the virtual visit and answer the reviewer's questions. MCO staff members should be able to describe how policies and procedures are implemented. HSAG may request that certain documentation be submitted to the HSAG SAFE site folders by the close of the virtual visit date as evidence of implementation of processes described during the interview sessions.

Table B-6—Operations and Systems Review Agenda

Section IV—Virtual Review Agenda	
Day 1	
Time Period (EST)	**Sessions and Activities**
8:00–8:30 a.m.	Set-up
8:30–9:00 a.m.	Opening session: • Introduction – Participants include MCO staff, HSAG, and DMAS • MCO opening remarks and overview
9:00–10:00 a.m.	Standard V—Adequate Capacity and Availability of Services
10:00–11:00 a.m.	Standard VII—Coverage and Authorization of Services Standard IV—Emergency and Poststabilization Services
11:00–11:15 a.m.	*Break*
11:15 a.m.–12:00 p.m.	Standard VI—Coordination and Continuity of Care
12:00–1:00 p.m.	*HSAG reviewers—working lunch*
1:00–1:30 p.m.	Standard VIII—Provider Selection
1:30–2:00 p.m.	Standard IX—Subcontractual Relationships and Delegation
2:00–3:00 p.m.	Standard XI—Health Information Systems
3:00–3:15 p.m.	*Break*
3:15–4:00 p.m.	Standard XIV—Program Integrity *HSAG document review time*
4:00–5:00 p.m.	*HSAG document review time–MCO follow-up on document requests*
5:00 p.m.	*End of day*
Day 2	
Time Period (EST)	**Sessions and Activities**
8:30–9:00 a.m.	Set-Up
9:00–10:00 a.m.	Standard II—Member Rights and Confidentiality
10:00–11:00 a.m.	Standard III—Member Information
11:00–11:15 a.m.	*Break*
11:15–11:45 a.m.	Standard I—Enrollment and Disenrollment
11:45 a.m.–12:15 p.m.	Standard X—Practice Guidelines
12:15–1:00 p.m.	*HSAG reviewers—working lunch*
1:00–2:00 p.m.	Standard XII—Quality Assessment and Performance Improvement
2:00–3:00 p.m.	Standard XIII—Grievance and Appeal Systems

Section IV—Virtual Review Agenda	
3:00–3:30 p.m.	Standard XV—EPSDT Services
3:30–4:00 p.m.	*HSAG reviewers prepare closing summation*
4:00–4:30 p.m.	Closing session: • Summary of HSAG's preliminary findings
4:30–5:00 p.m.	*End of day*

Encounter Data Validation Methodology

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DMAS requires its CCC Plus contracted MCOs to submit high-quality encounter data. DMAS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2020–2021, DMAS contracted HSAG to conduct an EDV study. In alignment with the CMS EQR Protocol 5, [B-4] HSAG conducted the following two core evaluation activities for the EDV study:

- Information systems review—assessment of DMAS' and the MCOs' information systems and processes. The goal of this activity is to examine the extent to which DMAS' and the MCOs' information systems infrastructures are likely to collect and process complete and accurate encounter data. This activity corresponds to Activity 1: Review State Requirements and Activity 2: Review the MCP's Capability in the CMS EQR Protocol 5.
- Administrative profile—analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity is to evaluate the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service in CY 2020. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

HSAG conducted the EDV study for the following six CCC Plus MCOs:

- 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)
- Virginia Premier Health Plan, Inc. (VA Premier)

[B-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 19, 2021,

In addition, because the MCOs terminated their contracts with DentaQuest on July 1, 2021, DMAS excluded the dental encounters from the study.

Information Systems Review

The information systems review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to DMAS is understood. The information systems review is key to understanding whether the information systems infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that includes a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the information systems review with a thorough desk review of existing documents related to encounter data initiatives/validation activities currently put forth by DMAS. Documents included data dictionaries, encounter system edits, DMAS' current encounter data submission requirements, monitoring reports, and documents to track issues, among others. The information obtained from this review was important for developing a targeted questionnaire to address important topics of interest to DMAS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG developed an MCO questionnaire customized in collaboration with DMAS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. The questionnaire also included a review of supplemental documentation regarding other data systems, including enrollment and provider data. Lastly, the questionnaire included specific topics of interest to DMAS.

The questionnaire for DMAS had similar domains as the questionnaire developed for the MCOs; however, it focused on DMAS' data exchange with the MCOs.

Since the encounter data submission requirements and processes for the CCC Plus and Medallion 4.0 are similar, HSAG sent one questionnaire to each MCO to collect information for both programs. If there were questions for the CCC Plus program only, HSAG clearly labelled them in the questionnaire. This approach helped prevent duplication.

Stage 3—Key Informant Interviews

After reviewing responses to the questionnaires, HSAG followed up with key DMAS and MCO information technology (IT) personnel to clarify any questions from the questionnaire responses.

Overall, the information systems reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis, HSAG was able to provide actionable recommendations to the existing encounter data systems on areas for improvement or enhancement.

Administrative Profile

An administrative profile, or analysis, of a state's encounter data is essential to gauging the general completeness, accuracy, and timeliness of encounter data, as well as whether encounter data are sufficiently robust for other uses such as performance measure calculation. The degree of data file completeness across the MCOs provides insight into the quality of DMAS' overall encounter data system and represents the basis for establishing confidence in subsequent analytical and rate setting activities.

HSAG assessed the final adjudicated encounters with service dates between January 1, 2020, and December 31, 2020, and extracted from the EPS database on or before July 8, 2021. In addition, the EDV study used member demographic/eligibility/enrollment data and provider data to evaluate the validity of key data elements in the encounter data. HSAG submitted a data submission requirements document to notify DMAS of the required data needed for the study. The data submission requirements document was based on the study objectives and data elements evaluated in this study. It included a brief description of the study, criteria for data extraction, required data elements, and information regarding the submission of the requested files. In addition, to assist DMAS in preparing the requested data files, HSAG followed the following two actions:

- Since this was the first time HSAG was to request encounter data from DMAS' EPS database, HSAG initially requested a set of test files from DMAS before DMAS extracted the complete set of data. The test data were smaller in size (e.g., encounters for one month) and allowed HSAG to detect any data extraction issues before the full data extract was submitted. In addition, the test data helped HSAG prepare the analyses in advance while waiting for the claim lag run-out to receive the complete data.
- After submitting the draft data submission requirements document to DMAS, HSAG scheduled a conference call with DMAS to review the document to ensure that all questions related to data preparation and extraction were addressed. Afterwards, HSAG submitted the final version of the data submission requirements document to DMAS for review/approval.

Once HSAG received the data files from DMAS, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and have values in those fields.
- Percentage of valid values—The values were as expected (e.g., valid International Classification of Diseases, Tenth Revision [ICD-10] codes in the diagnosis field).

Based on the preliminary file review results, HSAG followed up with DMAS to resubmit data, as needed.

Once the final data had been received and processed, HSAG conducted a series of analyses for metrics listed in the sections below. In general, HSAG calculated rates for each metric by MCO and encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], and National Council for Prescription Drug Programs [NCPDP]). However, when the results indicated a data quality issue(s), HSAG conducted additional investigation to determine whether the issue was for a specific category of service (e.g., nursing facilities, hospice); provider type (e.g., vision vendor, nonemergency

transportation vendor); or sub-population. HSAG documented all noteworthy findings in the aggregate report.

Encounter Data Completeness

HSAG evaluated the encounter data completeness through the following metrics:

- Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur): If the number of members remain stable and there are no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month indicates incomplete data. Of note, instead of the claim number, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key is based on the member ID, rendering provider NPI, and date of service.
- Monthly encounter volume (i.e., visits) per 1,000 member months (MM) by service month: Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the member counts by month for each MCO based on the member enrollment data extracted by DMAS.
- Paid amount per member per month (PMPM) by service month: This metric will allow DMAS to determine whether the encounter data were complete from a payment perspective. Of note, HSAG used the header paid amount to calculate this metric.
- TPL amount PMPM by service month: This metric will allow DMAS to determine whether the TPL amounts were complete and accurate.
- Percentage of duplicate encounters: This metric will allow DMAS to assess the number of potential duplicate encounters in DMAS' EPS database.

Encounter Data Timeliness

HSAG evaluated the encounter data timeliness through the following metrics:

- Percentage of encounters received by DMAS within 30 days, 60 days, 90 days, etc., from the MCO payment date. The MCO contract states that the MCOs should "Submit complete, timely, reasonable, and accurate encounter data to the Department within thirty (30) business days of the Contractor's payment date." This metric will allow DMAS to evaluate the extent to which the MCOs met the standard.
- Claims lag triangle to illustrate the percentage of encounters received by DMAS within two months, three months, etc., from the service month. This metric will allow DMAS to evaluate how soon it may use the encounter data in the EPS database for activities such as performance measure calculation and utilization statistics.

Field-Level Completeness and Accuracy

HSAG evaluated whether the data elements in the final paid encounters are complete and accurate through the two study indicators described in Table B-7 for the key data elements listed in Table B-8. In addition, Table B-8 shows the criteria HSAG used to evaluate the validity for each data element. These criteria are based on standard reference code sets or referential integrity checks against member or provider data.

Table B-7—Study Indicators for Percent Present and Percent Valid

Study Indicator	Denominator	Numerator
Percent Present: Percentage of records with values present for a specific key data element.	Total number of final paid encounter records based on the level of evaluation noted in Table B-8 (i.e., at either the header or detail line level) with dates of service in the study period.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table B-8.
Percent Valid: Percentage of records with values valid for a specific key data element.	Number of records with values present for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table B-8. Note: Since not all HCPCS/CPT codes have Medically Unlikely Edits (MUEs), only service units for procedure codes with an MUE were included in the denominator when calculating this indicator for the data element Service Units.	Number of records with values valid for a specific key data element based on the level of evaluation (i.e., at either the header or detail line level) noted in Table B-8. The criteria for validity are listed in Table B-8.

Table B-8—Key Data Elements for Percent Present and Percent Valid

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Member ID [H]	✔	✔	✔	• In member file • Enrolled in a specific MCO on the date of service • Member Date of Birth is on or before detail date of service
Header Service From Date [H]	✔	✔		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date [H]	✔	✔		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date [D]	✔	✔	✔	• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Detail Service To Date [D]	✔	✔	✔	• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Billing Provider NPI [H]	✔	✔	✔	In provider data when service occurred
Rendering Provider NPI [H]	✔			In provider data when service occurred
Attending Provider NPI [H]		✔		In provider data when service occurred
Servicing Provider Taxonomy Code [D]	✔	✔		• In standard taxonomy code set • Match with the value in provider data
Referring Provider NPI [H]	✔	✔		In provider data when service occurred
Prescribing Provider NPI			✔	In provider data when service occurred
Primary Diagnosis Codes [H]	✔	✔		In national ICD-10-Clinical Modification (CM) diagnosis code sets for the correct code year (e.g., in 2020 code set for services that occurred between October 1, 2019, and September 30, 2020)
Secondary Diagnosis Codes [H]	✔	✔		In national ICD-10-CM diagnosis code sets for the correct code year
CPT/HCPCS Codes [D]	✔			In national CPT and HCPCS code sets for the correct code year (e.g., in 2020 code set for services that occurred in 2020) AND satisfies CMS' Procedure to Procedure Edits [B-5]
Service Units [D]	✔	✔		Positive and below the maximum units of service according to CMS' MUE [B-6]

[B-5] Centers for Medicare & Medicaid Services. PTP Coding Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the Procedure to Procedure Edits in EPS, and HSAG will note this in the final aggregate report.

[B-6] Centers for Medicare & Medicaid Services. Medically Unlikely Edits. Available at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE. Accessed on: Oct 19, 2021. Currently, DMAS does not apply the MUE edits in EPS, and HSAG will note this in the final aggregate report.

Key Data Elements	837P Encounters	837I Encounters	NCPDP Encounters	Criteria for Validity
Primary Surgical Procedure Codes [H]		✔		In national ICD-10-CM surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes [H]		✔		In national ICD-10-CM surgical procedure code sets for the correct code year
Revenue Codes [D]		✔		In national standard revenue code sets for the correct code year
Diagnosis-Related Groups (DRG) Codes [H]		✔		In the list of all patients refined (APR) DRGs from DMAS [B-7]
Type of Bill Codes [H]		✔		In national standard type of code set
National Drug Codes (NDCs) [D]	✔	✔	✔	In national NDC code sets
HCPCS/NDC Combination [D]	✔	✔ (for type of bill codes starting with "13" or "83")		Met the criteria listed in 2020 Average Sales Price Drug Pricing files [B-8]
MCO Received Date (i.e., the date when the MCOs received claims from providers)	✔	✔	✔	MCO Paid Date ≥ MCO Received Date ≥ Detail Service To Date
MCO Paid Date [D]	✔	✔	✔	MCO Submission Date (i.e., the date when MCOs submit encounters to DMAS) ≥ MCO Paid Date ≥ MCO Received Date
Header Paid Amount [H]	✔	✔		Header Paid Amount equal to sum of the Detail Paid Amount
Header TPL Paid Amount [H]	✔	✔		Header TPL Paid Amount equal to sum of the Detail TPL Paid Amount
Detail Paid Amount [D]	✔	✔	✔	Zero or positive
Detail TPL Paid Amount [D]	✔	✔	✔	Zero or positive based on the TPL flag from the encounter data

[H] Conducted evaluation at the header level.

[B-7] Virginia Medicaid Department of Medical Assistance Services. Hospital Rates. Available at: https://www.dmas.virginia.gov/for-providers/rate-setting/hospital-rates/. Accessed on: Oct 15, 2021.

[B-8] Centers for Medicare & Medicaid Services. 2020 ASP Drug Pricing Files. Available at: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2020-asp-drug-pricing-files. Accessed on: Oct 19, 2021. Currently, DMAS does not apply this edit in EPS, and HSAG will note this in the final aggregate report.

[D] Conducted evaluation at the detail level.

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 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members and the CAHPS 5.1H Child Medicaid Health Plan Survey to child Medicaid members enrolled in their respective MCO.[B-9] Aetna, HealthKeepers, 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. In addition, Aetna, Optima, and United 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 2021.

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.[B-10] 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 5.1H Surveys include a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions [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

[B-9] Aetna, HealthKeepers, Magellan, Optima, United, and VA Premier administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions (CCC) measurement set to their child Medicaid populations. For purposes of this report, the child Medicaid CAHPS results presented for the MCOs represent the CAHPS results for their general child populations (i.e., general child CAHPS results).

[B-10] 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 2021 CAHPS scores for each MCO and the statewide aggregate were compared to the 2020 NCQA Medicaid national averages.[B-11] 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 2021 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 5.1H 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 5.1H 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.

[B-11] 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 MY 2020 HEDIS results, including MY 2020 CAHPS data from six Virginia MCOs serving the CCC Plus population for presentation in the 2021 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 MCO's CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2020. The *HEDIS MY 2020 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 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 2021 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, MCO customer service, and their overall health care.
- **Doctors' Communication**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding how well their doctors communicate and the overall ratings of personal doctors and specialists seen most often. This category also includes children with chronic conditions CAHPS composites and question summary rates related to family centered care and coordination of care for children with chronic conditions. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. Additionally, this category assesses a HEDIS measure related to adults' access to care and children with chronic conditions CAHPS question summary rates related to access to specialized services and prescription medications. Additionally, this category includes HEDIS measures on how well MCOs perform related to preventive screenings for breast cancer and cervical cancer, as well as appropriate treatment for acute bronchitis/bronchiolitis and low back pain.
- **Behavioral Health**: Includes HEDIS measures that assess how often members remain on medications, appropriate care for members with alcohol and other drug abuse or dependence, and follow-up services for mental illness and alcohol and other drug abuse or dependence.

- **Taking Care of Children**: Includes HEDIS measures regarding how often preventive services and appropriate treatment are provided to child members (e.g., immunizations, well-child/well-care visits, weight assessment and counseling for nutrition and physical activity, metabolic monitoring for children and adolescents on antipsychotics, and the use of psychosocial care as a first-line treatment for children and adolescents on antipsychotics).
- **Living With Illness**: Includes HEDIS measures related to the appropriate treatment for people who have chronic conditions (e.g., diabetes, high blood pressure, chronic obstructive pulmonary disease [COPD]). In addition, this category includes HEDIS measures that assess medication management for people with asthma and schizophrenia or bipolar disorder.

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 are included in this analysis, as well as many measures required by the CCC Plus Technical Manual for Reporting.[B-12] Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Survey with Children with Chronic Conditions item set was used for the child population.

Table B-9 lists the 67 measure indicators, 28 CAHPS and 39 HEDIS, and their associated weights.[B-13] Weights are 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 the Comparing MCO Performance section for more details.

Table B-9—CCC Plus Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Category: Overall Rating [B-14]	
Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
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 All Health Care (CAHPS Global Rating)	1
General Child Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Health Care (CAHPS Global Rating)	1

[B-12] Virginia Department of Medical Assistance Services. *CCC Plus Technical Manual*. Version 2.7.

[B-13] The following measures were removed from the 2021 Consumer Decision Support Tool analysis due to half the MCOs having *Not Applicable (NA)*, *Not Reported (NR)*, or *Biased Rate (BR)* designations: *General Child Medicaid—Customer Service* (CAHPS Composite), *Children with Chronic Conditions Medicaid—Customer Service* (CAHPS Composite), *Children with Chronic Conditions Medicaid—Coordination of Care for Children with Chronic Conditions* (CAHPS Question Summary Rates), and *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*.

[B-14] To calculate the Overall Rating category, all 67 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating category are exclusive to the reporting category.

Measures	Measure Weight
Adult Medicaid—Customer Service (CAHPS Composite)	1
Category: Doctors' Communication	
Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
General Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	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 Specialist Seen Most Often (CAHPS Global Rating)	1
General Child Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	1
Children with Chronic Conditions 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	
Adult Medicaid—Getting Needed Care (CAHPS Composite)	1
General Child Medicaid—Getting Needed Care (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Getting Needed Care (CAHPS Composite)	1
Adult Medicaid—Getting Care Quickly (CAHPS Composite)	1
General Child Medicaid—Getting Care Quickly (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Getting Care Quickly (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Access to Specialized Services (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
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	
3 Months–17 Years	1/3
18-64 Years	1/3

Measures	Measure Weight
65+ Years	1/3
Use of Imaging Studies for Low Back Pain	1
Breast Cancer Screening	1
Cervical Cancer Screening	1
Category: Behavioral Health	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Initiation of Alcohol and Other Drug Treatment—Total	1/2
Engagement of Alcohol and Other Drug Treatment—Total	1/2
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	1
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	1
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	1
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Category: Taking Care of Children	
Childhood Immunization Status—Combination 3	1
Immunizations for Adolescents—Combination 2	1
Well-Child Visits in the First 30 Months of Life	
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	1
Child and Adolescent Well-Care Visits	
3–11 Years	1
12–17 Years	1
18–21 Years	1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	1
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1
Category: Living With Illness	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	1/5

Measures	Measure Weight
HbA1c Poor Control (>9.0 Percent)	1/5
HbA1c Control (<8.0 Percent)	1/5
Eye Exam (Retinal) Performed	1/5
Blood Pressure Control (<140/90 mm Hg)	1/5
Controlling High Blood Pressure	1
Asthma Medication Ratio—Total	1
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	1/2
Bronchodilator	1/2
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1

Missing Values

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

- *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 six 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 six reporting categories (Overall Rating, Doctors' Communication, Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

- 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.
- 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:

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

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

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

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

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
$\bar{x}_j$ = MCO mean for question j
N = members responding to at least one question in the composite

- For MCOs with *NA* or *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.
- HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
- 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 weighting.
- HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
- 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

- 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.
- 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*

- 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.

