

# Commonwealth of Virginia Department of Medical Assistance Services

## 2023 External Quality Review Technical Report—Medallion 4.0 (Acute)

April 2024



## Table of Contents

<b>1. Executive Summary</b>	<b>1-1</b>
Overview of 2023 External Quality Review	1-1
Scope of External Quality Review Activities	1-2
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	1-10
<b>2. Overview of Virginia’s Managed Care Program</b>	<b>2-1</b>
Medicaid Managed Care in the Commonwealth of Virginia	2-1
The Department of Medical Assistance Services	2-1
Virginia’s 2023–2025 Quality Strategy	2-18
Quality Initiatives	2-20
Best and Emerging Practices	2-21
<b>3. MCO Comparative Information</b>	<b>3-1</b>
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
Cardinal Care Program Readiness Reviews	3-14
Network Adequacy Validation	3-16
MCO Comparative and Statewide Aggregate Secret Shopper Survey Results	3-18
Prenatal Care (PNC) Provider Secret Shopper Survey	3-18
Primary Care Provider (PCP) Secret Shopper Survey	3-24
Statewide Aggregate CAHPS Results	3-31
FAMIS Program Statewide Aggregate Results	3-34
MCO Comparative and Statewide Calculation of Additional PM Results	3-36
ARTS PM Specification Development and Maintenance Results	3-38
Focus Studies	3-38
MCO Comparative and Statewide Aggregate Consumer Decision Support Tool Results	3-38
Performance Withhold Program	3-40
<b>4. Validation of Performance Improvement Projects</b>	<b>4-1</b>
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	4-3
Recommendations	4-17
<b>5. Validation of Performance Measures</b>	<b>5-1</b>
Overview	5-1
Objectives	5-1
MCO-Specific HEDIS Measure Results	5-1
Aetna	5-1

HealthKeepers .....	5-3
Molina .....	5-4
Optima .....	5-6
United .....	5-7
VA Premier .....	5-8
<b>6. Review of Compliance With Medicaid and CHIP Managed Care Regulations .....</b>	<b>6-1</b>
Overview .....	6-1
Objectives .....	6-1
Deeming .....	6-2
Aetna .....	6-3
HealthKeepers .....	6-4
Molina .....	6-6
Optima .....	6-7
United .....	6-8
VA Premier .....	6-9
DMAS Intermediate Sanctions Applied .....	6-10
<b>7. Cardinal Care Program Readiness Reviews .....</b>	<b>7-1</b>
Cardinal Care Readiness Review .....	7-1
Aetna .....	7-2
HealthKeepers .....	7-3
Molina .....	7-5
Optima .....	7-6
United .....	7-7
VA Premier .....	7-8
<b>8. Secret Shopper Surveys .....</b>	<b>8-1</b>
Prenatal Care Secret Shopper Survey .....	8-1
Overview .....	8-1
Objectives .....	8-1
Statewide Results .....	8-1
MCO-Specific Results .....	8-3
PCP Secret Shopper Survey .....	8-15
Overview .....	8-15
Objectives .....	8-15
Statewide Results .....	8-15
General Recommendations .....	8-16
MCO-Specific Results .....	8-17
<b>9. Encounter Data Validation .....</b>	<b>9-1</b>
Overview .....	9-1
<b>10. Member Experience of Care Survey .....</b>	<b>10-1</b>
Overview .....	10-1
Objectives .....	10-1
MCO-Specific Results .....	10-1
Aetna .....	10-1
HealthKeepers .....	10-3
Molina .....	10-6
Optima .....	10-8
United .....	10-10
VA Premier .....	10-12

**11. ARTS Measure Specification Development and Maintenance .....11-1**  
 Overview.....11-1  
 Findings.....11-2  
 Conclusions.....11-3

**12. Focus Studies .....12-1**  
 Overview.....12-1  
 Medicaid and CHIP Maternal and Child Health Focus Study .....12-1  
 Foster Care Focus Study.....12-5  
 Dental Utilization in Pregnant Women Focus Study .....12-17

**13. Summary of MCO-Specific Strengths and Weaknesses .....13-1**  
 Aetna .....13-1  
 HealthKeepers .....13-3  
 Molina .....13-5  
 Optima .....13-8  
 United .....13-9  
 VA Premier .....13-12

**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. 2023–2025 Quality Strategy Status Assessment.....F-1**  
**Appendix G. Medallion 4.0 (Acute) Program 2023 Snapshot.....G-1**

## Glossary of Acronyms

42 CFR .....	Title 42 of the Code of Federal Regulations
AAP .....	American Academy of Pediatrics
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 <sup>®</sup> .1 .....	Consumer Assessment of Healthcare Providers and Systems
CAP .....	Corrective Action Plan
CC .....	Community Coaching
CCC .....	Children with Chronic Conditions
CCC Plus (MLTSS)..	Commonwealth Coordinated Care Plus (Managed Long Term Services and Supports)
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

---

<sup>1</sup> CAHPS<sup>®</sup> is a registered trademark of AHRQ.

CSB .....	Community Service Board
CSS .....	Center for the Study of Services
CT .....	Computerized Tomography
CY .....	Calendar Year
D-SNP .....	Dual-Eligible Special Needs Plan
DAA .....	Direct-Acting Antiviral
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
HbA1c .....	Hemoglobin A1c
HCBS .....	Home- and Community-Based Services
HEDIS <sup>®2</sup> .....	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

<sup>2</sup> HEDIS<sup>®</sup> is a registered trademark of NCQA.

HMO	Health Maintenance Organization
HPV	Human Papillomavirus
HRA	Health Risk Assessment
HSAG	Health Services Advisory Group, Inc.
IACCT	Independent Assessment Certification and Coordination Team
ICT	Intensive Community Treatment
ID	Identification
IDSS	Interactive Data Submission System
IIH	Intensive In-Home Services
IS	Information Systems
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
NIH .....	National Institutes of Health
NPI .....	National Provider Identifier
NR .....	Not Reported
NVS .....	Network Validation Survey
NVSS .....	National Vital Statistics System
OBAT .....	Office-Based Addiction Treatment
O/E .....	Observed-to-Expected
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
PDL .....	Preferred Drug List
PDSA .....	Plan-Do-Study-Act
PHE .....	Public Health Emergency
PHI .....	Protected Health Information
PIHP .....	Prepaid Inpatient Health Plan
PIP .....	Performance Improvement Project
PM .....	Performance Measure
MPPM .....	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
RAP .....	Risk Assessment Profile
RPR .....	Rapid Plasma Reagin
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
SDOH .....	Social Determinants of Health
SFC.....	Smiles for Children
SFTP.....	Secure File Transfer Protocol
SFY .....	State Fiscal Year
SHCN.....	Special Health Care Needs
SMART .....	Specific, Measurable, Attainable, Relevant, Time-Bound
SME .....	Subject Matter Expert
SNF .....	Skilled Nursing Facility
SSA.....	Social Security Act
SUD .....	Substance Use Disorder
SUPPORT Act .....	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
SVR .....	Sustained Virologic Response
TANF .....	Transitional Aid to Needy Families
TB .....	Tuberculosis
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 2023 External Quality Review

According to 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 CMS.<sup>1-1</sup>

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, 2023, through December 31, 2023 (CY 2023). 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 (Acute) 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 health and BH services to Medicaid and CHIP members. The MCOs contracted with DMAS during CY 2023 are displayed in Table 1-1.

**Table 1-1—Medicaid Medallion 4.0 (Acute) 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*

\*VA Premier merged with Optima during CY 2023.

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department’s FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. DMAS received CMS approval for an effective date of October 1, 2023, for the Cardinal Care program. The Cardinal Care program will ensure an efficient, well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth. The consolidated program will enable

<sup>1-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 15, 2023.

DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the populations served. The Cardinal Care program will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program will ensure a smoother transition for individuals whose healthcare needs evolve over time.

## Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS. The purpose of these activities, in general, is to improve states’ ability to oversee and manage MCOs they contract with for services and help MCOs improve their performance with respect to 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 2023 EQR technical report, HSAG used findings from the EQR activities conducted from January 1, 2023, through December 31, 2023. 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 (Acute) 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 12 of this report and Section 13—Summary of MCO-Specific Strengths and Weaknesses. 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
<b>Mandatory Activities</b>		
<b>PIPs</b>	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 2023 validation cycle.	<i>Protocol 1. Validation of Performance Improvement Projects</i>
<b>PMV</b>	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	<i>Protocol 2. Validation of Performance Measures</i>

Activity	Description	CMS EQR Protocol
	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, 2022, through December 31, 2022.	
<b>Compliance With Medicaid and CHIP Managed Care Regulations</b>	<p>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-specific requirements for the review period of July 1, 2021, through June 30, 2022.</p> <p>This activity assesses the readiness of each MCO with which DMAS contracts when the MCO will provide or arrange for the provision of covered benefits prior to DMAS implementing a managed care program, when the MCO has not previously contracted with the State; or when the MCO will provide or arrange for the provision of covered benefits to new eligibility groups.</p>	<i>Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations</i>
<b>Validation of Network Adequacy</b>	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.	<i>Protocol 4. Validation of Network Adequacy</i>
<b>Optional Activities</b>		
<b>EDV</b>	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	<i>Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan</i>

Activity	Description	CMS EQR Protocol
	complete, accurate, and submitted by the MCOs in a timely manner for encounters.	
<b>CAHPS Analysis</b>	<p>This activity assesses member experience with an MCO and its providers and the quality-of-care members receive.</p> <p><b>FAMIS CAHPS Survey</b>—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.</p>	<i>Protocol 6. Administration or Validation of Quality-of-Care Surveys</i>
<b>Calculation of Additional PMs</b>	<p>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.</p> <p>HSAG calculates one PM (selected by DMAS) for the Medicaid population stratified by geographic region and key demographic variables (race, gender, age, etc.).</p>	<i>Protocol 7. Calculation of Additional Performance Measures</i>
<b>ARTS Measure Specification Development and Maintenance</b>	HSAG identifies, when available, PMs from existing PM sets or develops PMs for the ARTS program.	
<b>Focus Studies</b>	<p>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.</p> <p><b>Medicaid and CHIP Maternal and Child Health Focus Study</b>—HSAG conducts a focus study that provides quantitative information about prenatal care and associated birth outcomes among Medicaid recipients.</p> <p><b>Child Welfare Focus Study</b>—HSAG conducts a Child Welfare Focus Study to evaluate healthcare utilization among children in foster care under the Medallion 4.0 (Acute) program.</p>	<i>Protocol 9. Conducting Focus Studies of Health Care Quality</i>

Activity	Description	CMS EQR Protocol
	<p><b>Dental Utilization in Pregnant Women Data Brief</b>—HSAG produces a data brief describing dental utilization among pregnant women enrolled in the Medicaid or FAMIS MOMS programs.</p>	
<p><b>Consumer Decision Support Tool</b></p>	<p>This activity provides information to help eligible members choose a Medicaid Medallion 4.0 (Acute) 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 (Acute) program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.</p>	<p><i>Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans</i></p>
<p><b>PWP</b></p>	<p>HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2023 PWP used HEDIS and non-HEDIS measures.</p>	
<p><b>QS Update</b></p>	<p>HSAG works with DMAS to update and maintain the Virginia 2023–2025 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.</p>	<p>Medicaid and CHIP Managed Care QS Toolkit</p>

## 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 (Acute) 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 (Acute) Program Conclusions: Quality, Access, and Timeliness**


Program Strengths	
Domain	Conclusion
 <b>Quality</b>	<p><b>Strength:</b> Overall, children’s preventive care demonstrates a strength for the Medallion 4.0 (Acute) program. PM results found that four of six MCOs’ rates met or exceeded the 50th percentile for the <i>Child and Adolescent Well-Care Visits—Total</i> and <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicators. These results align with the findings in the FAMIS CAHPS survey wherein the general child’s 2023 top-box score was statistically significantly higher than the 2022 top-box score for <i>Customer Service</i>.</p> <p><b>Strength:</b> Overall, the Maternal and Child Health Focus Study showed that FAMIS MOMS program results demonstrated strength, with rates for the <i>Births with Early and Adequate Prenatal Care</i>, <i>Preterm Births (&lt;37 Weeks Gestation)</i>, and <i>Newborns with Low Birth Weight (&lt;2,500 grams)</i> study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program had rates for the <i>Preterm Births (&lt;37 Weeks Gestation)</i> study indicator that outperformed national benchmarks in CYs 2020 and 2021, and had rates for the <i>Newborns with Low Birth Weight (&lt;2,500 grams)</i> study indicator that outperformed national benchmarks in CYs 2019, 2020, and 2021. Additionally, the Medicaid Expansion program’s rate for the <i>Births with Early and Adequate Prenatal Care</i> study indicator improved from CY 2020 and outperformed the national benchmark in CY 2021.</p>

Program Strengths	
Domain	Conclusion
	<p><b>Strength:</b> The Child Welfare Focus Study also demonstrated strength for the Medallion 4.0 (Acute) program. The study found that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (<i>Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services; and Topical Fluoride for Children—Dental or Oral Health Services</i> by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively); the <i>Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics</i> measure (by 20.8 percentage points); and the <i>Behavioral Health Encounters—CMH Services</i> indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics. The study results align with PMV results.</p> <p><b>Strength:</b> Implementation of PIPs is also an identified strength of the Medallion 4.0 (Acute) MCOs, with five of the six MCOs receiving 100 percent validation scores across all evaluation elements for Steps 1 through 8 and being assigned a <i>High Confidence</i> level for both PIPs. These MCOs calculated and reported baseline data accurately, implemented targeted interventions that addressed the identified barriers, and developed sound methodologies for evaluating the effectiveness for each intervention.</p>
+	<p><b>Access</b></p> <p><b>Strength:</b> Within the Care for Chronic Conditions domain, the Medallion 4.0 (Acute) program demonstrated strength, with five of six MCOs’ rates meeting or exceeding the 50th percentile for the <i>Asthma Medication Ratio—Total and Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i> PM indicators.</p>
+	<p><b>Timeliness</b></p> <p><b>Strength:</b> Overall, BH care and ARTS demonstrate strengths for the Medallion 4.0 (Acute) program. The ARTS study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The <i>Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis</i> indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators showed that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. Of members diagnosed with OUD, 44.2 percent initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an</p>



Program Strengths	
Domain	Conclusion
	<p>increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021.</p> <p>The emphasis and focus on the ARTS program may be driving improvement in BH measures. MCO performance within the Behavioral Health domain was strong, with all six MCOs' rates meeting or exceeding the 50th percentile for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day follow-Up—Total, and 30-Day Follow-Up—Total</i> and <i>Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment PM</i> indicators, and five of six MCOs' rates meeting or exceeding the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment PM</i> indicators.</p>
Program Weaknesses	
Domain	Conclusion
 <p>Quality</p>	<p><b>Weakness:</b> There are reoccurring opportunities for improvement within the Children's Preventive Care domain, with four of the six MCOs' rates falling below the 50th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits PM</i> indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the <i>Childhood Immunization Status—Combination 3 PM</i> indicator. The FAMIS CCC CAHPS survey 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for two measures: <i>Rating of All Health Care</i> and <i>Getting Needed Care</i>. The member experience survey results align with the PM results.</p> <p><b>Weakness:</b> Healthcare screenings continued to be an opportunity for improvement for the Medallion 4.0 (Acute) program MCOs. While one MCO improved performance over the prior year, the overall MCO performance was below the 50th percentile for the <i>Cervical Cancer Screening PM</i> indicator. In addition, all six MCOs' rates fell below the 50th percentile for the <i>Breast Cancer Screening</i> indicator. MCO performance suggests members are not receiving important health screenings.</p> <p><b>Weakness:</b> Within the Care for Chronic Conditions domain, five of the six Medallion 4.0 (Acute) MCOs' rates fell below the 50th percentile for the <i>Eye Exam for Patients With Diabetes—Total PM</i> indicator, reflecting an area of opportunity for improvement. MCO performance below the 50th percentile indicates some members with diabetes are not receiving</p>

Program Weaknesses	
Domain	Conclusion
	eye examinations as recommended to appropriately manage risks associated with diabetes.
 <b>Access</b>	<p><b>Weakness:</b> The Access to Care domain continues to represent an area of opportunity for improvement for the Medallion 4.0 (Acute) program, as all six MCOs' rates fell below the 50th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> PM indicator. MCO performance indicates that adult members are not routinely accessing preventive care in an ambulatory health setting.</p> <p><b>Weakness:</b> The results of the Medallion 4.0 (Acute) prenatal care secret shopper survey identified that overall, HSAG was unable to reach 36.0 percent of the sampled cases. Of the responsive cases, 46.3 percent of the respondents indicated that the provider location did not provide prenatal care services, 29.6 percent stated the office accepted the MCO, 27.3 percent stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients. In addition, among cases offering an appointment, 28.0 percent provided a first, second, or third trimester appointment date. Of the cases that were offered an appointment, 15.1 percent were compliant with DMAS' wait time standards for prenatal care services. In addition, all six MCOs' PMs were below the 50th percentile for the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> PM indicator. The results indicate that members are not receiving timely prenatal care that can potentially reduce the risk of pregnancy complications and maternal adverse outcomes. There is alignment in the PM and secret shopper survey results. The results indicate the continued need to ensure provider data accuracy and compliance with meeting contract appointment scheduling time frames to improve members' access to timely prenatal care.</p> <p><b>Weakness:</b> The Medallion 4.0 (Acute) program PCP secret shopper survey demonstrated similar results to the prenatal care secret shopper survey. Overall, approximately 83 percent of cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. The overall response rate was 63.2 percent, with 46.7 percent of the offices accepting the MCO, 43.3 percent accepting VA Medicaid, and 36.1 percent accepting new patients. Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent</p>

