Commonwealth of Virginia
Department of
Medical Assistance Services

2022 External Quality Review Technical Report—Medallion 4.0

March 2023

Table of Contents

1. **Executive Summary 1-1**
   - Overview of 2022 External Quality Review 1-1
   - Scope of External Quality Review Activities 1-1
   - Methodology for Aggregating and Analyzing EQR Activity Results 1-2
   - Virginia Managed Care Program Findings and Conclusions 1-5
   - Quality Strategy Recommendations for the Virginia Managed Care Program 1-9
2. **Overview of Virginia's Managed Care Program 2-1**
   - Medicaid Managed Care in the Commonwealth of Virginia 2-1
     - The Department of Medical Assistance Services 2-1
   - Virginia's 2020–2022 Quality Strategy 2-29
   - Quality Initiatives 2-30
   - Best and Emerging Practices 2-31
3. **MCO Comparative Information 3-1**
   - Comparative Analysis of the MCOs by Activity 3-1
     - Definitions 3-1
     - MCO Comparative and Statewide Aggregate PIP Results 3-2
     - MCO Comparative and Statewide Aggregate PMV Results 3-3
     - MCO Comparative and Statewide Aggregate HEDIS Results 3-6
     - Compliance With Standards Monitoring 3-12
     - Network Capacity Analysis 3-13
     - Statewide Aggregate CAHPS Results 3-14
     - Member Experience Survey Highlights 3-14
     - FAMIS Program Statewide Aggregate Results 3-20
     - MCO Comparative and Statewide Calculation of Additional PM Results 3-20
     - ARTS Measure Specification Development and Maintenance Results 3-22
     - Focus Studies 3-23
     - MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results 3-23
     - Performance Withhold Program 3-24
4. **Validation of Performance Improvement Projects 4-1**
   - Overview 4-1
   - Objectives 4-1
   - Approach to PIP Validation 4-2
     - PIP Validation Scoring 4-2
     - Training and Implementation 4-3
     - PIP Validation Status 4-3
     - Validation Findings 4-4
     - Recommendations 4-12
5. **Validation of Performance Measures 5-1**
   - Overview 5-1
   - Objectives 5-1
   - MCO-Specific HEDIS Measure Results 5-1
     - Aetna 5-1
     - HealthKeepers 5-3
     - Molina 5-4
     - Optima 5-5

United ... 5-6
VA Premier ... 5-8
6. Review of Compliance With Medicaid and CHIP Managed Care Regulations ... 6-1
Overview ... 6-1
Objectives ... 6-1
Deeming ... 6-2
Aetna ... 6-3
HealthKeepers ... 6-4
Molina ... 6-5
Optima ... 6-7
United ... 6-8
VA Premier ... 6-9
DMAS Intermediate Sanctions Applied ... 6-10
7. Member Experience of Care Survey ... 7-1
Overview ... 7-1
Objectives ... 7-1
MCO-Specific Results ... 7-1
Aetna ... 7-1
HealthKeepers ... 7-4
Molina ... 7-6
Optima ... 7-8
United ... 7-10
VA Premier ... 7-12
8. Focus Studies ... 8-1
Overview ... 8-1
Medicaid Maternal Child and Health Focus Study ... 8-1
Child Welfare Focus Study ... 8-5
Dental Utilization in Pregnant Women Focus Study ... 8-11
9. Summary of MCO-Specific Strengths and Weaknesses ... 9-1
Aetna ... 9-1
HealthKeepers ... 9-3
Molina ... 9-5
Optima ... 9-7
United ... 9-8
VA Premier ... 9-10
Appendix A. Technical Report and Regulatory Crosswalk ... A-1
Appendix B. Technical Methods of Data Collection and Analysis—MCOs ... B-1
Appendix C. MCO Best and Emerging Practices ... C-1
Appendix D. MCO Quality Strategy Quality Initiatives ... D-1
Appendix E. Assessment of Follow-Up on Prior Recommendations ... E-1
Appendix F. 2020–2022 Quality Strategy Status Assessment ... F-1
Appendix G. Medallion 4.0 Program 2022 Snapshot ... G-1

Glossary of Acronyms

42 CFR .... Title 42 of the Code of Federal Regulations
ABA .... Applied Behavior Analysis
ACOG .... American College of Obstetricians and Gynecologists
ADHD .... Attention-Deficit/Hyperactivity Disorder
Adult Core Set .... CMS Core Set of Adult Health Care Quality Measures for Medicaid
AHRQ .... Agency for Healthcare Research and Quality
AOD .... Alcohol and Other Drug
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
C-Section .... Cesarean Section
CAHPS®,[1] .... Consumer Assessment of Healthcare Providers and Systems
CAP .... Corrective Action Plan
CC .... Community Coaching
CCC .... Children with Chronic Conditions
CCC Plus .... Commonwealth Coordinated Care Plus
CDC .... Centers for Disease Control and Prevention
CE .... Community Engagement
CEG .... Clinical Estimate of Gestation
Child Core Set .... CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP
CHIP .... Children's Health Insurance Program
CHIPRA .... Children's Health Insurance Program Reauthorization Act of 2009
CI .... Confidence Interval
CMH .... Community Mental Health
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 System
CSB .... Community Service Board

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

CT .... Computerized Tomography
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
DNA .... Deoxyribonucleic Acid
DNR .... Do Not Report
DOC .... Department of Corrections
DSS .... Department of Social Services
ED .... Emergency Department
EDV .... Encounter Data Validation
EDWS .... Enterprise Data Warehouse System
EPS .... Encounter Processing Solution
EPSDT .... Early and Periodic Screening, Diagnostic and Treatment
EQR .... External Quality Review
EQRO .... External Quality Review Organization
FAMIS .... Family Access to Medical Insurance Security
FAR .... Final Audit Report
FFS .... Fee-for-Service
FFY .... Federal Fiscal Year
FIPS .... Federal Information Processing Standards
FIT .... Fecal Immunochemical Test
FMEA .... Failure Mode and Effects Analysis
FOBT .... Fecal Occult Blood Test
FPL .... Federal Poverty Level
FQHC .... Federally Qualified Health Center
FY .... Fiscal Year
HCBS .... Home- and Community-Based Services
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
HIV .... Human Immunodeficiency Virus
HMO .... Health Maintenance Organization
HSAG .... Health Services Advisory Group, Inc.
IACCT .... Independent Assessment Certification and Coordination Team
ICT .... Intensive Community Treatment

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

ID .... Identification
IDSS .... Interactive Data Submission System
IIH .... Intensive In-Home Services
IS .... Information Systems
ISCA .... Information Systems Capability Assessment
ISCAT .... Information Systems Capabilities Assessment Tool
ISP .... Individual Service Plan
LABA .... Licensed Applied Behavior Analyst
LBA .... Licensed Behavior Analyst
LCPA .... Licensed Child Placement Agency
LIFC .... Low-Income Families With Children
LMHP .... Licensed Mental Health Professional
LMHP-R .... Licensed Mental Health Professional—Resident
LMHP-RP .... Licensed Mental Health Professional Resident in Psychology
LMHP-S .... Licensed Mental Health Professional—Supervisee
LMP .... Last Menstrual Period
LO .... Licensed Organization
LOB .... Line of Business
LTSS .... Long-Term Services and Supports
MBHO .... Managed Behavioral Health Organization
MCE .... Managed Care Entity
MCO .... Managed Care Organization
MCP .... Managed Care Plan
MES .... Medicaid Enterprise System
MHP .... Mental Health Provider
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
MY .... Measurement Year
NASHP .... National Academy for State Health Policy
NCHS .... National Center for Health Statistics
NCQA .... National Committee for Quality Assurance
NDC .... National Drug Code
NF .... Nursing Facility
NR .... Not Reported

NVSS .... National Vital Statistics System
OB/GYN .... Obstetrics and Gynecology
OBOT .... Office-Based Opioid Treatment
OBRAF .... Obstetrical Risk Assessment Form
OSR .... Operational Systems Review
OTP .... Opioid Treatment Program
OUD .... Opioid Use Disorder
PAHP .... Prepaid Ambulatory Health Plan
PCCM .... Primary Care Case Management
PCP .... Primary Care Provider
PDF .... Portable Document Format
PDI .... Pediatric Quality Indicator
PDSA .... Plan-Do-Study-Act
PHE .... Public Health Emergency
PIHP .... Prepaid Inpatient Health Plan
PIP .... Performance Improvement Project
PM .... Performance Measure
PMPM .... Per Member Per Month
PMV .... Performance Measure Validation
PNC .... Prenatal Care
PPC .... Prenatal and Postpartum Care
PRTF .... Psychiatric Residential Treatment Facility
PSR .... Psychosocial Rehabilitation
PSV .... Primary Source Verification
PWP .... Performance Withhold Program
QAPI .... Quality Assessment and Performance Improvement
QI .... Quality Improvement
QS .... Quality Strategy
R .... Reportable
RTC .... Residential Treatment Center
SAFE .... Secure Access File Exchange
SARS-CoV-2 .... Severe Acute Respiratory Syndrome Coronavirus 2
SBIRT .... Screening, Brief Intervention, and Referral to Treatment
SFC .... Smiles for Children
SFY .... State Fiscal Year
SFTP .... Secure File Transfer Protocol
SHCN .... Special Health Care Needs
SMART .... Specific, Measurable, Attainable, Relevant, Time-Bound
SNF .... Skilled Nursing Facility

SUD .... Substance Use Disorder
TANF .... Transitional Aid to Needy Families
TDT .... Therapeutic Day Treatment
TGH .... Therapeutic Group Home
TPL .... Third Party Liability
USPSTF .... United States Preventive Services Task Force
VA .... Virginia
VBP .... Value-Based Purchasing
VCU .... Virginia Commonwealth University
VDH .... Virginia Department of Health
VDSS .... Virginia Department of Social Services
WIC .... Women, Infants and Children

1. Executive Summary

Overview of 2022 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. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1]

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, 2022, through December 31, 2022 (CY 2022). In addition, this report draws conclusions about the quality of, timeliness of, and access to healthcare services that the contracted MCOs provide. Effective implementation of the EQR-related activities will facilitate Commonwealth efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members.

DMAS administers the Medallion 4.0 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 BH services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2022 are displayed in Table 1-1.

Table 1-1—Medicaid Medallion 4.0 MCOs in Virginia

MCO Name	MCO Short Name
Aetna Better Health of Virginia	Aetna
HealthKeepers, Inc.	HealthKeepers
Molina Complete Care of Virginia	Molina
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

[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: Jan 3, 2023.

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 the quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate the Commonwealth's efforts to 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 2022 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2022, through December 31, 2022. 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 Medallion 4.0 program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO, please refer to the results of each activity in sections 4 through 9 of this report. Detailed information about each activity's methodology are 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		
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 2022 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 PMs follow Commonwealth 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, 2021, through December 31, 2021.	*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 Virginia-specific requirements, when applicable. HSAG conducted full compliance reviews (called OSRs) that included all federal and Virginia-	*Protocol 3.* Review of Compliance with Medicaid and CHIP Managed Care Regulations

Activity	Description	CMS EQR Protocol
	specific requirements for the review period of July 1, 2021, through June 30, 2022.	
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, BH, 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 Analysis	This activity assesses member experience with an MCO and its providers and the quality of care members receive. **FAMIS CAHPS Survey**—HSAG administers the CAHPS 5.1H Child Medicaid Health Plan Survey to FAMIS members receiving healthcare services through FFS or managed care. HSAG analyzes the CAHPS survey data and generates a FAMIS Program Member Satisfaction Report for DMAS.	*Protocol 6.* Administration or Validation of Quality-of-Care Surveys
Calculation of Additional PMs	This activity calculates quality measures to evaluate the degree to which evidence-based treatment guidelines are followed, where indicated, and to assess the results of care. HSAG calculates one PM (selected by DMAS) for the Medicaid population stratified by	*Protocol 7.* Calculation of Additional Performance Measures

Activity	Description	CMS EQR Protocol
	geographic region and key demographic variables (race, gender, age, etc.).	
ARTS Measure Specification Development and Maintenance	HSAG identifies, when available, PMs from existing PM sets or develops PMs for the ARTS program.	*Protocol 7.* Calculation of Additional Performance Measures
Focus Studies	This activity provides information about the healthcare quality for a particular aspect of care across managed care in the Commonwealth or for subpopulations served by managed care within the Commonwealth. **Medicaid and CHIP Maternal and Child Health Focus Study**—HSAG conducts a focus study that provides quantitative information about prenatal care and associated birth outcomes among Medicaid recipients. **Child Welfare Focus Study**—HSAG conducts a Child Welfare Focus Study to evaluate healthcare utilization among children in foster care under the Medallion 4.0 program. **Dental Utilization in Pregnant Women Data Brief**—HSAG produces a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs.	*Protocol 9.* Conducting Focus Studies of Health Care Quality
Consumer Decision Support Tool	This activity provides information to help eligible members choose a Medicaid Medallion 4.0 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 Medallion 4.0 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
PWP	HSAG developed a methodology to calculate the MCO results for the PWP for DMAS. The 2021 PWP used HEDIS and non-HEDIS PMs.	

Activity	Description	CMS EQR Protocol
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 Medallion 4.0 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 Medallion 4.0 Program Conclusions: Quality, Access, and Timeliness

Program Strengths		
Domain		**Conclusion**
+	**Quality**	**Strength:** Overall, the results of the 2021 compliance review and PM results for some PM indicators identified that the MCOs implemented processes to ensure access to care and services and to ensure that the service delivery met the accessibility, cultural, ethnic, racial, and linguistic needs of members including those with physical and behavioral SHCN. The well-child PM results demonstrate strong recovery from the COVID-19 PHE declines. PM results show that five of six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PM indicators. **Strength:** Overall, MCO members were satisfied with the quality of care provided through the Medallion 4.0 program. This is supported by improved PM rates, with all six MCOs' rates meeting or exceeding the 50th percentile for the *Asthma Medication Ratio—Total* PM indicator. Of note, two of the six MCOs displayed strong performance, with their rates exceeding the Virginia aggregate for six of 10 (60.0 percent) PM rates. The results suggest that providers were providing quality care for chronic conditions such as asthma. **Strength:** With well-care visits for children demonstrating a strong recovery from the PHE rates, members are also experiencing an increased use of first-line psychosocial care for children and adolescents prescribed antipsychotics. This may be due to increased access to in-person visits, catch-up schedules for well-child visits, or increased use of telemedicine visits. The results are demonstrated through five of six MCOs' rates meeting or exceeding the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
+	**Access**	**Strength:** BH treatment is a demonstrated strength for the MCOs and the Medallion 4.0 program overall. The 2021 compliance reviews of the MCOs identified strong implementation of the ARTS benefit, with few grievances or appeals filed with the MCOs, indicating members' access to needed behavioral and SUD treatment and services. The MCOs demonstrated access and timeliness of follow-up care for BH conditions as evidenced by five of six MCOs' rates meeting or exceeding the 50th percentile for the *Follow-Up After Emergency Department (ED) Visit for Mental Illness—7-Day Follow-Up—Total* PM indicator.

Program Strengths		
Domain		**Conclusion**
	Timeliness	**Strength:** With BH treatment identified as a strength for the MCOS, including increased access and timeliness of services, all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* PM indicator. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* PM indicator. These results suggest timely access to quality care for members diagnosed with depression .

Program Weaknesses		
Domain		**Conclusion**
	Quality	The COVID-19 PHE is a reminder of the importance of adult and childhood vaccinations. Medallion 4.0 MCOs experienced a decline in immunization rates during the PHE and continue to experience challenges in improving PM rates. Along with the importance of vaccinations, assessing the physical, emotional, and social development of children is important, and continues through every stage of life. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. The MCOs continue to struggle with ensuring children receive well care and vaccinations as evidenced by four of the six MCOs' rates falling below the 50th percentile for the *Childhood Immunization Status—Combination 3* and *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* PM indicators. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease. Medallion 4.0 MCOs continued to have challenges ensuring members diagnosed with chronic disease, such as hypertension, received ongoing and regular care and monitoring. This was evident in the *Controlling High Blood Pressure* PM, with all six MCOs' rates falling below the 50th percentile. Proper follow-up care is essential to manage ADHD medication use in children. PM rates indicate that the MCOs are continuing to have challenges ensuring that medications are prescribed and managed correctly. All six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* PM indicator, and four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* PM indicator.

Program Weaknesses		
Domain		**Conclusion**
—	**Access**	Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help address acute issues or manage chronic conditions. All six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. The low performance indicates members may be experiencing issues accessing providers for health services. The COVID-19 PHE had a significant impact on healthcare services, and providers are still recovering from its effects. Many provider offices were closed and offered limited telehealth services. Families also deferred going to the doctor's office for routine, nonemergency care. Although members were receiving access to preventive care, the PM rates suggest that members were not always able to access providers for preventive services in a timely manner.
—	**Timeliness**	MCO members are not completing recommended screenings, which may indicate a lack of understanding of healthcare or recommended preventive schedules. Although members may have had adequate access to timely early diagnosis, preventive, and well visits, members were not completing these visits or receiving necessary preventive and early detection care according to recommended guidelines. A factor that may have contributed to low performance was the temporary suspension of non-urgent services and in-person PCP appointments due to the COVID-19 PHE. Screenings can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs. Delays or missed opportunities for breast cancer and cervical cancer screening may have adverse health outcomes or may indicate cancer screening disparities among women already experiencing health inequities. All six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* PM, reflecting an opportunity for improvement. Five of the six MCOs' rates fell below the 50th percentile for the *Cervical Cancer Screening* PM. Timeliness of prenatal and postpartum care provides an opportunity to reduce risks and complications and improve long-term health outcomes for both mom and baby. All six MCOs' rates fell below the 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* PM indicators, reflecting an opportunity for improvement. PM results in the BH domain indicate that Virginia and the MCOs are not appropriately managing care for patients hospitalized with a mental health issue. This is a change from the prior year where all six MCOs'

Program Weaknesses		
Domain		**Conclusion**
		rates met or exceeded the 50th percentile for both of the *Follow-Up After Hospitalization for Mental Illness* PM. PM results show that four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* PM indicators. With the strong processes previously in place for BH and OUD, there is an opportunity to review the previous processes and focus on improving these PM indicator rates.

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 2023–2025 QS are included in Table 1-4.

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

Program Recommendations	
Recommendation	**Associated Virginia 2023–2025 QS Goal and/or Objective**
To improve program-wide performance in support of Objective 5.4 and improve outcomes for members in need of BH and developmental services, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • 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.	**Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness

Program Recommendations	
To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Measure 4.1.1.4:** Immunizations for Adolescents **Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life
To improve program-wide performance in support of Objective 4.2 and improve use of prenatal and postpartum care, HSAG recommends DMAS: • Require the MCOs to identify access- and timeliness-related PM indicators such as the *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care* PM indicators that fell below the NCQA Quality Compass®,[1-2] national Medicaid HMO 50th percentile, and focus QI efforts on identifying the root 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. DMAS should also require the MCOs to identify best practices for ensuring prenatal and postpartum care and ensure members receive all prenatal and maternity care according to recommended schedules. • Require the MCOs to identify best practices to improve care and services according to evidence-based guidelines.	**Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care **Measure: 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

[1-2] Quality Compass® is a registered trademark of NCQA.

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. Table 2-1 displays the average annual program enrollment during CY 2022.

Table 2-1—CY 2022 Average Annual Program Enrollment[2-1]

Program	SFY 2022 Enrollment as of 06/30/2022
Medallion 4.0	1,560,828
CCC Plus	305,846
Title XIX	1,866,674
Title XXI	180,608
Total Served	2,047,282

DMAS contracted with six privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2022 are displayed in Table 2-2.

Table 2-2—Medallion 4.0 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,	Accredited* through 03/09/24 LTSS Distinction through 03/09/24

[2-1] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 19, 2022.

MCO	Profile Description	MCO NCQA Accreditation Status
	headquartered in Indianapolis, Indiana.	
Molina	Molina Healthcare, Inc., headquartered in Long Beach, CA, provides managed healthcare services under the Medicaid and Medicare programs and through the state insurance marketplaces through its locally operated health plans.	Accredited* through 06/29/23 LTSS Distinction through 06/30/23
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.	Accredited through 07/26/25 LTSS Distinction through 07/26/25

**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.*[2-2]

[2-2] 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: Jan 4, 2023.

MCO Medallion 4.0 Enrollment Characteristics

Figure 2-1 through Figure 2-5 display the Medallion 4.0 program enrollment characteristics. Table 2-3 through Table 2-7 display the MCO and Medallion 4.0 program overall enrollment characteristics.

Figure 2-1 displays the Medallion 4.0 program CY 2022 eligibility categories.

Figure 2-1—Medallion 4.0 Program CY 2022 Eligibility Categories

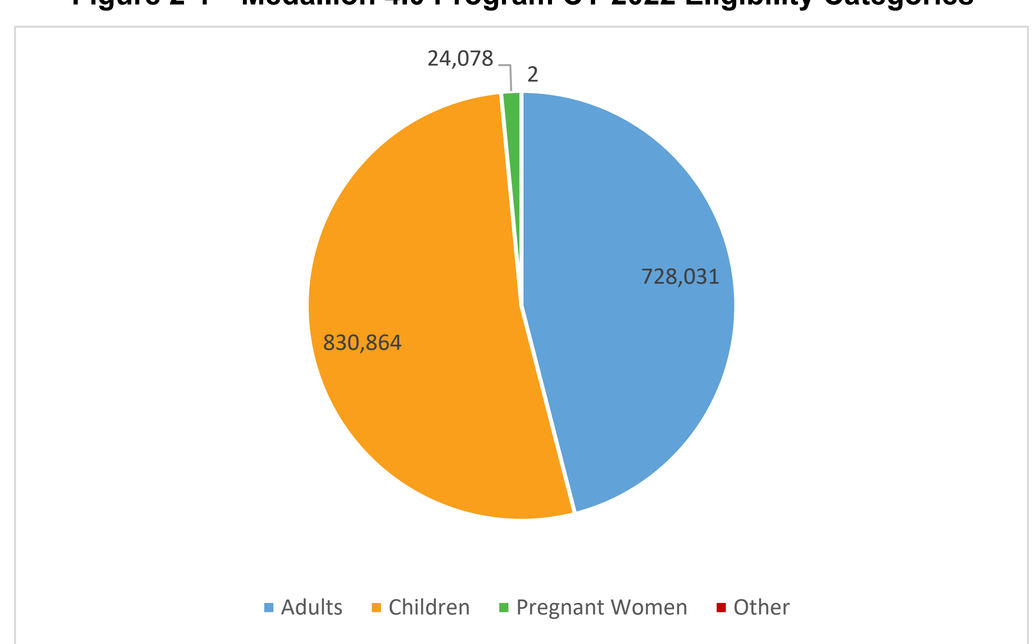


Table 2-3—Medallion 4.0 Program CY 2022 MCO Eligibility Categories[2-3]

Category	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	All
Eligibility							
Overall Total	214,204	480,251	103,633	306,558	167,986	310,343	1,582,975
Adults	122,206	192,525	60,545	135,804	82,088	134,863	728,031
Children	88,533	280,471	41,010	166,433	82,857	171,560	830,864
Pregnant Women	3,465	7,255	2,078	4,320	3,041	3,919	24,078
Other	0	0	0	1	0	1	2

[2-3] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 19, 2022.

Figure 2-2 displays the CY 2022 Medallion 4.0 program categories by race.

Figure 2-2—Medallion 4.0 Program CY 2022 Categories by Race

Table 2-4—Medallion 4.0 Program CY 2022 Categories by Race[2-4]

Category	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	All
Race							
White	53%	53%	52%	45%	58%	59%	53%
Black or African American	33%	34%	33%	45%	27%	30%	35%
Asian	4%	6%	4%	3%	6%	5%	5%
Other	8%	5%	10%	5%	8%	5%	6%
Native Hawaiian or Other Pacific Islander	1%	1%	1%	1%	1%	1%	1%
American Indian or Alaskan Native	1%	1%	1%	1%	1%	1%	1%

[2-4] Ibid.

Figure 2-3 displays the CY 2022 Medallion 4.0 program categories by ethnicity.

Figure 2-3—Medallion 4.0 Program CY 2022 Categories by Ethnicity

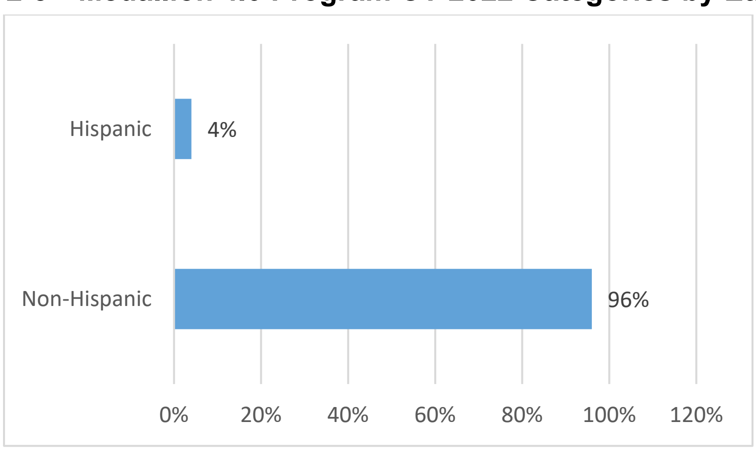


Table 2-5—Medallion 4.0 Program CY 2022 MCO Categories by Ethnicity[2-5]

Category	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	All
Ethnicity							
Non-Hispanic	96%	95%	96%	96%	95%	96%	96%
Hispanic	4%	5%	4%	4%	5%	4%	4%

[2-5] Ibid.

Figure 2-4 displays the CY 2022 Medallion 4.0 program percentage of members by gender.

Figure 2-4—Medallion 4.0 Program CY 2022 Percentage by Gender

Table 2-6—Medallion 4.0 Program CY 2022 MCO Percentage by Gender[2-6]

Category	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	All
Gender							
Male	45%	44%	48%	43%	47%	45%	45%
Female	55%	56%	52%	57%	53%	55%	55%

[2-6] Ibid.

Figure 2-5 displays the CY 2022 Medallion 4.0 program enrollment by age group.

Figure 2-5—Medallion 4.0 Program CY 2022 Enrollment by Age Group

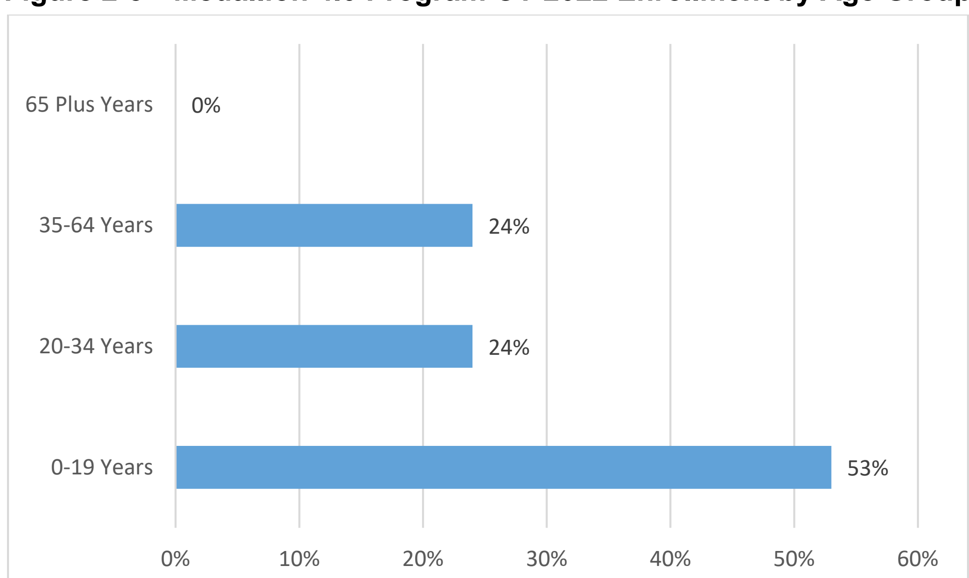


Table 2-7—Medallion 4.0 Program CY 2022 MCO Enrollment by Age Group[2-7]

Category	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	All
Age Groups							
0–19 Years	41%	58%	40%	54%	49%	55%	53%
20–34 Years	28%	21%	31%	23%	25%	22%	24%
35–64 Years	30%	21%	29%	22%	25%	23%	24%
65 Plus Years	0%	0%	0%	0%	0%	0%	0%

Medallion 4.0 Program

The Medallion 4.0 program is intended to ensure the delivery of acute and primary care services, prescription drug coverage, and BH services for Virginia's Medicaid Title XIX members and FAMIS members, Virginia's Title XXI CHIP program. The Medallion 4.0 population includes children, low-income parents and caretaker relatives living with children, pregnant women, FAMIS members, and current and former foster care and adoption assistance children.

Medicaid expansion coverage began in Virginia on January 1, 2019. Medicaid expansion 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

[2-7] Ibid.

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 August 1, 2022, 153,553 were also parents.[2-8] Males accounted for 45 percent of the Medicaid expansion population and 54 percent were female. Figure 2-6 displays services received by Medicaid expansion members since January 2019. Enrollment and service data were obtained from the August 1, 2022, Medicaid expansion data.[2-9] Data in Table 2-8 through Table 2-11 and Figure 2-6 through Figure 2-9 were obtained from the August 1, 2022, enrollment data.[2-10]

Figure 2-6—Medicaid Expansion Service Provision

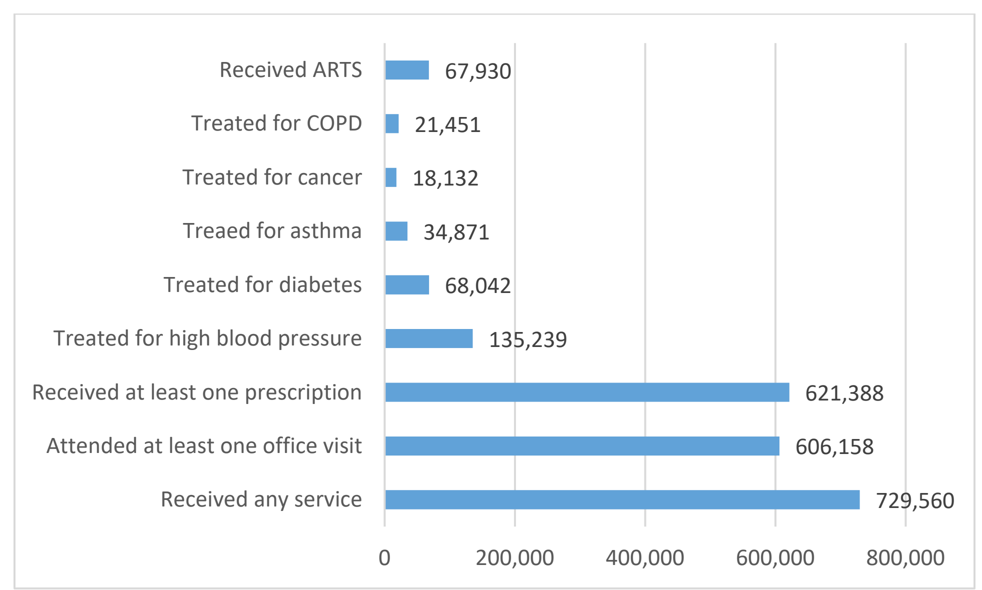


Table 2-8—CY 2022 Medicaid Expansion Service Provision[2-11]

Age Category	Number of Services Provided
Received ARTS	67,930
Treated for COPD	21,451
Treated for Cancer	18,132
Treated for Asthma	34,871
Treated for Diabetes	68,042
Treated for High Blood Pressure	135,239

[2-8] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid Expansion Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/. Accessed on: Dec 19, 2022.
[2-9] Ibid.
[2-10] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid Expansion Access. Available at: https://www.dmas.virginia.gov/data/medicaid-expansion-access. Accessed on: Dec 19, 2022.
[2-11] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid Expansion Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/. Accessed on: Dec 19, 2022.

Age Category	Number of Services Provided
Received at Least One Prescription	621,388
Attended at Least One Office Visit	606,158
Received Any Service	729,560

Figure 2-7 displays Medallion 4.0 program Medicaid expansion members by age as of January 2019.

Figure 2-7—Medallion 4.0 Program Medicaid Expansion Percentage of Members by Age Category

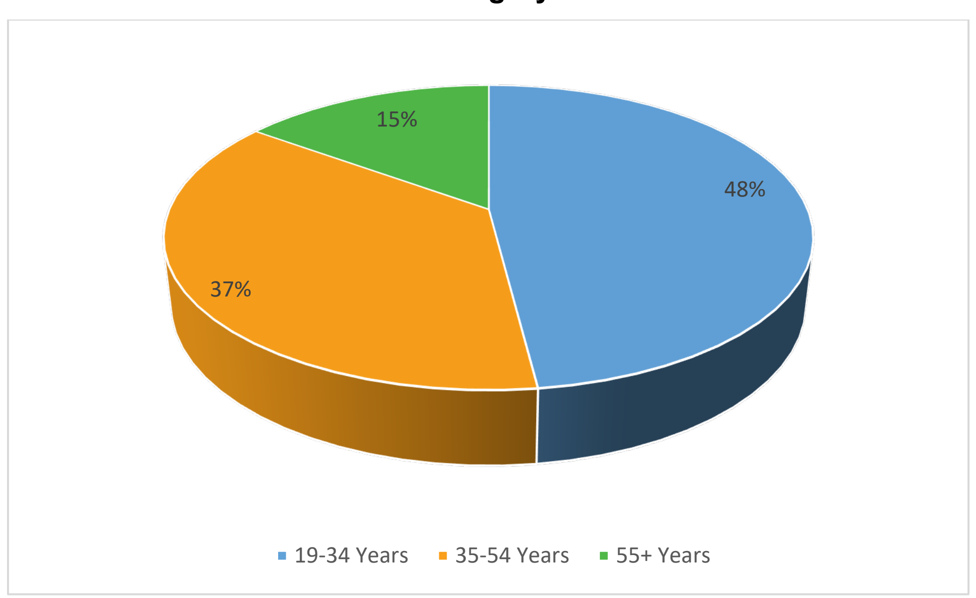


Table 2-9—Medallion 4.0 Program Medicaid Expansion Percentage by Age Category[2-12]

Age Category	Percentage
19–34 Years	48%
35–54 Years	37%
55+ Years	15%

Figure 2-8 displays Medallion 4.0 program Medicaid expansion count of members by FPL category as of January 2019.

[2-12] Ibid.

Figure 2-8—Medallion 4.0 Program Medicaid Expansion Members by FPL Category

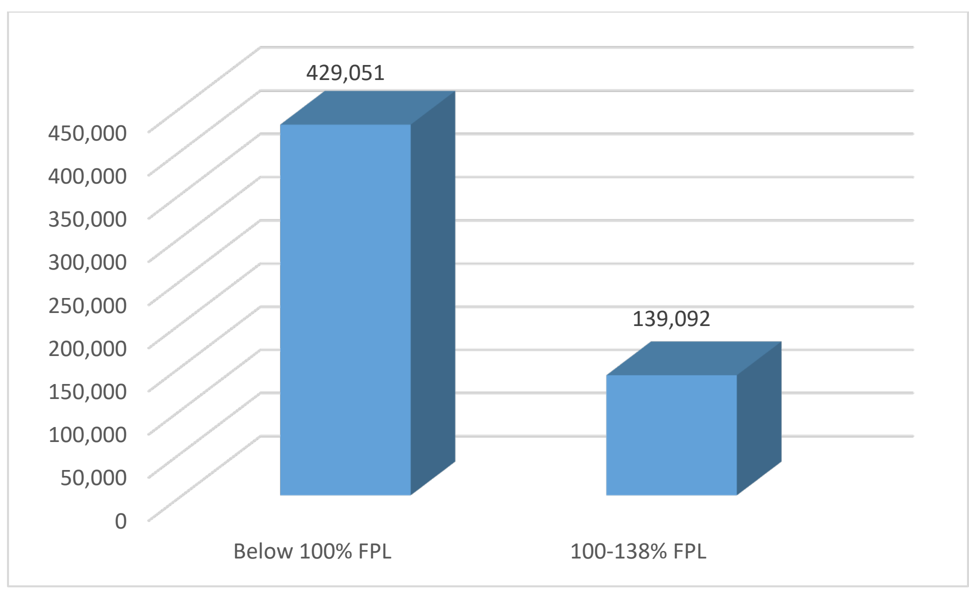


Table 2-10—Medallion 4.0 Program Medicaid Expansion Members by FPL Category[2-13]

FPL Level	Number
Below 100% FPL	429,051
100–138% FPL	139,092

[2-13] Ibid.

Figure 2-9 displays Medallion 4.0 program Medicaid expansion count of members by Medicaid Region as of January 2019.

Figure 2-9—Medallion 4.0 Medicaid Expansion Members by Medicaid Region

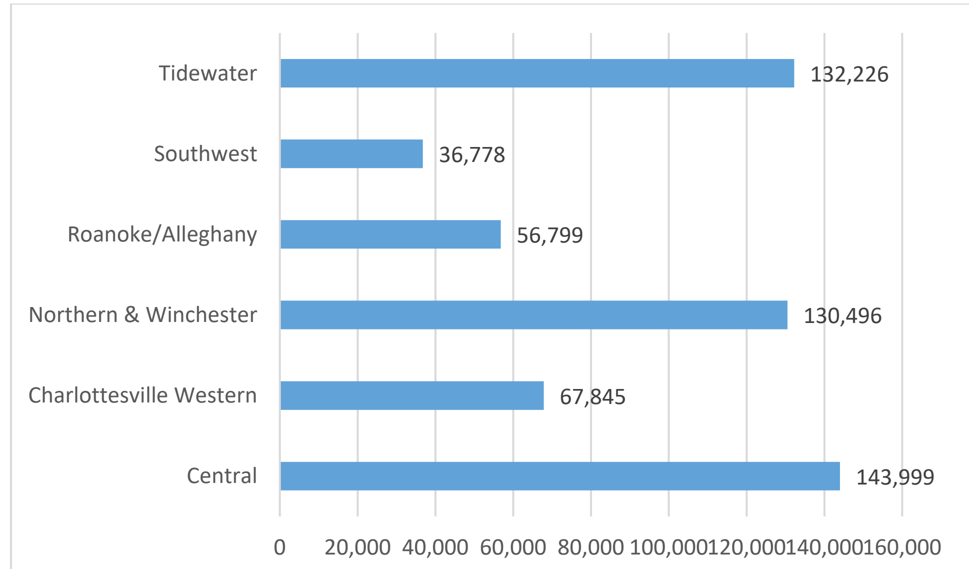


Table 2-11—Medallion 4.0 Medicaid Expansion Members by Medicaid Region[2-14]

Region	Number
Central Region	143,999
Charlottesville Western Region	67,845
Northern & Winchester Region	130,496
Roanoke/Alleghany Region	56,799
Southwest Region	36,778
Tidewater Region	132,226

COVID-19 Response

The PHE had a significant impact on healthcare services. Many provider offices were closed and offered limited telehealth services. The worldwide COVID-19 PHE impacted demand on accessing healthcare services, with some families electing to defer routine, nonemergency care to adhere to widespread guidance on physical distancing. COVID-19 became a PHE in January 2020 and was declared a PHE in March 2020. COVID-19 is a coronavirus disease caused by SARS-CoV-2. The first confirmed case in Virginia was declared on March 7, 2020. A State of Emergency in the Commonwealth of Virginia was declared on March 12, 2020.

[2-14] Ibid.

On July 2, 2020, DMAS directed each MCO to increase payments to network physicians and nonphysician practitioners by 29 percent for certain services provided between March 1 and June 30, 2020. The services included primary care, preventive care, telehealth visits, and EPSDT screenings and treatments.[2-15] DMAS also implemented flexibilities for care and services for members receiving LTSS. DMAS allowed flexibilities for specific face-to-face visit requirements and other HCBS. The flexibilities were designed to maintain provider staffing, maximize access to care, and minimize viral spread through community contact to protect the most vulnerable populations. Table 2-12 describes some of the LTSS flexibilities DMAS allowed during the PHE.[2-16]

Table 2-12—LTSS Flexibilities to Support Access to Care

COVID-19 Medicaid Flexibilities
No co-pays for any Medicaid or FAMIS covered services
Outreach to higher risk and older members to review critical needs
Encouraging use of telehealth
90-day supply of many routine medications
Ensuring members do not lose coverage due to lapses in paperwork

DMAS worked throughout the PHE to protect and support public health. Due to the COVID-19 PHE, healthcare demand also sometimes exceeded and stretched healthcare supply. In response to COVID-19, MCO care coordinators increased their outreach to members, ensuring access to services using telehealth medicine, suspending FAMIS copays, and automatically extending some service authorizations and the use of out-of-network providers when necessary.

In removing face-to-face contact with members due to COVID-19, DMAS and the MCOs were challenged with finding alternate means to assess members without relying on self-reports or information from others. To avoid disconnection with members, MCO care coordinators developed other means of communication such as telephone and telehealth to address members' concerns and meet their needs.

The MCOs developed an after-hours process to assist COVID-19 positive or exposed members with nonemergent transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments were not missed. In addition, the MCOs initiated an intensive 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, MCO staff members conducted outreach calls to high-risk members not using the mail order pharmacy benefit to ensure that members received their medications on time.

HSAG recognizes that EQR-related activities in FY 2020–2021 and, to a lesser extent, FY 2021–2022 were conducted during the unprecedented COVID-19 PHE; therefore, results and recommendations, particularly in the access to care domain for both FY 2020–2021 and FY 2021–2022, should be

[2-15] Georgetown University Health Policy Institute, Center for Children and Families. Redirecting Medicaid MCO Gains to Offset Network Provider Losses in the Time of COVID-19. Available at: https://ccf.georgetown.edu/2020/07/27/redirecting-medicaid-mco-gains-to-offset-network-provider-losses-in-the-time-of-covid-19/. Accessed on: Jan 4, 2023.

[2-16] Virginia Department of Medical Assistance Services. COVID-19 Response. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Jan 4, 2023.

considered with caution. Regardless, while some MCOs experienced lower scores across domains of care across these two reporting years, Virginia's Medicaid MCOs also found innovative and creative ways to address barriers and continued to provide services for Virginia's Medicaid members.

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 2-13 describes some of the flexibilities and waivers allowed during the PHE that continued throughout 2021.[2-17]

Table 2-13—COVID-19 Flexibilities[2-18]

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.
BH 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 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:

2-17 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: Jan 4, 2023.

2-18 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: Jan 4, 2023.

BH Services
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.
Applied Behavior Analysis—Face-to-face service requirements for family adaptive behavior treatment 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 LMHP, LMHP-R, LMHP-RP, LMHP-S, LBA, or LABA.
Applied Behavior Analysis—One service unit equaled 15 minutes. ABA service providers did not have a one-unit limit per day for audio-only communications.
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 Department made exceptions to their published Preferred Drug List if drug shortages occurred.
Support for Medicaid Providers—Streamlined Enrollment and Screening
Provider enrollment requirements were streamlined.

Support for Medicaid Providers—Streamlined Enrollment and Screening
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.
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).

Medicaid Enterprise System

Virginia was early to respond to requirements from CMS to upgrade to new and more flexible technology. DMAS developed a new modularized technology called MES to align the Department's Information Technology Road Map with CMS' Medicaid MITA layers. The MES is a new, modular solution. MES reassembles Medicaid information management into a modular, flexible, and upgradeable system.

MES supports DMAS to provide better and advanced data reporting and fraud detection. The separate MES modules represent each of the complex processes DMAS uses, 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.

The new system completely overhauled the existing system's framework and allowed for increased data collection, analytic, oversight, and reporting functions for DMAS. The MES includes the EDWS, a component that significantly enhanced DMAS' ability to analyze MCO data. Within the EDWS, there are powerful management, analytic, and visualization tools that allow DMAS to review and monitor the MCOs with increased oversight and detail. The new EPS, which is another component of the MES, enhances data quality through implementation of program-specific business rules.

One of the MES modules is a dynamic CRMS 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 securely captures information related to 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 implementation, DMAS has received millions of records with dates from the beginning of the CCC Plus and Medallion 4.0 programs. This data exchange was 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 and in FFS.

Care coordination in Medallion 4.0 is not mandatory for every member; however, it is strongly encouraged for the vulnerable populations. The vulnerable populations include children and youth with SHCN, adults with serious mental illness, members with SUD, children in foster care or adoption assistance, women with a high-risk pregnancy, and members with other complex or multiple chronic conditions. Comprehensive health risk assessments are conducted for children and youth with SHCN and members in foster care and adoption assistance. The MCOs are required to develop and maintain a program to address and improve the care and access of services among members requiring assessments.

ARTS[2-19]

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 ARTS 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 BH continuum of care.

DMAS provided a July 2021 report titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care 2016–2019* (report). The report was prepared by the VCU School of

[2-19] All data in this section were derived from a July 2021 report provided by DMAS titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care, 2016–2019*.

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 the report.

- 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 RTCs.
- 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 an RTC 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 an RTC 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.

Data included in a DMAS presentation for the drug court judges showed a 2,275 percent increase in residential treatment providers (ASAM 3), 327 percent increase in intensive outpatient programs (ASAM 2.1), 633 percent increase in OTPs, and a 469 percent increase in outpatient practitioners billing for ARTS services (ASAM 1). In addition, new provider types were added to the ARTS benefit, including 70 inpatient detox and 197 preferred office-based addiction treatment providers. The presentation also described how Medicaid worked with the Virginia courts to screen for health insurance and Medicaid enrollment and to help individuals without insurance enroll in Medicaid and connect the member to care.

The report states that of the 1.78 million people who were enrolled in Medicaid at some point during 2019, 5.4 percent had a diagnosed SUD of any type. The diagnosed prevalence of other SUD among Medicaid members increased between 2016 and 2019. There were about 96,000 Medicaid members who had a diagnosis of SUD in 2019 compared to 37,000 members diagnosed with SUD in 2018. Of those, about 42,000 (44 percent) enrolled through Medicaid expansion. Table 2-14 shows the percent change between 2016 and 2019 of diagnosed prevalence of SUD.

Table 2-14—Percent Change of Diagnosed Prevalence of SUD 2016–2019

Diagnosis	2016	2019	Percent Change 2016–2019
Any SUD	48,341	95,942	98.5%
OUD	17,129	40,361	135.6%
AUD	18,216	35,193	93.2%
Other stimulants (primarily methamphetamines)	2,169	9,544	340%
Cocaine	5,756	13,564	135.6%
Cannabinoids	13,325	26,905	101.9%

The prevalence of SUD between 2016 and 2019 are shown in Figure 2-10. The prevalence of OUD between 2016 and 2019 are shown in Figure 2-11. The prevalence of AUD between 2016 and 2019 are shown in Figure 2-12.

Figure 2-10—Diagnosed Prevalence of SUD

Figure 2-11—Diagnosed Prevalence of OUD

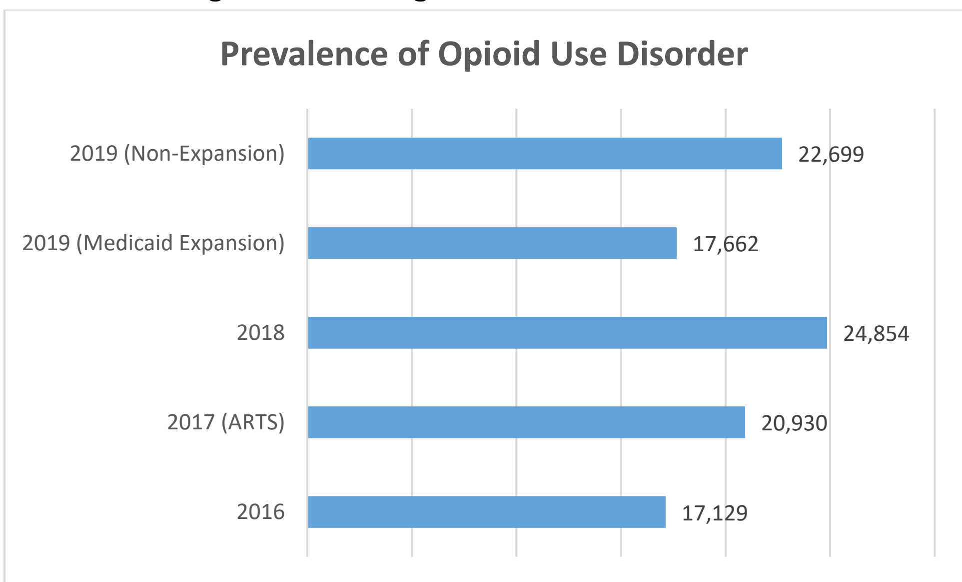
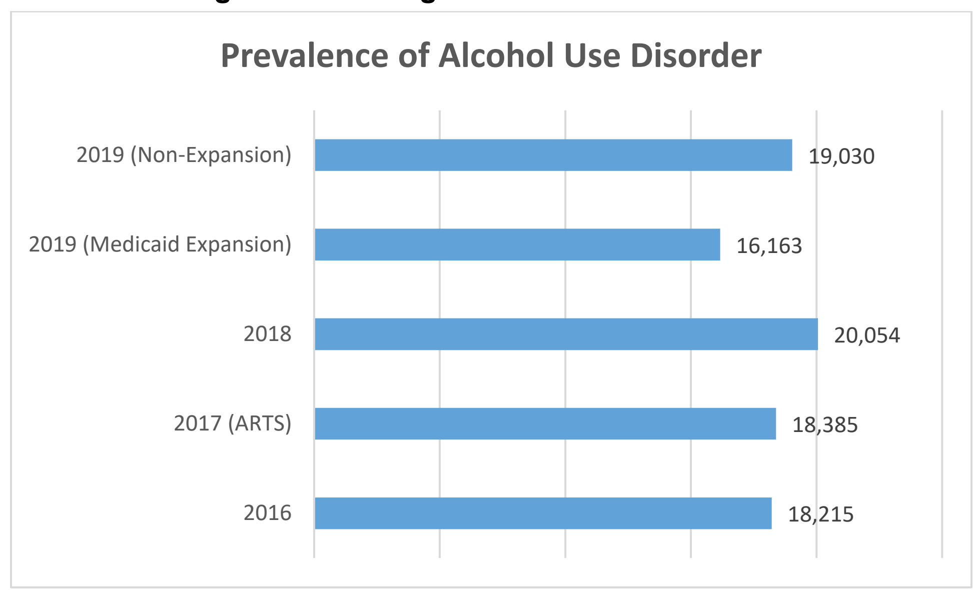


Figure 2-12—Diagnosed Prevalence of AUD



Characteristics of Members Receiving ARTS Benefit

Among members enrolled in Medicaid expansion, 53.4 percent received treatment for a diagnosed SUD, while 72.8 percent received treatment for a diagnosed OUD—similar to the treatment rates for nondisabled adults who qualified through pre-expansion income eligibility levels. Only about 5 percent with SUD who were enrolled through foster care programs received any treatment, while there were too few foster care members with OUD to estimate a treatment rate. Table 2-15 shows the SUD and OUD treatment rates by member groups.

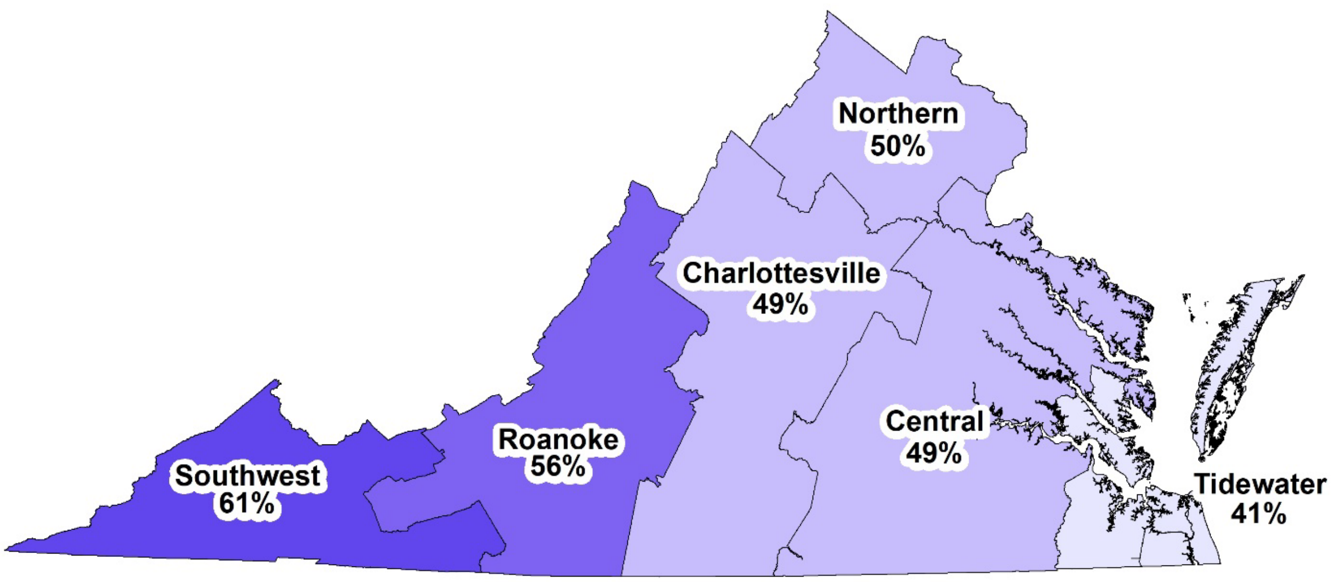
Table 2-15—SUD and OUD Treatment Rates by Member Group

Member Group	SUD Treatment Rate1	OUD Treatment Rate
Medicaid expansion	53.4%	72.8%
Nondisabled adults	52.7%	72.8%
Disabled adults	42.7%	57.1%
Foster Care	4.9%	Not Reportable

[1] Reflects the percentage of members with SUD (or OUD) who received any ARTS for that condition. Note: Services include those performed in an OBOT or OTP setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services, and pharmacotherapy.
Note: Members enrolled in the Governor's Access Plan who transitioned to Medicaid expansion coverage in 2019 are not included in this table.

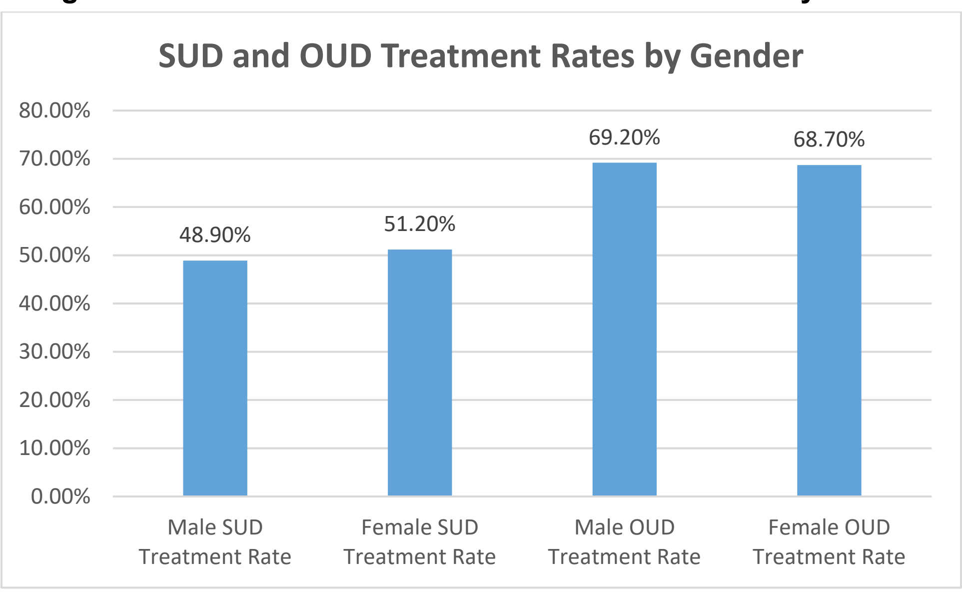
Among Virginia regions, the Southwest and Roanoke regions had the highest treatment rates for SUD (61 percent and 56 percent, respectively), and the Tidewater region had the lowest treatment rate (41 percent). Similar regional patterns were observed for OUD treatment rates. Figure 2-13 shows the SUD treatment rates for all members in 2019.