Table B-10 shows how the CCC Plus Consumer Decision Support Tool displays results were displayed:

Table B-10—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.
★★★★	**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.[B-15]

[B-15] 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 SFY 2021 PWP (i.e., CY 2020 data), as indicated in Table B-11.

Table B-11—SFY 2021 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Behavioral Health		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of Alcohol and Other Drug Treatment—Total—Total	HEDIS	Administrative
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of Alcohol and Other Drug 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—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 SFY 2021 PWP assesses CY 2020 performance measure data (i.e., the performance measures will be calculated following the HEDIS 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

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 B-12 provides the HEDIS and non-HEDIS audit designations that will be eligible or ineligible to receive points in the PWP.

Table B-12—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 B-12, 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)

SFY 2021 PWP

The SFY 2021 PWP will use the MCO's audited HEDIS MY 2020 and validated CMS FFY 2021 Adult Core Set performance measure data. Table B-13 shows the percentage of withhold associated with each performance measure indicator.

Table B-13—SFY 2021 PWP Measure Weights

Indicator	Measure Weight
Behavioral Health	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	7.5%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	7.5%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	10%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	10%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of Alcohol and Other Drug Treatment—Total—Total	7.5%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of Alcohol and Other Drug Treatment—Total—Total	7.5%
Chronic Conditions	
Comprehensive Diabetes Care—Hemoglobin A1c (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 C. MCO Best and Emerging Practices

Table C-1 identifies the MCOs' self-reported best and emerging practices. The narrative within the table was provided by the MCOs and has not been altered by HSAG except for minor formatting.

Table C-1—MCOs' Best and Emerging Practices

MCO	Best and Emerging Practices
Aetna	**Aetna Better Health of Virginia Education Series on Chronic Health Conditions** The Education Series Program's primary focus was to empower Aetna's members with the necessary education on managing their chronic conditions and other health concerns. Educating members on chronic condition management which, in return, promoted an improved quality of life. The Education Series on Chronic Health Conditions allowed members to meet with a panel that consisted of staff from care management, pharmacy, community outreach, and behavioral health. The panel also includes a team of affiliated in-network providers, including behavioral health professionals, endocrinologists, pediatricians, obstetricians/gynecologists, social workers, immunization subject matter experts, non-profit organizations, and other appropriate health care professionals that educated members about chronic health conditions. Topics included diabetes management, depression, hypertension, substance abuse and asthma. **Mobile Mammography** In 2021, Aetna Better Health of Virginia's Quality Management department developed a pilot program to partner with an approved in-network health system to offer Aetna Better Health of Virginia members mobile breast cancer screenings. Data analysis conducted determined that Central Virginia, Western/Charlottesville and the Tidewater Regions as having the highest breast cancer rates among MCO membership. As a result, the MCO chose to pilot its mobile mammography in these three regions and partner with University of Virginia Health and Chesapeake Regional Health Systems. Members also had the opportunity to receive an incentive once the screening was completed. Transportation was scheduled in advance for those members that needed assistance. There have been delays in the launch date due to COVID-19, but the MCO anticipated that this initiative will launch successfully in the first quarter of 2022. **Ted E. Bear M.D. Wellness Club** Aetna Better Health of Virginia's Ted E. Bear, M.D. Wellness Club was a program offered to members from newborns to 10 years of age. The program promoted and engaged parents to have their child/children complete an annual well-child check-up. The MCO incentivized each member that completed their annual well-child visit with a $10 Walmart gift card, teddy bear, coloring book, crayons, and bookmark. A well-child visit included a physical exam, shots (if applicable), and a growth and development check. Providers were asked to complete an incentive form at the time of the well-child visit that members returned to the MCO and received their incentives. The program was restructured make incentives more age appropriate.

MCO	Best and Emerging Practices
	In addition to EPSDT, the program also supported the following HEDIS measures: • Childhood Immunization Status - (CIS) • Immunizations for Adolescents - (IMA) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) • Child and Adolescent Well-Care Visits (WCV) • Well-Child Visits in the First 30 Months of Life (W30)
HealthKeepers	• Partnering with care coordinators and case managers to address gaps in care by sharing monthly gaps in care report • Used of Health Crowd vendor started in 2021 that used focused outreach messaging based on member's gaps in care • Continued Critical Performance Steering Committee and workgroups collaboration • Continued collaboration with Medicaid risk team to develop provider education with opportunities for providers/office staff to obtain continuing medical education/continuing education unit credits • Continued leveraging Collective Medical to notify care coordinators via email or text when member had an emergency department visit • Continued behavioral health homes • Refocused improvement for behavioral health and pharmacy measures • Refocused efforts to improve child and women measures • Used Obstetrical practice consultants employed by Anthem to support and collaborate with obstetrical clinicians and office staff to increase obstetrical provider office understanding of member and provider programs for obstetrics. • Used Early, Periodic, Screening, Diagnostic and Treatment co-branding opportunities • Implemented post office visit survey text message to evaluate visit and address complaints/concerns in order to improve member satisfaction
Magellan	**Pay for Quality (P4Q) Program** Magellan chose a set of select, but critical, quality measures for 2021 that were included in this incentive program. The MCO will pay the primary care group of record a dollar amount per each compliant member after that provider achieves the 50th percentile benchmark for that measure for their assigned panel. **Clinic Day** Magellan partnered with community providers by holding clinic day events for its members. The Clinic Day offered a fun way to encourage members to: • Obtain the health services they needed • Improve health outcomes. • Improve HEDIS score/close care gaps. • Improve member/provider experience.

MCO	Best and Emerging Practices
	Magellan's approach included 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's partnered with providers by scheduling member appointments, arranging transportation service, and performing reminder calls. As a result, the MCO reduced administrative burden on provider office staff, decreased no-show rates, and improved member/provider experience.
Optima	**Best Practices** • Weekly medical and behavioral care coordination /case management rounds with medical directors • Quarterly baby showers • Quarterly outreach Member Advisory Forums (currently virtual) • Dedicated Optima readmission prevention team with (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.) • Case management/care coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Partners in Pregnancy (PIP) program • Performance Withhold Program monthly tracking grid • Multidisciplinary team approach to improvement in quality measures, meeting monthly • Vendor/partners in care: EMMI, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group (IEG), Ontrak, Lexus Nexus, Focus Care in-home assessments, Progeny, Accordant, Inogen • Focused Early, Periodic, Screening, Diagnostic and Treatment Care Coordination • Behavioral health member engagement program to improve follow-up visits with providers after emergency department visits • Focused vendors for Community Partners in member care: Urban Baby Beginnings, CHIP, Healthy Families, Southeast trans for medical/behavioral health/non-medical transportation • Focused Community Partners for improving social determinants of health (SDoH): United Us, Local Food Banks, Religious Organizations, Salvation Army, STOP Inc (rent, utility assistance), Virginia Department of Health Baby Care Programs, Local Shelters, Local Woman's Shelters, GED Program with financial voucher • Readmission High Risk Discharge Target and Intervention Committee • Power Hour for all staff to provide weekly educational sessions (examples: Asthma, COPD, Diabetes, Motivational Interviewing, Policy and Documentation updates, etc.) • Follow up post-discharge activities (Cipher)

MCO	Best and Emerging Practices
	• Focused workgroups to impact DMAS Clinical Efficiency measures: – LANE – PPE – Readmissions • Staff training: – 2021 NCQA standards and HEDIS training for Medallion case management – Annual Medicare and Dual Special Needs Plan model of care/product training • Increased access for remote services for staff and members related to COVID-19 • Automated EMMI campaigns (educational videos for members) - Postpartum • Monthly collaboration with Prealize for case studies and process improvements • MCO Collaboratives with Virginia Health Information (VHI) • Collaborative Stakeholder with Brock Institute at Eastern Virginia Medical School for Substance Use Disorder in Pregnant Moms and Parenting Women • DMAS/Optima COVID-19 collaboration to improve member education and access to testing and vaccination • Collaborative partners with DMAS MCO Early Intervention Workgroup and DMAS MCO Foster Care Workgroup **Population Health:** • Newly Developed Population Health Department that encompassed population care, innovations portfolio management, and performance improvement teams • Population Care Team: – Provider-led – Developed and implemented health plan-based gap closure interventions: o A1c and FIT at home testing kit programs o Diabetic eye exam campaign collaboration with community eye care provider group • Innovation Portfolio Management Team: – Developed and utilized a standardized process for innovation portfolio management: o Research, Evaluation & Contracting o Pilot and Validation o Scaling, Monitoring and Promotion o Operations and Optimization – Maintained current partnerships with vendors to facilitate and promote member self-care management – Continued exploration of emerging technology and partnerships to improve health outcomes for our members • Performance Improvement Team:

MCO	Best and Emerging Practices
	– Created performance withhold program dashboard – Performance withhold program measure improvement reviewed monthly and as needed in interdepartmental collaborative meetings – In-home assessments for care gap closure – Establishment of standardized reports for all levels in the organization – Ensured that all team members in the organization had access to needed data to ensure improvement efforts were aligned – Establishment of a member and provider satisfaction improvement committee **Quality Improvement and Accreditation:** • Newly developed quality improvement and accreditation department that encompassed contractual and regulatory, NCQA / accreditation/ certifications, and HEDIS Teams • Contractual and Regulatory Team: – Reviews and reporting of Critical Incidents merged to one team. ○ Streamlined processes where possible. – Completed performance improvement projects. – Developed tracking grid for reporting requirements. • NCQA/Accreditation/Certifications Team: – Formalized annual NCQA standards training. – Developed plan for quarterly NCQA mock file audits. – Structured oversight of quality programs/committee governance. • HEDIS Team: – Implemented yearlong medical record retrievals, data abstractions, and overreads for gap closure. – Electronic medical record program – Daily review of quality improvement ancillary mailbox for gap closures from CCS and population health – Validating incentives for supplemental data **<u>Emerging Practices for Medallion 4.0 and CCC Plus:</u>** • Vendor/Partners in care: Ontrak (BH), Lexus Nexus, Focus Care in-home assessments, Dario, Carenet • Interdepartmental committee evaluating enhanced member benefits for 2022 to improve SDoH • Additional automated EMMI campaigns (educational videos for members) • Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection

MCO	Best and Emerging Practices
	• Targeted behavioral health care coordination focusing on inpatient discharges, emergency room utilization and high-risk readmission member focus from behavioral health facilities. • Dedicated behavioral health transition of care coordinators. • Increased focus on SDoH and health equities with creation of a focused SDoH team collaborating with medical and behavioral utilization management/case management departments. • New electronic medical record system with increased capturing of SDoH.
United	• During the COVID-19 national public health emergency, United supported primary care providers and Federally Qualified Health Centers by accelerating funds aligned with the MCO's Community Plan Primary Care Professional Incentive (CP-PCPi) Program, including adding a Capacity Building Pathways component to the Program for provider investment in one of the following areas: – Telemedicine and digital engagement – Novel care strategies – Transitions of care – Collaboration with community organizations – Addressing social needs • United worked with community providers by holding clinic day events for Medicaid members and the community at-large. COVID-19 vaccinations and immunizations were the focus, along with ensuring members obtained other health services as needed and to promote an improved member/provider experience. • United implemented telehealth visits (with both providers and care coordinators) in lieu of face-to-face visits during the COVID-19 PHE, allowing members to receive quality care coordination and services safely in their home. • United was focused on reducing health inequities. To that end, a cross-functional program fosters a holistic approach in reducing health disparities and enhancing the end-to-end consumer experience. Actions included: 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 creation of action plans to address any identified disparities. • **Regional, Complex and Behavioral Health Rounds:** United's regional, complex and behavioral health rounds program consisted of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly program addressed both immediate and long-term member needs, provides support and resources to ensure member's needs were met and promotes quality outcomes. • **Long-Term Care to Community Rounds:**

MCO	Best and Emerging Practices
	– United's long-term care to community rounds program consisted of care coordinators and representatives from pharmacy, behavioral health, utilization management, and external colleagues as needed. The weekly meeting focused on addressing barriers to transition to the community including natural support, home and community-based services (Personal Care/Attendant Care/Private Duty Nursing), environmental modifications and durable medical equipment. • In addition to using member-level HEDIS and other quality measures, renewed focus with team on monitoring under-utilization of key services that were critical to supporting member needs (e.g., home and community-based services, behavioral health).
VA Premier	**Behavioral Health** • Behavioral Health Care Coordination Crisis Stabilization Provider Outreach Initiative - Care coordination effort to prevent inappropriate or further usage of service for crisis stabilization in the Central Region. The initiative focused on member's discharge planning, referrals to additional services (i.e., behavioral health services, housing, etc.), and safety planning. • Behavioral Health Transition Care Coordination Initiative – Behavioral health care coordination team supported all members who had a behavioral health inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. • Behavioral health chronic care coordinators worked with the enhanced care coordination program that required targeted case managers employed with Community Service Boards (CSBs) to conduct seven-day follow-up with members discharged from acute care facilities. • Behavioral health inpatient reviewers sent notification at admission and discharge to member's care coordinator and/or transition coordinator to initiate discharge planning with inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce chance for member readmission. **Clinical Care Services** • Reorganized the transition of care (TOC) team and processes to provide higher level quality of care for our member • Targeted members prior to discharge within 72 hours of inpatient hospitalization. • Collaborated with the discharge planners at the facilities to ensure member's needs were met prior to discharge for a successful transition and to prevent readmission • Facilitated/collaborated with the nursing facility to ensure successful transition into community-based setting for CCC Plus members • Initiated skilled nursing facility rounds to decrease length of stay and to provide optimal transition back into the community

MCO	Best and Emerging Practices
	• Used the Theory of Constraints (TOC) model to enhance collaboration with high-risk behavioral health member needs • Measured goals based on current readmission rates for Medallion 4.0 and CCC Plus and percentage of transitions • Focus placed on SDoH, decreasing readmission rates, and increasing percentage of transitions. **Quality and Accreditation** • Practitioner Golden Globe Award (PGA) • Virginia Premier valued quality and safety, especially when coordinating and managing care for members. To promote, enhance, and salute excellence, the MCO sustained a physician recognition program. • Practitioners were recognized for their dedication to quality care, member safety, and improved member outcomes. Annually, the selected recipient was awarded a trophy and certificate for demonstrating commitment to quality and safety. • Quality NCQA internal auditing team • Used a corporate centralized team that managed every NCQA program and associated activities for all lines of business. A best practice model 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 consistent interpretation of standards, annual organizational training, monthly departmental collaborative meetings, and a standardized, quarterly auditing program with trended outcomes. As a result of audit outcomes, refresher training was developed and conducted as needed. • Conducted organizational provider virtual site visits • Due to the COVID-19 PHE, NCQA granted health plans the liberty to conduct virtual assessments as an acceptable form of survey. These types of visits enabled prompt service, productive follow-ups, and more specific scheduling. Virtual inspections were conducted between an organizational provider and the MCO using the video call function on a smartphone or tablet. **Virginia Premier utilized the following innovation to conduct virtual surveys:** • Google Earth – Allowed the MCO to review the exterior of a facility, building, or structure's accessibility, appearance, and adequacy. Google Earth allowed site

MCO	Best and Emerging Practices
	surveyors to review the following independent of assistance from the organizational provider: – Adequacy of parking and building access – Physical appearance – Exterior signs – Handicap parking – Ability to safely approach a facility As a result of this innovative initiative, Virginia Premier conducted 239 virtual Organizational Provider Site Surveys in 2020 and 187 year-to-date for 2021. 100 percent of providers received a passing score without any corrective action imposed. These providers were credentialed to provide needed services to members and help maintain network adequacy. **Member Outreach and Maternity Program** • Conducted outreach to pregnant and postpartum members at least monthly and screen for high-risk conditions and postpartum depression • Supplied new moms and families with healthy meals weekly • Provided source food vouchers for fresh fruits and vegetables in food deserts • Educated members on COVID-19, to include immunizations, via virtual social events, text messaging campaigns, and direct member contact • Administered contact free drop off for urgently needed supplies such as diapers, car seats, pack and plays, and formula for those awaiting WIC appointments • Supplied members with free breast pumps, education, and support of breastfeeding and pumping • Facilitated quarterly virtual baby showers and Member Advisory Committee meetings • Enhanced virtual presence to remotely reach members • Hosted Facebook Live events (COVID-19, breastfeeding awareness) **Pharmacy** Pediatric Atypical Antipsychotic Program • Implemented clinical coordination program for those members aged 6-12 who were taking an atypical antipsychotic • Mailed care coordination letters to member's primary care providers and prescriber of atypical antipsychotic • Ensured appropriate clinical monitoring of the member being completed and reported • Team meetings were held monthly to discuss program, suggest any improvements, and review data results

MCO	Best and Emerging Practices
	Hepatitis C Program • Maintained clinical program to help adherence and therapy completeness • Specialty pharmacy provided member information to care coordinators on who filled Hep C therapy • Care coordinators outreached to members to educate on side effects and provided any additional support needed • Specialty provider sent quarterly and annual reporting, including SVR12 lab work, to show effectiveness of program

Appendix D. MCO Quality Strategy Quality Initiatives

Table D-1 through Table D-6 provide examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2020–2022 Quality Strategy's goals and objectives. Note: The narrative within the Quality Initiatives section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

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

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	AAP SMS Soft Launch: Members will be sent approximately 1-3 messages each month. If a member is in multiple campaigns, ex. AWC, AAP, BCS, the messages will be staggered so that the member is not bombarded. The timeline can vary for each member, depending on when they are enrolled in the individual campaign.	**Metric 4.3.2:** (AAP) Adults' Access to Preventive/Ambulatory Health Services (Total)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	AAP SMS Soft Launch: Members will be sent approximately 1-3 messages each month. If a member is in multiple campaigns, ex. AWC, AAP, BCS, the messages will be staggered so that the member is not bombarded. The timeline can vary for each member, depending on when they are enrolled in the individual campaign.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 3: Smarter Spending **Goal 3.2:** Focus on Efficient Use of Program Funds	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (AAB) Avoidance of Antibiotic Treatment for Acute Bronchitis
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan	**Metric 4.3.2:** ((AAP) Adults' Access to Preventive/Ambulatory Health Services (45-64)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Prevention Services for Members	staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.2:** (AMR) Asthma Medication Ratio (Total)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (PBH) Persistence of Beta-Blocker Treatment after a Heart Attack
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation - Bronchodilator
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when	**Not a Quality Strategy Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	applicable), that will facilitate with educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Attention for Nephropathy
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with educating members on managing various chronic conditions.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Aetna Better Health of Virginia Education Series on Chronic Health Conditions: Various Education sessions for members with chronic conditions, which includes a panelist of health plan staff and non-profits (when applicable), that will facilitate with	**Not a Quality Strategy Metric:** (SPC) Statin Therapy for Patients With Cardiovascular Disease

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
	educating members on managing various chronic conditions.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Benefits of Quitting Tobacco Use Cessation in Pregnant Women: Flyer cobranded with the American Cancer Society to discuss the benefits of quitting smoking/tobacco cessation and the risks of smoking during pregnancy.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	BH Hospitalization Taskforce: To improve collaboration and support between UM, CM, and BH departments in working with members.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 30 days
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	BH Hospitalization Taskforce: To improve collaboration and support between UM, CM, and BH departments in working with members.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 7 days
	CVS Health Tags: Messages attached to Rx bags for flu vaccination.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes and Cholesterol Member Mailer: Educational letter sent to members pertaining to diabetes and cholesterol medication management.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Diabetes Mailer: Incentive for members that complete a yearly wellness and diabetic exam.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Emergency Department Visits Telephonic Outreach Visit: Call is made to member with 1 OP visit and 2+ ED visits.	**Metric 3.1.4:** (AMB) Ambulatory Care - Outpatient Visits/1000 MM (Total)
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Ensuring Timeliness of Prenatal Care Quitting for Good: Flyer outlining unsafe habits during pregnancy.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Ensuring Timeliness of Prenatal Care Telephonic Outreach: Call made to identified pregnant members to provide education and encourage 1st trimester prenatal care to reduce risk of preterm or low birth weights.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.1:** (ADV) Annual Dental Visit (11-14 Yrs.)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.4:** (AWC) Adolescent Well-Care Visits
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.6.3:** (CIS) Childhood Immunization Status