Program Weaknesses	
Domain	Conclusion
	<p>appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services.</p> <p>The survey results indicate the continued need to ensure provider data accuracy, including provider type and specialty, and compliance with meeting contract appointment scheduling time frames.</p>
 <p><b>Timeliness</b></p>	<p><b>Weakness:</b> The ARTS study findings show that engagement in OUD treatment may be declining. The <i>Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment</i> indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the COVID-19 PHE, since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE. The ARTS study findings are consistent with the overall Medallion 4.0 (Acute) PM results, with five of the six MCOs’ rates falling below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total</i> and <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> measure indicators. Additionally, four of the six MCOs’ rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total</i> PM indicator. This performance suggests that members have not received timely follow-up after ED visits and hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care.</p>

## Quality Strategy Recommendations for the Virginia Managed Care Program

The Virginia 2023–2025 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<sup>1-2</sup>**

Program Recommendations	
Recommendation	Associated Virginia 2023–2025 QS Objective, and Measure
<p>To improve program-wide performance in support of <b>Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4</b> and improve BH and developmental services for members, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> <li>• Work with the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization for mental illness and after ED visits for mental illness. HSAG also recommends that DMAS work with the MCOs to 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. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative<sup>1-3</sup> materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.</li> <li>• Continue work on the <i>Follow-Up After Emergency Department Visit for Mental Illness</i> measure through the PWP.</li> </ul>	<p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p> <p><b>Measure 5.4.1.1:</b> Follow-Up After Hospitalization for Mental Illness</p> <p><b>Measure 5.4.1.2:</b> Follow-Up After Emergency Department Visit for Mental Illness</p>
<p>To improve the accuracy of provider information available to members in support of <b>Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1</b> and <b>4.2</b> and improve access and timeliness of well-child visits and preventive healthcare for members under the age of 21 years, and the timeliness of pregnancy-related care, HSAG recommends that DMAS:</p> <ul style="list-style-type: none"> <li>• Work with the enrollment broker to address the data deficiencies identified during the PCP and prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers’ offices regarding the</li> </ul>	<p><b>Objective 4.1:</b> Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p><b>Measure 4.1.1.2:</b> Child and Adolescent Well-Care Visits</p> <p><b>Measure 4.1.1.3:</b> Childhood Immunization Status</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p> <p><b>Measure 4.2.1.1:</b> Prenatal and Postpartum Care—Timeliness of Prenatal Care</p> <p><b>Measure: 4.2.1.4:</b> Well-Child Visits in the First 30 Months of Life</p>

<sup>1-2</sup> Department of Medical Assistance Services. 2023–2025 Quality Strategy. Available at: <https://www.dmas.virginia.gov/media/5569/va2023-dmas-quality-strategy-f1.pdf>. Accessed on: Dec 20, 2023.

<sup>1-3</sup> Medicaid.gov. Improving Behavioral Health Follow-up Care Learning Collaborative. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html>. Accessed on: Dec 13, 2023.

### Program Recommendations

MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information, may result in improved access to care for members seeking well care, preventive healthcare, childhood immunizations, and pregnancy-related care.

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

## 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 2023.

**Table 2-1—CY 2023 Average Annual Program Enrollment<sup>2-1</sup>**

Program	SFY 2023 Enrollment as of 07/01/2023*
Medallion 4.0 (Acute)	1,670,831
CCC Plus (MLTSS)	307,904
Fee-for-Service	214,256
<b>Total Served</b>	<b>2,194,813</b>

*\*Point in time numbers. Categories are not intended to equal the total served.*

DMAS contracted with six privately owned MCOs to deliver physical health and BH services to Medicaid and CHIP members. During CY 2023, the Optima and VA Premier MCOs merged under the Optima name. The six MCOs contracted with DMAS on December 31, 2023, are displayed in Table 2-2.

**Table 2-2—Medallion 4.0 (Acute) 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 04/01/2024  LTSS Distinction through 04/01/2024
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 03/09/2024  LTSS Distinction through 03/09/2024

<sup>2-1</sup> 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: Feb 20, 2024.



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 11/01/2026 LTSS Distinction through 11/01/2026
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 04/01/2024 LTSS Distinction through 04/01/2024
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, DC	Accredited* through 03/10/2026 Electronic Clinical Data Distinction Health Equity through 07/08/2025 LTSS Distinction through 03/10/2026
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 07/26/2025 LTSS Distinction through 07/26/2025

\*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.<sup>2-2</sup>

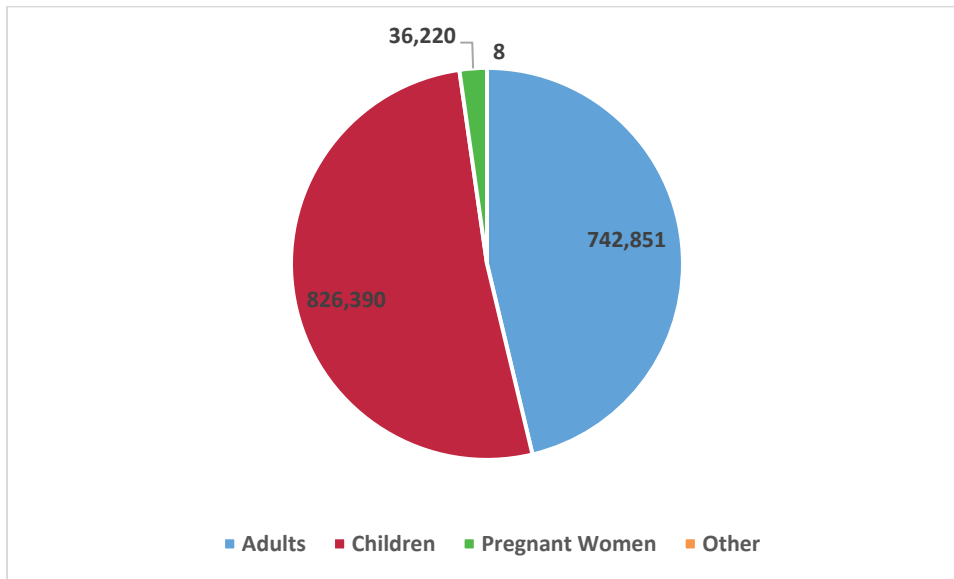
\*\*VA Premier merged with Optima during CY 2023.

<sup>2-2</sup> 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](https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf). Accessed on: Feb 20, 2024.

### MCO Medallion 4.0 (Acute) Enrollment Characteristics

Figure 2-1 through Figure 2-5 display the Medallion 4.0 (Acute) program enrollment characteristics. Table 2-3 through Table 2-7 display the MCO and Medallion 4.0 (Acute) program overall enrollment characteristics. Data contained in these tables and figures are from DMAS’ Cardinal Care Medicaid/FAMIS Enrollment dashboard.<sup>2-3</sup>

**Figure 2-1—Medallion 4.0 (Acute) Program CY 2023 MCO Eligibility Categories**



**Table 2-3—Medallion 4.0 (Acute) Program CY 2023 MCO Eligibility Categories<sup>2-4</sup>**

Category	Aetna	HealthKeepers	Molina	Optima	United	All
Overall Total	227,088	487,692	109,2202	595,991	185,226	1,605,199
Adults	127,056	275,939	62,518	324,737	92,319	742,851
Children	94,419	200,950	43,382	259,738	87,913	826,390
Pregnant Women	5,613	10,802	3,302	11,511	4,992	36,220
Other	0	1	0	5	2	8

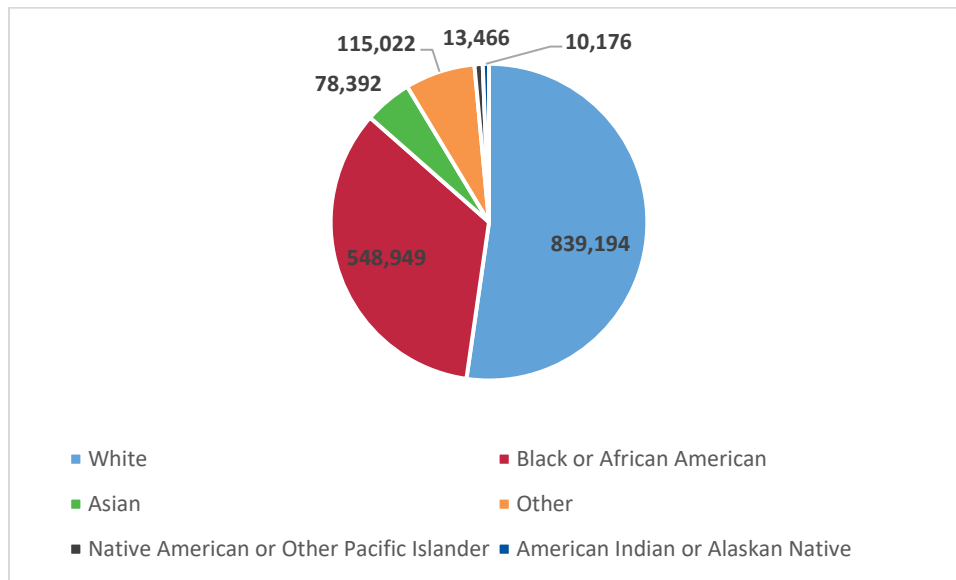
Note: The Optima and VA Premier MCO merged during CY 2023. The Optima numbers are inclusive of both MCO’s member populations.

<sup>2-3</sup> 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 14, 2023.

<sup>2-4</sup> Ibid.



**Figure 2-2—Medallion 4.0 (Acute) Program CY 2023 Categories by Race<sup>2-5</sup>**



**Table 2-4—Medallion 4.0 (Acute) Program CY 2023 Categories by Race<sup>2-6</sup>**

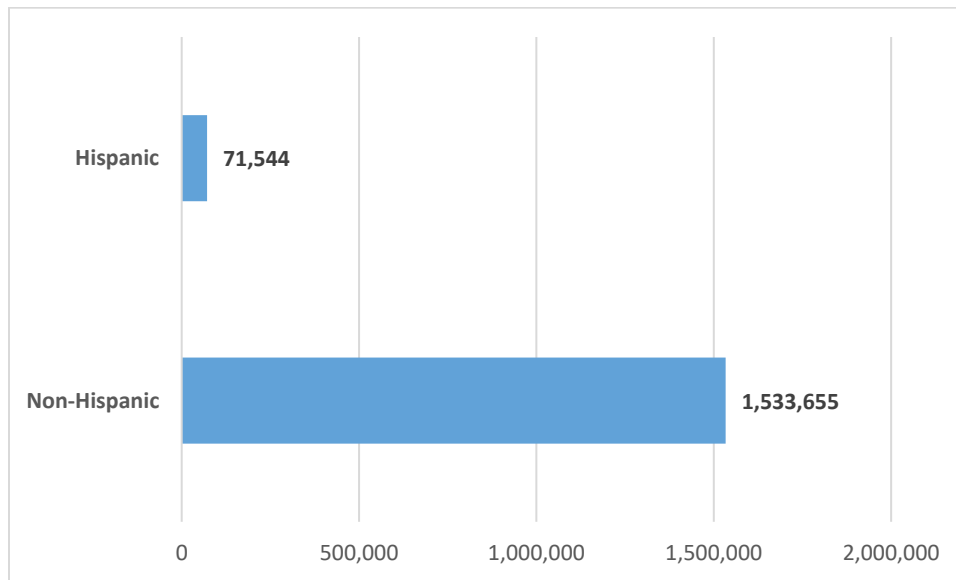
Category	Aetna	HealthKeepers	Molina	Optima	United	All
<i>White</i>	118,164	256,890	55,580	304,821	103,439	839,194
<i>Black or African American</i>	73,227	164,678	35,377	225,505	50,162	548,949
<i>Asian</i>	10,698	27,925	4,734	24,094	10,941	78,392
<i>Other</i>	21,349	30,736	11,893	33,434	17,610	115,022
<i>Native Hawaiian or Other Pacific Islander</i>	1,713	4,458	860	4,659	1,776	13,466
<i>American Indian or Alaskan Native</i>	1,637	3,005	758	3,478	1,298	10,176

Note: The Optima and VA Premier MCO merged during CY 2023. The Optima numbers are inclusive of both MCOs' member populations.

<sup>2-5</sup> Ibid.

<sup>2-6</sup> Ibid.

**Figure 2-3—Medallion 4.0 (Acute) Program CY 2023 MCO Categories by Ethnicity<sup>2-7</sup>**



**Table 2-5—Medallion 4.0 (Acute) Program CY 2023 MCO Categories by Ethnicity<sup>2-8</sup>**

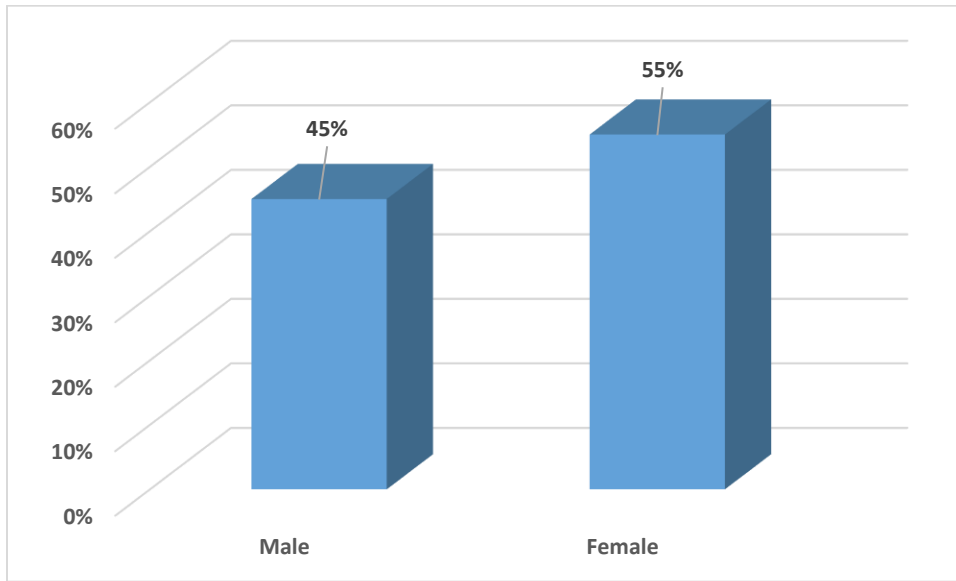
Category	Aetna	HealthKeepers	Molina	Optima	United	All
Non-Hispanic	217,651	464,199	104,732	570,803	176,270	1,533,655
Hispanic	9,437	23,493	4,470	25,188	8,956	71,544

Note: The Optima and VA Premier MCO merged during CY 2023. The Optima numbers are inclusive of both MCOs' member populations.

<sup>2-7</sup> Ibid.

<sup>2-8</sup> Ibid.

**Figure 2-4—Medallion 4.0 (Acute) Program CY 2023 MCO Percentage by Gender<sup>2-9</sup>**



**Table 2-6—Medallion 4.0 (Acute) Program CY 2023 MCO Percentage by Gender<sup>2-10</sup>**

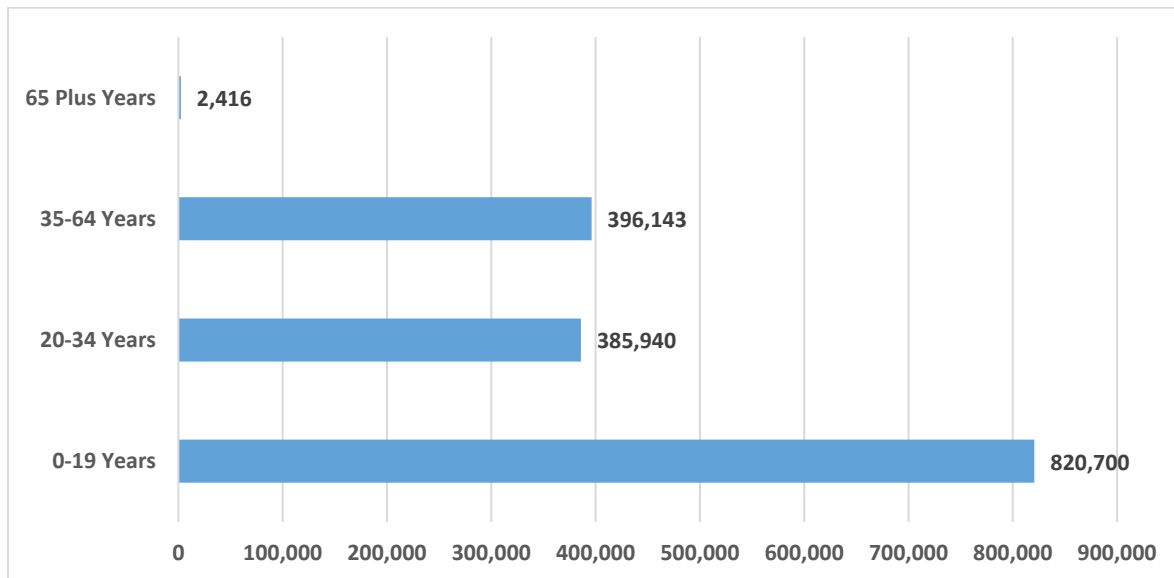
Category	Aetna	HealthKeepers	Molina	Optima	United	All
Male	45%	44%	49%	45%	47%	45%
Female	55%	56%	51%	55%	53%	55%

*Note: The Optima and VA Premier MCO merged during CY 2023. The Optima numbers are inclusive of both MCOs' member populations.*

<sup>2-9</sup> Ibid.

<sup>2-10</sup> Ibid.