Figure 2-13—SUD Treatment Rates for Members in 2019, All Members



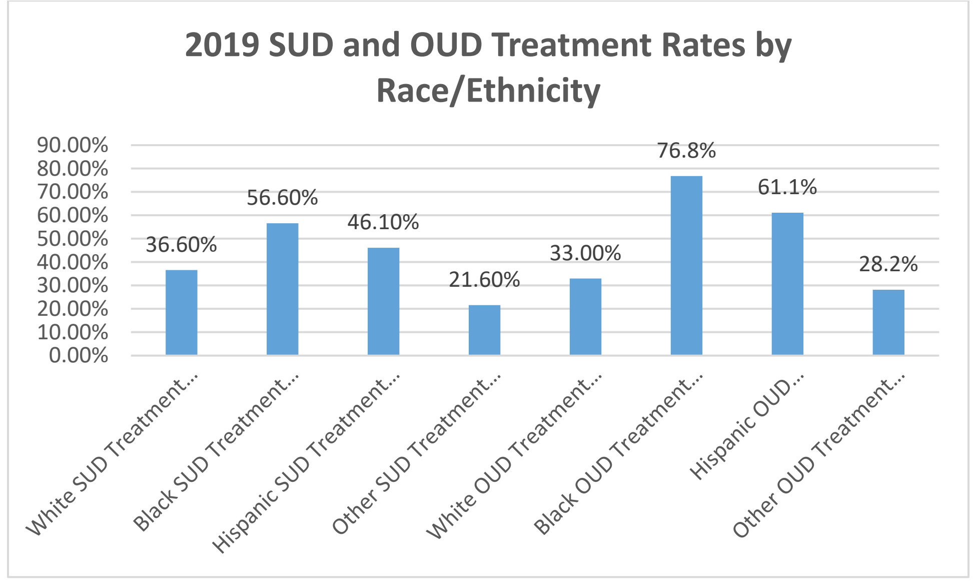
Members with a diagnosed SUD of any type represented 5.4 percent of the 1.78 million people in Virginia who were enrolled in Medicaid at some point in 2019. Figure 2-14 shows the prevalence, by gender, of members treated for SUD or OUD. Males were treated for an OUD at a higher rate than females. Females were treated for a SUD at a higher rate than males.

Figure 2-14—2019 Treatment Rates for SUD and OUD by Gender



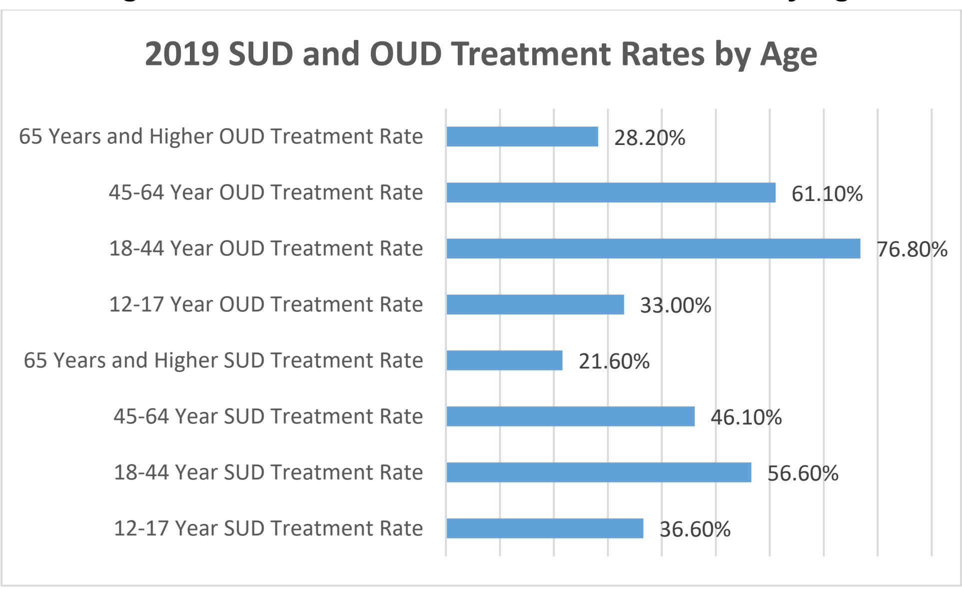
In reviewing the results published in the report, the prevalence of diagnosed SUD is lower among members identifying as Black (4.8 percent) and Hispanic (1.1 percent) compared to White members (6.3 percent). SUD and OUD treatment rates by race/ethnicity are depicted in Figure 2-15.

Figure 2-15—2019 Treatment Rates for SUD and OUD by Race/Ethnicity



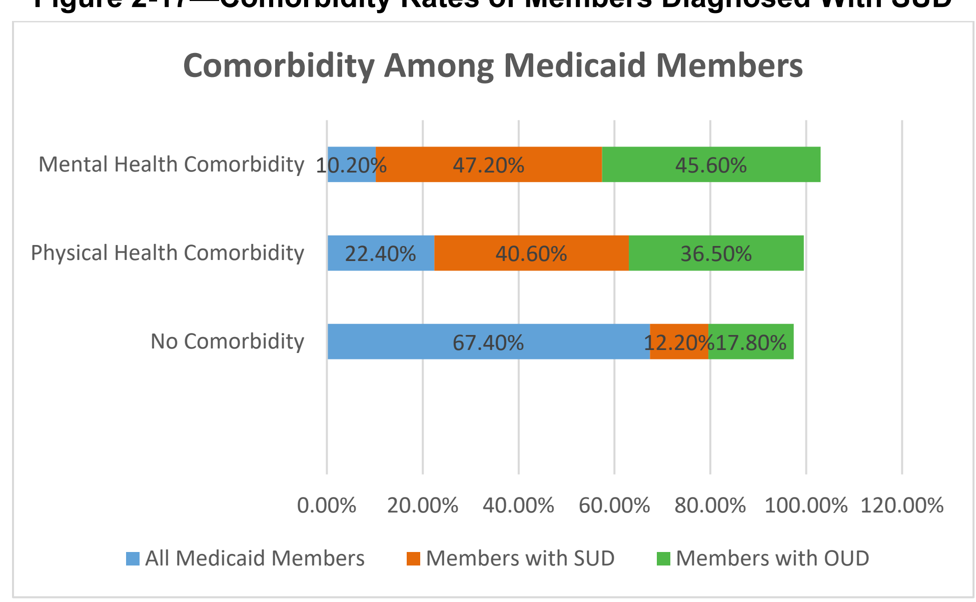
Variances in treatment rates for SUD and OUD were also identified by age group in the report. Members in the 45 to 64 age group had, by far, the highest diagnosed prevalence compared to other ages. Adolescents (ages 12 to 17) had the lowest diagnosed prevalence. Treatment rates for SUD and OUD by age are shown in Figure 2-16.

Figure 2-16—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. Among Medicaid members with SUD, 40.6 percent had a physical health comorbidity, while 47.2 percent had a mental health comorbidity. Only 12.2 percent of members with SUD had no comorbidities. Figure 2-17 shows the comorbidity rate of all Medicaid members, Medicaid members with diagnosed SUD, and Medicaid members diagnosed with OUD.

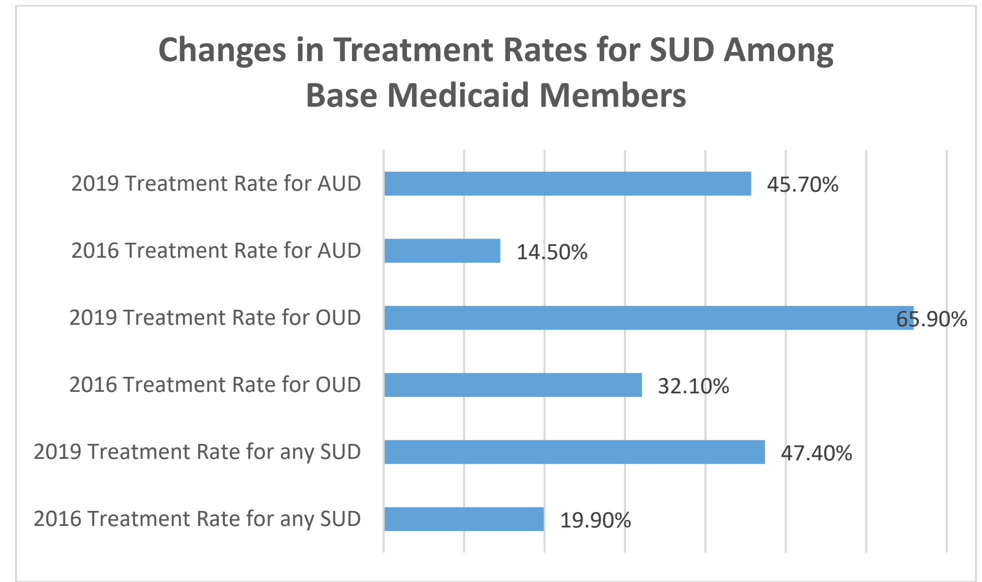
Figure 2-17—Comorbidity Rates of Members Diagnosed With SUD



Treatment rates for any SUD, OUD, and AUD continued to increase each year since the implementation of the ARTS benefit. The treatment rate for any SUD increased by 138.3 percent between 2016 and 2019. During the same time frame, the treatment rate for OUD increased by

104 percent, and the treatment rate for AUD increased by 215.4 percent. The changes in treatment rates for SUD among the base Medicaid member, which excludes Medicaid expansion members, are shown in Figure 2-18.

Figure 2-18—Change in Treatment Rates for SUD Among Base Members



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. Table 2-16 shows the number of ED visits per 100 base Medicaid members.

Table 2-16—Number of ED Visits Per 100 Base Medicaid Members

Visit Type	2016	2019	Percentage Change 2016–2019
All ED visits per 100 Medicaid members	66.2	74.2	12.1%
Non-SUD-related ED visits per 100 Medicaid members	66.3	74.2	11.9%
SUD-related ED visits per 100 Medicaid members with SUD	62.9	73.5	16.9%
OUD-related ED visits per 100 Medicaid members with OUD	34.8	33.3	-4.3%

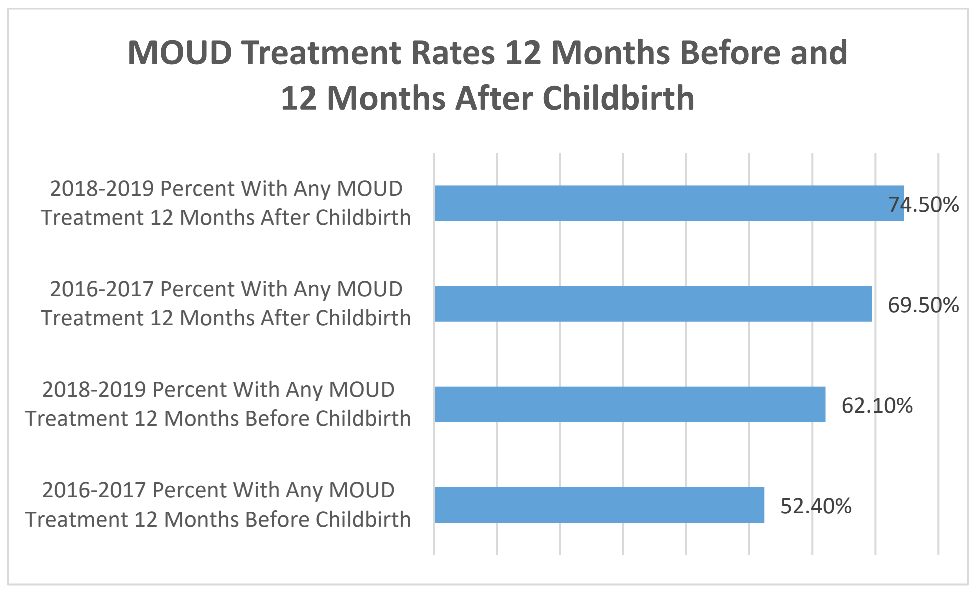
The report also states that use of services in 2019 increased greatly across all ASAM levels of care. In 2019, 46,520 members used a treatment service categorized with an ASAM level of care, a 79 percent increase from 2018, and a 172 percent increase since 2017, the first year of ARTS. There were increases in utilization across all levels of service, but increases between 2018 and 2019 were especially notable for early screening and interventions, residential treatment services (ASAM 3), the

use of OTP and Preferred OBOT providers, and the use of care coordination services at Preferred OBOTs:

- 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 7.0 months by 2018–2019. Diagnosed MOUD treatment rates 12 months before and after childbirth are shown in Figure 2-19.

Figure 2-19—Diagnosed MOUD Treatment Rates Among Individuals in the 12 Months Before and After Childbirth



DMAS shared an ARTS program success story in which a member's mother called to request assistance for her son, who was in the process of turning himself in for a violation of probation that would result in incarceration. The mother reported her son had significant SUD issues and was willing to seek help; he had even gone to the CSB to be assessed. DMAS obtained the contact information for her son's public defender and encouraged them to share the ARTS benefit, and the member still had full Medicaid benefits and was enrolled in an MCO that could help identify treatment options. The public defender agreed to talk with the MCO care coordinator. The MCO care coordinator contacted the CSB to obtain the assessment, then contacted the public defender and shared that the CSB determined

The public defender shared the information on the Medicaid ARTS benefit residential treatment provider available to the member during the court proceedings. The judge sentenced the member to the residential treatment provider in lieu of incarceration.

inpatient SUD treatment was the appropriate setting through the clinical assessment. The MCO was able to assist in locating a residential treatment provider who reviewed the member's assessment and was willing to admit him. The public defender shared this information during the court proceedings and the judge sentenced him to the residential treatment provider in lieu of incarceration.

Comparison of OUD Prevalence and Treatment With States Participating in the Medicaid Outcomes Distributed Research Network (MODRN)

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 2-17 displays characteristics of members receiving OUD treatment in Virginia compared to other states participating in MODRN.

Table 2-17—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%	29.4%
45–54	19.3%	16.9%
55–64	15.7%	10.3%
Gender		
Female	66.3%	51.2%
Male	15.7%	10.3%
Race/Ethnicity		
Non-Hispanic White	79.1%	76.2%

Member Characteristic	Percentage of Members With OUD Diagnosis	
	Virginia	Other MODRN States*
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 are from 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).

MOUD treatment rates increased to a much greater extent between 2016 and 2018 among Virginia Medicaid members compared to members in other MODRN states. Prior to the ARTS implementation in 2016, MOUD treatment rates were substantially lower in Virginia (33.6 percent) compared to other MODRN states (48.7 percent). MOUD treatment rates increased in both Virginia and other MODRN states between 2016 and 2018, but to a much greater extent in Virginia, following implementation of the ARTS benefit. By 2018, MOUD treatment rates among Virginia Medicaid members were comparable to members in other MODRN states. Table 2-18 shows the rate of MOUD treatment among Virginia Medicaid members ages 12 to 64 years compared to Medicaid members in other MODRN states.

Table 2-18—Rate of MOUD Treatment Among Virginia Medicaid Members Ages 12 to 64 Years Compared to Medicaid Members in other MODRN States

Medicaid Members	2016	2018	Percentage Point Change 2016–2018
MOUD treatment rate (includes members with OUD diagnosis)			
Virginia	33.6%	55.0%	+21.4%
Other MODRN states	48.7%	57.3%	+8.6%

Member Experience With ARTS Services[2-20]

The ARTS member survey, adapted from a version of the CAHPS survey, included a number of questions assessing the patient's experience with ARTS, including Preferred OBOT, OTP, and other outpatient treatment providers, identified based on Medicaid claims data at the time of the survey sampling. 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 were 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, 72.1 percent of respondents felt able to refuse a specific type of medicine or treatment, and 16.6 percent of respondents indicated that they stopped treatment against the advice of a doctor.

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

Health Disparities in SUD Treatment Services Among Medicaid Members[2-21]

The report stated that there were wide disparities in treatment rates for SUD and OUD among Medicaid members by race/ethnicity. Among members with any SUD diagnosis, 56 percent of White members received some type of treatment during 2019 compared to 40 percent of Black members and 45 percent among other racial/ethnic groups. Among members with any OUD diagnosis, 61 percent of White members received MOUD treatment compared to 48 percent of Black members and 54 percent among other racial/ethnic groups.

As described in the report, availability of treatment providers tends to vary the most by rural/urban areas. Counties in large metropolitan areas (1 million or more people) are more likely to have waivered prescribers (79 percent), OTP providers (35 percent), and Preferred OBOT providers (54 percent) compared to rural areas. However, the number of waivered prescribers relative to the population tends to be higher in rural areas (16.2 prescribers per 100,000 people) compared to large metropolitan areas

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[2-20] All data in this section were derived from a July 2021 report provided by DMAS titled, *Addiction and Recovery Treatment Services, Access, Utilization, and Quality of Care, 2016–2019*.

[2-21] Ibid.

(10.8 prescribers per 100,000), indicating that urban areas potentially have greater problems with treatment capacity. Metropolitan counties with the lowest per capita income were more likely to have a waivered prescriber (92 percent), a higher relative number of waivered prescribers (19 per 100,000 people), and a Preferred OBOT provider (65 percent) relative to counties with the highest per capita income.

Metropolitan areas that have the highest share of Black residents have a higher number of waivered prescribers (18.1 per 100,000 people) compared to counties with the lowest share of Black residents (13.8 per 100,000). Localities with the highest share of Black members are much more likely to have an OTP provider (55 percent) compared to localities with the smallest share of Black members (18 percent). In addition, lower income people and racial/ethnic minorities may experience greater transportation barriers or have to travel longer distances within counties to treatment providers.

Overall, about 44 percent of members initiated treatment within 14 days of a SUD diagnosis in 2018, a rate that is similar for Black members and White members, as well as for members living in urban and rural areas. However, Black members are less likely to initiate *and engage* with treatment following an initial diagnosis, meaning they had two or more additional treatment services or MOUD within 34 days of the initiation visit. Among Black members with any SUD diagnosis, only 8 percent initiated and engaged with treatment compared to 17 percent of White members. Of Black members with OUD, 19 percent initiated and engaged with treatment compared to 28 percent of White members.

Consistent with lower rates of engagement with treatment, episodes of outpatient treatment for OUD tend to be shorter for Black members (median of 86 days) compared to White members (99 days). MOUD treatment rates among Black members during an outpatient episode are only slightly lower (69.7 percent) compared to White members (72.0 percent), with Black members also having a somewhat shorter duration of MOUD treatment compared to White members. Rates of psychotherapy or counseling services used during an episode of treatment were slightly higher for Black members compared to White members, although claims for care coordination were much lower for Black members. Co-prescribing of opioid pain medications was slightly higher for Black members, while co-prescribing of benzodiazepines was higher for White members (14.2 percent) than Black members (8.5 percent).

Black Medicaid members were nearly twice as likely as White members to report housing insecurity (27 percent of Black members were housing insecure compared to 14 percent of White members). An equal percentage of Black members and White members reported they had stayed overnight or longer in jail or prison during the past 12 months (17 percent). Black members also lacked social support to a greater extent than White members; 14 percent of Black members reported that they had no one they could count on if they had serious problems (compared to 8 percent for White members), although a higher percentage of Black members reported three or more close contacts compared to White members.

Compared to White members, Black members receiving treatment were less likely to agree that the treatment provider (1) showed respect for what they had to say, (2) made them feel safe, and (3) involved them in treatment as much as they wanted. The largest disparity was that fewer Black members felt able to refuse a specific treatment (59 percent) compared to White members (76 percent). Perhaps because of this, fewer Black members reported that they discontinued treatment against the advice of doctors (12 percent) compared to White members (17 percent), although the difference was not statistically significant.

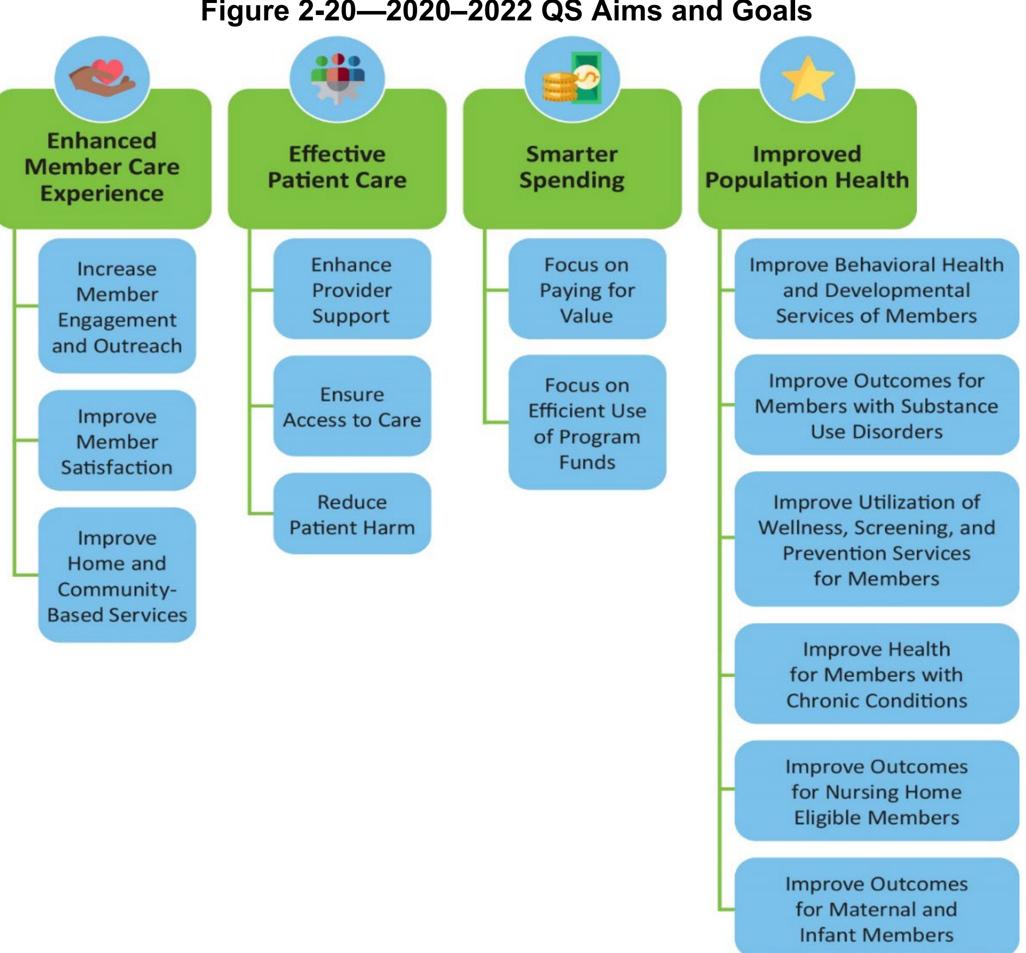
Virginia's 2020–2022 Quality Strategy

In 2022, 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. During 2022, DMAS also worked with HSAG to develop the fifth edition of its comprehensive Virginia 2023–2025 QS. DMAS will implement the 2023–2025 QS in 2023.

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 2-20 displays Virginia's 2020–2022 QS aims and goals. Appendix F contains Virginia's 2020–2022 QS aims, goals, objectives, and metrics.

Figure 2-20—2020–2022 QS 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 2-19 displays a sample of the initiatives DMAS implemented or continued during CY 2022 that support DMAS' efforts toward achieving the Virginia 2020–2022 QS' goals and objectives.

Table 2-19—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

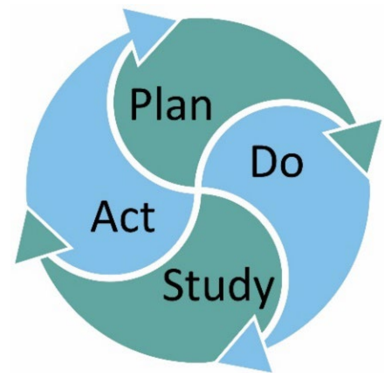
Virginia 2020–2022 QS Aim and Goal	DMAS Quality Initiative
Goal 4.6: Improve Outcomes for Maternal and Infant Members	Virginia QS. The DMAS maternity program, Baby Steps Virginia, actively partners with a variety of stakeholders including DMAS MCOs to improve quality maternity outcomes. All of these efforts have focused on eliminating racial disparities in maternal mortality by 2025, a key goal of 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 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.



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 2-20 identifies DMAS' best and emerging practices. The MCOs' self-reported best and emerging practices are found in Appendix C.

Table 2-20—DMAS' Best and Emerging Practices

Best and Emerging Practices
DMAS and its stakeholders actively participate as members of the NASHP Maternal/Child Health Policy Innovation Program policy academy. Project focus areas include the Virginia Community Doula Program and Medicaid Doula benefit implementation, which is a collaboration with the Community Doula Implementation team in the development of member flyers and postpartum 12-month coverage extension; and development of a member postpartum toolkit focused on postpartum coverage, postpartum visits, maternal mental health, and breastfeeding, with resources from ACOG. Virginia is the fourth state in the nation to implement community doula services under the state Medicaid program. The overall goal of the Virginia Community Doula Program and Medicaid Doula benefit is to improve maternal and infant outcomes in Virginia with Medicaid community doulas. Community doulas offer members physical, emotional, and informational support during pregnancy, at labor and delivery, and during the postpartum period. Doulas receive state certification through DMAS' sister agency, VDH. DMAS then begins provider enrollment and managed care contracting with the health plans. DMAS has also launched the Community Doula Program webpage to educate community stakeholders, doulas, and interested individuals about the Medicaid doula benefit and encourage doula state certification and Medicaid doula enrollment. As of September 2022, 38 doulas have received state certification. Of the 38 doulas, 24 have completed Medicaid enrollment and 22 have contracted with a health plan.
In August 2022, DMAS completed its first full year of hosting the Foster Care Partnership meetings with stakeholders from across the state. These stakeholders included those from the VDSS, the Virginia Commission on Youth, Local DSS, LCPAs, DMAS MCOs, the Virginia Office of Children's Services, among others. Two sub-groups met throughout the year to focus on actionable goals related to improving services for youth in foster care. Specific sub-group focus included transition planning and increasing utilization of services for the foster care member population. It is the goal of DMAS and the Foster Care Partnership to improve service utilization and outcomes for youth in foster care, provide adoption assistance, and guide former foster care individuals through these groups and the larger Foster Care Partnership.

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 Medallion 4.0 program.

Definitions

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of the domains of quality of, access to, and timeliness of care and services.

Quality CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired 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** CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2]	**Timeliness** The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely 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

In 2022, the MCOs initiated new PIPs based on the same DMAS-selected topics of *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The MCOs completed and submitted the PIP Design stage only (Steps 1 through 6 of CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 [EQR Protocol 1])[3-1] for validation. HSAG assessed the design of each PIP to ensure it was methodologically sound and met all State and federal requirements. HSAG provided feedback and recommendations to the MCOs in the initial validation tools, and the MCOs had an opportunity to resubmit the PIPs with corrections and additional documentation to potentially improve the 2022 PIP validation scores.

Strengths, Weaknesses, and Recommendations

Strengths	
	All six MCOs developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
	All six MCOs received 100 percent scores on all validation criteria for the first six steps validated.
Weaknesses and Recommendations	
	Weakness: None identified.
	Recommendations: Although no weaknesses were identified, HSAG has the following recommendations as the MCOs progress to the next steps of the PIP process. • The MCOs should use QI tools such as a causal/barrier analysis, key driver diagrams, process mapping, and/or FMEA to determine and prioritize barriers, drivers, and/or weaknesses within processes. The use of these tools will help the MCO determine what interventions to initiate and test. • The MCOs should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes. • The MCOs should develop a process or plan to evaluate the effectiveness of each individual intervention. • The MCOs should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 5, 2023.

Weaknesses and Recommendations	
	• The MCOs should revisit the causal/barrier analysis tools used at least annually to ensure the MCO remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.

MCO Comparative and Statewide Aggregate PMV Results

PMV Highlights

The PMV highlights are included in Table 3-1.

Table 3-1—PM Strengths and Weaknesses

Domain	Strengths	Weaknesses
Children's Preventive Care	Five of six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PM indicators.	Four of the six MCOs' rates fell below the 50th percentile for the *Childhood Immunization Status—Combination 3* and *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* PM indicators.
Women's Health	There were no identified strengths for PMs within the Women's Health domain.	All six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* PM indicators.
		Five of the six MCOs' rates fell below the 50th percentile for the *Cervical Cancer Screening* PM indicator.
Access to Care	There were no identified strengths for PMs within the Access to Care domain.	All six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
Care for Chronic Conditions	All six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* PM indicator. Of note, two of the six MCOs displayed strong performance, with their rates exceeding the Virginia aggregate for six of 10 (60.0 percent) PM rates.	All six MCOs' rates fell below the 50th percentile for the *Controlling High Blood Pressure* PM.

Domain	Strengths	Weaknesses
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* PM indicator. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicators.	All six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* PM indicators.

As part of performance measurement, the Virginia MCOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates were accurate and reliable, NCQA required each MCO to undergo an NCQA HEDIS Compliance Audit™,[3-2] conducted by a certified independent auditor.

Each MCO contracted with an NCQA LO to conduct the HEDIS Compliance Audit. 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 Medallion 4.0 Medicaid PMs for HEDIS MY 2021.

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

- *Asthma Admission Rate (Per 100,000 Member Months)*
- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care*
- *Follow-Up After ED Visit for Mental Illness*
- *Prenatal and Postpartum Care*

HSAG contracted with ALI Consulting Services, LLC, for assistance with the validation of the PMs. Using the validation methodology and protocols described in Appendix B, HSAG determined results for each PM. CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019 (EQR Protocol 2)[3-3] identifies two possible validation finding designations for PMs: *Reportable (R)*—PM data were compliant with HEDIS and DMAS specifications and the data

[3-2] HEDIS Compliance Audit™ is a trademark of NCQA.

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 6, 2023.

were valid as reported; or *Do Not Report (DNR)*—PM data were materially biased. HSAG's validation results for each MCO are summarized in Table 3-2, with all rates validated as *Reportable (R)*.

Table 3-2—HSAG MCO PMV Results

PM	Aetna	Health Keepers	Molina	Optima	United	VA Premier
Asthma Admission Rate (Per 100,000 Member Months)						
Asthma Admission Rate (Per 100,000 Member Months)	1.46	1.46	3.72	6.88	2.50	4.09
Child and Adolescent Well-Care Visits						
Total	45.46%	54.70%	36.60%	48.35%	53.96%	47.62%
Childhood Immunization Status						
Combination 3	52.55%	68.61%	56.93%	62.77%	65.94%	59.37%
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	83.70%	82.73%	80.05%	85.40%	88.81%	87.83%
*HbA1c Poor Control (>9.0%)**	50.12%	44.28%	61.56%	52.80%	38.93%	43.07%
HbA1c Control (<8.0%)	40.63%	43.80%	33.33%	39.42%	48.91%	44.28%
Eye Exam (Retinal) Performed	45.74%	44.53%	35.28%	43.55%	46.23%	52.80 %
Blood Pressure Control (<140/90 mm Hg)	50.36%	60.10%	47.20%	49.64%	60.34%	55.96%
Follow-Up After ED Visit for Mental Illness						
7-Day Follow-Up—Total	40.12%	45.43%	36.07%	44.36%	44.38%	42.47%
30-Day Follow-Up—Total	52.54%	59.04%	49.75%	57.27%	52.81%	54.58%
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	85.64%	80.29%	65.21%	69.59%	84.91%	74.45%
Postpartum Care	75.43%	65.69%	61.31%	63.50%	70.32%	68.86%

** 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. The following are the highlights of HSAG's validation findings:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by the MCOs, which included a review of file consolidations or extracts, 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—Each MCO's organizational infrastructure must support all necessary IS; its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing

of data and to provide data protection in the event of a disaster. HSAG validated the MCO's data control processes and determined that the data control processes in place were acceptable.

PM Documentation—While interviews and system demonstrations provide supplementary information, most validation review findings were based on documentation provided by the MCOs. HSAG reviewed all related documentation, which included the completed Roadmap, job logs, computer programming code, output files, workflow diagrams, 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

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

Each MCO contracted with an NCQA LO to conduct the HEDIS Compliance Audit. 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 Medallion 4.0 Medicaid PMs for HEDIS MY 2021.

Table 3-3 displays, by MCO, the HEDIS MY 2021 PM rate results compared to NCQA's Quality Compass national Medicaid HMO percentiles for the HEDIS MY 2020 50th percentiles and the Virginia aggregate, which represents the average of six MCOs' PM rates weighted by the eligible population. Of note, gray-shaded boxes indicate MCO PM rates that were at or above the 50th percentile. Rates indicating better performance than the Virginia aggregates are represented in burgundy font.

Table 3-3—MCO Comparative and Virginia Aggregate HEDIS MY 2021 PM Results

PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Children's Preventive Care							
Child and Adolescent Well-Care Visits							
Total	45.46%	**54.70%**	36.60%	48.35%	**53.96%**	47.62%	**50.27%**
Childhood Immunization Status							
Combination 3	52.55%	**68.61%**	56.93%	62.77%	**65.94%**	59.37%	**63.22%**
Well-Child Visits in the First 30 Months of Life							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	**66.60%**	**66.78%**	43.60%	**65.49%**	61.93%	55.48%	**62.04%**
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	**68.60%**	**73.02%**	57.96%	66.90%	**69.79%**	65.09%	**68.46%**
Women's Health							
Breast Cancer Screening							

PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Breast Cancer Screening	**48.95%**	**52.08%**	43.74%	48.11%	43.72%	**49.88%**	**48.89%**
Cervical Cancer Screening							
Cervical Cancer Screening	47.93%	**60.34%**	42.09%	48.66%	46.47%	**52.31%**	**52.05%**
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	**85.64%**	**80.29%**	65.21%	69.59%	**84.91%**	74.45%	**76.44%**
Postpartum Care	**75.43%**	65.69%	61.31%	63.50%	**70.32%**	**68.86%**	**66.76%**
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	**73.49%**	**76.16%**	59.60%	71.75%	70.56%	**72.46%**	**72.15%**
Care for Chronic Conditions							
Asthma Medication Ratio							
Total	**72.69%**	**70.83%**	**72.45%**	65.61%	67.58%	**71.70%**	**69.62%**
Comprehensive Diabetes Care							
HbA1c Testing	83.70%	82.73%	80.05%	**85.40%**	**88.81%**	**87.83%**	**84.85%**
*HbA1c Poor Control (>9.0%)**	50.12%	**44.28%**	61.56%	52.80%	**38.93%**	**43.07%**	**47.45%**
HbA1c Control (<8.0%)	40.63%	**43.80%**	33.33%	39.42%	**48.91%**	**44.28%**	**42.20%**
Eye Exam (Retinal) Performed	45.74%	44.53%	35.28%	43.55%	**46.23%**	**52.80%**	**45.78%**
Blood Pressure Control (<140/90 mm Hg)	50.36%	**60.10%**	47.20%	49.64%	**60.34%**	**55.96%**	**54.64%**
Controlling High Blood Pressure							
Controlling High Blood Pressure	48.66%	**52.07%**	41.12%	47.69%	**52.55%**	**51.09%**	**49.68%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	**74.63%**	NA	69.18%	NA	68.64%	NA	**70.84%**
Discussing Cessation Medications	45.11%	NA	**47.30%**	NA	43.48%	NA	**46.89%**
Discussing Cessation Strategies	**40.60%**	NA	39.46%	NA	33.91%	NA	**40.09%**
Behavioral Health							
Antidepressant Medication Management							
Effective Acute Phase Treatment	59.61%	58.04%	57.06%	**66.62%**	60.99%	**64.96%**	**61.64%**
Effective Continuation Phase Treatment	42.39%	40.65%	37.73%	**51.00%**	42.50%	**47.10%**	**44.30%**
Follow-Up Care for Children Prescribed ADHD Medication							
Initiation Phase	**43.21%**	37.11%	26.29%	31.23%	**40.82%**	**44.01%**	**37.42%**
Continuation and Maintenance Phase	**55.70%**	52.17%	39.62%	47.96%	**57.61%**	**61.30%**	**53.82%**

PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	40.12%	**45.43%**	36.07%	**44.36%**	**44.38%**	42.47%	**43.04%**
30-Day Follow-Up—Total	52.54%	**59.04%**	49.75%	**57.27%**	52.81%	54.58%	**55.53%**
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Total	**34.91%**	**42.57%**	16.67%	**40.08%**	33.51%	22.79%	**33.95%**
30-Day Follow-Up—Total	**54.89%**	**63.58%**	36.45%	**62.44%**	**56.66%**	41.69%	**54.76%**
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence							
7-Day Follow-Up—Total	**13.89%**	11.79%	12.04%	**16.79%**	13.19%	**14.02%**	**13.69%**
30-Day Follow-Up—Total	**22.41%**	19.35%	20.29%	**25.19%**	21.48%	20.98%	**21.61%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	**74.71%**	**68.21%**	**75.41%**	62.07%	**70.31%**	**69.47%**	**67.49%**

** For this indicator, a lower rate indicates better performance.*
NA indicates that the MCO followed the specifications, but the denominator was too small to report a valid rate.
***Note:** MCO PM rates indicating better performance than the Virginia aggregate are represented in burgundy.*
[shaded box] Indicates that the HEDIS MY 2021 rate was at or above the 50th percentile.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Children's Preventive Care domain, the MCOs demonstrated strength related to preventive care, as five of the six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* PM indicators. Moreover, HealthKeepers' rates met or exceeded the 50th percentile for all four PM indicators within the domain.
+	Within the Care for Chronic Conditions domain, all six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* PM indicator. Of note, United and VA Premier displayed strong performance, with their rates exceeding the Virginia aggregate for six of 10 (60.0 percent) PM indicators.
+	MCO performance within the BH domain was strong, with all six MCOs' rates meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* PM indicator, and five of six MCOs' rates meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total*, and *Use of First-Line*

Strengths	
	Psychosocial Care for Children and Adolescents on Antipsychotics—Total PM indicators. Within the BH domain, Optima demonstrated the highest performance, with its rates meeting or exceeding the 50th percentile for eight of the 11 (72.7 percent) PM indicators. Of note, HealthKeepers' and VA Premier's rates met or exceeded the 50th percentile for seven of the 11 (63.6 percent) PM indicators.

Weaknesses and Recommendations	
	Weakness: Within the Children's Preventive Care domain, four of the six MCOs' rates fell below the 50th percentile for the *Childhood Immunization Status—Combination 3* and *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* PM indicators. Childhood vaccines protect children from a number of serious and potentially life-threatening diseases, such as diphtheria, measles, meningitis, polio, tetanus, and whooping cough, at a time in their lives when they are most vulnerable to disease.[3-4] The COVID-19 PHE is a reminder of the importance of vaccination. The identified declines in routine pediatric vaccine ordering and doses administered might indicate that children in the United States and their communities face increased risks for outbreaks of vaccine-preventable diseases. Continued coordinated efforts between healthcare providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination.[3-5] Assessing physical, emotional, and social development is important at every stage of life, particularly with children. Well-care visits provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling.[3-6]
	Recommendations: HSAG recommends that the MCOs identify best practices for ensuring children receive all preventive vaccinations 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 Children's Preventive Care domain.
	Weakness: All six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal*

[3-4] National Committee for Quality Assurance. Childhood Immunization Status. Available at: https://www.ncqa.org/hedis/measures/childhood-immunization-status/. Accessed on: Jan 5, 2023.

[3-5] The Centers for Disease Control and Prevention. Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration—United States, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm/. Accessed on: Jan 5, 2023.

[3-6] National Committee for Quality Assurance. Child and Adolescent Well-Care Visits. Available at: https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/. Accessed on: Jan 5, 2023.

Weaknesses and Recommendations	
	Care and *Postpartum Care* PM indicators, and five of the six MCOs' rates fell below the 50th percentile for the *Cervical Cancer Screening* PM, reflecting areas of opportunity for improvement. Screenings can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs.[3-7] Prolonged delays in screening related to the COVID-19 PHE may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[3-8] Timeliness of prenatal and postpartum care reduces the risks for complications. Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[3-9]
	Recommendations: 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 cancer screenings, access prenatal and postpartum care, and make appropriate health decisions. In addition, 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 access to prenatal and postpartum care. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve access to and timeliness of cancer screenings and prenatal and postpartum care.
	Weakness: The Access to Care domain represented an area of opportunity for improvement, as all six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. Healthcare visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help address acute issues or manage chronic conditions.[3-10]
	Recommendations: HSAG recommends that the MCOs conduct a root cause analysis to determine why some adults are not accessing preventive and ambulatory health services. HSAG recommends that the MCOs consider conducting a focus group to identify barriers that their members are experiencing in accessing care and services in order to implement appropriate interventions. Additionally, HSAG recommends the MCOs explore or expand upon the use of

[3-7] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Jan 5, 2023.

[3-8] Centers for Disease Control and Prevention. Sharp Declines in Breast and Cervical Cancer Screening. https://www.cdc.gov/media/releases/2021/p0630-cancer-screenings.html. Accessed on: Jan 5, 2023.

[3-9] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Jan 5, 2023.

[3-10] National Committee for Quality Assurance. Adults' Access to Preventive/Ambulatory Health Services. Available at: https://www.ncqa.org/hedis/measures/adults-access-to-preventive-ambulatory-health-services/. Accessed on: Jan 5, 2023.

Weaknesses and Recommendations	
	telehealth services as an additional method for providing preventive and ambulatory health services.
−	**Weakness:** Within the Care for Chronic Conditions domain, all six MCOs' rates fell below the 50th percentile for the *Controlling High Blood Pressure* PM, reflecting an area of opportunity for improvement. Controlling high blood pressure is an important step in preventing heart attacks, stroke, and kidney disease, and in reducing the risk of developing other serious conditions.[3-11]
	Recommendations: HSAG recommends that the MCOs conduct a root cause analysis or focus study to determine why some members are not managing their high blood pressure at optimal levels. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to improve the performance related to this chronic condition.
−	**Weakness:** Within the BH domain, all six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* PM indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* PM indicators, reflecting areas of opportunity for improvement. Proper follow-up care is essential to manage ADHD medication. To ensure that medication is prescribed and managed correctly, it is important that children are monitored by a pediatrician with prescribing authority.[3-12] Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-13]
	Recommendations: HSAG recommends that the MCOs develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization and prescribed ADHD medication. 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.

[3-11] National Committee for Quality Assurance. Controlling High Blood Pressure. Available at: https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/. Accessed on: Jan 5, 2023.

[3-12] National Committee for Quality Assurance. Follow-Up Care for Children Prescribed ADHD Medication. Available at: https://www.ncqa.org/hedis/measures/follow-up-care-for-children-prescribed-adhd-medication/. Accessed on: Jan 5, 2023.

[3-13] National Committee for Quality Assurance. Follow-Up After Hospitalization for Mental Illness. Available at: https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/. Accessed on: Nov 14, 2022.

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 Medallion 4.0 program. During 2022, DMAS monitored the MCOs' implementation of federal and Commonwealth requirements and CAPs from the 2021 compliance reviews.

Operational Systems Review

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	Molina	Optima	United	VA Premier	Total Compliance Score
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	85.7%	97.6%
II.	438.100 438.224	Member 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	86.7%	80.0%	86.7%	66.7%	93.3%	66.7%	80.0%
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%	89.5%	100%	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%	83.3%	100%	83.3%	100%	100%	94.4%
XIII	438.228	Grievance and Appeal Systems	86.2%	82.8%	89.7%	100%	93.1%	79.3%	88.5%

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Total Compliance Score
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%	56.3%
TOTAL SCORE			**93.2%**	**92.6%**	**93.2%**	**94.4%**	**96.3%**	**88.9%**	**93.1%**

* 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.

The regulations at 42 CFR §438.242 and §457.1233(d) require the state to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development.

While the CMS EQR protocols published in October 2019 state that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the NCQA HEDIS Compliance Audit may be substituted for an ISCA. Findings from HSAG's review of the MCOs' HEDIS FARs are in the Validation of Performance Measures section of this report. HSAG also conducted components of an ISCA as part of the SFY 2022 PMV activities and the 2021 compliance review activities.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

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 stipulated 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
- BH
- 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 analysis 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.

Statewide Aggregate CAHPS Results

Member Experience Survey Highlights

Figure 3-1 shows the member experience survey highlights.

Figure 3-1—CAHPS Strengths and Weaknesses
CAHPS Strengths

Aetna's and Molina's 2022 child Medicaid top-box scores were statistically significantly higher than the 2021 top-box score for *Customer Service*.

VA Premier's 2022 child Medicaid top-box score was statistically significantly higher than the 2021 child Medicaid national average for *Rating of Health Plan*.

HealthKeeper's 2022 adult Medicaid top-box score was statistically significantly higher than the 2021 top-box score for *Rating of Specialist Seen Most Often*.

CAHPS Weaknesses

The Medallion 4.0 program's and Healthkeeper's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Personal Doctor*. In addition, the Medallion 4.0 program's and United's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*. Also, Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Rating of All Health Care*. In addition, Aetna's 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, United's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for *Rating of All Health Care*.

VA Premier's 2022 adult Medicaid top-box score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*. Also, Healthkeeper's 2022 child Medicaid top-box score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*. In addition, VA Premier's 2022 child Medicaid top-box score was statistically significantly lower than the 2021 top-box score for *Getting Needed Care*. Also, Aetna's 2022 top-box scores were statistically significantly lower than the 2021 adult Medicaid top-box scores for two measures: *Getting Needed Care* and *How Well Doctors Communicate*.

Adult Medicaid

Table 3-5 and Table 3-6 present the 2022 top-box scores for each MCO and the Medallion 4.0 program (i.e., all MCOs combined) compared to the 2021 adult Medicaid CAHPS scores for the global ratings

and composite measures. The 2022 CAHPS scores for each MCO and the Medallion 4.0 program were also compared to the 2021 adult Medicaid national averages.

Table 3-5—Comparison of 2021 and 2022 Adult Global Top-Box Scores

	Rating of Health Plan		*Rating of All Health Care*		*Rating of Personal Doctor*		*Rating of Specialist Seen Most Often*	
	2021	*2022*	*2021*	*2022*	*2021*	*2022*	*2021*	*2022*
Medallion 4.0 Program	62.5%	63.4%	55.8%	56.6%	68.0%	65.2%	64.8%	66.3%
Aetna	63.4%	60.3%	56.9%	53.6%	67.5%	65.4%	67.8%	59.5%+
HealthKeepers	61.1%	63.1%	60.3%	53.8%+	67.4%	65.3%	59.3%+	78.0%+▲
Molina	62.1%	60.1%	48.0%	56.6%	64.4%	66.9%	68.1%+	65.9%+
Optima	59.5%	64.3%	53.2%+	64.3%+	63.5%+	67.7%+	61.5%+	62.5%+
United	60.6%	56.2%	58.3%	47.8%+	64.8%	60.0%+	63.8%+	58.5%+
VA Premier	67.2%	69.5%	52.1%	58.8%+	75.9%	64.0%▼	71.8%+	62.5%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Indicates the 2022 score is statistically significantly higher in than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Table 3-6—Comparison of 2021 and 2022 Adult Composite Top-Box Scores

	Getting Needed Care		*Getting Care Quickly*		*How Well Doctors Communicate*		*Customer Service*	
	2021	*2022*	*2021*	*2022*	*2021*	*2022*	*2021*	*2022*
Medallion 4.0 Program	82.9%	81.1%	81.1%	80.2%	93.3%	91.0%	86.5%	87.5%
Aetna	84.3%	73.6%+▼	82.6%	73.1%+	93.8%	85.7%+▼	90.3%+	83.8%+
HealthKeepers	84.3%	84.7%+	81.6%+	84.4%+	92.8%	89.2%+	86.6%+	86.2%+
Molina	86.7%	83.4%+	81.8%+	76.1%+	91.6%	93.8%	84.3%+	88.0%+
Optima	85.2%+	78.4%+	79.9%+	82.2%+	93.7%+	93.1%+	73.5%+	85.3%+
United	77.5%	76.8%+	76.7%+	80.6%+	91.5%	90.9%+	89.8%+	84.8%+
VA Premier	79.5%+	85.2%+	82.3%+	79.0%+	94.6%	93.7%+	93.0%+	94.9%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Strengths	
	HealthKeepers' 2022 top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Rating of Specialist Seen Most Often.*
Weaknesses and Recommendations	
	Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, Aetna's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for two measures: *Getting Needed Care* and *How Well Doctors Communicate*.
	Recommendations: 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.
	Weakness: United's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for *Rating of All Health Care*. In addition, VA Premier's 2022 top-box score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*.
	Recommendations: 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.

Child Medicaid

Table 3-7 and Table 3-8 present the 2022 top-box scores for each MCO and the Medallion 4.0 program compared to the 2021 child Medicaid CAHPS scores for the global ratings and composite measures. The 2022 CAHPS scores for each MCO and the Medallion 4.0 program were also compared to the 2021 NCQA child Medicaid national averages.

Table 3-7—Comparison of 2021 and 2022 Child Global Top-Box Scores

	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2021	2022	2021	2022	2021	2022	2021	2022
Medallion 4.0 Program	75.6%	74.1%	75.7%	72.6%	77.7%	74.7%	72.3%	73.0%
Aetna	69.8%	74.0%	69.4%	66.9%	74.9%	75.8%	75.0%+	65.9%+
HealthKeepers	77.0%	74.8%	75.3%	74.4%	77.4%	71.2%▼	78.0%+	71.4%+
Molina	68.2%	67.3%	70.3%+	68.1%	74.8%	75.0%	66.7%+	71.7%
Optima	80.3%	71.3%	81.8%+	70.8%	83.6%	77.9%	75.0%+	76.8%+
United	65.8%	70.6%	71.1%	75.5%+	74.2%	74.1%	61.7%+	80.0%+
VA Premier	77.0%	78.8%	76.4%	72.8%	76.4%	77.2%	65.3%+	71.2%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2021 NCQA national Medicaid averages.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Table 3-8—Comparison of 2021 and 2022 Child Composite Top-Box Scores

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2021	2022	2021	2022	2021	2022	2021	2022
Medallion 4.0 Program	84.6%	82.5%	86.0%	83.9%	93.7%	93.2%	87.0%	86.8%
Aetna	82.1%+	82.8%	83.0%+	85.3%	94.1%	91.2%	73.9%+	88.0%+▲
HealthKeepers	83.0%	85.3%	84.8%	84.0%	92.7%	92.7%	91.6%	88.5%+
Molina	79.5%+	82.4%	86.3%+	86.8%	92.3%+	94.4%	75.4%+	89.2%▲
Optima	89.0%+	84.4%+	91.2%+	84.0%+	97.1%+	95.9%	93.5%+	89.2%+
United	72.9%+	74.5%+	79.3%+	76.1%+	91.8%	91.9%	78.3%+	82.3%+
VA Premier	90.6%+	79.7%+▼	87.3%+	85.9%+	93.4%	92.5%	85.0%+	82.9%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths	
+	Aetna's and Molina's 2022 top-box scores were statistically significantly higher than the 2021 top-box score for *Customer Service*.
+	VA Premier's 2022 top-box score was statistically significantly higher than the 2021 child Medicaid national average for one measure, *Rating of Health Plan*.

Weaknesses and Recommendations	
−	**Weakness:** The Medallion 4.0 program's and HealthKeepers' 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for *Rating of Personal Doctor*. In addition, the Medallion 4.0 program's and United's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Getting Needed Care* and *Getting Care Quickly*.
	Recommendations: 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.
−	**Weakness:** Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Rating of All Health Care*. In addition, HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*.
	Recommendations: 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.
−	**Weakness:** VA Premier's 2022 top-box score was statistically significantly lower than the 2021 top-box score for *Getting Needed Care*.
	Recommendations: 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.

FAMIS Program Statewide Aggregate Results

Table 3-9 presents the 2021 and 2022 FAMIS CAHPS top-box scores for the global ratings and composite measures. The FAMIS general child and CCC 2022 CAHPS scores were compared to the 2021 NCQA national child Medicaid and CCC Medicaid averages.[3-14] In addition, a trend analysis was performed that compared the 2022 CAHPS scores to corresponding 2021 CAHPS scores.

Table 3-9—Comparison of 2021 and 2022 FAMIS Program General Child and CCC Top-Box Scores

	General Child		CCC	
Global Ratings	**2021**	**2022**	**2021**	**2022**
Rating of Health Plan	72.9%	70.5%	72.6%	65.1%
Rating of All Health Care	72.8%	71.9%	66.2%+	62.8%
Rating of Personal Doctor	74.1%	77.4%	74.7%+	73.7%
Rating of Specialist Seen Most Often	75.8%+	69.4%+	77.8%+	68.6%
Composite Measures	**2021**	**2022**	**2021**	**2022**
Getting Needed Care	83.0%	83.3%+	90.2%+	82.3%▼
Getting Care Quickly	83.6%+	84.8%+	94.4%+	85.9%▼
How Well Doctors Communicate	95.7%	95.2%	95.5%+	95.6%
Customer Service	83.1%+	83.4%+	76.2%+	82.8%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

MCO Comparative and Statewide Calculation of Additional PM Results

Project Highlights

DMAS contracted with HSAG in 2022 to calculate the *Colorectal Cancer Screening (COL)* performance PM following the CMS *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*.[3-15] Table 3-10 displays the CY 2021 COL PM results stratified by Medicaid managed care program, Medicaid delivery

[3-14] For the NCQA national child Medicaid and CCC Medicaid averages, Quality Compass 2021 data were used with permission from NCQA. Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors; and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion.

[3-15] Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*, March 2022 (Updated July 2022). Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf. Accessed on: Jan 5, 2023.

system, MCO, geographic region, and select demographics (i.e., age, gender, and race). Additionally, Table 3-10 includes the percentage of each colorectal cancer screening type received.

Table 3-10—*COL* PM Results

Rate Stratification	CY 2021 Results
Virginia Total	32.73%
Medicaid Program	
CCC Plus	40.35%
Medallion 4.0	28.24%
More Than One Medicaid Program	35.80%
Medicaid Delivery System	
Managed Care	35.08%
FFS	4.84%
More Than One Delivery System	22.72%
MCO	
Aetna	31.10%
HealthKeepers	36.54%
Molina	25.72%
Optima	40.52%
United	31.36%
VA Premier	37.96%
More Than One MCO	39.01%
Geographic Region	
Central	31.90%
Charlottesville/Western	31.07%
Northern & Winchester	32.15%
Roanoke/Alleghany	32.62%
Southwest	31.61%
Tidewater	35.67%
Age	
51–64 Years	31.89%
65–75 Years	35.73%
Gender	
Male	28.40%
Female	36.07%
Race	
White	31.40%
Black/African American	35.79%
Asian	34.32%
Southeast Asian/Pacific Islander	31.55%
Hispanic	49.04%
More Than One Race/Other/Unknown	25.06%

Rate Stratification	CY 2021 Results
Screening Type	
FOBT	5.49%
Flexible Sigmoidoscopy	0.91%
Colonoscopy	26.56%
CT Colonography	0.08%
FIT–DNA Test	1.88%

Colorectal cancer is the third leading cause of death among men and women in the United States with an estimated 52,580 people projected to die of colorectal cancer in 2022.[3-16,3-17] The USPSTF has found that there is a substantial benefit from screening for colorectal cancer using stool-based tests with high sensitivity, colonoscopy, flexible sigmoidoscopy, and CT colonography in adults 50 to 75 years of age.[3-18] The *COL* Adult Core Set PM was calculated using administrative claims and encounter data for all members 51 to 75 years of age. The Virginia total *COL* rate for CY 2021 was 32.73 percent, with rates higher for the CCC Plus population than the Medallion 4.0 population (by approximately 12 percentage points) for those in the managed care population than the FFS population (by 30.24 percentage points). Rates by MCO varied, with Optima having the highest rate at 40.52 percent and Molina with the lowest rate at 25.72 percent. Additionally, colorectal cancer screening rates were higher among those 65 to 75 years of age, females, and the Hispanic race. Among the various screening types, colonoscopy was the primary screening type.

ARTS PM Specification Development and Maintenance Results

DMAS contracted with HSAG as its EQRO to develop and maintain custom PM specifications to evaluate the ARTS program. During 2021, HSAG calculated CY 2019 and CY 2020 information only PM rates for DMAS using administrative claims/encounter data for the following PMs:

- Concurrent Prescribing of Naloxone and High Dose Opioids
- Naloxone Use for High Risk of Overdose
- Treatment of Hepatitis C for Those With Hepatitis C and SUD
- Treatment of HIV for Those With HIV and SUD
- Preferred OBOT Compliance
- Cascade of Care for Members With OUD
- Cascade of Care for Members With Hepatitis C

[3-16] U.S. Preventive Services Task Force. *Final Recommended Statement: Colorectal Cancer: Screening*, May 18, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#citation1. Accessed on: Jan 5, 2023.

[3-17] American Cancer Society. *Cancer Facts & Figures: 2022*. Available at: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf. Accessed on: Jan 5, 2023.

[3-18] U.S. Preventive Services Task Force. *Final Recommended Statement: Colorectal Cancer: Screening*, May 18, 2021. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening#citation1. Accessed on: Jan 5, 2023.

- Cascade of Care for Members With HIV

During 2022, HSAG calculated CY 2021 rates and will be developing a formal report. The results are scheduled to be finalized in 2023.

Focus Studies

DMAS elected to continue the following clinical topics during the 2022 contract year: improving birth outcomes through adequate prenatal care (Medicaid and CHIP Maternal and Child Health Focus Study), improving the health of children in foster care (Child Welfare Focus Study), and Dental Utilization in Pregnant Women Focus Study. Based on methodological considerations, MCO-specific results produced for each focus study are available in the final activity reports.

MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results

DMAS contracted with HSAG in 2022 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs' HEDIS data and CAHPS survey results for the Medallion 4.0 MCOs. The Medallion 4.0 Consumer Decision Support Tool demonstrates how the Virginia Medicaid MCOs compare to one another overall and in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-11. Please refer to Appendix B for the detailed methodology used for this tool.

Table 3-11—Consumer Decision Support Tool Results—Performance Levels

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

Table 3-12 displays the Medallion 4.0 2022 Consumer Decision Support Tool results for each MCO.