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members		
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.3.4:** (IMA) Immunizations for Adolescents
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (LSC) Lead Screening in Children
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Metric 4.6.5:** (W15) Well-Child Visits in the first 15 Months of Life (6 or more visits)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (W34) Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - BMI percentile (Total)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date with any immunizations. Monthly mailing based on child's birthday and gaps in care.	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - for Nutrition (Total)
Aim 4: Improved Population Health	EPSDT Mailing: Mailer sent to members (parents), as a reminder for child to have wellness visits with PCP and to keep up to date	**Not a Quality Strategy Metric:** (WCC) Weight Assessment Counseling - Physical Activity (Total)

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	with any immunizations. Monthly mailing based on child's birthday and gaps in care.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Follow up After Discharge Keep Your Doctor in the Know: Letter mailed to identified members providing education of importance in engaging in follow up appointment within 30 days after hospital discharge.	**Metric 3.1.3:** (FUD) Follow Up After Discharge
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Follow up After Discharge Outbound Call Logic: Outbound caller ID is updated to identify CM calls to members; Member received education from CM re: the importance of engaging in a 30-day post-discharge follow up visit with a PCP or specialist and is provided with assistance with making the appointment if needed	**Metric 3.1.3:** (FUD) Follow Up After Discharge
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	Higher Utilizer Rounds: Integrative round with UM, BH, MM, CM, Pharmacy, PSS representation to focus on stabilizing one member at a time who is a high utilizer of BH IP hospitalizations.	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	Hospital Fax blast: The goal is to ensure that discharging physicians prescribe psychiatric medications that are on formulary, thereby avoiding delays and lack of continuity with medications.	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.2:** (PDI 14) Asthma Admission Rate 2-17 YO
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.3:** (PQI 05) COPD and Asthma in Older Adults Admissions Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Hospital Readmission Reduction Program: Clinical program focused on coordinating care between providers, Case Managers and Clinical Pharmacists as members are discharged from the hospital.	**Metric 4.4.1:** (PQI 08) Heart Failure Admissions Rate

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Maternity Incentive Program: Incentive for members going to all prenatal appointments and postpartum check-up.	**Metric 4.6.1:** (PPC) Prenatal and Postpartum Care - Postpartum Care
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Maternity Incentive Program: Incentive for members going to all prenatal appointments and postpartum check-up.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care - Timeliness of Prenatal Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MS Hold Line Flu Shot Message: When members call into plan, they will hear a recorded message reminding them to get their free flu shot.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Attention for Nephropathy
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health	PMMP Plan Education (Care Management): Pharmacy Advisor	**Metric 4.6.3:** (CIS) Childhood Immunization Status - Combo 3

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.6: Improve Outcomes for Maternal and Infant Members	led plan education for our Effectiveness of Care measures specifically for our Care Management department.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.6.3:** (CIS) Childhood Immunization Status - Combo 10
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	(IMA) Immunizations for Adolescents
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 30 days
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.1.1:** (FUH) Follow Up After Hosp For Mental Illness - 7 days
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.2:** (AMR) Asthma Medication Ratio (Total)
Aim 3: Smarter Spending **Goal 3.2:** Focus on Efficient Use of Program Funds	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (MRP) Medication Reconciliation Post Discharge

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Outcomes for Members with Substance Use Disorders	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.2.3:** (HDO) Use of Opioids at High Dosage
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.1:** (PQI 08) Heart Failure Admissions Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Not a Quality Strategy Metric:** (PQI 15) Asthma in Younger Adults Admission Rate
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	PMMP Plan Education (Care Management): Pharmacy Advisor led plan education for our Effectiveness of Care measures specifically for our Care Management department.	**Metric 4.4.2:** (PDI 14) Asthma Admission Rate 2-17 YO
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (COL) Colorectal Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.5:** (CBP) Controlling High Blood Pressure
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Blood Pressure Control (<140/90)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care - Eye Exams

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (PSA) Non-Recommended PSA-Based Screening in Older Men
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Primary Health Care Model for Adults: Brochures outlining important health screenings to complete with PCP and/or specialist; gender specific	**Not a Quality Strategy Metric:** (CHL) Chlamydia Screening in Women - Total
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Tobacco Use Cessation in Pregnant Women Telephonic Outreach: Calls made to identified pregnant smokers and inform members of available resources and options to engage in smoking cessation.	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care
Aim 4: Improved Population Health **Goal 4.3:** Improve Outcomes for Members with Substance Use Disorders	Weekly Overdose Outreach Project: Provides benchmark for how many members are in treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for Drug or ETOH overdose, these members are outreached by BH Department to assure safety and encourage engagement in OP SA services.).	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Outcomes for Members with Substance Use Disorders	Weekly Overdose Outreach Project: Provides benchmark for how many members are in treatment (reports from Pre-Manage are reviewed weekly for recent ED admits for Drug or ETOH overdose, these members are outreached by BH Department to assure safety and encourage engagement in OP SA services.).	**Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Well Woman Exam: Incentive for members that completes their Pap test and mammogram.	**Not a Quality Strategy Metric:** (BCS) Breast Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Well Woman Exam: Incentive for members that completes their Pap test and mammogram.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (BCS) Breast Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (CCS) Cervical Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (CDC) Comprehensive Diabetes Care - Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Metric 4.4.4:** (CDC) Comprehensive Diabetes Care – Hemoglobin A1c (HbA1c) Testing

Virginia Quality Strategy Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (COL) Colorectal Cancer Screening
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (Flu) Flu Vaccinations for Adults Ages 18-64
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Wellness Rewards Program: Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a Quality Strategy Metric:** (PSA) Non-Recommended PSA-Based Screening in Older Men

HealthKeepers

Table D-2—HealthKeepers' Quality Strategy Quality Initiatives

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1 :** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.2:** Ensure Access to Care	• Created a process for Care Coordinators to address Gaps in Care with members • Expanding text messaging and social media campaigns for member outreach • Tracking/trending SDOH needs of members to determine appropriate outreach for preventive care • Assessing for and reducing any disparities pertaining to race/ethnicity/language • Dedicated Case Managers to provide outreach to members who have had a recent ER visit to provide education	**Metric 1.2.3:** Rating of All Health Care **Metric 1.2.1:** Getting Care Quickly **Metric 2.2.3:** Getting Needed Care
Aim 1: Enhance Member Care Experience **Goal 1.1 :** Improve Member Satisfaction	Annually, Anthem Virginia completes a thorough evaluation of member experience by analyzing member complaints and appeals in	**Metric 1.2.3:** Rating of All Health Care **Metric 1.2.1:** Getting Care Quickly **Metric 2.2.3:** Getting Needed Care

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 2: Effective Patient Care **Goal 2.2:** Ensure Access to Care	conjunction with CAHPS member experience survey results. As a result, the following interventions were implemented: • Meetings held on a regular basis with transportation vendor • Corrective action plan put into place with transportation vendor • Provider offices can chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information can be submitted electronically to pre-authorization department • Added availability of provider telehealth to online physician directories • Added information to member website that has information on getting care that is easy to find, including Quick Start Guide • Network Operations Team enhanced servicing model to increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met. • Work with member communications group to determine the most meaningful way to display important information contained in member handbook • Pursuing digital communication capabilities for members and providers.	

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.3:** Improve Home and Community-Based Services	• Evaluated QMR process and made internal changes to that ensure accuracy of process and reporting • Added staff to ensure reviews were done timely and to ensure access to care	**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
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support	• Provider offices can chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information can be submitted electronically to pre-authorization department • Collaborated with Medicaid Risk Team to develop provider education opportunities for providers/office staff to obtain CMW/CEU credits • Network Operations Team enhanced servicing model to increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met.	**Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate
Aim 2: Effective Patient Care **Goal 2.2:** Ensure Access to Care	• Performed an analysis of primary care and behavioral health services along with specialty care practitioner appointment accessibility to ensure timely access to care for members. • Added availability of provider telehealth to online physician directories • Added information to member website that has information on getting care that is easy to find, including Quick Start Guide • Network Operations Team enhanced servicing model to	**Metric 2.2.3:** Getting Needed Care **Not Quality Strategy Metrics:** • Monitor Network Adequacy • Access and Availability Survey • After Hours Care Survey

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	increase proactive engagement with providers. • Provider Orientation webinars held monthly to educate providers, highlighting appointment standards and importance of compliance with standards. • Telehealth and Nurse Line was available. Outreach specialists made calls to high risk members to make sure their needs were met.	
Quality Strategy Aim not provided. Quality Strategy Goal: Reduce Patient Harm	• Identifying and monitoring complaints and grievances and reported quality of care and service issues • Analyze and take action on issues related to quality of care and patient safety • Monitor and provide information to members and practitioners regarding hospital quality data reports on patient safety • Monitor process to determine if critical incidents and potential quality of care concerned are identified, investigated, tracked and reported and any necessary corrections have been implemented. • Credentialing and re-credentialing process in place to confirm practitioners' and providers' credentials and qualifications to practice as network providers and to perform services appropriately within their scope of practice • Establish and monitor implemented procedures for safety in pharmaceutical prescribing and medication management through various operational alerts • Quality of Care Database to track the resolution of quality of care and critical incident issues • Conduct a monthly Medical Advisory Committee (MAC), composed of network providers,	**No Quality Strategy Metric**

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	representing primary care, Pediatrics, Psychiatry and Health Plan Medical Directors. The committee reviews and approves care management policies and guidelines, reviews and votes annually on our UM and CM program documents, provides critical input to Plan programs and initiatives, and reviews quality of care issues for referral to the plan's credentialing committee. • Developing a process for early identification of members with complex medical needs who may be eligible for additional services that will provide them with the highest quality of care by referring them to appropriate state agencies as indicated. Case Management Team will work to ensure that members are given guidance and support while going through the process of applying for community based waiver services ensuring that safety and medical needs are met.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	• Clinical Efficiencies-DMAS	**Metric 3.1.2:** Frequency of Emergency Department Visits
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	• Utilize 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 • Health Plan staff collaboration within Quality and BH depts. at Health Plan to evaluate member (gap in care) missing services list and implement interventions & strategies. • Telehealth option that provides both medical (urgent care) and behavioral health services (psychology and psychiatry).	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	HealthCrowd promotion/marketing. • Provider education to entire Anthem provider network to educate providers regarding HEDIS specifications. Includes both medical and behavior health HEDIS procedures and documentation requirements. • Field-based staff case management and/or non-clinical peer supports to locate and engage members to follow up with appointments and medications. • BH Provider Incentive Program-Partnership with select CMHCs to reward providers for improvements in selected HEDIS measures. • ADHD New Start Program-Analysis of pharmacy claims identify a new (first time) prescription for ADHD medications. Member IVR telephone New Start education, Member telephone IVR Follow Up Care education and education mailings. • ADHD Pharmacy - Prescriber Outreach- Retrospective drug utilization review (DUR), notifying most frequent Prescriber of ADHD recommendations with Pharmacy Care Notes (PCN). • Medication Synchronization-Enterprise Pharmacist: Allows pharmacy to override Refill Too Soon edit with a shorter day supply with a prorated copay so they can make one trip to the pharmacy for all refills- this will help with adherence.	
Aim 4: Improved Population Health **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders	• Utilize 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	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Health Plan staff collaboration within Quality and BH depts. at Health Plan to evaluate member (gap in care) missing services list and implement interventions & strategies. • Telehealth option that provides both medical (urgent care) and behavioral health services (psychology and psychiatry). HealthCrowd promotion/marketing. • Provider education to entire Anthem provider network to educate providers regarding HEDIS specifications. Includes both medical and behavior health HEDIS procedures and documentation requirements. • Field-based staff case management and/or non-clinical peer supports to locate and engage members to follow up with appointments and medications. • BH Provider Incentive Program-Partnership with select CMHCs to reward providers for improvements in selected HEDIS measures.	Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening and Prevention Services for Members **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Care Compass HEDIS Alerts: Case managers, during regular contact with members, provide reminders of missed services and education on missed services. • HealthCrowd: Multi-model (IVR call, SMS, email, Text) Informative/educational message to members regarding the 4 diabetes screenings & to remind them to make an appointment with their PCP. • Gaps in Care Reports: Data reports generated from HEDIS data set, and letters are sent to providers with list of members to follow-up to ensure services are completed. Returned medical records are data entered into the MRDB.	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life Child and Adolescent Well Care Visits **Not a Quality Strategy Metric** Breast Cancer Screening **Not a Quality Strategy Metric** Cervical Cancer Screening **Not a Quality Strategy Metric** Chlamydia Cancer Screening **Not a Quality Strategy Metric** Children and Adolescents Access to Primary Care Practitioners

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• PQIP - The Provider Quality Incentive Program (PQIP or the Program) rewards our valued providers for the quality care they provide our Medicaid members. Using a system of Scorecard Measures, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. Eligible PCPs who meet quality benchmarks and improvement and medical cost management targets will receive additional payments. • Provide information on new transportation vendor prominently on member website. • Partnering with CDT Team, Provider Relations, and Marketing to identify and educate providers with low quality scores. • Continuous HEDIS training for Case Managers/Care Coordinators. • Care Coordinators continue addressing gaps in care with members by using the Gap in Care Report. • Expanding HealthCrowd messaging campaigns. • Social Media ads Facebook/Instagram – monthly revolving topics. • Updated Coding Book for providers/CPT II Code cheat sheets. • American Cancer Society (ACS) collaboration. • Implementing Standing Order initiative for Breast Cancer Screenings. • Continue to investigate Mammogram Bus opportunities. • Tracking/trending SDOH needs of members to determine appropriate outreach for preventive care.	
Aim 4: Improved Population Health	• Anthem offers a Diabetes Disease Management Program to encourage member self-care efforts, health care education	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Goal 4.4: Improve Health for Members with Chronic Conditions	and provides effective intervention points. Diabetes Disease Management is offered to identify members by licensed clinicians. • Care Compass HEDIS Alerts: Case managers, during regular contact with members, provide reminders of missed services and education on missed services. • HealthCrowd: Multi-model (IVR call, SMS, email, Text) Informative/educational message to members regarding the 4 diabetes screenings & to remind them to make an appointment with their PCP. • Gaps in Care Reports: Data reports generated from HEDIS data set, and letters are sent to providers with list of members to follow-up to ensure services are completed. Returned medical records are data entered into the MRDB. • PQIP - The Provider Quality Incentive Program (PQIP or the Program) rewards our valued providers for the quality care they provide our Medicaid members. Using a system of Scorecard Measures, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. Eligible PCPs who meet quality benchmarks and improvement and medical cost management targets will receive additional payments. • Healthy Rewards offers diabetic members $25 to complete the diabetic retinal eye exam every 12 months.	**Metric 4.4.5:** Controlling High Blood Pressure **Not a Quality Strategy Metric** Comprehensive Management of Diabetes-all indicators
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Develop FAQ for the National Call Center to educate/inform members of Doula services and benefits beginning Jan 2022. • Educate members on importance of postpartum visit. Internal prevention-based program that	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	focuses on education and monitoring of pregnant women (during the prenatal/postpartum periods) and their newborns (through the first 90 days of life). This program, New Baby, New Life™- focuses on proactive outreach to both providers and members in an effort to address many of the barriers noted above. • Educate members on available transportation resources that may encourage member compliance. • Incentivize practitioners to schedule the postpartum visits and to encourage member compliance. • Incentivize members to schedule the postpartum visits and to encourage member compliance. • Maternal health education by telephone, text message, and by Smartphone app to pregnant and postpartum women. • Twice weekly messaging during the prenatal phase – Weekly postpartum calls – Weekly well child messaging – Interactive Voice Response (IVR) system and asked to complete the screener for high risk conditions – Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. • Identifying pregnant smokers via assessment and SDOH screener. • Developing a text messaging campaign to inform them of available resources and options to engage in smoking cessation. • Increasing participation in OBQIP provider incentive program. OB Practice Consultant will	**Metric 4.6.3:** Childhood Immunization Status

Virginia Quality Strategy Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	collaborate with Provider Relations to pitch program for interest.	

Magellan

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

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (BCS) Breast Cancer Screening **Not a Quality Strategy Metric** (CCS) Cervical Cancer Screening **Not a Quality Strategy Metric** (COL) Colorectal Cancer Screening
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach.	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Partner with community/providers and host immunization campaign and provide incentives and school supplies	(**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life **Not a Quality Strategy Metric** (IMA) Immunization for Adolescents **Not a Quality Strategy Metric** (LSC) Lead Screening in Children

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach. Compliant members receive incentives from our partnered vendor on an agreed upon cadence Claims research for service date and bundle code issues. Providers are educated on the issues and updated.	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	• Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done. • Compliant members receive incentives from our partnered vendor on an agreed upon cadence • Members will receive a certificate based on their A1c outcomes • Vision Centers are incentivized	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia Quality Strategy Aim and Goal	Magellan's Quality Initiative	Performance Metric
	to reach out to members, schedule them and complete the Dilated retinal eye exam • Blood Pressure cuffs sent to targeted members and telehealth visits are facilitated to capture required information • Members are sent home a HgA1c kit to complete	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done.	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC has partnered with MRx vendor partner to do outreach calls and identify barriers preventing members to be medication adherent	**Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio **Not a Quality Strategy Metric** (SAA) Adherence to Antipsychotic medications for individuals with Schizophrenia **Not a Quality Strategy Metric** (AMM) Antidepressant Medication Management
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Member outreach targeting kids before they turn two years old and helping them to schedule appointments to close the CIS measure gaps Compliant members receive incentives from our partnered vendor on an agreed upon cadence	**Metric 4.6.3:** Childhood Immunization Status
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (AMR) Asthma Medication Ratio
Aim: Focus on Screening and prevention **Goal:** Cancers are prevented or diagnosed at the earliest stage possible	MCC is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.	**Not a Quality Strategy Metric** (BCS) Breast Cancer Screening **Not a Quality Strategy Metric** (CCS) Cervical Cancer Screening **Not a Quality Strategy Metric** (COL) Colorectal Cancer Screening

Optima

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

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.2:** Ensure Access to Care *The quality initiative may impact other Quality Strategy aims and goals.*	• Outreach baby showers • Outreach member advisory forums (currently virtual) • Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services, medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Partners in Pregnancy (PIP) Program • Vendor/Partners in care: EMMI, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group, (IEG), Ontrak, Lexus Nexus, Focus Care in home assessments, Progeny, Accordant, and Inogen. • Focused EPST Care Coordination • Behavioral health engagement program to improve follow-up visits with providers after ED visits. • Focused Community Partners for improving Social Dominants of Health (SDOH): United Us, Local Food Banks, Religious Organizations, Salvation Army, STOP Inc.	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.2.3:** Getting Needed Care

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	(rent and utility assistance), VDH Baby Care programs, local shelters, local women's shelters, GED program with financial voucher • Readmission High Risk Discharge Target and Intervention Committee • Automated EMMI campaigns (educational videos for members)- Postpartum • Monthly collaboration with Prealize for case studies and process improvements • Collaborative Stakeholder with Brock Institute at Eastern Virginia Medical School for Substance use Disorder in Pregnant Moms and Parenting Women • DMAS/Optima COVID collaboration to improve member education and access to testing and vaccination • Collaborative partners with DMAS and MCO EI Workgroup and DMAS MCO Foster Care Workgroup • Formation of Corporate Satisfaction Committee- with goal of improving the member and provider experience leading to satisfaction, advancing clinical excellence while providing compassionate member centered care	
Aim 4: *Improved Population Health* **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders **Goal 4.3**: Improve Utilization of Wellness, Screening, and Prevention Services for Members	• Diabetic Eye incentive program, call campaigns, mobile diabetic eye exam events • Enhanced Sentara Diabetes Class communication • Predictive analysis data integration into clinical workflows, engaging members in closing care gaps • In home assessments and quality gap closures	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Metric 4.1.4:** Monitor Mental Health Utilization