**Figure 2-5—Medallion 4.0 (Acute) Program CY 2023 MCO Enrollment by Age Group<sup>2-11</sup>**



**Table 2-7—Medallion 4.0 (Acute) Program CY 2023 MCO Enrollment by Age Group<sup>2-12</sup>**

Category	Aetna	HealthKeepers	Molina	Optima*	United	All
0–19 Years	93,978	274,099	43,322	321,477	87,824	820,700
20–34 Years	63,161	106,355	33,066	136,239	47,119	385,940
35–64 Years	69,508	106,640	32,597	137,431	49,967	396,143
65+ Years	441	598	217	844	316	2,416

*Note: The Optima and VA Premier MCO merged during CY 2023. The Optima numbers are inclusive of both MCOs’ member populations.*

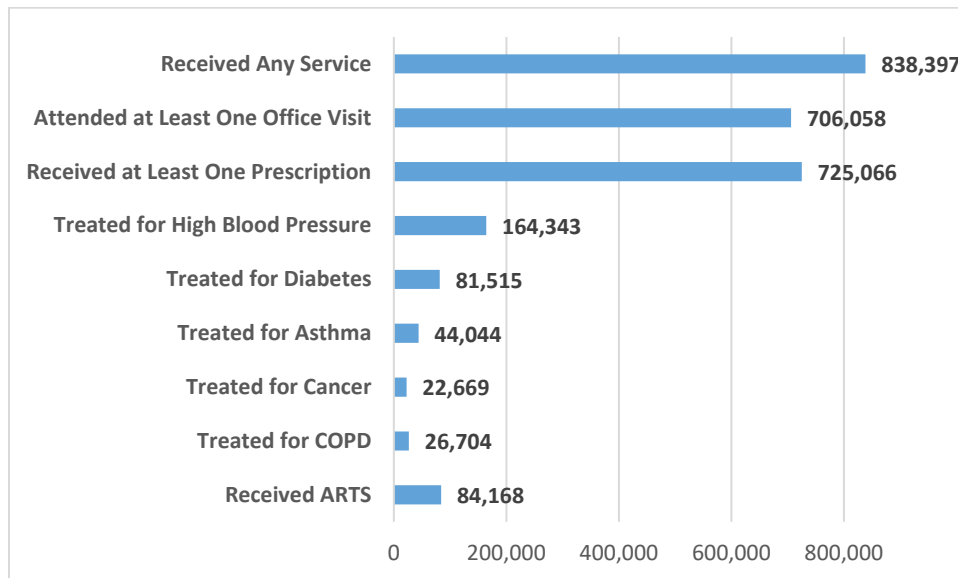
### Medallion 4.0 (Acute) Program

The Medallion 4.0 (Acute) 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 (Acute) 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.

<sup>2-11</sup> Ibid.

<sup>2-12</sup> Ibid.

**Figure 2-6—CY 2023 Medicaid Expansion Service Provision<sup>2-13</sup>**



**Table 2-8—CY 2023 Medicaid Expansion Service Provision<sup>2-14</sup>**

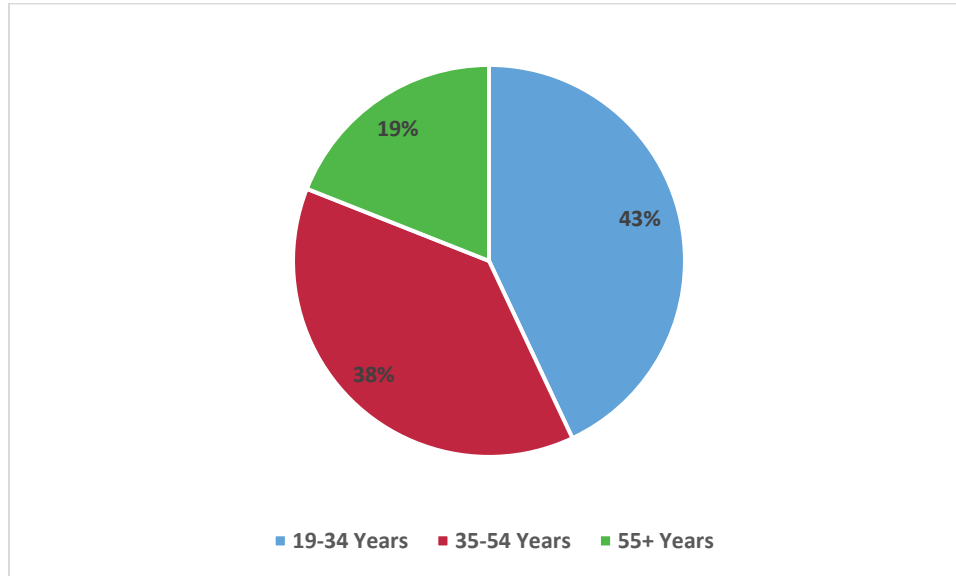
Age Category	Number of Services Provided
Received ARTS	84,168
Treated for COPD	26,704
Treated for Cancer	22,669
Treated for Asthma	44,044
Treated for Diabetes	81,515
Treated for High Blood Pressure	164,343
Received at Least One Prescription	725,066
Attended at Least One Office Visit	706,058
Received Any Service	838,397

Data from 12/06/2023 Enrollment Data at <https://www.dmas.virginia.gov/data/medicaid-expansion-access/>

<sup>2-13</sup> 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 22, 2023.

<sup>2-14</sup> Ibid.

**Figure 2-7—CY 2023 Program Medicaid Expansion Percentage by Age Category<sup>2-15</sup>**



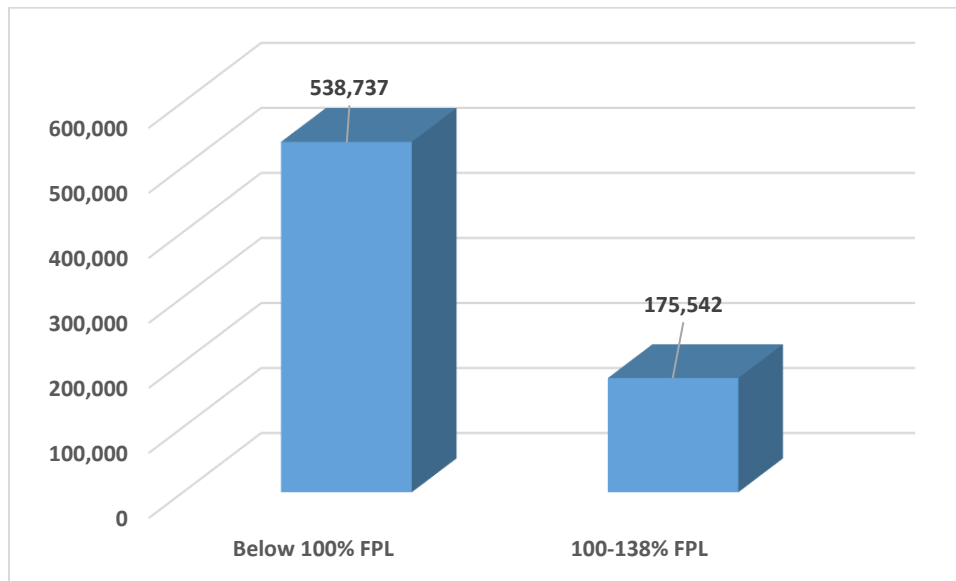
**Table 2-9—CY 2023 Program Medicaid Expansion Percentage by Age Category<sup>2-16</sup>**

Age Category	Percentage
19–34 Years	43%
35–54 Years	38%
55+ Years	19%

<sup>2-15</sup> 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 22, 2023.

<sup>2-16</sup> Ibid.

**Figure 2-8—CY 2023 Program Medicaid Expansion Members by FPL Category<sup>2-17</sup>**



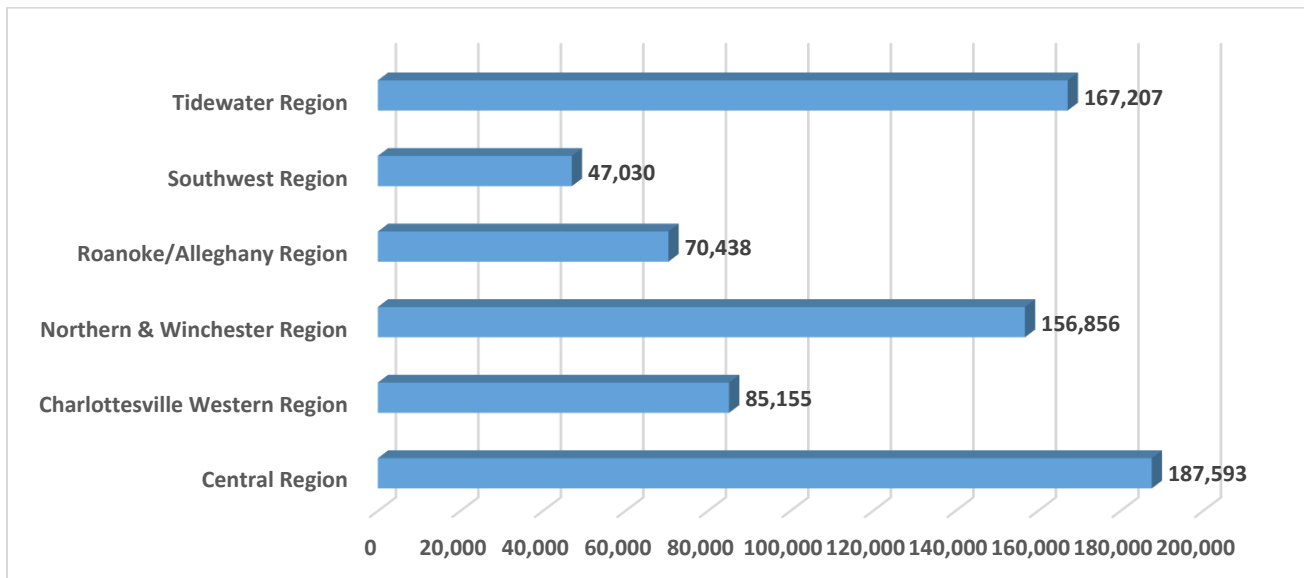
**Table 2-10—CY 2023 Program Medicaid Expansion Members by FPL Category<sup>2-18</sup>**

FPL Level	Number
Below 100% FPL	538,737
100–138% FPL	175,542

<sup>2-17</sup> Ibid.

<sup>2-18</sup> Ibid.

**Figure 2-9—CY 2023 Medicaid Expansion Members by Medicaid Region<sup>2-19</sup>**



**Table 2-11—Medicaid Expansion Members by Medicaid Region<sup>2-20</sup>**

Region	Number
Central Region	187,593
Charlottesville Western Region	85,155
Northern & Winchester Region	156,856
Roanoke/Alleghany Region	70,438
Southwest Region	47,030
Tidewater Region	167,207

Data from 12/06/2023 Enrollment Data at <https://www.dmas.virginia.gov/data/medicaid-expansion-enrollment/>

## 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 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.

<sup>2-19</sup> Ibid.

<sup>2-20</sup> 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.<sup>2-21</sup> 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 flexibilities DMAS allowed during the PHE.<sup>2-22</sup>

**Table 2-12—COVID-19 Flexibilities<sup>2-23</sup>**

Appeals
For all appeals filed during the state of emergency, Medicaid members will automatically keep their coverage. This flexibility is continuing under a 1902I(14) waiver approved by CMS.
There will be no financial recovery for continued coverage for appeals filed during the period of the emergency. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS.
Delay scheduling of fair hearings and issuing fair hearing decisions due to an emergency beyond the state’s control. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS for cases that involve existing coverage.
The state may offer to continue benefits to individuals who are requesting a fair hearing if the request comes later than the date of the action under 42 CFR §431.230. This flexibility is continuing under a 1902(e)(14) waiver approved by CMS.
Care and Services
Pre-approvals were not 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.
90-day supply for many drugs.
Drugs dispensed for 90 days were 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). In addition, the agency made exceptions to their published PDL if drug shortages occurred.
ARTS—Opioid treatment programs were able to administer medication as take-home dosages, up to a 28-day supply. Take home medications were made permanent for opioid treatment programs for up to 28 days. Allowance for home inductions via telemedicine for MOUD was allowed by the federal government.
A member’s home was able to serve as the originating site for buprenorphine prescription.
A copay was not required for Medicaid and FAMIS members.
Conducted outreach to higher risk and older members to review critical needs.

<sup>2-21</sup> Georgetown University McCourt School of Public Policy, 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: Dec 22, 2023.

<sup>2-22</sup> Virginia Department of Medical Assistance Services. COVID-19 Response. COVID-19 and the Return to Normal Enrollment. Available at: <https://www.dmas.virginia.gov/covid-19-response/>. Accessed on: Dec 22, 2023.

<sup>2-23</sup> Ibid.

Providers
Provider enrollment requirements were streamlined. Site visits, application fees, and certain background checks were waived to temporarily enroll providers in the Medicaid program. Deadlines for revalidations of providers were postponed.
Out-of-state providers were permitted to be reimbursed for services to Medicaid members.
Telehealth was permitted for many practice areas
Telehealth policies—waiver of penalties for HIPAA non-compliance and other privacy requirements.
Facilities were fully reimbursed for services rendered to an unlicensed facility (during PHE). This rule applied to facility-based providers only.
Electronic signatures were accepted for visits that were conducted through telehealth.
Enrollment and Eligibility
Ended continuous coverage requirement, reinstatement of eligibility determinations and renewals.
Implemented processes to ensure members did not lose coverage due to lapses in paperwork.

## 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 (MLTSS) and Medallion 4.0 (Acute) 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 expanded care coordination to all geographic areas, populations, and services within the managed care environment and in FFS.

Care coordination in Medallion 4.0 (Acute) 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 HRAs 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.

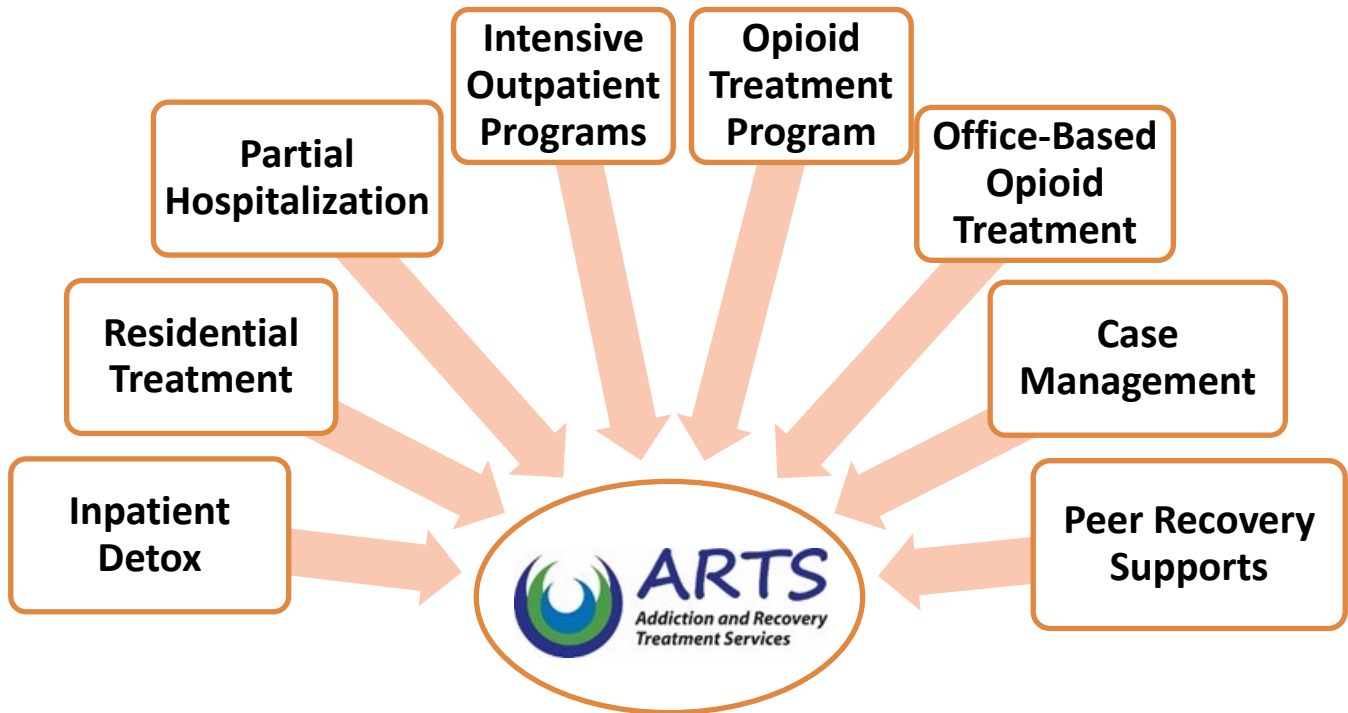
## ARTS<sup>2-24</sup>

In 2017, DMAS implemented the ARTS benefit and carved in all services into the CCC Plus (MLTSS) and Medallion 4.0 (Acute) 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. ARTS also increased provider reimbursement rates for many existing services and introduced a new care delivery model for treatment of OUD, the preferred OBAT provider. OBATs integrate MOUD with co-located behavioral and physical health by incentivizing increased use of care coordination activities. In addition, in accordance with requirements of Item 313, section ZZZ of the 2020 Appropriations Act, DMAS expanded the OBAT model effective March 1, 2022, to allow for other primary SUDs in addition to OUD.

ARTS 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 goal is to ensure that members are matched to the right level of care to meet their evolving needs as they enter and progress through treatment. The ARTS benefit is a fully integrated physical health and BH continuum of care.

---

<sup>2-24</sup> 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*. Available at: [FinalARTS3yearcomprehensivereportforPublishing\\_07142021\(1\).pdf \(vcu.edu\)](#). Accessed on: Dec 14, 2023.