Table 3-12—2022 Consumer Decision Support Tool Results

MCO	Overall Rating*	Doctors' Communication	Getting Care	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★★	★★★	★★★	★★★	★★★	★★★★★
HealthKeepers	★★★★★	★★★	★★★★	★★★★★	★★★	★★★★★
Molina	★	★★★	★	★	★	★
Optima	★★★	★★★	★★★★	★★	★★★	★
United	★★★	★★★	★★★	★★★★★	★★★★	★★★
VA Premier	★★★★	★★★	★★★	★★★	★★★★★	★★★★

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

Strengths and Weaknesses

For 2022, the MCOs demonstrated similar performance with the *Doctors' Communication* category, with all MCOs receiving the Average Performance level. The remaining categories showed large variations in performance between the MCOs for 2022, with star ratings from one to five.

Strengths	
+	HealthKeepers demonstrated the strongest performance by achieving the Highest Performance level for the *Overall Rating*, *Keeping Kids Healthy*, and *Taking Care of Women* categories; High Performance level for the *Getting Care* category; and Average Performance level for the *Doctors' Communication* category.
+	VA Premier demonstrated strong performance by achieving the Highest Performance level for the *Living With Illness* category; High Performance level for the *Overall Rating* and *Taking Care of Women* categories; and Average Performance level for the *Doctors' Communication*, *Getting Care*, and *Keeping Kids Healthy* categories.
Weaknesses	
−	Molina demonstrated the lowest performance by achieving the Lowest Performance level for the *Overall Rating*, *Getting Care*, *Keeping Kids Healthy*, *Living With Illness*, and *Taking Care of Women* categories, and the Average Performance level for the *Doctors' Communication* category.

Performance Withhold Program

In 2022, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 PWP. The SFY 2022 PWP was the first pay-for-performance year for the PWP and assessed CY 2021 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2022 PWP, the Medallion 4.0 MCOs could earn all or a portion of their 1 percent quality withhold based on sufficiently reporting the required PM rates for five NCQA HEDIS PMs and one AHRQ PDI PM. The SFY 2022 PWP was based on comparisons to the NCQA Quality

Compass national Medicaid HMO percentiles for all HEDIS PMs and comparisons to CY 2019 rates for the AHRQ PDI PMs. For detailed information related to the PWP, please see the *Medallion 4.0 SFY 2022 PWP Methodology* on DMAS' website.[3-19]

[3-19] Health Services Advisory Group, Inc. *SFY 2022 Medallion 4.0 Performance Withhold Program Methodology.* Available at: https://www.dmas.virginia.gov/media/3054/medallion-40-sfy-2022-pwp-methodology.pdf. Accessed on: Jan 5, 2023.

4. Validation of Performance Improvement Projects

Overview

This section presents HSAG's findings and conclusions from the PIP 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 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

As part of the Commonwealth's QS, each 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 CMS EQR Protocol 1.

Each PIP must involve:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve QI.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

The primary objective of PIP validation is to determine the MCO's compliance with the requirements of 42 CFR §438.330(d). HSAG's evaluation of the PIP includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, indicator[s], sampling techniques, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once designed, an MCO's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, identification of causes and barriers, and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCO improves its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results).

The goal of HSAG's PIP validation is to ensure that 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 QI strategies and activities conducted by the MCO during the PIP.

Approach to PIP Validation

In its PIP evaluation and validation, HSAG used CMS EQR Protocol 1. HSAG, in collaboration with DMAS, developed the PIP Submission Form. Each MCO completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured all CMS PIP protocol requirements were addressed.

HSAG, with DMAS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR protocols. The HSAG PIP validation staff consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. The CMS EQR protocols identify nine steps that should be validated for each PIP. For the 2022 submissions, the MCOs completed and validated for steps 1 through 6 in the PIP Validation Tool. The nine steps included in the PIP Validation Tool are:

- Step 1: Review the Selected PIP Topic
- Step 2: Review the PIP Aim Statement
- Step 3: Review the Identified PIP Population
- Step 4: Review the Sampling Method
- Step 5: Review the Selected Performance Indicator(s)
- Step 6: Review the Data Collection Procedures
- Step 7: Review the Data Analysis and Interpretation of PIP Results
- Step 8: Assess the Improvement Strategies
- Step 9: Assess the Likelihood that Significant and Sustained Improvement Occurred

PIP Validation Scoring

HSAG used the following methodology to evaluate PIPs conducted by the MCO's to determine PIP validity and to rate the percentage of compliance with CMS EQR Protocol 1.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must achieve a *Met* score.

Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating of *Not Met* for the PIP. The MCO is assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical

elements are *Partially Met*. HSAG provides general feedback when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results as follows:

- ***Met:*** High Confidence/Confidence in reported PIP results. All critical elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- ***Partially Met:*** Low Confidence in reported PIP results. All critical elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Partially Met*.
- ***Not Met:*** All critical elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical elements were *Not Met*. The MCOs had an opportunity to resubmit a revised PIP Submission Form and provide additional information or documentation in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG offered technical assistance to any MCO that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

HSAG conducted a final validation for any resubmitted PIPs and documented the findings and recommendations for each PIP. HSAG will prepare a report of its findings and recommendations for each MCO. These reports, which comply with 42 CFR §438.364, will be provided to DMAS and the MCOs.

Training and Implementation

HSAG trained the MCOs on the PIP Submission Form and PIP process prior to the submission due dates and provides technical assistance throughout the process.

PIP Validation Status

For the new PIPs, the MCOs progressed to reporting the first six steps (topic selection, Aim statement, population, sampling methodology, performance indicator measure, and data collection process) for the 2022 annual validation. This year's submissions did not include baseline data or interventions and QI processes. These will be reported in the 2023 submission and included in the next annual EQR technical report. The validation findings for each MCO are provided below.

Validation Findings

Aetna

In 2022, Aetna submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-1 displays Aetna's PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Aetna Better Health of Virginia?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of pregnant women screened for tobacco use during at least one prenatal visit?	
Performance Indicator Measure	The percentage of pregnant women who are screened for tobacco use.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

Aetna has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-2 and Table 4-3 display the intervention summary of each PIP. Table 4-4 displays Aetna's PIP strengths, weaknesses, and recommendations.

Table 4-2—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
To be determined (TBD)	TBD

Table 4-3—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-4—Aetna's PIP Strengths, Weaknesses and Recommendations

Strengths	
+	Aetna developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

HealthKeepers

In 2022, HealthKeepers submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-5 displays HealthKeepers' PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-5—PIP Aim Statements and Results: HealthKeepers

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with the organization?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date or within 42 days of enrollment in the organization.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that were screened for tobacco use during at least one prenatal care visit?	

Tobacco Use Cessation in Pregnant Women		
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization who had screening for tobacco use within one of the first two prenatal visits. This is a modified version of the HEDIS 2022 *PPC* measure.	
Validation Scores	*Overall Score: 100%*	*Critical Elements Score: 100%*
Validation status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

HealthKeepers has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-6 and Table 4-7 display the intervention summary of each PIP. Table 4-8 displays HealthKeepers' PIP strengths, weaknesses, and recommendations.

Table 4-6—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
TBD	TBD

Table 4-7—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-8—HealthKeepers' PIP Strengths, Weaknesses and Recommendations

Strengths	
+	HealthKeepers developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

Molina

In 2022, Molina submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and

services. Table 4-9 displays Molina's PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-9—PIP Aim Statements and Results: Molina

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries that had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment with Molina Complete Care of Virginia?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date, or within 42 days of enrollment with Molina Complete Care as defined by the HEDIS MY 2022 PPC Technical Specifications.	
Validation Scores	*Overall Score: 100%*	*Critical Elements Score: 100%*
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions decrease the use of tobacco products or smoking in pregnant women?	
Performance Indicator Measure	All pregnant women, as defined by the HEDIS MY 2022 PPC Technical Specifications, identified as smokers or tobacco users.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

Molina has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-10 and Table 4-11 display the intervention summary of each PIP. Table 4-12 displays Molina's PIP strengths, weaknesses, and recommendations.

Table 4-10—Intervention Summary for *Improve Timeliness of Prenatal Care*

Intervention	Intervention Status
TBD	TBD

Table 4-11—Intervention Summary for *Reduce Tobacco Use in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-12—Molina's PIP Strengths, Weaknesses and Recommendations

Strengths	
	Molina developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	Weakness: None identified.
	Recommendations: NA

Optima

In 2022, Optima submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-13 displays Optima's PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-13—PIP Aim Statements and Results: Optima

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization?	
Performance Indicator Measure	This indicator is based on the 2022 HEDIS *PPC* measure, which is the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.	
Validation Scores	*Overall Score: 100%*	*Critical Elements Score: 100%*
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of identified non-smoking pregnant members during the measurement period?	
Performance Indicator Measure	The percentage of Optima Health Medallion deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year—Optima Health Medallion pregnant members	

Tobacco Use Cessation in Pregnant Women		
	with the following pregnant smoking codes: 099.330, 099.331, 099.332, 099.333, 099.334, and 099.335.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

Optima has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-14 and Table 4-15 display the intervention summary of each PIP. Table 4-16 displays Optima's PIP strengths, weaknesses, and recommendations.

Table 4-14—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
TBD	TBD

Table 4-15—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-16—Optima's PIP Strengths, Weaknesses and Recommendations

Strengths	
+	Optima developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

United

In 2022, United submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-17 displays United's PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-17—PIP Aim Statements and Results: United

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Targeted intervention supported by the Virginia UnitedHealthcare Medallion Plan and focused on member outreach and engagement will increase the percentage of women who receive a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment for the Medallion 4.0 population	
Performance Indicator Measure	This indicator is based on the 2022 HEDIS *PPC* measure which is the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.	
Validation Scores	*Overall Score: 100%*	*Critical Elements Score: 100%*
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Targeted intervention supported by the Virginia UnitedHealthcare Medallion Plan and focused on member engagement will increase the percentage of pregnant women (identified as tobacco users) who receive advice to quit smoking and/or who discussed or were provided cessation methods or strategies among pregnant women.	
Performance Indicator Measure	The percentage of pregnant members with tobacco use who received smoking cessation services from case management during the period.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

United has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. provide the interventions that United selected to test for the PIPs and the MCO's decision for each intervention. Table 4-18 and Table 4-19 display the intervention summary of each PIP. Table 4-20 displays United's PIP strengths, weaknesses, and recommendations.

Table 4-18—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
TBD	TBD

Table 4-19—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-20—United's PIP Strengths, Weaknesses and Recommendations

Strengths	
	United developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	Weakness: None identified.
	Recommendations: NA

VA Premier

In 2022, VA Premier submitted the following new PIPs for validation: *Timeliness of Prenatal Care* and *Tobacco Use Cessation in Pregnant Women*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-21 displays VA Premier's PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-21—PIP Aim Statements and Results: VA Premier

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Do targeted interventions increase the percentage of deliveries who had a prenatal care visit during the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the Virginia Premier Health Plan during the measurement period?	
Performance Indicator Measure	The percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date or within 42 days of enrollment in the organization.	
Validation Scores	*Overall Score: 100%*	*Critical Elements Score: 100%*
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Do targeted interventions increase the percentage of pregnant members who report smoking cessation during the measurement year?	
Performance Indicator Measure	The percentage of Virginia Premier Medallion deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year—Medallion pregnant members with the following	

Tobacco Use Cessation in Pregnant Women		
	pregnant smoking codes: 099.330, 099.331, 099.332, 099.333, 099.334, and 099.335.	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Validation Status/Confidence Level	*Met/High Confidence/Confidence in reported PIP results*: All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

VA Premier has not progressed to reporting baseline data and conducting QI activities and interventions. This information will be reported in the 2023 submission and will be included in the next annual EQR technical report. For both topics, the MCO performed well with no opportunities for improvement identified. Table 4-22 and Table 4-23 display the intervention summary of each PIP. Table 4-24 displays VA Premier's PIP strengths, weaknesses, and recommendations.

Table 4-22—Intervention Summary for *Timeliness of Prenatal Care*

Intervention	Intervention Status
TBD	TBD

Table 4-23—Intervention Summary for *Tobacco Use Cessation in Pregnant Women*

Intervention	Intervention Status
TBD	TBD

Strengths, Weaknesses, and Recommendations

Table 4-24—VA Premier's PIP Strengths, Weaknesses and Recommendations

Strengths	
+	VA Premier developed methodologically sound projects that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

Recommendations

As the MCOs progress to the next stage of the PIP process, HSAG has the following recommendations:

- The MCOs should use QI tools such as a causal/barrier analysis, key driver diagrams, process mapping, and/or FMEA to determine and prioritize barriers, drivers, and/or weaknesses within

processes. The use of these tools will help the MCO determine what interventions to initiate and test.

- The MCOs should develop active, innovative interventions that have the potential for impacting the performance indicator outcomes.
- The MCOs should develop a process or plan to evaluate the effectiveness of each individual intervention.
- The MCOs should use PDSA cycles as part of the improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- The MCOs should revisit the causal/barrier analysis tools used at least annually to ensure the MCO remains on track and the identified barriers and opportunities for improvement are still relevant and applicable.

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 PMs such as the CMS Core Set measures, MLTSS measures, and PMs pertaining to BH 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 PMs is occurring.

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

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

Section 3, Table 3-2, displays, by MCO, the HEDIS MY 2021 PM 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 PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that Aetna followed the PM specifications and produced reportable rates for all PMs 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 MRR 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 PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Care for Chronic Conditions domain, Aetna displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Within the BH domain, Aetna's rate met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Cervical Cancer Screening* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure*
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis or focus study as it relates to these PMs within the Children's Preventive Care, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, 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.

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 PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that HealthKeepers followed the PM specifications and produced reportable rates for all PMs 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' MRR 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 PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Within the Children's Preventive Care domain, HealthKeepers displayed strong performance within the *Child and Adolescent Well-Care Visits—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Prenatal and Postpartum Care—Postpartum Care*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study as it relates to these PMs within the BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition,

Weaknesses and Recommendations	
	HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

Molina

Molina's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Molina submitted valid and reportable rates for all PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that Molina followed the PM specifications and produced reportable rates for all PMs 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 Molina's claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with Molina's eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with Molina's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Molina's MRR processes.
- *Supplemental Data:* HSAG identified no concerns with Molina's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Molina's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Care for Chronic Conditions domain, Molina displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Within the BH domain, Molina's rates met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening*

Weaknesses and Recommendations	
	• *Child and Adolescent Well-Care Visits—Total* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *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*
	Recommendations: HSAG recommends that Molina conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

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 PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that Optima followed the PM specifications and produced reportable rates for all PMs 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 provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Optima's MRR 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 PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
	Within the BH domain, Optima's rates met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Cervical Cancer Screening* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
	Recommendations: HSAG recommends that Optima conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

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 PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that United followed the PM specifications and produced reportable rates for all PMs 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 MRR 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 PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Children's Preventive Care domain, United displayed strong performance within the *Child and Adolescent Well-Care Visits—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Within the Care for Chronic Conditions domain, United displayed strong performance within the *Comprehensive Diabetes Care—HbA1c Testing* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile.
+	Within the BH domain, United's rate ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • *Adult's Access to Preventive/Ambulatory Health Services—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Postpartum Care*
	Recommendations: HSAG recommends that United conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, 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.

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 PMs in the scope of the HEDIS Compliance Audit.

HSAG determined that VA Premier followed the PM specifications and produced reportable rates for all PMs 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 provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with VA Premier's MRR 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 PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Care for Chronic Conditions domain, VA Premier displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Within the BH domain, VA Premier's rates met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • *Adult's Access to Preventive/Ambulatory Health Services—Total* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *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*

Weaknesses and Recommendations	
	Recommendations: HSAG recommends that VA Premier conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and 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.

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 (EQR Protocol 3).[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: Jan 5, 2023.

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—Virginia OSR for All MCOs

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 Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	Aetna		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			85.7%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			86.7%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			75.0%
X.	438.236	Practice Guidelines			100%

	CFR	Compliance Reviews	Aetna		
		Standard Name	2019	2020	2021
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			86.2%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**93.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
	Weakness: Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

HealthKeepers

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

Table 6-3—HealthKeepers' Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	HealthKeepers		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			80.0%

	CFR	Compliance Reviews	HealthKeepers		
		Standard Name	**2019**	**2020**	**2021**
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			100%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			83.3%
XIII.	438.228	Grievance and Appeal Systems			82.8%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**92.6%**

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

Molina

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

Table 6-4—Molina's Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	Molina		
		Standard Name	**2019**	**2020**	**2021**
I.	438.56	Enrollment and Disenrollment			100%

	CFR	Compliance Reviews	Molina		
		Standard Name	2019	2020	2021
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			95.2%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			86.7%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			89.5%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			100%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			89.7%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**93.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
	Weakness: Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

Optima

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

Table 6-5—Optima's Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	Optima		
		Standard Name	**2019**	**2020**	**2021**
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			95.2%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			66.7%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			75.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			83.3%
XIII.	438.228	Grievance and Appeal Systems			100%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			87.5%
TOTAL SCORE					**94.4%**

Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
	Weakness: Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

United

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

Table 6-6—United's Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	United		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			93/3%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			50.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			93.1%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			87.5%
TOTAL SCORE					**96.3%**

Strengths, Weaknesses, and Recommendations

Strengths

Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations

Weakness: Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Recommendations: MCO follow-up on recommendations can be found in Appendix E.

VA Premier

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

Table 6-7—VA Premier's Medallion 4.0 OSR Standards and Scores

	CFR	Compliance Reviews	VA Premier		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			85.7%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			90.5%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			66.7%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			75.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			79.3%
XIV.	438.608	Program Integrity			100%
XV.	441.58	EPSDT Services			62.5%

	CFR	Compliance Reviews	VA Premier		
		Standard Name	2019	2020	2021
	Section 1905 of the SSA				
TOTAL SCORE					**88.9%**

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E.

DMAS Intermediate Sanctions Applied

During 2022, DMAS monitored the MCOs' implementation of federal and State requirements and CAPs from prior years' compliance reviews. Table 6-8 contains the compliance actions taken.

Table 6-8—DMAS Compliance Actions Taken

MCO/Vendor	Compliance Action
HealthKeepers	HealthKeepers contracted with a new transportation subcontractor (Access2Care), which caused delays in submitting transportation encounter data. DMAS Systems and Reporting monitored for completion of encounter backlog submission, which was completed by May 2021.

7. 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 Medallion 4.0 Medicaid managed care population to obtain information on the levels of satisfaction of adult and child Medicaid members. For the Medallion 4.0 MCOs (Aetna, HealthKeepers, Molina, 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.

In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., CHIP members in FFS or managed care).

MCO-Specific Results

Aetna

Table 7-1 and Table 7-2 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Aetna's 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2022 CAHPS scores for Aetna were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-1—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: Aetna

	2021	2022
Global Ratings		
Rating of Health Plan	63.4%	60.3%
Rating of All Health Care	56.9%	53.6%
Rating of Personal Doctor	67.5%	65.4%

	2021	2022
Rating of Specialist Seen Most Often	67.8%	59.5%+
Composite Measures		
Getting Needed Care	84.3%	73.6%+▼
Getting Care Quickly	82.6%	73.1%+
How Well Doctors Communicate	93.8%	85.7%+▼
Customer Service	90.3%+	83.8%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ *Indicates the 2022 score is statistically significantly lower than the 2021 score.*
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Aetna's 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for three measures: *Getting Needed Care, Getting Care Quickly,* and *How Well Doctors Communicate*.
	Recommendations: HSAG recommends that Aetna 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 Aetna continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.
	Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for two measures, *Getting Needed Care* and *How Well Doctors Communicate*.
	Recommendations: HSAG recommends that Aetna 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 Aetna continue to monitor

Weaknesses and Recommendations	
	the measures to ensure significant decreases in scores over time do not continue to occur.

Table 7-2—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: Aetna

	2021	2022
Global Ratings		
Rating of Health Plan	69.8%	74.0%
Rating of All Health Care	69.4%	66.9%
Rating of Personal Doctor	74.9%	75.8%
Rating of Specialist Seen Most Often	75.0%+	65.9%+
Composite Measures		
Getting Needed Care	82.1%+	82.8%
Getting Care Quickly	83.0%+	85.3%
How Well Doctors Communicate	94.1%	91.2%
Customer Service	73.9%+	88.0%+ ▲

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.

Strengths, Weaknesses, and Recommendations

Aetna's 2021 and 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna's 2022 top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Customer Service*.

Weaknesses and Recommendations	
	Weakness: Aetna's 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.

HealthKeepers

Table 7-3 and Table 7-4 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared HealthKeepers' 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2022 CAHPS scores for HealthKeepers were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-3—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: HealthKeepers

	2021	2022
Global Ratings		
Rating of Health Plan	61.1%	63.1%
Rating of All Health Care	60.3%	53.8%+
Rating of Personal Doctor	67.4%	65.3%
Rating of Specialist Seen Most Often	59.3%+	78.0%+ ▲
Composite Measures		
Getting Needed Care	84.3%	84.7%+
Getting Care Quickly	81.6%+	84.4%+
How Well Doctors Communicate	92.8%	89.2%+
Customer Service	86.6%+	86.2%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Strengths	
	HealthKeepers' 2022 top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Rating of Specialist Seen Most Often*.

Weaknesses and Recommendations	
	Weakness: HealthKeepers' 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.

Table 7-4—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: HealthKeepers

	2021	2022
Global Ratings		
Rating of Health Plan	77.0%	74.8%
Rating of All Health Care	75.3%	74.4%
Rating of Personal Doctor	77.4%	71.2%▼
Rating of Specialist Seen Most Often	78.0%+	71.4%+
Composite Measures		
Getting Needed Care	83.0%	85.3%
Getting Care Quickly	84.8%	84.0%
How Well Doctors Communicate	92.7%	92.7%
Customer Service	91.6%	88.5%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

HealthKeepers' 2021 and 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	HealthKeepers' 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 top-box score and the NQCA child Medicaid national average for one measure, *Rating of Personal Doctor*.
	Recommendations: HSAG recommends that HealthKeepers 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 HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Molina

Table 7-5 and Table 7-6 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Molina's 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2022 CAHPS scores for Molina were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-5—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: Molina

	2021	2022
Global Ratings		
Rating of Health Plan	62.1%	60.1%
Rating of All Health Care	48.0%	56.6%
Rating of Personal Doctor	64.4%	66.9%
Rating of Specialist Seen Most Often	68.1%+	65.9%+
Composite Measures		
Getting Needed Care	86.7%	83.4%+
Getting Care Quickly	81.8%+	76.1%+
How Well Doctors Communicate	91.6%	93.8%
Customer Service	84.3%+	88.0%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

Strengths, Weaknesses, and Recommendations

Molina's 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Strengths	
	Molina's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: Molina's 2022 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur.

Table 7-6—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: Molina

	2021	2022
Global Ratings		
Rating of Health Plan	68.2%	67.3%
Rating of All Health Care	70.3%+	68.1%
Rating of Personal Doctor	74.8%	75.0%
Rating of Specialist Seen Most Often	66.7%+	71.7%
Composite Measures		
Getting Needed Care	79.5%+	82.4%
Getting Care Quickly	86.3%+	86.8%
How Well Doctors Communicate	92.3%+	94.4%
Customer Service	75.4%+	89.2%▲

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

Molina's 2021 and 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Molina's 2022 top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Customer Service*.

Weaknesses and Recommendations	
	Weakness: Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures, *Rating of Health Plan* and *Rating of All Health Care*.
	Recommendations: HSAG recommends that Molina 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 Molina continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Optima

Table 7-7 and Table 7-8 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2022 adult Medicaid CAHPS scores to its corresponding 2021 CAHPS scores.[7-1] In addition, the 2022 CAHPS scores for Optima were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-7—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: Optima

	2021	2022
Global Ratings		
Rating of Health Plan	59.5%	64.3%
Rating of All Health Care	53.2%+	64.3%+
Rating of Personal Doctor	63.5%+	67.7%+
Rating of Specialist Seen Most Often	61.5%+	62.5%+
Composite Measures		
Getting Needed Care	85.2%+	78.4%+
Getting Care Quickly	79.9%+	82.2%+
How Well Doctors Communicate	93.7%+	93.1%+
Customer Service	73.5%+	85.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

Strengths, Weaknesses, and Recommendations

Optima's 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed there were no differences observed.

Strengths	
	Optima's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	Weakness: Optima's 2022 top-box scores were not statistically significantly lower than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.

[7-1] In 2020, Optima did not administer a separate survey to its child Medicaid population; therefore, results are NR.

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

Table 7-8—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: Optima

	2021	2022
Global Ratings		
Rating of Health Plan	80.3%	71.3%▼
Rating of All Health Care	81.8%+	70.8%
Rating of Personal Doctor	83.6%	77.9%
Rating of Specialist Seen Most Often	75.0%+	76.8%+
Composite Measures		
Getting Needed Care	89.0%+	84.4%+
Getting Care Quickly	91.2%+	84.0%+
How Well Doctors Communicate	97.1%+	95.9%
Customer Service	93.5%+	89.2%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.

Strengths, Weaknesses, and Recommendations

Optima's 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Optima's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: Optima's 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Health Plan*.
	Recommendations: HSAG recommends that Optima 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 Optima continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

United

Table 7-9 and Table 7-10 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared United's 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2021 CAHPS scores for United were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-9—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: United

	2021	2022
Global Ratings		
Rating of Health Plan	60.6%	56.2%
Rating of All Health Care	58.3%	47.8%+
Rating of Personal Doctor	64.8%	60.0%+
Rating of Specialist Seen Most Often	63.8%+	58.5%+
Composite Measures		
Getting Needed Care	77.5%	76.8%+
Getting Care Quickly	76.7%+	80.6%+
How Well Doctors Communicate	91.5%	90.9%+
Customer Service	89.8%+	84.8%+

+ 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 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: United's 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*.
	Recommendations: HSAG recommends that United conduct root cause analyses of study indicators that have been identified as areas of low performance.

Weaknesses and Recommendations	
	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 Molina continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Table 7-10—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: United

	2021	2022
Global Ratings		
Rating of Health Plan	65.8%	70.6%
Rating of All Health Care	71.1%	75.5%+
Rating of Personal Doctor	74.2%	74.1%
Rating of Specialist Seen Most Often	61.7%+	80.0%+
Composite Measures		
Getting Needed Care	72.9%+	74.5%+
Getting Care Quickly	79.3%+	76.1%+
How Well Doctors Communicate	91.8%	91.9%
Customer Service	78.3%+	82.3%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
Cells highlighted in gray represent rates that are statistically significantly lower than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

United's 2021 and 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: United's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures, *Getting Needed Care* and *Getting Care Quickly.*
	Recommendations: HSAG recommends that United 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

Weaknesses and Recommendations	
	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 continue to occur.

VA Premier

Table 7-11 and Table 7-12 present the 2021 and 2022 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 2022 CAHPS scores to its corresponding 2021 CAHPS scores. In addition, the 2022 CAHPS scores for VA Premier were compared to the 2021 NCQA national adult and child Medicaid averages.

Table 7-11—Comparison of 2021 and 2022 Adult Medicaid CAHPS Results: VA Premier

	2021	2022
Global Ratings		
Rating of Health Plan	67.2%	69.5%
Rating of All Health Care	52.1%	58.8%+
Rating of Personal Doctor	75.9%	64.0%▼
Rating of Specialist Seen Most Often	71.8%+	62.5%+
Composite Measures		
Getting Needed Care	79.5%+	85.2%+
Getting Care Quickly	82.3%+	79.0%+
How Well Doctors Communicate	94.6%	93.7%+
Customer Service	93.0%+	94.9%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.

▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.

Strengths, Weaknesses, and Recommendations

VA Premier's 2021 and 2022 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	VA Premier's 2022 top-box scores were not statistically significantly higher than the 2021 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

Weaknesses and Recommendations	
	Weakness: VA Premier's 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*.
	Recommendations: HSAG recommends that VA Premier 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 United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Table 7-12—Comparison of 2021 and 2022 Child Medicaid CAHPS Results: VA Premier

	2021	2022
Global Ratings		
Rating of Health Plan	77.0%	78.8%
Rating of All Health Care	76.4%	72.8%
Rating of Personal Doctor	76.4%	77.2%
Rating of Specialist Seen Most Often	65.3%+	71.2%+
Composite Measures		
Getting Needed Care	90.6%+	79.7%+▼
Getting Care Quickly	87.3%+	85.9%+
How Well Doctors Communicate	93.4%	92.5%
Customer Service	85.0%+	82.9%+

+ Indicates fewer than 100 respondents for a measure. Caution should be exercised when interpreting these results.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
Cells highlighted in orange represent rates that are statistically significantly higher than the 2021 NCQA national Medicaid averages.

Strengths, Weaknesses, and Recommendations

VA Premier's 2021 and 2022 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	VA Premier's 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.

Weaknesses and Recommendations	
	Weakness: VA Premier's 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Getting Needed Care*.
	Recommendations: HSAG recommends that VA Premier conduct a root cause analysis of the study indicator 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 VA Premier continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

8. Focus Studies

This section presents HSAG's findings and conclusions from the focus study 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 have addressed the recommendations for QI made by HSAG during the previous year. The methodology for each study can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

Overview

Medicaid Maternal Child and Health Focus Study

The contract year 2020–2021 Medicaid Maternal Child and Health focus study, titled the Prenatal Care and Birth Outcomes Focus Study addressed the following questions:

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

The Prenatal Care and Birth Outcomes Focus Study included four study indicators calculated among singleton births occurring during CY 2020 and paid by Virginia Medicaid: percentage of births with early and adequate prenatal care, percentage of births with inadequate prenatal care, percentage of preterm births (<37 weeks gestation), and percentage of newborns with low birth weight (<2,500g). Study results included all live births paid by Virginia Medicaid, and were assigned to one of five Medicaid programs (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, LIFC, or Other Medicaid). Please note, study results are not limited to the women in the Medallion 4.0 program. Additionally, women may have changed service delivery systems or MCOs while pregnant; as such, analytic stratifications in this study reflect the service delivery system (i.e., managed care or FFS) and Medicaid program in which the woman was enrolled at the time of delivery. Table 8-1 presents study indicator results by Medicaid delivery system within each measurement period (i.e., CY 2018, CY 2019, and CY 2020).

Table 8-1—Overall Study Indicator Findings Among Singleton Births by Medicaid Delivery System, CY 2018–CY 2020

Study Indicator	National Benchmark	CY 2018		CY 2019		CY 2020	
		Number	Percent	Number	Percent	Number	Percent
FFS							
Births With Early and Adequate Prenatal Care	76.4%	3,856	68.9%	2,357	65.0%	1,881	64.8%
*Births With Inadequate Prenatal Care**	*NA*	977	17.5%	693	19.1%	562	19.4%

Study Indicator	National Benchmark	CY 2018		CY 2019		CY 2020	
		Number	Percent	Number	Percent	Number	Percent
*Births With No Prenatal Care**	*NA*	219	3.9%	193	5.3%	117	4.0%
Preterm Births (<37 Weeks Gestation)*	9.4%	626	10.7%	488	12.8%	334	11.0%
Newborns With Low Birth Weight (<2,500g)*	9.7%	594	10.1%	457	12.0%	280	9.3%
Managed Care							
Births With Early and Adequate Prenatal Care	76.4%	17,120	72.1%	20,035	73.2%	20,364	72.7%
*Births With Inadequate Prenatal Care**	*NA*	3,853	16.2%	4,350	15.9%	4,089	14.6%
*Births With No Prenatal Care**	*NA*	339	1.4%	495	1.8%	417	1.5%
Preterm Births (<37 Weeks Gestation)*	9.4%	2,316	9.3%	2,775	9.7%	2,834	9.7%
Newborns With Low Birth Weight (<2,500g)*	9.7%	2,307	9.3%	2,613	9.1%	2,699	9.2%

**a lower rate indicates better performance for this indicator.*
NA indicates there is not an applicable national benchmark for this indicator.

Women enrolled in managed care had better outcomes than women in the FFS population in CY 2020. The CY 2020 rate for women in managed care exceeded the national benchmark for the *Newborns With Low Birth Weight (<2,500 grams)* indicator but continued to fall below the national benchmark for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* indicators. Of note, the CY 2020 rate for women in FFS improved from prior measurement periods to outperform the national benchmark for *Newborns With Low Birth Weight (<2,500 grams)*.

Table 8-2 presents the study indicator results by Medicaid program for each measurement period.

Table 8-2—Overall Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2018–CY 2020

Study Indicator	National Benchmark	CY 2018		CY 2019		CY 2020	
		Number	Percent	Number	Percent	Number	Percent
Medicaid for Pregnant Women							
Births With Early and Adequate Prenatal Care	76.4%	16,249	72.2%	16,028	73.1%	13,737	72.4%
*Births With Inadequate Prenatal Care**	*NA*	3,637	16.2%	3,451	15.7%	2,839	15.0%

Study Indicator	National Benchmark	CY 2018		CY 2019		CY 2020	
		Number	Percent	Number	Percent	Number	Percent
*Births With No Prenatal Care**	*NA*	368	1.6%	393	1.8%	241	1.3%
Preterm Births (<37 Weeks Gestation)*	9.4%	2,124	9.0%	2,173	9.5%	1,750	8.9%
Newborns With Low Birth Weight (<2,500g)*	9.7%	2,103	8.9%	2,062	9.0%	1,699	8.6%
Medicaid Expansion							
Births With Early and Adequate Prenatal Care	76.4%	—	—	1,462	70.9%	3,249	73.8%
*Births With Inadequate Prenatal Care**	*NA*	—	—	330	16.0%	578	13.1%
*Births With No Prenatal Care**	*NA*	—	—	74	3.6%	90	2.0%
Preterm Births (<37 Weeks Gestation)*	9.4%	—	—	261	12.1%	544	11.9%
Newborns With Low Birth Weight (<2,500g)*	9.7%	—	—	235	10.9%	463	10.1%
FAMIS MOMS							
Births With Early and Adequate Prenatal Care	76.4%	1,311	76.8%	1,626	77.2%	1,564	76.8%
*Births With Inadequate Prenatal Care**	*NA*	228	13.4%	292	13.9%	261	12.8%
*Births With No Prenatal Care**	*NA*	14	0.8%	28	1.3%	11	0.5%
Preterm Births (<37 Weeks Gestation)*	9.4%	136	7.7%	168	7.7%	163	7.8%
Newborns With Low Birth Weight (<2,500g)*	9.7%	131	7.4%	158	7.2%	150	7.2%
LIFC							
Births With Early and Adequate Prenatal Care	76.4%	1,637	66.2%	1,576	66.1%	1,908	66.8%
*Births With Inadequate Prenatal Care**	*NA*	459	18.6%	487	20.4%	481	16.8%
*Births With No Prenatal Care**	*NA*	95	3.8%	105	4.4%	109	3.8%

Study Indicator	National Benchmark	CY 2018		CY 2019		CY 2020	
		Number	Percent	Number	Percent	Number	Percent
Preterm Births (<37 Weeks Gestation)*	9.4%	354	13.8%	347	13.9%	393	13.1%
Newborns With Low Birth Weight (<2,500g)*	9.7%	348	13.6%	300	12.0%	336	11.2%
Other Medicaid							
Births With Early and Adequate Prenatal Care	76.4%	1,779	67.0%	1,700	67.7%	1,787	67.0%
*Births With Inadequate Prenatal Care**	*NA*	506	19.0%	483	19.2%	492	18.4%
*Births With No Prenatal Care**	*NA*	81	3.0%	88	3.5%	83	3.1%
Preterm Births (<37 Weeks Gestation)*	9.4%	328	11.7%	314	12.0%	318	11.3%
Newborns With Low Birth Weight (<2,500g)*	9.7%	319	11.4%	315	12.0%	331	11.8%

**a lower rate indicates better performance for this indicator.*
NA indicates there is not an applicable national benchmark for this indicator.
—indicates Medicaid expansion was not implemented until January 1, 2019; therefore, there were no births covered by the Medicaid expansion program during CY 2018.

Births to women in the FAMIS MOMS program had the highest rates of *Births With Early and Adequate Prenatal Care* and the lowest rates of *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500g)* for all three measurement periods. Of note, the rates for the FAMIS MOMS program met or exceeded the national benchmarks for all study indicators with applicable benchmarks for all three measurement periods, demonstrating strength for the FAMIS MOMS program. Additionally, the Medicaid for Pregnant Women program outperformed the national benchmarks for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500g)* indicators for CY 2020. While the Medicaid expansion rates did not meet the national benchmarks in CY 2020, improvements were seen from CY 2019 to CY 2020, especially for the *Births With Early and Adequate Prenatal Care* and *Newborns With Low Birth Weight (<2,500g)* study indicators. The LIFC and Other Medicaid program rates demonstrate an opportunity for improvement given women in these two programs have the lowest rates of *Births With Early and Adequate Prenatal Care* and some of the highest rates of *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500g)*.

During 2022, HSAG initiated the seventh annual Medicaid and CHIP Maternal and Child Health Focus Study, covering births during CY 2021. The methodology is similar to prior studies with the exception of an additional analysis related to maternal health outcomes. The results from this study are scheduled to be released in 2023.

Foster Care Focus Study

In contract year 2020–2021, HSAG conducted the sixth annual Child Welfare Focus Study, titled the Foster Care Focus Study, to determine the extent to which children in foster care received the expected preventive and therapeutic medical care under a managed care service delivery program compared to children not in foster care and receiving Medicaid managed care benefits during MY 2020 (i.e., January 1, 2020–December 31, 2020). Historically, the Foster Care Focus Study evaluated a single study population (i.e., children in foster care); however, for this year's focus study, DMAS requested HSAG also evaluate children in the adoption assistance program and former foster care children ages 19 to 26 in order to establish baseline rates of healthcare utilization for these populations. Children in the adoption assistance program are children who have been adopted from foster care for whom adoptive placement without financial assistance was unlikely due to medical conditions or risk of future disability, membership in a minority group or sibling group, or extended time spent in foster care.[8-1] Former foster care children are young adults who were in foster care and enrolled in Medicaid at the time of their 18th birthday, who will continue to qualify for Medicaid through age 26. Additionally, historical studies evaluated healthcare utilization of foster care members enrolled in Virginia's Medallion 4.0 managed care program, which primarily provides healthcare services for women, children, and low-income adults. However, for this year's study, DMAS requested HSAG also include children in foster care enrolled in Virginia's CCC Plus managed care program, which covers older adults, children or adults with disabilities, dual eligible members (i.e., members eligible for both Medicare and full Medicaid benefits), Medicaid LTSS members, or medically complex members.

This year's study assessed how the healthcare utilization among members in foster care or adoption assistance programs (i.e., children in foster care, children in the adoption assistance program, and young adults formerly in foster care) compares to utilization among similar members not in foster care or adoption assistance programs and receiving Medicaid managed care benefits during MY 2020 (henceforth referred to as "controls"). Given the changes to this year's study (i.e., evaluating three foster care programs), comparisons to historical results (i.e., MY 2018 and MY 2019) are only available for the children in foster care population.

During CY 2018, DMAS transitioned from the Medallion 3.0 program to the Medallion 4.0 program. Due to the program change and changes in the participating MCOs, some members were transitioned to new MCOs during CY 2018. Given the MCO must work directly with either the social worker or the foster parent on any decisions regarding their medical care, the Medallion transition may or may not have caused delays in enrollment changes, potentially resulting in an impact to the healthcare and coverage for the children in foster care at that time. Additionally, the Medallion 4.0 program began covering and coordinating services, such as early intervention and non-traditional BH services, that were previously paid through traditional FFS Medicaid (i.e., "carved out" of managed care). As a result, MY 2018 and MY 2019 results presented in this report should be evaluated with caution given that the transitional period may have impacted care during these measurement years. Further, stakeholders should continue to monitor children in foster care's healthcare to understand the impact of the program change on study indicators.

[8-1] Virginia Department of Social Services. Adoption Assistance Screening Tool. Available at: https://dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-06-eng.pdf. Accessed on: Jan 6, 2023.

A policy statement published in 2015 by the American Academy for Pediatrics outlined a significant number of barriers in providing adequate health services to children in foster care.[8-2] These issues, compounded with the complexities of care for children with histories of trauma and potentially limited healthcare access, make the assessment of preventive and baseline healthcare services critical for a population in the developmental stages of life. Additionally, children in foster care are likely to require services from both physical and BH providers,[8-3] necessitating levels of care coordination and follow-up beyond those expected for most children and adolescents. These physical and BH conditions create additional challenges for youth aging out of the foster care system, who were unable to find a permanent home and must now navigate the transition into adulthood and adult healthcare.[8-4] Given the changes to Medicaid managed care benefits and the barriers to healthcare that children in foster care face, this study examined how healthcare utilization among children in foster care, adoption assistance children, and former foster children compared to utilization among comparable members not in a foster care or adoption assistance program.

For alignment with other quality initiatives, healthcare utilization PMs were based on either the CMS Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or the HEDIS Measurement Year 2020 & Measurement Year 2021 Technical Specifications for Health Plans.[8-5] This study assessed 13 PMs, representing 20 study indicators, across five domains:

- Primary Care
- Oral Health
- Behavioral Health
- Reproductive Health
- Respiratory Health

Table 8-3 through Table 8-5 present study indicator results for the children in foster care, adoption assistance children, and former foster children study populations and their associated controls. *P*-values indicate whether the rate differences between the study population and their controls are statistically significant.

[8-2] American Academy of Pediatrics. Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *Pediatrics*. Oct 2015:136:4. Available at: https://publications.aap.org/pediatrics/article/136/4/e1131/73819/Health-Care-Issues-for-Children-and-Adolescents-in. Accessed on: Jan 6, 2023.

[8-3] Deutsch SA, Lynch A, Zlotnik S, et.al. Mental health, behavioral and developmental issues for youth in foster care. *Curr Probl Pediatr Adolesc Health Care*. 2015; 45:292–297.

[8-4] Dworsky A, Courtney M. Addressing the Mental Health Service Needs of Foster Youth During the Transition to Adulthood: How Big is the Problem and What Can States Do? *Journal of Adolescent Health*.2009; 44:1–2.

[8-5] HEDIS Measurement Year 2020 & 2021 Volume 2 Technical Specifications for Health Plans align with indicator results reported to NCQA for the measurement period from January 1, 2020, through December 31, 2020.

Table 8-3—Overall Study PM Indicator Results for Children in Foster Care and Controls

PM	Children in Foster Care Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	68.0%	48.5%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	65.1%	56.1%	0.09
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	77.6%	74.5%	0.48
Oral Health			
Annual Dental Visit	79.1%	50.0%	<0.001*
Preventive Dental Services	72.0%	42.8%	<0.001*
Behavioral Health			
Seven-Day Follow-Up After Hospitalization for Mental Illness	65.6%	59.2%	0.45
Thirty-Day Follow-Up After ED Visit for Mental Illness	87.8%	78.9%	0.45
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.3%	27.8%	0.05
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	92.4%	78.9%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication Within 1 Month	86.8%	74.8%	0.02*
Follow-Up Care for Children Prescribed ADHD Medication Within 2 Months	92.5%	85.4%	0.09
Follow-Up Care for Children Prescribed ADHD Medication Within 3 Months	95.3%	87.8%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication Within 6 Months	99.1%	95.9%	0.22
Follow-Up Care for Children Prescribed ADHD Medication Within 9 Months	99.1%	96.7%	0.38
Substance Abuse			
Thirty-Day Follow-Up After ED Visit for AOD Abuse or Dependence[†]	S	S	NC
Initiation of AOD Abuse or Dependence Treatment	29.1%	45.8%	0.15
Engagement in AOD Abuse or Dependence Treatment	S	S	0.26
Reproductive Health			
Contraceptive Care (Most Effective or Moderately Effective Method)	46.0%	31.9%	<0.001*
Contraceptive Care (Long-Acting Reversible Method)	8.6%	5.6%	0.09
Respiratory Health			
Asthma Medication Ratio	89.8%	75.9%	0.05*

** Indicates that the rates are statistically different between the children in foster care and controls.*
† This indicator has denominators of 2 and 1 for children in foster care and controls, respectively, so rates may be unreliable.
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
NC indicates that the p-value could not be calculated since there was no variation in numerator compliance for children in foster care and controls.
P-values were calculated using chi-square tests and Fisher exact tests to quantify the relationship between foster care status and numerator compliance. PM rates and p-values presented in this table are not adjusted for demographic and health characteristics. Denominators vary by study indicator; please refer to the technical specifications for denominator criteria.

Table 8-4—Overall Study PM Indicator Results for Adoption Assistance Children and Controls

PM	Adoption Assistance Children Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	42.8%	40.8%	0.02*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	S	52.3%	1.00
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	79.4%	64.3%	0.08
Oral Health			
Annual Dental Visit	54.1%	49.9%	<0.001*
Preventive Dental Services	49.2%	43.5%	<0.001*
Behavioral Health			
Seven-Day Follow-Up After Hospitalization for Mental Illness	60.2%	58.7%	0.83
Thirty-Day Follow-Up After ED Visit for Mental Illness	77.8%	86.8%	0.20
Metabolic Monitoring for Children and Adolescents on Antipsychotics	27.7%	25.1%	0.52
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	59.3%	61.5%	0.81
Follow-Up Care for Children Prescribed ADHD Medication Within 1 Month	57.6%	54.0%	0.41
Follow-Up Care for Children Prescribed ADHD Medication Within 2 Months	71.8%	76.1%	0.27
Follow-Up Care for Children Prescribed ADHD Medication Within 3 Months	79.2%	85.1%	0.07
Follow-Up Care for Children Prescribed ADHD Medication Within 6 Months	89.0%	94.2%	0.03*
Follow-Up Care for Children Prescribed ADHD Medication Within 9 Months	91.8%	96.0%	0.04*
Substance Abuse			
Thirty-Day Follow-Up After ED Visit for AOD Abuse or Dependence†	S	S	0.25
Initiation of AOD Abuse or Dependence Treatment	57.1%	36.2%	0.07
Engagement in AOD Abuse or Dependence Treatment	S	S	0.04*
Reproductive Health			
Contraceptive Care (Most Effective or Moderately Effective Method)	22.1%	32.0%	<0.001*
Contraceptive Care (Long-Acting Reversible Method)	3.5%	3.5%	0.98
Respiratory Health			
Asthma Medication Ratio	83.4%	76.2%	0.08

** Indicates that the rates are statistically different between the adoption assistance children and controls.*
† This indicator has denominators of 3 and 9 for adoption assistance children and controls, respectively, so rates may be unreliable.
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
P-values were calculated using chi-square tests and Fisher exact tests to quantify the relationship between adoption assistance status and numerator compliance. PM rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Denominators vary by study indicator; please refer to the technical specifications for denominator criteria.

Table 8-5—Overall Study PM Indicator Results for Former Foster Children and Controls

PM	Former Foster Children Rate	Controls Rate	*p*
Primary Care			
Child and Adolescent Well-Care Visits	15.3%	14.7%	0.79
Oral Health			
Annual Dental Visit	26.5%	24.8%	0.67
Preventive Dental Services	20.3%	16.1%	0.23
Behavioral Health			
Seven-Day Follow-Up After Hospitalization for Mental Illness	22.6%	S	0.40
Thirty-Day Follow-Up After ED Visit for Mental Illness	36.1%	S	0.24
Substance Abuse			
Thirty-Day Follow-Up After ED Visit for AOD Abuse or Dependence†	S	S	0.03*
Initiation of AOD Abuse or Dependence Treatment	43.0%	47.3%	0.57
Engagement in AOD Abuse or Dependence Treatment	13.0%	23.0%	0.09
Reproductive Health			
Contraceptive Care (Most Effective or Moderately Effective Method)	35.8%	41.4%	0.05*
Contraceptive Care (Long-Acting Reversible Method)	5.5%	5.9%	0.76
Respiratory Health			
Asthma Medication Ratio	S	S	0.40

** Indicates that the rates are statistically different between the former foster children and controls.*
† This indicator has denominators of 17 and 9 for former foster children and controls, respectively, so rates may be unreliable.
S indicates that the rate has been suppressed due to a small numerator or denominator (i.e., less than or equal to 10).
P-values were calculated using chi-square tests and Fisher exact tests to quantify the relationship between former foster care status and numerator compliance. PM rates and p-values presented in this table are not adjusted for demographic and health characteristics.
Some PMs were not calculated for the former foster care population as the PM indicators are not applicable to members 19 to 26 years of age.
Denominators vary by study indicator; please refer to the technical specifications for denominator criteria.

This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators, and this finding is consistent across all three measurement years. Study findings show that rate differences between children in foster care and controls were greatest among dental PMs, where the rates of annual dental visits and preventive dental services among children in foster care were nearly 30 percentage points higher than the rates for controls. Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics. During MY 2020, children in foster care had lower rates compared to controls for only two study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment*. For initiation of AOD abuse or dependence treatment, children in foster care had a higher rate than controls during MY 2019 and a lower rate during MY 2018. For engagement of AOD abuse or dependence treatment, children in foster care had a higher rate than controls for both MY 2018 and MY 2019. Therefore, despite lower rates in MY 2020, children in foster care have not historically had lower rates than controls for these indicators.

Among children in foster care, nine study indicator rates decreased from MY 2019 to MY 2020, and 13 study indicator rates decreased from MY 2018 to MY 2020. Among controls for children in foster care, six study indicator rates decreased from MY 2019 to MY 2020, and five study indicator rates decreased from MY 2018 to MY 2020. These trends may be attributable to the COVID-19 PHE during MY 2020. For instance, from March 2020 to May 2020, most elective procedures and outpatient visits were cancelled or postponed nationwide.[8-6] Additionally, while outpatient visits rebounded by summer 2020 for adults, healthcare utilization of children remained low.[8-7] Despite the widespread decline in healthcare utilization, MY 2020 was the first measurement year in which children in foster care had a higher rate for the *7-Day Follow-Up After Hospitalization for Mental Illness* PM compared to controls. Some of this improvement may be attributable to changes to the PM specifications, which allows clinics to be considered MHPs; however, the increase in children in foster care's MY 2020 rates from MY 2019 (26.9 percentage points) was still larger than the increase in the controls' rates (14.6 percentage points) and the increase in the national Medicaid 50th percentile among children (4.5 percentage points). This finding demonstrates that children in foster care more frequently receive mental health follow-up care in a clinic setting compared to controls.

Study findings indicate that adoption assistance children had higher rates of appropriate healthcare utilization than comparable controls for 60 percent of study indicators, of which three were significantly better than controls (i.e., *Child and Adolescent Well-Care Visits*, *Annual Dental Visit*, and *Preventive Dental Services*). During MY 2020, adoption assistance children had lower rates than controls for eight study indicators, of which three were significantly lower than controls (i.e., *Contraceptive Care [Most or Moderately Effective Method]* and *Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up and Nine-Month Follow-Up*). Adoption assistance children also had lower rates than children in foster care for 16 study indicators; however, these rate differences may be attributable to external factors, such as program requirements (e.g., service workers must ensure children in foster care meet a mandated schedule of medical services, whereas adoption assistance children are not held to this schedule) and who has responsibility for provision of healthcare services.

The present study found that former foster children had higher rates of appropriate healthcare utilization than comparable controls for 45 percent of study indicators; however, none of these rate differences were statistically significant. During MY 2020, former foster children had lower rates than controls for more than half of study indicators, of which two study indicators were significantly lower than controls (i.e., *Thirty-Day Follow-Up After ED Visit for AOD Abuse or Dependence* and *Contraceptive Care [Most Effective or Moderately Effective Method]*). Former foster children also had the lowest healthcare utilization among the three study populations; however, these rate differences may be attributable to age (i.e., older adolescent and adult members tend to have lower rates of well-care and dental utilization compared to younger members) and to external factors, such as differences in program requirements between the foster care, adoption assistance, and former foster care programs.

During 2022, HSAG also initiated the seventh annual Foster Care Focus Study, renamed the Child Welfare Focus Study, to assess utilization outcomes among members in foster care or adoption

[8-6] Choi SE, Simon L, Basu S, Barrow JR. ***Changes in dental care use patterns due to COVID-19 among insured patients in the United States***. Journal of the American Dental Association. 2021. Available at: https://jada.ada.org/article/S0002-8177(21)00417-7/pdf. Accessed on: Jan 6, 2023.

[8-7] Mehrotra A, Chernew M, Linetsky D, Hatch H, Cutler D, Schneider E. ***The Impact of COVID-19 on Outpatient Visits in 2020: Visits Remained Stable, Despite a Late Surge in Cases.*** The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge. Accessed on: Jan 6, 2023.

assistance programs (i.e., children in foster care, children in the adoption assistance program, and young adults formerly in foster care) for CY 2021 using a methodology similar to prior studies. Results from this study are scheduled to be released in 2023.

Dental Utilization in Pregnant Women Focus Study

As a supplement to the Prenatal Care and Birth Outcomes Focus Study, DMAS contracted with HSAG to assess dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population on March 1, 2015, through the SFC program that is administered by DentaQuest.[8-8]

During 2022, HSAG completed a Dental Utilization in Pregnant Women Focus Study, referred to as the Dental Utilization in Pregnant Women Data Brief, that included all women 21 years of age or older with deliveries from January 1 through December 31, 2021 (i.e., CY 2021). HSAG used dental encounter data to identify which dental services, if any, were utilized during the woman's perinatal period (i.e., time of conception to the end of the month following the 60th day after delivery).[8-9] Dental services were identified and grouped according to DentaQuest's covered services and categories.

In addition to calculating dental utilization rates, HSAG also performed a statistical analysis related to the association of the receipt of dental health services and the following birth outcomes:

- Relationship between dental utilization and preterm birth (<37 weeks gestation)
- Relationship between dental utilization and newborns with low birth weight (<2,500 grams)
- Relationship between dental utilization and adequate prenatal care
- Relationship between dental utilization and postpartum ED utilization for non-traumatic dental-related services
- Relationship between dental utilization and postpartum ambulatory care utilization

Overall, HSAG identified 34,401 deliveries from January 1 through December 31, 2021. HSAG excluded 5,397 deliveries from the study population because the woman was less than 21 years of age at the start of the prenatal period (i.e., the time of conception based on gestational age at birth). The final study population included 29,004 deliveries among 28,962 women.

The distribution of deliveries among women receiving perinatal dental services varied widely by Medicaid program (i.e., Medicaid for Pregnant Women, Medicaid expansion, FAMIS MOMS,[8-10] LIFC, or Other Medicaid[8-11]), managed care program (i.e., Medallion 4.0, CCC Plus, or FAMIS), and delivery

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[8-8] The SFC program is administered by DentaQuest and covers most perinatal dental services for women ages 21 years and older. The latest DMAS program information is available at: https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/pregnant-women/.

[8-9] The analysis only includes paid claims. All zero-paid claims were excluded.

[8-10] Starting on July 1, 2021, DMAS began enrolling pregnant women who do not meet immigration status rules for other coverage into the FAMIS Prenatal Coverage program. Within this year's report, these members are included in the FAMIS MOMS Medicaid program.

[8-11] Other Medicaid includes all other births not covered by Medicaid for Pregnant Women, Medicaid expansion, FAMIS MOMS, and LIFC. Please note that Other Medicaid excludes births to women in Plan First and the DOC, which are included in the Not Enrolled category.

system (i.e., managed care or FFS). Table 8-6 presents the number and percentage of deliveries where perinatal dental services were received, stratified by Medicaid program, managed care program, and delivery system, as of the woman's date of delivery.

Table 8-6—Distribution of Women With Perinatal Dental Utilization, by Medicaid Program at Time of Delivery

Medicaid Program, Managed Care Program, and Delivery System at Time of Delivery	Count of Deliveries	Percent of Study Population (n=29,004)	Count of Deliveries With Any Covered Dental Service	Percent of Deliveries With Perinatal Dental Services Received
Any Program*	29,004	100.00%	4,749	16.37%
Medicaid Program				
Medicaid for Pregnant Women	13,674	47.15%	2,641	19.31%
Medicaid expansion	5,639	19.44%	832	14.75%
FAMIS MOMS	3,377	11.64%	485	14.36%
LIFC	3,431	11.83%	506	14.75%
Other Medicaid	1,621	5.59%	281	17.33%
Medicaid Managed Care Program				
Medallion 4.0	21,541	74.27%	3,999	18.56%
CCC Plus	779	2.69%	152	19.51%
FAMIS	2,100	7.24%	381	18.14%
Medicaid Delivery System				
Managed Care	24,420	84.20%	4,532	18.56%
FFS	3,322	11.45%	213	6.41%

**Please note 1,262 members who were not enrolled on their date of delivery are included in the Any Program rate but are not included in any other stratification.*

Among the CY 2021 study population, most services were covered by the Medicaid managed care delivery system (84.20 percent; n=24,420), with 18.56 percent (n=4,532) of those deliveries to women who received perinatal dental services. Conversely, while FFS covered 11.45 percent (n=3,322) of services, only 6.41 percent (n=213) of those deliveries were to women who received perinatal dental services. Within the managed care delivery system, 74.27 percent (n=21,541) of deliveries were covered by the Medallion 4.0 program, with 18.56 percent (n=3,999) of these deliveries to women who had received perinatal dental services. Of note, the CCC Plus program had the highest percentage of deliveries where the woman received perinatal dental services (19.51 percent, n=152). Additionally, women enrolled in the Medicaid for Pregnant Women program accounted for the largest proportion of deliveries by Medicaid program (47.15 percent; n=13,674), with 19.31 percent (n=2,641) of these deliveries to women who received perinatal dental services.