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal 4.4: Improve Health for Members with Chronic Conditions **Goal 4.6:** Improve Outcomes for Maternal and Infant Members *The quality initiative may impact other Quality Strategy aims and goals.*	• Collaboration with provider groups to assist with follow up and treatment visit scheduling • Emerging intervention-Partnerships with vendors to facilitate and promote member self-care management • Emerging intervention-Exploration of emerging technology and partnerships to improve health outcomes for our members • Predictive analytics to identify high risk members utilized for CMs to contact and provide asthma control education • Member level care gap data integration into clinical workflows to inform/engage members in closing care gaps • Education resource utilization for educational videos • Outreach team calls identification of asthmatic members for CMs to contact • Outreach baby showers • Outreach member advisory forums (currently virtual) • Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services, medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care	**Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.4.1:** PQI 08: Heart Failure Admission Rate **Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life **Not a Quality Strategy Metric** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescence (WCC) **Not a Quality Strategy Metric** Immunizations for Adolescents (IMA) **Not a Quality Strategy Metric** Plan All Cause Readmission (PCR)

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	gaps when engaging with members • Partners in Pregnancy (PIP) Program • Vendor/Partners in care: EMMI, CipherHealth, BiolQ, MDLive, Prealize, Integrated Eye Group, (IEG), Ontrak, Lexus Nexus, Focus Care in home assessments, Progeny, Accordant, and Inogen. • Focused EPST Care Coordination • Behavioral health engagement program to improve follow-up visits with providers after ED visits. • Automated EMMI campaigns (educational videos for members)- Postpartum • Monthly collaboration with Prealize for case studies and process improvements	
Aim 1: Enhance Member Care Experience Goal 1.1: Improve Member Satisfaction **Aim 2:** Effective Patient Care Goal 2.1: Enhance Provider Support **Goal 2.2**: Ensure Access to Care Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.2:** Improve Outcomes for Members with Substance Use Disorders **Goal 4.4:** Improve Health for Members with Chronic Conditions *The quality initiative may impact other Quality Strategy aims and goals.*	• Care coordination technician member outreach along with medical and behavioral care coordination/case management rounds with Medical Directors. • Dedicated Readmission Team with (Cipherhealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns-(home health services, medications, discharge instructions, etc.) • Case management/Care Coordination care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Behavioral health engagement program to improve follow-up visits with providers after ED visits.	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate **Metric 2.2.3:** Getting Needed Care **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Diabetic Eye incentive program, call campaigns, mobile diabetic eye exam events • Enhanced Sentara Diabetes Class communication • Predictive analysis data integration into clinical workflows, engaging members in closing care gaps • In home assessments and quality gap closures • Emerging intervention- Partnerships with vendors to facilitate and promote member self-care management • Emerging intervention- Exploration of emerging technology and partnerships to improve health outcomes for our members Emerging interventions- • Vendor/Partners in care: Ontrak (BH), Lexus Nexus, Focus Care in home assessments, Dario, Carenet • Interdepartmental committee evaluating enhanced member benefits for 2022 to improve SDOH • Additional Automated EMMI campaigns (educational videos for members) • Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection • Targeted Behavioral Health Care Coordination focusing on Inpatient discharges, Emergency Room utilization and high-risk readmission member focus from Behavioral Health Facilities. • Dedicated Behavioral Health Transition of Care Coordinators.	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Increased focus on SDOH and health equities with creation of a focused SDOH team collaborating with Medical and Behavioral UM/CM departments. New EMR system with increased capturing of SDOH Optima Health understands that a "one size fits all" approach is not sufficient for member and community outreach. Therefore, we have created a program that uses both traditional and non-traditional means to reach our member population and address unmet health-related social needs. We use a multi-modality platform for engaging our members, community partners, staff, and subcontractors. Our outreach and education program includes targeted communication and outreach by region, focusing on community-based organizations, continuing advocacy, and keeping members engaged by helping them understand the value of program benefits and services. Additionally, we support those members who may require unique communication solutions like TTY, Braille, interpretive services, or the use of community health workers to fully engage in their member benefits. We also use regular mail, member website and provide options for member engagement through social media, texting, and member email. Examples of Member Outreach Activities- • Member outreach – initial health screenings • Member Advisory Forums • Community member Advisory Forums • Maternity Care Outreach	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Emergency Department Follow Up Initiative • Outreach for Homeless Members Examples of SDOH Activities- • Faith based initiatives • Partnering with organizations such as Veterans Helping Veterans, Tidewater Community College, Portsmouth Parks and Recreation, 100 Black Men, YMCA of the Eastern Shore, Lynchburg Boys and Girls Club, Big Brothers and Big Sisters of Danville, and many more. • Optima Health, Read, learn, Grow literacy program • Developmental Screening Delays- connecting members to resources • Zero to Three • Home Visits – Ages and Stages Questionnaire • Healthy Savings – supporting food security and good nutrition • COVID Specific Activities Collaborating with Health care Providers Social Determinants Health Technology Initiatives developed and implemented by the MCO to meet goals and objective in the Virginia Quality Strategy also include, but are not limited to the following: • Quality Improvement Program • Quality Improvement Committee structure and governance • HEDIS performance monitoring and targeted improvement plan.	

Virginia Quality Strategy Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Population Health program including yearlong engagement with members to close gaps • Value-based purchasing • Member safety initiatives • Culturally and linguistically appropriate services (CLAS) competency provider training • Utilization management program • Reducing emergency department utilization • Patient utilization and safety (PUMS) program • Behavioral Health/ARTS benefit • Member and Provider Outreach and Engagement This report and the various initiatives cover a multitude of departments which ultimately contributes to the quality outcomes for the MCO's member's and providers.	

United

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

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	UHC (Medallion and CCC Plus) has quality integrated into all facets of the health plan; aimed at ensuring quality services to members, ensuring members have appropriate access to care and improving health outcomes. In supporting the goals and objectives in the Virginia Quality Strategy, UHC conducts routine, diligent monitoring of rates for numerous quality measures; including those on the DMAS Quality Strategy Dashboard.	

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	Some core approaches that UHC has taken to support the Virginia Quality Strategy include, but are not limited to:	
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction **Aim 2:** Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care	UHC's care coordination model and individualized care management plans for members ensure the integration of physical and behavioral health, incorporates medical management (pharmacy services) and unites with the needs for HCBS services and other supports. These care plans focus on member goals for positive health outcomes while aiming to improve appropriate use of services and reduce inappropriate utilization. Embedded within UHC's care management planning and monitoring is a core focus on Social Determinants of Health; evaluating members' needs and ensuring a strong engagement and connection with community resources. UHC monitors provider and member satisfaction with services through various instruments and forums – including CAHPS, Care Coordination surveys, NPS surveys, provider surveys, and Member Advisory Committees (MACs) among others.	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.3:** Rating of All Health Care **Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.2:** How Well Doctors Communicate **Metric 2.2.3:** Getting Needed Care
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care	UHC diligently monitors and maintains network adequacy, so members have appropriate access to quality care. UHC strictly monitors to ensure we are meeting DMAS network adequacy standards and conducts routine evaluations of the quality of care provided by our valued provider partners. UHC ensures providers have the most current information on both core Medicaid/Medicare benefits as well as UHC's enhanced benefit	**Not linked to specific quality strategy metrics.**

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	offerings and resources to facilitate meaningful care conversations with members. UHC partners with providers and enables member support through such activities as: 1. Providing PCPs with detailed data on members experiencing gaps in care and engaging with providers in periodic reviews 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 provider appointments and other key non-medical appointments, and 4. Partnering with Federally Qualified Health Centers (FQHCs), health systems and other entities for member care and support of community events.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	UHC continually monitors to ensure it is operating as efficiently and effectively as possible in supporting its members and. There is also focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and emergency department visits. UHC initiated and continues its Community Plan Primary Care Provider Incentive (CP-PCPi) Program which is a value-based incentive program with the goal of compensating primary care providers for performance for key member outcome measures. UHC assists in the identification of members who need preventive	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions **Metric 3.1.2:** Frequency of Emergency Department Visits **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits

Virginia Quality Strategy Aim and Goal	United's Quality Initiative	Performance Metric
	services so primary care providers can appropriately outreach and schedule appointments with these members.	
Aim: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	Through a variety of methodologies UHC provides member education and outreach, with appropriate focus on sub populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the performance measure validation section on HEDIS measure activities. At a macro level, UHC continually reviews metrics globally to identify where outreach is most needed and to identify emerging trends statewide or regionally. At a micro level, each care coordinator has immediate access to known gaps at the individual member level when accessing their record for either proactive/planned care management activities or in responding to and supporting unplanned/reactive care events for the member. In addition, UHC has supported and encouraged the use of telemedicine throughout the PHE to assist members with continued access to care. UHC has worked to deploy enhanced virtual models to further assist members with various care needs and social needs and to maintain/improve member engagement and outcomes.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

VA Premier

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

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	• Secret Shopper Survey-Quarterly. Provider Satisfaction Survey and Provider Access and Availability Survey-Annually. • Skilled Nursing Facility (SNF) rounds to decrease length of stay and to provide optimal transition back into the community. • Patient Utilization Management and Safety (PUMS) Program- PUMS is a safety program that targets overutilization. In cases involving buprenorphine use, the member will automatically be in the PUMS program. • Enhanced Care Coordination Program- Behavioral Health Chronic Care Coordinators work with targeted case managers employed with CSBs to conduct 7 day follow up with members discharged from acute facilities. • Pediatric Atypical Antipsychotic Program-Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic.	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Not a Quality Strategy Metric** Plan All-Cause Readmissions—Observed/Expected (O/E) Ratio—Total—18–64 and 65+
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	• Provider Education Visits-educate providers on the importance of screenings and immunizations to promote health and wealth. • Watch Me Grow-Members age 0-24 months, whose parents enroll, receive text messages with reminders of upcoming well child visits and immunizations.	**Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

Virginia Quality Strategy Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Healthy Heartbeats Program** Provide outreach to pregnant and postpartum members at least monthly and screen for high-risk conditions & postpartum depression.	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	**Chronic Care Management Programs** Nurses contact members at a minimum every 90 days to provide education, identify barriers and move the member toward achieving their goals. The Nurses work up to 12 months with members with Diabetes, Asthma, Coronary Artery Disease, Hypertension, Heart Failure, and Chronic Obstructive Pulmonary Disease.	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

Appendix E. Assessment of Follow-Up on Prior Recommendations

DMAS Follow-Up on Prior Year Recommendations for the CCC Plus Program

From the overall findings of the CCC Plus CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CCC Plus program. The recommendations provided to DMAS for the EQR activities in the *Calendar Year 2020 External Quality Review Technical Report* are summarized in Table E-1. Table E-1 also describes the interventions undertaken by DMAS to address the EQR recommendations, QI achieved as a result of the interventions, and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Table E-1—Prior Year Recommendations and Responses—CCC Plus Program Overall

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits
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 recommended 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.		
DMAS' 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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:		

Recommendation—Performance Improvement Projects
• Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019: NR 2020: NR **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits 2019: 93.33 2020: 77.45
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
• HSAG recommended 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 recommended 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 recommended that the MCOs implement appropriate interventions to increase the screening rates due to the low rates for both measures.		
DMAS' 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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website		

Recommendation—Performance Measure Validation
• Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 90.51% 2020: 87.12% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 39.86%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.4:** Monitor Mental Health Utilization
• HSAG recommended that the MCOs develop processes to ensure providers understand and implement recommended care guidelines. • HSAG recommended that the MCOs consider if there were disparities within the MCOs' populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of a disparity-driven issue, HSAG recommended that the MCOs implement appropriate interventions to improve use of evidence-based practices in the provision of behavioral healthcare and services.		
DMAS' 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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage		

Recommendation—Performance Measure Validation
• Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.1.4:** Monitor Mental Health Utilization 2019: 28.00% 2020: 25.34%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.4:** Child and Adolescent Well-Care Visits
• HSAG recommended that the MCOs identify best practices for ensuring children receive all preventive and well-child services according to recommended schedules. • HSAG recommended 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.		
DMAS' 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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results show: **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 39.86%		
Identify any barriers to implementing initiatives:		

Recommendation—Performance Measure Validation		
DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control **Metric 4.4.5:** Controlling High Blood Pressure
• HSAG recommended that the MCOs conduct a root cause analysis to determine why members were not maintaining their chronic health conditions at optimal levels. • Upon identification of a root cause, HSAG recommended that the MCOs implement appropriate interventions to improve the performance related to these chronic conditions.		
DMAS' 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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed the following: **Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control 2019: 50.36% 2020: 48.91% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 53.28% 2020: 55.47%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of Health Plan **Metric 1.2.3:** *Rating of all Health Care*

Recommendation—Member Experience of Care Survey - Adult

- HSAG recommended that 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, HSAG recommended that MCO efforts should focus on improving survey response rates.

DMAS' 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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

DMAS is committed to promoting members. To address the EQRO recommendations, DMAS:

- Increased access to health coverage for lawful permanent residents
- Expanded Quality and Population Health Team
- Developed a dedicated QPH website and resources on the DMAS website
- Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022)
- Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs
- Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices
- Received an extension of FAMIS Moms coverage
- Added new adult dental benefit
- Added behavioral health service access points
- Extended contraceptive benefit to 12 months postpartum

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
CAHPS results show:
Metric 1.2.2: Rating of Health Plan
2020: 65.5%
2021: 64.7%
Metric 1.2.3: *Rating of all Health Care*
2020: 57.5%
2021: 58.7%

Identify any barriers to implementing initiatives:

DMAS did not identify any barriers to implementing initiatives.

HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child

Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of Health Plan **Metric 1.2.3:** *Rating of all Health Care*

- HSAG recommended that 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, HSAG recommended that the MCO efforts should focus on improving survey response rates.

DMAS' 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)

Recommendation—Member Experience of Care Survey - Adult
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: DMAS is committed to promoting members. To address the EQRO recommendations, DMAS: • Increased access to health coverage for lawful permanent residents • Expanded Quality and Population Health Team • Developed a dedicated QPH website and resources on the DMAS website • Designed a tableau based HEDIS dashboard (estimated to be published no later than January 2022) • Reviewed and updated MCO meeting and communication protocols between DMAS and the MCOs • Held quarterly collaboratives focused on Maternal and Child Health, Quality Data Transparency and Reporting, and Quality Best Practices • Received an extension of FAMIS Moms coverage • Added new adult dental benefit • Added behavioral health service access points • Extended contraceptive benefit to 12 months postpartum
Identify any noted performance improvement as a result of initiatives implemented (if applicable): CAHPS results show: **Metric 1.2.2:** Rating of Health Plan 2020: 65.5% 2021: 64.7% **Metric 1.2.3:** *Rating of all Health Care* 2020: 57.5% 2021: 58.7%
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that DMAS has addressed the recommendations in the prior year's annual technical report.

MCOs' Follow-Up on Prior Year Recommendations

From the findings of each MCO's performance for the CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CCC Plus program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2020 External Quality Review Technical Report* are summarized in Table E-2 through Table E-7. Table E-2 through Table E-7 also describe the interventions undertaken by the MCOs to address the EQR recommendations, quality improvement achieved as a result of the interventions and identified barriers to implementing the interventions focused on addressing the recommendations, if applicable.

Aetna

Table E-2—Prior Year Recommendations and Responses—Aetna

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

For the CCC Plus PIPs, HSAG recommended 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.
- Specify 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

AMB PIP:

- The MCO revised the Intervention Planning Table to reflect the correct intervention being tested.
- The MCO added the appropriate identification step to the process to address the general comment in the HSAG validation tool.
- The MCO updated Module 5 to reflect the failure modes and interventions to address those failure modes as listed in the Intervention Determination Table in Module 3
- The MCO updated Module 5 to reflect the failure modes and interventions to address those failure modes as listed in the Intervention Determination Table in Module 3
- The MCO added the timeframe that will be reviewed after receiving the intervention to the numerator per HSAG feedback.
- The MCO added the following verbiage to the denominator per HSAG's recommendation: *"and successfully received telephone outreach during the measurement month."*
- The MCO updated the SMART Aim run chart to include the numerators and denominators for each month's SMART Aim measure result per HSAG's feedback.
- The MCO updated the denominator description in the Intervention Effectiveness Measure in Module 4 to include receipt of intervention.

FUH PIP:

- The MCO updated Table 1 in Module 4 to include member identification information per HSAG feedback.

Recommendation—Performance Improvement Projects
• The MCO updated Module 5 to reflect the failure modes and interventions to address those failure modes as listed in the Intervention Determination Table in Module 3 • The MCO added the timeframe that will be reviewed after receiving the intervention to the numerator per HSAG feedback. • The Interpretation of Results section was inadvertently removed from the initial submission of Modules 4 & 5. The MCO re-added the numerators and denominators for each month's SMART Aim measure result. • The MCO revised the denominator description in the Intervention Effectiveness Measure Table to include the following verbiage per HSAG's feedback: *"and received an educational UTR letter during the measurement month."*
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019: 2020: NR **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits 2019: 108.98 2020: 84.31 **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO stated that it inadvertently missed addressing HSAG's feedback regarding whether claims lag would impact receiving the intervention results.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control **Metric 4.4.5:** Controlling High Blood Pressure

• HSAG recommended that Aetna conduct a root cause analysis to determine why members were not consistently accessing and completing well-child visits, childhood immunizations, cancer screenings, behavioral health services, and care and services for chronic conditions. • HSAG recommended that Aetna analyze its data and consider if there were disparities within their populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Recommendation—Performance Measure Validation
• Prior to the PHE, wellness visits and care for those members with chronic conditions was and remains an area in need of improvement. The MCO continued to develop new and monitored current initiatives and interventions (as provided in the uploaded document named Aetna Better Health of VA_2021 Initiatives.xlsx). • The MCO conducted analyses of its CCC Plus population. These analyses were reported in an annual assessment to support NCQA accreditation requirements and drive member programs and quality improvement initiatives.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): • A key finding for the measurement year 2020 was that the race with the most prominent rate of risk for disparities for all chronic conditions when weighted proportionally against White CCC Plus population representation was found in the American Indian/Alaskan Native subpopulation at 33 percent. This places them at a 1.3 percent to14.8 percent higher risk for exhibiting a chronic condition than other non-White counterparts, but not at a greater risk than White counterparts who rated at 2 percent greater risk than this subpopulation. PMV results showed the following: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 88.22% 2020: 87.05% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 38.68% **Metric 4.4.4:** Comprehensive Diabetes Care, Hemoglobin A1c (HbA1c) Poor Control 2019: 50.36% 2020: 48.91% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 53.28% 2020: 55.47%
Identify any barriers to implementing initiatives: • The MCO believes that the COVID-19 PHE significantly impacted members visiting the doctor for routine and follow-up care.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.4:** Ambulatory Care, Emergency (ED) Visits
• Upon identification of a root cause, HSAG recommended 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.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: A subpopulation was targeted for intervention for the AMB PIP, where telephonic outreach was made to members with one outpatient visit and two or more emergency department visits. Also, the MCO had a hospital readmission reduction program, which was a clinical program focused on coordinating care between providers, case managers, and clinical pharmacists as members were discharged from the hospital.		

Recommendation—Performance Measure Validation
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits 2019: 108.98 2020: 84.31
Identify any barriers to implementing initiatives: The MCO believes that the COVID-19 PHE significantly impacted members visiting the doctor for routine and follow-up care.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** CAHPS Composite Measures – *Getting Care Quickly* **Metric 1.2.3:** *Rating of all Health Care*

- HSAG recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Aetna Better Health of Virginia focused on identifying sub-populations of members that would benefit from MCO intervention and implemented programs and services to improve or maintain member health and overall satisfaction. Specifically, the MCO defined the measurement and their accompanying goals used to evaluate the performance of such programs and services. Goals were developed based upon past performance, available industry benchmarks, program resources, and desired results.