DMAS provided an April 2023 report titled, *Addiction and Recovery Treatment Services, Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022* (report).<sup>2-25</sup> The report was prepared by the VCU School of Medicine, Health Behavior and Policy. The primary objective of this report is to examine SUD prevalence, treatment utilization, and outcomes among Virginia Medicaid members during SFYs 2020, 2021, and the first two quarters of SFY 2022 (covering the period July 2019 through December 2022). The report states that the Commonwealth of Virginia has made substantial progress since the implementation of the ARTS benefit in 2017 in building a robust treatment infrastructure for Medicaid members, with the number of treatment providers, members using services, and treatment rates for those with SUD diagnoses increasing every year since 2017. The highlights of the results of the implementation of the ARTS benefit discussed in the report include:

**Increased prevalence of SUD**

- Over 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14.3 percent from SFY 2020.
- OUD was the most frequently diagnosed SUD in SFY 2021 (48,008 members) followed by AUD (44,038 members); cannabis (35,911 members, a 26.9 percent increase); and stimulants, which includes the use of methamphetamines (27,226 members, a 19.4 percent increase).

<sup>2-25</sup> VCU School of Medicine Health Behavior and Policy. *Addiction and Recovery Treatment Services: Evaluation Report for State Fiscal Years 2020, 2021, and the first half of 2022*. April 2023. Available at: <https://hbp.vcu.edu/media/hbp-2023/FinalARTSComprehensiveReport.4.27.23.docx.pdf>. Accessed on: Dec 15, 2023.

- Use of ARTS services continued to increase between SFY 2020 and SFY 2021, with a total of 53,614 members receiving any type of ARTS treatment service in SFY 2021 (a 24 percent increase from SFY 2020).
- Treatment rates (the percentage of members with a diagnosed SUD who received any ARTS treatment service) are highest among members with an OUD diagnosis (69.4 percent) but lower among members with other SUD diagnoses, such as AUD (27.1 percent), stimulant use disorder (34.3 percent) and cannabis use disorder (16.5 percent).
- MOUD treatment rates (the percentage of those with OUD diagnoses who were treated with one of three MOUD medications) increased from 64 percent in SFY 2020 to 78 percent in SFY 2021. While buprenorphine remains the most frequently prescribed MOUD treatment, use of methadone and naltrexone also increased.

---

***Over 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14.3 percent from SFY 2020.***

---

### ***Residential treatment and pharmacotherapy account for half of ARTS expenditures***

- Among members who used ARTS services in SFY 2021, only 9 percent utilized residential treatment services (ASAM 3), with an average length of stay of 15.5 days. However, residential treatment services account for 26.3 percent of all expenditures for ARTS services.
- Medically managed intensive inpatient services (ASAM 4) are acute hospital or inpatient psychiatric admissions related to SUD, offering 24-hour nursing care and daily physician care for severe, unstable problems. While these services account for a small fraction of ARTS expenditures (2.5 percent), they are the most expensive on a per member basis (\$50,562 per member who used ASAM 4 services in SFY 2021).
- While pharmacotherapy for MOUD is one of the most heavily utilized ARTS services and accounts for about one-fourth of ARTS expenditures, it has relatively low expenditures on a per member basis (\$2,220 per member who utilized pharmacotherapy in SFY 2021).

### ***Treatment gaps in transitions from emergency departments and residential treatment***

- Many members who had OUD-related ED visits did not receive follow-up care or MOUD treatment. Only 27 percent of members with an OUD-related ED visit received MOUD treatment within seven days of the ED visit, and 37 percent received MOUD within 30 days of the visit. Receipt of MOUD following the ED visit was especially low among those who were not receiving treatment prior to the ED visit.
- More members received follow-up care after discharge from residential treatment, with 54 percent receiving MOUD within 30 days of discharge. However, follow-up MOUD use was lower among those who had not been receiving MOUD treatment prior to the residential stay.

### ***Recently incarcerated at great risk for OUD and overdoses***


- New Medicaid enrollees recently released from State prisons were four times as likely as other new Medicaid enrollees to receive an OUD diagnosis within six months of enrollment, and they were five times as likely to have had a fatal or nonfatal overdose.

- Once diagnosed with OUD, formerly incarcerated members tended to have higher rates of outpatient and MOUD treatment compared to other new Medicaid enrollees with OUD, and they were only slightly more likely to experience an overdose.

**OUD-related overdose rates may have peaked**

- OUD-related overdoses per 100,000 Medicaid members (fatal and nonfatal) increased 25 percent between SFY 2020 and SFY 2021.
- A more detailed quarterly analysis of overdose rates shows that while they rose precipitously through most of 2020, overdose rates have fluctuated since then. Also, overdose rates decreased during the first two quarters of SFY 2022.

The expansion of the provider network supported through ARTS has benefited all individuals in the Commonwealth through increased access to treatment and recovery services based on ASAM Criteria. In addition, the percentage change from 2019 through 2022 of buprenorphine waived prescribers was 80.8 percent. The rate of pharmacies with any prescription for buprenorphine increased 43.9 percent.



**The percentage change from 2019 through 2022 of buprenorphine waived prescribers was 80.8 percent.**

The report indicated that the number of addiction treatment providers continued to increase in 2022. There were 1,540 practitioners in Virginia in 2022 who had federal authorization to prescribe buprenorphine, including 642 nurse practitioners and 148 physician assistants. Table 2-13 demonstrates the increase in ARTS providers by provider type.

**Table 2-13—Providers of ARTS Services**

Addiction Provider Type	# of Providers Before ARTS (2017)	# of Providers in 2020	# of Providers in 2022
Inpatient Detox (ASAM 4.0)	NA	51	70
Residential Treatment (ASAM 3.1, 3.3, 3.5, and 3.7)	4	123	95
Partial Hospitalization Programs (ASAM 2.5)	NA	41	40
Intensive Outpatient Programs (ASAM 2.1)	49	252	209
Opioid Treatment Programs (OTP)	6	40	43
Preferred Office-Based Addiction Treatment Providers (OBAT)	NA	154	200
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	5,089	6,184



## Member Utilization of the ARTS Benefit

Among members enrolled in Medicaid, the percentage of members using any ARTS service in SFY 2021 compared to SFY 2020 increased 23.6 percent. Most Medicaid members who used ARTS services used ASAM 1 outpatient services (81 percent of all service users). Pharmacotherapy, almost all of which is MOUD treatment, was the second most frequently used service. Overall, there was a 10.8 percent increase in service use per 100,000 members in SFY 2021 compared to SFY 2020. The report identified that in SFY 2021, 43.3 percent of Medicaid members with any SUD diagnosis used ARTS services compared to 69.4 percent of members with any OUD diagnosis.

Members receiving MOUD treatment increased 21.0 percent from SFY 2020 to SFY 2021. As in prior years, buprenorphine treatment was the most common form of MOUD treatment (18,941 members, or 57 percent of all members receiving MOUD), followed by methadone treatment and naltrexone (11,278 and 4,227 members, respectively).

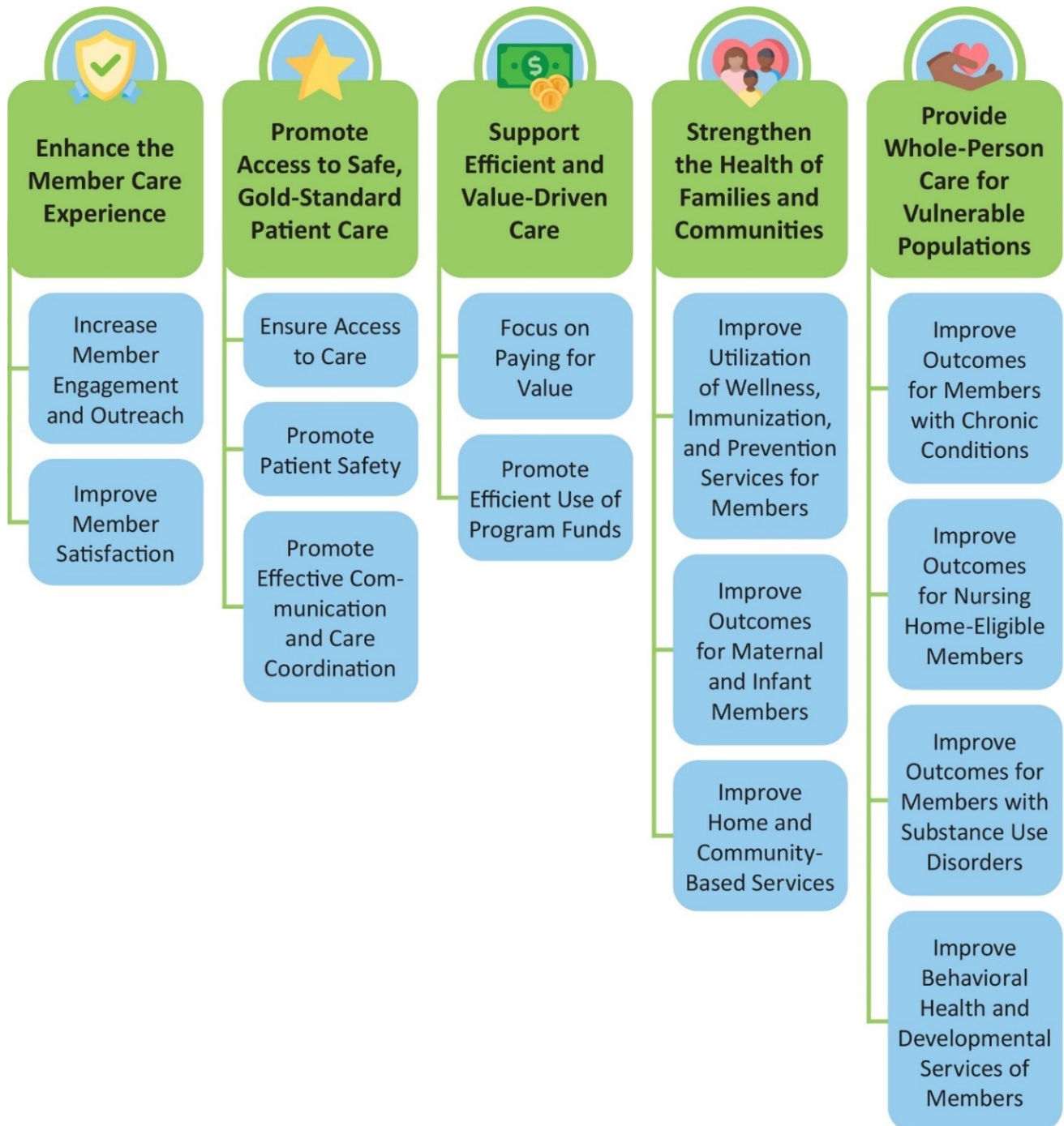
Between SFY 2020 and SFY 2021, the number of members with an ED visit increased. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6 percent increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5 percent increase from the prior year. By comparison, the overall number of ED visits per 1,000 Medicaid members decreased by almost 15 percent from SFY 2020 to SFY 2021.

## Virginia's 2023–2025 Quality Strategy

During 2022, DMAS worked with HSAG to develop the fifth edition of its comprehensive Virginia 2023–2025 QS. DMAS implemented 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 2023–2025 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 2023–2025 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 2-10 displays Virginia's 2023–2025 QS goals and objectives. Appendix F contains Virginia's 2023–2025 QS goals, objectives, and metrics.

**Figure 2-10—Virginia's 2023–2025 QS Goals and Objectives**





## 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 2-14 displays a sample of the initiatives DMAS implemented or continued during CY 2023 that support DMAS’ efforts toward achieving the Virginia 2023–2025 QS goals and objectives.

**Table 2-14—DMAS Quality Initiatives Driving Improvement**

Virginia 2023–2025 QS Goal, Objective, and Metric	DMAS Quality Initiative
<p><b>Goal 5.:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p> <p><b>Metric 5.3.1.2:</b> Follow-Up After Emergency Department Visit for Substance Use</p>	<p>DMAS was awarded funding from the Opioid Abatement Authority to support expansion of the Emergency Department Bridge Clinic model throughout the Commonwealth and provide training and technical assistance to hospitals and health groups who implement this model. This work will begin in October 2023.</p>
<p><b>Goal 5.:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p> <p><b>Metric 5.3.1.2:</b> Follow-Up After Emergency Department Visit for Substance Use</p>	<p>Through numerous efforts, including the SUPPORT Act Grant, DMAS has been working with stakeholders to identify ways to increase engagement and retention in SUD treatment. This includes supporting the Emergency Department Bridge Clinic model, supporting providers looking to provide Peer Recovery Support Services, providing technical assistance on the ASAM multidimensional assessment to providers, and other initiatives. DMAS is also exploring ways to support members with SUD who are being released from legal/carceral settings by exploring options to strengthen supports provided during that transition.</p>

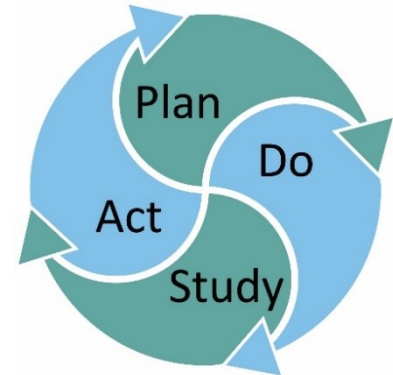
The MCOs’ ongoing QAPI programs objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

Appendix D provides examples of the quality initiatives the MCOs highlighted as their efforts toward achieving the Virginia 2023–2025 QS goals and objectives.

## Best and Emerging Practices

The Virginia 2023–2025 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. DMAS' best and emerging practices are found in Appendix C.






### 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 (Acute) 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.



		
<h3>Quality</h3> <p>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.”<sup>1</sup></p>	<h3>Access</h3> <p>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).”<sup>2</sup></p>	<h3>Timeliness</h3> <p>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.”<sup>3</sup> 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.</p>
<p><sup>1</sup> Department of Health and Human Services, Centers for Medicare &amp; 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.  <sup>2</sup> Ibid.  <sup>3</sup> National Committee for Quality Assurance. 2013 Standards and Guidelines for MBHOs and MCOs.</p>		

## MCO Comparative and Statewide Aggregate PIP Results

### PIP Highlights

In 2023, the MCOs continued the DMAS-selected topics of *Ensuring Timeliness of Prenatal Care* (HEDIS PPC measure) and *Tobacco Cessation in Pregnant Women*. The MCOs progressed to reporting baseline data and interventions, updating their PIP submission forms through Step 8 (Quality Improvement Strategies and Interventions). HSAG validated the baseline data and QI processes and interventions implemented and provided feedback and recommendations to the MCOs in the initial validation tools. The MCOs had an opportunity to seek technical assistance and resubmit the PIPs with corrections or additional documentation to potentially improve the 2023 final PIP validation score and overall confidence rating.

### Strengths, Weaknesses, and Recommendations

Strengths	
	Five of the six MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a <i>High Confidence</i> level for both PIPs. These MCOs calculated and reported baseline data accurately, implemented targeted interventions that addressed the identified barriers, and developed sound methodologies for evaluating the effectiveness for each intervention.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> One MCO had opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and providing the QI processes used to identify and prioritize barriers.</p> <p><b>Recommendations:</b> The MCO should define the performance indicators correctly and ensure that the measurement data for the performance indicators are calculated and reported accurately. The MCO should ensure it includes all required information related to QI processes.</p>

**Table 3-1—PIP Baseline Performance Results**

PIP Topic	Aetna	Health Keepers	Molina	Optima	United	VA Premier
<i>Timeliness of Prenatal Care</i>	78.59%	60.23%	47.51%	68.13%	57.25%	57.61%
<i>Tobacco Use Cessation in Pregnant Women</i>	2.09%	2.17%	29.46%	89.97	37.79%	14.5%

## MCO Comparative and Statewide Aggregate PMV Results

### PMV Highlights

The PMV highlights are included in Table 3-2.

**Table 3-2—PM Strengths and Weaknesses**

Domain	Strengths	Weaknesses
<b>Children’s Preventive Care</b>	Four of six MCOs’ rates met or exceeded the 50th percentile for the <i>Child and Adolescent Well-Care Visits—Total</i> and <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicators.	Four of the six MCOs’ rates fell below the 50th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i> and <i>Childhood Immunization Status—Combination 3</i> PM indicators.
<b>Women’s Health</b>	There were no identified strengths for PMs within the Women’s Health domain.	All six MCOs’ rates fell below the 50th percentile for the <i>Breast Cancer Screening and Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> PM indicators.
		Five of the six MCOs’ rates fell below the 50th percentile for the <i>Cervical Cancer Screening</i> PM indicator.
<b>Access to Care</b>	There were no identified strengths for PMs within the Access to Care domain.	All six MCOs’ rates fell below the 50th percentile for the <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i> PM indicator.
<b>Care for Chronic Conditions</b>	Five of six MCOs’ rates met or exceeded the 50th percentile for the <i>Asthma Medication Ratio—Total</i> and <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i> measure indicators.	Five of the six MCOs’ rates fell below the 50th percentile for the <i>Eye Exam for Patients With Diabetes—Total</i> PM indicator.
<b>Behavioral Health</b>	All six MCOs’ rates met or exceeded the 50th percentile for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total, and Initiation and Engagement of Substance Use Disorder</i>	Five of the six MCOs’ rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total, and Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> measure

Domain	Strengths	Weaknesses
	<p><i>Treatment—Engagement of SUD Treatment</i> PM indicators. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> PM indicators.</p>	<p>indicators. Additionally, four of the six MCOs' rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total</i> PM indicator.</p>

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™,3-1 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 (Acute) Medicaid PMs for HEDIS MY 2022.

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

- *Asthma Admission Rate (Per 100,000 Member Months)*
- *Blood Pressure Control for Patients With Diabetes*
- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*
- *Eye Exam for Patients With Diabetes*
- *Follow-Up After ED Visit for Mental Illness*
- *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes*
- *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, February 2023*.3-2 identifies two possible validation finding designations for PMs: *Reportable (R)*—PM data were compliant with HEDIS and DMAS specifications and the data 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 3-3, with all rates validated as *Reportable (R)*.