HSAG additionally performed a statistical analysis related to the association of the receipt of prenatal dental health services and birth outcomes. Table 8-7 presents the total number of deliveries among continuously enrolled women and the number and percentage of deliveries with any dental service during the prenatal period, by birth outcome. Additionally, Table 8-7 presents the results of the Pearson's chi-square test with significance between the two rates for each birth outcome indicated by an up arrow (i.e., the Any Dental Services group's rate is significantly higher than the No Dental Services group's rate) or a down arrow (i.e., the Any Dental Services group's rate is significantly lower than the No Dental Services group's rate) on the Any Dental Services group's rate.

Table 8-7—Prenatal Dental Utilization and Birth Outcomes Chi-Square Analysis—Any Dental Services

	Total Deliveries	Number of Deliveries With Birth Outcome	Percentage of Deliveries With Birth Outcome
Preterm Births (<37 Weeks Gestation)*			
Any Dental Services	3,629	348	9.59%
No Dental Services	25,370	2,590	10.21%
Newborns With Low Birth Weight (<2,500 grams)*			
Any Dental Services	3,627	301	8.30%
No Dental Services	25,367	2,325	9.17%
Births With Adequate Prenatal Care			
Any Dental Services	3,568	2,796	78.36% ↑
No Dental Services	24,565	18,301	74.50%
Postpartum ED Utilization for Non-Traumatic Dental Services*			
Any Dental Services	3,628	15	0.41%
No Dental Services	24,114	74	0.31%
Postpartum Ambulatory Care Utilization			
Any Dental Services	3,628	2,495	68.77% ↑
No Dental Services	24,114	13,575	56.30%

**a lower rate indicates better performance for this indicator.*
↓ indicates that the Any Dental Services group's rate was significantly lower than the No Dental Services group's rate within the birth outcome.
↑ indicates that the Any Dental Services group's rate was significantly higher than the No Dental Services group's rate within the birth outcome.

Table 8-7 shows that there were statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for two of the birth outcomes: *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*. The percentage of deliveries for *Births With Adequate Prenatal Care* was significantly higher for those who received at least one prenatal dental service (78.36 percent) compared to those who received no prenatal dental services (74.50 percent). For *Postpartum Ambulatory Care Utilization*, the deliveries where at least one prenatal dental service was received had significantly higher rates (68.77 percent) compared to deliveries that received no dental services (56.30 percent).

Table 8-8 presents the total number of deliveries among continuously enrolled women and the number and percentage of deliveries with preventive dental services during the prenatal period, by birth

outcome. Additionally, Table 8-8 presents the results of the Pearson's chi-square test with significance between the two rates for each birth outcome indicated by an up arrow (i.e., the Preventive Services group's rate is significantly higher than the No Preventive Services group's rate) or a down arrow (i.e., the Preventive Services group's rate is significantly lower than the No Preventive Services group's rate) on the Preventive Services group's rate.

Table 8-8—Prenatal Dental Utilization and Birth Outcomes Correlation Analysis—Preventive Dental Services

	Total Deliveries	Number of Deliveries With Birth Outcome	Percentage of Deliveries With Birth Outcome
Preterm Births (<37 Weeks Gestation)*			
Preventive Services	1,642	137	8.34%
No Preventive Services	27,357	2,801	10.24%
Newborns With Low Birth Weight (<2,500 grams)*			
Preventive Services	1,642	116	7.06% ↓
No Preventive Services	27,352	2,510	9.18%
Births With Adequate Prenatal Care			
Preventive Services	1,620	1,281	79.07% ↑
No Preventive Services	26,513	19,816	74.74%
Postpartum ED Utilization for Non-Traumatic Dental Services*			
Preventive Services	1,640	*S*	*S*
No Preventive Services	26,102	*S*	*S*
Postpartum Ambulatory Care Utilization			
Preventive Services	1,640	1,144	69.76% ↑
No Preventive Services	26,102	14,926	57.18%

** a lower rate indicates better performance for this indicator.*
↓ indicates that the Preventive Services group's rate was significantly lower than the No Preventive Services group's rate within the birth outcome.
↑ indicates that the Preventive Services group's rate was significantly higher than the No Preventive Services group's rate within the birth outcome.
S indicates that the data were suppressed due to a small numerator or denominator (i.e., fewer than 11). In instances where only one stratification was suppressed, the value for the second smallest population was also suppressed, even if the value was 11 or more.

Table 8-8 shows that there were statistically significant differences in the rates for deliveries that received preventive services versus those that did not receive any preventive services for three of the birth outcomes: *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. Deliveries receiving preventive services had significantly lower rates of *Newborns With Low Birth Weight (<2,500 grams)* (7.06 percent) compared to deliveries that did not receive preventive services (9.18 percent). Deliveries receiving preventive services also had significantly higher rates of *Births With Adequate Prenatal Care* (79.07 percent) compared to deliveries that did not receive preventive services (74.74 percent). For *Postpartum Ambulatory Care Utilization*, the rate for deliveries receiving preventive services (69.76 percent) was significantly higher than the rate for deliveries with no preventive services (57.18 percent).

Enhanced oral healthcare among pregnant women is essential for both mother and baby. Pregnancy may result in changes in oral health (e.g., pregnancy gingivitis, periodontic disease). Poor oral health is associated with cardiovascular disease and diabetes, and periodontic disease is associated with an increased risk for preterm birth.[8-12] Therefore, delaying necessary dental treatment could result in significant risk for mother and baby (e.g., an infection of a tooth could spread throughout the body).[8-13] The SFC program provides pregnant women with a critically important opportunity to receive dental services during the prenatal and postpartum periods, and the VDH offers guidance for providers providing dental services to pregnant women.[8-14] In CY 2021, relatively few women (16.37 percent; n=4,749) received dental services during or after pregnancy, and only 7.67 percent (n=2,226) of eligible women received preventive dental services (e.g., a dental cleaning) during the perinatal period.

Health insurance coverage and other access to care considerations (e.g., provider availability) play a role in whether women access dental services for which they are eligible. This is demonstrated by the finding that 18.56 percent (n=4,532) of deliveries to women covered by managed care on their date of delivery had perinatal dental utilization, compared to 6.41 percent (n=213) of deliveries among women with FFS coverage. Overall, dental utilization was similar among the various Medicaid programs, with Medicaid expansion, LIFC, FAMIS MOMS, and Other Medicaid ranging between 14.36 percent and 17.33 percent receiving perinatal dental services. Additionally, perinatal dental services were received for only 11.51 percent of deliveries for women who were not continuously enrolled in Medicaid for 90 days prior to and including their date of delivery.

Overall, perinatal dental utilization and the receipt of preventive dental services varied by managed care region. Among women with continuous enrollment, utilization was highest in the Northern & Winchester region and lowest in the Roanoke/Alleghany region. Perinatal dental utilization was highest for deliveries among Asian, Non-Hispanic women (29.17 percent; n=271) and lowest among deliveries to women of Other/Unknown race (15.50 percent; n=106). The statewide patterns for race/ethnicity varied within each managed care region. It should be noted that women may have received services that DMAS did not cover (e.g., the services were covered by other public health initiatives);[8-15] however, the regional distribution of perinatal dental utilization may be indicative of regional differences in women's access to dental providers.

When reviewing the relationship between birth outcomes and dental utilization, deliveries that received any dental service (including preventive services) during the prenatal period had a significantly higher rate for *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization* than those who did not receive any services. Additionally, those who received preventive services during the

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[8-12] The American College of Obstetricians and Gynecologists. Oral Health Care During Pregnancy and Through the Lifespan. Committee Opinion No. 569. *Obstet Gynecol* 2013;122:417–22. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan. Accessed on: Jan 6, 2023.

[8-13] Oral Health Care During Pregnancy Expert Workgroup. 2012. Oral Health Care During Pregnancy: A National Consensus Statement. Washington, DC: National Maternal and Child Oral Health Resource Center. Available at: https://www.mchoralhealth.org/PDFs/OralHealthPregnancyConsensus.pdf. Accessed on: Jan 6, 2023.

[8-14] Virginia Department of Health, Dental Health Program. Oral Health During Pregnancy: Practice Guidance for Virginia's Prenatal and Dental Providers. Available at: https://www.vdh.virginia.gov/content/uploads/sites/30/2019/03/PracticeGuideforVirginiaPrenatalDentalProvidersWEB.pdf. Accessed on: Jan 6, 2023.

[8-15] Perinatal and Infant Oral Health Quality Improvement Expansion Program 2019 Final Progress Narrative. Richmond, VA: Virginia Department of Health. Available at: https://www.mchoralhealth.org/PDFs/H47MC28478.pdf. Accessed on: Jan 6, 2023.

prenatal period also had a significantly lower rate of *Newborns With Low Birth Weight (<2,500 grams)* than deliveries that did not receive preventive services during the prenatal period. It is important to note that this analysis focuses on the relationship between dental utilization and birth outcomes. While the rates were significantly different for several birth outcomes between deliveries that received dental services and those that did not, many additional factors can contribute to each birth outcome.

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 9 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 10 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 MCE.

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

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

Strengths Related to Quality	
+	Aetna's PM results demonstrated quality with medication management and chronic illness management of recommended care. Within the Care for Chronic Conditions domain, Aetna displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Aetna demonstrated that it had processes in place to ensure overall care recommendations for children receiving antipsychotics were in place and were followed. Within the BH domain, Aetna's rate met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.

Strengths Related to Quality	
	The results of Aetna's CAHPS scores identified that members perceived that Aetna is responsive to members when contacting the MCO. Aetna's 2022 CAHPS child top-box score was statistically significantly higher than the 2021 top-box score for one PM, *Customer Service*.
	Aetna developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Strengths Related to Access and Timeliness	
	None identified.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Cervical Cancer Screening* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure*
	Recommendations: Although contract requirements were met in the 2021 compliance review, Aetna's PM rates indicated potential access to care issues with early detection screenings and recommended care for chronic conditions. HSAG recommends that Aetna conduct a root cause analysis or focus study as it relates to these PMs within the Children's Preventive Care, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, 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. These results may also indicate that members may have a lack of understanding of recommended or needed care, or that a disparity may exist.
	Weakness: Aetna's 2022 CAHPS adult top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. These results may indicate issues regarding access to care, the network, or disparities in care.
	Recommendations: HSAG recommends that Aetna 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

Weaknesses and Recommendations	
	strategies. In addition, HSAG also recommends that Aetna continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.
−	**Weakness:** Aetna's 2022 CAHPS adult top-box scores were statistically significantly lower than the 2021 top-box scores for two measures, *Getting Needed Care* and *How Well Doctors Communicate*. These results may indicate issues regarding access to care, the network, or disparities in care.
	Recommendations: HSAG recommends that Aetna 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 Aetna continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

HealthKeepers

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

Strengths Related to Quality	
+	HealthKeepers' PM results demonstrated quality with medication and chronic illness management of recommended care. Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	HealthKeepers' 2022 CAHPS adult top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Rating of Specialist Seen Most Often*. The score indicates member satisfaction with HealthKeepers' specialists providing care and services.
+	HealthKeepers developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Strengths Related to Access and Timeliness	
+	PM results for access and preventive care showed that within the Children's Preventive Care domain, HealthKeepers displayed strong performance within the *Child and Adolescent Well-Care Visits—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile. Compliance review results supported access to care with HealthKeepers monitoring its network to ensure providers provided physical access, reasonable accommodations, and accessible equipment for members

Strengths Related to Access and Timeliness	
	with SHCN. HealthKeepers also ensured that the provider network met the cultural, ethnic, racial, and linguistic needs of its members.

Weaknesses and Recommendations	
	Weakness: Although contract requirements were met in the 2021 compliance review, HealthKeepers' PM rates indicated potential access to care issues with early detection screenings, preventive care, and recommended care for chronic conditions. The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for HealthKeepers: • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Prenatal and Postpartum Care—Postpartum Care*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study as it relates to these PMs within the BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that HealthKeepers analyze its data and consider if there are disparities within its populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
	Weakness: HealthKeepers' 2022 CAHPS child top-box score was statistically significantly lower than the 2021 top-box score and NQCA child Medicaid national average for one measure, *Rating of Personal Doctor*. The results may reflect the timeliness of or access to care linked to how healthcare visit needs were addressed during the PHE.
	Recommendations: Although potentially impacted by service delivery during the PHE, HSAG recommends that HealthKeepers 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 HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Molina

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

Strengths Related to Quality	
+	Molina's PM results demonstrated quality with medication and chronic illness management of recommended care. Within the Care for Chronic Conditions domain, Molina displayed strong performance within the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Molina demonstrated that it had processes in place to ensure overall care recommendations for children receiving antipsychotics were in place and were followed. Within the BH domain, Molina's rates met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
+	The results of Molina's CAHPS scores identified that members perceived that Molina is responsive to members' concerns when contacting the MCO. Molina's 2022 CAHPS child top-box score was statistically significantly higher than the 2021 top-box score for one measure, *Customer Service*.
+	Molina developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Strengths Related to Access and Timeliness	
	None identified.
Weaknesses and Recommendations	
	Weakness: The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Child and Adolescent Well-Care Visits—Total* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure*

Weaknesses and Recommendations	
	• *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *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*
	Recommendations: HSAG recommends that Molina focus quality and performance improvement efforts on all PMs/indicators that fall below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile, including those PMs that are not included in the PWP. With PMs falling below the 25th percentile across multiple domains, it is important that Molina conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement and to fully understand the poor PM results. In addition, HSAG recommends that Molina analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. The work conducted within the PMs also may result in improved member experience survey results.
	Weakness: Molina's 2022 CAHPS child top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures, *Rating of Health Plan* and *Rating of All Health Care*. These scores may align with the PM rates in the Children's Preventive Care domain, with at least six indicators falling below the 25th percentile, most of which are not included in the PWP.
	Recommendations: HSAG recommends that Molina 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 Molina continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. HSAG recommends that Molina focus quality and performance improvement efforts on all measures/indicators that fall below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile, including those measures that are not included in the PWP. Efforts focused on these measures/indicators may have a positive impact on both the adult and child CAHPS scores.

Optima

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

Strengths Related to Quality	
	Optima demonstrated effective care management processes to ensure continued service delivery and monitoring for individuals receiving antidepressant medications. Evidence of the quality of care were found in Optima's performance within the BH domain, with Optima's rates meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
	Optima developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Strengths Related to Access and Timeliness	
	None identified.
Weaknesses and Recommendations	
	Weakness: Although contract requirements were met in the 2021 compliance review, Optima's PM rates indicated potential access to care issues with early detection screenings, preventive care for children, recommended care for chronic conditions, and mental health follow-up care PM indicator rates falling below the following NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. These PM indicators were determined to be opportunities for improvement for Optima: • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Cervical Cancer Screening* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure* • *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
	Recommendations: HSAG recommends that Optima focus quality and performance improvement efforts on all PMs that fall below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile, including those PMs that are not included in the PWP. HSAG recommends that Optima conduct a root cause analysis or focus study as it relates to these PMs within the Access to

Weaknesses and Recommendations	
	Care, Children's Preventive Care, BH, Women's Health, and Care for Chronic Conditions domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
−	**Weakness:** Optima's 2022 CAHPS child top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Health Plan*.
	Recommendations: HSAG recommends that Optima 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 Optima continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. HSAG recommends that Optima focus performance and QI efforts on all PM measures/indicators that are below the 25h percentile, including those that are not included in the PWP. This focus may result in improved CAHPS scores.

United

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

Strengths Related to Quality	
+	United displayed quality within the Care for Chronic Conditions domain, including strong performance for the *Comprehensive Diabetes Care—HbA1c Testing* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 90th percentile.
+	United demonstrated that it had processes in place to ensure overall care recommendations for children receiving antipsychotics were in place and were followed. Within the BH domain, United's rates ranked at or above NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* PM indicator.
+	United developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.

<table>
<tr><th colspan="2">Strengths Related to Access and Timeliness</th></tr>
<tr><td> </td><td>Although not all PMs in the Children’s Preventive Care domain were considered strengths, United displayed strong performance within the Child and Adolescent Well-Care Visits—Total PM indicator, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.</td></tr>
</table>

<table>
<tr><th colspan="2">Weaknesses and Recommendations</th></tr>
<tr><td rowspan="2"> </td><td>Weakness: Although contract requirements were met in the 2021 compliance review, United’s PM rates indicated potential access to care issues with early detection screenings, adults’ access to care, and prenatal and postpartum care falling below NCQA’s Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. These results may also indicate that members may have a lack of understanding of recommended or needed care, or that a disparity may exist. The following HEDIS MY 2021 PM rates fell below NCQA’s Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United:
• Adult’s Access to Preventive/Ambulatory Health Services—Total
• Breast Cancer Screening
• Cervical Cancer Screening
• Prenatal and Postpartum Care—Postpartum Care</td></tr>
<tr><td>Recommendations: HSAG recommends that United conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care and Women’s Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, 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.</td></tr>
<tr><td rowspan="2"> </td><td>Weakness: The CAHPS adult member experience survey results align with some performance measure results in the early detection screenings, adults’ access to care, and prenatal and postpartum care, with these rates falling below NCQA’s Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. These results may align with United’s 2022 CAHPS adult top-box score, which was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, Rating of All Health Care. The adult member experience survey results may indicate that members have some challenges accessing care, or members do not perceive that they are receiving quality care through the MCO.</td></tr>
<tr><td>Recommendations: HSAG recommends that United 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 United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. These efforts</td></tr>
</table>

Weaknesses and Recommendations	
	may lead to improved screening and preventive and chronic care performance measure rates, in addition to improving member experience survey scores.
−	**Weakness:** United's 2022 CAHPS child top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for two measures: *Getting Needed Care* and *Getting Care Quickly.* The member experience survey results may indicate that members have some challenges accessing care when they need it. Members' ability to access care when they need it or as quickly as they perceive they need it may indicate network issues or disparities in healthcare.
	Recommendations: HSAG recommends that United 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 United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur. These efforts may also lead to improved screening and preventive and chronic care performance measure rates, in addition to improving member experience survey scores.

VA Premier

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

Strengths Related to Quality	
+	VA Premier demonstrated quality in its processes to monitor medication use. Within the Care for Chronic Conditions domain, VA Premier displayed strong performance for the *Asthma Medication Ratio—Total* PM indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile.
+	Member CAHPS experience survey results demonstrated that VA Premier's child members believed that they had access to needed care and received quality care through their health plan. VA Premier's CAHPS child 2022 top-box score was statistically significantly higher than the 2021 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.
+	VA Premier developed methodologically sound PIPs that met both State and federal requirements. A sound design created the foundation for the MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project.

Strengths Related to Access and Timeliness	
	VA Premier demonstrated effective care management processes to ensure continued service delivery and monitoring for individuals receiving antidepressant medications. Evidence of the quality were found in VA Premier's PM rates. Within the BH domain, VA Premier's rates met or exceeded NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 75th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.

Weaknesses and Recommendations	
	Weakness: Although contract requirements were met in the 2021 compliance review, VA Premier's PM rates indicated potential access to care issues or a lack of member understanding of the need for well and preventive care for adults and children, and prenatal and postpartum care, with PM indicator rates falling below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. The results also may indicate a lack of care coordination or a member's lack of understanding of the need for follow-up care after inpatient events. The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier: • *Adult's Access to Preventive/Ambulatory Health Services—Total* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *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*
	Recommendations: HSAG recommends that VA Premier conduct a root cause analysis or focus study as it relates to these PMs within the Access to Care, Children's Preventive Care, BH, and Women's Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier analyze its data and 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.
	Weakness: VA Premier's 2022 CAHPS adult top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*. This score may be a result of members' experience in accessing care with their PCP during the PHE.
	Recommendations: HSAG recommends that VA Premier 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 VA Premier continue to

Weaknesses and Recommendations	
	monitor the measures to ensure significant decreases in scores over time do not continue to occur.
	Weakness: VA Premier's 2022 CAHPS child top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Getting Needed Care*. This score may be a result of members' experience in accessing care when needed during the PHE.
	Recommendations: HSAG recommends that VA Premier conduct a root cause analysis of the study indicator 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 VA Premier continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

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; 2-1
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.**	1-5
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.	1-9 – 1-10
3d	Recommend improvements to the quality of health care services furnished by each MCP.	Section 9
3e	Provides state-level recommendations for performance improvement.	1-6 – 1-10
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**	4-4 – 4-12
4b	Validation of performance improvement projects (PIPs): • **Objectives;**	4-1 4-4 – 4-12 Appendix B B-1

	Required Elements	Page Number
4c	Validation of performance improvement projects (PIPs): • **Technical methods of data collection and analysis;**	Appendix B B-1 – B-3
4d	Validation of performance improvement projects (PIPs): • **Description of data obtained; and**	4-4 – 4-12 Appendix B B-3
4e	Validation of performance improvement projects (PIPs): • **Conclusions drawn from the data.**	4-4 – 4-13
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 Appendix B B-4
5b	Validation of performance measure validation (PMV): • **Technical methods of data collection and analysis;**	Appendix B B-3 – B-7
5c	Validation of performance measure validation (PMV): • **Description of data obtained; and**	Appendix B B-5
5d	Validation of performance measure validation (PMV): • **Conclusions drawn from the data.**	5-1 – 5-9
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 Appendix B B-9
6b	Review for compliance: • **Technical methods of data collection and analysis;**	Appendix B B-8 – B-12
6c	Review for compliance: • **Description of data obtained; and**	6-1 – 6-2 Appendix B B-11
6d	Review for compliance: • **Conclusions drawn from the data.**	6-3 – 6-10
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a.1	Optional activities: Member Experience of Care Survey • **Objectives;**	7-1

	Required Elements	Page Number
		Appendix B B-13
7b.1	Optional activities: • **Technical methods of data collection and analysis;**	Appendix b B-13
7c.1	Optional activities: • **Description of data obtained; and**	Appendix B B-14 – B-15
7d.1	Optional activities: • **Conclusions drawn from the data.**	7-1 – 7-14
7a.2	Optional activities: Calculation of Additional PM Results **Objectives;**	3-21 Appendix B B-16
7b.2	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-17
7c.2	Optional activities: **Description of data obtained; and**	Appendix B B-17
7d.2	Optional activities: **Conclusions drawn from the data.**	3-21 – 3-23
7a.3	Optional activities: Medicaid and CHIP Maternal and Child Health Focus Study **Objectives;**	8-1 Appendix B B-20
7b.3	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-21
7c.3	Optional activities: **Description of data obtained; and**	Appendix B B-21
7d.3	Optional activities: **Conclusions drawn from the data.**	8-1 – 8-4
7a.4	Optional activities: Child Welfare Focus Study **Objectives;**	8-5 – 8-6 Appendix B B-28 – B-29
7b.4	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-30
7c.4	Optional activities: **Description of data obtained; and**	Appendix B B-30
7d.4	Optional activities: **Conclusions drawn from the data.**	8-7 – 8-10
7a.5	Optional activities: Dental Utilization in Pregnant Women Data Brief **Objectives;**	8-11 – 8-12 Appendix B B-35
7b.5	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-35

	Required Elements	Page Number
7c.5	Optional activities: **Description of data obtained; and**	Appendix B B-35
7d.5	Optional activities: **Conclusions drawn from the data.**	8-12 – 8-16
7a.6	Optional activities: Consumer Decision Support Tool **Objectives;**	3-24 Appendix B B-41
7b.6	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-41
7c.6	Optional activities: **Description of data obtained; and**	Appendix B B-41
7d.6	Optional activities: **Conclusions drawn from the data.**	3-24 – 3-25
7a.7	Optional activities: Performance Withhold Program **Objectives;**	3-25 Appendix B B-47
7b.7	Optional activities: **Technical methods of data collection and analysis;**	Appendix B B-47 – B-48
7c.7	Optional activities: **Description of data obtained; and**	Appendix B B-48
7d.7	Optional activities: **Conclusions drawn from the data.**	3-25

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:

- PIP Validation Approach and Methodology
- Validation of Performance Measure Methodology
- Assessment of Compliance With Medicaid Managed Care Regulations—Operational Systems Review Methodology
- Member Experience of Care Survey Methodology
- MCO Comparative and Statewide Calculation of Additional PM Results
- Medicaid and CHIP Maternal and Child Health Focus Study Methodology
- Child Welfare Focus Study Methodology
- Dental Utilization in Pregnant Women Data Brief Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

PIP Validation Approach and Methodology

During the 2022 EQR contract year with DMAS, HSAG validated two PIPs conducted by the MCOs. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the validation activities.

Objectives

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. DMAS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating PIPs. Validation of PIPs is a CMS mandatory activity.

The primary objective of HSAG's PIP validation was to determine the MCO's compliance with requirements set forth in 42 CFR §438.330(d)(2)(i-iv), including:

- Measurement of performance using objective quality indicators.
- Implementation system interventions to achieve improvement in the access to and quality of care.
- Evaluating the effectiveness of the interventions.
- Planning and initiation of activities for increasing and sustaining improvement.

Technical Methods of Data Collection

The data source for each of the MCO's PIPs was administrative data with the plans following HEDIS or DMAS measure specifications.

HSAG conducted the validation consistent with CMS EQR Protocol 1, cited earlier in this report. HSAG, with DMAS' input and approval, developed the PIP Validation Tool to ensure uniform and consistent validation of the PIP. Using this tool, HSAG determined the overall methodological validity of the PIP, and in future submissions, will determine the overall success in achieving significant and sustained improvement. Over the course of the PIP, HSAG will validate the following CMS EQR Protocol 1 steps:

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Indicator(s)
- Step 6—Review the Data Collection Procedures
- Step 7—Review Data Analysis and Interpretation of Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess for Significant and Sustained Improvement

HSAG's PIP validation process consisted of two independent validations that included a validation by team members with expertise in statistics, PIP design and methodology, and quality and performance improvement. The PIP Team conducted the validation process as follows:

- HSAG reviewed the PIP submission documentation to ensure that all required documentation was received.
- HSAG conducted the validation, and the PIP Validation Tool was completed.
- HSAG reconciled the scores by a secondary review. If the two reviewers produced scoring discrepancies, the PIP Team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required CMS EQR Protocol 1 step consisted of evaluation elements necessary to complete the validation of that activity. The PIP Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable (NA)*, or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All critical elements must have received a *Met* score to produce valid and reliable results. The scoring methodology included the *NA* designation for situations in which the evaluation element did not apply to the PIP. HSAG used the Not Assessed scoring designation when the PIP had not progressed to the remaining activities. HSAG used a General Comment when documentation for an evaluation element included the basic components to meet the requirements for the element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS EQR Protocol 1.

HSAG's criteria for determining the score were as follows:

1. *Met:* High Confidence/Confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
2. *Partially Met:* Low Confidence in reported PIP results. All critical elements were *Met* and 60 percent to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
3. *Not Met:* All critical evaluation elements were *Met* and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*
4. Not Applicable (NA): Elements designated *NA* (including critical elements) were removed from all scoring.
5. Not Assessed: Elements (including critical elements) were removed from all scoring.

In addition to a validation status (e.g., *Met*), HSAG gave the PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total elements *Met* by the sum of all applicable elements that were assessed (as *Met, Partially Met*, and *Not Met*). A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements that were assessed (as *Met, Partially Met*, and *Not Met*).

Description of Data Obtained

HSAG reviewed the documentation the MCOs submitted for each PIP validated by HSAG. The PIP was submitted using HSAG's PIP Submission Form, which HSAG developed to collect all required data elements for the PIP validation process. The MCOs completed the PIP Submission Form following instructions provided by the HSAG PIP Team regarding the level of documentation required to address each PIP evaluation element. The MCOs were also instructed to submit any supporting documentation that could provide further details and background information. HSAG was available to provide technical assistance throughout the PIP process. If the MCO achieved all validation criteria with the first submission, a resubmission was not necessary.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care the MCOs provided, HSAG determined which components of the PIP could be used to assess these domains. During 2022, the MCOs completed steps 1 through 6 only, and there were no reported data or QI processes and interventions conducted this year. Therefore, no conclusions could be drawn related to the PIP. These conclusions will be formulated after remeasurement data are reported and results from intervention testing are provided. PIP outcomes will be reported in future annual EQR technical

Validation of Performance Measure Methodology

DMAS contracted with HSAG, as its EQRO, to conduct PMV for the MCOs. 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, PAHPs, or PCCM entities to have a qualified EQRO perform an annual EQR that includes validation of contracted entity PMs (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 PM rates by the MCOs in accordance with CMS EQR Protocol 2.

DMAS is responsible for administering the Medicaid program and CHIP in the Commonwealth of Virginia. DMAS refers to its CHIP program as FAMIS. The Medallion 4.0 program provides services to the Medicaid and FAMIS populations. DMAS contracted with six privately owned MCOs to provide services to members enrolled in the Medallion 4.0 program for CY 2021. DMAS identified a set of PMs that the MCOs were required to calculate and report.

The purpose of the PMV was to assess the accuracy of PMs reported by the Medallion 4.0 MCOs and to determine the extent to which PMs reported by the MCOs followed State specifications and reporting requirements. Table B-1 displays the Medallion 4.0 MCOs that were included in the PMV.

Table B-1—CY 2021 Medallion 4.0 MCOs

MCO Name
Aetna
HealthKeepers
Molina
Optima
United
VA Premier

Objectives

The primary objectives of the PMV process were to evaluate the accuracy of the PM data collected by the MCO and determine the extent to which the specific PMs calculated by the MCO (or on behalf of the MCO) followed the specifications established for each PM. A PM-specific review was performed on a subset of Medallion 4.0 MCO PMs, all part of quality withhold PMs, to evaluate the accuracy of reported PM data. PMV results provided DMAS with MCO-specific PM designations to additional information for MCO quality withhold payments.

Technical Methods of Data Collection

HSAG conducted the validation activities as outlined in CMS EQR Protocol 2. To complete the validation activities for MCOs, HSAG obtained a list of the PMs 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 PM data element values for each PM, a completed 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-virtual on-site phase.

Approximately two weeks prior to the virtual on-site visit, HSAG provided the MCOs with an agenda describing all virtual on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-virtual on-site conference call with MCOs to discuss virtual on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the 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 PMs and conducting the PMV for each MCO. The team was composed of a lead auditor and several team members.

Description of Data Obtained

CMS EQR Protocol 2 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 Compliance 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 Compliance Audit standards. Additionally, the MCOs completed and submitted an ISCAT for HSAG's review of the PMs. 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-virtual on-site assessment of IS.
- **Medical record documentation—**The MCOs were responsible for completing the medical records review section within the Roadmap for the PMs 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 MRR 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 PM. 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 PM rate.
- **Source code (programming language) for PMs—**The MCOs that calculate the PMs using internally developed source code will be required to submit source code for each PM being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the PM specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the PM 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 PM calculation. If the MCOs outsourced programming for HEDIS PM production to an outside vendor, the MCOs were required to submit the vendor's NCQA PM 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, PM certification reports, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

How Data Were Aggregated and Analyzed

During the virtual 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 virtual on-site was combined for the Medallion 4.0 and CCC Plus programs. The virtual 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 PMs. 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 IS, 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 PMs. 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 PMs. 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 IS and evaluation of processes used to collect, calculate, and report the PMs, 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 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 PMs to verify that the MCOs have system documentation that supports that the MCO appropriately includes records for PM 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 virtual on-site visit, HSAG summarized preliminary findings, discuss follow-up items, and revisit the documentation requirements for any post-virtual on-site activities.

How Conclusions Were Drawn

After the virtual on-site visit, HSAG reviewed final PM 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 virtual 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 Medallion 4.0 for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each PM. CMS EQR Protocol 2 identifies possible validation results for PMs, defined in Table B-2.

Table B-2—Validation Results and Definitions for PMs

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

According to CMS EQR Protocol 2, the validation result for each PM 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 PM rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "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 PM DNR.

Table B-3 lists the PMs 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—PM List for SFY 2022

PM	Specifications	Method*
Asthma Admission Rate (Per 100,000 Member Months)	AHRQ PDI	Admin
Child and Adolescent Well-Care Visits	HEDIS MY 2021	Admin
Childhood Immunization Status—Combination 3	HEDIS MY 2021	Hybrid
Comprehensive Diabetes Care	HEDIS MY 2021	Hybrid
Follow-Up After ED Visit for Mental Illness	HEDIS MY 2021	Admin
Prenatal and Postpartum Care	HEDIS MY 2021	Hybrid

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

Assessment of Compliance With Medicaid Managed Care Regulations

Compliance reviews (Operational Systems Review or OSRs) are a mandatory activity that are used to determine the extent to which Medicaid and CHIP MCPs are in compliance with federal standards. HHS developed standards for MCPs, which are codified at 42 CFR §438 and 42 CFR §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.

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table B-4 describes the standards and associated regulations and requirements reviewed for each standard during the OSRs.

Table B-4—Summary of Compliance Standards and Associated Regulations

Standard	Federal Requirements Included	Standard	Federal Requirements Included
Standard I—Enrollment and Disenrollment	42 CFR §438.3(d) 42 CFR §438.56	Standard VIII—Provider Selection	42 CFR §438.12 42 CFR §438.102 42 CFR §438.106 42 CFR §438.214
Standard II—Member Rights and Confidentiality	42 CFR §438.100 42 CFR §438.224 42 CFR §422.128	Standard IX—Subcontractual Relationships and Delegation	42 CFR §438.230
Standard III—Member Information	42 CFR §438.10	Standard X—Practice Guidelines	42 CFR §438.236
Standard IV—Emergency and Poststabilization Services	42 CFR §438.114	Standard XI—Health Information Systems*	42 CFR §438.242
Standard V—Adequate Capacity and Availability of Services	42 CFR §438.206 42 CFR §438.207	Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330
Standard VI—Coordination and Continuity of Care	42 CFR §438.208	Standard XIII—Grievance and Appeal Systems	42 CFR §438.228 42 CFR §438.400 - 42 CFR §438.424
Standard VII—Coverage and Authorization of Services	42 CFR §438.210 42 CFR §438.404	Standard XIV—Program Integrity	42 CFR §438.602(b) 42 CFR §438.608 42 CFR §438.610

*Requirement §438.242: Validation of IS standards for each MCE was conducted under the PMV activity.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. During CY 2020–2021, HSAG conducted a full review of the Part 438 Subpart D and QAPI standards for all MCOs to ensure compliance with federal requirements. The objective of each virtual site review was to provide meaningful information to DMAS and the MCOs regarding:

- The MCOs' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the MCOs into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to care and services furnished by the MCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the MCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess for MCOs' compliance with regulations, HSAG conducted the five activities described in CMS EQR Protocol 3. Table B-5 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table B-5—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DMAS contract requirements: a. HSAG and DMAS participated in virtual meetings to determine the timing and scope of the reviews, as well as scoring strategies. b. HSAG collaborated with DMAS to develop monitoring tools, record review tools, report templates, agendas, and set review dates. c. HSAG submitted all materials to DMAS for review and approval. d. HSAG conducted training for all reviewers to ensure consistency in scoring across the MCOs.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO training webinar to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations.

<table>
<tr><th>For this protocol activity,</th><th>HSAG completed the following activities:</th></tr>
<tr><td></td><td>• HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate.
• No less than 60 days prior to the scheduled date of the review, HSAG notified the MCO in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. Thirty days prior to the review, the MCO provided data files from which HSAG chose sample grievance, appeal, and denial cases to be reviewed. HSAG provided the final samples to the MCOs via HSAG's SAFE site. No less than 30 days prior to the scheduled review, the MCO provided documentation for the desk review, as requested.
• Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.
• The HSAG review team reviewed all documentation submitted prior to the scheduled virtual review and prepared a request for further documentation and an interview guide to use during the webinar.</td></tr>
<tr><td>Activity 3:</td><td>Conduct MCO Review</td></tr>
<tr><td></td><td>• During the review, HSAG met with the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance.
• HSAG requested, collected, and reviewed additional documents, as needed.
• At the close of the virtual review, HSAG provided MCO staff members and DMAS personnel an overview of preliminary findings.</td></tr>
<tr><td>Activity 4:</td><td>Compile and Analyze Findings</td></tr>
<tr><td></td><td>• HSAG used the CY 2020–2021 DMAS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities.
• HSAG analyzed the findings and calculated final scores based on DMAS-approved scoring strategies.
• HSAG determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.</td></tr>
<tr><td>Activity 5:</td><td>Report Results to DMAS</td></tr>
<tr><td></td><td>• HSAG populated the DMAS-approved report template.
• HSAG submitted the draft report to DMAS for review and comment.</td></tr>
</table>

For this protocol activity,	HSAG completed the following activities:
	• HSAG incorporated the DMAS comments, as applicable, and submitted the draft report to the MCO for review and comment. • HSAG incorporated the MCO's comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Not Met*). • HSAG distributed the final report to the MCO and DMAS.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with key MCO staff members conducted virtually

How Data Were Aggregated and Analyzed

HSAG aggregated and analyzed the data resulting from desk review, the review of grievance, appeal, denial records, and provider and subcontractor agreements provided by each MCO; virtual interviews conducted with key MCO personnel; and any additional documents submitted as a result of the interviews. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.

- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to DMAS and to each MCO's staff members for their review and comment prior to issuing final reports.

HSAG analyzed the quantitative results obtained from the above compliance activity to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by each MCO. HSAG then identified common themes and the salient patterns that emerged across MCOs related to the compliance activity conducted.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the MCOs. Table B-6 depicts assignment of the standards to the domains of care.

Table B-6—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Enrollment and Disenrollment	✓		✓
Standard II—Member Rights and Confidentiality			✓
Standard III—Member Information			✓
Standard IV—Emergency and Poststabilization Services		✓	✓
Standard V—Adequate Capacity and Availability of Services		✓	✓
Standard VI—Coordination and Continuity of Care	✓	✓	✓
Standard VII—Coverage and Authorization of Services		✓	✓
Standard VIII—Provider Selection	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	✓		
Standard X—Practice Guidelines	✓		
Standard XI—Health Information Systems	✓		✓
Standard XII—Quality Assessment and Performance Improvement	✓		
Standard XIII—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Program Integrity	✓	✓	✓

Member Experience of Care Survey Methodology

Objectives

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 the Medallion 4.0 MCOs (Aetna, HealthKeepers, Molina, Optima, United, and VA Premier) with their MCO and healthcare.

Technical Methods of Data Collection

MCO CAHPS

For the Medallion 4.0 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-1] The mode of CAHPS survey data collection varied slightly among the MCOs. Aetna, HealthKeepers, Molina, 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, United, and VA Premier included the option for adult and child members to complete the survey via the Internet, and Optima included the option for adult members only to complete the survey via the 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 2022.

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-2] These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

FAMIS CAHPS

For the FAMIS CAHPS surveys, the technical method of data collection was through administration of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. In accordance with CMS' CHIPRA reporting requirements, the CAHPS survey was

[B-1] HealthKeepers administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations, while the other MCOs administered the CAHPS 5.1H Child Survey without the CCC measurement set. For purposes of this report, the child Medicaid CAHPS results presented for HealthKeepers represent the CAHPS results for their general child population (i.e., general child CAHPS results).

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

administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., CHIP members in FFS or managed care). To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select the general child and CCC members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data.

Child members included as eligible for the survey were 17 years of age or younger as of February 28, 2022. A mail-only methodology for data collection was utilized. Parents/caretakers of child members completed the surveys between the time period of March to June 2022. The surveys were administered in English and Spanish. Members identified as Spanish speaking through administrative data received a Spanish version of the survey with the option to complete the survey in English. All other members received an English version of the survey with the option to complete the survey in Spanish.

The CAHPS surveys include a set of standardized items (40 items for the CAHPS Adult Medicaid Health Plan Survey, 41 items for the CAHPS Child Medicaid Health Plan Survey without the CCC measurement set, and 76 items for the CAHPS Child Medicaid Health Plan Survey with the CCC measurement set) that assess members' perspectives on care. The CAHPS survey questions were categorized into eight measures of member 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 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-box experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive, or top-box, response was calculated. CAHPS composite question response choices fell into the following categories: "Never," "Sometimes," "Usually," or "Always." A top-box response for the composite measures was defined as a response of "Usually" or "Always." These percentages are referred to as top-box scores.

Description of Data Obtained

The CAHPS surveys ask 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 2022 for the Medallion 4.0 MCOs, and from March to June 2022 for the FAMIS program.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H 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 without the CCC measurement, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 22, 26, and 31. For the CAHPS 5.1 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 child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid

(they did not meet the eligible population criteria), or they had a language barrier. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. Ineligible members were identified during the survey process.

How Data Were Aggregated and Analyzed

Following the administration of the FAMIS CAHPS surveys, HSAG produced a single aggregate CAHPS report that synthesized the FAMIS program's CAHPS survey results (i.e., survey results for FFS and managed care members reported as one unit) and appropriately reflected the CAHPS measures included in the CAHPS 5.1 Child Medicaid Health Plan Survey with the CCC measurement set. The aggregate CAHPS report included the results for both the general child and CCC populations. HSAG utilized the CAHPS scoring approach recommended by NCQA in HEDIS Measurement Year 2022 Volume 3 Specifications for Survey Measures to generate the 2022 CAHPS survey results for the FAMIS program's general child and CCC populations.[B-3]

The 2022 top-box scores for each MCO, the statewide aggregate, and the FAMIS program were compared to the 2021 NCQA Medicaid national averages.[B-4,B-5,B-6] Statistically significant differences are noted with colors. A cell is 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 is highlighted in gray. An MCO's score that was not statistically significantly different than the national average is not highlighted.

Additionally, a trend analysis was performed for each MCO and the FAMIS program, where applicable, that compared the 2022 top-box scores to their corresponding 2021 top-box scores to determine whether there were statistically significant differences. Scores that were statistically significantly higher in 2022 than in 2021 are noted with upward (▲) triangles. Scores that were statistically significantly lower in 2022 than in 2021 are noted with downward (▼) triangles. Scores in 2022 that were not statistically significantly different from scores in 2021 are not noted with triangles.

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

[B-3] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA; 2021.

[B-4] For the NCQA child and CCC Medicaid national averages, the source for data contained in this publication is Quality Compass 2021 data and is used with the permission of NCQA. Quality Compass 2021 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA.

[B-5] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA, September 2021.

[B-6] NCQA national averages were not available for 2022 at the time this report was prepared; therefore, 2021 national data are presented.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the MCOs, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table B-7.

Table B-7—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

	Quality	Timeliness	Access
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Composite Measures			
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		

MCO Comparative and Statewide Calculation of Additional PM Results[B-7]

Project Overview

DMAS contracts with HSAG to calculate one PM as part of the Task J—PM Calculation activity. For the CY 2021 PMV activity, DMAS requested that HSAG calculate the *COL* PM. This document provides an overview of the methodology for the CY 2021 *COL* PM rate calculation.

Performance Measure

For the CY 2021 PM calculation, HSAG will calculate the *COL* performance measure, which PMs the percentage of members 51 to 75 years of age who had appropriate screening for colorectal cancer.

[B-7] Note: This methodology is presented as it appeared in the final report for this activity.

HSAG will follow the CMS *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*.[B-8]

Performance Period

In 2022, HSAG will calculate the *COL* PM rates for CY 2021 using data collected by DMAS and submitted to HSAG.

Data Collection

The *COL* PM will be calculated using administrative data sources, including demographic, enrollment, professional claims/encounters, institutional claims/encounters, and pharmacy data for Medicaid eligible individuals from DMAS. DMAS will supply SAS® data sets extracted by claims' paid dates.[B-9] HSAG will retrieve data files from DMAS' SFTP site.

HSAG will use SAS software to perform all analytics. Upon receiving data, HSAG will confirm the reasonability and completeness of the data.

PM Calculation

HSAG will develop SAS program code to calculate the PM rates following the PM specifications. A lead analyst and validation analyst will independently calculate the *COL* PM rates. The lead analyst will produce production programming code to generate the results and output for DMAS. In parallel with the work being performed by the lead analyst, the validation analyst will create separate code and confirm the rates generated by the lead analyst. The director overseeing PM calculations will perform a final review of the rates, which will include rate review by the chief data officer, as necessary. Prior to the rate deliverable submission, HSAG will review the final output for appropriate formatting and numerical reasonability.

HSAG will calculate a Virginia total PM rate and will stratify results by Medicaid program, Medicaid delivery system, MCO, and managed care geographic region using FIPS codes. In addition, rates will be stratified by age, race, and gender. Table B-8 presents the *COL* PM rate stratifications and values for Medicaid program, Medicaid delivery system, MCO, geographic region, age group, and gender.

[B-8] Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*, March 2022 (Updated July 2022). Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf. Accessed on: Jan 5, 2023.

[B-9] SAS is a registered trademark of the SAS Institute, Inc.

Table B-8—Medicaid Program, Medicaid Delivery System, MCO, Geographic Region, Age Group, and Gender Stratification Values

Stratification	Values
Medicaid Program	• CCC Plus • Medallion 4.0
Medicaid Delivery System	• FFS • Managed Care
MCO	• Aetna • HealthKeepers • Molina • Optima • United • VA Premier
Geographic Region	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Age Group	• 51–64 • 65–75 • Total
Gender	• Male • Female

For results stratified by race, DMAS provided race categories; however, to increase the utility of these rates, the original race categories were combined into larger groupings as shown in Table B-9. Table B-10 presents the *COL* PM race stratifications that may be reported by HSAG with a crosswalk to DMAS' race categories.

Table B-9—Race Category Stratification Values

Reported Race Categories	DMAS' Race Categories
White	White
Black/African American	Black/African American
Asian	Oriental/Asian, Chinese, Japanese, Korean, Vietnamese, Asian Indian, Other Asian

Reported Race Categories	DMAS' Race Categories
Southeast Asian/Pacific Islander	Native Hawaiian or Other Pacific Islander, Filipino, Guamanian or Chamorro, Samoan
Hispanic	Spanish American/Hispanic
More than One Race/Other/Unknown	American Indian/Alaskan Native, Asian & White, Black/African American & White, Asian & Black/African American, Other, Unknown

In order to understand the types of screenings for colorectal cancer that members are receiving, HSAG will also stratify the numerator-positive members by each type of colorectal cancer screening received. The colorectal cancer screening stratifications and descriptions are listed in Table B-10.

Table B-10—Colorectal Cancer Screening Stratifications

Type of Screening	Description
Received FOBT	Members in the eligible population who received an FOBT during the measurement period.
Received Flexible Sigmoidoscopy	Members in the eligible population who received a flexible sigmoidoscopy during the measurement period or the four years prior to the measurement year.
Received Colonoscopy	Members in the eligible population who received a colonoscopy during the measurement period or the nine years prior to the measurement period.
Received CT Colonography	Members in the eligible population who received a CT colonography during the measurement period or the four years prior to the measurement period.
Received FIT-DNA Test	Members in the eligible population who received a FIT-DNA test during the measurement period or the two years prior to the measurement period.

Once rates are generated, HSAG will produce a single Microsoft Excel workbook containing numerator, denominator, and rate results. HSAG will denote PM rates based on relatively small numerators or denominators (i.e., fewer than 11) within the report. Please note, rates based on small numerators or denominators should not be made publicly available. HSAG will also provide DMAS with a member-level file that includes the member's demographic information and flags for the screenings for which the member was numerator-positive.

Medicaid and CHIP Maternal and Child Health Focus Study Methodology[B-10]

DMAS has contracted with HSAG since SFY 2015–2016, as its EQRO, to conduct an annual Medicaid and CHIP Maternal and Child Health Focus Study (Prenatal Care and Birth Outcomes Focus Study) that will provide quantitative information about PNC and associated birth outcomes among women with births paid by Title XIX or Title XXI, which includes the Medicaid, FAMIS, FAMIS MOMS, Medicaid expansion, and LIFC programs. The SFY 2020–2021 (Contract Year 7) Task J.1 Prenatal Care and Birth Outcomes Focus Study will continue to address the following study questions:

- To what extent do women enrolled with Medicaid receive early and adequate PNC during pregnancy?
- What clinical outcomes are associated with births to women enrolled in Medicaid?

Study Design

Eligible Population

The eligible population will consist of all live births to women enrolled in Virginia Medicaid on the date of delivery during CY 2020, regardless of whether the births occurred in Virginia. Births paid by Virginia Medicaid were assigned to one of five full-scope Medicaid program categories based on the mother's enrollment in the program at the time of delivery:

The FAMIS MOMS program uses Title XXI (CHIP Demonstration Waiver) funding to serve pregnant women with incomes up to 200 percent[B-11] of the FPL and provides benefits similar to Medicaid through the duration of pregnancy and for 60 days postpartum.

- The Medicaid for Pregnant Women program uses Title XIX (Medicaid State Plan) funding to serve pregnant women with incomes up to 143 percent of the FPL.
- The Medicaid expansion program uses Title XIX funding to serve adults 19 years of age and older with incomes up to 138 percent of the FPL.
- The LIFC program uses Title XIX funding to serve low-income adults with children under the age of 18 who are eligible for the TANF program based on their monthly income at the time of enrollment.
- The "Other Medicaid" programs include births paid by Medicaid that do not fall within the FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, or LIFC programs. Please note, births to women in Plan First or the DOC are excluded.[B-12]

[B-10] Note: This methodology is presented as it appeared in the final report for this activity.
[B-11] A standard disregard of 5 percent FPL is applied if the woman's income is slightly above the FPL.
[B-12] Prior to the 2020–2021 Birth Outcomes Focus Study, births to women in the LIFC program, Plan First, and DOC were included in the Other Medicaid program. Therefore, HSAG will re-calculate historical (i.e., CY 2018 and CY 2019) Other Medicaid program rates to exclude births to women in LIFC, Plan First, and DOC.

Births covered by emergency-only benefits will also be included in the eligible population for this study. However, because women covered by emergency-only benefits were enrolled in Medicaid on the day before or the day of the delivery, these births will be evaluated separately.

Data Collection

From the Medicaid member demographic and eligibility data provided by DMAS, HSAG will assemble a list (i.e., a Finder's File) of female members between the ages of 10 and 55 years with any Medicaid eligibility during CY 2020. HSAG will submit the Finder's File to DMAS with instructions for conducting two types of data linkages. DMAS will work with VDH to obtain the birth registry data and conduct the following data linkages:

1. DMAS will use probabilistic data linking to match HSAG's list of women eligible for the study to birth registry records.
2. DMAS will match HSAG's list of study-eligible members to birth registry records using social security numbers (i.e., deterministic data linking).

DMAS will return data files to HSAG containing the information from the Finder's File and select birth registry data fields for matching members for each of the data linkage processes, as well as documentation regarding the linked data files. The data files DMAS submits to HSAG will only include information for live births (i.e., non-live births are excluded from the linked registry records). HSAG will include all probabilistically or deterministically linked birth registry records from births occurring during CY 2020 in the overall eligible population for this focus study.

HSAG will use the linked birth registry data in conjunction with the Medicaid claims and encounter data files to calculate study indicator results and stratifications.

Study Indicators

Table B-11 presents the study indicators that HSAG will calculate for this study limited to singleton births, defined using the Plurality field in the birth registry data.

Table B-11—Study Indicators†

Indicator	Denominator	Numerator
Births With Early and Adequate PNC	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births with an Adequacy of PNC Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent).
Births With Inadequate PNC	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births with a Kotelchuck Index score less than 50 percent.

Indicator	Denominator	Numerator
Births With No PNC	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births with no PNC.
Preterm Births (<37 Weeks Gestation)*	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: • Preterm: Less than 37 weeks – Late preterm: 34–36 weeks – Moderate preterm: 32–33 weeks – Very preterm: 28–31 weeks – Extremely preterm: <28 weeks
Newborns With Low Birth Weight (<2,500 grams)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: • Overall low birth weight: <2,500 grams – Moderately low birth weight: 1,500 grams–2,499 grams – Very low birth weight: <1,500 grams

†Births with missing information for these study indicators will be excluded from the denominator.

**Estimated gestational age will be based upon the CEG provided on the birth certificate. In the event this estimate is not available, HSAG will attempt to calculate gestation using the date of the LMP indicated on the birth certificate. Birth certification records missing both CEG and LMP values will be captured in a "missing gestational age" category.*

Where applicable, HSAG will compare the study indicators to national benchmarks. HSAG will use the Healthy People 2030 goals[B-13] using data derived from the CDC, NCHS, and NVSS, for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators, and will use the FFY 2020 CMS Core Set benchmarks, if available, for the *Newborns With Low Birth Weight (<2,500 grams)* study indicator.[B-14]

HSAG will also present CY 2020 study indicator results compared to historical results (i.e., CY 2018 and CY 2019). Please note, HSAG will re-calculate historical study indicator results to exclude births covered by emergency-only benefits, Plan First, and DOC that were previously included in the CY 2018 and CY 2019 results. For CY 2020, the births covered by emergency-only benefits will be calculated and reported separately.

Additionally, HSAG will also perform a cross-measure analysis to better understand the relationship between the *Births With Early and Adequate Prenatal Care* study indicator and the *Preterm Births (<37 Weeks Gestation)* and the *Newborns With Low Birth Weight (<2,500 grams)* study indicators.

[B-13] Healthy People 2030. Pregnancy and Childbirth. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth. Accessed on: Dec 10, 2022.

[B-14] If the FFY 2020 CMS Core Set benchmarks are not available at the time of producing the report, HSAG will use the FFY 2019 CMS Core Set benchmarks.

Study Indicator Stratifications

HSAG will stratify the CY 2020 study indicator rates by the categories listed in Table B-12.

Table B-12—Study Indicator Stratifications

Stratification	Category Values
Medicaid Program at Delivery	• FAMIS MOMS (eligibility category 005) • Medicaid for Pregnant Women (eligibility categories 091 and 097) • Medicaid expansion (aid categories 100, 101, 102, 103, 106, and 108) • LIFC (aid category 081) • Other Medicaid (will include all other births not covered by FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, and LIFC; will exclude births to women in Plan First [aid category: 080] and DOC [aid category: 109])
Medicaid Delivery System at Delivery	• FFS • Managed Care
Managed Care Program at Delivery	• Medallion 4.0 • CCC Plus • FAMIS
MCO at Delivery	• Aetna • HealthKeepers • Molina • Optima • United • VA Premier
Length of Continuous Enrollment Prior to Delivery	• ≤ 30 Days • 31–90 Days • 91–180 Days • > 180 Days
Trimester of PNC Initiation *Note: Defined from the birth registry data.*	• First Trimester • Second Trimester • Third Trimester • No PNC • Unknown

Stratification	Category Values
Managed Care Region of Maternal Residence *Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.*	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Maternal Race/Ethnicity *Note: Defined from the birth registry data as non-Hispanic race (i.e., White, non-Hispanic), with Hispanic women of any race reported in the Hispanic category.*	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

In addition to the study indicator results and trending, HSAG will present the study indicator results stratified by MCO (Medallion 4.0, CCC Plus, and FAMIS combined), including MCO study indicator results stratified by demographics within the Findings section of the report. HSAG will present program-specific (Medallion 4.0, CCC Plus, and FAMIS) results for each MCO in the appendix of the report.

Comparative Analysis

To facilitate DMAS' program evaluation efforts, HSAG will perform a comparative analysis by grouping births into a study population and a comparison group based upon the timing and length of Medicaid enrollment.

- The study population will include women continuously enrolled in the following programs or combination of programs for a minimum of 120 days prior to, and including, the date of delivery: FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, LIFC, or Other Medicaid.
- The comparison group will include women enrolled in any of the five Medicaid programs (i.e., FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, LIFC, or Other Medicaid) defined above on the date of delivery, but less than 120 days of continuous enrollment prior to the date of delivery.

HSAG will calculate the study indicator results for the five Medicaid programs stratified by a study population and comparison group. Additionally, HSAG will note the denominator sizes of the study population and comparison group for FAMIS MOMS.

Additional Population-Specific Stratifications

FAMIS MOMS

For the FAMIS MOMS study indicator results, HSAG will also stratify the CY 2020 results by Medicaid delivery system, maternal race/ethnicity, maternal age at delivery, managed care region of maternal

residence, length of continuous enrollment prior to delivery, and trimester of PNC initiation. Please refer to the category values defined in Table B-12 for more information regarding these stratifications.

Emergency-Only Benefits

For the emergency-only benefits study indicator results, HSAG will stratify the CY 2020 results by maternal race/ethnicity, maternal age at delivery, and managed care region of maternal residence. Additionally, HSAG will compare the CY 2020 study indicators to the CY 2019 study indicator results for the women covered by emergency-only benefits. Please refer to the category values defined in Table 2 for more information regarding these stratifications.

Member-Level Data File

HSAG will produce a member-level data file and Microsoft Excel spreadsheet that DMAS can use for internal purposes. The member-level data file will include all data elements listed in Table B-13.