Results were assessed against goals to determine which goals were met or not met. The MCO conducted barrier analysis to determine the root causes for those goals not met. Subsequently, the MCO developed interventions to break down barriers to improve performance and satisfaction. Specific evidence-based efforts included:

- Strengthening case management follow-up processes to evaluate for further need after information/assistance is provided and enhancing outreach and engagement for members with chronic conditions
- Educating providers on rules surrounding balance billing Medicaid members
- Educating members on the importance of providing identification cards to providers during visits
- Improving member understanding of benefit coverage details for the relative line of business
- Simplifying information regarding benefit coverage throughout the member website after receiving direct feedback from members surveyed in Member Advisory Committee meetings. (Website updates scheduled to be completed by January 2022)

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Overall, Aetna Better Health demonstrated improvement in ten of the CCC Plus Adult measures compared to the 2020 reported rates, one of which was statistically significant.
CAHPS results showed the following:

Recommendation—Member Experience of Care Survey - Adult
Metric 1.2.1: CAHPS Composite Measures – *Getting Care Quickly* 2020: 86.2% 2021: 84.1%% **Metric 1.2.3:** CAHPS Composite Measures – *Rating of all Health Care* 2020: 56.1% 2021: 57.9%
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.1:** CAHPS Composite Measure – *Getting Care Quickly* **Metric 1.2.3:** *Composite Measure - Rating of all Health Care*

- HSAG recommended 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*).*

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

- The MCO conducted a rate comparison analysis for the aggregated survey as well as for each line of business to gain better insight into what membership contributed to low star ratings.
- The analyses were presented and discussed in both the Quality Management Oversight Committee as well as the Service Improvement Committee to focus on those composites that fell below three stars.
- Discussion identified opportunities to review appointment access and availability for pediatricians, improve connections between members and conveniently located providers, review specialist authorization process to identify drivers that could impact the effectiveness of care and improve member awareness of benefits offered by the MCO.
- The MCO repurposed its CAHPS workgroup to include a rotation of MCO representatives to incorporate a fresh perspective on improvement opportunities.
- The workgroup also implemented small break-out sessions to brainstorm opportunities to improve composite measures that fell below three stars.
- Specific improvement actions included:
  - Conducted a root cause analysis via fishbone diagram to identify key drivers of dissatisfaction
  - Educated providers about CAHPS in provider newsletters and the provider manual
  - Developed a series of internal educational snippet emails to educate staff members about CAHPS (i.e., purpose, survey timeframe, how regulatory bodies use the survey results, etc.).
  - Provided CAHPS education during Member Advisory Committee meetings regarding the importance of completing the survey.
  - Implemented a text messaging campaign preparing and educating members on the survey.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The MCO did not note performance improvement as a result of the initiatives implemented.
CAHPS results showed the following:
Metric 1.2.1: CAHPS Composite Measures – *Getting Care Quickly*
2020: 86.2%

Recommendation—Member Experience of Care Survey - Adult		
2021: 84.1%% **Metric 1.2.3:** CAHPS Composite Measures – *Rating of all Health Care* 2020: 56.1% 2021: 57.9%		
Identify any barriers to implementing initiatives: The MCO did not identify barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** CAHPS Composite Measure – *Getting Needed Care*
• HSAG recommended that Aetna conduct a root cause analysis of study indicators that had been identified as areas of low performance.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: The MCO conducted a root cause analysis of the low satisfaction with the MCO among parents/guardians of children. The analysis results indicated a barrier of a potential issue with the effectiveness of care, specifically, the correlation between high specialist utilization and dissatisfaction.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. CAHPS results showed the following: **Metric 2.2.3:** CAHPS Composite Measure – *Getting Needed Care* 2020: 83.8% 2021: 86.0%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhanced Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.3:** CAHPS Composite Measure – *Rating of all Health Care*
• HSAG recommended that Aetna focus initiatives on raising member satisfaction regarding overall healthcare and continue to monitor the measures to ensure there were no significant decreases in scores over time.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:		

Recommendation—Member Experience of Care Survey - Child
• Aetna continued to identify opportunities for improvement and identify root causes of dissatisfaction and barriers to improvement. • The MCO developed action plans and monitored activities quarterly to drive service improvements through feedback from the Member Advisory Committee and Service Improvement Committee. The Service Improvement Committee and the Outreach Committee worked to identify prospective barriers and potential issues when assessing responses to CAHPS survey questions.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): Overall, Aetna Better Health demonstrated improvement in 12 of the CCC Plus Child measures compared to the 2020 reported rates. CAHPS results showed the following: **Metric 1.2.3:** CAHPS Composite Measures – *Rating of all Health Care* 2020: 56.1% 2021: 57.9%%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

HealthKeepers

Table E-3—Prior Year Recommendations and Responses—HealthKeepers

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits
HSAG recommended 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.		
MCO'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)		

Recommendation—Performance Improvement Projects
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: HealthKeepers will adhere to the recommendations from HSAG.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020:NR **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019:NR 2020:NR **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits 2019: 87.27 2020: 70.40
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO had not addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
Aim 4: Improved Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

- HSAG recommended that HealthKeepers conduct a root cause analysis to determine why members were not consistently following evidence-based care guidelines or receiving recommended screenings, care, or services.

MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: HealthKeepers reviewed and continued to monitor the performance for cancer screenings and recommended services for comprehensive diabetes care and care and services for chronic conditions. Critical Performance Steering Committee workgroups were established to determine key drivers for performance and to establish interventions for improvement. HealthKeepers believes that the following barriers were possible reasons for the decline: • Members may not be aware that they are due for the exam or not know the importance of having an exam done

Recommendation—Performance Measure Validation
• Members were apprehensive to go to the doctor/emergency room for any kind of issue • Many members tend to seek care only when they're sick • Successfully contacting members is difficult • Members seek emergency room treatment instead of preventive visits • Low dollar member incentives • Inappropriate provider coding or provider documentation for preventive visits • Members' lack of knowledge about their benefits • Member education about healthy living • Social determinants of health • Member may not be aware of transportation benefit • Providers only seeing patients if sick • Primary providers may not be aware that their patient has not completed the exam • Primary providers may not have advised their patient to get the exam due to lack of reminder • Primary care providers may not be aware that their patient has not completed the exam and are not incentivized • COVID-19 HealthKeepers addressed the barriers by implementing the following interventions: Diabetes • HealthKeepers offered a diabetes disease management program to encourage member self-care efforts, health care education and provides effective intervention points. Diabetes disease management was offered to identify members by licensed clinicians. • Care Compass HEDIS Alerts: Case managers, during regular contact with members, provided reminders of missed services and education on missed services. • HealthCrowd: Multi-model (interactive voice response call, short message service, email, text) Informative/educational message to members regarding the four diabetes screenings and to remind them to make an appointment with their primary care provider. • Gaps in Care Reports: Data reports generated from HEDIS data set, and letters are sent to providers with list of members to follow-up to ensure services are completed. Returned medical records are data entered into the medical record data base. • PQIP - The Provider Quality Incentive Program (PQIP or the Program) rewards our valued providers for the quality care they provide our Medicaid members. Using a system of scorecard measures, PQIP seeks to encourage efficient, preventive and cost-effective health care practices. Eligible PCPs who meet quality benchmarks and improvement and medical cost management targets will receive additional payments. • Healthy Rewards offers diabetic members $25 to complete the diabetic retinal eye exam every 12 months. • Provide information on new transportation vendor prominently on member website. • Partnering with Care Delivery Transformation Team, Provider Relations, and Marketing to identify and educate providers with low quality scores • Continuous HEDIS training for case managers/care coordinators • Care coordinators continue addressing gaps in care with members by using the gap in care report • Expanding HealthCrowd messaging campaigns • Social media ads Facebook/Instagram – monthly revolving topics • Updated coding book for providers/Current Procedural Terminology II code cheat sheets • American Cancer Society (ACS) collaboration • Implementing standing order initiative for breast cancer screenings • Continue to investigate mammogram bus opportunities • Tracking/trending SDoH needs of members to determine appropriate outreach for preventive care
Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Recommendation—Performance Measure Validation
The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 92.71% 2020: 88.70% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 44.78% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 50.12% 2020: 46.47% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 40.39% 2020: 49.64%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal: 3.1:** Focus on Paying for Value	**Metric 3.1.2:** Frequency of Emergency Department Visits

- HSAG recommended that HealthKeepers analyze its data and consider if there were disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Over the last five years, HealthKeepers has seen improvements in the following areas:

The number of disparities, demonstrated through HEDIS and CAHPS data, continues to be low. It's felt our provider education and tools, associate education and increased awareness around the importance of cultural competency and improvements in member materials have contributed to this success.

Literature review and supported by our HEDIS data to a limited extent, revealed disparities in the areas of prevention and screening, and maternal health. Initiatives included:

- EPSTD corporate mailers were updated to improve reading ease and facilitate understanding
- Development of a comprehensive infographic, Promoting Birth Equity, for maternal health practices (office staff and providers) to help practices:
  - Articulate practice-level factors that impact birth equity, recognize that racial and ethnic biases exist in the maternal health care setting and use tools for defeating them
  - Demonstrate good communication skills — even while wearing a face mask,
  - Practice patient-centered communication skills focused on listening respectfully and responding appropriately in the maternal health care setting
  - Raise awareness of maternal health care disparities among staff members and provide tools and guidance for improving birth equity. The resource will be available on mydiversepatients.com in 2021.

Recommendation—Performance Measure Validation
To help address disparities in CAHPS and facilitate positive patient experiences, Anthem worked extensively on promoting the online educational program, Improving the Patient Experience, with practices, including newsletter articles, provider flyers and specific training resources • In October 2020, HealthKeepers hosted a Racial Trauma Forum for providers. HealthKeepers partnered with Motivo, the first HIPAA-compliant platform connecting mental health therapists to clinical supervisors. The purpose of the event was to provide insight and guidance on the experiences of racial trauma, the impact of prolonged exposure to racial injustice for black and brown people, and the important role healthcare and mental healthcare professionals can play in identifying, treating, and addressing racial trauma. This webinar was designed for Anthem/Amerigroup/Beacon providers who would like to gain a deeper understanding of the impact of racial trauma, share experiences, learn about self-care, and better support their patients/clients. Over 420 providers participated on the call.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 3.1.2:** Frequency of Emergency Department Visits 2019: 87.27 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions **Metric 3.1.2:** Frequency of Emergency Department Visits
• Upon identification of a root cause or causes, HSAG recommended 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 emergency department use and inpatient utilization.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: HealthKeepers assessed the needs of its population annually in order to determine appropriate actions to meet the needs of members. HealthKeepers' overall top three-inpatient diagnosis contained two maternal delivery diagnoses and one acute but severe condition requiring hospitalization. The top outpatient diagnosis was related to exposure to viral communicative diseases with second being hypertension, a chronic condition and third is a respiratory infection which could also coincide with the top reason. HealthKeepers had implemented interventions to address the identified top three diagnoses for both inpatient and outpatient services: **Maternal Care**- My Advocate™ Program: An opt-in program maternal health education by telephone, text message, and by smart phone application to pregnant and postpartum women. Twice weekly messaging during the prenatal phase.		

Recommendation—Performance Measure Validation
New Baby, New Life℠ is a comprehensive maternity management program supports pregnant members during the prenatal and postpartum period and newborn members up to 90 days after discharge, including those hospitalized and discharged from Neonatal Intensive Care Units (NICU). Mothers of newborns are supported and encouraged to complete well-child checks through the first year of life. Depending on the health assessment and preferences of the member, HealthKeepers services may include: • Health education materials • Interactive care and case management support • Health assessment and development of a care plan for ongoing support • Facilitation of transfer to other internal programs, as needed • Coordination with governmental and community resources • Support understanding benefits of mother and newborn **OBQIP Program:** Pay for Quality Provider Incentive Plan FindCare.com – community resource referral Obstetrical case management for higher risk pregnant women identified and stratified by high-risk screener providing telephonic support through pregnancy and delivery and through 6-8 weeks postpartum. Obstetrical nurses provided pregnancy related education and benefits overview related to pregnancy and new baby. **Infectious Disease Support**- Encouraged telehealth visits for members, educate on appropriate level of care needed for members. Community Resources: Anthem Virginia has partnered with certain CVS pharmacies as optional locations where members may receive their flu vaccine outside of the primary care provider offices. Department of Health offered free Influenza vaccine throughout Influenza season. **COVID Resources-** Case managers provided resources on where to obtain COVID testing and provided education on symptoms and treatments. Additionally, all case managers were able to provide community resources on wide variety of social issues as a result of community impact of the virus during the year. **Emergency Room Program**- Outreach program to members identified as having an emergency room visit to help educate them on alternatives to emergency room care if appropriate such as urgent care facilities and the 24 hours nurse line, as well as identifying members for engagement in the complex case management programs for all age groups. **Emergency Department Care Coordination (EDCC)**-"Pre-managed" EDCC implemented by the state. All MCOs were notified in real-time when their members accessed the emergency department. The project expedites intervention from care coordinators to improve transitions of care and assure needs are met for members. **Chronic Disease Management** - Population Health Programs: COPD, Asthma, Hypertension and Case Management
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. PMV results showed the following: **Metric 3.1.1:** Frequency of Potentially Preventable Admissions 2019: NR 2020: NR **Metric 3.1.2:** Frequency of Emergency Department Visits 2019: 87.27 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.

Recommendation—Performance Measure Validation		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

- HSAG recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Annually, HealthKeepers completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gives HealthKeepers a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The top sub-categories of all appeals were Personal care aid. HealthKeepers did not meet the goal for rating of the health plan, getting care quickly and getting needed care with the Adult CAHPS survey. All other measures were above goal. The barriers identified during the analysis included:

Complaints

- For the MCO: Relationship with new delegated transportation vendor
- For providers: Providers were unaware they couldn't bill Medicaid members
- For members: Members were not always aware of their responsibility for transportation

Appeals

- For providers: Providers not submitting all of the information needed to process an initial utilization management request, such as personal care aid.

Adult CAHPs

- Access to primary care providers who provide primary care was an issue
- Members not able to reach providers due to COVID-19
- MCO increased in membership related to COVID-19

HealthKeepers addressed the barriers by implementing the following interventions:

Transportation-

- Meetings held on a regular basis with transportation vendor.
- Corrective action plan put into place with transportation vendor.

Member Appeals-

- Provider offices could chat directly electronically with the prior authorization department to have questions answered.
- Updates and additional clinical information could be submitted electronically to pre-authorization department.

CAHPS-

Recommendation—Member Experience of Care Survey - Adult
• Added availability of provider telehealth to online physician directories. • Member website had information on getting care that is easy to find, including Quick Start Guide.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. CAHPS results showed the following: **Metric 1.2.3:** Rating of All Health Care 2019: 57.1% 2020: 57.3%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
• HSAG recommended 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 recommended that HealthKeepers conduct a root cause analysis of study indicators that have been identified as areas of low performance. • HSAG recommended 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.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: Annually, HealthKeepers completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gives HealthKeepers a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The top sub-category of all appeals were personal care aid. HealthKeepers did not meet the goal for rating of personal doctor, getting care quickly, getting needed care, and customer service. All other measures were above goal. The barriers identified during the analysis included: Complaints • For the MCO: Relationship with new delegated transportation vendor • For providers: Providers were unaware they couldn't bill Medicaid members • For members: Members were not always aware of their responsibility for transportation Appeals • For providers: Providers not submitting all of the information needed to process an initial utilization management request, such as personal care aid. Child CAHPs • Lack of provider awareness of tools available and how to use		

Recommendation—Member Experience of Care Survey - Child

- Member unaware of physician interaction regarding their care
- Access to primary care providers who provide primary care is an issue
- Members not able to reach providers due to COVID-19
- MCO increased in membership related to COVID-19

HealthKeepers addressed the barriers by implementing the following interventions:

Transportation-

- Meetings held on a regular basis with transportation vendor.
- Corrective action plan put into place with transportation vendor.

Member Appeals-

- Provider offices chat directly electronically with the prior authorization department to have questions answered.
- Updates and additional clinical information submitted electronically to pre-authorization department.

CAHPS-

- Added availability of provider telehealth to online physician directories.
- Member website had information on getting care that is easy to find, including Quick Start Guide.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The MCO did not note performance improvement results from the initiatives implemented.
CAHPS results showed the following:
Metric 1.2.3: Rating of All Health Care
2019: 57.1%
2020: 57.3%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of all Health Care

- HSAG recommended that HealthKeepers conduct a root cause analysis of study indicators that have been identified as areas of low performance.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Annually, HealthKeepers completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gives HealthKeepers a 360° view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The top sub-category of all appeals were personal care aid. HealthKeepers did not meet the goal for rating of personal doctor, getting care quickly,

Recommendation—Member Experience of Care Survey - Child		
getting needed care, and customer service. All other measures were above goal. The barriers identified during the analysis included: Complaints • For the MCO: Relationship with new delegated transportation vendor • For providers: Providers were unaware they couldn't bill Medicaid members • For members: Members were not always aware of their responsibility for transportation Appeals • For providers: Providers not submitting all of the information needed to process an initial utilization management request, such as personal care aid. Child CAHPs • Lack of provider awareness of tools available and how to use • Member unaware of physician interaction regarding their care • Access to primary care providers who provide primary care is an issue • Members not able to reach providers due to COVID-19 • MCO increased in membership related to COVID-19 HealthKeepers addressed the barriers by implementing the following interventions: Transportation • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. Member Appeals- • Provider offices chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. CAHPS- • Added availability of provider telehealth to online physician directories. • Member website had information on getting care that is easy to find, including Quick Start Guide.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. CAHPS results showed the following: **Metric 1.2.3:** Rating of All Health Care 2019: 57.1% 2020: 57.3%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Enrollee Rating of Health Care

Recommendation—Member Experience of Care Survey - Child
• HSAG recommended 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.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: Annually, HealthKeepers completes a thorough evaluation of member experience by analyzing member complaints and appeals in conjunction with CAHPS member experience survey results. This gives HealthKeepers a 360-degree view of the member experience. A drill down into the data revealed that the complaints about transportation represent 44 percent of total complaints. The top sub-category of all appeals were personal care aid. HealthKeepers did not meet the goal for rating of personal doctor, getting care quickly, getting needed care, and customer service. All other measures were above goal. The barriers identified during the analysis included: Complaints • For the MCO: Relationship with new delegated transportation vendor • For providers: Providers were unaware they couldn't bill Medicaid members • For members: Members were not always aware of their responsibility for transportation Appeals • For providers: Providers not submitting all of the information needed to process an initial utilization management request, such as personal care aid. Child CAHPs • Lack of provider awareness of tools available and how to use • Member unaware of physician interaction regarding their care • Access to primary care providers who provide primary care is an issue • Members not able to reach providers due to COVID-19 • MCO increased in membership related to COVID-19 HealthKeepers addressed the barriers by implementing the following interventions: Transportation- • Meetings held on a regular basis with transportation vendor. • Corrective action plan put into place with transportation vendor. Member Appeals- • Provider offices chat directly electronically with the prior authorization department to have questions answered. • Updates and additional clinical information submitted electronically to pre-authorization department. CAHPS • Add availability of provider telehealth to online physician directories. • Member website had information on getting care that is easy to find, including Quick Start Guide. • HealthKeepers will continue to monitor the measures to ensure there are no significant decreases in rates over time.