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

3-2 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. External Quality Review (EQR) Protocols, February 2023*. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 27, 2023.



**Table 3-3—HSAG MCO PMV Results**

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier
<b>Asthma Admission Rate (Per 100,000 Member Months)</b>						
Asthma Admission Rate (Per 100,000 Member Months)	5.88	3.85	5.62	7.16	5.10	8.10
<b>Blood Pressure Control for Patients With Diabetes</b>						
Blood Pressure Control for Patients With Diabetes	53.04%	54.01%	39.66%	57.66%	62.53%	62.29%
<b>Child and Adolescent Well-Care Visits</b>						
Total	47.31%	53.27%	38.16%	46.56%	54.90%	43.23%
<b>Childhood Immunization Status</b>						
Combination 3	58.88%	65.45%	54.99%	63.75%	69.10%	68.37%
<b>Eye Exam for Patients With Diabetes</b>						
Eye Exam for Patients With Diabetes	48.42%	45.01%	27.25%	47.20%	44.53%	54.01%
<b>Follow-Up After ED Visit for Mental Illness</b>						
7-Day Follow-Up—Total	43.69%	41.11%	34.23%	35.41%	36.59%	40.94%
30-Day Follow-Up—Total	46.24%	55.01%	45.41%	49.05%	49.53%	53.27%
<b>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes</b>						
HbA1c Poor Control (>9.0%)*	43.55%	36.74%	62.53%	47.69%	39.42%	36.74%
HbA1c Control (<8.0%)	49.39%	53.77%	33.58%	47.20%	50.36%	52.07%
<b>Prenatal and Postpartum Care</b>						
Timeliness of Prenatal Care	78.59%	84.57%	62.77%	68.13%	80.54%	76.89%
Postpartum Care	70.56%	79.26%	61.56%	61.07%	79.32%	72.51%

\* 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 (Acute) Medicaid PMs for HEDIS MY 2022.

Table 3-4 displays, by MCO, the HEDIS MY 2022 PM rate results compared to NCQA's Quality Compass national Medicaid HMO percentiles for the HEDIS MY 2021 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 3-4—MCO Comparative and Virginia Aggregate HEDIS MY 2022 PM Results**

PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
<b>Children's Preventive Care</b>							
<b>Child and Adolescent Well-Care Visits</b>							
Total	47.31%	53.27%	38.16%	46.56%	54.90%	43.23%	48.66%
<b>Childhood Immunization Status</b>							
Combination 3	58.88%	65.45%	54.99%	63.75%	69.10%	68.37%	64.49%
<b>Well-Child Visits in the First 30 Months of Life</b>							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	63.42%	65.19%	44.11%	63.74%	57.52%	51.41%	60.02%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	69.58%	73.18%	61.31%	67.78%	71.94%	62.30%	68.76%
<b>Women's Health</b>							
<b>Breast Cancer Screening</b>							
Total	51.14%	53.73%	40.20%	48.23%	46.46%	52.10%	50.23%
<b>Cervical Cancer Screening</b>							
Total	54.74%	60.76%	37.71%	54.50%	46.47%	50.36%	53.79%
<b>Prenatal and Postpartum Care</b>							



PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
<i>Timeliness of Prenatal Care</i>	<b>78.59%</b>	<b>84.57%</b>	62.77%	68.13%	<b>80.54%</b>	76.89%	<b>77.10%</b>
<i>Postpartum Care</i>	70.56%	<b>79.26%</b>	61.56%	61.07%	<b>79.32%</b>	<b>72.51%</b>	<b>71.94%</b>
<b>Access to Care</b>							
<b>Adults' Access to Preventive/Ambulatory Health Services</b>							
<i>Total</i>	<b>69.31%</b>	<b>73.53%</b>	55.77%	67.82%	67.67%	68.26%	<b>68.79%</b>
<b>Care for Chronic Conditions</b>							
<b>Asthma Medication Ratio</b>							
<i>Total</i>	<b>73.30%</b>	<b>69.00%</b>	<b>72.20%</b>	64.35%	67.03%	<b>70.00%</b>	<b>68.37%</b>
<b>Blood Pressure Control for Patients With Diabetes</b>							
<i>Total</i>	53.04%	54.01%	39.66%	<b>57.66%</b>	<b>62.53%</b>	<b>62.29%</b>	<b>56.19%</b>
<b>Eye Exam for Patients With Diabetes</b>							
<i>Total</i>	<b>48.42%</b>	45.01%	27.25%	<b>47.20%</b>	44.53%	<b>54.01%</b>	<b>46.73%</b>
<b>Hemoglobin A1c Control for Patients With Diabetes</b>							
<i>HbA1c Control (&lt;8.0%)</i>	49.39%	<b>53.77%</b>	33.58%	47.20%	<b>50.36%</b>	<b>52.07%</b>	<b>49.83%</b>
<i>HbA1c Poor Control (&gt;9.0%)*</i>	43.55%	<b>36.74%</b>	62.53%	47.69%	<b>39.42%</b>	<b>36.74%</b>	<b>41.89%</b>
<b>Controlling High Blood Pressure</b>							
<i>Total</i>	53.53%	53.28%	32.60%	<b>54.74%</b>	<b>57.91%</b>	<b>58.39%</b>	<b>53.68%</b>
<b>Medical Assistance With Smoking and Tobacco Use Cessation</b>							
<i>Advising Smokers and Tobacco Users to Quit</i>	65.87%	NA	67.11%	NA	NA	NA	<b>70.03%</b>
<i>Discussing Cessation Medications</i>	45.60%	NA	44.97%	NA	NA	NA	<b>45.92%</b>
<i>Discussing Cessation Strategies</i>	<b>41.60%</b>	NA	33.11%	NA	NA	NA	<b>38.35%</b>
<b>Behavioral Health</b>							
<b>Antidepressant Medication Management</b>							
<i>Effective Acute Phase Treatment</i>	57.20%	56.34%	57.14%	<b>59.99%</b>	<b>61.34%</b>	<b>62.43%</b>	<b>58.87%</b>
<i>Effective Continuation Phase Treatment</i>	37.62%	37.00%	<b>40.85%</b>	<b>42.03%</b>	<b>44.37%</b>	<b>43.20%</b>	<b>40.24%</b>
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>							
<i>Initiation Phase</i>	<b>47.24%</b>	<b>44.54%</b>	38.64%	37.48%	<b>46.33%</b>	40.33%	<b>41.79%</b>
<i>Continuation and Maintenance Phase</i>	<b>60.25%</b>	<b>57.38%</b>	51.79%	50.51%	<b>56.56%</b>	50.86%	<b>53.94%</b>

PMs	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
<b>Follow-Up After ED Visit for Mental Illness</b>							
7-Day Follow-Up—Total	33.38%	<b>41.11%</b>	34.23%	35.41%	36.59%	<b>40.94%</b>	<b>37.90%</b>
30-Day Follow-Up—Total	46.24%	<b>55.01%</b>	45.41%	49.05%	49.53%	<b>53.27%</b>	<b>50.96%</b>
<b>Follow-Up After Hospitalization for Mental Illness</b>							
7-Day Follow-Up—Total	30.91%	<b>40.73%</b>	22.27%	<b>35.41%</b>	30.39%	22.67%	<b>32.11%</b>
30-Day Follow-Up—Total	<b>54.05%</b>	<b>64.00%</b>	39.29%	<b>58.70%</b>	<b>54.32%</b>	40.05%	<b>53.76%</b>
<b>Follow-Up After Emergency Department Visit for Substance Use</b>							
7-Day Follow-Up—Total	<b>25.57%</b>	22.72%	20.78%	<b>31.17%</b>	22.16%	22.17%	<b>24.57%</b>
30-Day Follow-Up—Total	<b>35.86%</b>	32.05%	29.85%	<b>42.39%</b>	32.53%	31.90%	<b>34.61%</b>
<b>Initiation and Engagement of Substance Use Disorder Treatment</b>							
Initiation of SUD Treatment	<b>49.29%</b>	46.39%	<b>52.11%</b>	44.50%	<b>49.01%</b>	<b>52.71%</b>	<b>48.49%</b>
Engagement of SUD Treatment	<b>22.66%</b>	20.78%	<b>25.23%</b>	18.09%	20.32%	<b>24.20%</b>	<b>21.57%</b>
<b>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</b>							
Total	<b>65.00%</b>	<b>66.67%</b>	<b>66.10%</b>	61.52%	<b>68.52%</b>	62.72%	<b>64.40%</b>

\* 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 bold *burgundy*.

Indicates that the HEDIS MY 2022 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 four of the six MCOs’ rates met or exceeded the 50th percentile for the <i>Child and Adolescent Well-Care Visits—Total</i> and <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicators. Moreover, United’s rates met or exceeded the 50th percentile for all four PM indicators within the domain.
	Within the Care for Chronic Conditions domain, five of six MCOs’ rates met or exceeded the 50th percentile for the <i>Asthma Medication Ratio—Total</i> and <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i> PM indicators. Of note, VA Premier displayed strong performance, with its rates exceeding the Virginia aggregate for six of nine (66.7 percent) PM indicators.

**Strengths**



MCO performance within the Behavioral Health domain was strong, with all six MCOs' rates meeting or exceeding the 50th percentile for the *Follow-Up After Emergency Department Visit for Substance Use—7-Day and 30-Day Follow-Up—Totals* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM indicators, and five of six MCOs' rates meeting or exceeding the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* PM indicators. Within the Behavioral Health domain, HealthKeepers demonstrated the best performance, with its rates meeting or exceeding the 50th percentile for 11 of the 13 (84.6 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 *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* PM indicator. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Childhood Immunization Status—Combination 3* PM indicator. Of note, Molina demonstrated the worst performance within the Children's Preventive Care domain, falling below the 50th percentile for all four (100.0 percent) measure rates within the domain.



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.<sup>3-3</sup> While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCO performance below the 50th percentile suggests children are not receiving vaccines at a rate in line with national benchmarks.

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.<sup>3-4</sup>

**Recommendations:** Considering the recurring MCO opportunities related to measures in the Children's Preventive Care domain, HSAG continues to recommend 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 identify and implement new interventions based on their completed root cause analyses which identified

<sup>3-3</sup> National Committee for Quality Assurance. Childhood Immunization Status. Available at: <https://www.ncqa.org/hedis/measures/childhood-immunization-status/>. Accessed on: Dec 27, 2023.



<sup>3-4</sup> 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: Dec 27, 2023.

Weaknesses and Recommendations	
	specific barriers that members’ parents and guardians have experienced in accessing care and services.
	<p><b>Weakness:</b> All six MCOs’ rates fell below the 50th percentile for the <i>Breast Cancer Screening</i> and <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> PM indicators, and five of the six MCOs’ rates fell below the 50th percentile for the <i>Cervical Cancer Screening</i> PM, reflecting areas of opportunity for improvement.</p> <p>While one MCO improved performance over the prior year, the overall continued MCO performance below the 50th percentile for the <i>Cervical Cancer Screening</i> PM indicator suggests members are not receiving important health screenings that can improve outcomes and lead to early detection of life-threatening conditions, thereby reducing the risk of dying, and leading to a greater range of treatment options and lower healthcare costs.<sup>3-5</sup> Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.<sup>3-6</sup></p> <p>Additionally, all six MCOs’ continued performance below the 50th percentile in the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> PM indicator indicates that members are not receiving timely prenatal care that can reduce the risk of pregnancy complications. Timely and adequate prenatal care can set the stage for the long-term health and well-being of new mothers and their infants.<sup>3-7</sup></p> <p><b>Recommendations:</b> 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 care, and make appropriate health decisions. In addition, HSAG continues to recommend 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 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 care.</p>
	<p><b>Weakness:</b> The Access to Care domain represented an area of opportunity for improvement, as all six MCOs’ rates fell below the 50th percentile for the <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i> PM indicator.</p> <p>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</p>

<sup>3-5</sup> National Committee for Quality Assurance. Breast Cancer Screening. Available at: <https://www.ncqa.org/hedis/measures/breast-cancer-screening/>. Accessed on: Dec 27, 2023.

<sup>3-6</sup> Centers for Disease Control and Prevention. Preventing Breast, Cervical, and Colorectal Cancer Deaths: Assessing the Impact of Increased Screening. Available at: [https://www.cdc.gov/pcd/issues/2020/20\\_0039.htm](https://www.cdc.gov/pcd/issues/2020/20_0039.htm). Accessed on: Dec 27, 2023.

<sup>3-7</sup> National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: <https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/>. Accessed on: Dec 27, 2023.

Weaknesses and Recommendations	
	<p>address acute issues or manage chronic conditions.<sup>3-8</sup> MCO performance indicates that adult members are not routinely accessing preventive care in an ambulatory health setting.</p> <p><b>Recommendations:</b> Considering the MCOs' continued performance below the 50th percentile, HSAG recommends that the MCOs identify updated interventions to implement that are based on the results of the previously conducted root cause analysis that identified why some adults are not accessing preventive and ambulatory health services. If MCOs have not previously conducted focus groups with members, HSAG recommends that the MCOs consider facilitating focus groups to identify barriers that their members are experiencing in accessing care and services. Additionally, HSAG recommends that the MCOs continue to evaluate the best use of telehealth services as an additional method for providing preventive and ambulatory health services.</p>
	<p><b>Weakness:</b> Within the Care for Chronic Conditions domain, five of the six MCOs' rates fell below the 50th percentile for the <i>Eye Exam for Patients With Diabetes—Total</i> PM indicator, reflecting an area of opportunity for improvement. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. If unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.<sup>3-9</sup> MCO performance below the 50th percentile indicates some members with diabetes are not receiving eye examinations as recommended to appropriately manage risks associated with diabetes.</p> <p><b>Recommendations:</b> HSAG recommends that the MCOs evaluate the impact of interventions from the prior year, which resulted in members getting their eye exams, then consider the potential to expand on these successful interventions to support members in better managing their diabetes at optimal levels. MCOs may also consider enhancing provider education, leveraging the American Diabetes Association 2022 <i>Focus on Diabetes Impact Report</i> as a resource.<sup>3-10</sup></p>
	<p><b>Weakness:</b> Within the Behavioral Health domain, five of the six MCOs' rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total</i>, and <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> measure indicators, reflecting areas of opportunity for improvement.</p> <p>This performance suggests that members have not received timely follow-up after ED visits and hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing</p>

<sup>3-8</sup> 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: Dec 27, 2023.

<sup>3-9</sup> National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: <https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/>. Accessed on: Dec 27, 2023.

<sup>3-10</sup> American Diabetes Association. *Focus on Diabetes Impact Report*. Available at: [https://diabetes.org/sites/default/files/2023-09/ADA\\_2022\\_FOD\\_Impact\\_Report\\_FINAL.pdf](https://diabetes.org/sites/default/files/2023-09/ADA_2022_FOD_Impact_Report_FINAL.pdf). Accessed on: Dec 12, 2023.



### Weaknesses and Recommendations

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.<sup>3-11</sup>

**Recommendations:** HSAG recommends that the MCOs develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. 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. Additionally, HSAG recommends that the MCOs leverage the CMS Improving Behavioral Health Follow-up Care Learning Collaborative<sup>3-12</sup> materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.

### 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 (Acute) program. During 2022, DMAS monitored the MCOs’ implementation of federal and Commonwealth requirements and CAPs from the 2021 compliance reviews.

### Operational Systems Review

Table 3-5 displays the scores for the current three-year period of OSRs conducted in 2021.

**Table 3-5—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%

<sup>3-11</sup> 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: Dec 27, 2023.

<sup>3-12</sup> Medicaid.gov. Improving Behavioral Health Follow-up Care Learning Collaborative. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html>. Accessed on: Dec 20, 2023.

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Total Compliance Score
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%
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%
<b>TOTAL SCORE</b>			<b>93.2%</b>	<b>92.6%</b>	<b>93.2%</b>	<b>94.4%</b>	<b>96.3%</b>	<b>88.9%</b>	<b>93.1%</b>

\* 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	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 <i>External Quality Review Technical Report—Medallion 4.0</i> dated March 2022.</p>

## Cardinal Care Program Readiness Reviews

DMAS contracted with HSAG to conduct readiness reviews for the Cardinal Care program that focused on the MCOs’ ability and capacity to comply with the Cardinal Care contract requirements and the 2020 Medicaid and CHIP Managed Care Final Rules.<sup>3-13</sup> The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4). A readiness review primary objective was to assess the ability and capacity of the MCOs to satisfactorily perform the new Model of Care contract requirements. In addition, HSAG assessed the ability and capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the Medicaid and CHIP Managed Care Final Rule regulations and the Cardinal Care MCO contract. Table 3-6 displays the summary of results for the comprehensive 2023 Cardinal Care program readiness review.

**Table 3-6—Summary of Results for the Comprehensive 2023 Cardinal Care Program Readiness Review**

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
<b>OSR Results*</b>									
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	100%	100%
II.	438.100 438.224	Member Rights* and Confidentiality	100%	100%	100%	100%	100%	100%	100%
III.	438.10	Member Information	100%	100%	100%	100%	100%	100%	100%
IV.	438.114	Emergency and Poststabilization Services*	100%	100%	100%	100%	100%	100%	100%
V.	438.206 438.207	Assurance of Adequate Capacity	100%	100%	100%	100%	100%	100%	100%

<sup>3-13</sup> Medicaid and CHIP Managed Care Final Rules. Available at: <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>. Accessed on: Dec 27, 2023.