Table B-13—Member-Level Data File

Demographic Category	Category Values
Singleton Birth Indicator	• Singleton • Multiple
Medicaid Program at Delivery	• FAMIS MOMS • Medicaid for Pregnant Women • Medicaid expansion • LIFC • Other Medicaid
Comparative Analysis Population Group	• Study Population • Comparison Group • Not Applicable (NA)
Medicaid Delivery System at Delivery	• FFS • Managed Care
MCO at Delivery	• Aetna • HealthKeepers • Molina • Optima • United • VA Premier

Demographic Category	Category Values
MCO Enrollment	• Not enrolled with an MCO prior to delivery (e.g., FFS) • Enrolled with one MCO prior to delivery • Enrolled with more than one MCO prior to delivery
Continuous Enrollment	• The number of days continuously enrolled in Virginia Medicaid
Length of Continuous Enrollment Prior to Delivery	• $\leq$ 30 Days • 31–90 Days • 91–180 Days • $>$ 180 Days • Not continuously enrolled prior to delivery
Maternal Gravidity *Note: Defined from the birth registry data.*	• The number of pregnancies, including the current pregnancy
Trimester of PNC Initiation	• First Trimester • Second Trimester • Third Trimester • No PNC • Unknown
Managed Care Region of Maternal Residence *Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.*	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater • Unknown/Missing
Maternal Race/Ethnicity *Note: Defined from the birth registry data as non-Hispanic race (i.e., White, non-Hispanic), with Hispanic women of any race reported in the Hispanic category.*	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown
Maternal Age at Delivery	• 15 Years and Younger • 16–17 Years • 18–20 Years • 21–24 Years • 25–29 Years • 30–34 Years

Demographic Category	Category Values
	• 35–39 Years • 40–44 Years • 45 Years and Older • Unknown
Maternal Citizenship Status *Note: Defined from DMAS' demographic data.*	• U.S. Citizen (Citizenship Status = "C", "N") • Documented immigrant (Citizenship Status = "E", "I", "P", "R") • Undocumented immigrant (Citizenship Status = "A") • Other (Citizenship Status = "V")
Emergency-Only Benefits	• Emergency-Only Benefits • NA
Maternal Asthma[B-15]	• Asthma • No Asthma • NA
Maternal Diabetes[B-16]	• Diabetes • No Diabetes • NA
Maternal Gestational Diabetes[B-17]	• Gestational Diabetes • No Gestational Diabetes • NA
PNC Index	• Adequate Plus PNC • Adequate PNC • Intermediate PNC • Inadequate PNC • Missing Info
Gestational Age	• Preterm: Less than 37 weeks – Late preterm: 34–36 weeks – Moderate preterm: 32–33 weeks – Very preterm: 28–31 weeks – Extremely preterm: <28 weeks

[B-15] Identification of asthma will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.
[B-16] Identification of diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.
[B-17] Identification of gestational diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

Demographic Category	Category Values
	• Term: 37–41 weeks – Late Term: 41 weeks – Full Term: 39–40 weeks – Early Term: 37–38 weeks • Post Term: > 42 weeks
Birth Weight	• Moderately Low • Very Low • Not Low • Missing
Method of Delivery *Note: Defined from the birth registry data.*	• C-Section Delivery • Vaginal Delivery • Missing
Birth in Administrative Data *Note: Defined using HEDIS MY 2020 Deliveries Value Set from the Prenatal and Postpartum Care PM and applied to DMAS' claims and encounter data.*	• Yes • No
High-Risk Pregnancies *Note: Defined using medications (e.g., progesterone) and diagnoses (e.g., prior high-risk pregnancy, preeclampsia, obesity, gestational diabetes) considered to be risk factors for high-risk pregnancies and applied to DMAS' claims and encounter data.*	• Yes • No

Child Welfare Focus Study Methodology[B-18]

Purpose

DMAS has contracted with HSAG since SFY 2015–2016 to conduct a child welfare focus study that assesses healthcare utilization among foster care children receiving medical services through MCOs (Foster Care Focus Study). The SFY 2020–2021 (Contract Year 7) Task J.2 Foster Care Focus Study will assess how the healthcare utilization among members in foster care or adoption assistance programs (i.e., children in foster care, children in the adoption assistance program, and young adults

[B-18] Note: This methodology is presented as it appeared in the final report for this activity.

formerly in foster care) compares to utilization among members not in foster care or adoption assistance programs and receiving Medicaid managed care benefits.

Study Design

Measurement Period

The study will include members in a foster care or adoption assistance program for any length of enrollment between January 1, 2020, and December 31, 2020.

Eligible Populations

HSAG will identify the eligible populations for each foster care or adoption assistance program being assessed using the specific program's aid category to determine member enrollment at any point during the measurement period:[B-19]

- Foster Children—All children enrolled in Medicaid under 18 years of age as of January 1, 2020, and identified by DMAS as enrolled in Medicaid under the aid category "76" for children in foster care.
- Adoption Assistance Children—All children enrolled in Medicaid under 18 years of age as of January 1, 2020, and identified by DMAS as enrolled in Medicaid under the aid category "72" for children in the adoption assistance program.
- Former Foster Children—All members enrolled in Medicaid aged 19 to 26 years as of January 1, 2020, and identified by DMAS as enrolled in Medicaid under the aid category "70" for young adults formerly in foster care.

As study indicators will apply to different sub-groups of members in the eligible populations, HSAG will then assign the members of each eligible population to the following sub-groups based on Medicaid enrollment; a member may be assigned to multiple groups:

- Continuously enrolled populations: All members in the eligible population continuously enrolled in a single managed care program (i.e., Medallion 4.0 or CCC Plus)[B-20] and a single aid category (e.g., continuously enrolled foster children must be continuously enrolled with aid category "76") with any MCO or combination of MCOs from January 1, 2020, through December 31, 2020, with one or more gaps in enrollment totaling no more than 45 days.
- Study populations: All children in the continuously enrolled population for which comparable members not in the foster care or adoption assistance programs and receiving Medicaid managed care benefits were identified.

Since this study will compare healthcare utilization among members in foster care or adoption assistance programs and their Medicaid peers not in foster care or adoption assistance programs, HSAG will identify a comparison group of members who are continuously enrolled through an aid

[B-19] The Foster Children eligible population and Adoption Assistance Children eligible population are not mutually exclusive; a member may be included in both the Foster Children eligible population and Adoption Assistance Children eligible population.

[B-20] Based on analyses, HSAG and DMAS will determine whether members enrolled in CCC Plus will be excluded from the study or whether the analyses will stratify by managed care program.

category other than the foster care or adoption assistance programs (i.e., an aid category that is not "76", "72", or "70") and receiving Medicaid managed care benefits for each study population. HSAG will determine the most appropriate method to identify a group of members not in foster care or adoption assistance programs that is statistically similar to each continuously enrolled foster care or adoption assistance program population. Once the comparison groups have been identified, HSAG will evaluate the similarity between the study populations (i.e., members in foster care or adoption assistance programs) and the comparison groups (i.e., members not in foster care or adoption assistance programs) through a variety of tests and assessments.[B-21]

As part of a sub-analysis, HSAG will also identify former foster children originating from out of state. DMAS will supply a methodology or a list of member IDs for identifying these members. HSAG will not identify a comparison group for this population.

Data Collection

HSAG will extract information needed for the study from administrative claims and encounter data, as well as member, provider, eligibility, and enrollment data to be supplied by DMAS. In addition, DMAS will supply HSAG with dental encounter data during the measurement period from the Medicaid Dental Benefit Manager, DentaQuest, and BH encounter data from Molina. A six-month data run-out period will be allowed between the end of the measurement period and data extraction; data extraction will begin no earlier than July 1, 2021.

Indicators

The unit of analysis for this study will be Medicaid members, and indicators will vary by population group (i.e., the eligible populations, the continuously enrolled populations, and the study populations, described in the Eligible Populations section), as described in Table B-14. Indicators will be calculated for each foster care or adoption assistance program independently.

For consistency with other quality initiatives, healthcare utilization indicators are based on either the CMS' Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or the HEDIS Measurement Year 2020 & Measurement Year 2021 Technical Specifications for Health Plans, where applicable.[B-22] However, HSAG will modify the HEDIS continuous enrollment criteria to reflect the ability of members in foster care or adoption assistance programs to move between MCOs during the measurement period. Additionally, indicators for the continuously enrolled populations and the study populations will also be calculated for the comparison groups. For sub-analysis indicators for former foster children originating from out of state, DMAS will provide custom PM specifications.

When identification of provider types is necessary for study indicator calculations, HSAG will work with DMAS to classify PCPs and MHPs as defined in the HEDIS MY 2020 technical specifications. Providers identified as PCPs may include, but are not limited to, pediatricians, family practice

[B-21] HSAG will evaluate covariate balance between each eligible population's matched groups using bivariate statistical testing (i.e., chi-square and two-sample *t*-tests), an assessment of standardized differences, and an omnibus test to evaluate statistical balance across all covariates simultaneously.

[B-22] HEDIS Measurement Year 2020 & 2021 Volume 2 Technical Specifications for Health Plans align with indicator results reported to NCQA for the measurement period from January 1, 2020, through December 31, 2020.

physicians, general practice physicians, internal medicine physicians, nurse practitioners, physician assistants, and FQHCs.

Table B-14—Study Indicators

Indicator	Description and/or Category Values
Eligible Populations—Demographic Characteristics of Medicaid Members in Foster Care or Adoption Assistance Programs [B-23]	
Sex	Category Values: Female, Male, Other
Age Category	Category Values for Foster Care and Adoption Assistance: Infant [≤ 2 Years], Preschool [3 to 5 Years], Elementary School [6 to 10 Years], Middle School [11 to 13 Years], High School [≥ 14 Years] Category Values for Former Foster Care: Young Adult [19 to 22 Years], Adult [23 to 26 Years]
Race	Category Values: White, Black or African American, Other Race categories do not include consideration of ethnicity data.
Region of Residence	Category Values: Central, Southwest, Northern & Winchester, Roanoke/Alleghany, Tidewater, Charlottesville/Western Region of residence will be defined based on members' county of residence as of December 31, 2020, using the Virginia managed care regions.
MCO	Category Values: • Aetna • HealthKeepers • Molina • Optima • United • VA Premier Since the foster care population includes every member enrolled in foster care during the measurement year for any length of time, the latest MCO a member was enrolled with during the measurement year will be used.
Psychotropic Medication Utilization	The psychotropic medication utilization rates among members in the eligible populations, limited to NDCs for psychotropic medications. For the foster care and adoption assistance eligible

[B-23] Indicators in this category will be provided for all members in a foster care or adoption assistance program at any point during the measurement period for informational purposes only and will not be subject to continuous enrollment criteria.

Indicator	Description and/or Category Values
	populations, psychotropic medications will be limited to those commonly prescribed for children and adolescents. Mirroring the SFY 2018–2019 and SFY 2019–2020 analyses, this indicator will constitute a sub-analysis and will be reported in a Microsoft Excel spreadsheet separate from other study deliverables.
Continuously Enrolled Populations—Demographic and Health Characteristics of Medicaid Members in Foster Care or Adoption Assistance Programs and Medicaid Members Not in Foster Care or Adoption Assistance Programs	
Sex	Category Values: Female, Male, Other
Age Category	Category Values for Foster Care and Adoption Assistance: Infant [≤ 2 Years], Preschool [3 to 5 Years], Elementary School [6 to 10 Years], Middle School [11 to 13 Years], High School [≥ 14 Years] Category Values for Former Foster Care: Young Adult [19 to 22 Years], Adult [23 to 26 Years]
Race	Category Values: White, Black or African American, Other Race categories do not include consideration of ethnicity data.
Region of Residence	Category Values: Central, Southwest, Northern & Winchester, Roanoke/Alleghany, Tidewater, Charlottesville/Western Region of residence will be defined based on members' county of residence as of December 31, 2020, using the Virginia managed care regions.
MCO	Category Values: • Aetna • HealthKeepers • Molina • Optima • United • Virginia Premier • Other A member continuously enrolled with a single MCO during the measurement year with no more than one gap in enrollment of no more than 45 days will be attributed to that MCO. Otherwise, a member continuously enrolled with more than one MCO or more than one gap in enrollment will be attributed to "Other."
Health Characteristics	Category Values: Diagnosed, Not Diagnosed (e.g., psychotic disorders, ADHD)

Indicator	Description and/or Category Values
	HSAG will identify health conditions for which prevalence differs between the continuously enrolled members in each foster care or adoption assistance program and the continuously enrolled members not in foster care or adoption assistance programs and present the proportion of members in each group who are diagnosed with each health condition.
Study Populations—Healthcare Utilization Among Medicaid Members in Foster Care or Adoption Assistance Programs and Comparable Medicaid Members Not in Foster Care or Adoption Assistance Programs[B-24]	
Primary Care	
Child and Adolescent Well-Care Visits (WCV)	Defined using the FFY 2021 Child Core Set technical specifications for the WCV indicator, with study-specific continuous enrollment modifications.
Well-Child Visits in the First 30 Months of Life (W30)	Defined using the FFY 2021 Child Core Set technical specifications for the W30 indicator, with study-specific continuous enrollment modifications.
Oral Health	
Annual Dental Visit (ADV)	Defined using the HEDIS MY 2020 technical specifications for the ADV indicator, with study-specific continuous enrollment modifications.
Preventive Dental Services (PDENT-CH)	Defined using the FFY 2021 Child Core Set technical specifications for the PDENT-CH indicator, with study-specific continuous enrollment modifications.
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up	Defined using the FFY 2021 Adult and Child Core Set technical specifications for the FUH–7-Day indicator, with study-specific continuous enrollment modifications.
Follow-Up After ED Visit for Mental Illness (FUM)—30-Day Follow-Up	Defined using the HEDIS MY 2020 technical specifications for the FUM–30-Day indicator, with study-specific continuous enrollment modifications.
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Defined using the FFY 2021 Child Core Set technical specifications for the APM indicator, with study-specific continuous enrollment modifications.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Defined using the FFY 2021 Child Core Set technical specifications for the APP indicator, with study-specific continuous enrollment modifications.

[B-24] Indicators in this category will be subject to continuous enrollment criteria and calculated for applicable programs based on age.

Indicator	Description and/or Category Values
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Defined using the FFY 2021 Child Core Set technical specifications for the ADD indicator, with study-specific continuous enrollment modifications and modifications to the follow-up windows.
Substance Use	
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)—30-Day Follow-Up	Defined using HEDIS MY 2020 technical specifications for the FUA–30-Day indicator, with study-specific continuous enrollment modifications.
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	Defined using the HEDIS MY 2020 technical specifications for the IET indicator, with study-specific continuous enrollment modifications and a two-month look-back period from the earliest eligible encounter with a diagnosis of AOD abuse or dependence for all eligible members.
Reproductive Health	
Contraceptive Care (CCW-CH)—All Women	Defined using the FFY 2021 Adult and Child Core Set technical specifications for the CCW-CH indicator, limited to females between 15 and 26 years of age, with study-specific continuous enrollment modifications.
Respiratory Health	
Asthma Medication Ratio (AMR)	Defined using the FFY 2021 Adult and Child Core Set technical specifications for the AMR indicator, with study-specific continuous enrollment modifications and a one-year look-back period for all eligible members.
Sub-Analysis Population—Former Foster Children Originating From Out of State	
Ambulatory Care Visits	Defined by DMAS as the percent of members who had an ambulatory care visit among the total number of members. This indicator will constitute a sub-analysis and will be reported in a Microsoft Excel spreadsheet separate from other study deliverables.
ED Visits	Defined by DMAS as the percent of members who had an ED visit among the total number of members. This indicator will constitute a sub-analysis and will be reported in a Microsoft Excel spreadsheet separate from other study deliverables.
Inpatient Visits	Defined by DMAS as the percent of members who had an inpatient visit among the total number of members.

Indicator	Description and/or Category Values
	This indicator will constitute a sub-analysis and will be reported in a Microsoft Excel spreadsheet separate from other study deliverables.
Behavioral Health Encounters	Defined by DMAS as the percent of members who had a BH visit among the total number of members, stratified by traditional, CMH, RTC, therapeutic services, and ARTS. This indicator will constitute a sub-analysis and will be reported in an Excel spreadsheet separate from other study deliverables.

Comparative Analyses

Following calculation of the Table B-14 indicator rates for the study populations and their comparison groups, HSAG will perform appropriate statistical testing to assess whether the indicator rates are statistically different between the members in the study populations and their respective comparison groups. HSAG anticipates using regression analyses to compare any differences in study indicator rates between the two populations. The statistical methods used to identify each comparison group should improve covariate balance between the two matched groups. However, once the groups are subset at the study indicator level (i.e., excluding individuals who do not meet denominator criteria for a selected indicator), the indicator-specific groups may no longer be balanced. To control for any imbalance between groups at the study indicator level, HSAG will evaluate outcomes using either a linear or logistic regression with observable covariates used as controls.

Dental Utilization in Pregnant Women Data Brief Methodology[B-25]

Overview

DMAS contracted with HSAG to conduct the 2021–2022 EQR Task N: Dental Utilization in Pregnant Women Data Brief activity, which assesses dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or FAMIS MOMS through the Virginia Medicaid SFC program that is administered by DentaQuest. This document outlines HSAG's methodology for performing this analysis.

Data Sources

HSAG will use vital statistics data provided by DMAS and VDH. If vital statistics data are not received by August 5, 2022, HSAG will use the member enrollment and eligibility, and claims/encounter data files provided by DMAS in July 2022 for the analysis.

[B-25] Note: This methodology is presented as it appeared in the final report for this activity.

Measurement Period

HSAG will assess the utilization of dental services during the prenatal and postpartum periods for women with deliveries during CY 2021 (i.e., January 1, 2021, through December 31, 2021).[B-26]

Eligible Population

If vital statistics data are received by August 5, 2022, HSAG will use vital statistics data to identify deliveries to women during CY 2021. If vital statistics data are not available, HSAG will identify women with a delivery during the measurement period using the member enrollment/eligibility and claims/encounter data provided by DMAS. HSAG will identify deliveries using the *Deliveries Value Set* from the *Prenatal and Postpartum Care* PM in the FFY 2022 CMS Adult and Child Core Set of Health Care Quality Measures.[B-27] HSAG will exclude non-live births from the deliveries using the *Non-Live Birth Value Set* for the *Prenatal and Postpartum Care* PM.[B-28]

HSAG will only include women 21 years of age and older at the time of conception through the end of the month following their 60th day postpartum. HSAG will use the vital statistics data to determine gestational age. In the absence of vital statistics data, HSAG will estimate the time of conception as 280 days prior to the date of delivery.[B-29]

Study Indicators

Dental Utilization

HSAG will use the dental encounter data to determine which dental services, if any, were utilized during the member's pregnancy or postpartum period, using the following code sets:[B-30]

- Any Dental Service Code Set
- Adjunctive Services Code Set
- Diagnostic Services Code Set
- Endodontics Code Set
- Oral & Maxillofacial Surgery Code Set

[B-26] A woman's pregnancy would begin during March 2020 for a live birth delivered on January 1, 2021. Therefore, all women with deliveries beginning in CY 2021 would have been eligible for the Virginia Medicaid SFC program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

[B-27] Centers for Medicare & Medicaid Services. *Core Set of Adult and Child Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting*, March 2022. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html. Accessed on: Apr 26, 2022.

[B-28] Ibid.

[B-29] The Virginia Medicaid SFC program covers most dental services for pregnant women aged 21 years and older through their pregnancy and postpartum period. Further information about the program is available at: https://www.dentaquest.com/getattachment/State-Plans/Regions/Virginia/Dentist-Page/VA-Smiles-For-Children-ORM.pdf/?lang=en-US.

[B-30] For detailed information related to the code sets used for this report, please refer to the *VA Task N_Dental Utilization in Pregnant Women Data Brief Code Set* Microsoft Excel file.

- Periodontics Code Set
- Preventive Services Code Set
- Prosthodontics Code Set
- Restorative Code Set

Dental Utilization Stratifications

HSAG will stratify the CY 2021 dental utilization study indicator rates by the categories listed in Table B-15.

Table B-15—Dental Utilization Study Indicator Stratifications

Stratification	Description/Values
Medicaid Program	The Medicaid program the woman was enrolled with on the date of delivery: • FAMIS MOMS (eligibility category 005) • Medicaid for Pregnant Women (eligibility categories 091 and 097) • Medicaid expansion (aid categories 100, 101, 102, 103, 106, and 108) • LIFC (aid category 081) • Other Medicaid (will include all other births not covered by FAMIS MOMS, Medicaid for Pregnant Women, Medicaid expansion, and LIFC; will exclude births to women in Plan First [aid category: 080] and DOC [aid category: 109]) • Not Enrolled
Managed Care Program	• Medallion 4.0 • CCC Plus • FAMIS • Not Enrolled
Medicaid Delivery System	• FFS • Managed Care • Not Enrolled
Perinatal Timing of Dental Service	The perinatal timing of the utilization of dental services. The following categories will be presented: • Prenatal period: the start of the first trimester based on gestational age at time of delivery (or the 280 days prior to the date of delivery if only administrative data are available)

Stratification	Description/Values
	• Postpartum period: through the end of the month following the 60th day postpartum • Both: anytime during the prenatal and postpartum periods defined above
Continuous Enrollment During Dental Service	Dental service utilization occurred for members continuously enrolled in any Medicaid program for a minimum of 90 days prior to, and including, the date of delivery.
Age	The age of the woman on the date of delivery. The following age groups will be presented: • 21–24 • 25–29 • 30–34 • 35–39 • 40 and Older
Race/Ethnicity	The race/ethnicity of the woman. The following race/ethnicity categories will be presented: • White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown
Managed Care Region of Residence	The region of the woman's residence at the time of delivery. The following regions will be presented: • Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater

Birth Outcomes

In addition to dental utilization rates, HSAG will perform a statistical analysis related to the association of the receipt of dental health services and birth outcomes. To determine the association between dental health services and each of the birth outcomes listed below, HSAG will use Pearson's correlation coefficient (r) and interpret the strength of the correlation based on the following guidelines, as displayed in Table B-16.

Table B-16—Pearson's Correlation Coefficient (r) and Strength of Correlation Guidelines

Correlation Coefficient (r)	Interpretation
0.90 to 1.00 (-0.90 to -1.00)	Very high positive (negative) correlation
0.70 to 0.90 (-0.70 to -0.90)	High positive (negative) correlation
0.50 to 0.70 (-0.50 to -0.70)	Moderate positive (negative) correlation
0.30 to 0.50 (-0.30 to -0.50)	Low positive (negative) correlation
0.00 to 0.30 (0.00 to -0.30)	Negligible correlation

Additionally, HSAG will use a p-value <0.05 to identify significant correlations.

HSAG will include the following comparisons in the report:

- Relationship between dental utilization and preterm birth (<37 weeks gestation)
- Relationship between dental utilization and newborns with low birth weight (<2,500 grams)
- Relationship between dental utilization and postpartum ED utilization for non-traumatic dental related services
- Relationship between dental utilization and postpartum ambulatory care utilization
- Relationship between dental utilization and timely PNC

In the absence of vital statistics data, HSAG will not be able to calculate the relationship between dental utilization and preterm birth (<37 weeks gestation) or newborns with low birth weight (<2,500 grams).

Table B-17 presents details into the birth outcomes that HSAG will assess for this data brief.

Table B-17—Birth Outcomes Analysis

Indicator	Denominator	Numerator
Preterm Births (<37 Weeks Gestation)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: • Preterm: Less than 37 weeks – Late preterm: 34–36 weeks – Moderate preterm: 32–33 weeks – Very preterm: 28–31 weeks – Extremely preterm: <28 weeks
Newborns With Low Birth Weight (<2,500 grams)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: • Overall low birth weight: <2,500 grams – Moderately low birth weight: 1,500 grams–2,499 grams

Indicator	Denominator	Numerator
		− Very low birth weight: <1,500 grams
Postpartum ED Utilization for Non-Traumatic Dental Services	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ED services (ED Visits Code Set) for either of the following within 60 days of delivery: • A primary diagnosis of a non-traumatic dental condition (Non-Traumatic Dental Conditions Code Set) • A primary diagnosis for other non-traumatic dental conditions (Other Non-Traumatic Dental Cond Code Set) with a secondary diagnosis of non-traumatic dental conditions (Non-Traumatic Dental Cond Code Set)
Postpartum Ambulatory Care Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 60 days of delivery. Ambulatory visits are identified as: • An ambulatory outpatient visit (Ambulatory Outpatient Visits Code Set) • A telephone visit (Telephone Visits Code Set) or online assessment (Online Assessments Code Set) • Any one of the following − An ED visit (ED Code Set) − An ED procedure code (ED Procedure Code Set) with an ED POS code (ED POS Code Set)
Births With Early and Adequate PNC	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with an Adequacy of PNC Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent).

Consumer Decision Support Tool Methodology

Project Overview

DMAS contracted with HSAG to analyze MY 2021 HEDIS results, including MY 2021 CAHPS data from six Virginia Medallion 4.0 MCOs for presentation in the 2022 Virginia Medallion 4.0 Consumer Decision Support Tool. The Consumer Decision Support Tool analysis helps support DMAS' public reporting of MCO performance information.

Data Collection

For this activity, HSAG received the MCOs' CAHPS member-level data files and HEDIS data from the MCOs. The CAHPS survey was most recently administered in 2021. The *HEDIS MY 2021 Technical Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2020 & MY 2021 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS PMs.

Reporting Categories

The Medallion 4.0 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 2022 Consumer Decision Support Tool analysis. This category also includes adult and child CAHPS measures on consumer perceptions of the overall rating of the MCO and adults' rating of their overall healthcare.
- **Doctors' Communication:** Includes a child CAHPS composite on consumer perceptions about how well their doctors communicate and an adult and child CAHPS measure on consumer perceptions about their overall ratings of personal doctors. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Getting Care:** Includes child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' access to care, as well as appropriate follow-up for mental illness and AOD abuse or dependence.
- **Keeping Kids Healthy:** Includes HEDIS measures of how often preventive services and appropriate treatment are provided (e.g., child immunizations, well-child/well-care visits, ADHD medication follow-up care, and first-line psychosocial care for children and adolescents prior to prescribing antipsychotics).
- **Living With Illness:** Includes HEDIS measures that assess how well the MCOs take care of people who have chronic conditions (e.g., diabetes and high blood pressure). In addition, this category includes HEDIS measures that assess medication management for people living with depression and asthma.
- **Taking Care of Women:** Includes HEDIS measures that assess how often women-specific services are provided (e.g., screenings for breast cancer and cervical cancer, and prenatal and postpartum care).

Measures Used in Analysis

DMAS, in collaboration with HSAG, chose measures for this year's Consumer Decision Support Tool based on a number of factors. In an effort to align with the PWP, the administrative HEDIS measures evaluated as part of the PWP were included in this analysis, as well as other administrative HEDIS and CAHPS survey measures required by the Medallion 4.0 managed care contract for reporting. 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 Medicaid Health Plan Survey instrument was used for the child population.

Table B-18 lists the 40 measure indicators, 11 CAHPS and 29 HEDIS, and their associated weights.[B-31] Weights were applied when calculating the category summary scores and the CIs 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-18—Medallion 4.0 Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measure	Measure Weight
Overall Rating[B-32]	
Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Child Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Child Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
Doctors' Communication	
Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	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
Getting Care	
Child Medicaid—Getting Needed Care (CAHPS Composite)	1
Child Medicaid—Getting Care Quickly (CAHPS Composite)	1
Adults' Access to Preventive/Ambulatory Health Services	

[B-31] The following measures have been removed from the 2022 Consumer Decision Support Tool analysis due to more than half of the MCOs having *Not Applicable (NA)* audit designations: Adult Medicaid—*Rating of Health Care* (CAHPS Global Rating), Adult Medicaid—*Customer Service* (CAHPS Composite), Child Medicaid—*Customer Service* (CAHPS Composite), Adult Medicaid—*How Well Doctors Communicate* (CAHPS Composite), Adult Medicaid—*Rating of Specialist Seen Most Often* (CAHPS Global Rating), Child Medicaid—*Rating of Specialist Seen Most Often* (CAHPS Global Rating), Adult Medicaid—*Getting Needed Care* (CAHPS Composite), and Adult Medicaid—*Getting Care Quickly* (CAHPS Composite).

[B-32] To calculate the Overall Rating category, all 40 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.

Measure	Measure Weight
20–44 Years	1/3
45–64 Years	1/3
65+ Years	1/3
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	1
Follow-Up After ED Visit for Mental Illness	
7-Day Follow-Up—Total	1/2
30-Day Follow-Up—Total	1/2
Keeping Kids Healthy	
Childhood Immunization Status—Combination 3	1
Well-Child Visit in the First 30 Months of Life	
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	1
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
Follow-Up Care for Children Prescribed ADHD Medication	
Initiation Phase	1/2
Continuation and Maintenance Phase	1/2
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	1/5
HbA1c Poor Control (>9.0%)	1/5
HbA1c Control (<8.0%)	1/5
Eye Exam (Retinal) Performed	1/5
Blood Pressure Control (<140/90 mm Hg)	1/5
Controlling High Blood Pressure	1

Measure	Measure Weight
Asthma Medication Ratio—Total[B-33]	1
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Taking Care of Women	
Breast Cancer Screening	1
Cervical Cancer Screening	1
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	1
Postpartum Care	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' PM 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 PM).

In developing scores and ratings for the reporting categories, HSAG handled the missing rates for PMs 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 PMs with an *NA* audit result, HSAG used the mean of non-missing observations across all MCOs. For PMs 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 more than half of the plans had an *NR*, *BR*, or *NA* for any PM, then the PM was excluded from the analysis.

[B-33] This measure is not required in the Medallion 4.0 managed care contract; however, the *Medication Management for People With Asthma* measure was retired and DMAS allows for the use of this measure as a replacement in the Consumer Decision Support Tool.

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 PMs 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, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) were calculated from MCO scores on selected HEDIS PMs and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., “Usually/Always,” “9/10,” and “Yes,” where applicable) to a 1 for each individual question, as described in *HEDIS MY 2021 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.
2. For each HEDIS and CAHPS measure, HSAG calculated the measure variance. The measure variance for HEDIS PMs 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 PM sample for MCO *k*

For CAHPS global rating measures, the variance was calculated as follows:

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

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

For 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

3. 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.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category weighting.
6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO *k*, HSAG calculated the category variance, CV_k as:

$$CV_k = \sum_{j=1}^{m}\frac{w_j}{c_j^2}V_j$$

where: j = 1,…,*m* HEDIS or CAHPS measures in the summary
V_j = variance for measure j
c_j = group standard deviation for measure j
w_j = measure weight for measure j

8. The summary scores were used to compute the group mean and the difference scores. The group mean was the average of the MCO summary measure scores. The difference score, d_k, was calculated as d_k = MCO *k* score – group mean.
9. For each MCO *k*, HSAG calculated the variance of the difference scores, *Var*(d_k), as:

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

where: P = total number of MCOs
CV_k = category variance for MCO *k*

10. The statistical significance of each difference was determined by computing a 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:

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

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

How Conclusions Were Drawn

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-19 shows how the Medallion 4.0 Consumer Decision Support Tool results were displayed:

Table B-19—Medallion 4.0 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.

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 Medallion 4.0 PWP. For the Medallion 4.0 PWP, the MCOs' performance is evaluated on five NCQA HEDIS PMs (11 PM indicators) and one AHRQ PDI PM (one PM indicator). The EQRO is responsible for collecting the MCOs' audited HEDIS PM rates and the AHRQ PDI PM rate from DMAS. The EQRO derives PWP scores for each PM and calculates the portion of the 1 percent quality withhold earned back for each MCO.

The following sections provide the PWP calculation methodology for SFY 2022. SFY 2022 is the initial performance year for the PWP; therefore, the MCOs will be eligible to earn back all or a portion of their 1 percent quality withhold based on the scoring methods and quality withhold funds model described in this document.

Performance Measures

DMAS selected the following five HEDIS PMs (11 measure indicators) and one AHRQ PDI PM (one PM indicator) for the PWP indicated in Table B-20.

Table B-20—PWP PMs

PM Indicator	Measure Specification	Required Reporting Method
Child and Adolescent Well-Care Visits—Total	HEDIS	Administrative
Childhood Immunization Status—Combination 3	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Testing, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	HEDIS	Hybrid
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS	Administrative
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	HEDIS	Hybrid
Asthma Admission Rate (Per 100,000 Member Months)	AHRQ PDI	Administrative

Performance Period

The SFY 2022 PWP assesses CY 2021 PM data (i.e., the PMs will be calculated following HEDIS MY 2021 and AHRQ's PDI Technical Specifications [July 2019]) to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2022 (i.e., the 1 percent of capitation payments withheld from July 1, 2021, through June 30, 2022).[B-34]

Data Collection

The HEDIS IDSS files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS PM rates will be provided to the EQRO by the MCOs. DMAS will contract with its EQRO to validate the AHRQ PDI PM in accordance with CMS EQR Protocol 2. Following the PMV, the EQRO will provide the true, audited rates for the AHRQ PDI PM to DMAS.

[B-34] Per the technical measure specifications, the *Asthma Admission Rate* is reported per 100,000 population. However, this measure should be reported per 100,000 member months (MM) instead. This slight deviation is in alignment with the approach for reporting AHRQ's Prevention Quality Indicator (PQI) measures in the Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set).

PWP Calculation

The following sections provide a detailed description and examples of the PWP scoring and quality withhold funds model for the SFY 2022 PWP (i.e., the initial performance year). With receipt of audited HEDIS PM rates and the validated AHRQ PDI PM rate (i.e., the non-HEDIS PM rate), each PM will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back.

Only PM rates with a "*Reportable (R)*" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the PM in alignment with the technical specifications) will be included in the PWP calculation. PM rates with a "*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 excluded from the PWP calculation. PM rates with any audit result other than "*Reportable (R)*" or "*Small Denominator (NA)*" 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 PM).

SFY 2022 PWP

As indicated above, the SFY 2022 PWP is the initial performance period and will use the MCOs' audited HEDIS MY 2021 and validated CY 2021 AHRQ PDI PM data. Table B-21 shows the percentage of withhold associated with each PM indicator.

Table B-21—SFY 2022 PWP PM Weights

PM Indicator	PM Weight†
Child and Adolescent Well-Care Visits—Total	16.67%
Childhood Immunization Status—Combination 3	16.67%
Comprehensive Diabetes Care—HbA1c Testing, *HbA1c Poor Control (>9.0%)*,* *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	16.67%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	16.67%
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	16.67%
*Asthma Admission Rate (Per 100,000 Member Months)**	16.67%

†Please note, the weights listed in the table are rounded values.
**For this PM indicator, a lower rate indicates better performance.*

Scoring Methods

The next several sections describe the PWP calculation method for the SFY 2022 PWP (i.e., the initial performance year).

Indicator Partial Score

For SFY 2022 (i.e., the initial performance year), the performance scores for the AHRQ PDI PM will be determined by comparing the rate for the current year to the CY 2019 rate and calculating the relative

difference.[B-35] Beginning with the SFY 2023 PWP and forward, DMAS will attempt to set benchmarks for determining the Medallion 4.0 MCO performance scores for the AHRQ PDI PM based on available data from prior years. However, this process will need to account for, and better understand, the future availability of such data and the impact of COVID-19 on such data in designated years before committing to such benchmarks.

Table B-22 presents the possible scores for the AHRQ PDI indicator based on MCO performance. For the AHRQ PDI PM, a lower rate indicates better performance.

Table B-22—PWP AHRQ PDI PM Indicator Scoring

Criteria for Each Indicator	Score
MCO's rate either declined or demonstrated a relative improvement of less than 2 percent from CY 2019	0.00
MCO's rate demonstrated relative improvement of at least 2 percent but less than 4 percent from CY 2019	0.25
MCO's rate demonstrated relative improvement of at least 4 percent but less than 6 percent from CY 2019	0.50
MCO's rate demonstrated relative improvement of at least 6 percent but less than 8 percent from CY 2019	0.75
MCO's rate demonstrated relative improvement of at least 8 percent from CY 2019	1.00

AHRQ PDI indicator rates that demonstrate a decline in performance from CY 2019 (i.e., the rate increases) or a relative improvement from CY 2019 of less than 2 percent will receive a score of zero (i.e., no portion of the quality withhold will be earned back for this indicator). Indicator rates that demonstrate at least 2 percent will receive at least 0.25 points up to a maximum of 1 point for relative improvement at or above 8 percent. The relative difference will be derived using the following formula, keeping in mind that a current year rate that is lower than the CY 2019 rate indicates an improvement in performance:

$$Relative\ Difference = \left[\frac{(MCO\ CY\ 2019\ Rate\ - MCO\ Current\ Year\ Rate)}{MCO\ CY\ 2019\ Rate}\right] \times 100$$

The performance scores for the HEDIS PMs will be determined by comparing each rate to NCQA's Quality Compass national Medicaid HMO percentiles (referred to in this document as percentiles).

Table B-23 presents the possible scores for each HEDIS indicator based on the MCO performance for the current year. Rates will be rounded to two decimals prior to comparing to the percentiles and determining the PM score, and no scores will be dropped.

[B-35] Due to the impact COVID-19 will likely have on the CY 2020 rates, DMAS has elected to use the CY 2019 AHRQ PDI measure rate as a comparison to the current year rates.

Table B-23—PWP HEDIS PM Indicator Scoring

Criteria for Each Indicator	Score
MCO's rate is below the 25th percentile	0
MCO's rate is at or above the 25th percentile but below the 50th percentile	Between 0 and 1
MCO's rate is at or above the 50th percentile	1

HEDIS indicator rates that are below the 25th percentile will receive a score of zero (i.e., no portion of the quality withhold will be earned for this indicator). Indicator rates that are at or above the 50th percentile will receive the maximum score for that indicator (i.e., 1 point). If an indicator rate is at or above the 25th percentile but below the 50th percentile, the MCO will be eligible to receive a partial score (i.e., a partial point value that falls between 0 and 1). To calculate the partial points at the indicator level, each MCO's rate will be compared to the percentiles to determine how close the MCO's rate is to the 50th percentile. In future iterations of the PWP, the minimum performance level (i.e., 25th percentile) may increase to encourage continued positive performance and QI. The partial score for each PM will be derived using the following formula:

$$Partial\ Point\ Value = \left[\frac{(MCO\ Rate - 25th\ Percentile)}{(50th\ Percentile - 25th\ Percentile)}\right]$$

For example, if the 25th percentile is 40 percent and the 50th percentile is 60 percent, and an MCO has a rate of 55 percent for an indicator, then the partial point value is calculated as follows:

$$Partial\ Point\ Value = \left[\frac{(55 - 40)}{(60 - 40)}\right] = 0.75$$

Improvement Bonus

For the AHRQ PDI PM indicator, DMAS will determine an appropriate method of assigning improvement bonus points for the SFY 2023 PWP, if applicable.

For the SFY 2022 PWP, MCOs that failed to meet the 50th percentile in CY 2019 (i.e., HEDIS 2020 data) for a HEDIS indicator may be eligible to earn an improvement bonus if an indicator rate demonstrates substantial improvement from CY 2019.[B-36] Substantial improvement will be defined as 20 percent of the difference between the 25th and 50th percentile. An improvement bonus of 0.25 points will be awarded for each indicator, if the MCO was below the 50th percentile in CY 2019 and the following is true:

$$|\ MCO\ Current\ Rate - MCO\ CY\ 2019\ Rate\ | \geq \left|\left[\frac{(50th\ Percentile - 25th\ Percentile)}{5}\right]\right|$$

[B-36] In future iterations of the PWP, the improvement bonus will be based on improvement over the prior year; however, this methodology skips CY 2020 due to the impact of COVID-19 on MCO performance and measure results.

For each MCO, HSAG will assess which indicator rates are eligible for an improvement determination. HSAG will only determine improvement bonus eligibility if an indicator meets the following criteria:

- The MCO current year rate demonstrated an improvement from the CY 2019 rate.
- The MCO reported the indicator rate in both the current year and CY 2019.
- The MCO's reported indicator rate was below the 50th percentile in CY 2019.
- The MCO reported the indicator rate using the same reporting methodology in both years (e.g., the reporting methodology did not change from administrative in CY 2019 to hybrid in the current year).
- NCQA did not recommend a break in trending for the indicator due to a change in the technical specifications for the Medicaid product line.

If an MCO demonstrates substantial improvement for an indicator rate and meets all criteria for improvement bonus determinations, then the MCO will receive an improvement bonus for that indicator.

High Performance Bonus

For the AHRQ PDI PM indicator, DMAS will determine an appropriate method of assigning high performance bonus points for future iterations of the PWP, if applicable.

For the SFY 2022 PWP, if an MCO demonstrates a strong performance trend over time for a HEDIS indicator, the MCO will be eligible for a high performance bonus. The high performance bonus will be awarded for indicator rates that exceed the 66.67th percentile for both the current year and CY 2019.[B-37] Each indicator rate that ranks above the 66.67th percentile for the current year and CY 2019 will be eligible for a maximum high performance bonus of 0.25 points that will be added to the indicator partial score described above (i.e., 1 point).

Scoring Model Example

Table B-24 and Table B-25 provide examples of how indicator partial scores will be determined, by MCO. All data presented in the tables below (both PM rates and percentile values) are mock data and do not represent actual data or results.

Table B-24—Indicator Partial Score Calculations—HEDIS PMs
(Example Using Mock Data)

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
Child and Adolescent Well-Care Visits				
Total	55.55%	44.28%	54.26%	**1**
Childhood Immunization Status				
Combination 3	73.82%	65.45%	70.68%	**1**
Comprehensive Diabetes Care				
HbA1c Testing	82.44%	85.36%	86.44%	**0**

[B-37] In future iterations of the PWP, the high performance bonus will be based on sustained high performance over the prior year; however, this methodology skips CY 2020 due to the impact of COVID-19 on MCO performance and measure results.

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
*HbA1c Poor Control (>9.0%)**	50.70%	45.55%	38.66%	**0**
HbA1c Control (<8.0%)	54.74%	44.11%	51.22%	**1**
Eye Exam (Retinal) Performed	42.68%	41.77%	52.00%	**0.09**
Blood Pressure Control (<140/90 mm Hg)	53.00%	50.23%	54.55%	**0.64**
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	46.22%	29.21%	35.49%	**1**
30-Day Follow-Up—Total	58.92%	43.17%	51.45%	**1**
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	78.01%	78.10%	83.76%	**0**
Postpartum Care	64.70%	59.38%	65.69%	**0.84**

Table B-25—Indicator Partial Score Calculations—AHRQ PDI PM
(Example Using Mock Data)

Indicator	CY 2019 Rate	Current Year Rate	Relative Difference	Indicator Partial Score
Asthma Admission Rate (Per 100,000 Member Months)*				
Total	9.15	8.72	4.70%	**0.50**

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

The indicator partial scores for the HEDIS PMs are calculated by first determining the applicable percentile level for the indicator rate. For example, the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* PM indicator received an indicator partial score of one point because the rate (46.22 percent) is above the 50th percentile (35.49 percent). For the AHRQ PDI PM, the *Asthma Admission Rate (Per 100,000 Member Months)—Total* PM indicator receives an indicator partial score of 0.50 because the relative difference (4.70 percent) was at or above 4 percent but less than 6 percent.

Table B-26 provides an example of how the improvement bonus scores will be determined by MCO based on performance for the current year and CY 2019 for the HEDIS PMs. Improvement bonus determinations for the AHRQ PDI PM will be evaluated for future iterations of the PWP.

Table B-26—Indicator Improvement Bonus Score Calculations—HEDIS PMs
(Example Using Mock Data)

Indicator	CY 2019 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in CY 2019	Met Substantial Improvement	Improvement Bonus†
Child and Adolescent Well-Care Visits							
Total	50.85%	55.55%	4.70%	2.00%	Y	Y	0.25
Childhood Immunization Status							
Combination 3	71.29%	73.82%	2.53%	1.05%	N	Y	0

Indicator	CY 2019 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in CY 2019	Met Substantial Improvement	Improvement Bonus†
Comprehensive Diabetes Care							
HbA1c Testing	80.68%	82.44%	1.76%	0.22%	Y	Y	0.25
*HbA1c Poor Control (>9.0%)**	52.26%	50.70%	-1.56%	-1.38%	Y	Y	0.25
HbA1c Control (<8.0%)	57.41%	54.74%	-2.67%	1.42%	N	N	0
Eye Exam (Retinal) Performed	44.27%	42.68%	-1.59%	2.05%	Y	N	0
Blood Pressure Control (<140/90 mm Hg)	53.25%	53.00%	-0.25%	0.86%	Y	N	0
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	45.12%	46.22%	1.10%	1.26%	N	N	0
30-Day Follow-Up—Total	59.67%	58.92%	-0.75%	1.66%	N	N	0
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	77.62%	78.01%	0.39%	1.13%	Y	N	0
Postpartum Care	60.58%	64.70%	4.12%	1.26%	Y	Y	0.25

†A PM indicator is eligible for an improvement bonus if the indicator rate was below the 50th percentile in CY 2019 and the indicator rate demonstrated substantial improvement from CY 2019.
**For this indicator, a lower rate indicates better performance.*

Table B-27 provides an example of how the high performance bonus scores will be determined, by MCO, based on performance for the current year and CY 2019 for the HEDIS PMs. Once the high performance bonus scores are determined, the indicator partial score, the improvement bonus score, and high performance bonus score (i.e., 0 or 0.25) will be summed to obtain the final indicator score. High performance bonus determinations for the AHRQ PDI PM will be evaluated for future iterations of the PWP.

Table B-27—High Performance Bonus Score Calculations—HEDIS PMs
(Example Using Mock Data)

Indicator	CY 2019 Rate	CY 2019 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					CY 2019	Current Year	Points Earned
Child and Adolescent Well-Care Visits							
Total	50.85%	59.49%	55.55%	60.34%	N	N	0
Childhood Immunization Status							
Combination 3	71.29%	73.72%	73.82%	72.75%	N	Y	0
Comprehensive Diabetes Care							
HbA1c Testing	80.68%	87.23%	82.44%	86.95%	N	N	0

Indicator	CY 2019 Rate	CY 2019 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					CY 2019	Current Year	Points Earned
*HbA1c Poor Control (>9.0%)**	52.26%	33.23%	50.70%	34.15%	N	N	0
HbA1c Control (<8.0%)	57.41%	53.48%	54.74%	54.51%	Y	Y	0.25
Eye Exam (Retinal) Performed	44.27%	57.16%	42.68%	58.02%	N	N	0
Blood Pressure Control (<140/90 mm Hg)	53.25%	56.12%	53.00%	57.89%	N	N	0
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	45.12%	44.56%	46.22%	45.77%	Y	Y	0.25
30-Day Follow-Up—Total	59.67%	60.82%	58.92%	61.68%	N	N	0
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	77.62%	85.59%	78.01%	86.37%	N	N	0
Postpartum Care	60.58%	67.82%	64.70%	68.36%	N	N	0

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

Table B-28 shows the PM-level score calculations for each MCO by determining the average of the indicator-level scores for each PM.

Table B-28—Measure-Level Score Calculations
(Example Using Mock Data)

Indicator	Indicator-Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	PM-Level Score
Child and Adolescent Well-Care Visits					
Total	1	0.25	0	1.25	**1.25**
Childhood Immunization Status					
Combination 3	1	0	0	0.50	**1**
Comprehensive Diabetes Care					
HbA1c Testing	0	0.25	0	0.25	**0.50**
HbA1c Poor Control (>9.0%)	0	0.25	0	0.25	
HbA1c Control (<8.0%)	1	0	0.25	1.25	
Eye Exam (Retinal) Performed	0.09	0	0	0.09	

Indicator	Indicator-Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	PM-Level Score
Blood Pressure Control (<140/90 mm Hg)	0.64	0	0	0.64	
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	1	0	0.25	1.25	**1.13**
30-Day Follow-Up—Total	1	0	0	1	
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	0	0	0	0	**0.55**
Postpartum Care	0.84	0.25	0	1.09	
Asthma Admission Rate (Per 100,000 Member Months)					
Total	0.50	NE	NE	0.50	**0.50**

NE indicates the PM is not eligible for an Improvement Bonus or High Performance Bonus at this time.

As shown above, the *Follow-Up After ED Visit for Mental Illness* PM-level score (1.13) was obtained by averaging the indicator level scores for *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* (1.25 and 1.00, respectively).

Table B-29 provides an example of how the percentage of the quality withhold is derived (i.e., overall withhold earned) based on the six PM-level scores calculated above. The percentage of the quality withhold that the MCO is eligible to earn back is calculated by multiplying the PM-level score with the applicable PM weight and then summing the PM withhold earned values together. An MCO is not able to earn back more than 100 percent of its total withhold amount. If an overall withhold amount is greater than 100 percent (due to bonus points), the overall withhold earned will be reduced to 100 percent.

Table B-29—Percentage Withhold Earned
(Example Using Mock Data)

Indicator	PM-Level Score	Weight	PM Withhold Earned	Overall Withhold Earned†
Child and Adolescent Well-Care Visits	1.25	16.67%	20.83%	**82.00%**
Childhood Immunization Status	1.00	16.67%	16.67%	
Comprehensive Diabetes Care	0.50	16.67%	8.33%	
Follow-Up After ED Visit for Mental Illness	1.13	16.67%	18.75%	
Prenatal and Postpartum Care	0.55	16.67%	9.08%	
Asthma Admission Rate (Per 1,000 Member Months)	0.50	16.67%	8.33%	

†Please note, the PM Withhold Earned may not sum to the Overall Withhold Earned due to rounding.

Quality Withhold Funds Model

The quality withhold percentage is 1 percent of the total MCO capitation payments for the year. An MCO is eligible to earn the entire quality withhold by having 100 percent for the overall withhold as shown (i.e., the MCO would not lose any quality withhold funds). Table B-30 displays the PWP funds allocation.

Table B-30—PWP Funds Allocation
(Example Using Mock Data)

MCO Name	Total Capitation Payment	Maximum At-Risk Amount (1% Withhold)	Percentage Withhold Earned	Final Withhold Earned Back Amount
MCO	$735,790,000.00	$7,357,900.00	82.00%	$6,033,478.00

As shown in Table B-30, the 1 percent at risk amount for the example MCO is $7,357,900.00. The MCO earned 82.00 percent of the quality withhold through the review of the HEDIS and AHRQ PDI PM indicator rates, thus the MCO is eligible to receive $6,033,478.00 of the quality withhold according to the following equation:

$$Final\ Withhold\ Earned\ Back\ Amount = (Maximum\ At\ Risk\ Amount \times Percentage\ Withhold\ Earned)$$

Appendix C. MCO Best and Emerging Practices

Table C-1 identifies the MCOs' self-reported best and emerging practices.

Table C-1—MCOs' Best and Emerging Practices

MCO	Best and Emerging Practices
Aetna	**Topic/Title:** Moving On: Transitioning from Pediatrics to Primary Care Incentives **Description:** Aetna Better Health of Virginia encourages young adult members to take the next steps in managing their healthcare needs and provide a resource for recommended screenings and adult vaccinations. Young adults aged 18-20 years that are preparing to transition from pediatric to adult primary care can earn a gift card for seeing primary adult health care. **Topic/Title:** ARTS High-Utilizer Pilot Program **Description:** An integrative pilot program that outreaches to members who are utilizing high levels of ASAM care and are often resistant to engage in the program or are unable to reach. Specific focus is placed on members identified as high utilizers of Addiction Recovery and Treatment Services based on three or more distinct admissions to inpatient or residential levels of care within the last six months. **Topic/Title:** High Utilizers of Virginia (HUV) Program **Description:** The Virginia Department of BH and Development Services (DBHDS) in conjunction with Community Based Coordination Solutions (CBCS) launched a HUV program that emphasizes in-person engagement with individuals at time of program enrollment, engagement and coordination with local resources, 24/7/365 program access for enrollees, including crisis availability, close follow-up with participants after every provider encounter, close coordination with the collective medical tools, and customized care plans. The program is intended to improve enrollee care, decrease duplicative care efforts among providers, reduce mental health admissions, general hospital admissions, ED visits, and overall cost of care for and among participants. **Topic/Title:** Member Services Post-Call Survey **Description:** Offers members the opportunity to provide feedback through post-call survey following the completion of all customer service representative calls. **Topic/Title:** Addressing Social Determinants of Health **Description:** Aetna Better Health of Virginia also initiated the use of a social determinants of health (SDoH) software application to assist in identifying specific needs in each region and using *FindHelp* to assist members in finding resources for health care inequities.