Recommendation—Member Experience of Care Survey - Child
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement results from the initiatives implemented. CAHPS results showed the following: **Metric 1.2.3:** Rating of All Health Care 2019: 57.1% 2020: 57.3%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Magellan

Table E-4—Prior Year Recommendations and Responses—Magellan

Recommendation—Performance Improvement Projects		
Aim 4: Improved Population Health	**Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care
HSAG recommended 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.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: **Improve Timeliness of Prenatal Care** Enroll Member in a Prenatal Incentive Program: MCC Care Coordinators introduce members to the prenatal incentive program and enroll members into the program. Upon enrollment, members receive frequent monitoring by the care coordination team, educational and community resources, and financial incentive upon completing all prenatal visits. This intervention was selected because – compared to other interventions in the Failure Mode Priority Ranking, the failure "Member doesn't go to appointment" had the highest risk priority number (RPN) of 40 [Level of Severity – Very High (5); Likelihood of Detection – Low (2); Probability of Failure – Very High (5)]. Although there was another failure mode (wrong number or no contact information) with the same RPN, it was determined that an intervention to mitigate the failure mode of members not going to appointments would have a greater level of success and therefore be more likely to have a positive impact on the SMART Aim. MCC therefore determined that this intervention should be prioritized. **Reduce Tobacco Use in Pregnant Women**		

Recommendation—Performance Improvement Projects
Tobacco Cessation Incentive Program: MCC Care coordinators introduce member to smoking cessation incentive program and enroll member into the program. Member receives frequent monitoring by care coordination team, tobacco cessation resources, and financial incentive upon successful cessation. This intervention was selected because – compared to other interventions – in the Failure Mode Priority Ranking this failure had the highest risk priority number (RPN) of 100 [Level of Severity – Very High (5); Likelihood of Detection – High (4); Probability of Failure – Very High (5)]. All other failure modes scored a 75 RPN or less. MCC therefore determined that this intervention focused on tobacco cessation for pregnant women should be prioritized.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not identify results from the initiatives implemented. **Improve Timeliness of Prenatal Care:** The performance measure rate baseline rate (2/1/2019 – 1/31/2020) was 37 percent. A remeasurement (6/1/2020 – 5/31/2021) showed a rate of 34.2 percent. **Reduce Tobacco Use in Pregnant Women:** The performance measure rate baseline rate (2/1/2019 – 1/31/2020) was 94.5 percent. A remeasurement (6/1/2020 – 5/31/2021) showed a rate of 97.4 percent. PMV results showed the following: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives. **Improve Timeliness of Prenatal Care:** Barriers were not identified in implementing the initiative. **Reduce Tobacco Use in Pregnant Women:** During intervention, MCC found that many members did not join the incentive program for various reasons. MCC did not have all the members' contact information so some members may not have known about the incentive program, some members were not interested in participating, some members were in "Do-Not-Call" list and MCC was not able to contact them, and some members had already delivered a baby.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.4:** Monitor Mental Health Utilization
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
• HSAG recommended that Magellan conduct a root cause analysis or focus groups to identify the reasons why members were not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions.		

Recommendation—Performance Measure Validation
• HSAG recommended 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 contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. • Upon identification of root causes, HSAG recommended that Magellan implement appropriate evidence-based interventions to improve access to, and timeliness of care and services across low-scoring healthcare domains.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: MCC acknowledged the need to conduct a root cause analysis to identify the reasons why members were not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions. MCC worked with the concerned department to make members aware of their assigned PCP and provide outreach support to the providers and reaching out on all HEDIS measures to educate members of preventive screenings and well visit. MCC analyzed membership race and ethnicity at least annually to ensure that care and services meet the needs of the population. Race and ethnicity were further analyzed by county to assess the areas where the MCO should be concentrating and expanding its network. CAHPS demographic data was used if internal data showed a high proportion of Unknown or Other membership. Providers were sent monthly gaps in care reports and educated on the importance of non-established members getting needed care on time. MCC also hosted monthly clinic days and concentrate on scheduling non established members for required visits.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not identify results from the initiatives implemented. PMV results showed the following: **Metric 4.1.4:** Monitor Mental Health Utilization 2019: 38.66% 2020: 32.69% **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 80.32% 2020: 78.26% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 57.66% 2020: 59.85%
Identify any barriers to implementing initiatives: MCC was able to identify the main cause for low scores was non established members (members are not seen by the assigned PCP even once) and assigned PCP are unwilling to do any outreach to non-established members.
HSAG Assessment: HSAG determined that the MCO had not addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of Health Plan **Metric 1.2.3:** Rating of All Health Care

Recommendation—Member Experience of Care Survey - Child
• HSAG recommended 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 recommended that Magellan conduct a root cause analysis of study indicators that have been identified as areas of low performance. • HSAG recommended 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 recommended 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.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: MCC acknowledges that quality improvement efforts are required to improve scores that were significantly lower than NCQA Medicaid national averages. MCC published member newsletters that provide education on offered services (transportation, dental, and vision) as well as preparation tips on what to expect at a doctor's appointment. MCC educated providers to prescribe refills for 90 days instead of 30 days. This timeframe makes it easier for the member to pick up the medicine every three months than every month. MCC acknowledges the need to do a root cause analysis of study indicators that have been identified as areas of low performance. MCC identified overscheduling of members was an important cause for the doctor not to spend enough time with members. So, education was provided to providers to dedicate time to each member as needed. MCC also identified that members had transportation issues to go to pharmacy to pick up medicines. So MCC educated the providers on discussing the home delivery option with members for medicines. MCC acknowledges the need for initiatives on raising the statistically significant lower scores and continuous monitoring. MCC had workflows created to improve and monitor member experiences at different steps in the process for a member – pre-service, receiving services, post services. MCC acknowledges the need to increase response rates to CAHPS survey. MCC believes in every member counts campaign and all employees were educated and engaged to increase knowledge of CAHPS, customer service techniques, and special awareness during survey period. Intranet articles were released throughout the year that MCC staff would have had access to along with two ILearn trainings.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not identify any performance improvement as a result of the initiatives implemented. CAHPS results showed the following: **Metric 1.2.2:** Rating of Health Plan 2020: 61.3% 2021: 62.4% **Metric 1.2.3:** Rating of All Health Care 2019: 53.5% 2020: 58.4%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.

Recommendation—Member Experience of Care Survey - Child
HSAG Assessment: HSAG determined that the MCO had not addressed the recommendations in the prior year's annual technical report.

Optima

Table E-5—Prior Year Recommendations and Responses—Optima

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric 3.1.2:** Frequency of Emergency Department Visits **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions
HSAG recommended 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.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: Optima Health has complied with all recommendations and feedback from HSAG within the PIP documents. This is evidenced within each PIP document and revision that has been submitted to HSAG over the course of the PIP cycle. Feedback was addressed and expeditiously returned as requested or addressed at the next PIP cycle due date. **Clinical - Reducing Utilization of the ED PIP:** Module 4 detailed the intervention process steps for both interventions- 1. Scripted Post-ED discharge automated phone call and 2. Scripted Post-ED discharge In-Person Care Coordinator call. Both interventions were included in Module 3: "Develop a template to work from when following-up with members after ED discharge." Table 2 in Module 4 of both interventions defined the intervention effectiveness measure accurately. Data collection and analysis were all provided in both interventions- Modules 4. The SMART Aim's run chart includes all the measurement periods required following the rolling 12-month methodology. Collective Medical PreManage real time data was investigated to avoid claims lag. A combination of claims reports and PreManage reports were utilized to evaluate the effectiveness of the intervention. **Non-Clinical - Improving Compliance in 30-day Ambulatory Follow-Up Appointments PIP:** Module 4 detailed the intervention process steps for both- 1. Scripted Post-Inpatient Discharge automated phone call and 2. Scripted Post-Inpatient Discharge In-Person Care Coordinator Call. Both interventions were included in Module 3: "Develop tool for member post-discharge follow-up phone call." Table 2 in Module 4 of both interventions defined the intervention effectiveness measure accurately. Data collection and analysis were all provided in both interventions- Modules 4. The SMART Aim's run chart includes all the measurement periods required following the rolling 12-month methodology. Collective Medical PreManage real time data was		

Recommendation—Performance Improvement Projects
investigated to avoid claims lag though it could not be utilized because PreManage does not track ambulatory visits.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not include performance improvement results as a result of the initiatives implemented. PMR results showed: **Metric 3.1.2:** Frequency of Emergency Department Visits 2019: 95.39 2020: NR **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing the initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status
HSAG recommended that Optima conduct a root cause analysis or focus group to determine why members were not receiving well visits, immunizations, and screenings according to recommended schedules. • HSAG also recommended 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 recommended that Optima consider whether there were 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 recommended 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.		

MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: Optima Health understands that a "one size fits all" approach is not sufficient for member and community outreach. Therefore, Optima has created a program that uses both traditional and non-traditional means to reach our member population and address unmet health-related social needs. Optima used a multi-modality platform for engaging our members, community partners, staff, and subcontractors. Optima's outreach and education program included targeted communication and outreach by region, focusing on community-based organizations, continuing advocacy, and keeping members engaged by helping them understand the value of program benefits and services. Additionally, Optima supported those members who required unique communication solutions like TTY, Braille, interpretive services, or the use of

Recommendation—Performance Measure Validation
community health workers to fully engage in their member benefits. Optima also used regular mail, member website and provide options for member engagement through social media, texting, and member email. **Behavioral Health:** • Identification and engagement of BH members that need a provider follow-up or treatment visit and assist with scheduling, transportation, etc. • Exploration of BH telehealth opportunities • Collaboration with discharging facilities for transition of care needs • Collaboration with provider group to assist with follow-up and treatment visit scheduling **Comprehensive Diabetes Care (CDC)** **Current Interventions**: • Diabetic Eye incentive program • Diabetic Eye Exam Call Campaign • Monthly Video Distribution • Mobile Diabetic Eye Exam Events • At-home A1c • Enhanced Sentara Diabetes Class communication • Education resources training for CC teams • Predictive analysis data integration into clinical workflows • Member level care gap data integration into clinical workflows to inform/engage members in closing care gaps • In-home assessment and quality gap closures **Emerging Interventions:** • Partnerships with vendors to facilitate and promote member self-care management • Exploration of emerging technology and partnerships to improve health outcomes for our members **PQI Admission Rates:** • COPD Respiratory Therapy (RT) CM vendor partnership • Care Coordinators conduct outreach to members to engage regarding identified needs • Predictive analytics data utilization in Care Coordination workflows to identify high risk members • Implementation of member actions plans by CCs • Education resources training for CC teams • Cipher/RPT follow-up phone calls post discharge to ensure transition of care needs are met **Emerging Interventions:** • Collaboration with Pharmacy team to outreach to members and provide medication education
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **CIS**- When comparing CCC Plus- CY2019 (57.43%) to CY2020 (61.25%) for CIS Combo 3 there is an increase of 6.4%. This increase not statistically significant per Chi-squared testing and failed to meet any short or long-term goals. Although there was an increase, this rate is in the 10th percentile, when compared to the 2020 Quality Compass Benchmarks. **W30**- For MY2020 NCQA revised the Specifications for Well Child/ Adolescent Visits. This is a first-year measure for CCC Plus. The current rate CY2020 (79.12%) is over the 75th Percentile when compared to the 2021 Quality Compass Benchmarks. **WCV**-The current rate CY2020 (40.59%) is at the 25th Percentile when compared to the 2021Quality Compass Benchmarks. **CDC**- When comparing CCC Plus- CY2019 (55.9%) to CY2020 (46.72%) for CDC Eye Exam there was an 18% decrease in rate. The CBP measure CY2020 (43.31%) also had a 17% decrease in rate. Both of these decreases are significant per Chi-squared testing and both failed to meet any short or long-term goals. The HbA1c rate CY2020 (35.52%) showed a slight increase of .68% and did not meet the short-term goal of

Recommendation—Performance Measure Validation
52.36%. All 3 rates for CDC measure in CCC Plus failed to meet the Long-Term Goal of NCQA Accreditation Benchmark 50th Percentile. **FUM-** When comparing CCC Plus- CY2019 (45.49%) to CY2020 (43.58%) for FUM there was a decrease of 4.2%. The 30 Day follow up for FUM CY2019 (62.01%) compared to CY2020 (60.54%) decreased 2.39%. Both rates fell below the 2% short-term goal and the 2021 Quality Compass National Benchmarks 66.67th percentile (61.28%). **FUA-** CY2019 (14.01%) compared to CY2020 (11.87%) decreased 16.53%. This decrease was not statistically significant per Chi-squared testing and failed to reach the 2021 Quality Compass National Benchmarks 50th percentile (13.6%). FUA-30 Day follow up CY2019 (19.51%) compared to CY2020 (21.11%) saw an increase of 7.87%. Although this increase was not statistically significant, it did surpass the CY2019 short term goals of 19.90%. This increase fell short of meeting the 2021 Quality Compass National Benchmark 50th percentile (21.31%). **IET-** When comparing CCC Plus- CY2019 (47.29%) to CY2020 (45.05%) for Initiation phase there was a 4.8% decrease in rate. The Engagement phase CY2019 (10.14%) compared to CY2020 (10.03%) had a slight decrease of 1.09%. These decreases were not statistically significant per Chi-squared testing and both failed to meet any short or long- term goals. The Engagement phase fell below the 2021 Quality Compass National Benchmarks 50th percentile (11.27%). PMV results showed: **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 90.32% 2020: 87.46% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 40.59%
Identify any barriers to implementing initiatives: • Decrease visits to Pediatricians due to the COVID-19 PHE • Lack of childcare for parents, siblings not allowed in waiting areas due to Covid restrictions • Knowledge/Awareness Deficit: – Language /Communication Barriers – Unaware of vaccination recommendations – Concerns over overloading immune system and side effects or adverse reactions of vaccines • Access Issues – Cost – Inappropriate/limited-service hours (limited days/hours; sessions begin late/end early) – Fragmented Care (No-Shows, Cancellations) – Transportation issues • Board Certified Child/Adolescent Psychiatrists remain in short supply statewide, increasing wait times for appointments for very young members. • Limited availability of Behavioral Health providers through MD Live. • Members reluctant to schedule telephonic visits with MD Live providers. • Difficulty of identifying members seen in ER for Mental Health or Substance Disorders in a timely manner to facilitate scheduling follow up appointments, particularly for the 7-day time frame. • Reluctance by some medical and behavioral health providers to formally screen clients for substance use (or to code this diagnosis) for a variety of reasons: lack of time, lack of reimbursement, lack of recognition of prevalence of substance use disorders co-occurring with other medical and behavioral health conditions, concern re: implications of this diagnosis for members in the military or other occupations requiring security clearance, discomfort with topic.

Recommendation—Performance Measure Validation

- Lack of knowledge or use of Virginia Prescription Monitoring Program by providers.
- Hesitance of members to accept the diagnosis due to denial, and/or to seek treatment for substance use issues due to perceived stigma, privacy concerns.
- Financial concerns (related to copays) and time commitment for intensive outpatient substance abuse programs, which may meet 3 times/week.
- Meeting specifications of the IET HEDIS measure is complicated due to the variety of types of providers/practitioners and settings involved (primary care, specialty care, inpatient, outpatient). There is not a singular point of intervention at which to focus an initiative to impact rates.

Members

- Knowledge/ Awareness Deficit:
- Decrease visits to PCP or Specialist due to the COVID-19 PHE
- Lack of concern for diabetes
- Language/Communication
- Lack of knowledge of insurance benefits
- Lack of awareness of importance of dilated eye exams
- Lack of awareness of symptoms related to diabetic disease process
- Member has more than 1 chronic disease process making it difficult to control each
- Member not wanting to make multiple appointments with provider to address several issues that are all related
- Access Issues:
- Socioeconomic hardships/cultural issues
- Continuity of care with same doctor
- Member not happy with care/unsatisfactory care
- Poor communication with provider
- Perceived control of disease process

Providers

- Not incorporating preventive care guidelines in each visit
- Lack of care coordination among multiple providers
- Unaware of noncompliant members with healthcare gaps/dismissive of gap in care letters
- Not enough providers
- Language/cultural
- Ability/knowledge of staff to assist members
- Providers wanting separate visits for issues instead of addressing 2 or 3 at a visit

Optima understands the barriers and challenges in each of the six regions and are uniquely positioned to successfully implement the Medicaid program. Proactive attention and focus on the unique properties of each region is a key component of our SDOH strategy. Below outlines some of the barriers and challenges in each region.

Tidewater Region-

- In the **urban areas of the Commonwealth of Virginia, we see greater challenges with opioid use**. Through our Addiction and Recovery Treatment Services (ARTS) program and working with providers to help identify and enroll members in our lock-in program (PUMS), we can work with communities to combat this national epidemic.
- We are also aware of the **high infant mortality rate in Norfolk** and have deployed our Partners in Pregnancy program in that area. We also refer pregnant members and members with newborns to the Comprehensive Health Investment Project (CHIP) of Virginia program and Urban Babies, which both

Recommendation—Performance Measure Validation

provide home visiting services using a care management approach to promote wellness, minimize preterm births and low birthweight babies and improve children's health. Additionally, Hampton (8.6%) and Newport News (9.5%) had high percentages of babies born with a low birth weight and high infant mortality rates compared to US (8.1%) and Virginia (7.9%). Optima Health supports organizations like Smart Beginnings of Virginia Peninsula, which is an organization of health care workers, community leaders, teachers, and parents to work with parents to focus on minimizing preterm births and low birthweight babies.

- Although **obesity** can sometimes be genetic, access to healthy food options, income/poverty, and other socio-economic factors are the cause of high obesity rates. Obesity rates are higher in Norfolk (30.7%), Portsmouth (36.6%), and Suffolk (33.1%) than Virginia (30.3%) and the USA (30.6%). Obesity leads to serious health conditions including hypertension, Type 2 diabetes, heart disease, stroke, sleep apnea/breathing problems, and others. Optima Health provides access to healthy foods through our Healthy Savings program and education about healthy alternatives through our health literacy program to our members.
- Optima Health offers incentives to encourage increased prenatal and postpartum care of all pregnant women.

Central Region-

- **Overweight and obesity issues are well known in the Southwest and Central regions, where we also find high rates of prediabetes and diabetes**. In addition to our care management interventions, we are also offering enhanced benefits targeting weight management for our general membership, as well as specific interventions for members diagnosed with prediabetes and diabetes.
- Despite a decline in recent years, homelessness remains high in this area.
- Safe and affordable housing is difficult to find.
- Members frequently relocate
- Food insufficiency, literacy (including digital literacy), lack of transportation, and crime are other challenges.

Northern/Winchester-

- Diverse population and language challenges
- Although the Northern/Winchester Region is home to the highest income counties in the Commonwealth, severe housing problems can be found in Manassas City and Winchester City and food insufficiency.
- There are two additional needs: food insufficiency and mental health. Food pantries in the area have seen 200%-400% increases in their volume of clients with many of these pantries struggling to stay stocked in food for the communities they serve. Mental health issues have also been on the rise because of the drastic life changes, economic instability, and racial inequalities to name a few factors. Tensions in the home have increased as well as families are learning to navigate the new normal with working and schooling from home. There has also been an unfortunate increase in domestic violence. Mental health facilities have reported growing waitlists as capacity in facilities have been reduced due to COVID-19. Optima Health is partnering with community organizations to address each of these issues.

Charlottesville/Western-

- Limited transportation opportunities in difficult-to-reach locations. We will work with our transportation vendor to address this challenge and provide acceptable options.
- Safe and affordable housing is difficult to find
- With six of the 22 counties primarily rural, provider contracting and recruitment in rural areas is a common network development challenge due to the shortage of providers in rural areas.