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
<b>OSR Results*</b>									
		and Availability of Services							
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%	100%	100%	100%	100%	100%
VIII.	438.214	Provider Selection	100%	100%	100%	100%	100%	100%	100%
IX.	438.230	Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%	100%	100%
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%	100%	100%	100%	100%	100%	100%
XIII.	438.228	Grievance and Appeal Systems	100%	100%	100%	100%	100%	100%	100%
XIV.	438.608	Program Integrity	100%	100%	100%	100%	100%	100%	100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services	100%	100%	100%	100%	100%	100%	100%
<b>OSR Total</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Readiness Review Results**</b>									
<b>Network Adequacy</b>			95.0%	95.0%	100%	95.0	90.0%	90.0%	94.2%
<b>Model of Care</b>			100%	100%	100%	100%	98.1%	100%	99.7%
<b>Organizational Structure, Operations, and Systems</b>			100%	100%	100%	100%	100%	100%	100%
<b>Readiness Review Total</b>			<b>99.2%</b>	<b>99.2%</b>	<b>100%</b>	<b>99.2%</b>	<b>97.0%</b>	<b>98.5%</b>	
<b>Readiness Review CAP Review Results</b>									
<b>Phase I CAP Review Results</b>			100%	100%	100%	100%	100%	100%	100%
<b>Phase II CAP Review Results</b>			100%	100%	100%	100%	100%	100%	100%
<b>Phase III CAP Review Results</b>			100%	100%	100%	100%	100%	100%	100%
<b>Comprehensive Total</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*OSR scores include DMAS review of the MCOs' implementation of CAPs.

\*\*Score includes Phase II and Phase II Corrective Action Plan element review scores.

## **Network Adequacy Validation**

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

- Primary care (adult and pediatric)
- OB/GYN
- BH
- Specialist (adult and pediatric)
- Hospital
- Pharmacy
- Pediatric dental
- Additional provider types when they promote the objectives of the Medicaid program

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

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

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

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

In February 2023, CMS released the final *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (EQR NAV Protocol).<sup>3-14</sup> The protocol requires that states must ensure that Medicaid and CHIP managed care plans maintain provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. As set forth in 42 CFR §438.68, states are required to set quantitative network adequacy standards for MCOs that account for regional factors and the needs of the state's Medicaid and CHIP populations. HSAG conducts the validation of MCO network adequacy during the preceding 12 months to comply with 42 CFR §438.68, including validating data to determine whether the network standards, as defined by DMAS, were met.

DMAS defines network adequacy standards in the State's QS as required under 42 CFR §340(b)(1). DMAS works with the MCOs to drive improvement in network adequacy and beneficiary access to care, according to the Virginia QS goals and objectives and QAPI program.

DMAS requires the MCOs to conduct various activities to assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy. DMAS requires MCOs to conduct:

- Geo-mapping to determine if provider networks meet quantitative time and distance standards.
- Calculation of provider-to-enrollee ratios, by type of provider and geographic region.
- Analysis of in- and out-of-network utilization data to determine gaps in realized access.
- Appointment availability and accessibility studies, including the proportion of in-network providers accepting new patients and the average wait time for an appointment.
- Validation of provider directory information.

DMAS and the MCOs share data, analyses, and results from their network adequacy assessment activities with HSAG. HSAG's NAV activity includes (1) validating the data and methods used by MCOs to assess network adequacy, and (2) validating the results and generating a validation rating. HSAG will report the validation findings in the annual EQR technical report, beginning in 2025. The DMAS NAV activity will review and validate the MCO NAV data submitted to ensure accuracy, completeness, and consistency. Through this process, HSAG will evaluate each MCO's ability to:

- Collect, capture, and monitor valid network adequacy data.
- Evaluate the adequacy of the provider network using sound analytic methods.
- Produce accurate results to support MCO network adequacy monitoring.
- Provide DMAS with accurate network adequacy indicator rates for each required standard.

HSAG will calculate a validation rating for each network adequacy indicator for each MCO.

---

<sup>3-14</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Dec 15, 2023.

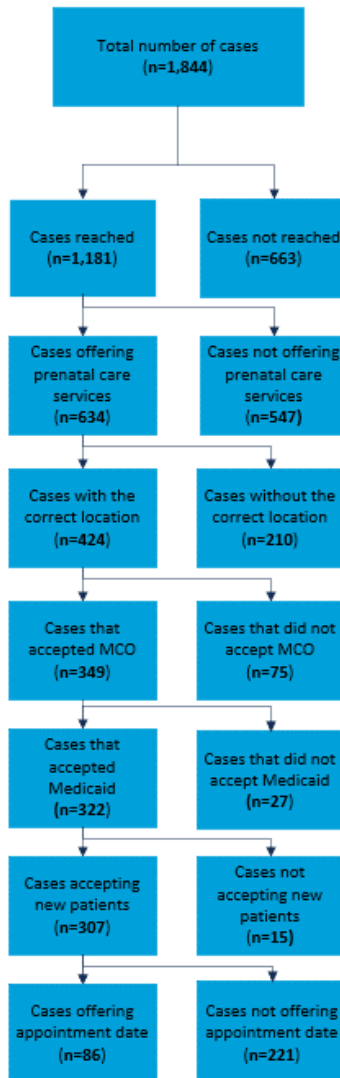
# MCO Comparative and Statewide Aggregate Secret Shopper Survey Results

## Prenatal Care (PNC) Provider Secret Shopper Survey

### Secret Shopper Project Highlights

HSAG attempted to contact 1,844 sampled provider locations (i.e., “cases”), with an overall response rate of 64.0 percent across provider locations. Nonresponsive cases included both provider locations that could not be reached (n=663) and locations that did not provide prenatal care services (n=547) as shown in Figure 3-1.

**Figure 3-1—Secret Shopper Survey Data Collection Hierarchy and Count of Cases With Each Outcome**



As shown in Table 3-7, among the cases where survey callers indicated successful contact with the provider location, 29.6 percent stated the office accepted the MCO, 27.3 percent stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients.

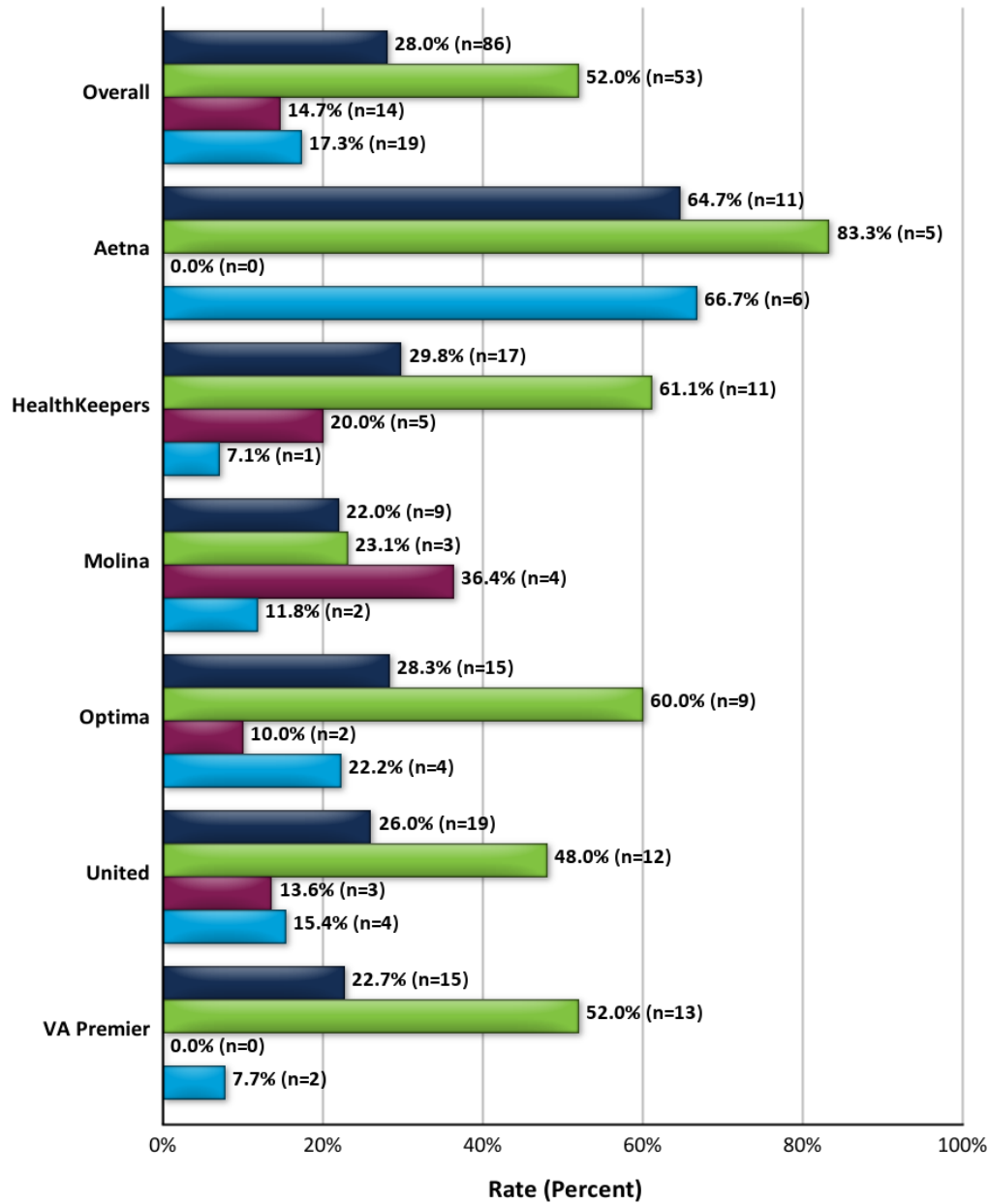
**Table 3-7—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Denominator <sup>1</sup>	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
Aetna	114	16.7%	15.8%	14.9%
HealthKeepers	238	26.9%	25.6%	23.9%
Molina	199	21.6%	20.6%	20.6%
Optima	188	30.9%	30.3%	28.2%
United	237	40.5%	32.5%	30.8%
VA Premier	205	33.7%	33.2%	32.2%
<b>All MCOs</b>	<b>1,181</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

<sup>1</sup>The denominator includes cases reached.

As shown in Figure 3-2 and Figure 3-3, 28.0 percent of the total calls provided a first, second, and third trimester appointment date. Of the appointments that were offered, 15.1 percent were compliant with DMAS wait time standards. There was a substantial difference in the percentage of appointments offered by trimester (i.e., first, second, or third). For cases that were offered a first trimester appointment, 15.1 percent (n=8) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a second trimester appointment, 21.4 percent (n=3) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a third trimester appointment, 10.5 percent (n=2) were compliant with the three-business-day standard for prenatal care services.

**Figure 3-2—New Patient Appointment Availability**

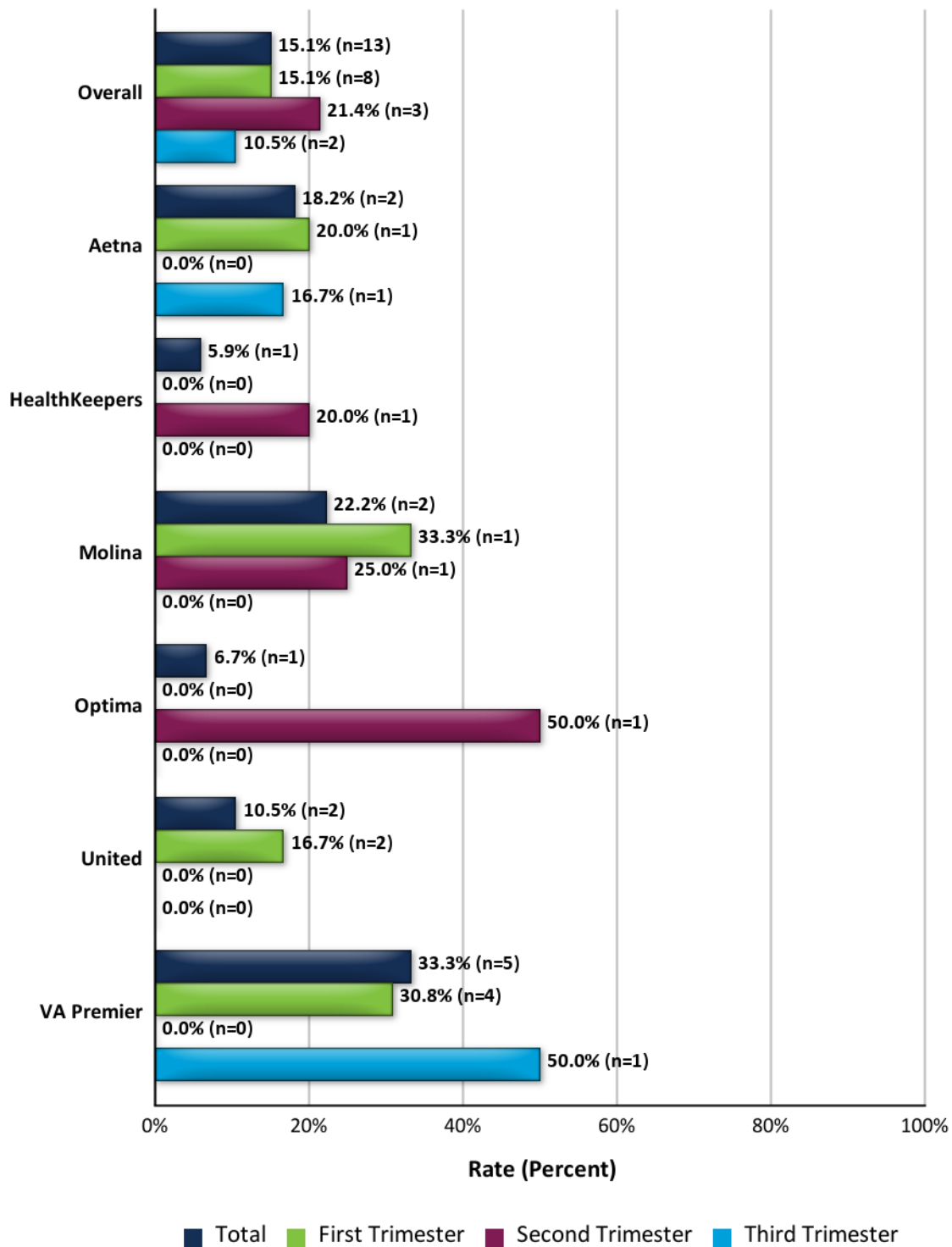


■ Total ■ First Trimester ■ Second Trimester ■ Third Trimester

The denominator includes cases reached and accepting new patients.



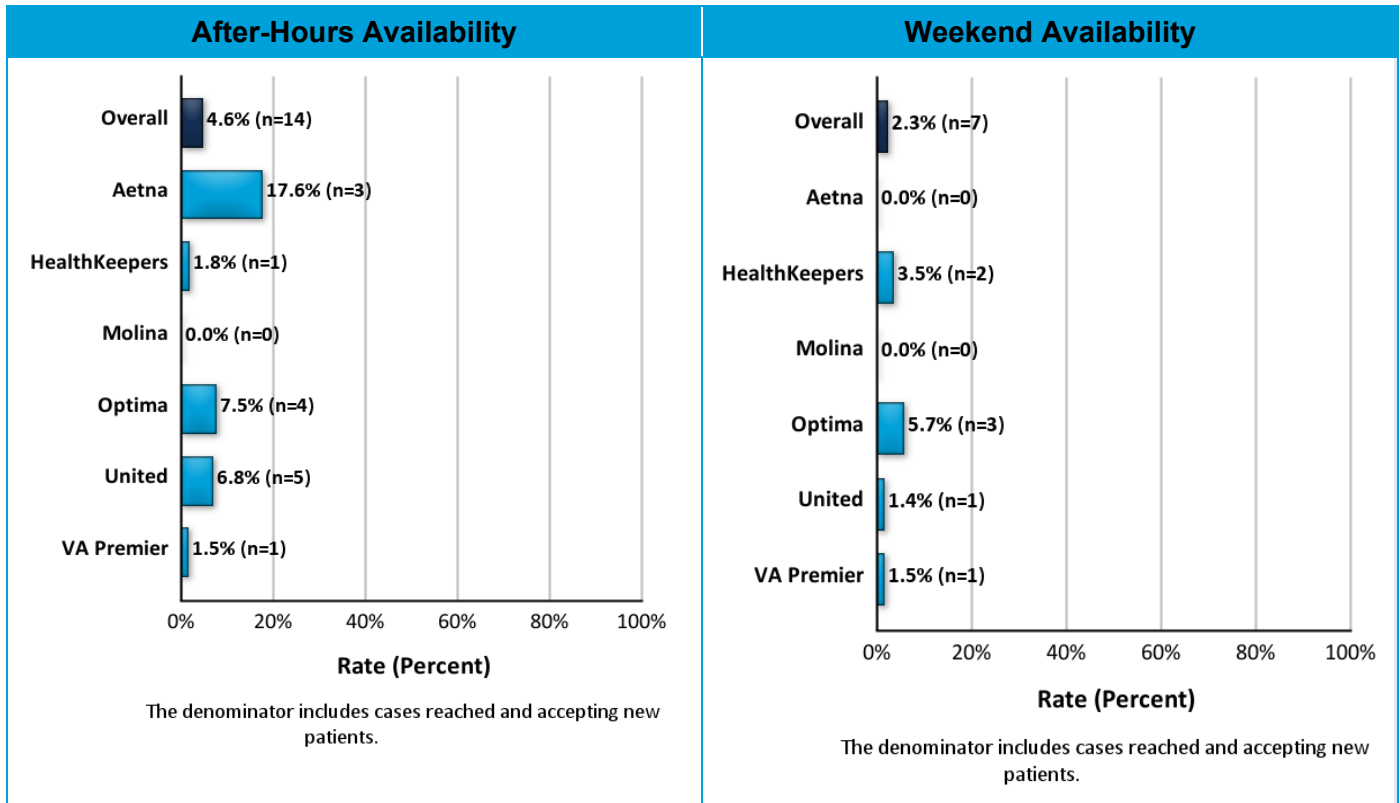
**Figure 3-3—Appointments Meeting Compliance Standards**



The denominator includes cases reached, accepting new patients and offered an appointment date.