MCO	Best and Emerging Practices
HealthKeepers	**Topic/Title:** Social Drivers of Health Program Provider Incentive Program (SDOHPIP) **Description: Provider Incentive Program** Effective July 2020, Anthem started a provider incentive program (SDOHPIP), collaborating with providers across the state. The goal of this program is to engage providers to address SDOH needs that research is showing impacts clinical needs. When these providers identify SDOH needs they can work with their patient to address the obstacle with the goal to make an impact on clinical care as well. This supports a holistic view of the member's needs. To do this we educate providers regarding SDOH needs, identify resources surrounding the provider's office, and incentivize the providers for documenting z codes corresponding to food and housing, assessing, referring, and following up on referrals to close the loop. **Topic/Title:** Stepping-Stones Program **Description:** HealthKeepers, Inc. recognizes that barriers in communication about, knowledge of, and access to available community resources impact members' quality of life. HealthKeepers also realizes that members need support from community-based organizations (CBOs) in addition to their health insurance plan. HealthKeepers wants to be the link that supports both the CBO partners and Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) members, and to bridge the communication gap. HealthKeepers, Inc. strives to support the community organizations that are making a difference in the lives of members each and every day, and this is why HealthKeepers is rolling out the Stepping Stones Program. The goal of Stepping Stones is to break barriers, support CBOs, and promote communication to empower the community and impact the quality of life for both Anthem HealthKeepers Plus members and the organizations that provide them with stepping stones to better lives. • HealthKeepers, Inc. supports CBOs by identifying a CBO need and working to provide supportive funding for things such as a library for an employment agency, funds to purchase meals for a food bank, computers for a housing agency, or blankets and pillows for an emergency shelter. • CBOs use the funds the best way for their organization and partner with HealthKeepers, Inc. to share HEDIS information, use f *FindHelp*, and refer Anthem HealthKeepers Plus members for assistance as needed. The CBO follows up with HealthKeepers, Inc. to share how the support helped. • *FindHelp*, The social care network, available at https://www.findhelp.org, connects anyone in need to free and reduced-cost programs in their local area. *FindHelp* provides free tools and free support to CBOs to manage their programs, respond to requests for services, and track/report on outcomes. **Topic/Title:** SDOH *FindHelp* Partnership **Description:** Anthem is engaged in a partnership with FindHelp to bring knowledge and community resource together for assisting members who have

MCO	Best and Emerging Practices
	SDOH needs. FindHelp is an online community resources tool, which allows both member and associates to have access to FindHelp's expansive and updated list of resources for assisting members. This partnership allows Anthem to affect food security, housing, and employment needs for members in an efficient and uniform way. Utilizing this partnership allows Anthem and *FindHelp* to identify which partnerships are being referred more than others, which members are receiving referrals, which determinants are receiving referrals. This partnership allows Anthem and *FindHelp* to work together to create automatic note types within Anthem's system straight from the referrals website so that care coordinators and case managers receive a dated and timed record of the outreach in the documentation platform. This partnerships aids in the ability for the care coordinator or case manager to follow up with the member and ensure the referral was successful. **Topic/Title:** Network Tables **Description:** A network table is a group of volunteers trained to form a "network table" and access social networks in their community (social capital) to link supports, including relationships, goods and services to the specific need of a partner organization or friend (Anthem HealthKeepers Plus Member). Based on the project, network tables access their social capital and community networks to solve one specific challenge at a time (called a priority support) for a defined number of friends. The friend may be an individual or family being served by the partner organization that can benefit from access to the relational and social capital available in the community. The friend is identified and determined by the partner organization through a care coordinator, case manager, or other organizational representative. Network tables range from 8-12 volunteers. Network tables can work to solve the challenges of multiple friends simultaneously. **Topic/Title:** Population Health Sprint **Description:** HealthKeepers Inc. completed a population health sprint that was comprised of three separate work groups with representation from across the health plan in maternity, BH, and physical health. Within these groups, measurable goals are being formulated along with objectives and interventions. By utilizing the Virginia population health analysis, the health plan can focus on not only the state specific priorities, but ensure equitable, whole person healthcare across membership. **Topic/Title:** FUSE **Description:** HealthKeepers Inc. has partnered with the FUSE team to discuss how the health plan can move towards further whole-person health/integration. Several general areas of opportunity have been identified with a detailed work plan expected that will outline suggestions and ideas for optimal integration. The Virginia market will utilize the FUSE team in a consultant capacity for a period and

MCO	Best and Emerging Practices
	continued to work with assigned regional vice president's and the governance board to ensure solid strategy leading to maximized outcomes.
Molina	**Topic/Title:** Pay for Quality (P4Q) Program **Description:** Molina chose a set of select, but critical, quality PMs for 2022 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 PM for their assigned panel. **Topic/Title:** Clinic Day **Description:** Molina 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 Molina's approach included identification of members in need of care, offering healthcare access to members by connecting them with PCPs and providing health education. All these activities contributed to improved overall health outcome and experience. Molina's partner with providers to schedule new and/or existing 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. **Topic/Title:** Provider Network and Quality Partnership **Description:** Molina's quality team in collaboration with the provider network team to identify and target providers in each region to build relationships, provider health plan education, and improve member health outcomes and overall patient satisfaction.
Optima	**Topic/Title:** Clinical Care Services **Description:** 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 ED 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

MCO	Best and Emerging Practices
	• Partners in pregnancy (PIP) program • Performance Withhold Program monthly tracking dashboard (Tableau) • Multidisciplinary team approach to improvement in quality PMs, 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, Optum, Alere, Dario, Carenet • Focused EPSDT care coordination • BH member engagement program to improve follow-up visits with providers after ED visits • Dedicated BH transition of care coordinators • Focused vendors for community partners in member care: Urban Baby Beginnings, CHIP, Healthy Families, Southeast trans for medical/BH/non-medical transportation, nurse family partnership • Focused community partners for improving social determinants of health (SDOH): United Us, local food banks, religious organizations, Salvation Army, STOP Inc (rent, utility assistance), VDH 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) • Focused workgroups to impact DMAS clinical efficiency PMs: – LANE – PPA – Readmissions • Staff training: – NCQA standards and HEDIS training for Medallion case management – Annual Medicare and Dual Eligible Special Needs Plan (DSNP) model of care/product training – Change management and building resilience training • Increased access for remote services for staff and members related to COVID • 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 collaboration to improve member education and access to testing and vaccination

MCO	Best and Emerging Practices
	• Collaborative partners with DMAS MCO EI Workgroup and DMAS MCO Foster Care Workgroup • Targeted BH care coordination focusing on inpatient discharges, Emergency room utilization and high-risk readmission member focus from BH facilities. • Targeted case management for justice-involved members • Quarterly BH provider education launched through the “Now Let’s Talk!” virtual platform • Value-based agreements with providers to promote “Best In Class” outcomes for our BH and substance abuse members **Description:** Emerging Practices • Collaboration with the Virginia Department of Health Diabetes Prevention Program to offer targeted services to members at-risk for diabetes • Collaboration with Virginia Beach Department of Health Community Education Series to target pregnant members • Vendor/partners in care: Ovia, Focus care in-home assessments • Interdepartmental committee evaluating enhanced member benefits for 2023 to improve SDOH • Interdepartmental collaboration for improved regulatory and internal reporting processes and data collection • 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 social determinants of health • Chronic condition and social determinants of health risk factor monthly tracking dashboard (Tableau) • Focused workgroup to target childhood vaccine hesitancy • New doula benefit to augment member benefits and provide additional support during pregnancy and the post-partum period • Post discharge meal benefit for members (Nations Food) • Prosphire Consulting Group for enhancement of chronic condition management program • Care plan alignment for chronic condition management • Transition of care enhancement for Medicaid products • Integrated BH coaching for members identified through predictive analytics to be a potential risk for developing anxiety, depression, substance, or alcohol abuse along with those members identified as high-cost and high-needs members • Culturally diverse integrated case management focused on adults and adolescents in the seven tribal communities across Virginia

MCO	Best and Emerging Practices
	• Targeted BH case management for pregnant and parenting members with substance use disorders **Topic/Title:** Quality HEDIS Team **Description:** • Implemented year-long medical record retrievals, data abstractions, and 100 percent overreads for gap closure • Electronic medical record program • Daily review of quality improvement ancillary mailbox for gap closures from CCS and Pop Health • Validating incentives for supplemental data **Topic/Title:** Quality Accreditation Team **Description:** The NCQA internal mock file audits is used to maintain organizational readiness and verify that the management process documented in the records complies with NCQA Standards. Audits are conducted quarterly with random files selected. Annual audits are conducted on non-accredited delegates. The quality accreditation team used the NCQA methodology of eight (8) and 30 file sampling process. The team reviews an initial sample of eight (8) files then review an additional sample of 22 files if any of the original eight files fail the review for a total of 30 records. **Topic/Title:** Quality Regulatory Team • Reporting for all critical incidents and quality of care/service grievances, within newly launched care management system for all lines of business (LOBs) • Following QMR closure, team debriefs other departments such as care coordination, utilization management, etc. Opportunities for process improvement are identified and discussed • Increased efficiency with flow of information between Optima Health and LTSS providers by having a dedicated QMR email and fax number **Topic/Title:** Population Health – Performance Withhold Program Performance Improvement Workgroup **Description:** Performance Withhold Program Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate, review, and discuss performance withhold program PM data trends, interventions, and barriers. **Topic/Title:** Population Health – CAHPS Improvement Workgroup

MCO	Best and Emerging Practices
	Description: CAHPS Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate and discuss interventions to improve the bottom three CAHPS PMs for both M4 and CCCP. **Topic/Title:** Population Health – Interactive Voice Response (IVR) and Educational Video Campaigns **Description:** Population Health – IVR and Educational Video Campaigns **Topic/Title:** Population Health – Preventive Screening Kits **Description:** The health plan collaborates with two vendor partners to provide screening kits to members of both the CCC Plus and Medallion 4.0 product lines. Focus Care provides in-home assessments to these members as well as provides screening kits for A1c, diabetic retinal eye exams, kidney evaluation, and FIT kits for colorectal cancer screening for members that have gaps in these PMs. Optima collaborates with another vendor, BioIQ, which automatically mails screening kits for A1c, KED, and FIT kits to all members with gaps in these PMs. This is an effort to improve performance withhold program PMs as well as improve overall population health and member satisfaction by making the preventative screenings easily accessible. **Topic/Title:** Population Health – Newly Developed Population Health Department **Description:** In 2021, Optima Health further developed the Population Health Department to focus solely on improving population health both through internal and external means and seek out best practices and technologies to target our high-risk members and providers. The department encompasses population care, innovations portfolio management, and performance improvement teams. In its first year, Population Health continued to grow and determine best practices as well as develop a future state. The department is currently planning a population health assessment to be completed in 2023. **Topic/Title:** Member Advisory Committee Meetings **Description:** The Member Advisory Committee meetings included a comprehensive communication method and approach to targeting the members to engage them in the member facing events. The goal being to elicit member feedback and improve the member experience. Members were engaged by email, mail, phone, social media, and the web. The member planning committee primarily included the member outreach team and the communications team using a collaborative approach to increasing member participation, engagement, and member satisfaction. Meeting and member outcomes are reviewed, and member feedback is used to make decisions on member led and chosen content for future meetings.
United	**Topic/Title:** Sticks For Kicks **Description:** To assist the Commonwealth with preventing infectious diseases, UnitedHealthcare (UHC) has implemented best practices to increase vaccination rates. One of our reward programs, Sticks for Kicks, offers incentives to members

MCO	Best and Emerging Practices
	ages 5-18 for receiving certain vaccines. When members receive a qualifying "stick" (shot), they can earn a $50 gift card to buy "kicks" (shoes) and activewear at Foot Locker. If they receive any other qualifying vaccine, they can earn a second $50 Foot Locker gift card, up to a total of $100. **Topic/Title:** FiveMedicine COVID Clinic **Description:** UnitedHealthcare (UHC) collaborated with local organizations in the Tidewater region to improve vaccine access and decrease the spread of infectious diseases through a mobile clinic, including Virginia Department of Health, Southeastern Virginia Health System and Peninsula Health District. UHC partnered with FiveMedicine to host two clinic events for first and second COVID-19 vaccinations. To build awareness, UHC's care coordinators contacted members in the Tidewater area to encourage them to visit the clinic, answered questions, and arranged transportation. Many of these individuals manage chronic health conditions. During the two-day event, nearly 700 vaccines were administered to members of the community. **Topic/Title:** Preventative Health Initiatives **Description:** To improve health disparities and the health & well-being of underserved communities in the Commonwealth, UnitedHealthcare leverages an approach we designed and deploy in communities that combines localized data with community-level collaborations to improve health outcomes to drive meaningful change. This approach was most recently focused in Petersburgh, VA, but our overall approach includes creating unique and creative engagements with families through partnerships with community-based organizations including faith-based, non-profit, and trusted community mainstays to increase trust and sense of community. • Annual Grandparents Day – UnitedHealthcare partners with Sesame Street Workshop to celebrate National Grandparents Day. The "*Grow Every Day, Every Way*" event features healthy snacks, games, activities, and giveaways along with UHC representatives to answer questions about healthy habits and managed care benefits. Most recently in Petersburg, VA, UHC's Chief Medical Officer gave over 100 attendees blood pressure devices and shared preventative health guidance. This fun, no-cost event supported Petersburg residents of all ages where they were, and featured the new resource "*Happy, Healthy, Hopeful: Stretching Our Food Dollars*" from Sesame Street to help families stay healthy and strong, every day and every way. • Pop-Up Clinics – UnitedHealthcare partners with Color Health to provide preventative clinic services, including vaccinations, health screenings, and health education. By being flexible and meeting people where they are, we increase access, convenience, and participation. UHC will continue to identify and partner with local community organizations to educate the community, increase participation, support joint canvassing and awareness efforts, and build trust and credibility with the member population we serve.

MCO	Best and Emerging Practices
	Topic/Title: One Pass **Description:** To improve physical and mental well-being for members, UHC offers an enhanced benefit to members ages 18 and older. Through this program, members gain access to more than 300 fitness locations in Virginia, including a digital library of more than 20,000 on-demand and livestream classes. As an emerging practice, UHC is expanding this program to our CCC Plus population in support of the transition to Cardinal Care. **Topic/Title:** Housing + Health **Description:** UnitedHealthcare believes that creating sustainable programs that address and integrate all the key elements required for health (including social, behavior, and medical) requires innovative thinking, unconventional partnerships, and the ability to tailor and fund these programs for the most complex populations. Housing + Health is a community and social health initiatives model that is aligned with our Community & State Population Health approach. Housing + Health operates with the mission to compassionately drive change by unifying the strengths of members and the community to make the housing and health systems achieve equitable outcomes for all. To achieve this mission, it focuses on creating data-driven and evidence-based solutions that help communities and individuals solve clear and specific housing challenges, curb health care costs for members, and improve health outcomes and self-sufficiency. Housing + Health works alongside community partners and health plan housing navigators to achieve positive outcomes.
VA Premier	**Topic/Title:** Complex Wellness Team/Program **Description:** The Complex Wellness Program includes representation from care coordination, BH, and the social determinants of health (SDOH) team via social workers. Virginia Premier's (VP) pilot began with VCU Health System in May 2022. In addition to the direct care stakeholders, the Complex Wellness Team includes medical directors, population health, pharmacy, utilization management, and quality. External partners include community service providers and VCU staff. Members who are inpatient or have had an ED visit, with VP as primary payor, are assessed via inclusion criteria: **C**omorbidity/**A**dmission Type and Acuity/**P**lan/last **S**ix (6) months (CAPS) score, diagnosis, comorbidities, admission history, SDOH needs, open Care gaps, and medication adherence. Each member's "case" is reviewed by the stakeholder group to assess for potential medical, behavioral, and social impacts effecting health outcomes. This very targeted approach ensures that members with high-needs and high-supports receive the necessary interventions for full wrap-around care. **Topic/Title:** Member Advisory Committee Meetings **Description:** The Member Advisory Committee meetings include a comprehensive communication method and approach to targeting the members to engage them in the member facing events. The goal being to elicit member feedback and improve

MCO	Best and Emerging Practices
	the member experience. Members are engaged by email, mail, phone, social media, and the web. The member planning committee primarily includes the member outreach team and the communications team using a collaborative approach to increasing member participation, engagement, and member satisfaction. Meeting and member outcomes are reviewed, and member feedback is used to make decisions on member led and chosen content for future meetings. **Topic/Title:** Pediatric Atypical Antipsychotic Program **Description:** • Care coordination program for those members aged 6-12 years who are taking an atypical antipsychotic • Care coordination letters are sent to member's PCP and prescriber of atypical antipsychotic • Goal is to ensure appropriate clinical monitoring of the member is being completed and reported • Team meetings are held monthly to discuss program, suggest any improvements, and review data results **Topic/Title:** Hepatitis C Program **Description:** • Clinical program to help adherence and therapy completeness • Specialty pharmacy provides member information to care coordinators on who fills Hep C therapy • Care coordinators outreach members to educate on side effects and provide any additional support needed • Specialty provider sends quarterly and annual reporting, including SVR12 lab work, to show effectiveness of program **Topic/Title:** Vendor Management Organization (VMO) Team Structure **Description:** The VMO established the following teams and processes to support the business by strategically delivering results through successful vendor partnerships, ultimately generating value for our members and customers. • Strategic Sourcing: Assess and select best-in-class vendors that further Virginia Premier objectives and ensure minimal compliance, legal, financial and security risks. • Non-Provider Contract Management: Execute and manage contracts that provide Virginia Premier with a vendor portfolio which allows for the safe, effective, and efficient delivery of services.

MCO	Best and Emerging Practices
	• Vendor Support: Implement and support the operational and regulatory requirements of select Virginia Premier vendor programs in partnership with assigned business owners. • Vendor Oversight: Oversee and manage vendor financial and operational performance to help ensure Virginia Premier compliance and vendor obligation delivery. • Vendor Systems and Support: Centralized support across all VMO teams, responsible for managing and supporting VMO contract & vendor systems and data. **Topic/Title:** BH Transitions of Care **Description:** Behavioral health Transition care coordination initiative – BH care coordination team supports all members who have a BH inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. BH inpatient reviewers send notification at admission and discharge to members care coordinators 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. **Topic/Title:** BH Chronic Care Coordination **Description:** BH chronic care coordinators work with the enhanced care coordination program that requires targeted case managers employed with Community Service Boards (CSBs) to conduct seven-day follow-up with members discharged from acute care facilities. **Topic/Title:** Continuity of Care **Description:** BH inpatient reviewers send notification at admission and discharge to members 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. **Topic/Title:** Peer Support Program **Description:** In October 2022, VP will launch a peer recovery support program. Peer support is an evidenced-based practice that has proven outcomes in reducing the costs of admissions/readmissions, increasing the quality of life for individuals challenged with mental health (MH) and substance-use disorder (SUD). Certified peer support specialists, who have lived experience with MH, SUD, and/or trauma, and who are also trained, join along members who on their own path to recovery, wellness, and resiliency. Individuals engaged in peer support are often more

MCO	Best and Emerging Practices
	engaged in treatment and navigate crises in a healthy way due to the support from peer support specialists. **Topic/Title:** Annual Quality Summit **Description:** Typically held the week of World Quality Week. The theme of the summit provides an opportunity to reflect on how corporate culture and conscience can help or hinder an organization to make decisions and 'do the right thing' for all stakeholders. The two-day interactive conference inclusive of speaker from the health plan senior leaders, DMAS, vendors and other quality leaders in the community who provide insight to how they contribute to quality. This quality initiative is regarded as a best practice because it allows the quality staff to know and understand why the plan does what it does, how the work impacts members, other department, providers, practitioners, pharmacies, regulatory bodies, and the community as a whole. Topics of discussion include but are not limited to: member engagement, new strategic opportunities, cultural competency standards, health equity, and HEDIS medical record procurement/acquisitions. **Topic/Title:** Quality HEDIS Team **Description:** • Implemented year-long medical record retrievals, data abstractions, and 100 percent overreads for gap closure • Electronic medical record program • Daily review of quality improvement ancillary mailbox for gap closures from CCS and Pop Health • Validating incentives for supplemental data

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 QS's goals and objectives.

Aetna

Table D-1—Aetna's QS Quality Initiatives

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	*Follow up After Discharge:* PIP intervention involving educating members about the importance of engaging in a 30-day post-discharge follow up visit with a PCP or specialist. MCO staff assist with scheduling appointment as needed.	**Metric 3.1.3:** (FUD) Follow Up After Discharge
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 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	*ED Visits* *Telephonic Outreach Visit:* PIP intervention involving conducting telephonic outreach to members identified as having one outpatient visits and two or more ED visits. *Avoidable ED Visits NBA Campaign:* Promote health behavior changes and choices with one or more past visits to the ED for avoidable reasons through direct mail and IVR microsite.	**Metric 3.1.4:** (AMB) Ambulatory Care—Outpatient Visits/1000 MM (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	**Metric:** (MRP) Medication Reconciliation Post Discharge

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	measures specifically for our Care management department.	
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 utilization management, case management, and BH departments in working with members. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for the effectiveness of care measures specifically for our care management department.	**Metric 4.1.1:** (FUH) Follow Up After Hosp for Mental Illness—7 days **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	*Higher Utilizer Rounds:* Integrative round with utilization management, BH, medical management, case management, pharmacy, PSS representation to focus on stabilizing one member at a time who is a high utilizer of BH inpatient hospitalizations.	**Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence
Aim 4: Improved Population Health **Goal 4.2:** 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 4.2:** 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 outpatient substance use services.).	**Metric 4.2.4:** (IET) Initiation and Engagement of AOD Abuse or Dependence Treatment

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.2:** 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 outpatient substance abuse services.).	**Metric 4.2.4:** (IET) Initiation and Engagement of AOD Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*EPSDT Birthday Mailers:* 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	*AAP SMS:* Members are sent one to three messages each month. If a member is included in multiple text campaigns, messages are staggered as to avoid member abrasion. The timeline varies for when each member receives messages, due to individual enrollment into the campaign. *Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. *Wellness Rewards Program:* Program that incentivizes members for completing various cancer screenings and yearly wellness exams.	**Metric 4.3.2:** (AAP) Adults' Access to Preventive/Ambulatory Health Services (Total)

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	Moving On Transitioning from Pediatrics to Primary Care: Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*AAP SMS:* Members are sent one to three messages each month. If a member is included in multiple text campaigns, messages are staggered as to avoid member abrasion. The timeline varies for when each member receives messages, due to individual enrollment into the campaign. *Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	**Metric 4.3.2:** (CBP) Controlling Blood Pressure
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*EPSDT Birthday Mailers:* 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	**Metric 4.3.4:** (AWC) Adolescent Well-Care Visits

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	based on child's birthday and gaps in care. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*EPSDT Birthday Mailers:* 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. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon Program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	**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 Birthday Mailers:* 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	**Not a QS Metric:** (LSC) Lead Screening in Children

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	based on child's birthday and gaps in care. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*EPSDT Birthday Mailers:* 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. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	**Not a QS 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 Birthday Mailers:* Parents of child members receives a reminder for child to have wellness visits with PCP and obtain recommended immunizations. Monthly mailing based on child's birthday and gaps in care. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit.	**Not a QS Metric:** (WCC) Weight Assessment Counseling—BMI percentile (Total) **Not a QS Metric:** (WCC) Weight Assessment Counseling—for Nutrition (Total) **Not a QS Metric:** (WCC) Weight Assessment Counseling—Physical Activity (Total)

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*CVS Health Tags:* Messages attached to prescription bags educating members about the importance of flu vaccination *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. *PMMP Plan Education (Care Management):* Pharmacy Advisor led plan education for our effectiveness of care measures specifically for the care management department. *Primary Health Care Model for Adults:* Gender specific educational brochures about the importance of completing recommended health screenings with PCP and/or specialist. *Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams. *Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary	**Not a QS Metric:** (COL) Colorectal Cancer Screening **Not a QS Metric:** Non-Recommended PSA-Based Screening in Older Men

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	
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. *Well Woman Wellness Rewards:* Incentive for members that completes their pap test and mammogram.	**Not a QS 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. *Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	**Not a QS Metric:** (CHL) Chlamydia Screening in Women —Total
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Mobile Mammography:* Collaboration with Virginia Health Systems offering female members mobile units for mammograms. *Well Woman Wellness Rewards Program:* Program that incentivizes members for	**Not a QS Metric:** (BCS) Breast Cancer Screening

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	completing various screenings and yearly wellness exams.	
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. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for the 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	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for MCO care management department.	**Metric 4.4.2:** (AMR) Asthma Medication Ratio (Total)
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 MCO care management department. *Hospital Readmission Reduction Program:* Clinical program focused on coordinating care between providers, case managers and clinical pharmacists as	**Metric 4.4.2:** (PDI 14) Asthma Admission Rate 2–17 Years

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	members are discharged from the hospital.	
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	*PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. *Asthma Value Based Care Pilot:* Collaboration and alignment between CVS Retail patient care capabilities with Aetna Better Health member needs to impact asthma care of cost by decreasing emergency room/inpatient/ambulatory visits from asthma exacerbations	**Not a QS 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. *Asthma Value Based Care Pilot:* Collaboration and alignment between CVS retail patient care capabilities with Aetna Better Health member needs to impact asthma care of cost by decreasing emergency room/inpatient/ambulatory visits from asthma exacerbations	**Not a QS Metric:** (PQI 15) Asthma in Younger Adults Admission Rate
Aim 4: Improved Population Health	*Chronic Condition Education Series:* Educational sessions for members with chronic	**Metric 4.4.4:**

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Goal 4.4: Improve Health for Members with Chronic Conditions	conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. *Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management. *Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. *Primary Health Care Model for Adults:* Gender specific educational brochures informing about the importance of completing recommended health screenings with PCP and/or specialist. *Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams. *Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics	(CDC) Comprehensive Diabetes Care—HbA1c Testing

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	
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. *Primary Health Care Model for Adults:* Gender specific educational brochures informing about the importance of completing recommended health screenings with PCP and/or specialist.	**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—Attention for Nephropathy
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their 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

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	Primary Health Care Model for Adults: Gender specific educational brochures about the importance of completing recommended health screenings with PCP and/or specialist. *Moving On Transitioning from Pediatrics to Primary Care:* Initiative incentivizing members aged 18-20 years who are transitioning from pediatrics health care to adult primary care. Eligible members receive a gift card for completing various services including, preventive care services, adult medical screenings, weight management, and recommended vaccines.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.	**Not a QS 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	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.	**Not a QS Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation— Bronchodilator
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.	**Not a QS Metric:** (PCE) Pharmacotherapy Management of COPD Exacerbation— Systemic Corticosteroid

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. *Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management. *Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. *Primary Health Care Model for Adults:* Gender specific educational brochures about the importance of completing recommended health screenings with PCP and/or specialist.	**Not a QS 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	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.	**Not a QS Metric:** (CDC) Comprehensive Diabetes Care—Attention for Nephropathy

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions. *Diabetes and Cholesterol Member Mailer:* Educational letter sent to members pertaining to diabetes and cholesterol medication management. *Diabetes Mailer:* Incentive for members that complete a yearly wellness and diabetic exam. *Wellness Rewards Program:* Program that incentivizes members for completing various screenings and yearly wellness exams.	**Not a QS Metric:** (CDC) Comprehensive Diabetes Care—Eye Exams
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Chronic Condition Education Series:* Educational sessions for members with chronic conditions that include MCO staff and non-profit organization guest speakers to help members better manage their chronic conditions.	**Not a QS Metric:** (SPC) Statin Therapy for Patients with Cardiovascular Disease
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	*Ensuring Timeliness of PNC Telephonic Outreach:* Outreach conducted to identified pregnant members to provide education and encourage first	**Metric 4.6.2:** (PPC) Prenatal and Postpartum Care—Timeliness of Prenatal Care

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	trimester PNC to reduce risk of preterm or low birth weights. *Tobacco Use Cessation in Pregnant Women Telephonic Outreach:* Outreach to identified pregnant smokers and inform members of available resources and options to engage in smoking cessation. *Ensuring Timeliness of PNC Quitting for Good:* Flyer outlining unsafe habits during pregnancy. *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.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*EPSDT Birthday Mailers:* 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. *PMMP Plan Education (Care Management):* Pharmacy advisor led plan education for our effectiveness of care measures specifically for our care management department. *Wellness Rewards Program:* Program that incentivizes members for completing	**Metric 4.6.3:** (CIS) Childhood Immunization Status **Metric 4.6.3:** (CIS) Childhood Immunization Status—Combo 3 **Metric 4.6.3:** (CIS) Childhood Immunization Status—Combo 10

Virginia QS Aim and Goal	Aetna's Quality Initiative	Performance Metric
	various screenings and yearly wellness exams. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*EPSDT Birthday Mailers:* 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. *Ted E. Bear M.D. Wellness Club:* Program encourages parents to ensure their child completes their well child visit. Child receives age-appropriate gift upon Program enrollment and parent receives gift card (amount varies based on child age group) upon completion of preventive service.	**Metric 4.6.5:** (W15) Well-Child Visits in the first 15 Months of Life (6 or more visits)

HealthKeepers

Table D-2—HealthKeepers' Quality Strategy Quality Initiatives

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Aim 2:** Effective Patient Care	*Network Adequacy Assessment:* Assessed the adequacy of the MCO's network by reviewing data from the following reports: Member Experience report	**Metric 1.2.1:** Getting Care Quickly **Metric 2.2.3:** Getting Needed Care

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Goal 1.1: Improve Member Satisfaction **Goal 2.2:** Ensure Access to Care	pertaining to complaints, Health Disparities and CLAS Evaluation report from our MHC Distinction, Availability report, Accessibility report and Calendar Year Out of Network utilization requests (approved and denied) and Utilization Data. As a results of the analysis, non- compliant providers were educated by letter reminding them of appointment standards. *Provider Education:* Providers continued to receive educations on the standards monthly during provider orientation meetings. Providers were educated via provider newsletter about HealthKeepers adoption of prior authorization app in Availity. A provider continuing medical education online course was added to the provider website to promote the CME class "Telehealth: Building a Sustainable Model." Added availability of provider telehealth to online physician directories to educate members regarding accessibility to PCP Telehealth. *Member Education:* Educated members regarding accessibility to alternatives to emergency room, such as nurse line and urgent care centers and telehealth.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Improving Maternal and Child Services:* Conducted an evaluation of HealthKeepers' Population Health Management Strategy that focused on clinical,	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3:** Childhood Immunizations Status Combo 10

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	cost/utilization, and program feedback from members. In 2021, a 'snapshot' of the July membership indicated approximately 1.08 percent of the plan's membership was comprised of maternity and/or perinatal women. Timely PNC helps promote healthy birth outcomes for both mother and baby. A focus on improving this PM therefore had a positive impact not only for the 1.08 percent of perinatal women in the plan membership but extended the benefit to essentially twice that amount when considering their newborns. This PM had been identified as a state priority to improve maternal health outcomes for women. Approximately 2.11 percent of MCO members were in the denominator for the PM indicator Combo 10 Childhood Immunization Status. Assuring members were vaccinated prevented morbidity and mortality caused by serious illnesses in the younger population. The HEDIS work group which consisted of the HEDIS team and corporate quality directors analyzed trends and determined barriers for HEDIS PMs. The Anthem Virginia HEDIS Root Cause Analysis (RCA) work group also reviewed the data trends to determine barriers for the PMs. Opportunities identified included educating parents regarding the need for all immunizations and educating members regarding the	

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	need for prenatal visits. As a result of the analysis, HealthKeepers, Inc implemented the following interventions: • PPC: Doula program available to all Medicaid members reimbursing for prenatal, delivery and postpartum doula services. Referral from licensed provider required and incentive to doula for member to pursue services. • Increased participation in OBQIP to increase prenatal and postpartum visits. Incentive in OBQIP was increased. • Stepping-Stones (partner with CBOs and shared grant funds and provided resources to provide to clients). • Monthly SDOH report that looked at pregnancy assessment and if member had social needs as well. • Worked with transportation vendor on improving reliability of transportation. • Educated providers on the importance of reminding members of follow-up appointments.	
Aim: 4 Improved Population Health **Goal: 4.4** Improve Health for Members with Chronic Conditions	*Improving Supportive Care and Disease Management* Conducted an evaluation of the Population Health Management Strategy that focused on clinical, cost/utilization, and program feedback from members. *Reviewed Data* In 2021, a 'snapshot' of the July membership indicated approximately 6.54 percent of the plan's membership had a	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) HbA1c Poor Control **Metric 4.4.5:** Controlling High Blood Pressure

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	diagnosis of diabetes. Controlling HbA1c levels is known to reduce the long-term risk of microvascular complications in people with diabetes. Focusing on improving the CDC (Blood Pressure 140/90) PM helped improve the lives of members with diabetes by reducing the cardiovascular risk related to high blood pressure. A focus on these PMs also aligned with the state's QS to improve care and outcomes for members with chronic diseases. *Conducted Root Cause Analysis* The HEDIS work group which consisted of the HEDIS team and corporate quality directors analyzed trends and determined barriers for HEDIS PMs. The Anthem Virginia HEDIS Root Cause Analysis (RCA) work group also reviewed the data trends to determine barriers for the PMs. *Implemented Interventions:* Opportunities identified included educating parents regarding the need for all immunizations and educating members regarding the need for prenatal visits. As a result of the analysis, HealthKeepers Inc. implemented the following interventions: • mPulse text campaign • Gap in care reports distributed internally by case management. • Hypertension adherence program through pharmacy. • Mail order delivery of prescriptions.	

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	• Pay for Quality Provider Incentive Program - non PQIP providers who could earn incentives for closing gaps in care. • IngenioRx outreach	
Aim: 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	*Improving Cost/Utilization* Conducted an evaluation of the population health management strategy that focused on clinical, cost/utilization, and program feedback from members. In the trended analysis of the ambulatory care. ED visits PM, HealthKeepers Inc. saw a considerable drop in the per thousand calculation of emergency room visits year-over-year. The MCO believed that this could have been attributed to members avoiding the emergency room during the PHE due to the risk of coming in contact with the virus, in addition to extreme wait times that have occurred during this time period. The MCO also focused on providing other alternatives to care other than the emergency room, including urgent care facilities, encouraging members to contact their PCP after hours, and to use telehealth. For and Inpatient Utilization PM, (ALOS) Covid-19 attributed to the increase. Case management will continue to monitor inpatient stays by focusing on team education with case reviews, and case management rounds. *Member Education* Opportunities identified for emergency room visits included educating members regarding alternatives to emergency room	**Metric 4.4.4:** Ambulatory Care: ED visits (AMB) **Not a QS Metric:** Inpatient Utilization PM, (ALOS) (IPU)

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	care when appropriate, reaching out to members who were high utilizers of the emergency room to assist them in alternative care, as well as addressing health the condition that was causing the visits. *Early Discharge Planning* Opportunities identified for average length of stay reduction included beginning discharge planning upon admission, earlier collaboration between the health plan, case management and utilization management with hospital discharge planners and additional collaboration with sub-acute facilities, home health and durable medical equipment companies to ensure services were able to meet the needs of the MCO's member population. *Implemented Interventions* As a result of the analysis, HealthKeepers Inc. implemented the following interventions: • Utilization management department/staff and plan's medical director implemented a process to decrease length of stay admissions. • Prominent information placed on the landing page of the member website with alternatives to emergency room utilization. • Dedicated case managers identified to outreach to those members on the ED care coordination list to provide support, education about appropriate use of the emergency room, alternate	

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
	providers and follow up with PCP. • Revisions were made to the identifiers for complex rounds in effort to recognize those potential members sooner who had challenges at discharge. This helped to establish a transition in care plan prior to discharge. • Enhanced the use of the collective medical system to identify and outreach to members who had utilized the emergency room for non-emergent visits. *Effective Care Coordination* Emergency room visits and longer than required hospital stays continued to be a focus due to the quality-of-life issues they raise. Effective care coordination between the health plan and the providers was essential in delivering optimal outcomes.	
Aim 2: Effective Patient Care **Goal 2.2:** Ensure Access to Care **Aim 4:** Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members **Aim 4:** Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions **Aim 4:** Improved Population Health	*Collaboration with Behavioral Health to Close Gaps; Telehealth Investment Fund Initiative* With HealthKeepers Inc. allocated funds, the Virginia Medicaid market partnered with select providers to enhance their market position by increasing member access to care through innovative digital and technology solutions. Select providers were offered up to five telehealth offerings (Telehealth OS-Provider Platform, Virtual Visit Platform, Digital Solutions Kiosk Program, eConsults, Telehealth Member Kits). Participating BH providers elected to utilize the Telehealth OS Platform, Kiosk program and	**Metric 2.2.3:** Getting Needed Care **Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Aim and Goal	HealthKeepers' Quality Initiative	Performance Metric
Goal 4.4: Improve Outcomes for Maternal and Infant Members	member kits. The kiosks increased access to care via telehealth, eliminated language barriers and improved health equity for multi-cultural patients. The telehealth member kits provided basis medical devices to help PCP's/BH providers make a better assessment and diagnosis of members during telehealth visits. Specialty kits offered support to members so that they could better manage their chronic conditions. Telehealth specific kits included high-risk pregnancy, asthma, BH, blood pressure control, and diabetes kits.	
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	*Provider Incentive Programs* Implemented provider incentive programs that rewarded qualifying providers for quality and cost-effective care provided to members: • BHQIP: OP BH Providers • BHFIP: Inpatient BH Facilities • SUDFIP: Inpatient and RTC ARTS providers • SDOHPIP	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed ADHD Medication **Metric 4.2.4:** Initiation and Engagement of AOD Abuse or Dependence Treatment **Not a QS Metric:** Follow-Up After High-Intensity Care for Substance Use Disorder at 7 Days **Not a QS Metric:** 30,60,90-day Readmission Rates **Metric NA:** SDOH

Molina

Table D-3—Molina's Quality Strategy Quality Initiatives

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.3.2:** (AAP) Adults' Access to Primary Care (Preventive/Ambulatory Health Services)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.4.2:** Asthma Admission Rate (Ages 2–17) **Metric 4.4.3:** Asthma Admission Rate (Ages 2–17)
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.4.2:** Asthma Admission Rate (Ages 2–17) **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Not a QS Metric:** BCS) Breast Cancer Screening **Not a QS Metric:** (CCS) Cervical Cancer Screening
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	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. *Immunization Campaign*	**Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.6.3:** Childhood Immunization Status **Not a QS Metric:** Lead Screening in Children

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
Members	*Partnerships* Partnered with community/ providers and hosted immunization campaign and provided incentives and school supplies	
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	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness **Metric 4.2.4:** Initiation and Engagement of AOD Abuse or Dependence Treatment
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach. *Member Incentives* Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence. *Provider Education* Claims researched for service date and bundle code issues. Providers were 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
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Clinic Days* Hosted clinic days in providers' 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	*Clinic Days* Hosted clinic days in providers' offices to have an open day for appointments for members to get their services done. *Member Incentives* Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence. Members received a certificate based on their A1c outcomes. *Provider Incentives* Vision centers were incentivized to reach out to members, schedule, and complete the dilated retinal eye exam. *Telehealth* Blood pressure cuffs sent to targeted members and telehealth visits were facilitated to capture required information. Members were sent an HbA1c kit to complete at home.	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
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	*Clinic Days* Hosted clinic days in providers' offices to have an open day for appointments for members to get their services done.	**Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

Virginia QS Aim and Goal	Molina's Quality Initiative	Performance Metric
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	*Conduct Outreach Calls* The MCO partnered with MRx vendor partner to do outreach calls and identify barriers preventing members from being adherent to medication.	**Not a QS Metric:** Asthma Medication Ratio **Not a QS Metric:** Adherence to Antipsychotic medications for individuals with Schizophrenia **Not a QS Metric:** Antidepressant Medication Management
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Targeted Interventions* Member outreach targeted kids before they turned two years old and helped them to schedule appointments to close the CIS PM gaps. Compliant members received incentives from the MCO's partnered vendor on an agreed upon cadence	**Metric 4.6.3:** Childhood Immunization Status
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	*Conduct Outreach Calls* The MCO partnered with MRx vendor partner to do outreach calls and identify barriers preventing members from being adherent to medication.	**Not a QS Metric:** Asthma Medication Ratio **Not a QS Metric:** Adherence to Antipsychotic medications for individuals with Schizophrenia **Not a QS Metric:** Antidepressant Medication Management
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Communicate and Share with Providers* The MCO worked with individual provider/ provider groups, conduct monthly meetings, sent gaps in care reports, provided support for member outreach.	**Metric 4.6.3:** Childhood Immunization Status

Optima

Table D-4—Optima's QS Quality Initiatives

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction **Goal 1.2:** Improve Home and Community-Based Services	*CAHPS benchmarks and initiatives* • Number and percent of Waiver Individuals who have service plans that are adequate and appropriate to their need and personal goals who receive services in the scope specified by their service plan • Weekly medical and behavioral care coordination and case management rounds with medical directors • Care coordination/case management care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Focused vendors for community partners for improving social determinants of health (SDOH) • Quarterly outreach member advisory forums (currently virtual due to COVID-19)	**Metric 1.2.3:** Rating of All Health Care **Metric 1.2.1:** 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 **Goal 2.2:** Ensure Access to Care	*CAHPS benchmarks and initiatives* • Dedicated Optima readmission prevention team • Readmission high-risk discharge target and intervention committee • Vendors/partners in care: EMMI, CipherHealth, BioIQ, MDLive, Prealize, Integrated Eye Group (IEG), Ontrak, Lexus Nexus,	**Metric 2.1.1:** Rating of Personal Doctor **Metric 2.1.1:** Getting Needed Care

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	Focus Care In-Home Assessments, Progeny, Accordant, Inogen, Optum, Alere, Dario, CareNet • Follow-up post- discharge activities	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value **Goal 3.2:** Focus on Efficient Use of Program Funds	*VBP/PWP Performance targets and initiatives. NCQA Quality Compass 50th percentiles* • Focused workgroups to impact DMAS clinical efficiency measures: LANE PPA Readmissions • PWP monthly tracking dashboard (Tableau) • Readmission High-Risk Discharge Target and Intervention Committee • Care coordinators/case managers care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • BH value-based agreements with medication assisted treatment (MAT) clinics and Community Service Boards (CSB) focused on tapering members receiving prescriptive medications within the MAT programs while providing alternative wrap around BH outpatient services such as peer recovery support, day treatment, partial hospitalization, Mental Health Intensive outpatient and utilization of long-acting opioid blockers causing long-term savings with the prevention of overdoses and hospital utilization	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.2.1:** Monitor MLR annually by managed care program and aggregate total

Virginia QS Aim and Goal	Optima'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 **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions **Goal 4.5:** Improve Outcomes for Nursing Home Eligible Members **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*VBP/PWP Performance targets and initiatives. NCQA Quality Compass 50th percentiles* • Performance withhold program monthly tracking dashboard (Tableau) • Case management/care coordinator care gap dashboard (Tableau) to assist in identifying and closing care gaps when engaging with members • Quarterly Baby Showers • Partners in Pregnancy (PIP) program • Focused EPSDT care coordination • Targeted BH care coordination focusing on inpatient discharges, emergency room utilization and high-risk readmission member focus from BH facilities • Targeted case management for justice-involved members • Quarterly BH provider education • Dedicated Optima readmission prevention team with (CipherHealth) to conduct hospital and ED post-discharge follow-up calls to members to assist with any member-identified concerns (home health, medications, discharge instructions, etc. • Power hour for all staff to provide weekly educational sessions (examples: asthma, COPD, diabetes, motivational interviewing, policy, and documentation updates, etc.)	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness **Metric 4.1.4:** Monitor Mental Health Utilization **Metric 4.2.2:** Follow-Up After ED Visit for AOD 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 AOD Abuse or Dependence Treatment **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 **Metric 4.4.1:** PQI 08: Heart Failure Admission Rate **Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17) **Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.6.1:**

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	• Improve access to follow-up after inpatient and emergency room visits with enhanced care coordination, member education, and scheduling of follow-up care within seven-10 days of discharge utilizing BH care center for members with mental health • Collaboration with CSBs, MAT facilities, and other local agencies to develop peer recovery support specialists to provide additional guidance and education upon release from incarceration for members with substance and alcohol use, ensuring members receive support to initiate and engage in substance abuse treatment	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 4.6.4:** Live Births Weighing Less than 2,500 Grams **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	*Member and Provider Outreach and Engagement* • Case management engagement with members to assist in managing care, making appointments, and scheduling transportation • Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health • Provider enablement provides data to VBC providers regarding preventative PMs and discuss their performance/progress towards the goals • Network Management:	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	– Includes appointment availability standards in QTR newsletters as a standing item – Reviews standards and after-hours requirements with Providers during QTR webinars – Review standards during individual provider meetings with network educators • Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health assessment to be completed 7/2023.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Member Outreach and Assessments* • Screening reminders sent to women 21 years and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month • Letter is sent to providers of members with cervical care gap • Clinical guidelines reviewed and providers are notified of updated clinical guidelines	**Not a QS Metric:** Cervical Cancer Screening

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	via newsletter and provider site • Articles in the member newsletter • Population health assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health assessment to be completed 7/2023.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Member Outreach and Engagement* • Childhood immunization incentive program • EMMI well-child and immunizations IVR campaign • EMMI manager utilization for educational videos • Prealize data utilized to identify members to refer to case management (CM) • Case management utilization of Tableau care gap report when engaging members • Case management documentation of care gap information received from members • FTE for EPSDT gap closures • Immunization program in development to improve member and clinician	**Metric 4.6.3:** Childhood Immunization Status

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the Commonwealth's Department of Health regarding vaccination data. Launch target of Q1 2023. • Population health assessment work group established 7/2022. NCQA Standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health assessment to be completed 7/2023.	
Aim 4: Improved Population Health **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Member Outreach and Engagement* • Diabetic eye exam incentive program • EMMI manager utilization for educational videos • Prealize data utilized to identify members to refer to case management • Case management utilization of Tableau care gap report when engaging members • Case management documentation of care gap information received from members in Symphony/JIVA • Population care diabetic eye exam campaign	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	• BioIQ at-home A1c program. • Focus Care In-Home A1c testing and DEE • HEDIS 4th QTR push case management member outreach • Diabetic eye exam article for member newsletter • Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted • Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need • Retina Labs: Clinic-based and in-home tele-retinal screening solution for early detection of diabetic retinopathy in diabetic members. This will help close critical Diabetes care gaps and improve health outcomes for members. Implementation target of fourth quarter 2022. • Dario: The Dario Pilot covers 1,500 Optima Health Medallion 4.0 and CCC plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain	

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members. • Population health assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health Assessment to be completed 7/2023.	
Aim 4: Improved Population Health **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	*Member Outreach and Engagement* • Prenatal visit incentive program. • Postpartum visit incentive program. • Healthy pregnancy mailing, self-care guide and parenting magazine subscription. • Healthy pregnancy mailing at 20 weeks gestation, dealing with stress while pregnant, and a preterm labor card. • Healthy pregnancy mailing at seven months including a letter, dealing with stress flyer, and early labor signs card. • Healthy pregnancy mailing at 38 weeks gestation, dealing with postpartum	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	depression, and an immunization with checkups magnet. • Baby showers. • Member outreach calls. • EMMI manager utilization for educational videos. Prealize data utilized to identify members to refer to case management • Case management utilization of Tableau care gap report when engaging members. • Case management documentation of care gap information received from members. • Referral to Optima's Partners in Pregnancy Program. • Referral to CHIP. • Referral to Urban Baby Beginnings. • Text for Baby Program through March of Dimes. • Partners in Pregnancy Case Management Referral Form. • Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted. • Barriers assessed with clinical team, childcare and transportation continue to be major barriers for this population; collaborating with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need. • Ovia Health, on demand virtual prenatal and post-	

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	partum care, implemented 9/2022. • Ovia's robust digital solution provides support to female members 13 plus years and male members 18 plus years through three different programs – Ovia Fertility, Ovia Pregnancy and Ovia Parenting. • The digital app provides increased access to care with Ovia coaches available 365 days per year, from 9 am to 9 pm eastern standard time. • Support includes coaching and education, and member engagement begins with an intake questionnaire to ensure appropriate material is pushed to the member based on their unique concerns. • Members are also asked about their mental health so any red flags noted can be immediately escalated to a health coach for appropriate intervention. • The Ovia app is open to each member's support network, adding another layer of coverage to help ensure the member obtains all the timely prenatal and postpartum care required and the most positive birth outcome possible. • Population health assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to:	

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health assessment to be completed 7/2023.	
Aim 1: Enhance Member Care Experience **Aim 2**: Effective Patient Care **Goal 1.1:** Improve Member Satisfaction **Goal 2.1** Enhance Provider Support	*Care Coordination and Customer Service* • CAHPS 101 Education annual CBT for all member-facing teams to increase awareness and importance. • CAHPS mid-year reminder to review customer service and the importance of the member experience. • Customer service post-survey member calls to drive continuous improvement opportunities. • Member outreach calls to assist members in navigating their healthcare needs. • Care coordination assistance with patient/provider appointment scheduling and transportation.	**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
Aim 1: Enhanced Member Care Experience **Goal 1.1:** Improve Member Satisfaction	*Member Experience of Care Survey* CAHPS Performance Improvement workgroup consisting of key stakeholders across the organization established to collaborate and discuss interventions to improve the bottom three CAHPS measures for both Medallion 4.0 and CCC Plus. Interventions include: • Development of annual CAHPS 101 training for all	**Metric 1.2.3:** Rating of All Health Care

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
	member-facing team members • Development of CAHPS reminder one-pager for member-facing teams' mid-year • Provider newsletter articles	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Review Data Trends* Performance improvement of HEDIS PMs to increase the screening and preventive services for members. Collaborate with teams across the organization to review data trends, identify opportunities, implement interventions, and track impact of initiatives.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 1: Enhanced Member Care Experience **Aim 4:** Improved Population Health **Goal 1.1:** Improve Member Satisfaction **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Educational IVR and Member Outreach* Educational IVR and video campaigns via email to improve understanding of preventive screenings and gaps in care. Reminds members of preventive screenings due and answers questions they may have about their care. Follow-up live calls from a nurse are made as needed. Improves members satisfaction, experience, and overall health outcomes.	**Metric 1.2.3:** Rating of All Health Care **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Aim 1: Enhanced Member Care Experience **Aim 4:** Improved Population Health **Goal 1.2:** Improve Member Satisfaction **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*In-Home Care and Assessments* Provide screening kits to members via mail and through in-home health assessments makes it convenient for members to complete screenings and gaps in care by providing it to the member without the need for the member to take an action. This improves member satisfaction,	**Metric 1.2.3:** Rating of All Health Care **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
Goal 4.4: Improve Health for Members with Chronic Conditions	experience, and health outcomes.	
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Dedicated Population Health Team:* By having a dedicated Population Health department, efforts and interventions across the health plan can be centralized in one location for a more targeted approach at improving health outcomes for members. The Population Health Performance Improvement Team facilitates, organizes, and coordinates plan-level quality PMs improvement projects and evaluates improvement initiatives.	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services
Aim 1: Enhanced Member Care Experience **Aim 4:** Improved Population Health **Goal 1.2:** Improve Member Satisfaction **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	*Digital/Electronic Health Monitoring* Ovia is a digital app accessible to members on their phone and supports them through coaching and education on their pregnancy and birth journey. The engagement starts with an intake questionnaire and material pushed to the member is tailored to address any concerns that are identified. The member also answers a few questions daily to assess their pregnancy and mental health. Any red flags are immediately escalated to a health coach. The app is available to members' support system as well so they can be engaged in ensuring a positive birth outcome for their loved ones.	**Metric 1.2.3:** Rating of All Health Care **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams

Virginia QS Aim and Goal	Optima's Quality Initiative	Performance Metric
Aim 1: Enhanced Member Care Experience **Aim 4:** Improved Population Health **Goal 1.2:** Improve Member Satisfaction **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for Members with Chronic Conditions	*Diabetes Management Program* Dario: The Dario Pilot is taking 1,500 Optima Health Medicaid and DSNP members and enrolls them into Dario's Type 2 Diabetes program. The solution provides adaptive, personalized member experiences that drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching that inspire individuals to improve health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, we will scale it to the larger organization. • Onduo – This is also a T2D initiative that targets all lines-of-business not touched by Dario. Onduo does not have the capability to take on Medicaid membership at this time • Retina Labs – Clinic-based and in-home diabetic retinal screening solution for early detection of diabetic retinopathy. This will help close critical diabetes care gaps and improve health outcomes for members. Aiming for QTR4 (CY2022) go-live	**Metric 1.2.3:** Rating of All Health Care **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)

United

Table D-5—United's QS Quality Initiatives

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
Aim 1: Enhance Member Care Experience **Goal 1.1:** Improve Member Satisfaction	*Care Coordination, Member Engagement and Member Experience of Care Survey* • UHC's care coordination model and individualized care management plans for members ensure the integration of physical and BH, incorporating medical management, resources, and other supports. Member care plans are member-centered and focus on the member's goals for positive health outcomes. • UHC's core focus is on social determinants of health; identifying and trending SDoH needs to determine each members' needs for preventative care while ensuring a strong engagement and connection with community resources. • UHC assesses and monitors disparities in relation to race, ethnicity, and language across the Commonwealth to develop appropriate interventions within the communities. • UHC monitors provider and member satisfaction with services through various surveys, events, and forums – including CAHPS, care coordination and LTSS surveys, NPS surveys, provider surveys, and Member Advisory Committees (MAC), among others.	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.2:** Enrollees Rating of Health Plan **Metric 1.2.3:** Rating of All Health Care

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support **Goal 2.2:** Ensure Access to Care	*Network Monitoring, Provider Incentives, Expanding Telehealth* • UHC diligently monitors network adequacy to ensure members have appropriate access to quality care. UHC conducts routine evaluations of the quality of care provided by our valued provider partners. • UHC partners with providers and enables member support through activities such as: • Ensuring providers have the most current information on Medicaid and Medicare benefits as well as UHC's enhanced benefits and initiatives to facilitate meaningful care with members. • Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care. • Expanding telehealth to increase availability of access to care for members. • Identifying ED visits through the ED care coordination (EDCC) interface and working with ED on adequate discharge plans and follow-up appointments. • Weekly medical, maternal, and behavioral care	**Metric 2.1.2:** How Well Doctors Communicate **Metric 2.2.3:** Getting Needed Care

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	coordination/ member case rounds with medical directors. • Targeted BH care coordination for emergency room utilization, inpatient discharges, and high-risk readmissions. • Facilitating transportation to/from provider appointments and other key non-medical appointments. • Partnership with Federally Qualified Health Centers (FQHCs), health systems and other community partners for member care and support of community events. • Partnership with community entities to facilitate and promote member self-care and resources.	
Aim 3: Smarter Spending **Goal 3.1:** Focus on Paying for Value	*Monitoring and Provider Incentives* • UHC continually monitors to ensure it is operating as efficiently and effectively as possible in supporting its members. There is also focus on medically unnecessary or potentially preventable spending for hospital admissions, hospital readmissions, and ED visits. • Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and	**Metric 3.1.1:** Frequency of Potentially Preventable Admissions **Metric 3.1.2:** Frequency of ED Visits **Metric 3.1.3:** Frequency of Potentially Preventable Readmissions **Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	outreach of members to close gaps in care. • UHC continues to monitor clinical efficiencies to track and evaluate success in reducing preventable, avoidable, and medically unnecessary utilization. • Utilization and monitoring collective medical data to identify high-utilization members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention.	
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	*Member Outreach and Education* Through a variety of methodologies, UHC provides member and provider education and member outreach, with appropriate focus on sub-populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the PM validation section on HEDIS PM activities. • Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care. • Utilization and monitoring Collective Medical data to identify high-utilization	**Metric 4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Metric 4.2.1:** Monitor Identification of AOD Services **Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence **Metric 4.2.4:** Initiation and Engagement of AOD Abuse or Dependence Treatment—Total

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention. • High-utilization member outreach and follow-up following ED or inpatient admission for mental health, alcohol, or other substance abuse. • Member incentives for members who complete follow-up appointment after ED or mental health inpatient admission. • Partnership with community service boards and other community resources. • Supports and encourages the use of telemedicine 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. • Regional, complex, maternity, and BH rounds: United's regional, complex, maternity, and BH rounds program consist of care coordinators and representatives from pharmacy, BH, utilization management, and external colleagues as needed. The weekly programs address both immediate and long-term member needs, provides support and resources to ensure	

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	member's needs were met and promotes quality outcomes. • In addition to using member-level HEDIS and other quality PMs, UHC continues to monitor under-utilization of key services that are critical to supporting member needs (e.g., home and community-based services, BH).	
Aim 4: 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	*Member and Provider Outreach and Engagement* Through a variety of methodologies, UHC provides member and provider education and member outreach, with appropriate focus on sub-populations with special ongoing or episodic needs. Many of these outreach programs are outlined in the PM validation section on HEDIS PM activities. • UHC continually reviews metrics globally to identify where outreach is most needed and to identify emerging trends statewide or regionally. 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 and assists the member with scheduling and completed care events. • CVS Health Tag – Partnered with CVS pharmacies to include messages	**Metric 4.4.2:** PDI 14: Asthma Admission Rate **Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate **Metric 4.4.4:** Comprehensive Diabetes Care: 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

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	encouraging members to receive a vaccine shot when picking up their prescriptions. • Community Plan Primary Care Provider Incentive (CP-PCPi) Program: With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care. • Utilization and monitoring Collective Medical data to identify high-utilization members; cross-functional collaboration with SDoH focus to determine gaps in care and provide high-intensity care coordination, strategies, and intervention. • Complex Care Management Team: Provides increased outreach, education, and care coordination for members with chronic conditions. • Regional, Complex, Maternity, and BH Rounds: United's regional, complex, maternity, and BH rounds program consist of care coordinators and representatives from pharmacy, BH, utilization management, and external colleagues as needed. The weekly programs address both immediate and long-term member needs, provides support and resources to ensure	

Virginia QS Aim and Goal	United's Quality Initiative	Performance Metric
	member's needs were met and promotes quality outcomes. • In addition to using member-level HEDIS and other quality PMs, UHC continues to monitor under-utilization of key services that are critical to supporting member needs (e.g., home and community-based services, BH). • Supports and encourages the use of telemedicine 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.	

VA Premier

Table D-6—VA Premier's QS Quality Initiatives

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support	*Contracting and Provider Services* Conduct provider implementation meetings to review new initiatives with providers, ensure they understand the processes involved, introduce them to their key points of contact, and address any questions or concerns they may have. Facilitate meetings with providers to address any contract related issues and concerns they may have as	**Metric 2.2.3:** Getting Needed Care

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
	well as to review any obligations they have under the terms of their contractual agreement. Outreach is made by the provider services team ensure they remain compliant with access standards. Those providers who are non-compliant would receive additional outreach, follow-up and training and practice to become compliant. Provider services would partner with the contracting team to obtain any missing information and a tracking system to document the issue, when it occurred, and how it will be resolved.	
Aim 2: Effective Patient Care **Goal 2.1:** Enhance Provider Support	*Contracting and Provider Services* Educate providers and practitioners on value-based care incentives and other provider-related topics to give providers/practitioners an opportunity to listen to updates and ask questions from each operational department Provider education meetings (PEM) occur quarterly in every region to discuss new initiatives and processes. The purpose of the PEMs is to engage with our provider community and share updates while allowing them an opportunity to ask questions. The MCO covers the newest provider information for all lines of business: Claims submission and issue resolution, utilization management, and quality improvement. We also cover	**Metric 2.1.1:** Maintain Provider Engagement

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
	VPHP's many providers self-service tools available through our website. We also touch on the latest guidance from DMAS and how that applies to Virginia Premier.	
Aim 4: Improved Population Health **Goal 4.1:** Improve Behavioral Health and Developmental Services of Members	*Implementation of the DMAS Enhanced Behavioral Health (EBH) Services* The BH department successfully led the implementation of nine new mandated services, which required inter- and cross departmental work to ensure all impacted systems were configured, providers were educated and contracted or credentialed to provide the services, and utilization/care coordination staff were fully trained on the new services. BH will continue to monitor the utilization trends for these new services and work with cost of care and programs to build reports to assess the impact of these services on member outcomes, ED utilization, and readmissions.	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness
Aim 4: Improved Population Health **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members	*Timeliness of Prenatal Care and Postpartum Care* Population Health Assessment work group was established 7/2022. NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care,	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
	preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population health assessment to be completed 7/2023.	

Appendix E. Assessment of Follow-Up on Prior Recommendations

DMAS Follow-Up on Prior Year Recommendations for the CCC Plus Program

Introduction

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that DMAS and the MCOs reported completing in response to HSAG's SFY 2020–2021 recommendations. Please note, content included in this section is presented verbatim as received from the MCOs and has not been edited or validated by HSAG.

Scoring

In accordance with CMS guidance, HSAG used a three-point rating system. The response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

1. DMAS or the MCO implemented new initiatives or revised current initiatives that were applicable to the recommendation.
2. Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, DMAS or the MCO identified barriers that were specific to the initiative.
3. DMAS or the MCO included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

1. DMAS or the MCO continued previous initiatives that were applicable to the recommendation.
2. Performance improvement was noted that may or may not be directly attributable to the initiative.
3. If performance did not improve, DMAS or the MCO identified barriers that may or may not be specific to the initiative.
4. DMAS or the MCO included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

1. DMAS or the MCO did not implement an initiative or the initiative was not applicable to the recommendation.
2. No performance improvement was noted *and* DMAS or the MCO did not identify barriers that were specific to the initiative.
3. DMAS or the MCO's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Table E-1—Prior Year Recommendations and Responses—Medallion 4.0 Program Overall

Recommendation		
Aim 4: Improve population health	**Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Objective:** Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits
HSAG Recommendation: 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.		
DMAS' Response		
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 included the PM *Well-Child Visits in the First 30 Months of Life* PM in its PWP which provides an incentive to MCOs to increase performance and close gaps.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:		

Recommendation

Metric: Child and Adolescent Well Care Visits
MY 2020: 46.57%
MY 2021: 50.27%%

Identify any barriers to implementing initiatives: None identified.

HSAG Assessment:

Recommendation

Aim 4: Improve Population Health	**Goal 4.4:** Improve Health for Members with Chronic Conditions **Objective:** Decrease Diabetes Poor Control **Objective:** Increase Control of High Blood Pressure	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

HSAG Recommendation: 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 Care for Chronic Conditions domain PMs' data to focus QI efforts on a disparate population.