Recommendation—Performance Measure Validation
Roanoke/Alleghany- • **Adequate and timely transportation in rural areas is a challenge** to members who live in those locales, such as the Southwest and Roanoke/Alleghany regions. We work with these members and transportation providers to offer solutions. We are also working to expand telemedicine capacity in these rural areas to eliminate the need for transportation to a provider site when appropriate. • **Technology**: expanded broadband, increased hot spot locations, technology centers, telehealth equipment (smart phones, laptops, hot spots), and Chromebooks for students. • In the **far southwest region of Virginia, there has been an increase in the number of children in foster care and children who are raised by their grandparents**. There is some evidence that children in foster care have been removed from their families of origin due to sexual abuse or domestic violence. These children often have gaps in care, such as that provided through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) periodicity schedule. Our Outreach team and Care Managers work with these families to ensure they access this care, addressing any barriers that exist. These young members may need mental health screening as well, and we collaborate with the Community Service Boards to schedule that service. Grandparents in these areas who are caring for their grandchildren may also need referral to resources to provide support and, at times, respite care. This region also experiences greater substance use and abuse, including high rates of tobacco use. • Fewer provider groups to work with and limited access to specialists. • Limited community resources in Alleghany. • Food insufficiency, housing and literacy are additional challenges. **Southwest** • **Overweight and obesity issues are well known in the Southwest and Central regions, where we also find high rates of prediabetes and diabetes**. In addition to our care management interventions, we are also offering enhanced benefits targeting weight management for our general membership, as well as specific interventions for members diagnosed with prediabetes and diabetes. • **Adequate and timely transportation in rural areas is a challenge** to members who live in those locales, such as the Southwest and Roanoke/Alleghany regions. We work with these members and transportation providers to offer solutions. We are also working to expand telemedicine capacity in these rural areas to eliminate the need for transportation to a provider site when appropriate. • **Technology**: expanded broadband, increased hot spot locations, technology centers, telehealth equipment (smart phones, laptops, hot spots), and Chromebooks for students. • Substance abuse is prevalent. This region has a higher incident of opioid overdoses. Optima Health offers incentives for members and providers to encourage screening of all pregnant women.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
HSAG recommended that Optima focus quality improvement efforts on improving overall members' experience with care and services.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • Established a member and provider satisfaction improvement committee • Collaboration with Network Management team to communicate and educate within Medicaid providers		

Recommendation—Member Experience of Care Survey - Adult		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not identify performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.3:** Rating of All Health Care 2020: 67.5% 2021: 69.8%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing the initiatives.		
HSAG Response: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Member Experience of Care Survey - Child		
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.1:** Rating of Personal Doctor
HSAG recommended that Optima continue to monitor the measure results to ensure there are no significant decreases in scores over time.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • Established a member and provider satisfaction improvement committee • Collaboration with Network Management team to communicate and educate within Medicaid providers		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note any performance improvement as a result of initiatives implemented. CAHPS scores showed: **Metric 2.1.1:** Rating of Personal Doctor 2019: 79.0% 2020: 82.4%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		

United

Table E-6—Prior Year Recommendations and Responses—United

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1:** Focus on Paying for Value	**Metric3.1.2:** Frequency of Emergency Department Visits **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions

Recommendation—Performance Improvement Projects
HSAG recommended 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.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: • UHC completed and summitted Modules 1 - 5 documents for the *Ambulatory Care – Emergency Department Visits* and *Follow-Up After Discharge.* CCC Plus PIPs received validation feedback and recommendations from HSAG. UHCCP VA addressed all module feedback or recommendations that were provided by HSAG. • HSAG's validated all modules and instructed UHC to resubmit Module 4 and Module 5 as an opportunity to provide additional SMART Aim measure and intervention evaluation data with a possibility of improving the score for the PIP. • Two interventions were implemented for each PIP and we continue to monitor results. Resubmissions are due to HSAG September 30, 2021. • CCC Plus has adopted all four interventions, expanding two of these to additional regions in the state.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO continued to monitor results but did not provide any noted performance improvement as a result of the initiatives implemented. PMV results showed: **Metric3.1.2:** Frequency of Emergency Department Visits 2019: 80.75 2020: NR **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Response: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.4:** Monitor Mental Health Utilization
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits

Recommendation—Performance Measure Validation		
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

- HSAG recommended that United conduct a root cause analysis or focus group(s) to determine why members were not consistently receiving well care, screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules or evidence-based guidelines.
- HSAG also recommended that United conduct data analyses to better understand barriers members may experience in receiving care for chronic conditions.
- HSAG recommended that United consider whether there were disparities within the MCO's 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 recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

During the COVID-19 national public health emergency, UHC determined members were primarily seeing providers for sick visits only.

UHC has improved member access to behavioral healthcare as a result of Virginia's focus on the ARTS benefit and the development of member-centric behavioral healthcare and services.

These continue to be key areas of focus.

In addition to identifying chronic conditions through routine health risk assessments, on an ongoing basis, UHC conducts risk scoring and uses other algorithms to identify and stratify members with chronic conditions, short-term care needs, long-term care needs or social supports. These members are subsequently connected with enhanced care coordination and outreach activities.

UHC appreciates HSAG's recommendation and on an ongoing basis continues to evaluate data and identify areas of opportunity and strategies to address health disparities.

One example is where UHC performed an analysis of PPC HEDIS data of prenatal compliance, postpartum compliance, and prenatal/postpartum compliance by age, language, subpopulation, region, and BH diagnosis; with one specific model conducting a deeper dive into select health districts in the Tidewater region.

Members in the Peninsula Health District showed a lower prenatal compliance than the overall Tidewater compliance. Members with a BH diagnosis did not show significant differences from the non-BH members.

UHC performs many interventions on an ongoing basis to ensure timeliness of preventive screenings and visits. A recent example would include our analysis and identification of common barriers expressed by care coordinators with members accessing and receiving timely preventative visits, screenings, and services.

As UHC identifies members with chronic conditions through routine health assessments, our enhanced complex care coordinators:

- Ensure our members have a PCP and/or specialist, and will assist the member with obtaining one if needed
- Assist the member with scheduling appointments with each provider visit
- Arrange transportation if needed

Recommendation—Performance Measure Validation

- Schedule timely follow-up calls with the member post provider visit to provide additional evidenced-based education, assist member with diagnostic-specific care services and resources.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

The MCO did not identify performance improvement as a result of initiatives implemented.
PMVR results showed:
Metric 4.1.4: Monitor Mental Health Utilization
2019: 24.99%
2020: 23.74%
Metric 4.3.2: Adults' Access to Preventive/Ambulatory Health Services
2019: 89.62%
2020: 87.54%
Metric 4.3.4: Child and Adolescent Well-Care Visits
2019: NR
2020: 30.04%
Metric 4.4.4: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2019: 37.80%
2020: 34.55%
Metric 4.4.5: Controlling High Blood Pressure
2019: 65.45%
2020: 55.96%

Identify any barriers to implementing initiatives:

Feedback from care coordinators that engage with members indicate the most common barriers for connecting members with care have included:

- Office closures, limited support staff and clinician access (COVID-related)
- Member hesitancy to return to provider office (COVID-related)
- Ability to reach members

UHC continues to evaluate data and identify strategies for barrier removal as part of our ongoing processes.

HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child

Aim 1:	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
Enhance Member Care Experience		

- HSAG recommended 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 recommended that United conduct a root cause analysis of the study indicator that has been identified as an area of low performance.
- HSAG recommended 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 recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Recommendation—Member Experience of Care Survey - Child
UHC has focused on various improvement efforts, including: • Ensuring all member materials are accurate, up-to-date, consistent, and use concise language • Supporting members and collaborating with providers to enhance routine and urgent access to care through innovative, proactive approaches within Care Management, Chronic Care, and Quality Management. • Emphasizing comprehensive, collaborative, and high-quality customer/member services as a critical priority across all areas of the organization. Medallion and CCC Plus adult and child surveys were reviewed. The areas identified as opportunities came from 5 questions that align to two larger topics. • Customer Service • Physician/Member Communication UHC continues to monitor all measures to ensure there are no significant decrease in rates over time. UHC has focused on multiple best practice initiatives, including: • Ensuring all member materials are accurate, up-to-date, consistent, and use concise language, • Supporting members and collaborating with providers to enhance routine and urgent access to care through innovative, proactive approaches within Care Management, Chronic Care, and Quality Management. • Emphasizing comprehensive, collaborative, and high-quality customer/member services as a critical priority across all areas of the organization. UHC will work to incorporate this feedback into the ongoing formation and evaluation of our processes, practices, systems and training in our efforts to increase the response rates.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS rates showed: **Metric 1.2.3:** Rating of All Health Care 2020: 59.3% 2021: 59.9%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

VA Premier

Table E-7—Prior Year Recommendations and Responses—VA Premier

Recommendation—Performance Improvement Projects		
Aim 3: Smarter Spending	**Goal 3.1 :** Focus on Paying for Value	**Metric 3.1.2:** Frequency of Emergency Department Visits **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits

Recommendation—Performance Improvement Projects		
	Goal 3.1: Focus on Paying for Value	**Metric:** Decrease Potentially Preventable Readmissions
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services

HSAG recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

By 12/31/2020, decrease the rate of Emergency Department (ED) visits among members 20-44 years old from 127.04 to 112.68. Total number of ED visits among members 20-44 years old during the measurement months (January 2020 through May 2021). Metric monitoring for rate of ED utilization in designated age group.

- Jiva is our Care Management Platform. VA Premier successfully maximized our software integration capabilities with Collective Medical (PreManage).
- PreManage technology integrates within the EMR (Electronic Medical Record) at the hospital level (Epic, Cerner, Meditech) and within seconds PreManage can receive this ADT information, analyze, and deliver to those who are involved in the patient's care.
- The eligibility file received by PreManage from our VA Premier team proves the TPO (Treatment, Payment and Healthcare Operations) relationship for all members. This is how they can transmit these real time encounters over to its team within one to two minutes of our members' arrival to the emergency department.
- VA Premier created two master spreadsheets: (1) Care Coordinators and their email addresses and (2) care coordination assignments. VA Premier determined that having the ability to directly notify its care coordinators eliminated the need for a "bucket email" for alerts and dependence upon third party dissemination was as a barrier to timely notification.
- After its initial pilot was completed (which included an initial six care coordinators), VA Premier determined the "Big Bang Go-Live" date for all ~125 MLTSS care coordinators. Based upon the comparison from the mid-May dashboard with the April dashboard, the initial list contained 47,312 members. The mid-May dashboard showed an enrollment of 47,984.

Recommendation—Performance Improvement Projects

- A focus group met to discuss the education needs for consistent dissemination to MLTSS coordinators regarding the PreManage Big Bang upload and the process for future state caseload uploads.
- VA Premier determined a "glitch" during our pilot. The glitch included a "switch" that needed to be turned on for its care coordinators to access the member for whom the alert was received. Essentially, when the alert came to the care coordinators' email, they should merely have to click a link to be taken directly to the member's care management record.
- Track and trend reports were created for accurate and "real-time" feedback to the VA Premier team and to aid in determining the accuracy of notifications. Member discharge status was directly pulled from authorization services discharge utilization review episodes from Jiva.
- VA Premier also aligned our alerts to ensure we captured our contractual clinical platform ADT feeds.
- It was determined that the most efficient means of timely notification of emergency department visits was via direct ADT feed into Jiva.
- New track and trend models were created.
- An additional intervention evaluation plan was created. A report was sent to our integrated care manager designee (ICM). The ICM will receive this report monthly. This report pulls directly from Jiva and looks at care coordination documentation.
- This data will be presented at an ongoing workgroup and will be utilized to provide updates to leadership. Data calculation has been updated to May 2021.

By 12/31/2020, increase the percentage of follow-up within 30 days after discharge among hospitalized members age 18-64 years old from 70 percent to 75 percent.

- Of the discharges among members 18-64 reported in the denominator, the number of discharges where the member had an ambulatory follow-up visit within 30 days of discharge to assess the member's health. Numerator = Number of discharges from a hospital among members 18-64 years old during the reporting period. Exclude discharges followed by readmission or death. Denominator = 18-64 years of age on the date of discharge
- PIP designation was based upon 2018 data. PIP Smart Aim data tracking began January 2020. As identified in October 2019, the interventions for testing were: Partner with Collective Medical to develop and implement accurate Admission and Discharge encounter reporting and create a streamlined care coordinator notification process.
- VA Premier's key findings were that real-time alert notifications to our care coordination Teams were essential for early intervention. With an alert activity task directly assigned to our care coordinators/case managers in the care management platform, VA Premier also increased team satisfaction and helped to decrease "alert fatigue". The median result of our measurement months was 85.50 percent.
- Jiva is VA Premier's care management platform. VA Premier successfully maximized its software integration capabilities with Collective Medical (PreManage). In doing so, VA Premier was able to identify documentation process issues and provide education to team members Team collaboration identified the following:
- Concerns with uniform documentation practices which captured care coordination efforts. standard operating procedures (SOPs) were reviewed, revised if needed and staff were trained in team huddles.
- Collective mindfulness pertaining to functioning across silos was examined. VA Premier examined its team's approach and knowledge base relative to referrals and member population assignment. VA Premier determined that additional education was needed for its care coordinators/case managers. This finding will be advanced forward and incorporated into VA Premier's future focus and work groups. This finding included waiver members who may have no longer qualified for waiver services. However, in compliance with the DMAS mandate during the COVID PHE, these members were not denied waiver services. March 2020 through May 2020, VA Premier performed a pilot test group, reviewed alerts to be triggered, and performed assignment validation.
- Care coordinator/case management caseload upload to PreManage was completed and VA Premier then coordinated its roll-out to include team trainings. With completion of upload validation and training, VA Premier's Go Live was 6/1/2020.

Recommendation—Performance Improvement Projects		
• VA Premier also determined to utilize daily inpatient admissions census report for administrative oversight, present follow-up data to leadership. In October 2020, A Collective Medical Software update was completed. It was confirmed that care coordinators received ADT (admission, discharge, transfer) alert notifications directly to their assigned calendars in Jiva in the form of an "activity" for follow-up. Secondary to this upgrade feature, email alerts were no longer needed.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): **ED Visits:** Although VA Premier did not sustain below its goal line for the measurement period, VA Premier did consistently stay below its baseline of 127.04. The median result of its measurement months was 73.35.u Beginning January 1, 2020 VA Premier's rate was 12.93. It peaked in December 2020 at 133.23 and began to decline again. In May of 2021, the rate of emergency department utilization was 41.07. PMV rates showed the following: **Metric 3.1.2:** Frequency of Emergency Department Visits 2019: NR 2020: NR **Metric 3.1.4:** Ambulatory Care: Emergency Department (ED) Visits 2019: 98.98 2020: NR		
Identify any barriers to implementing initiatives: VA Premier's challenges included software manipulation, accurate data collection, and understanding the effects of the COVID PHE on its efforts. In January 2021 VA Premier identified a barrier regarding email alerts. After further discussion, it was decided to discontinue the email alert notification secondary to upload and the maintenance process was not efficient.		
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.		
Recommendation—Performance Measure Validation		
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Examples:** • BCS-E: Breast Cancer Screening • ADD-E: Follow-Up Care for Children Prescribed ADHD Medication • AIS-E Adult Immunization Status • PRS-E Prenatal Immunization Status
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status

Recommendation—Performance Measure Validation
• HSAG recommended 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 recommended VA Premier explore potential data sources to impact the ECDS measures and enable future reporting, as VA Premier did not report these measures. • HSAG recommended that VA Premier ensure that the mapping of provider specialties to HEDIS provider types is compliant with NCQA guidelines.
MCO'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)
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**: The Quality HEDIS team at Virginia Premier worked with providers yearlong to review and educate regarding their records and update providers on any new updates to the value set code. The Analytical teams did this as well internally. Virginia Premier reported the following ECDS measures: • BCS-E: Breast Cancer Screening • ADD-E: Follow-Up Care for Children Prescribed ADHD Medication • AIS-E Adult Immunization Status • PRS-E Prenatal Immunization Status The Analytics and HEDIS team at Virginia Premier partnered with its certified HEDIS vendor, Inovalon, to ensure that the mapping of provider specialties to HEDIS provider types was compliant with NCQA guidelines.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. PMV rates showed: **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication 2019:NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Performance Measure Validation		
Aim 1: Enhance Member Care Experience	**Goal 1.3:** Improve Home and Community-Based Services	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan
Aim 4: Improved Population Health	**Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness

Recommendation—Performance Measure Validation		
		Metric 4.1.3: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Metric 4.1.4:** Monitor Mental Health Utilization
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	**Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	Goal 4.3: Improve Utilization of Wellness, Screening, and Prevention Services for Members	**Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.3.4:** Child and Adolescent Well-Care Visits
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life
• HSAG recommended that VA Premier conduct root cause or data analysis or conduct focus group(s) to determine why members were not consistently receiving well visits, preventive screenings, behavioral healthcare, or care for chronic conditions according to recommended schedules. • HSAG recommended that VA Premier consider whether there are disparities within the MCO's 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 recommended that VA Premier implement appropriate interventions to improve access to and timeliness of well and preventive visits and screenings and		

Recommendation—Performance Measure Validation
recommended services for members diagnosed with a behavioral health or chronic condition, and follow-up assistance to ensure services are scheduled and received.
MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

- Virginia Premier works with the analytics team to identify members with Gaps in Care and have implemented the following interventions to improve a member's care:
- Member Outreach through:
  - IVR calls
  - Person to Person calls
  - Text messaging
  - Email
  - Letters and Postcard notifications
- Provider Education conducted across all regions to discuss the importance of members closing care gaps
- Conduct assessments on all members, to monitor, educate, and recommend services based on member's health.
- Conducts ASQs (Developmental screening) on children under the age of 3, who may qualify for Early Intervention or other services such as physical therapy or speech therapy.
- Care Coordinators (CCs) are also assigned to contact members who needs education and reminders of dental care and vision.
- Quality Nurses contact members to encourage and provide education on immunizations and assist with closing care gaps by building a rapport with providers and giving out incentives to members.
- Virginia Premier's High-Risk Teams assist with monitoring and educating members on services who have been diagnosed with behavioral health or have chronic illnesses.
- Virginia Premier's Watch Me Grow program is responsible for sending out text messages for member who choose to enroll, on reminders of upcoming well child visits and immunizations.
- Virginia Premier has developed a dedicated Quality Measures Improvement Committee. This committee includes representatives from each operational area within the organization. This Committee's sole function is to discuss measure improvement opportunities which includes monitoring, tracking, and trending of rates month-over-month and year-over-year. Measures are assigned to a business owner and interventions are tracked within an interventions grid and reviewed monthly for any updates or changes.

Social Determinants of Health:

- VP 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. VP is dedicated to ensuring our membership is assessed and provided the appropriate referrals and access to address all social determinants of health needs. In 2020, VP developed an SDOH Department to provide a greater focus on this pertinent area of healthcare delivery. The Social Determinants of Health (SDOH) program will identify members that contribute to lower performance for a particular race, ethnicity, age group, and region.