Figure 3-4 displays the percentage of cases in which the respondent confirmed that the sampled location offered after-hours or weekend appointments.

**Figure 3-4—After-Hours and Weekend Appointment Availability Rate**



### Strengths, Weaknesses, and Recommendations

#### Weaknesses and Recommendations



**Weakness:** Overall, HSAG was unable to reach 36.0 percent of the sampled cases. Of the responsive cases, 46.3 percent of the respondents indicated that the provider location did not provide prenatal care services, 29.6 percent stated the office accepted the MCO, 27.3 percent stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients.

**Recommendations:** Since DMAS’ enrollment broker supplied HSAG with the PNC data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location’s address and appropriate provider type and specialty. Additionally, DMAS could consider requesting that the MCOs provide evidence of training offered, by the MCO, to providers’ offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff members responsible for scheduling appointments have been educated on the

**Weaknesses and Recommendations**

MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover.

**Weaknesses and Recommendations**



**Weakness:** Among cases offering an appointment, 28.0 percent provided a first, second, or third trimester appointment date. Of the cases that were offered an appointment, 15.1 percent were compliant with DMAS’ wait time standards for prenatal care services.

**Recommendations:** HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices’ requirements to ensure that these considerations to scheduling appointments do not unduly burden members’ ability to access prenatal care and to streamline the process of scheduling new patient appointments within the seven-calendar-day standard for first and second trimester appointments and three-business-day standard for third trimester appointments.

**Conclusions**

Survey findings support specific opportunities for improving the quality of prenatal care provider data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 95 percent (n=1,758) of overall cases were unable to be reached, did not offer prenatal care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. Key findings are listed below.

- The CY 2022–2023 prenatal care secret shopper survey overall response rate was 64.0 percent, primarily because the provider location was not able to be reached (36.0 percent) or the location did not provide prenatal care services (29.7 percent).
  - Response rates by MCO ranged from 44.2 percent (Aetna) to 76.5 percent (VA Premier).
  - Aetna had the highest percentage of cases where the provider location was not able to be reached (55.8 percent).
  - Molina had the highest percentage of cases where the provider location did not offer prenatal care services (40.1 percent).
- Of the responsive cases:
  - 11.4 percent reported that the sampled address was incorrect, and a forwarding number was not available for the requested address. Aetna had the highest rate (26.7 percent) and Molina had the lowest rate (6.1 percent) of cases with incorrect addresses.
  - 29.6 percent accepted the MCO. Aetna had the lowest rate (16.7 percent) and United had the highest rate (40.5 percent) of responsive cases accepting the MCO’s members.
  - 27.3 percent accepted VA Medicaid. Aetna had the lowest rate (15.8 percent) and VA Premier had the highest rate (33.2 percent) of responsive cases accepting VA Medicaid.
  - 26.0 percent of provider locations reported accepting new patients. New patient acceptance rates ranged from 14.9 percent (Aetna) to 32.2 percent (VA Premier). Comments provided by locations not taking new patients included only taking the MCO and/or VA Medicaid for

established patients, not taking new patients at the stated trimester, and not taking any new prenatal care patients at the location at all.

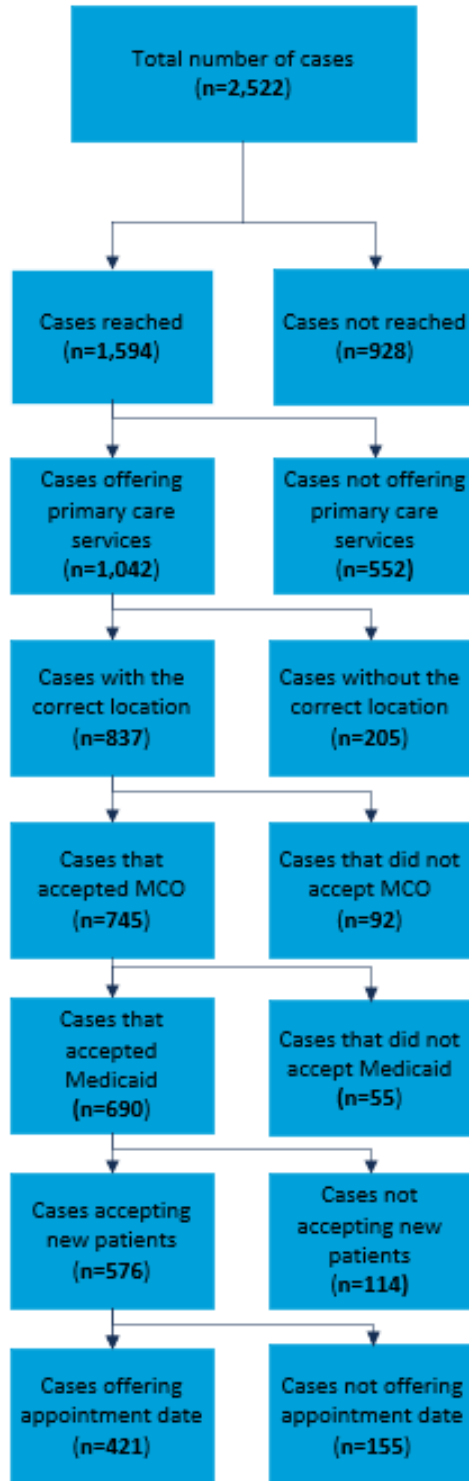
- Among cases offering an appointment, 28.0 percent provided a first, second, or third trimester appointment date. There was a substantial difference in the percentage of appointments offered by trimester (i.e., first, second, or third). Common reasons for not scheduling prenatal care appointments included requiring preregistration, personal information, medical records, or physician approval prior to scheduling the appointment.
  - 52.0 percent of first trimester calls were offered an appointment.
  - 14.7 percent of second trimester calls were offered an appointment.
  - 17.3 percent of third trimester calls were offered an appointment.
- The overall median wait time was 14, 13, and 17 calendar days for a first, second, or third trimester appointment, respectively. Survey findings indicate appointment wait times outside of DMAS' compliance standards for all MCOs and visit types. National healthcare staffing shortages and workforce issues may be contributing to these longer wait times.
- For cases that were offered a first trimester appointment, 15.1 percent (n=8) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a second trimester appointment, 21.4 percent (n=3) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a third trimester appointment, 10.5 percent (n=2) were compliant with the three-business-day standard for prenatal care services.

## ***Primary Care Provider (PCP) Secret Shopper Survey***

### **Secret Shopper Project Highlights**

HSAG attempted to contact 2,522 sampled provider locations (i.e., “cases”), with an overall response rate of 63.2 percent across provider locations. Nonresponsive cases included both provider locations that could not be reached (n=928) and locations that did not provide primary care services (n=552) as shown in Figure 3-5.

**Figure 3-5—Secret Shopper Survey Data Collection Hierarchy and Count of Cases With Each Outcome**



As shown in Table 3-8, among the cases where survey callers indicated successful contact with the provider location, 46.7 percent stated that the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients.

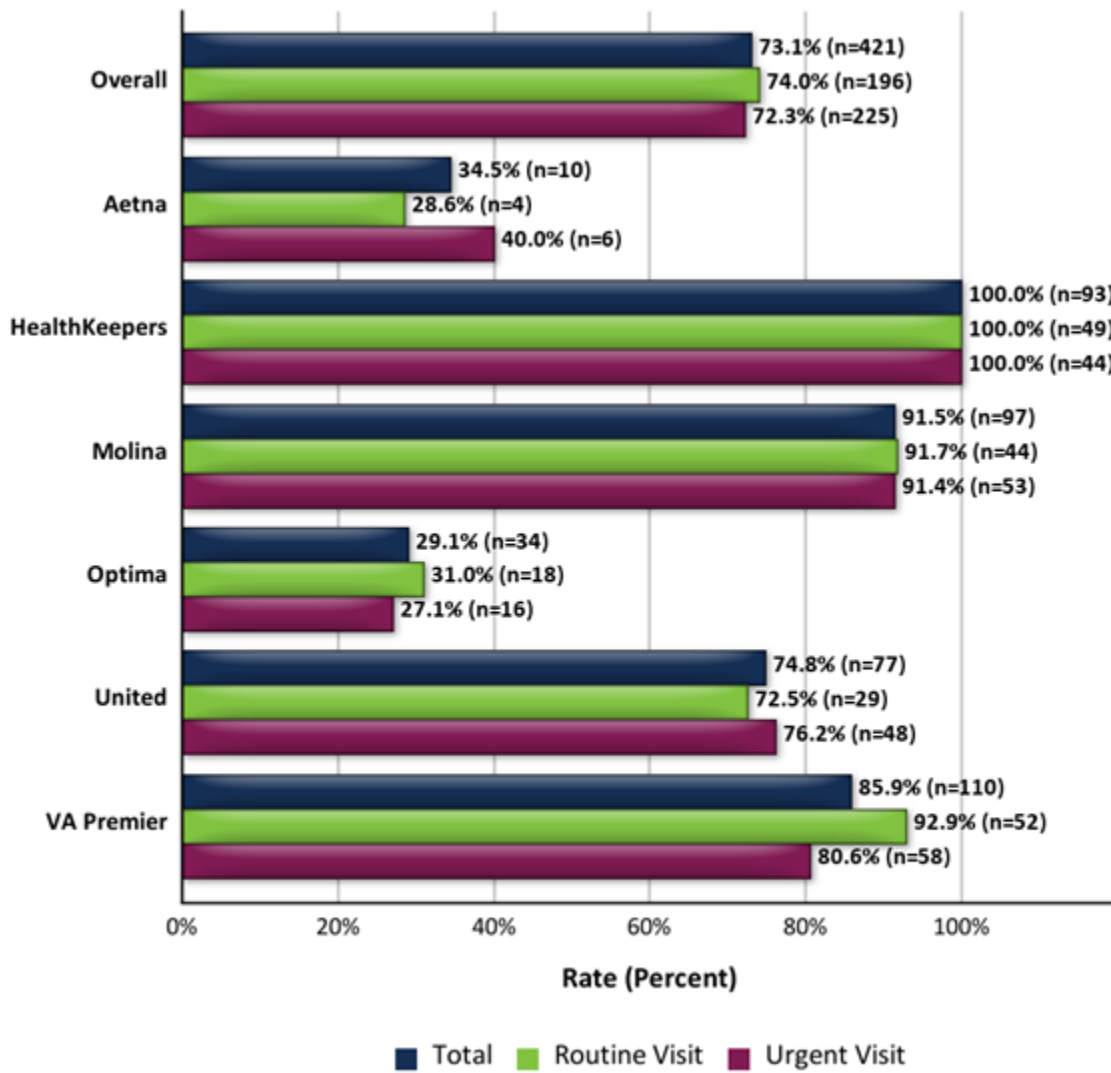
**Table 3-8—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Denominator <sup>1</sup>	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
Aetna	184	20.1%	19.0%	15.8%
HealthKeepers	273	45.4%	41.8%	34.1%
Molina	254	56.3%	54.3%	41.7%
Optima	283	55.5%	47.7%	41.3%
United	301	44.5%	40.5%	34.2%
VA Premier	299	50.2%	48.8%	42.8%
<b>MCO Total</b>	<b>1,594</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

<sup>1</sup> The denominator includes cases responding to the survey.

As shown in Figure 3-6 and Figure 3-7, 74.0 percent of calls were offered an appointment date for a routine appointment and 72.3 percent were offered an appointment date for an urgent appointment. Of the appointments that were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments, with values ranging from 50.0 percent for Aetna to 88.6 percent for Molina. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments, with rates ranging from 0 percent for Aetna to 25.9 percent for VA Premier.

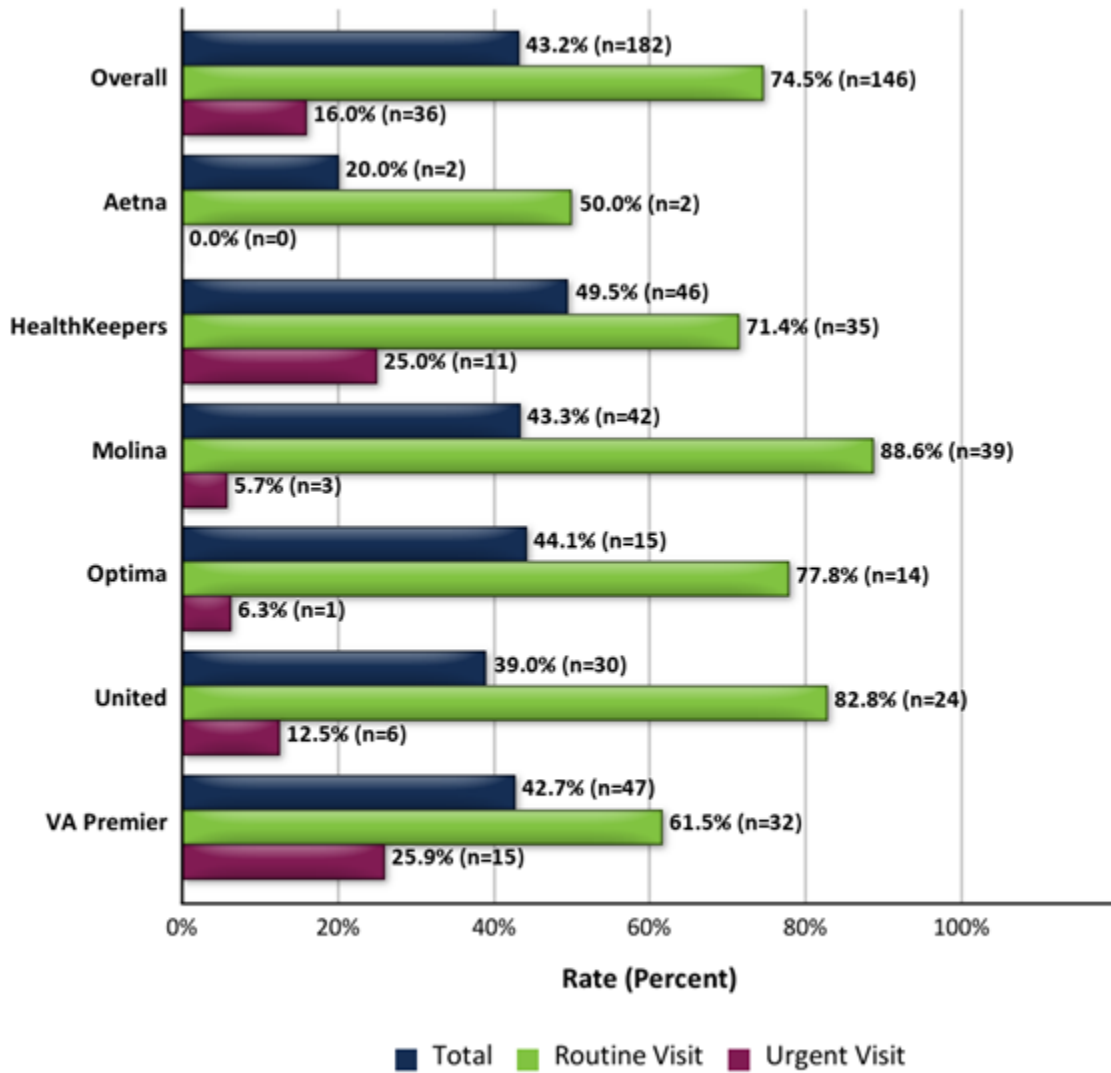
**Figure 3-6—New Patient Appointment Availability**



The denominator includes cases reached and accepting new patients.





**Figure 3-7—Appointments Meeting Compliance Standards**



The denominator includes cases reached, accepting new patients, and offering an appointment.

## Strengths, Weaknesses, and Recommendations

Weaknesses and Recommendations	
	<p><b>Weakness:</b> Overall, approximately 83 percent (n=2,101) of cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. The overall response rate was 63.2 percent with 46.7 percent of the offices accepting the MCO, 43.3 percent accepting VA Medicaid, and 36.1 percent accepting new patients.</p> <p><b>Recommendations:</b> Since DMAS’ enrollment broker supplied HSAG with the PCP data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location’s address and appropriate provider type and specialty. DMAS could also consider requesting that the MCOs provide evidence of training offered by the MCOs to providers’ offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff members responsible for scheduling appointments have been educated on the MCO names and benefit coverage, and that the offices have a plan in place for educating new staff members in the event of staff turnover.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services.</p> <p><b>Recommendations:</b> HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices’ requirements to ensure that these considerations for scheduling appointments do not unduly burden members’ ability to access primary care and to streamline the process of scheduling new patient appointments within the routine (30-day) and urgent (one-day) appointment standards.</p>

## Conclusions

Survey findings support specific opportunities for improving the quality of PCP data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 83 percent (n=2,101) of overall cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date. Key findings are listed below:

- The CY 2022–2023 PCP secret shopper survey overall response rate was 63.2 percent, primarily because the provider location was not able to be reached (36.8 percent) or the location did not provide primary care services (21.9 percent).
  - Response rates by MCO ranged from 44.0 percent (Aetna) to 75.9 percent (VA Premier).
  - Aetna had the highest percentage of cases where the provider location was not able to be reached (56.0 percent).
  - United had the highest percentage of cases where the provider location did not offer primary care services (31.4 percent).
- Of the responsive cases:
  - 8.1 percent reported that the sampled address was incorrect, and a forwarding number was not available for the requested address. Aetna had the highest rate (23.9 percent) and Molina had the lowest rate (2.0 percent) of cases with incorrect addresses.
  - 46.7 percent accepted the MCO. Aetna had the lowest rate (20.1 percent) and Molina had the highest rate (56.3 percent) of responsive cases accepting the MCO’s members.
  - 43.3 percent accepted VA Medicaid. Aetna had the lowest rate (19.0 percent) and Molina had the highest rate (54.3 percent) of responsive cases accepting VA Medicaid.
  - 36.1 percent of provider locations reported accepting new patients. New patient acceptance rates ranged from 15.8 percent (Aetna) to 42.8 percent (VA Premier). Comments provided by locations not taking new patients included only taking the MCO and/or VA Medicaid for established patients, not taking new patients due to provider retirement, and not taking new patients at the location at all.
- Among cases offering an appointment, 73.1 percent provided a routine or urgent care appointment date. There was not a substantial difference in the percentage of appointments offered by appointment type (i.e., routine or urgent). Common reasons for not scheduling routine or urgent appointments included requiring preregistration, personal information, or medical records prior to scheduling the appointment.
- The overall median wait time was 12 and 14 calendar days for an urgent and routine appointment, respectively.
- For cases that were offered a routine appointment, 74.5 percent were compliant with the 30-day standard for routine primary care services. For cases that were offered an urgent appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services.