DMAS' Response

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 included the PM *Comprehensive Diabetes Care HbA1c Poor Control (>9.0%)* PM in its PWP which provides an incentive to MCOs to increase performance and close gaps.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: Comprehensive Diabetes Care HbA1c Poor Control (>9.0%)
MY 2020: 50.30%
MY 2021: 47.45%

Metric: Controlling High Blood Pressure
MY 2020: 46.91%
MY 2021: 49.68%

Identify any barriers to implementing initiatives:

Recommendation
DMAS did not identify any barriers to implementing initiatives.
HSAG Assessment:

MCOs' Follow-Up on Prior Year Recommendations

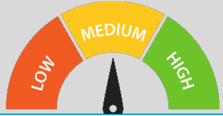
From the findings of each MCO's performance for the CY 2021 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 program. The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

Table E-2—Prior Year Recommendations and Responses—Aetna

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
Weakness: Aetna received *Low Confidence* for both PIPs. **Why the weakness exists:** For the *Ensuring Timeliness of PNC* PIP, although the SMART Aim goal was achieved, the MCO determined that it was likely not due to the interventions. For the *Tobacco Use Cessation in Pregnant Women* PIP, the SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that Aetna: • Focus on testing active and engaging interventions. • Ensure that interventions reach the maximum number of eligible members. • Provide additional SMART Aim measure data points in the resubmission.		
MCO's Response		
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): • Per HSAG's recommendation to focus on testing active and engaging interventions, Aetna Better Health of Virginia continued to test its active PPC and PNS interventions until intervention testing ceased on 6/1/2021 and 5/31/2021, respectively. • PPC Intervention #1 Testing: – Per HSAG's recommendation to ensure interventions reach the maximum number of eligible members, Aetna Better Health of Virginia continued to monitor intervention success and explore ways to identify additional members for intervention testing. In March 2021, the MCO identified a data error, which was escalated to informatics and leadership, which further		

Recommendation—Performance Improvement Projects
resulted in revising internal reporting of pregnant members. The revised reporting successfully identified the maximum number of eligible members for targeted intervention testing. – During intervention testing, Aetna Better Health of Virginia added an addition step to its PPC intervention #1 testing to follow up with members to verify receipt of educational material. – Per HSAG's recommendation to provide SMART Aim measure data points in the PIP resubmission, Aetna Better Health of Virginia updated its PPC run chart with corrected prenatal visit rate data and added the SMART Aim data points for the additional testing months in the 9/2021 resubmission. • PPC Intervention #2 Testing: – During intervention #2 testing for PPC, Aetna Better Health of Virginia continued to monitor intervention progress and explore additional ways to identify members for intervention testing. In March 2021, the MCO updated its reporting used to identify members to include correct diagnosis codes. Upon continued testing of new reporting, low denominators continued, resulting in the MCO choosing to discontinue the intervention. – Per HSAG's recommendation to provide SMART Aim measures data points in the PIP resubmission, Aetna Better Health of Virginia updated is PPC run chart for with corrected prenatal visit data and added the SMART Aim data points for the additional testing months in the 9/2021 resubmission. • PNS Intervention #1 Testing: – Per HSAG's recommendation to ensure interventions reach the maximum number of eligible members, Aetna Better Health of Virginia continued to monitor intervention success and explore ways to identify additional members for intervention testing. In March 2021, the MCO included additional diagnosis codes to identify additional members for intervention testing. – Per HSAG's recommendation to provide additional SMART Aim data points in the PIP resubmission, Aetna Better Health of Virginia updated its PNS run chart by adding the SMART Aim data points to reflect the additional testing months in the 9/2021 resubmission. • PNS Intervention #2 Testing: – Per HSAG's recommendation to ensure interventions reach the maximum number of eligible members, Aetna Better Health of Virginia continued to monitor intervention success and explore ways to identify additional members for intervention testing. In March 2021, the MCO updated its report methodology to include additional diagnosis codes and implemented new lookback period of six months prior to pregnancy to counterbalance claims lag. Unfortunately, neither action resulted in identifying additional members for intervention testing. – Per HSAG's recommendation to provide additional SMART Aim data points in the PIP resubmission, Aetna Better Health of Virginia updated its PNS run chart by adding the SMART Aim data points to reflect the additional testing months in the 9/2021 resubmission.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Prenatal and Postpartum Care: Timeliness of PNC 2020: 68.61% 2021: 85.64%
Identify any barriers to implementing initiatives: Barriers identified with implementing PPC PIP initiatives included:

Recommendation—Performance Improvement Projects
• Inaccurate data reports hindered the MCO's ability to identify all eligible members during initial stages of intervention testing • COVID significantly impacted the MCO's ability to implement initiatives during the PIP's early intervention testing stages • The Plan's inability to work out logistics of initial methodology for including educational materials in the ARTS welcome packet Barriers identified with implementing PNS PIP initiatives included: • Inaccurate or deficient data reports hindered the Plan's ability to identify all eligible members during initial stages of intervention testing. • COVID significantly impacted the Plan's ability to perform a concurrent provider intervention, which the MCO believes would have enhanced participant identification and metric rate success.
HSAG Assessment: 

Recommendation—PM Validation		
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	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care **Metric 4.6.3** Childhood Immunization Status: Increase Childhood Immunization Status (Combination 3)
Weakness: The following HEDIS MY 2020 PM rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna: • *Adults' Access to Preventive/Ambulatory Health Services—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—HbA1c Testing* and *Eye Exam (Retinal) Performed* • *Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **Why the weakness exists:** Although Aetna members may have adequate access to timely care and services, members are not completing timely visits, screenings, or recommended care for chronic		

Recommendation—PM Validation
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 focus study to determine why members are not consistently accessing and completing preventive screenings, childhood immunizations, and care and services for chronic conditions. HSAG recommends that Aetna analyze its data and consider if 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, HSAG recommends that Aetna implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members.
MCO's Response
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): • Per HSAG's recommendation Aetna Better Health of Virginia continues to develop new and monitor current initiatives and interventions. Specifically, the MCO conducted a health equities analysis to evaluate our membership population. The MCO also designated PM subject matter experts (SMEs) to complete deep dives into race, ethnicity, language, age group, and ZIP code for various PMs to drive initiatives. One initiative implemented as a result of the analysis, includes targeted outreach to members aged 18-21 years who were identified as non-compliant with preventative healthcare. The MCO also initiated the use of a social determinants of health (SDoH) software application to assist in identifying specific needs in each region and using *FindHelp* to assist members in finding resources for health care inequities.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Adults' Access to Preventive/Ambulatory Health Services 2020: 75.79% 2021: 73.49% **Metric:** Breast Cancer Screening 2020: 38.66% 2021: 48.95% **Metric:** Cervical Cancer Screening 2020: 45.74% 2021: 47.93% **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2020: 68.61% 2021: 85.64% **Metric 4.6.2:** Prenatal and Postpartum Care: Postpartum Care 2020: 61.31% 2021: 75.43%

Recommendation—PM Validation

Metric 4.6.2: Childhood Immunization Status Combination 3
2020: 59.61%
2021: 75.43%

Identify any barriers to implementing initiatives:
Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim N/A:	**Goal N/A:**	**Metric N/A:**

Weakness: The MCO did not ensure policies, procedures, processes, and delegated agreements and subcontracts contained current federal and DMAS contract requirements. Examples included:

- The MCO's network adequacy policies and analysis did not align with federal and Commonwealth requirements for all provider types.
- The MCO developed a Virginia Addendum, but it was not consistently applied to the subcontractor and delegated entity agreements.

Why the weakness exists: The MCO may not have updated its policies to include the current DMAS contract requirements or the requirements in the 2020 Medicaid Managed Care Rule.

Recommendation: The MCO must update its policies and analysis procedures to include all current federal and Commonwealth requirements for all provider types. The MCO must also update its subcontractor and delegated entity agreements to include the Virginia-specific requirements.

MCO's Response

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):

- Per HSAG's recommendation to update MCO policies and analysis procedures to include all current federal and Commonwealth requirements for all provider types, Aetna Better Health of Virginia updated its *Access to Care Plan* policy to ensure the appointment time frames for all provider types align with federal and Commonwealth requirements. The Plan will continue to review the policy annually to ensure the access requirements continue to reflect federal and state requirements.
- Per HSAG's recommendation to update MCO subcontractor and delegated entity agreements to include the Virginia-specific requirements, Aetna Better Health of Virginia developed a desktop to define the process for ensuring our Regulatory Compliance Addendum be included in all delegated entity agreements and available to all delegated providers. Additionally, the MCO updated the MCO's provider manual and website to include the most recent DMAS approved Regulatory Compliance Addendums. Additionally, Quality Management and Compliance conduct routine audits to assess compliance with delegated entity agreements containing current Regulatory Compliance Addendums. Audit results demonstrate 100 percent compliance with the recommendation.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Metric: Not applicable

Identify any barriers to implementing initiatives:
Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim N/A:	**Goal N/A:**	**Metric:** N/A

Weakness: The MCO did not consistently send grievance resolution letters to members.

Why the weakness exists: The MCO did not monitor that grievance resolution letters were consistently sent to members.

Recommendation: The MCO must implement a process and establish monitoring to ensure that grievance resolution letters are sent consistently to members.

MCO's Response

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):

- Per HSAG's recommendation to implement a process and establish monitoring to ensure that grievance resolution letters are consistently sent to members, Aetna Better Health of Virginia developed an internal job aid for the Grievance team that established a step-by-step instructions for documenting and processing a standard grievance. The MCO also conducted training on 12/31/2021 to educate staff about the importance of providing written grievance resolution notices timely and in an easy-to-understand format. The Grievance department conducts ongoing random audits to ensure staff compliance with training.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed: N/A
Metric: Not applicable.

Identify any barriers to implementing initiatives:
Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim N/A:	**Goal N/A:**	**Metric:** N/A

Weakness: The MCO did not consistently conduct a secondary review for coverage of services under the EPSDT benefit and notify the member that the secondary review was conducted. The MCO did not consistently inform members that although a service was carved out and therefore not

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

covered under the member's MCO, 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 did not have an implemented process that ensured a secondary review for EPSDT services that considered the EPSDT's correct or ameliorate criteria.

Recommendation: The MCO must implement a secondary review process for EPSDT services, include the reason for the denial of EPSDT services in its notice of action to the member, and inform the member that the denied service may be available through DMAS under the Medicaid State Plan.

MCO's Response

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):

- Per HSAG's recommendation to implement a secondary review process for EPSDT services, to include the denial reason of EPSDT services in the MCO's member notification and inform the member that the denied service may be available through DMAS under the Medicaid State Plan, Aetna Better Health of Virginia added the recommended language to our appeal backers under "Member Rights and Responsibilities." Additionally, during December 2021 and January 2022, the Plan educated the UM staff on the new process to insert a "secondary review was conducted" in our adverse determination letters along with the primary and secondary medical director name, as well as the physician's board certification. This training is also conducted with new hires. Auditing staff were also educated to ensure the verbiage is reflected in the letter as part of their auditing process.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed: N/A

Metric: Not applicable.

Identify any barriers to implementing initiatives:

Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

HSAG Assessment:

Recommendation—Encounter Data Validation

Aim N/A:	**Goal N/A:**	**Metric:** N/A

Weakness: Aetna did not meet the timeliness standard for institutional and pharmacy 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 seek to identify the root cause of any delays in submitting institutional and pharmacy encounters to rectify any issues.

MCO's Response

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—Encounter Data Validation

- Aetna Better Health of Virginia experienced a drop in timeliness due to an encounter system migration, which was fully resolved in February 2021. The MCO was performing required state testing against all file types. Timeliness misses were directly related to receiving approval of our test plans to move into production. DMAS was aware of these misses/holding of production files until the testing phase was complete. Since the migration, submission timeliness has been 99+ percent respectively for Institutional and Pharmacy form types.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Not applicable.

Identify any barriers to implementing initiatives:

Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey

Aim 1: Enhance Member Care Experience	**Goal 1.2:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care (CAHPS)

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.

MCO's Response

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):

- Per HSAG's recommendation to monitor the PMs to ensure significant decreases in scores over time do not occur, the MCO implemented a workplan to be proactive to focus on activities to address PMs. Specifically, the NCO merged its HEDIS and CAHPS workgroups to avoid duplicative efforts among departments. The MCO performed a barrier analysis to identify the issues or problems believed to cause the decrease in scores. Quality management then developed a workplan to address the identified issues or problems, explore the actions necessary to address the identified root issues, and included a series of two-week sprints for completing planned activities. Quality management also identified specific staff for attendance and participation in biweekly meetings to update the group on the progress of planned/completed activities.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care (CAHPS)

Recommendation—Member Experience of Care Survey
Adult 2021: 56.9% 2022: 53.6% *Child* 2021: 69.4% 2022: 66.9%
Identify any barriers to implementing initiatives: Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.
HSAG Assessment:

Recommendation—Member Experience of Care Survey		
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.2:** How Well Doctors Communicate (CAHPS)
Weakness: Aetna's top-box scores were statistically significantly lower than the 2020 top-box scores and NCQA child Medicaid national averages for two measures: *Getting Care Quickly* and *Customer Service*. **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 their child's ability to receive access to care or services in a timely manner. **Recommendation:** HSAG recommends that Aetna 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 Aetna continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.		
MCO's Response		
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): • Per HSAG's recommendation, Aetna Better Health of Virginia conducted a root cause analysis of study indicators identified as areas of low performance. Based on the identified root causes, the MCO implemented a workplan to actively focus on activities to address the issues. Quality management then developed a workplan to explore the actions necessary to address the identified root issues and included a series of two-week sprints for completing planned activities. Quality management also identified specific staff for attendance and participation in biweekly meetings to update the group on the progress of planned/completed activities.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** How Well Doctors Communicate (CAHPS) *Adult*		

Recommendation—Member Experience of Care Survey
2021: 93.8% 2022: 85.7% *Child* 2021: 94.1% 2022: 91.2%
Identify any barriers to implementing initiatives: Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.
HSAG Assessment:

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
Weakness: HealthKeepers received *Low Confidence* for both PIPs. **Why the weakness exists:** The MCO did not link improvement in the SMART Aim measure results to interventions that were tested for the PIP. **Recommendation:** HSAG recommends that HealthKeepers: • If an intervention is not having an impact, quickly make modifications and continually review the data to assess for improvement. • Provide additional SMART Aim measure data points in the resubmission.		
MCO's Response		
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 did not provide a description of initiatives implemented to address this recommendation.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Prenatal and Postpartum Care: Timeliness of Prenatal Care MY 2020: 68.61% MY 2021: 80.29%		
Identify any barriers to implementing initiatives:		

Recommendation—Performance Improvement Projects

The MCO did not provide a description of barriers identified related to implementing initiatives.

HSAG Assessment:

Recommendation—PM 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
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
	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

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: HealthKeepers' rates for several PM indicators in the Women's Health, Access to Care, and Care for Chronic Conditions domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentiles suggests a lack of access to care or understanding of recommended or needed care, or that a disparity may exist in access and availability of care. HealthKeepers' members with chronic conditions may have access to care; however, these members are not consistently receiving recommended screenings and care for chronic conditions. 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 to determine why members are not consistently receiving cancer screenings or recommended services

Recommendation—PM Validation
for comprehensive diabetes care and care and services for chronic conditions. HSAG recommends that HealthKeepers analyze its data and consider if 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, HSAG recommends that HealthKeepers implement appropriate evidence-based interventions to improve the receipt of recommended care and services that impact the health of its members and to reduce unnecessary ED use and inpatient utilization.
MCO's Response
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 Inc. conducted a Root Cause Analysis and identified the following barriers and implemented interventions for PMs that did not meet goal: **Barriers** • Providers only seeing patients if sick • Elective procedures temporarily postponed • Members were apprehensive to go to the doctor/emergency room for any kind of issue • Successfully contacting members is difficult • Many members tend to seek care only when they're sick • BH issues affecting care • Lack of staffing to reach out to members (case managers and care coordinators have large caseloads) • 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 **Interventions** • Partnering with Care Delivery Transformation Team, Provider Relations, and Marketing to identify and educate providers with low quality scores • HEDIS RNs attend Clinic Days to educate providers on HEDIS or educate remotely by WebEx or Microsoft Teams meetings • Continuous HEDIS training for case managers/care coordinators • CPT II code provider incentives • 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

Recommendation—PM Validation

- American Cancer Society (ACS) collaboration
- American Health Catalyst collaboration (advocacy group for oral health)
- Anthem Foundation/American Heart and Lung Association collaboration
- ImmunizeVA collaboration
- Implementing the standing order initiative for breast cancer screenings
- Continue to investigate mammogram bus opportunities
- Working BH fail lists
- BH homes
- Developing provider fax blasts that focus on accreditation measures
- Continue leveraging Collective Medical to notify care coordinators via email or text when member has an ED visit
- 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):
PMV results showed:
Metric: Adults' Access to Preventive/Ambulatory Health Services
MY 2020: 75.79%
MY 2021: 76.16%

Identify any barriers to implementing initiatives:
The MCO did not provide a description of barriers identified related to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

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 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.4.5:** Controlling High Blood Pressure

Weakness: The MCO's policies and procedures did not consistently contain all federal requirements related to adequate capacity and availability of services. The MCO also did not consistently monitor that its network included sufficient family planning providers to ensure timely access to covered

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations
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 may not have updated its policies to include the current DMAS contract requirements or the requirements in the 2020 Medicaid Managed Care Rule or monitor to ensure adequate capacity and availability of services. For example, although the MCO discussed a wide variety of provider types it considered to be family planning providers, policies, procedures, and network assessments did not include a definition or a process to ensure timely access. **Recommendation:** The MCO must update its policies and procedures and ensure that all DMAS contract requirements and the requirements contained in the 2020 Medicaid Managed Care Rule are addressed, including defining provider types designated as family planning providers, and implementing processes to ensure adequate capacity and availability of services.
MCO's Response
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, Inc. has updated the Practitioner Availability Monitoring and Analysis - VA policy. In addition to the policy, HealthKeepers, Inc. has reviewed our geo access report and added a cover page to the report that includes the date of the report. • HealthKeepers, Inc. has added a coversheet to our geo access report to define family planning providers as obstetricians/gynecologists, pediatricians, internal medicine providers, and family medicine providers. HealthKeepers, Inc. monitors access to these providers through its geo access report. • HealthKeepers, Inc. submits to DMAS a weekly enrollment broker file, and quarterly provider network file. These allow HealthKeepers, Inc. and DMAS to monitor that time and distance standards are being met and significant changes can be identified. On-going reporting continues to be submitted according to current DMAS requirements. Request for DMAS to add dates the reporting specifications for these reports was sent to DMAS 12/16/2021. Changes to the report specifications will depend on approval by DMAS to add a date as an element.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Adults' Access to Preventive/Ambulatory Health Services MY 2020: 75.79% MY 2021: 76.16% **Metric:** Child and Adolescent Well-Care Visits MY 2020: 43.39% MY 2021: 54.70% **Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2020: 45.50% MY 2021: 44.28% **Metric:** Controlling High Blood Pressure MY 2020: 50.85% MY 2021: 52.07%

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations
Identify any barriers to implementing initiatives: The MCO did not provide a description of barriers identified related to implementing initiatives.
HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 3: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

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 did not demonstrate that it had implemented a process to identify and assess the quality and appropriateness of care furnished to members with SHCN.

Recommendation: The MCO's QAPI program must include a process to assess the quality and appropriateness of care furnished to members with SHCN.

MCO's Response

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, Inc also ensures the delivery of quality, family centered care for children and youth with special health care needs (CYSHCN), who have been identified as having needs that are not typical of the general pediatric population. Examples of CYSHCN:
  - Children on Supplemental Security Income (SSI) (as identified from our reporting mechanism)
  - Children identified as early intervention (EI) per the state
  - Children with childhood obesity
  - Children with chronic or complex conditions (diabetes, asthma, cystic fibrosis [CF], sickle cell, cancers)
  - Children with disabilities (autism, cerebral palsy [CP], etc.)
  - Those with increased utilization of services above what would be expected for a child that age
  - Foster children
  - Those covered under adoption assistance
  - Children participating under the Health and Acute Care Program (HAP)
  - Members with special health care needs, including people with disabilities or chronic or complex medical and BH conditions and individuals participating under HAP and children and youth with special health care needs, who may need enhanced services to promote a better quality of life, are proactively identified.
- HealthKeepers, Inc has policies and procedures for identifying members, children and youth with special health care needs. The policy defines Anthem's Predictive Model of Case Management that uses lists of acuity rankings, claims, pharmacy, pre-authorization and other data to identify

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
new and existing children and youth with special needs. Based upon screening of this collective data, referrals are made to health plan case management units for further assessment by case management staff (RN, social worker, licensed mental health providers, and variable support staff) and/or social worker, HealthKeepers, Inc Predictive Model of Case Management uses lists of acuity rankings, claims, pharmacy, pre-authorization and other data to identify new and existing children and youth with special needs. Monthly data sweeps of the Transition file, EI file, SSI report, BH Services Authorizations Report, operational CYSHCN report are also done. • HealthKeepers, Inc makes every effort to conduct a comprehensive health assessment of all MSHCN, including CYSHCN, as identified and reported by the Virginia Department of Medical Assistance Services (DMAS) or identified through other means, within 60 calendar days of enrollment and yearly thereafter. After the initial assessment, HealthKeepers, Inc will assess Members with Special Health Care Needs (MSHCN) every year thereafter and aged and disabled members at least once every year. All CYSHCN shall be assessed pursuant to Section 8.6, except that foster care and adoption assistance children shall be assessed pursuant to the standards in the Virginia Medicaid and FAMIS Performance Measure Validation Technical Specifications and will be evaluated on a sixty (60) day timeframe.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Rating of All Health Care *Adult* MY 2021: 60.3% MY 2022: 53.8% *Child* MY 2021: 75.3% MY 2022: 74.4%		
Identify any barriers to implementing initiatives: The MCO did not provide a description of barriers identified related to implementing initiatives.		
HSAG Assessment:		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
Weakness: The MCO's appeal policy was not updated to include all requirements in the most current 2020 Medicaid Managed Care Rule such as the inclusion of all member rights. In addition, member grievance notices were not consistently in a format and language that was easily understood by the member or clearly stated the resolution so that it was easily understood by the member. **Why the weakness exists:** The MCO did not review or update all policies and procedures to ensure compliance with the 2020 Medicaid Managed Care Rule. As a result, not all member rights were included. In addition, the MCO did not describe an implemented process to ensure that member		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations
notices would be easily understood by the member and contained the information necessary for the member to understand any additional member rights. **Recommendation:** The MCO should develop a process to review or monitor grievance and appeal notifications to ensure that they are easily understood and include all requirements, including all member rights. The MCO should develop a process to ensure that internal processes align with the federal and Commonwealth requirements.
MCO's Response
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, Inc. updated the policies, procedures, and process to ensure all 2020 Medicaid Managed Care Rule and DMAS contract requirements were met. Member notices have been formatted with language easily understood by the members. The Grievance and Appeals team also perform quality assurance reviews of all resolution letters.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Rating of All Health Care *Adult* MY 2021: 60.3% MY 2022: 53.8% *Child* MY 2021: 75.3% MY 2022: 74.4%
Identify any barriers to implementing initiatives: The MCO did not provide a description of barriers identified related to implementing initiatives.
HSAG Assessment:

Recommendation—Encounter Data Validation		
Aim 3: Smarter Spending	**Goal 3.2:** Focus on Efficient Use of Program Funds	**Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total
Weakness: HealthKeepers did not meet the validity criteria 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 HealthKeepers: Incorporate additional logic and referential checks to assess the validity of data elements.		

Recommendation—Encounter Data Validation

MCO's Response

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, Inc. will heed to the recommendations of HSAG and will incorporate additional logic and referential checks to assess the validity of data elements.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Not reported

Identify any barriers to implementing initiatives:

The MCO did not provide a description of barriers identified related to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey - Adult

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly

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.

MCO's Response

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, Inc will continue to monitor measures to ensure significant decreases in scores over time do not occur.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Getting Care Quickly

Adult

MY 2021: 81.6%

MY 2022: 84.4%

Child

MY 2021: 84.8%

MY 2022: 84.0%

Identify any barriers to implementing initiatives:

Recommendation—Member Experience of Care Survey - Adult
The MCO did not provide a description of barriers identified related to implementing initiatives.
HSAG Assessment:

Recommendation—Member Experience of Care Survey - Child		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.1:** Getting Care Quickly

Weakness: HealthKeepers' 2021 top-box scores were statistically significantly lower than the 2020 NQCA child Medicaid national averages for two measures: *Getting Care Quickly* 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 HealthKeepers, 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 HealthKeepers 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 HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

MCO's Response

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, Inc conducted a root cause analysis, completed an analyses of complaint data and identified the following barriers:
  - Access to PCP's 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.
- As a result of the analysis, the following interventions were implemented
  - Added availability of provider telehealth to online physician directories.
  - Member website has information on getting care that is easy to find, including Quick Start Guide.
  - 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.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:

Recommendation—Member Experience of Care Survey - Child
Metric: Getting Care Quickly *Adult* MY 2021: 81.6% MY 2022: 84.4% *Child* MY 2021: 84.8% MY 2022: 84.0%
Identify any barriers to implementing initiatives: The MCO did not provide a description of barriers identified related to implementing initiatives.
HSAG Assessment:

Molina

Table E-4—Prior Year Recommendations and Responses—Molina

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
Weakness: The *Timeliness of Prenatal Care* PIP received *Low Confidence*. **Why the weakness exists:** The SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that Molina: • Identify eligible members for the intervention using a method other than claims to avoid claims lag. • Obtain up-to-date member contact information. • Test more than one intervention per PIP.		
MCO's Response		
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): • Review enrollment and pregnancy files monthly for identification of outreach and provide to clinical outreach staff for outreach to providers. • Create a list of eligible members identified with pregnancy diagnose to compare to the list provided by the care managers, • Review and compare member details to ensure the most up to date information • Care managers and quality specialist conduct outreach calls to inform of the incentive program, provide support, inform of resource, assist with scheduling needs, verify member contact information		

Recommendation—Performance Improvement Projects

- Review monthly outcomes of data to assess missed appointments or identify needs

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care
MY 2020: 77.62%
MY 2021: 65.21%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—PM Validation

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

Weakness: Molina did not improve the score for the *Reduce Tobacco Use in Pregnant Women* PIP with the resubmission.

Why the weakness exists: The MCO provided an explanation regarding members for the intervention; however, it did not explain the reduction in the SMART Aim eligible population. The SMART Aim PM should be calculated in alignment with the rolling 12-month methodology.

Recommendation: HSAG recommends that Molina ensure understanding of the PIP methodology and data reporting requirements.

MCO's Response

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):

- Molina care coordination upon identification of a pregnant members who smokes, will conduct outreach calls to inform and enroll the mom to be in the Tobacco Cessation Incentive program.
- Member will receive frequent check ins to assess how well things are progressing and address any identified barriers.
- Member will be rewarded after successfully completing the program

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care
MY 2020: 77.62%
MY 2021: 65.21%

Identify any barriers to implementing initiatives:

Recommendation—PM Validation
The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Recommendation—PM Validation		
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 **Goal 4.4:** Improve Health for Members with Chronic Conditions **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.3:** Follow-Up Care for Children Prescribed ADHD Medication **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Childhood Immunization Status—Combination 3*

Recommendation—PM Validation

- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Several of Molina's PM rates in the Children's Preventive Health, Women's Health, Access to Care, Care for Chronic Conditions, and BH domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to preventive care, screenings, care for chronic conditions, and behavioral healthcare. Molina'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. Molina's members may need the tools 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 Molina conduct a root cause analysis or focus groups to identify the reasons why members are not accessing well care, preventive care, behavioral healthcare, and care for chronic conditions. HSAG recommends that Molina analyze its data and results of any root cause analysis or focus groups to identify opportunities to reduce any disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of root causes, HSAG recommends that Molina implement appropriate evidence-based interventions to improve the performance related to these low-scoring healthcare domains.

MCO's Response

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):

- Provider partnership and meetings to identify and target member with open gaps.
- Identification of member attribution barriers, to help members get properly aligned with PCP care
- Timely distribution and meetings with of provider scorecards to include monthly strategy
- Increase member awareness of importance of wellness and preventative care through member outreach activities, community events, mobile and pop-up clinics throughout each region of Virginia.
- A1C Champions program to enroll members identified based on HEDIS gaps for poor control and/or control to enroll in the program to help monitor, provider resources and support. Upon completion member receives a certificate.
- Prenatal and postpartum care and smoking cessation in pregnant women incentive to reward for meeting scheduled appointments.
- Target small events based on zip codes for Clinic Days, while working with providers to target members with gaps in care

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Recommendation—PM Validation
PMV results showed: **Metric:** Follow-Up After Hospitalization for Mental Illness *7-Day* MY 2020: 42.74% MY 2021: 42.57% *30-Day* MY 2020: 64.92% MY 2021: 63.58% **Metric:** Follow-Up Care for Children Prescribed ADHD Medication *7-Day* MY 2020: 44.63% MY 2021: 42.57% *30-Day* MY 2020: 57.99% MY 2021: 63.58% **Metric:** Adults' Access to Preventive/Ambulatory Health Services MY 2020: 75.60% MY 2021: 59.60% **Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2020: 47.69% MY 2021: 61.56% **Metric:** Childhood Immunization Status MY 2020: 70.32% MY 2021: 56.93% **Metric:** Prenatal and Postpartum Care: Timeliness of Prenatal Care MY 2020: 77.62% MY 2021: 65.21% **Metric:** Prenatal and Postpartum Care: Postpartum Care MY 2020: 70.32% MY 2021: 61.31%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Weakness: 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 verify that the required machine-readable formulary and provider directory requirements were met.

Recommendation: The MCO must include a machine-readable file and format formulary on the MCO's website.

MCO's Response

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):

- Molina has collaborated with the internal marketing and communication teams to identify barriers to ensuring information on the website is in the proper format and is readable
- Testing prior to go live to identify areas of concerns and opportunities when updating the website to ensure guidelines are met and validate all information is in a machine-readable format.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

MY 2021: 48.0%

MY 2022: 56.6%

Child

MY 2021: 70.3%

MY 2022: 68.1%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

Weakness: The MCO did not ensure that members had access to the required number of providers in each category as outlined in the contract. The MCO did not ensure the network included sufficient family planning providers to ensure timely access to these services. The MCO also did not monitor its network for adequate capacity to serve its members or ensure that there were enough providers in each region, depending upon its rural versus urban designation, during the time period under review.

Why the weakness exists: The MCO did not have an implemented process to assess its network to ensure DMAS contract requirements were met or to ensure network sufficiency to ensure members had timely access to services.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Recommendation: The MCO must implement a process to assess, monitor, and demonstrate that its network includes the required number of providers in each category in its contract and sufficient providers to ensure timely access to covered services in each provider category, region, rural and urban.

MCO's Response

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):

- Molina use data across Virginia to evaluate and identify high value providers within each region to optimize for network planning
- Molina is working to negotiate better contracts and rates, including provider performance and outcomes.
- Provider network team has been in the field working to support and help providers with concerns and barriers to build a better relationship and grow the network.
- Identify contracting gaps vs standards across the markets and regions; developing dashboards that drive alignment on network improvement

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

MY 2021: 48.0%

MY 2022: 56.6%

Child

MY 2021: 70.3%

MY 2022: 68.1%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan

Weakness: A review of denial case files, grievances, and appeals identified that the MCO did not consistently meet the time frame to mail the notice of adverse benefit determination to the member. The MCO's adverse benefit determination, grievance, and appeal notices did not consistently include all federal and DMAS contract requirements or member rights.

Why the weakness exists: The MCO did not have an implemented process to monitor or review member adverse benefit determination, grievance, or appeal resolution notices to ensure that all required member rights were included.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Recommendation: The MCO must develop a process to ensure that the grievance resolution notice to the member includes the reason for the decision and a clear explanation of any further rights available to the member.

MCO's Response

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):

- Molina will use monthly reports to track and monitor the life cycle of member's adverse benefit determination.
- Molina will review prior to sending mailing to ensure all guidelines and requirements are met.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Enrollees' Ratings Rating of Health Plan

Adult

MY 2021: 62.1%

MY 2022: 60.1%

Child

MY 2021: 68.2%

MY 2022: 67.3%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim	Goal	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 **Goal 4.6:** Improve Outcomes for Maternal and Infant Members	**Metric 4.1.3:** Follow-Up Care for Children Prescribed ADHD Medication **Metric 4.3.4:** Child and Adolescent Well-Care Visits **Metric 4.6.3:** Childhood Immunization Status

Weakness: The MCO did not ensure members eligible for EPSDT services obtained all the care and services they needed, including medical and BH needs and community-based resources.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations
Why the weakness exists: The MCO did not have a documented or implemented process to identify the needs of EPSDT age members, or how they ensured that needed care, including medical and BH services, and community-based resources were provided to its members. **Recommendation:** The MCO must implement a process to conduct follow-up to verify timely and appropriate treatment is received for medical and BH needs, including necessary referrals, prior authorizations, and case management for members eligible for EPSDT services.
MCO's Response
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): • Monthly track and monitor of member's identified as eligible for EPSDT services to provide a target list to the assigned provider for scheduling. • Weekly review of services requiring prior auth to ensure services was rendered timely • Telephonic outreach to follow up to ensure timely treatment, assist with appointment scheduling, identification of resources • Collaborate with care coordinators to ensure members are receiving services, identification of missed services.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase MY 2020: 44.63% MY 2021: 26.29% Continuation and Maintenance Phase MY 2020: 57.99% MY 2021: 39.62% **Metric:** Child and Adolescent Well-Care Visits MY 2020: 51.62% MY 2021: 36.60% **Metric:** Childhood Immunization Status MY 2020: 70.32% MY 2021: 56.93%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Recommendation—Encounter Data Validation		
Aim 3: Smarter Spending	**Goal 3.2:** Focus on Efficient Use of Program Funds	**Metric 3.2.3:** Monitor MLR annually by managed care program and aggregate total

Weakness: The IS review revealed Molina could improve its internal monitoring tools for assessing quality and timeliness of encounter data. In addition, Molina had low header TPL paid amounts PMPM for institutional encounters compared to other MCOs.

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 weakness in header TPL paid amounts, the IS review and administrative profile analysis did not identify the specific root cause of the weakness.

Recommendation: HSAG recommends Molina:

- 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.
- Identify the root cause of missing header TPL paid amounts in its institutional encounters to rectify any issues.

MCO's Response

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):

- Work with the Molina data team to enhance the applications for quality and encounter data to be more effective.
- Identify areas of concern with quality data and claims, to mitigate risk and ensure timely claims processing of claims, which will provide timely action for quality engagement and activities
- Create meaning logic to validate data
- Data mining to assess it accuracy

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Monitor MLR annually by managed care program and aggregate total

MY 2020: Not reported

MY 2021: Not reported

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

Recommendation—Member Experience of Care Survey

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

Why the weakness exists: Based on the survey results, adult members have a lower level of satisfaction with their provision in healthcare overall, which may be associated with their perception of their ability to receive care or services.

Recommendation: HSAG recommends that Molina conduct a root cause analysis of the study indicator 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 Molina continue to monitor the measures to ensure significant decreases in scores over time do not occur.

MCO's Response

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):

- Molina is participating in more community engagement to increase awareness of services and benefits to our members
- Molina conducts member outreach to check in and provide assistance with member needs, to ensure coordination of care and access to care, build health plan awareness.
- Molina to send out mailers to inform members of where to go for care, numbers to call, resources available and provide support in between office visits.
- Molina with working with providers to team up and partner to better support member needs.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

MY 2021: 48.0%

MY 2022: 56.6%

Child

MY 2021: 70.3%

MY 2022: 68.1%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan

Weakness: Molina's 2021 top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for one measure, *Customer Service*.

Recommendation—Member Experience of Care Survey
Why the weakness exists: Based on the survey results, parents/caretakers of child members have a lower level of satisfaction with Molina overall, which may be associated with their perception of their child's ability to receive care or services from customer service. **Recommendation:** HSAG recommends that Molina 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 Molina continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.
MCO's Response
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): • Molina conducts customer service training and refreshers for all member interaction roles • Care coordinators and staff conducting outreach are working to ensure each contact with a member has a pleasant experience and the message conveyed is to support their needs. • Member mailings to convey there are resources available and where to obtain those service.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Enrollees' Ratings Rating of Health Plan *Adult* MY 2021: 62.1% MY 2022: 60.1% *Child* MY 2021: 68.2% MY 2022: 67.3%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Optima

Table E-5—Prior Year Recommendations and Responses—Optima

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

Recommendation—Performance Improvement Projects

Weakness: Optima received *Low Confidence* for the *Tobacco Use Cessation in Pregnant Women* PIP.

Why the weakness exists: The SMART Aim goal was not achieved.

Recommendation: HSAG recommends that Optima:

- Have a live person make telephone calls to members.
- Test more than one intervention per PIP.

MCO's Response

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's Partner's in Pregnancy (PIP) Team makes outreach via voice telephone live contact to all pregnant members. These members are assessed for tobacco use. Pregnant smoking members are educated through engagement with case management, Optima's Health and Prevention Team, and education about tobacco cessation is offered via WebMD.
- Ovia is a new digital health engagement solutions platform for pregnant members launching 1/1/2023. This digital platform may appeal to members more than traditional case management outreach methods due to ease of usage and convenience to access information from members' smartphone electronic device. The platform provides an innovative solution to improving outcomes by supporting daily personalized engagement while proactively identifying potential health risks.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: The number of pregnant members with a smoking Dx code within city of Norfolk (month to month Rolling methodology)

2020: 10.75%

2021: 10.65%

Metric: Prenatal and Postpartum Care: Timeliness of Prenatal Care

2020: 60.58%

2021: 69.59%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to Implementing initiatives.

HSAG Assessment:

Recommendation—PM 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

Recommendation—PM Validation		
		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: HbA1c Poor Control (>9.0%)
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** Childhood Immunization Status **Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life

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

- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Optima's performance on several PM rates in the Children's Preventive Care, Women's Health, Access to Care, and Care for Chronic Conditions domains falling below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile suggests a lack of access to preventive care, women's health, and care for chronic conditions. Optima's members are not consistently scheduling well-care visits or receiving childhood immunizations according to the recommended schedules. Chronic care PM results indicate that members may not be following up on 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 Optima conduct a root cause analysis or focus groups to determine why children are not receiving immunizations according to recommended schedules. HSAG recommends Optima conduct a focus study to determine why women are not receiving timely prenatal and postpartum care. HSAG also recommends that Optima conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions. HSAG recommends that Optima consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that Optima implement appropriate interventions to improve access to and timeliness of preventive visits, screenings, and recommended services for members diagnosed with a chronic condition.

MCO's Response

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—PM Validation

Adults' Access to Preventive/Ambulatory Health Services—Total

Initiatives:

- Case management engagement with members to assist in managing care, making appointments, and scheduling transportation
- Birthday cards mailing that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health
- Provider enablement provides data to VBC providers regarding preventative PMs and discuss their performance/progress towards the goals
- Network Management
  - Includes appointment availability standards in quarterly newsletters as a standing item
  - Reviews standards and after-hours requirements with Providers during quarterly webinars
  - Review standards during individual provider meetings with network educators
- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023

Cervical Cancer Screening

Initiatives:

- Screening reminders sent to women 21 and older who have not had a cervical cancer screening in the previous 12 months receive a postcard during their birthday month
- Letter is sent to providers of members with cervical care gap
- Clinical guidelines reviewed and providers are notified of updated clinical guidelines via newsletter and provider site
- Articles in the member newsletters
- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023

Childhood Immunization Status—Combination 3

Initiatives:

- Childhood Immunization Incentive Program
- EMMI Well-Child and Immunizations IVR campaign
- EMMI Manager utilization for educational videos
- Prealize data utilized to identify members to refer to case management (CM)
- CM utilization of Tableau care gap report when engaging members
- CM documentation of care gap information received from members

Recommendation—PM Validation
• FTE for EPSDT gap closures • Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted • Barriers assessed with clinical team; transportation continues to be a major barrier for this population; collaborating with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need • Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023. • Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023 ***Comprehensive Diabetes Care—HbA1c Testing*****,** ***HbA1c Poor Control (>9.0%)*****,** ***HbA1c Control (<8.0%)*****, and** ***Eye Exam (Retinal) Performed*** Initiatives: • Diabetic eye exam incentive program • EMMI Manager utilization for educational videos • Prealize data utilized to identify members to refer to case management • CM utilization of Tableau care gap report when engaging members • CM documentation of care gap information received from members in Symphony/JIVA • Pop Care Diabetic Eye Exam campaign • BioIQ at-home A1c program • Focus Care In-Home A1c testing and DEE • HEDIS 4th quarter push case manager member outreach • Diabetic eye exam article for member newsletter • Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted • Collaboration with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need • Retina Labs: Clinic-based and in-home tele-retinal screening solution for early detection of diabetic retinopathy in diabetic members. This will help close critical diabetes care gaps and improve health outcomes for members. Implementation target of fourth quarter 2022 • Dario: The Dario Pilot covers 1,500 Optima Health Plan Medallion 4.0 and CCC Plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members

Recommendation—PM Validation

• Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023
 	
Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care
Initiatives:
• Prenatal Visit Incentive Program
• Postpartum Visit Incentive Program
• Healthy Pregnancy mailing, self-care guide and parenting magazine subscription
• Healthy Pregnancy mailing at 20 weeks gestation, dealing with stress while pregnant, and a preterm labor card
• Healthy Pregnancy mailing at 7 months including a letter, dealing with stress flyer, and early labor signs card
• Healthy Pregnancy mailing at 38 weeks gestation, dealing with postpartum depression, and an immunization with checkups magnet
• Baby Showers
• Member outreach calls
• EMMI Manager utilization for educational videos
• Prealize data utilized to identify members to refer to case management
• Case management utilization of Tableau care gap report when engaging members
• Case management documentation of care gap information received from members
• Referral to Optima's Partners in Pregnancy Program
• Referral to Children’s Health Information Program (CHIP)
• Referral to Urban Baby Beginnings
• Text for Baby Program through March of Dimes
• PIP case management referral form
• Conducted a data analysis of care gaps by region to determine if any possible trends in barriers existed, no trends were noted
• Barriers assessed with clinical team, childcare and transportation continue to be major barriers for this population; collaborating with the Sentara Cares Mobile Health Services van to provide convenient access to care to areas in need
• Ovia Health, on demand virtual prenatal and post-partum care, implemented 9/2022
  – Ovia’s robust digital solution provides support to female members 13 plus years and male members 18 plus years through three different programs – Ovia Fertility, Ovia Pregnancy and Ovia Parenting
  – The digital app provides increased access to care with Ovia coaches available 365 days per year, from 9 am to 9 pm eastern standard time

Recommendation—PM Validation

- Support includes coaching and education, and member engagement begins with an intake questionnaire to ensure appropriate material is pushed to the member based on their unique concerns
- Members are also asked about their mental health so any red flags noted can be immediately escalated to a health coach for appropriate intervention
- The Ovia app is open to each member's support network, adding another layer of coverage to help ensure the member obtains all the timely prenatal and postpartum care required and the most positive birth outcome possible

- Population Health Assessment work group established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to: SDoH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment to be completed 7/2023

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Eye Exam (Retinal) Performed

HbA1cTesting:

2020: 80.78%

2021: 85.4%

HbA1c Poor Control:

2020: 59.37%

2021: 52.8%

HbA1c Control:

2020: 35.28%

2021: 39.42%

Eye Exam (Retinal) Performed:

2020: 38.44%

2021: 43.55%

Metric: Adults' Access to Preventive/Ambulatory Health Services

2020: 72.95%

2021: 71.75%

Metric: Child and Adolescent Well-Care Visits

2020: 44.49%

2021: 48.35%

Metric: Well-Child Visits in the First 30 Months of Life

Well-Child Visits in the First 15 Months-Six or More Well-Child Visits:

2020: 58.47%

2021: 65.49%

Metric: Well-Child Visits in the First 30 Months of Life

Well-Child Visits in the Age 15 Months-30 Months - Six or More Well-Child Visits:

2020: 71.45%

Recommendation—PM Validation
2021: 66.90% **Metric:** Childhood Immunization Status 2020: 64.23% 2021: 62.77%
Identify any barriers to implementing initiatives: ***Adults' Access to Preventive/Ambulatory Health Services—Total*** • Decrease outpatient ambulatory or preventive care visits due to COVID-19 PHE • Lack of appointment availability in outpatient settings • Poor communication between member and provider regarding need for preventive care ***Cervical Cancer Screening*** • The coronavirus PHE impact on health plan business operations, including its potential effect on medical record data collection due to imposed travel bans, limited access to provider offices, quarantines, and risk to staff. • To decrease the risk of transmitting the virus to either patients or health care workers within healthcare practices, providers deferred elective and preventive visits, such as annual physicals. • Lack of awareness that the Affordable Care Act (ACA) has eliminated out of pocket expenses for women's preventive services such as mammograms, screenings for cervical cancer, and other services. • Logistical barriers like childcare, transportation problems, and taking time off from work are still having implications for women accessing preventive health care services. • Emotional barriers (fear, embarrassment, and anticipated shame) and low perceived risk might contribute to explaining lower cervical screening coverage for some ethnic groups. • Lack of awareness regarding recommended screening intervals for HPV vaccine recipients and non-recipients. • Cultural and psychosocial barriers regarding the screening procedure. ***Childhood Immunization Status—Combination 3*** • Decrease visits to pediatricians due to COVID-19 PHE • Lack of childcare for parents, children not allowed in waiting areas due to COVID-19 • 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

Recommendation—PM Validation

Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed

- Decreased visits to PCP or specialist due to COVID-19 PHE
- Language/communication barrier between members and providers
- Member unaware of benefits offered by MMCO
- Lack of awareness of importance of dilated eye exams
- Member unaware of symptoms related to diabetic disease
- Member unable to attend provider appointments due to transportation challenges
- Member experiencing socioeconomic hardships/cultural issues
- Member dissatisfied with level of care received
- Lack of communication between member and provider
- Providers not incorporating preventive care guidelines in each visit
- Providers unaware of noncompliant members with healthcare gaps/dismissive of gap in care letters sent from the MCO
- Member experiencing difficulty obtaining needed provider appointments
- Language/cultural barriers

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

- To decrease the risk of transmitting COVID-19 to either patients or health care workers within healthcare practices, providers deferred elective and preventive visits, such as annual physicals
- Implementation of telehealth visits and expanded telehealth codes not being captured for prenatal and postpartum visits
- Lack of awareness and knowledge of available preventive and maternal care services under the Affordable Care Act
- Social, cultural, and economic barriers persist despite implementation of the health care reform
- Untimely identification of the pregnancy and lack of understanding of the importance of prenatal and postpartum care
- Logistical barriers such as inaccessible transportation, long waits during appointments, and lack of childcare further limit the likelihood of a postpartum visit
- Rural members living far away from care facilities
- Member confusion as to when to schedule prenatal and/or postpartum visit
- Coding discrepancies with the bundled coding in Inovalon not capturing all prenatal visits

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 1: Enhance Member Care Experience	**Goal 1.3:** Improve Member Satisfaction	**Metric 1.3.2:** Rating of All Health Care
Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.1.2:** How Well Doctors Communicate
Weakness: The MCO did not have a machine-readable provider directory file/link on the MCO website that functioned appropriately. **Why the weakness exists:** Although it appeared that the MCO had a machine-readable provider directory on its website, the MCO had not tested it to ensure that it functioned appropriately. **Recommendation:** The MCO must work with its vendor to ensure that the machine-readable provider directory file/link on the MCO website functions appropriately.		
MCO's Response		
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 machine-readable link functionality has been resolved. It is located at the footer of the online directory page and takes the user to the landing page, which is a text file. • The Provider Directory Policy NM024 was updated for the current accuracy and accessibility oversight process of the provider file. • Optima Health monitors the machine-readable link monthly to ensure the link is working as expected. Any disruption to link access would be escalated to the vendor for resolution.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Rating of All Health Care *Adult* MY 2021: 53.2% MY 2022: 64.3% *Child* MY 2021: 81.8% MY 2022: 70.8% **Metric:** How Well Doctors Communicate *Adult* MY 2021: 93.7% MY 2022: 93.1% *Child* MY 2021: 97.1% MY 2022: 95.9%		
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.3:** Improve Member Satisfaction	**Metric 1.3.2:** Rating of All Health Care

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.

Why the weakness exists: The MCO did not include all required provider types or ratios in its policies or procedures or describe a process to assess the network against the contract travel time and distance standards.

Recommendation: The MCO must update its policy and include all of the required provider types and describe the number of providers the MCO must offer to members. The MCO must update its policies to ensure that all time and distance requirements are documented correctly. The MCO must implement a process to measure and assess the network adequacy for all PCPs and specialists against the travel time and distance standards required in the DMAS contract.

MCO's Response

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):

- Policy NM006 Network Adequacy was updated to reflect the provider types available to members. Optima Health follows the quantitative network adequacy standards as required by the DMAS contract.
- Network adequacy is assessed and submitted to DMAS on a daily, monthly, and quarterly basis as required by DMAS. Any time a significant change impacts Optima Health's service area or other operations, DMAS is notified.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

MY 2021: 53.2%

MY 2022: 64.3%

Child

MY 2021: 81.8%

MY 2022: 70.8%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care

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

Why the weakness exists: The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements were all reviewed or updated to include all current DMAS contract requirements.

Recommendation: The MCO must update its Medicaid Addendum to include the DMAS Medallion 4.0 contract requirements. The MCO must consistently include the Medicaid Addendum with subcontractor and delegated entity agreements.

MCO's Response

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 Medicaid Addendum document was updated to include all contractually required language.
- Program Administration is included in the review of all contracts to ensure the Medicaid Addendum is included prior to submission to DMAS for review and approval.
- Program Administration completes the MCO Subcontractor Agreement Checklist for all subcontracts submitted to DMAS.
- The Vendor Management Office is updating all existing subcontracts with the most current version of the Medicaid Addendum.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Getting Needed Care

Adult

MY 2021: 85.2%

MY 2022: 78.4%

Child

MY 2021: 89.0%

MY 2022: 84.4%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
HSAG Assessment: 		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care
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 was 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 did not have an implemented process to ensure that denial notices for EPSDT-age members completed a secondary review for EPST requirements and, if denied, ensured that the denial notice included information on how the services may be available through DMAS. **Recommendation:** The MCO must send a denial notice to the member upon denial of a secondary review for EPSDT requirements. Any such denial (non-covered, out-of-network, and/or experimental) must also state that EPSDT criteria were reviewed and the reason the requested service did not fit the criteria. Additionally, the MCO must inform members that, although a service is not covered under the member's managed care health plan, it may be available through DMAS under the Medicaid State Plan, and the appropriate contact information must be provided for the member to inquire with DMAS.		
MCO's Response		
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): • Language was created and EPSDT letter was sent to DMAS for approval. • Updated letter was sent to AIM Specialty Health. AIM team was educated on how and when to use this letter. • Alternative services are listed in the letter. The language used may include, but is not limited to, refer to your MD for other treatment options, discuss plan of care with your care coordinator.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Getting Needed Care *Adult* MY 2021: 85.2% MY 2022: 78.4% *Child* MY 2021: 89.0% MY 2022: 84.4%		
Identify any barriers to implementing initiatives:		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Encounter Data Validation

Aim 4: Improved Population Health	**Goal 4.1:** Improve Follow-Up After Hospitalization for Mental Illness **Goal 4.2:** Improve Outcomes for members with Substance Use Disorders **Goal 4.3:** Improve Utilization of Wellness, Screening, and Prevention Services for Members **Goal 4.4:** Improve Health for member with Chronic Conditions **Goal 4.5:** Improve outcomes for Nursing Home Eligible Members **Goal 4.6**: Improve Outcomes for Maternal and Infant Members	**Metric 4.1.1:** Follow-Up After Hospitalization for Mental Illness **Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

Weakness: The IS review revealed Optima could improve its internal monitoring tools for assessing quality and timeliness of encounter data.

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.

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.

MCO's Response

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 leverages a suite of tools / processes to ensure continued monitoring of both quality and timeliness of encounter data resulting from claims processing, of which general monitoring of acceptance rates is a single component. These include, but are not limited to:

- Automated schedules for encounter file generation, review, and submission to DMAS (weekly cadence), with system notifications communicating to key encounters and information technology stakeholders the completion/failure during key steps of the process.

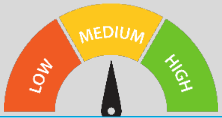
Recommendation—Encounter Data Validation
• System-managed automated review of generated files out of Optima's primary claims adjudication system (CSC), which applies a variety of conditional logic and data completeness steps to identify and quarantine for correction those records that could potentially create an error when submitted to DMAS.   – Ongoing active review of current automated review (above) conditions to keep updated as DMAS updates requirements for encounters submissions. • Assigned encounters analysts for Medicaid encounter submissions, who maintain active and current knowledge of DMAS encounters submissions standards. In additional to the ongoing responsibility for encounters submissions and overall accuracy and acceptance of records submitted, these individuals also act as subject matter experts (SMEs) for DMAS encounters requirements, engaging with DMAS encounters, internal departmental stakeholders, and external vendor partners to further ongoing improvements and system enhancements towards general quality and timeliness goals. • The table is representative of an example of internal tracking of encounters submissions / acceptance, providing comparison across not just different submission types, but also YTD comparison and trend analysis. Any monthly / quarterly / YTD indications (color codes) that imply an issue are investigated, remediated, and reported to claims and operational leadership on a monthly basis.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Follow-Up After Hospitalization for Mental Illness *7-Day* MY 2020: 41.05% MY 2021: 40.08% *30-Day* MY 2020: 64.77% MY 2021: 62.44% **Metric:** Follow-Up After ED Visit for AOD Abuse or Dependence *7-Day* MY 2020: 41.05% MY 2021: 16.79% *30-Day* MY 2020: 64.77% MY 2021: 25.19% **Metric:** Adults' Access to Preventive/Ambulatory Health Services MY 2020: 72.95% MY 2021: 71.75% **Metric:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2020: 59.37% MY 2021: 52.80% **Metric:** Prenatal and Postpartum Care: Timeliness of Prenatal Care MY 2020: 74.45%

Recommendation—Encounter Data Validation

MY 2021: 69.59%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:



Recommendation—Member Experience of Care Survey—Adult

Aim 1: Enhanced Member Care Experience **Aim 2:** Effective Patient Care	**Goal 1.2:** Improve Member Satisfaction **Goal 2.1:** Enhance Provider Support	**Metric 1.2.3:** Rating of All Health Care **Metric 2.1.1:** Rating of Personal Doctor

Weakness: Optima's top-box score was statistically significantly lower than the 2020 NCQA adult Medicaid national average for one measure, *Customer Service*. In addition, Optima's 2021 top-box scores were statistically significantly lower than the 2020 top-box scores for four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Customer Service*.

Why the weakness exists: Based on the survey results, adult 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 from their personal doctors and customer service.

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

MCO's Response

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):

- CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance
- CAHPS mid-year reminder to review customer service and the importance of the member experience
- Customer service post-survey member calls to drive continuous improvement opportunities
- Member outreach calls to assist members in navigating their healthcare needs
- Care coordination assistance with patient/provider appointment scheduling and transportation

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: Rating of Health Plan
Adult
2021: 59.5%

Recommendation—Member Experience of Care Survey—Adult
2022: 64.3% *Child* 2021: 80.3% 2022: 71.3% **Metric:** Rating of All Health Care *Adult* 2021: 53.2% 2022: 64.3% *Child* 2021: 81.8% 2022: 70.8% **Metric:** Rating of Personal Doctor *Adult* 2021: 63.5% 2022: 67.7% *Child* 2021: 83.6% 2022: 77.9% **Metric:** Customer Service *Adult* 2021: 73.5% 2022: 85.3% *Child* 2021: 93.5% 2022: 89.2%
Identify any barriers to implementing initiatives: The COVID-19 PHE caused significant disruption throughout most of 2020 and continuing through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years.
HSAG Assessment:

Recommendation—Member Experience of Care Survey—Child		
Aim 1: Enhanced Member Care Experience **Aim 2:** Effective Patient Care	**Goal 1.2:** Improve Member Satisfaction **Goal 2.1:** Enhance Provider Support	**Metric 1.2.3:** Rating of All Health Care **Metric 2.1.2:** How Well Doctors Communicate

Recommendation—Member Experience of Care Survey—Child

Weakness: Optima's 2021 top-box scores were not statistically significantly lower than the 2020 NCQA child 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.

MCO's Response

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):

- CAHPS 101 education annual CBT for all member-facing teams to increase awareness and importance
- CAHPS mid-year reminder to review customer service and the importance of the member experience
- Customer service post-survey member calls to drive continuous improvement opportunities
- Member outreach calls to assist members in navigating their healthcare need
- Care coordination assistance with patient/provider appointment scheduling and transportation

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

2021: 53.2%

2022: 64.3%

Child

2021: 81.8%

2022: 70.8%

Metric: Rating of Specialist

Adult

2021: 61.5%

2022: 62.5%

Child

2021: 75.0%

2022: 76.8%

Identify any barriers to implementing initiatives:

The COVID-19 PHE caused significant disruption throughout most of 2020 and continuing through today. The disruption is reflected in the variation we've seen in health system experience scores over the last few years.