Virginia Premier works with the analytics team to identify members with Gaps in Care and have implemented the following interventions to improve a member's care:

- Member Outreach through
  - IVR calls
  - Person to Person calls
  - Text messaging

Recommendation—Performance Measure Validation
– Email – Letters and Postcard notifications • Provider Education conducted with providers across all regions to discuss the importance of members closing care gaps • Members receive education as to the importance of early treatment, and preventative measures • Leverage technology to provide members access to more convenient timeframes, access to providers before or after school, weekends • Hired seven Patient Services Coordinators to streamline workflow (early disease detection, increase survival rates, prevent further illness) • Activated Key Performance Indicators for teams to measure user performance. • Virginia Premier 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-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. • Virginia Premier will continue to review and monitor the measures bi-monthly at the Quality Satisfaction Committee, which reports to the Quality Improvement Committee. The Quality Satisfaction Committee monitors the CAHPS interventions on a bi-monthly basis to ensure interventions are having a positive impact on the measures to maintain or exceed benchmark.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. PMV rates showed: **Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan 2019: NR 2020: NR **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness (30 day) 2019: 2020: 37.86% **Metric 4.1.2:** Follow-Up After Emergency Department Visit for Mental Illness (30 day) 2019: 29.15% 2020: 62.79% **Metric 4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication 2019: NR 2020:NR **Metric 4.1.4:** Monitor Mental Health Utilization 2019: 29.15% 2020: 22.40% **Metric 4.2.1:** Monitor Identification of Alcohol and Other Drug Services 2019: 13.89% 2020: 13.17% **Metric 4.2.2:** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day) 2019:13.27% 2020: 20.63% **Metric 4.2.3:** Use of Opioids at High Dosage in Persons Without Cancer

Recommendation—Performance Measure Validation
2019: 7.40% 2020: 6.65% **Metric 4.2.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 2019: Initiation: 51.53%; Engagement: 11.32% 2020: Initiation: 46.09%%; Engagement: 13.88% **Metric 4.3.1:** Percentage of Eligibles who Receive Preventive Dental Services 2019: NR 2020: NR **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services 2019: 91.08% 2020: 87.19% **Metric 4.3.4:** Child and Adolescent Well-Care Visits 2019: NR 2020: 39.21% **Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 2019: 53.04% 2020: 55.47% **Metric 4.4.5:** Controlling High Blood Pressure 2019: 47.93% 2020: 45.54% **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care 2019: NR 2020: NR **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2019: NR 2020: NR **Metric 4.6.3:** Childhood Immunization Status 2019: Combination 1: 72.46% Combination 2: 27.27% 2020: NR **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life 2019: NR 2020: NR
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Adult		
Aim 1: Enhanced Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
• HSAG recommended that VA Premier focus evidence-based quality improvement efforts on improving overall member experience with care and services.		
MCO'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)		
Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:		

Recommendation—Member Experience of Care Survey - Adult
Virginia Premier will continue to review and monitor the measures bi-monthly at the Quality Satisfaction Committee, which reports to the Quality Improvement Committee. The Quality Satisfaction Committee monitors the CAHPS interventions on a bi-monthly basis to ensure interventions are having a positive impact on the measures to maintain or exceed benchmark.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.3:** Rating of All Health Care 2020: 74.1% 2021: 70.4%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

- HSAG recommended that VA Premier focus evidence-based quality improvement efforts on improving overall members' experience with care and services.
- HSAG recommended that VA Premier continue to monitor the measure results to ensure that there are no significant decreases in scores over time.
- HSAG recommended 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.

MCO'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)

Describe initiatives implemented based on recommendations **(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)**:

Virginia Premier will continue to review and monitor the measures bi-monthly at the Quality Satisfaction Committee, which reports to the Quality Improvement Committee. The Quality Satisfaction Committee monitors the CAHPS interventions on a bi-monthly basis to ensure interventions are having a positive impact on the measures to maintain or exceed benchmark.

Virginia Premier will continue to review and monitor the measures to early detect statistically significant decreases in rates over time.

Quality Satisfaction Committee (QSC)

In addition, VP's Quality Satisfaction Committee (QSC) is comprised of key stakeholders from all functional/operational areas. Survey scores are reviewed, and improvement implementation strategies are discussed, documented, and tracked. The QSC meets bi-monthly to discuss opportunities for improvement.

Quality Measures Improvement Committee (QMIC)

Virginia Premier has also developed a dedicated Quality Measures Improvement Committee. This committee includes representatives from each operational area within the organization. This Committee's sole function is to discuss measure improvement opportunities which includes monitoring, tracking, and trending of rates

Recommendation—Member Experience of Care Survey - Adult
month-over-month and year-over-year. Measures are assigned to a business owner and interventions are tracked within an interventions grid and reviewed monthly for any updates or changes. The Medicaid Child response rate for the 2021 decreased by 5.0% to 11.3% in comparison to the 2020 response rate of 16.3%. The CAHPS Survey was mailed out during the COVID-19 PHE which may have caused the low response rate. Surveys were collected via a mail and phone methodology. Members eligible for the survey were parents of those 17 years and younger (as of December 31 of the measurement year) who were continuously enrolled in the plan for at least five of the last six months of the measurement year. In effort to prevent the continual decline in response rates Virginia Premier will implement the following interventions: • Increase notifications to members informing them of upcoming CAHPS survey via email and/or text notification • Oversampling • Ensure questions are in easy-to-understand language • Assess all relevant internal data. Conduct additional surveys, data analyses as needed.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): The MCO did not note performance improvement as a result of initiatives implemented. CAHPS results showed: **Metric 1.2.3:** Rating of All Health Care 2020: 74.1% 2021: 70.4%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing the initiatives.
HSAG Assessment: HSAG determined that the MCO addressed the recommendations in the prior year's annual technical report.

Appendix F. 2020–2022 Quality Strategy Status Assessment

Evaluation Methodology Description

DMAS compares the baseline data for each measure along with the results from the QS Tracking Table, as well as performance results from other initiatives outlined in the Virginia 2020–2022 QS and reported through each annual EQR-related deliverable (i.e., PIPs, compliance review, network adequacy validation) and the annual EQR, to evaluate the quality of the managed care services offered to Virginia Medicaid managed care members and, subsequently, the overall effectiveness of the existing QS goals and objectives.

The methodology used by DMAS to evaluate the effectiveness of the Virginia 2020–2022 QS includes tracking and monitoring the MCOs' performance for the priority areas outlined in the Virginia 2020–2022 QS. DMAS annually tracks the progress of achieving the goals and objectives outlined in the Virginia 2020–2022 QS to further promote positive performance related to the quality of, timeliness of, and access to quality care and services provided by the DMAS-contracted MCOs. Overall effectiveness of achieving the Virginia 2020–2022 QS goals and objectives will be determined in 2023 using rates from 2023. In CY 2021, DMAS tracked the aggregated annual results of PMs included in the QS to measure improvement.

During the CY 2021 time frame, Virginia experienced unprecedented challenges due to the COVID-19 PHE. The PHE resulted in the implementation of innovative methods to ensure care delivery and receipt of early diagnosis, preventive, and well care. To continue progress on achieving the Virginia 2020–2022 QS goals and objectives and in response to COVID-19, the MCO care coordinators increased their outreach to members, ensuring access to services using telehealth medicine and automatically extending service authorizations and the use of out-of-network providers when necessary.

The MCOs developed processes to assist COVID-19 positive or exposed members with non-emergent transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments were not missed. In addition, the MCOs initiated an 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 PHE, the MCOs conducted outreach calls to high-risk members to ensure they received their medications on time.

Measure Alignment

DMAS has aligned the goals, objectives, and quality metrics detailed in its Virginia 2020–2022 QS with MCO PM requirements outlined in the MCO's contract with the Commonwealth. Performance metrics align closely with the CMS Adult and Child Core Set measures and NCQA's revised HEDIS measures. DMAS also requires the MCOs to be NCQA accredited and to conduct HEDIS PM reporting using an NCQA LO. In addition, DMAS requires the MCOs to undergo PMV with the EQRO for CMS Adult and Child Core Set measures not included in HEDIS reporting.

Table F-1 provides DMAS's baseline rates and progress in achieving the 2020–2022 Quality Strategy Goals. The table identifies the goals, measures, baseline rate, and the aggregate 2021 remeasurement rate.

Table F-1—Virginia Medicaid 2020–2022 Quality Strategy Status Assessment

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
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	81.1%	CAHPS benchmarks	✔	
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Rating of Health Plan	CMS Adult Core Set: CPA-AD	62.5%	CAHPS benchmarks	✔	
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD	55.8%	CAHPS benchmarks	✔	
	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)	91%♦	86%	✔	
		Ensure Access to Care	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in	Quality Management Review (QMR)	96%♦	86%	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
			the Scope Specified in the Service Plan					
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	68.0%	CAHPS benchmarks	✔	
		Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD	93.3%	CAHPS benchmarks	✔	
	Goal 2.2: Ensure Access to Care	Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD	82.9%	CAHPS benchmarks	✔	
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: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.2:** Frequency of Emergency Department Visits	VBP Reporting Team: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team: Clinical Efficiencies Data	*	VBP/PWP Performance Target	✔	✔
		Decrease Emergency Department Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS	50th: 40.96	NCQA Quality Compass 50th and 75th percentile	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	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	85%	Minimum Loss Ration in Final Rule	✔	✔
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	7-Day – Total: 35.63% 30-Day – Total: 56.84%	NCQA Quality Compass 50th and 75th percentile	✔	
		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	7-Day – Total: 45.34% 30-Day – Total: 57.38%	VBP/PWP Performance Target	✔	
		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	Initiation Phase: 45.20% Continuation and Maintenance Phase: 58.61%	NCQA Quality Compass 50th and 75th percentile	✔	✔
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT	12.41	NCQA Quality Compass 50th percentile	✔	
		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	69.58%	NCQA Quality Compass 50th and 75th percentile	✔	✔
	Goal 4.2: Improve Outcomes for	Increase Identification of Alcohol and Other Drug Services	**Metric 4.2.1:** Monitor Identification of	NCQA HEDIS IAD	2.21	NCQA Quality Compass 50th percentile	✔	

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Members with Substance Use Disorders		Alcohol and Other Drug Services					
		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	7-Day – Total: 13.92% 30-Day – Total: 21.88%	VBP/PWP Performance Target	✔	
		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	50th: 5.12	NCQA Quality Compass 50th and 75th percentile	✔	
		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 - Total	CMS Adult Core Set: IET-AD	7.5%	VBP/PWP Performance Target♦♦	✔	
	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	44.35%	CMS Child Core Set Benchmark	✔	✔
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP	72.75%	NCQA Quality Compass 50th and 75th percentile	✔	
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH	46.57%	VBP/PWP Performance Target**	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	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 - Total	CMS Adult Core Set PQI08-AD	15%	VBP/PWP Performance Target♦♦	✔	
		Decrease Asthma Admission Rate	**Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) (per 100,000 member months)	AHRQ Quality Indicators PDI 14	16.67%	VBP/PWP Performance Target♦♦		
		Decrease COPD and Asthma in Older Adults' Admission Rate	**Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate - Total	CMS Adult Core Set PQI05-AD	15%	VBP/PWP Performance Target♦♦	✔	
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set HPC-AD	50.30%	VBP/PWP Performance Target**	✔	
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD	46.91%	NCQA Quality Compass 50th and 75th percentile	✔	
	Goal 4.5: Improve Outcomes for Nursing Home Eligible Members	Decrease Use of High-Risk Medications in Older Adults (Elderly)	**Metric 4.5.1:** Use of High-Risk Medications in Older Adults (Elderly) (Medicare Rate)	NCQA HEDIS DAE	*	NCQA Quality Compass 50th and 75th percentile	✔	
	Goal 4.6: Improve Outcomes for	Increase Postpartum Care	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care	CMS Adult Core Set PPC-AD	66.91%	VBP/PWP Performance Target**	✔	✔

AIM	Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	Program	
							Medicaid	CHIP
	Maternal and Infant Members	Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH	74.45%	VBP/PWP Performance Target**	✔	✔
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH	65.82%	VBP/PWP Performance Target**	✔	✔
		Decrease Low Birth Weight Babies	**Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams	CMS Child Core Set LBW-CH	9.9	CDC Wonder Data from CMS benchmarks	✔	✔
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH	First 15 Months: 54.35% 15 Months to 30 Months: 72.10%	NCQA Quality Compass 50th and 75th percentile	✔	✔

**The baseline measure rate is the final validated 2020 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*

***Target established in the CY2021 PWP Methodology.*

****The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2022 Annual Technical Report and posted to the DMAS website.*

^The baseline measure rate is the final 2020 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2020 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2020 rate reported by the DMAS Finance Team

♦ *MY2019 HEDIS data was utilized*

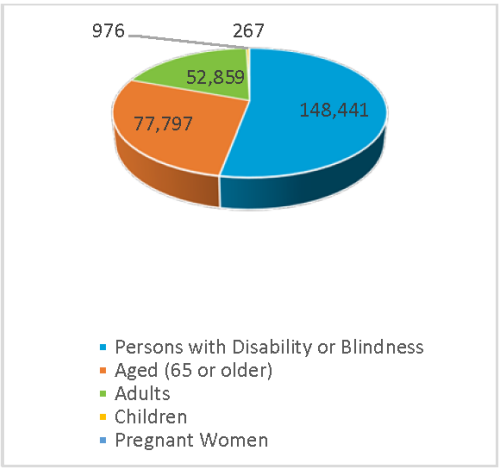
♦♦ *2019 data was used to establish the target*

Appendix G. CCC Plus Program 2021 Snapshot

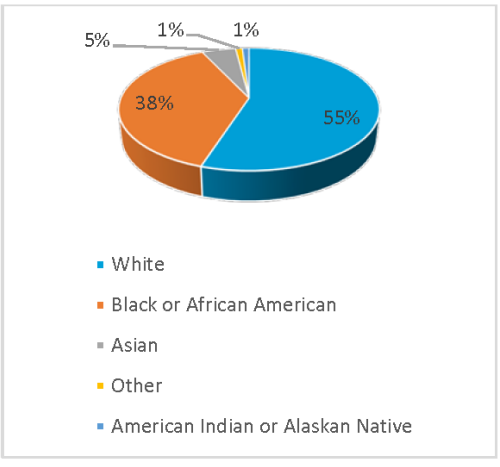
CCC Plus 2021 Snapshot

CCC Plus Program Demographics

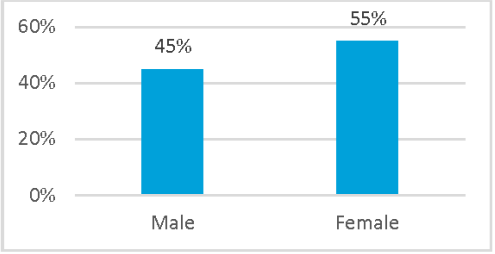
Eligibility Categories



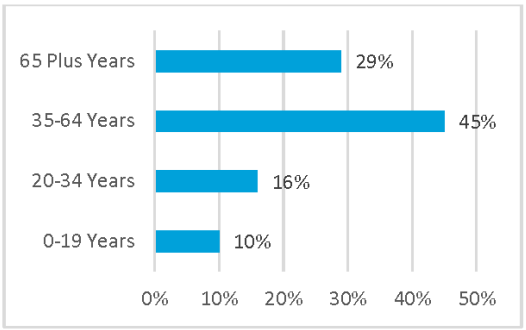
Categories by Race



Percentage by Gender



Enrollment by Age Group

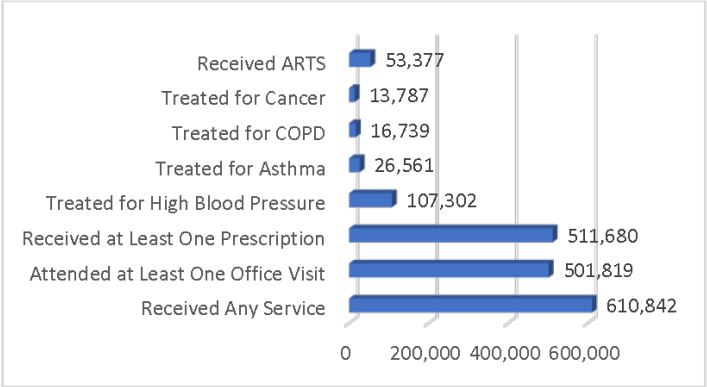


Medicaid Expansion

As of September 15, 2021, 584,631 adults were newly enrolled in Medicaid as a result of Virginia's Medicaid expansion. 147,182 expansion members were also parents.

Male	Female	
46%	54%	
19-34 Years	**35-54 Years**	**55 Plus Years**
45%	38%	17%

Medicaid Expansion Service Provision



Performance Improvement Projects

Intervention Status
MCOs Adopted four successful interventions
MCOs Adapted seven interventions

CCC Plus 2021 Snapshot

Performance Measure Validation

Strengths

Domain	Strengths
Access and Preventive Care	Five of the MCOs met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.
Behavioral Health	All six MCOs met or exceeded the 50th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Initiation of Alcohol and Other Drug—Total—Total* measure indicators.
Taking Care of Children	One of the MCOs met or exceeded the 50th percentile for the *Childhood Immunization Status—Combination 3* measure.
Living With Illness	Five of six MCOs meeting or exceeding the 50th percentile for the *Discussing Cessation Medications* and *Discussing Cessation Strategies* measure indicators and all six MCOs meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* measure indicator. Three of the MCOs met or exceeded the 50th percentile for the *Pharmacotherapy Management of COPD Exacerbation* measure indicator rates. Four MCOs met or exceeded the 50th percentile for the *Asthma Medication Ratio* measure.
Use of Opioids	Three MCOs met or exceeded the 50th percentile for at least two of the three *Use of Opioids From Multiple Providers* measure indicator rates.

Weaknesses

Domain	Strengths
Access and Preventive Care	All reportable MCO rates fell below the 50th percentile for the *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Use of Imaging Studies for Low Back Pain* measures.
Behavioral Health	All MCO rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total*, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement of Alcohol and Other Drug—Total—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics —Total* measure indicators rates.
Taking Care of Children	All six MCOs have opportunities for improvement related to the *Immunizations for Adolescents*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicator rates, as none of the MCOs' rates met or exceeded the 50th percentile.
Living With Illness	All MCO rates fell below the 50th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Comprehensive Diabetes Care—HbA1c Testing* measures. Five of the six MCOs' rates fell below the 50th percentile for *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed* measure indicators.
Use of Opioids	Five of the six MCOs' rates fell below the 50th percentile for the *Use of Opioids at High Dosage* measure.

CCC Plus 2021 Snapshot

Compliance with Standards Monitoring

MCOs' compliance scores ranged from 86.2% to 95.2%. All six MCOs received a 100% compliance score for the following standards:

Standards
Emergency and Poststabilization Services
Coordination and Continuity of Care
Provider Selection
Practice Guidelines
Health Information Systems
Program Integrity

Encounter Data Validation

MCO Encounter Data Completeness
Encounter data completeness ranged from 0% - 99.2%
MCO Statewide Timeliness Ranges
Institutional: 95.9%
Professional: 95.0%
Pharmacy: 92.0%

Member Experience of Care

Strengths
The CCC Plus program scored statistically significantly higher than the 2020 NCQA adult Medicaid national averages for six measures.

Opportunities for Improvement
The top-box scores for the *Rating of Health Plan*, *Rating of All Health Care*, and *How Well Doctors Communicate* measures for the CCC Plus program were statistically significantly lower than the 2020 NCQA child Medicaid national averages.
The scores for *Rating of Health Plan* for five out of six MCOs were statistically significantly lower than the 2020 NCQA child Medicaid national averages.
The 2021 top-box scores for the CCC Plus program were statistically significantly lower than the 2020 child Medicaid scores for the *Getting Care Quickly* and *How Well Doctors Communicate* measures.

Consumer Decision Support Tool

MCO	Overall Rating*	Doctors' Communication	Access and Preventive Care
Aetna	✓✓✓	✓	✓✓✓
HealthKeepers	✓✓✓	✓✓✓	✓✓✓
Magellan	✓	✓✓✓	✓✓
Optima	✓✓✓✓	✓✓✓✓✓	✓✓✓
United	✓✓✓	✓✓	✓✓✓
VA Premier	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓

MCO	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	✓✓✓	✓✓✓✓	✓✓✓✓✓
HealthKeepers	✓✓✓✓	✓✓✓✓✓	✓✓✓✓✓
Magellan	✓	✓✓	✓
Optima	✓✓	✓✓✓	✓
United	✓✓✓	✓✓	✓✓✓✓✓
VA Premier	✓✓✓✓✓	✓✓✓	✓

Key:
Highest Performance: ✓✓✓✓✓
High Performance: ✓✓✓✓
Average Performance: ✓✓✓
Low Performance: ✓✓
Lowest Performance: ✓