HSAG Assessment:

United

Table E-6—Prior Year Recommendations and Responses—United

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
Weakness: United received *Low Confidence* for the *Timeliness of Prenatal Care* PIP. **Why the weakness exists:** The SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that United: • Ensure that interventions reach the maximum number of eligible members. • Continue efforts to achieve further improvement and spread interventions to other populations.		
MCO's Response		
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): • OBRAF Provider Education - Educating OB providers on the submission of OBRAFs to submit correct forms to capture more information about members' timely PNC (Intervention completed, as OB providers are submitting OBRAF's on the proper form). • OBRAF Incentive Program - Offering provider incentives for use of and timely submission of OBRAF forms. • Member Incentives for member completion of timely PNC visit. • Provider Incentives and co-branded letters for member completion of timely PNC visit. • Member outreach calls to remind members and assist with scheduling timely prenatal visit. • Healthy First Steps Program—focuses on the importance of prenatal and postpartum care in addition to the social determinants of health. Our locally-based nurse coordinators and Community Health Workers (CHW) not only serve as the single point of contact for our highest risk, complex needs members, but they are also integral in providing education, coordination, and consult to obstetric and pediatric practitioners to optimize the health of our members. • UHC will continue to improve member outreach by adding additional care coordination staff, to engage all pregnant members identified as "healthy" pregnancy. Care coordinators will ensure members are linked to PNC and review all health plan benefits with members, including the Healthy First Steps program. • UHC will ensure that interventions reach the maximum number of eligible members and will continue efforts to achieve further improvement by spreading interventions to other populations.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care 2020: 65.45% 2021: 84.91%		
Identify any barriers to implementing initiatives: UHC did not identify any barriers to implementing initiatives.		

Recommendation—Performance Improvement Projects		
HSAG Assessment:		
Recommendation—PM Validation		
Aim 4: 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	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services **Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care **Metric 4.6.2**: Prenatal and Postpartum Care: Timeliness of Prenatal Care **Not a QS Metric:** Breast Cancer and Cervical Cancer Screenings
Weakness: The following HEDIS MY 2020 PM rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for United: • *Adult's Access to Preventive/Ambulatory Health Services—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* **Why the weakness exists:** United's PM rates in the Women's Health, Access to Care, and Care for Chronic Conditions domains falling below the HEDIS MY 2019 25th percentile suggests a lack of access to preventive care, screenings, and care for chronic conditions. United's members are not completing timely visits, screenings, or 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 United conduct a root cause analysis or focus groups to determine why members are not accessing and completing preventive screenings or accessing care according to recommended schedules. HSAG also recommends that United conduct similar processes and analyses of data to better understand barriers members experience in receiving care for chronic conditions. HSAG recommends that United consider whether there are disparities within		

Recommendation—PM Validation
the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that VA Premier implement appropriate interventions to improve access to and timeliness of visits, screenings, behavioral healthcare, and recommended services for members diagnosed with a chronic condition.
MCO's Response
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 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 conducted root cause analysis based on race, ethnicity, and language state-wide and implemented multiple interventions, including member events and increased member outreach activities to improve access to and timeliness of preventative screenings and members diagnosed with a chronic condition. • Identified trending SDoH needs to determine members' needs for preventative care while ensuring a strong engagement and connection with community resources. • CP-PCPi Program – Provide PCPs with up-to-date data of members experiencing gaps in care and partnering with providers and facilities to promote member events to close gaps in care. • Expanded telehealth to increase availability of access to care for members. • Partnership with Federally Qualified Health Centers (FQHCs), health systems and other community partners for member care and support of community events. • Partnership with community entities to facilitate and promote member self-care and resources. • UHC continues to evaluate data and identify areas of opportunity and strategies to address health disparities.
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 2020: 67.65% 2021: 70.56% **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services: Breast Cancer Screening 2020: 36.07% 2021: 43.72% **Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services: Cervical Cancer Screening 2020: 43.31% 2021: 46.47% **Metric:** Comprehensive Diabetes Care: HbA1c Testing: 2020: 84.43% 2021: 88.81% **Metric:** Comprehensive Diabetes Care: HbA1c Control (<8.0%): 2020: 41.36% 2021: 48.91%

Recommendation—PM Validation

Metric: Comprehensive Diabetes Care: Eye Exam (Retinal) Performed:
2020: 43.55%
2021: 46.23%
Metric 4.6.2: Prenatal and Postpartum Care: Timeliness of Prenatal Care:
2020: 65.45%
2021: 84.91%
Metric 4.6.2: Prenatal and Postpartum Care: Postpartum Care:
2020: 69.34%
2021: 70.32%

Identify any barriers to implementing initiatives:
During the COVID-19 national public health emergency, UHC determined members were primarily seeing providers for sick visits and delayed preventative care visits. Provider office closures, limited support staff, clinician access, and member hesitancy to return to provider offices also contributed to screening declines.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

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

Why the weakness exists: The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements were not all reviewed or updated to ensure that all current DMAS contract requirements were included.

Recommendation: The MCO must update its Medicaid Addendum to include the DMAS Medallion 4.0 contract requirements. The MCO must consistently include the Medicaid Addendum with its subcontractor and delegated entity agreements.

MCO's Response

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):

In March 2022, in follow-up to the HSAG OSR audit, UHC received approval from DMAS of its updated Medicaid Regulatory Appendices containing all applicable DMAS requirements. Subsequently following approval, UHC coordinated contract amendments with delegated entities to append the updated appendix to those contracts. UHC submitted evidence of amended contracts to DMAS in May 2022, and the corrective action was approved for closure.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Metric: Rating of All Health Care
Adult
2021: 58.3%
2022: 47.8%
Child
2021: 71.1%
2022: 75.5%

Identify any barriers to implementing initiatives:
UHC did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care

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 had not consistently updated policies and procedures to include the 2020 Medicaid Managed Care Rule requirements.

Recommendation: The MCO must update its policies and procedures to address requirements included in the 2020 Medicaid Managed Care Rule such as removing the requirement that an oral appeal request must be followed with a written and signed request for an appeal.

MCO's Response

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 correction had been made in response to the HSAG OSR 2021 audit. The updated Appeals and Grievance policy and procedure was provided at that required time. UHC continues to operate according to the updated policy and procedure.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: Rating of All Health Care
Adult
2021: 58.3%
2022: 47.8%
Child
2021: 71.1%
2022: 75.5%

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Identify any barriers to implementing initiatives: UHC did not identify any barriers to implementing initiatives.		
HSAG Assessment: 		
Recommendation—Encounter Data Validation		
Aim: NA	**Goal:** NA	Not a QS Metric
Weakness: United did not meet the timeliness standards for both institutional and pharmacy encounters. **Why the weakness exists:** Approximately 80 percent of United pharmacy encounters reported a submission date prior to the payment date. **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 dates.		
MCO's Response		
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): • State guidelines require encounters to be submitted with the actual check date. UHC's pharmacy vendor batches claims every three days which allows them to set check dates and check numbers to claims. Those dates are posted to claims and subsequently reported on the encounter. The posted check dates have potential to be future dates.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Not applicable		
Identify any barriers to implementing initiatives: UHC did not identify any barriers to implementing initiatives.		
HSAG Assessment: 		
Recommendation—Member Experience of Care Survey		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.3:** Rating of All Health Care
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—Member Experience of Care Survey

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

MCO's Response

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 continues to survey providers on appointment availability. Outreach and education were provided to providers on scheduling best practices and how to improve access to routine/urgent care.
- UHC regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and uses commonly used medical and insurance terms in easy-to-understand language available in multiple languages. These materials enhance communication between health care professionals and members, while also facilitating member's ability to make informed healthcare decisions.
- UHC continues to monitor measures to evaluate areas of opportunity and strategies to provide continuous improvement.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Rating of All Health Care

Adult

2021: 58.3%

2022: 47.8%

Child

2021: 71.1%

2022: 75.5%

Metric 1.2.2: Enrollees' Rating of Health Plan: Customer Service

Adult

2021: 89.8%

2022: 84.8%

Child

2021: 78.3%

2022: 82.3%

Identify any barriers to implementing initiatives:

UHC did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey		
Aim 1: Enhance Member Care Experience **Aim 2:** Effective Patient Care	**Goal 1.1:** Improve Member Satisfaction **Goal 2.2:** Ensure Access to Care	**Metric 1.2.1:** Getting Care Quickly **Metric 1.2.2:** Rating of Health Plan **Metric: 1.2.4:** Customer Service **Metric 2.2.3:** Getting Needed Care

Weakness: United's top-box score was statistically significantly lower than the 2020 NCQA child Medicaid national average for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. In addition, United's 2021 top-box score was statistically significantly lower than the 2020 top-box score 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 their child's ability to receive access to care or services in a timely manner.

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

MCO's Response

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 continued to evaluate data and identify strategies for barrier removal as part of United's ongoing processes.
- How Well Doctors Communicate was an identified opportunity noted in previous year report. This metric has shown an increase from previous year.
- UHC conducted focus group studies with parents to better understand barriers to their child receiving access to care or services in a timely manner. UHC additionally obtained feedback from care coordinators and member advisory committees.
- On an ongoing basis, UHC continues to evaluate areas of opportunity and strategies to promote continuous improvement in this area.
- UHC continues to monitor all measures to ensure there are no significant decrease in rates over time.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

UHC did not identify performance improvement in the above metrics as a result of initiatives implemented. However, How Well Doctors Communicate did reflect improvement from 2020 to 2021.

Metric: Getting Care Quickly

Adult

2021: 76.7%

2022: 80.6%

Child

2021: 79.3%

2022: 76.1%

Metric: Rating of All Health Care

Recommendation—Member Experience of Care Survey
Adult 2021: 58.3% 2022: 47.8% *Child* 2021: 71.1% 2022: 75.5% **Metric:** Customer Service *Adult* 2021: 89.8% 2022: 84.8% *Child* 2021: 78.3% 2022: 82.3% **Metric:** Getting Needed Care *Adult* 2021: 77.5% 2022: 76.8% *Child* 2021: 72.9% 2022: 74.5% **Metric 2.1.2:** How Well Doctors Communicate *Adult* 2021: 91.5% 2022: 90.9% *Child* 2021: 91.8% 2022: 91.9%
Identify any barriers to implementing initiatives: UHC did not identify any barriers to implementing initiatives.
HSAG Assessment:

VA Premier

Table E-7—Prior Year Recommendations and Responses—VA Premier

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
Weakness: VA Premier received *Low Confidence* for both PIPs. **Why the weakness exists:** The MCO resubmitted the PIPs; however, it appeared that there were no updates. The SMART Aim goal was not achieved. **Recommendation:** HSAG recommends that VA Premier: • If an intervention is not having an impact, quickly make modifications and continually review the data to assess for improvement. • Provide additional SMART Aim measure data points in the resubmission. • Test more than one intervention per PIP.		
MCO's Response		
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): HSAG PIP recommendations are appreciated and taken under advisement. With improved intervention monitoring, we will be able to respond quickly to challenges with data capture and adjust interventions for improved outcomes. In the future, we will include additional SMART Aim measure data points to increase opportunity for measurable improvement. We will test more than one intervention per PIP to increase opportunity to impact member outcomes and improve the confidence level of the PIPs project. One of the primary takeaways from the previous PIPs project was to better structure intervention monitoring (track and trend) to determine impact to outcomes data.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care: 2020: 74.45% 2021: 74.45%		
Identify any barriers to implementing initiatives: The greatest barrier to implementing initiatives was the COVID-19 PHE. Provider offices became less accessible to our members, due to member reluctance to go to on-site appointments during the PHE, and there were office restrictions against bringing others to appointments, causing childcare issues for some members. One of the methods we use for outreach and education is baby showers which were suspended due to safety precautions under COVID-19. However, we adapted and held two successful virtual baby showers. We were also restricted from reaching out to providers, limiting our ability to influence physician education about smoking cessation. Several members were not interested in quitting smoking, citing stress levels due to PHE fears, lack of school for older children, job loss, and other factors.		

Recommendation—Performance Improvement Projects

HSAG Assessment:

Recommendation—PM Validation

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
	Goal 4.4: Improve Health for Members with Chronic Conditions	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
	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

Weakness: The following HEDIS MY 2020 PM rates fell below NCQA's Quality Compass HEDIS MY 2019 Medicaid HMO 75th percentile and were determined to be opportunities for improvement for VA Premier:

- *Adult's Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Why the weakness exists: Although VA Premier members may have adequate access to timely care and services, members are not completing timely visits, screenings, or 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

Recommendation—PM Validation
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 analyses or conduct focus groups to determine why members are not consistently accessing and completing preventive screenings, childhood immunizations, and care and services for chronic conditions. HSAG recommends that VA Premier analyze its data and consider whether there are disparities within the MCO's populations that contribute to lower performance for a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause or causes, HSAG recommends that VA Premier implement appropriate interventions to improve the receipt of recommended care and services that impact the health of its members and to reduce unnecessary use of ambulatory services, which can significantly reduce non-urgent ED visits.
MCO's Response
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): **Adult's Access to Preventive/Ambulatory Health Services—Total** • Formalized Population Health Committee and workgroups established as part of quality governance structure • NCQA PHM standards and readiness tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. • Population Health Assessment to be completed 7/2023 • Workgroups established for each focus area of CAHPS to assess, research best practices, and pilot interventions to improve each area of focus **Breast Cancer Screening** • Formalized Population Health Committee and Formalized HEDIS workgroups established as part of quality governance structure • Performs live outreach calls to discuss the importance of breast cancer screening and remind members they are due for mammogram • Makes direct calls monthly to members with breast cancer screening gaps • Newly formed Population Care Team sends letters to members with multiple gaps. Members are identified by using predictive analytics and targeted when they are most likely to close the gap • Included Rewards/Incentive language in care gap letters • Partners with network education to distribute patient gap reports • Population Health Assessment work group was established 7/2022 • NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023

Recommendation—PM Validation

Childhood Immunization Status—Combination 3

- Developed a Childhood Immunization Incentive Program
- Hosts *Back to School* fairs across the State
- Runs Well Child and Immunization Campaigns
- Providers educational outreach
- Data from VIS and Health Fair Capture is used to close gaps and refer to case management when appropriate
- Added a full-time employee to support EPSDT
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023
- Population Health Assessment work group was established 7/2022
- NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023
- Population Care is currently in the process of developing a reminder letter specific for Combo 3 to remind members aged 18 to 23 months of the importance of vaccinations

Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Eye Exam (Retinal) Performed

- Implemented a pilot with Dario which covers 1,500 Virginia Premier Health Plan Medallion 4.0 and CCC Plus members in the Dario Type 2 Diabetes program. The solution provides adaptive, personalized member experiences to drive behavior change through evidence-based interventions, intuitive, clinically proven digital tools, high-quality software, and coaching to encourage individuals to improve their health and sustain meaningful outcomes. If the pilot proves effective at closing Type 2 Diabetes care gaps, it will be scaled to include all eligible members
- Similar to Dario, Virginia Premier is implementing a program with Onduo, a T2D initiative to target the VPHP Medallion 4.0 and CCC Plus population
- An initiative with Retina Labs should be implemented in the fourth quarter 2022 to support the completion of diabetic eye exams for members in Virginia Premier Health Plan Medallion 4.0 and CCC Plus with a diagnosis of diabetics: Members with diabetes will be offered either clinic-based or in-home tele-retinal screening for early detection of diabetic retinopathy. Providing a choice of screening options will help improve member satisfaction, close this critical diabetes care gap, and improve health outcomes for Virginia Premier Health Plan members
- Performs live outreach calls to discuss the importance of A1c testing and blood sugar control as well as retinal eye exams
- Population Care (Pop Care) sends letters to members with multiple gaps. Members are identified by using respective analytics and targeted when they are most likely to close the gap. Rewards/incentive language is included in these care gap letters

Recommendation—PM Validation
• Population Care works in partnership with Bio IQ to send at-home diabetes testing kits to members who have not completed and A1c during the measurement period. The health plan is currently developing a process to refer members with elevated results to case management • Population Care works in partnership with Focus Care to complete in-home assessments for eligible members. Part of the assessment includes assistance in completing at home A1c testing and diabetic eye exams. The health plan recently started offering retinal eye exams to members who are not eligible for home assessments through focus care to improve access to care **Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total** • BH Care Coordination Team supports all members who have a BH inpatient admission with the intent to reduce/eliminate readmissions by engaging members and linking them to community-based services and supports. BH Inpatient Reviewers send notification at admission and discharge to members 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 • BH Inpatient Reviewers send notification at admission and discharge to members 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 **Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies; and** **Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care** • Population Health Assessment work group was established 7/2022 • NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023 • Population Health Assessment work group was established 7/2022 • NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Breast Cancer Screening 2020: 41.88% 2021: 49.88% **Metric:** Cervical Cancer Screening 2020: 47.45% 2021: 52.31%

Recommendation—PM Validation
Metric: Child Immunization Status – Combination 3 2020: 65.59% 2021: 65.69% **Metric:** Comprehensive Diabetes Care –HbA1c Testing 2020: 82.97% 2021: 87.83% **Metric:** Comprehensive Diabetes Care – HbA1c Poor Control (>9.0%) 2020: 48.91% 2021: 43.07% **Metric:** Comprehensive Diabetes Care – HbA1c Control (< 8.0%) 2020: 40.63% 2021: 44.28% **Metric:** Comprehensive Diabetes Care – Eye Exam (Retinal) Performed 2020: 49.88% 2021: 52.80% **Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care: 2020: 74.45% 2021: 74.45% **Metric:** Postpartum Care 2020: 66.91% 2021: 68.86%
Identify any barriers to implementing initiatives: • Even with vaccines readily available to the public and restrictions have loosened up, the COVID PHE is still an ongoing issue and continues to be a barrier in the decrease of outpatient ambulatory or preventive care visits • Lack of appointment availability in outpatient settings due staffing issues • Poor communication between member and provider regarding need for preventive care • Formalized Population Health Committee and formalized HEDIS workgroups established as part of quality governance structure • Performs live outreach calls to discuss the importance of breast cancer screening and remind members they are due for mammogram • Makes direct calls monthly to members with breast cancer screening gaps • Newly Formed Pop Care Team sends letters to members with multiple gaps. Members are identified by using predictive analytics and targeted when they are most likely to close the gap • Rewards/Incentive language is included in these care gap letters • Partners with network education to distribute patient gap reports • Population Health Assessment work group was established 7/2022 • NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023

Recommendation—PM Validation

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care

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's policies did not include the requirement for a formulary to be available on the MCO's website in a machine-readable format. A review of the MCO's website identified a formulary page at: https://www.virginiapremier.com/members/medicaid/pharmacy/. A searchable formulary and a PDF version were available; however, a machine-readable file and format was not located on the MCO's website.

Recommendation: The MCO must include a machine-readable file and format formulary on the MCO's website.

MCO's Response

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 updated the provider directory available on the website to include a machine-readable format. This was deployed on 9/22/2021. Virginia Premier updated the provider directory requirements policy to include a verification process of confirming accessibility to the machine-readable file on a monthly basis.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Getting Needed Care

Adult

2021: 79.5%

2022: 85.2%

Child

2021: 90.6%

2022: 79.7%

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care

Weakness: 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. The MCO did not appropriately apply its appointment access standards to the entire network.

Why the weakness exists: The MCO's policies, procedures, and provider manual did not include all or correct access standards to all provider types. The MCO did not have an implemented process to monitor accessibility against correct requirements.

Recommendation: The MCO must have mechanisms to ensure compliance by network providers regarding timely access to services, monitor network providers regularly to determine compliance, and take corrective action if there is failure to comply with requirements.

MCO's Response

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 policy title was changed to be consistent with the file name. The old policy name was CON 001 Requirements for Maintaining Network Adequacy Access to Care Standards and has been changed to Policy 3413–CON–Requirements for Provider Network Management & Mandated Reporting Procedures. Virginia Premier will continue to monitor provider availability by running bi-weekly adequacy reports to ensure that any deficiencies and access gaps are addressed in a timely manner when reported to confirm compliance by our network to ensure access to services, monitor network providers regularly, and institute corrective action for any notable deficiencies if applicable. Virginia Premier will continue to report to DMAS, (by provider type) that the access standards are being monitored and that requirements are being met.

To monitor timeliness of services, Virginia Premier utilizes a vendor, SPH, to conduct yearly access audits. The results of those surveys are shared across the organization to ensure any areas of noncompliance are addressed in a timely manner. Outreach is made by the provider services team to those providers who are noncompliant with access standards. The Provider Services team would then conduct further outreach, follow-up, and training to work with the provider or practice to provide education on the standards. Further collaboration would involve working together with the contracting team to document the issue in the tracking system to record when outreach occurred and how it will be resolved. This process is reflected in Policy 3413.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Getting Needed Care

Adult

2021: 79.5%

2022: 85.2%

Child

2021: 90.6%

2022: 79.7%

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 2: Effective Patient Care	**Goal 2.2:** Ensure Access to Care	**Metric 2.2.3:** Getting Needed Care

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

Why the weakness exists: The MCO did not have an implemented process to ensure its subcontractor and delegated entity agreements are all reviewed or updated to include all current DMAS contract requirements.

Recommendation: The MCO must include in its Medicaid Addendum all delegated entity requirements required by DMAS within the Virginia Medicaid Medallion 4.0 contract. The MCO must consistently include the Medicaid Addendum within its subcontractor and delegated entity agreements.

MCO's Response

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 Non-Provider Contract Management (NPCM) process was implemented as the standard process to review and approve Virginia Premier's non-provider contracts. This process requires that internal business owners submit their contract requests to the Vendor Management Organization (VMO) for review and approval. Contract approval includes the review of the contract by an established, cross-functional set of subject matter experts. These subject matter experts are referred to as NPCM stakeholders and include representation from the following business areas: Vendor Oversight, Finance, Data Analytics, IT, IT Security, Quality, Medicaid Compliance, Medicare Compliance, Commercial Compliance, and Legal. The Medicaid Compliance stakeholders review contracts to ensure the Medicaid Addendum and DMAS requirements are included, as deemed appropriately. Contracts requiring DMAS review are identified and sent to DMAS for review and approval.

The VMO is currently partnering with the Virginia Premier Medicaid Compliance Lead to add the updated Medicaid Addendum to identified vendor contracts by end of year 2022. This effort ensures that applicable contracts include the Medicaid Addendum, and that the Medicaid Addendum includes all approved DMAS language.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: Getting Needed Care

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations
Adult 2021: 79.5% 2022: 85.2% *Child* 2021: 90.6% 2022: 79.7%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations		
Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of All Health Care
Weakness: The MCO's grievance and appeal policies and procedures did not contain all of the federal and DMAS contract requirements. The MCO's grievance and appeals policies and procedures did not consistently require the member's approval for an authorized representative or provider to act on his or her behalf when filing a grievance or appeal. The policies and procedures did not address informing the member of the right to request a State fair hearing. The MCO required oral requests for an appeal to be followed by a written appeal. **Why the weakness exists:** The MCO did not update its policies and procedures to include all requirements specified in the 2020 Medicaid Managed Care Final Rule. **Recommendation:** The MCO must update the Medical Management/Grievances and Appeals policy to include all federal requirements listed in this element.		
MCO's Response		
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): • Review of CCC Plus MCO Contract for managed care to align with the internal MCO Grievance and Appeals Policy • Medicaid Grievance Policy updated, reviewed, and approved at Policy and Procedure Committee (May 2022) • Daily huddles to review cases and update employees on any issues to ensure requirements are met and/or exceeded • Employee training on contract and Medical Management/Grievance and Appeals policies which aligns with DMAS contractual requirements		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Rating of All Health Care		

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Adult
2021: 52.1%
2022: 58.8%
Child
2021: 76.4%
2022: 72.8%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 1: Enhance Member Care Experience	**Goal 1.1:** Improve Member Satisfaction	**Metric 1.2.2:** Rating of All Health Care

Weakness: The MCO's appeal resolution notices to the member were not consistently sent, or when sent, did not consistently include all member rights.

Why the weakness exists: The MCO did not have an implemented process to ensure that appeal resolution notices are accurate, complete, and consistently sent to members.

Recommendation: The MCO must implement a process to ensure that appeal resolution notices are accurate, complete, and consistently sent to members.

MCO's Response

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):

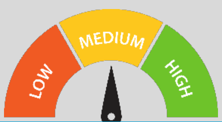
- Appeals Coordinators were retrained on sending out resolution letters and attaching the appropriate documents (appeals rights and multi-language inserts).
- The templates were updated to include the documents to eliminate errors for the future.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:
Metric: Rating of All Health Care
Adult
2021: 52.1%
2022: 58.8%
Child
2021: 76.4%
2022: 72.8%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

HSAG Assessment:



Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

Aim 2: Effective Patient Care	**Goal 2.1:** Enhance Provider Support	**Metric 2.2.3:** Getting Needed Care

Weakness: The MCO did not sufficiently inform providers about EPSDT services it is required to provide, adequately monitor service provision, and implement interventions to improve member participation in EPSDT services.

Why the weakness exists: The MCO's policies and procedures did not demonstrate how the MCO monitors, evaluates, and implements interventions to improve EPSDT participation.

Recommendation: The MCO must inform all PCPs about EPSDT services, including federal requirements, and DMAS EPSDT requirements. The MCO must monitor, evaluate, and implement interventions to improve EPSDT participation. The MCO must implement provider and member outreach activities and implement process improvement activities as necessary to improve member participation in EPSDT/well-child services.

MCO's Response

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 care management team has a dedicated EPSDT coordinator that reviews monthly reports and provides member outreach to ensure any gaps in EPSDT services are provided. The EPSDT standard operating procedure has been updated to reflect the work that the EPSDT coordinator is completing, such as: lead, immunizations, vision, obesity, and dental varnish. Care management worked collaboratively with network provider relations to create EPSDT flyer and provider resources, which will be placed on the network provider site once completed for 2022.

Virginia Premier educates providers about EPSDT services during provider education meetings and has established an EPSDT provider resource website page to aid providers. Providers will have access to a EPSDT specific self-service training in January 2023. Additionally, information about EPSDT and EPSDT training is included in the Virginia Premier Medicaid provider manual. Virginia Premier has updated the provider education meeting policy to document the training that providers receive for EPSDT.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Getting Needed Care

Adult

2021: 82.3%

2022: 79.0%

Child

Recommendation—Compliance with Medicaid and CHIP Managed Care Regulations

2021: 76.4%
2022: 72.8%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Encounter Data Validation

Aim 3: Smarter Spending	**Goal 3.2:** Focus on Efficient Use of Program Funds	**Metric 3.2:** Ensure High Value Appropriate Care

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 had low header TPL paid amounts PMPM for institutional encounters compared to other MCOs.

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. For the weakness in header TPL paid amounts, the IS review and administrative profile analysis did not identify the specific root cause of the weakness.

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 missing header TPL paid amounts in its institutional encounters to rectify any issues.

MCO's Response

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 leverages a suite of tools/processes to ensure continued monitoring of both quality and timeliness of encounter data resulting from claims processing, of which general monitoring of acceptance rates is a single component. These include, but are not limited to:

- Capital investment in a stand-alone encounters management system (EDM – Encounter Data Manager) This tool allows for the extraction of adjudicated claims data from both internal and external data sources and leverages 837 / NCPDP D.0 standard mappings augmented with requirements received from DMAS via Companion Guides and Technical Manuals. Functions within this tool include:
  - Direct command / control, and progress monitoring to support cadences submission schedule by line of business, data availability, and DMAS contractual timeliness requirements.
  - Conditional data records edits "scrubs" that can be individually and / or collectively updated and applied to some or all encounters submissions, based on need or requirements known.

Recommendation—Encounter Data Validation

These “scrubs” isolate records in need of correction from submission, while allowing those transactions that can be submitted to proceed through.

- Assigned encounters analysts for Medicaid encounter submissions, who maintain active and current knowledge of DMAS encounters submissions standards. In additional to the ongoing responsibility for encounters submissions and overall accuracy and acceptance of records submitted, these individuals also act as subject matter experts (SMEs) for DMAS encounters requirements, engaging with DMAS Encounters, internal departmental stakeholders, and external vendor partners to further ongoing improvements and system enhancements towards general quality and timeliness goals.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

Metric: Not reported

Identify any barriers to implementing initiatives:

The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey

Aim 1: Enhance Member Care Experience	**Goal 1.3:** Increase Member Satisfaction	**Metric 1.2.2:** Rating of All Health Care

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.

MCO’s Response

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):

Customer Satisfaction Performance Improvement Committee (CSPIC) has been formalized into quality improvement governance in 2022. Chartered Initiatives/projects are all aimed at development to improve member and clinician engagement which includes targeted outreach and educational initiatives:

- Monthly workgroup structure created to review current performance and interventions for barrier analysis
- Provider education communication related to CAHPS opportunities throughout the year via various methods (i.e.: newsletters, website, etc.)

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

Recommendation—Member Experience of Care Survey

PMV results showed:
Metric: Rating of All Health Care
Adult
2021: 52.1%
2022: 58.8%
Child
2021: 76.4%
2022: 72.8%

Identify any barriers to implementing initiatives:
The MCO did not identify any barriers to implementing initiatives.

HSAG Assessment:

Recommendation—Member Experience of Care Survey

Aim 1: Enhance Member Care Experience	**Goal 1.3:** Increase Member Satisfaction	**Metric 1.2.2:** Rating of All Health Care

Weakness: VA Premier's top-box score was statistically significantly lower than the 2020 top-box score for one measure, *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 VA Premier's specialists, which may be associated with their perception of their child's ability to receive care or services from their child's specialist.

Recommendation: HSAG recommends that VA Premier conduct a root cause analysis of the study indicator 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 VA Premier continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

MCO's Response

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):

- Customer Service Improvement Committee (CPSIC) has been formalized into quality improvement governance in 2022. Chartered initiatives/projects are all aimed at development to improve member and clinician engagement which includes targeted outreach and educational initiatives. Additionally, increased collaboration with the commonwealth's department of health regarding vaccination data. Launch target of first quarter 2023.
- Population Health Assessment work group was established 7/2022.
- NCQA PHM standards and audit tools purchased to perform a comprehensive population health assessment to include but not limited to: SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code etc. Population Health Assessment to be completed 7/2023.

Recommendation—Member Experience of Care Survey
• Pop Care is currently in the process of developing a reminder letter specific for combo 3 to remind members aged 18 to 23 months of the importance of vaccinations.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Metric:** Rating of All Health Care *Adult* 2021: 52.1% 2022: 58.8% *Child* 2021: 76.4% 2022: 72.8%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment:

Appendix F. 2020–2022 Quality Strategy Status Assessment

Evaluation Methodology Description

DMAS compares the baseline data for each PM 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 DMAS 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 and access to 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 20223. In CY 2021, DMAS tracked the aggregated annual results of PMs included in the QS to measure improvement.

During the CY 2022 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 QS goals and objectives and in response to the COVID-19 PHE, MCO care coordinators increased their outreach to members, ensuring access to services using telehealth medicine and automatically extending service authorizations and use of out-of-network providers when necessary.

It is noted that because of the COVID-19 PHE during MY 2021, many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. The MCOs developed processes to assist COVID-19 positive or exposed members with nonemergent transportation needs after discharge from the hospital and to ensure dialysis and chemotherapy appointments were not missed. In addition, 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 most of 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 Child and Adult Core Set PMs and NCQA's revised HEDIS PMs. 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 PMs not included in HEDIS reporting. Table F-1 provides a summary of the MCOs' performance including rates that improved or declined from the baseline rate.

Table F-1—Virginia Medicaid 2020–2022 QS Status Assessment

AIM	Goal	Objective	Measure Name	Metric Specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2021 Aggregate Rate
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	82.1%*	CAHPS benchmarks	81.1%
		Increase Member Satisfaction	**Metric 1.2.2:** Enrollees' Ratings Rating of Health Plan	CMS Adult Core Set: CPA-AD	62.5%*	CAHPS benchmarks	62.5%
		Increase Member Satisfaction with Care	**Metric 1.2.3:** Rating of All Health Care	CMS Adult Core Set: CPA-AD	59.0%*	CAHPS benchmarks	55.8%
	Goal 1.2: 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)	^^	86%	Not Reported
		Ensure Access to Care	**Metric 1.3.2:** Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	Quality Management Review (QMR)	^^	86%	Not Reported
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	71.3%*▲	CAHPS benchmarks	68.0%
	Goal 2.1: Enhance Provider Support; **Goal 2.2:** Ensure Access to Care	Improve Health Communication	**Metric 2.1.2:** How Well Doctors Communicate	CMS Adult Core Set: CPA-AD	94.6%*	CAHPS benchmarks	93.3%

AIM	Goal	Objective	Measure Name	Metric Specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2021 Aggregate Rate
		Increase Access to Care	**Metric 2.2.3:** Getting Needed Care	CMS Adult Core Set: CPA-AD	83.3%*	CAHPS benchmarks	82.9%
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	^	VBP/CE Performance Target	SFY 2021 Medallion 4.0: 0.249 SFY 2021 CCC Plus: 2.484
		Decrease ED Visits	**Metric 3.1.2:** Frequency of ED Visits	VBP Reporting Team	^	VBP/CE Performance Target	SFY 2021 Medallion 4.0: 14.30% SFY 2021 CCC Plus: 29.95%
		Decrease Potentially Preventable Readmissions	**Metric 3.1.3:** Frequency of Potentially Preventable Readmissions	VBP Reporting Team	^	VBP/CE Performance Target	SFY 2021 Medallion 4.0: 6.62% SFY 2021 CCC Plus: 18.40%
		Decrease ED Visits	**Metric 3.1.4:** Ambulatory Care: Emergency (ED) Visits	NCQA HEDIS	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
	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	^^^	Minimum Loss Ration in Final Rule	Not Reported
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: 38.74%* 30-Day—Total: 60.89%*	NCQA Quality Compass 50th and 75th percentile	7-Day—Total: 35.63% 30-Day—Total: 56.84%
		Increase Follow-Up Visits After ED Visit for Mental Illness	**Metric 4.1.2:** Follow-Up After ED Visit for Mental Illness	CMS Adult Core Set: FUM-AD	7-Day—Total: 48.75%* 30-Day—Total: 61.31%*	VBP/PWP Performance Target	7-Day—Total: 45.34% 30-Day—Total: 57.38%

AIM	Goal	Objective	Measure Name	Metric Specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2021 Aggregate Rate
		Increase Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	**Metric 4.1.3:** Follow-Up Care for Children Prescribed ADHD Medication	CMS Child Core Set: ADD-CH	Initiation Phase: 39.00%* Continuation and Maintenance Phase: 55.33%*	NCQA Quality Compass 50th and 75th percentile	Initiation Phase: 45.20% Continuation and Maintenance Phase: 58.61%
		Increase Mental Health Utilization	**Metric 4.1.4:** Monitor Mental Health Utilization	NCQA HEDIS MPT	*	NCQA Quality Compass 50th and 75th percentile	13.04%
		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	Total: 72.83%*	NCQA Quality Compass 50th and 75th percentile	Total: 65.43%
	Goal 4.2: Improve Outcomes for Members with Substance Use Disorders	Increase Identification of AOD Services	**Metric 4.2.1:** Monitor Identification of AOD Services	NCQA HEDIS IAD	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
		Increase Follow-Up After ED Visit for AOD Abuse or Dependence	**Metric 4.2.2:** Follow-Up After ED Visit for AOD Abuse or Dependence	CMS Adult Core Set: FUA-AD	7-Day—Total: 13.11%* 30-Day—Total: 20.04%*	VBP/PWP Performance Target	Medallion 4.0: 7-Day—Total: 11.44% 30-Day—Total: 21.31%
		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	*	NCQA Quality Compass 50th and 75th percentile	4.83%
		Increase Initiation and Engagement of AOD Abuse or Dependence Treatment	**Metric 4.2.4:** Initiation and Engagement of AOD Abuse or Dependence Treatment	CMS Adult Core Set: IET-AD	*	VBP/PWP Performance Target	CCC Plus: Initiation: 46.41% Engagement: 12.51%

AIM	Goal	Objective	Measure Name	Metric Specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2021 Aggregate Rate
	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	*	CMS Child Core Set Benchmark	Not Reported
		Increase Adults' Access to Preventive/Ambulatory Health Services	**Metric 4.3.2:** Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS AAP	Total: 76.40%*	NCQA Quality Compass 50th and 75th percentile	Total: 72.75%
		Increase Child and Adolescent Well-Care Visits	**Metric 4.3.4:** Child and Adolescent Well-Care Visits	CMS Child Core Set AWC-CH	Total: 46.57%***	VBP/PWP Performance Target**	46.57%
	Goal 4.4: Improve Health for Members with Chronic Conditions	Decrease Heart Failure Admission Rate	**Metric 4.4.1:** PQI 08: Heart Failure Admission Rate	CMS Adult Core Set PQI08-AD	*	VBP/PWP Performance Target**	ND FFY 2020
		Decrease Asthma Admission Rate	**Metric 4.4.2:** PDI 14: Asthma Admission Rate (Ages 2–17)	AHRQ Quality Indicators PDI 14	^	VBP/PWP Performance Target**	Not Reported
		Decrease COPD and Asthma in Older Adults' Admission Rate	**Metric 4.4.3:** PQI 05: COPD and Asthma in Older Adults' Admission Rate	CMS Adult Core Set PQI05-AD	*	VBP/PWP Performance Target**	ND FFY 2020
		Decrease Diabetes Poor Control	**Metric 4.4.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CMS Adult Core Set HPC-AD	48.43%*	VBP/PWP Performance Target**	Medallion 4.0: 50.30% CCC Plus: 51.42%
		Increase Control of High Blood Pressure	**Metric 4.4.5:** Controlling High Blood Pressure	CMS Adult Core Set CBP-AD	44.09%*	NCQA Quality Compass 50th and 75th percentile	46.91%

AIM	Goal	Objective	Measure Name	Metric Specifications	HEDIS 2020 Baseline Performance	Performance Measure Target	MY 2021 Aggregate Rate
	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)	NCQA HEDIS DAE	*	NCQA Quality Compass 50th and 75th percentile	Not Reported
	Goal 4.6: Improve Outcomes for Maternal and Infant Members	Increase Postpartum Care	**Metric 4.6.1:** Prenatal and Postpartum Care: Postpartum Care	CMS Adult Core Set PPC-AD	64.23%*	VBP/PWP Performance Target**	66.52%
		Increase Timeliness of Prenatal Care	**Metric 4.6.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care	CMS Child Core Set PPC-CH	73.27%*	VBP/PWP Performance Target**	73.00%
		Increase Childhood Immunization Status	**Metric 4.6.3:** Childhood Immunization Status	CMS Child Core Set CIS-CH	Combination 3: 66.26%*	VBP/PWP Performance Target**	Combination 3: 65.82%*
		Decrease Low Birth Weight Babies	**Metric 4.6.4:** Live Births Weighing Less than 2,500 Grams	CMS Child Core Set LBW-CH	State Mean: 9.9	CDC Wonder Data from CMS benchmarks	Not Reported
		Increase Well-Child Visits	**Metric 4.6.5:** Well-Child Visits in the First 30 Months of Life	CMS Child Core Set W30-CH	Six or More Visits: 54.35% Two or More Visits: 72.10%***	NCQA Quality Compass 50th and 75th percentile	Not Reported

**The baseline PM rate is the final validated 2020 HEDIS PM rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.*
***Target established in the CCC Plus SFY 2022 PWP Methodology.*
****The baseline PM rate is the final validated 2020 HEDIS rate reported in the 2022 Annual Technical Report and posted to the DMAS website.*
^The baseline PM rate is the final 2020 rate calculated by HSAG for the PWP.
^^The baseline PM rate is the final 2020 rate reported by DMAS for the Quality Management Review.
^^^The baseline PM rate is the final 2020 rate reported by the DMAS Finance Team.

▲ *Statistically significantly higher in 2020 than in 2019.*

▼ *Statistically significantly lower in 2020 than in 2019.*

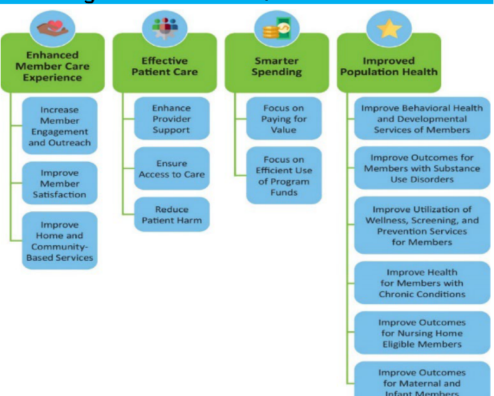
Appendix G. Medallion 4.0 Program 2022 Snapshot

Commonwealth of Virginia
Department of Medical Assistance Services
2022 External Quality Review Medallion 4.0 Program Technical Report Snapshot

Virginia Medicaid Background

DMAS administers the Medallion 4.0 program, which includes the Virginia Medicaid program and the FAMIS program, the Commonwealth's CHIP.

Virginia's 2020–2022 QS Aims and Goals



Medallion 4.0 Program Participating NCQA Accredited MCOs

DMAS contracted with six privately owned MCOs to deliver physical and behavioral health services to Medicaid and CHIP members.

MCO Name
Aetna Better Health of Virginia (Aetna)*
HealthKeepers, Inc. (HealthKeepers)*
Molina Complete Care of Virginia (Molina)*
Optima Health (Optima)*
United Healthcare of the Mid-Atlantic, Inc. (United)*
Virginia Premier Health Plan, Inc. (VA Premier)*

*NCQA health plan and LTSS distinction accredited

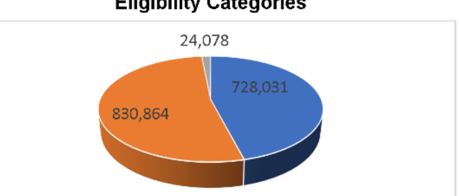
Medallion 4.0 Program Enrollment

CY 2022 Average Annual Program Enrollment

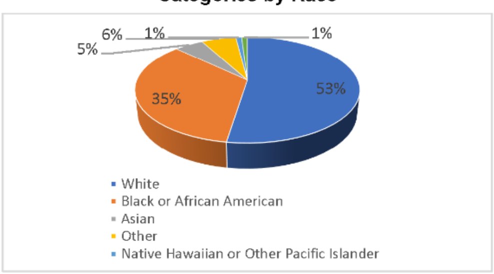
Program	SFY 2022 Enrollment as of 06/30/2022
Medallion 4.0	1,560,828

Medallion 4.0 Program Demographics

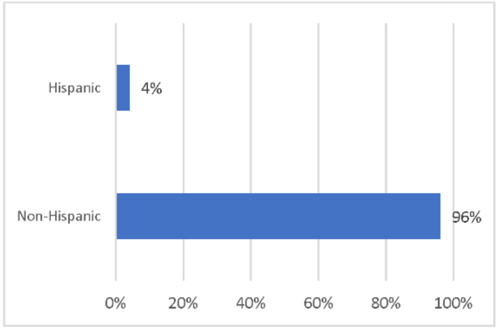
Eligibility Categories



Categories by Race



Categories by Ethnicity



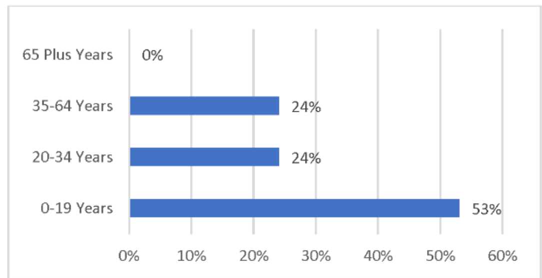
Medallion 4.0 Program Demographics

Percentage by Gender

60%
40%
20%
0%
45%
55%
Male
Female

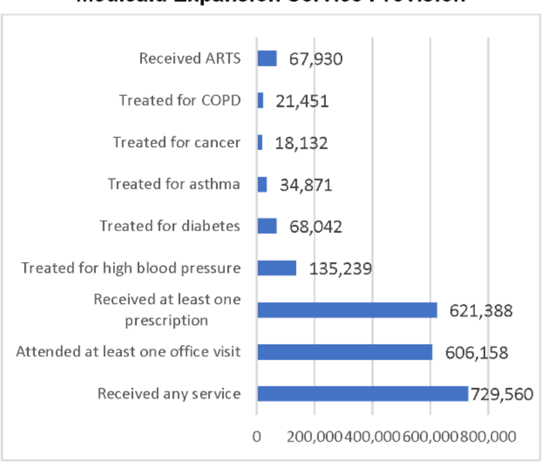
Commonwealth of Virginia
Department of Medical Assistance Services
2022 External Quality Review Medallion 4.0 Program Technical Report Snapshot

Enrollment by Age Group



Medicaid Expansion

Medicaid Expansion Service Provision

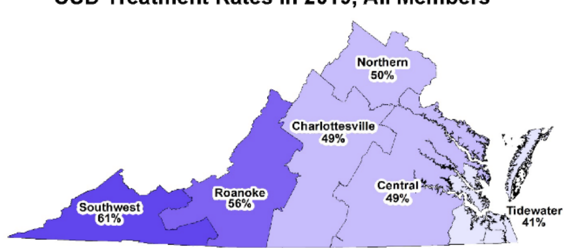


DMAS COVID-19 LTSS Access Flexibilities

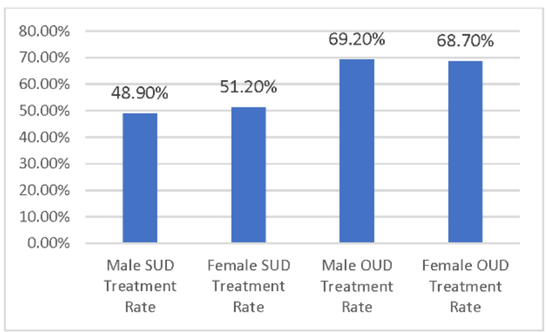
COVID-19 Medicaid Flexibilities
No co-pays for any Medicaid or FAMIS covered services.
Outreach to higher risk and older members to review critical needs.
Encouraging use of telehealth.
90-day supply of many routine medications.
Ensuring members do not lose coverage due to lapses in paperwork.

ARTS Benefit

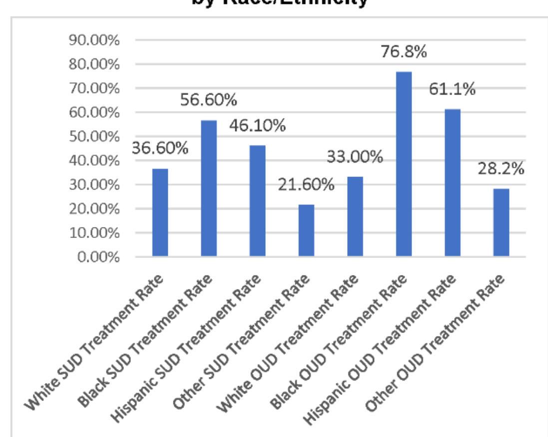
SUD Treatment Rates in 2019, All Members



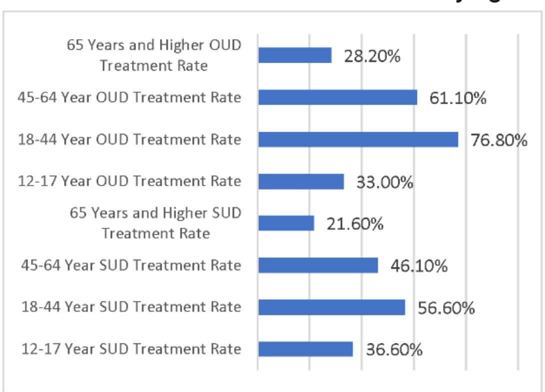
2019 Treatment Rates for SUD and OUD by Gender



2019 Treatment Rates for SUD and OUD by Race/Ethnicity



2019 Treatment Rates for SUD and OUD by Age



Commonwealth of Virginia
Department of Medical Assistance Services
2022 External Quality Review Medallion 4.0 Program Technical Report Snapshot

2022 Statewide Aggregate PIP Results

PIP Topics:

- Timeliness of Prenatal Care
- Tobacco Use Cessation in Pregnant Women

Strengths	
	• All six MCOs developed methodologically sound projects that met both Commonwealth and federal requirements. A sound design created the foundation for each MCO to progress to subsequent PIP stages—collecting data and initiating and testing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. • All six MCOs received 100 percent scores on all validation criteria for the first six steps validated.

Performance Measure Validation Results

Domain	Strengths
Children's Preventive Care	Five of six MCOs' rates met or exceeded the 50th percentile for the *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicators.
Care for Chronic Conditions	All six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* measure indicator. Of note, two of the six MCOs displayed strong performance, with their rates exceeding the Virginia aggregate for six of 10 (60.0 percent) measures.
Behavioral Health	All six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* measure indicator. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Continuation Phase Treatment*, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicators.
Domain	**Opportunities for Improvement**
Children's Preventive Care	Four of six MCOs' rates fell below the 50th percentile for the *Childhood Immunization Status—Combination 3* and *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* measure indicators.

Domain	Strengths
Women's Health	All MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, reflecting an opportunity for improvement. Five of six MCOs' rates fell below the 50th percentile for the *Cervical Cancer Screening* measure indicator.
Access to Care	All six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.
Care for Chronic Conditions	All six MCOs' rates fell below the 50th percentile for the *Controlling High Blood Pressure* measure indicator.
Behavioral Health	All six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator. Additionally, four of six MCOs' rates fell below the 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators.

Compliance With Standards Monitoring Results

The MCOs' 2021 compliance with federal requirements scores, for the three-year cycle, ranged from 92.6 percent to 96.3 percent. All six MCOs received a 100 percent compliance score for the following standards:

Standard Number	Description
IV	Emergency and Poststabilization Services
VI	Coordination and Continuity of Care
VIII	Provider Selection
X	Practice Guidelines
XI	Health Information Systems
XIV	Program Integrity

Member Experience of Care Survey Results

Strengths

2022 Medicaid top-box score results:

- Child—Two MCOs' 2022 scores were statistically significantly higher than the 2021 top-box score for *Customer Service*.
- Child—One MCO's 2022 score was statistically significantly higher than the 2021 child Medicaid national average for *Rating of Health Plan*.
- Adult—One MCO's 2022 score was statistically significantly higher than the 2021 top-box score for *Rating of Specialist Seen Most Often*.

Commonwealth of Virginia
Department of Medical Assistance Services
2022 External Quality Review Medallion 4.0 Program Technical Report Snapshot

Opportunities for Improvement
2022 Medicaid top-box score results: • Child—The Medallion 4.0 program's and one MCO's 2022 scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three *Rating of Personal Doctor, Getting Needed Care,* and *Getting Care Quickly*. • Child—One MCO's 2022 scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for two measures: *Rating of Health Plan* and *Rating of All Health Care*. • Adult—One MCO's 2022 scores were statistically significantly lower than the 2021 NCQA adult Medicaid national averages for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. • Adult—One MCO's 2022 score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for *Rating of All Health Care*.
• Adult—One MCO's2022 score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*. • Child—One MCO's 2022 score was statistically significantly lower than the 2021 top-box score for *Rating of Personal Doctor*. • Child—One MCO's 2022 score was statistically significantly lower than the 2021 top-box score for *Getting Needed Care*. • Child—One MCO's 2022 scores were statistically significantly lower than the 2021 adult Medicaid top-box scores for two measures: *Getting Needed Care* and *How Well Doctors Communicate*.

Performance Measure Calculation Results

HSAG calculated the *Colorectal Cancer Screening (COL)* performance measure following the CMS *Core Set of Adult Health Care Quality Measures for Medicaid*. The Virginia Medicaid total and the Medallion 4.0 program results were:

Medicaid Program	CY 2021 Results
Virginia Total	32.73%
Medallion 4.0	28.84%

Consumer Decision Support Tool

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.

MCO	Overall Rating	Doctors' Communication	Getting Care
Aetna	★★★	★★★	★★★
HealthKeepers	★★★★★	★★★	★★★★
Molina	★	★★★	★
Optima	★★★	★★★	★★★★
United	★★★	★★★	★★★
VA Premier	★★★★	★★★	★★★

MCO	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★★	★★★	★★★★★
HealthKeepers	★★★★★	★★★	★★★★★
Molina	★	★	★
Optima	★★	★★★	★
United	★★★★★	★★★★	★★★
VA Premier	★★★	★★★★★	★★★★

Medicaid Maternal and Child Health Focus Study

The Medicaid Maternal and Child Health Focus Study included four study indicators calculated among singleton births occurring during CY 2020 and paid by Virginia Medicaid: percentage of births with early and adequate prenatal care, percentage of births with inadequate prenatal care, percentage of preterm births (<37 weeks gestation), and percentage of newborns with low birth weight (<2,500g). Study results were not limited to the women in the Medallion 4.0 program.

Strengths
• Women enrolled in *managed care* had better outcomes than women in the FFS population in CY 2020. The CY 2020 rate for women in managed care exceeded the national benchmark for the *Newborns With Low Birth Weight (<2,500 grams)* study indicator but continued to fall below the national benchmark for the *Births With Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators. • The CY 2020 rate for women in *FFS* improved from prior measurement periods to outperform the national benchmark for *Newborns With Low Birth Weight (<2,500 grams)*. • Births to women in the *FAMIS MOMS* program had the highest rates of *Births With Early and Adequate Prenatal Care* and the lowest rates of *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight*

Commonwealth of Virginia
Department of Medical Assistance Services
2022 External Quality Review Medallion 4.0 Program Technical Report Snapshot

(<2,500g) for all three measurement periods (CY 2018, CY 2019, and CY 2020).

- The rates for the *FAMIS MOMS* program met or exceeded the national benchmarks for all study indicators with applicable benchmarks for all three measurement periods.
- The *Medicaid for Pregnant Women* program outperformed the national benchmarks for the *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500g)* study indicators for CY 2020.
- The *Medicaid expansion* rates did not meet the national benchmarks in CY 2020; however, improvements were seen from CY 2019 to CY 2020, especially for the *Births With Early and Adequate Prenatal Care* and *Newborns With Low Birth Weight (<2,500g)* study indicators.

Opportunities for Improvement

The *LIFC* and *Other Medicaid* program rates demonstrated an opportunity for improvement given women in these two programs had the lowest rates of *Births With Early and Adequate Prenatal Care* and some of the highest rates of *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500g)*.

Child Welfare Focus Study

The annual Child Welfare Focus Study, titled the Foster Care Focus Study, determined the extent to which children in foster care received the expected preventive and therapeutic medical care under a managed care service delivery program compared to children not in foster care and receiving Medicaid managed care (control group) benefits during MY 2020.

Strengths

- The Child Welfare Focus Study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than the comparable control group for most study indicators. This finding is consistent across all three measurement years (MY 2018, MY 2019, MY 2020).
- Rate differences between children in foster care and the control group were greatest among dental measures, where the rates of annual dental visits and preventive dental services among children in foster care were nearly 30 percentage points higher than the rates for the control group.

Opportunities for Improvement

- During MY 2020, children in foster care had lower rates compared to the control group for only two study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment*.
- For initiation of AOD abuse or dependence treatment, children in foster care had a higher rate than the control group during MY 2019 and a lower rate during MY 2018.
- For engagement of AOD abuse or dependence treatment, children in foster care had a higher rate than the control group for both MY 2018 and MY 2019.

Dental Utilization in Pregnant Women Data Brief

The Dental Utilization in Pregnant Women Focus Study (Data Brief) included all women 21 years of age or older with deliveries during CY 2021. The Data Brief was designed to assess dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program through the SFC program that was administered by DentaQuest.

Strengths

- Among the CY 2021 study population, 84.20 percent of services were covered by the Medicaid managed care delivery system, with 18.56 percent of those deliveries to women who received perinatal dental services.
- Within the managed care delivery system, 74.27 percent of deliveries were covered by the Medallion 4.0 program, with 18.56 percent of these deliveries to women who had received perinatal dental services.
- Women enrolled in the Medicaid for Pregnant Women program accounted for the largest proportion of deliveries by Medicaid program (47.15 percent), with 19.31 percent of these deliveries to women who received perinatal dental services.
- The percentage of deliveries for members meeting the performance measure numerator for *Births With Adequate Prenatal Care* was significantly higher for those who received at least one prenatal dental service (78.36 percent) compared to those who received no prenatal dental services (74.50 percent).
- For *Postpartum Ambulatory Care Utilization*, the deliveries where at least one prenatal dental service was received had significantly higher rates (68.77 percent) compared to deliveries that received no dental services (56.30 percent).
- Deliveries receiving preventive services had significantly lower rates of *Newborns With Low Birth Weight (<2,500 grams)* (7.06 percent) compared to deliveries that did not receive preventive services (9.18 percent).
- Deliveries receiving preventive services also had significantly higher rates of *Births With Adequate Prenatal Care* (79.07 percent) compared to deliveries that did not receive preventive services (74.74 percent).
- For *Postpartum Ambulatory Care Utilization*, the rate for deliveries receiving preventive services (69.76 percent) was significantly higher than the rate for deliveries with no preventive services (57.18 percent).
- Among women with continuous enrollment, utilization was highest in the Northern & Winchester region.
- Perinatal dental utilization was highest for deliveries among Asian, Non-Hispanic women (29.17 percent).

Opportunities for Improvement

- FFS covered 11.45 percent of services; however, only 6.41 percent of those deliveries were to women who received perinatal dental services.
- Among women with continuous enrollment, utilization was lowest in the Roanoke/Alleghany region.
- Perinatal dental utilization was lowest among deliveries to women of Other/Unknown race (15.50 percent).