## Statewide Aggregate CAHPS Results

### Adult Medicaid

Table 3-9 and Table 3-10 present the 2023 top-box scores for each MCO and the Medallion 4.0 (Acute) program (i.e., all MCOs combined) compared to the 2022 adult Medicaid CAHPS scores for the global ratings and composite measures. The 2023 CAHPS scores for each MCO and the Medallion 4.0 (Acute) program were also compared to the 2022 NCQA adult Medicaid national averages.

**Table 3-9—Comparison of 2022 and 2023 Adult Global Top-Box Scores**

	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2022	2023	2022	2023	2022	2023	2022	2023
Medallion 4.0 (Acute) Program	63.4%	58.9%	56.6%	54.0%	65.2%	66.5%	66.3%	65.7%
Aetna	60.3%	58.3%	53.6%	53.5%	65.4%	70.7%	59.5% <sup>+</sup>	66.7% <sup>+</sup>
HealthKeepers	63.1%	52.8%	53.8% <sup>+</sup>	48.1%	65.3%	59.7%	78.0% <sup>+</sup>	63.0% <sup>+</sup>
Molina	60.1%	57.3%	56.6%	59.2%	66.9%	68.1%	65.9% <sup>+</sup>	65.0%
Optima	64.3%	64.1% <sup>+</sup>	64.3% <sup>+</sup>	52.4% <sup>+</sup>	67.7% <sup>+</sup>	71.4% <sup>+</sup>	62.5% <sup>+</sup>	64.1% <sup>+</sup>
United	56.2%	69.5% <sup>▲</sup>	47.8% <sup>+</sup>	59.6% <sup>+</sup>	60.0% <sup>+</sup>	66.0%	58.5% <sup>+</sup>	67.9% <sup>+</sup>
VA Premier	69.5%	58.4% <sup>▼</sup>	58.8% <sup>+</sup>	60.0%	64.0%	68.2%	62.5% <sup>+</sup>	70.1% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

**Table 3-10—Comparison of 2022 and 2023 Adult Composite Top-Box Scores**

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2022	2023	2022	2023	2022	2023	2022	2023
Medallion 4.0 (Acute) Program	81.1%	82.2%	80.2%	81.1%	91.0%	92.8%	87.5%	88.0%
Aetna	73.6% <sup>+</sup>	76.2%	73.1% <sup>+</sup>	76.7% <sup>+</sup>	85.7% <sup>+</sup>	91.1%	83.8% <sup>+</sup>	88.1% <sup>+</sup>
HealthKeepers	84.7% <sup>+</sup>	84.9% <sup>+</sup>	84.4% <sup>+</sup>	80.9% <sup>+</sup>	89.2% <sup>+</sup>	92.9% <sup>+</sup>	86.2% <sup>+</sup>	91.4% <sup>+</sup>
Molina	83.4% <sup>+</sup>	83.3%	76.1% <sup>+</sup>	76.7%	93.8%	93.7%	88.0% <sup>+</sup>	88.9%
Optima	78.4% <sup>+</sup>	83.1% <sup>+</sup>	82.2% <sup>+</sup>	86.1% <sup>+</sup>	93.1% <sup>+</sup>	95.2% <sup>+</sup>	85.3% <sup>+</sup>	81.0% <sup>+</sup>

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2022	2023	2022	2023	2022	2023	2022	2023
United	76.8% <sup>+</sup>	80.2% <sup>+</sup>	80.6% <sup>+</sup>	82.9% <sup>+</sup>	90.9% <sup>+</sup>	89.5% <sup>+</sup>	84.8% <sup>+</sup>	88.2% <sup>+</sup>
VA Premier	85.2% <sup>+</sup>	82.2% <sup>+</sup>	79.0% <sup>+</sup>	80.1% <sup>+</sup>	93.7% <sup>+</sup>	92.8% <sup>+</sup>	94.9% <sup>+</sup>	89.4% <sup>+</sup>

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



▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

Strengths	
	United’s 2023 top-box score was statistically significantly higher than the 2022 top-box score and the 2022 NCQA adult Medicaid national average for <i>Rating of Health Plan</i> .
Weaknesses and Recommendations	
	<p><b>Weakness:</b> HealthKeepers’ 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for <i>Rating of Health Plan</i>.</p> <p><b>Weakness:</b> VA Premier’s 2023 top-box score was statistically significantly lower than the 2022 top-box score for <i>Rating of Health Plan</i>.</p> <p><b>Recommendations:</b> 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 recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.</p>

### Child Medicaid

Table 3-11 and Table 3-12 present the 2023 top-box scores for each MCO and the Medallion 4.0 program compared to the 2022 child Medicaid CAHPS scores for the global ratings and composite measures. The 2023 CAHPS scores for each MCO and the Medallion 4.0 program were also compared to the 2022 NCQA child Medicaid national averages.

**Table 3-11—Comparison of 2022 and 2023 Child Global Top-Box Scores**

	Rating of Health Plan		Rating of All Health Care		Rating of Personal Doctor		Rating of Specialist Seen Most Often	
	2022	2023	2022	2023	2022	2023	2022	2023
Medallion 4.0 (Acute) Program	74.1%	74.2%	72.6%	71.7%	74.7%	74.7%	73.0%	74.6%
Aetna	74.0%	70.9%	66.9%	66.0%	75.8%	74.7%	65.9% <sup>+</sup>	65.4% <sup>+</sup>
HealthKeepers	74.8%	73.5%	74.4%	70.9%	71.2%	73.6%	71.4% <sup>+</sup>	82.7% <sup>+</sup>
Molina	67.3%	68.6%	68.1%	69.4%	75.0%	72.1%	71.7%	75.6% <sup>+</sup>
Optima	71.3%	74.9%	70.8%	70.0%	77.9%	78.6%	76.8% <sup>+</sup>	79.5% <sup>+</sup>
United	70.6%	68.3%	75.5% <sup>+</sup>	76.4%	74.1%	66.4%	80.0% <sup>+</sup>	50.0% <sup>+</sup> ▼
VA Premier	78.8%	80.5%	72.8%	76.2%	77.2%	77.1%	71.2% <sup>+</sup>	71.7% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

**Table 3-12—Comparison of 2022 and 2023 Child Composite Top-Box Scores**

	Getting Needed Care		Getting Care Quickly		How Well Doctors Communicate		Customer Service	
	2022	2023	2022	2023	2022	2023	2022	2023
Medallion 4.0 (Acute) Program	82.5%	83.4%	83.9%	83.4%	93.2%	93.5%	86.8%	87.1%
Aetna	82.8%	83.1%	85.3%	85.5%	91.2%	95.2%	88.0% <sup>+</sup>	85.3% <sup>+</sup>
HealthKeepers	85.3%	83.7%	84.0%	85.1%	92.7%	92.3%	88.5% <sup>+</sup>	89.7% <sup>+</sup>
Molina	82.4%	74.0%▼	86.8%	79.0%▼	94.4%	91.2%▼	89.2%	78.6%▼
Optima	84.4% <sup>+</sup>	84.1% <sup>+</sup>	84.0% <sup>+</sup>	81.9% <sup>+</sup>	95.9%	96.8%	89.2% <sup>+</sup>	88.2% <sup>+</sup>
United	74.5% <sup>+</sup>	79.8% <sup>+</sup>	76.1% <sup>+</sup>	81.5% <sup>+</sup>	91.9%	89.4%	82.3% <sup>+</sup>	90.4% <sup>+</sup>
VA Premier	79.7% <sup>+</sup>	86.3%	85.9% <sup>+</sup>	82.8%	92.5%	93.7%	82.9% <sup>+</sup>	82.5% <sup>+</sup>

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





▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

## Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths	
	VA Premier’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for <i>Rating of Health Plan</i> .
	Optima’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for <i>How Well Doctors Communicate</i> .
Weaknesses and Recommendations	
	<b>Weakness:</b> United’s 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for two measures: <i>Rating of Personal Doctor</i> and <i>Rating of Specialist Seen Most Often</i> . Additionally, United’s 2023 top box score for <i>Rating of Specialist Seen Most Often</i> was statistically significantly lower than the 2022 top-box score.
	<b>Weakness:</b> Molina’s 2023 top-box scores were statistically significantly lower than the 2022 top-box scores and the 2022 NCQA child Medicaid national averages for four measures: <i>Getting Needed Care</i> , <i>Getting Care Quickly</i> , <i>How Well Doctors Communicate</i> , and <i>Customer Service</i> .
	<b>Weakness:</b> The Medallion 4.0 (Acute) program’s 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for <i>Getting Care Quickly</i> .
	<b>Recommendations:</b> 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 3-13 presents the 2022 and 2023 FAMIS CAHPS top-box scores for the global ratings and composite measures. The FAMIS general child and CCC 2023 CAHPS scores were compared to the 2022 NCQA child Medicaid national and CCC Medicaid averages.<sup>3-15</sup> In addition, a trend analysis was performed that compared the 2023 CAHPS scores to corresponding 2022 CAHPS scores.

<sup>3-15</sup> For the NCQA child Medicaid national and CCC Medicaid averages, Quality Compass 2022 data were used with permission from NCQA. Quality Compass 2022 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.



**Table 3-13—Comparison of 2022 and 2023 FAMIS Program General Child and CCC Top-Box Scores**

Global Ratings	General Child		CCC	
	2022	2023	2022	2023
Rating of Health Plan	70.5%	72.7%	65.1%	65.9%
Rating of All Health Care	71.9%	67.0% <sup>+</sup>	62.8%	56.4%
Rating of Personal Doctor	77.4%	78.8%	73.7%	74.8%
Rating of Specialist Seen Most Often	69.4% <sup>+</sup>	73.9% <sup>+</sup>	68.6%	63.9% <sup>+</sup>
Composite Measures	2022	2023	2022	2023
Getting Needed Care	83.3% <sup>+</sup>	83.3% <sup>+</sup>	82.3%	76.2%
Getting Care Quickly	84.8% <sup>+</sup>	90.7% <sup>+</sup>	85.9%	87.7% <sup>+</sup>
How Well Doctors Communicate	95.2%	93.7% <sup>+</sup>	95.6%	92.2%
Customer Service	83.4% <sup>+</sup>	95.0% <sup>+</sup> ▲	82.8% <sup>+</sup>	89.3% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

The 2022 NCQA national average for Customer Service measure was not available; therefore, no orange bar is presented in the figure.

### Summary of Strengths, Weaknesses, and Overall Conclusions

Strengths	
	The general child’s 2023 top-box score was statistically significantly higher than the 2022 top-box score for <i>Customer Service</i> .
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The CCC’s 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for two measures: <i>Rating of All Health Care</i> and <i>Getting Needed Care</i>.</p> <p><b>Recommendations:</b> HSAG recommends that the MCOs conduct root cause analyses of the 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.</p>

## MCO Comparative and Statewide Calculation of Additional PM Results

### Project Highlights

DMAS contracted with HSAG in 2023 to calculate the *Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay (MLTSS-8)* PM following the 2022 CMS *Medicaid MLTSS Measures Technical Specifications and Resource Manual*.<sup>3-16</sup> Table 3-14 displays the CY 2022 *MLTSS-8* PM results stratified by Medicaid managed care program, Medicaid delivery system, MCO, geographic region, and select demographics (e.g., age, gender, and race).

**Table 3-14—MLTSS-8 PM Results**

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Virginia Total	4,578	33.70%	67.61%	0.50
<b>Medicaid Program</b>				
CCC Plus (MLTSS)	3,742	31.11%	67.90%	0.46
Medallion 4.0 (Acute)	86	79.07%	57.92%	1.37
More than One Medicaid Program	147	64.63%	53.74%	1.20
<b>Medicaid Delivery System</b>				
Fee-for-Service	166	18.07%	74.93%	0.24
Managed Care	3,975	33.38%	67.16%	0.50
More than One Delivery System	437	42.56%	68.86%	0.62
<b>MCO</b>				
Aetna	779	38.25%	66.14%	0.58
HealthKeepers	1,013	42.74%	65.02%	0.66
Molina	532	28.57%	68.55%	0.42
Optima	572	20.63%	69.86%	0.30
United	431	26.45%	68.50%	0.39
VA Premier	568	30.11%	68.40%	0.44
More than One MCO	80	51.25%	59.79%	0.86
<b>Geographic Region</b>				
Central	1,192	35.82%	66.51%	0.54

<sup>3-16</sup> 2022 Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf>. Accessed on: Oct 19, 2023.

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Charlottesville/Western	663	29.71%	69.18%	0.43
Northern & Winchester	727	36.73%	68.28%	0.54
Roanoke/Alleghany	566	31.63%	68.49%	0.46
Southwest	S	S	S	S
Tidewater	966	33.75%	66.71%	0.51
Unknown	S	S	S	S
<b>Age</b>				
18–44 Years	331	55.29%	53.24%	1.04
45–64 Years	1,674	43.49%	60.67%	0.72
65–74 Years	1,180	26.69%	74.59%	0.36
75–84 Years	878	21.53%	74.56%	0.29
85+ Years	515	24.85%	71.55%	0.35
<b>Gender</b>				
Male	2,000	35.10%	66.82%	0.53
Female	2,578	32.62%	68.22%	0.48
<b>Race</b>				
White	2,828	32.21%	68.64%	0.47
Black/African American	1,572	34.67%	66.09%	0.52
Asian	90	52.22%	66.40%	0.79
Southeast Asian/Pacific Islander	S	S	S	S
Hispanic	S	S	S	S
More than One Race/Other/Unknown	54	51.85%	59.88%	0.87

\* Please note that for the O/E Ratio, a higher rate indicates more favorable performance; therefore, an O/E Ratio greater than 1 indicates that more residents were successfully transitioned to the community from their facility than were expected based on the resident case mix (i.e., the residents’ age, gender, chronic conditions, and Medicaid status).

<sup>S</sup> 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.

Successfully transitioning a long-term facility resident back into community settings has shown a significant boost in residents’ overall quality of life and satisfaction given the independence associated

with being back in the community.<sup>3-17</sup> For Virginia Medicaid, the O/E ratio was 0.5 for CY 2022, indicating that fewer Virginia Medicaid members were successfully discharged to the community after 100 days than expected. Members enrolled in Medallion 4.0 (Acute) and More than One Medicaid Program were more likely to be successfully discharged to the community after 100 days, with an O/E ratio of 1.37 and 1.20, respectively. It is important to note that the risk-adjusted model for this measure expects older people to be successfully discharged to the community at a higher rate than younger people; however, in Virginia, younger residents (i.e., members between the ages of 18 and 64) were more likely to be successfully discharged to the community after 100 days of admission than older residents.

## **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. During 2023, HSAG calculated CY 2020 and CY 2021 rates. The results are found in Section 11 of this report 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*
- *Cascade of Care for Members With HIV*

## **Focus Studies**

DMAS elected to continue the following clinical topics during the 2023 contract year: improving birth outcomes through adequate PNC (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 Data Brief. 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**

### **Tool Results**

---

<sup>3-17</sup> Gassoumis ZD, Fike KT, Rahman AN, et al. Who transitions to the community from nursing homes? Comparing patterns and predictors for short-stay and long-stay residents. *Home Health Care Serv Q.* 2013;32(2):75-91. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3711511/>. Accessed on: Nov. 6, 2023.

DMAS contracted with HSAG in 2023 to produce a Consumer Decision Support Tool using Virginia Medicaid MCOs’ HEDIS data and CAHPS survey results for the Medallion 4.0 (Acute) MCOs. The Medallion 4.0 (Acute) Consumer Decision Support Tool demonstrates how the Virginia Medicaid Medallion 4.0 (Acute) MCOs compared to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-15. Please refer to Appendix B for the detailed methodology used for this tool.

**Table 3-15—Medallion 4.0 (Acute) Consumer Decision Support Tool—Performance Ratings**

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

Table 3-16 displays the Medallion 4.0 (Acute) 2023 Consumer Decision Support Tool results for each MCO.




**Table 3-16—2023 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	★★★★★	★	★★★	★★★★★	★★★★★	★★★★★

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

\*\*Data for Optima also include data for members enrolled in VA Premier in 2022.

## Strengths and Weaknesses

Strengths	
	Aetna demonstrated the strongest performance by achieving the Highest Performance level for the Doctors' Communication and Taking Care of Women categories; High Performance for the Overall Rating, Getting Care, and Living With Illness categories; and Average Performance level for the Keeping Kids Healthy category.
	HealthKeepers also demonstrated strong performance by achieving the Highest Performance level for the Overall Rating, Getting Care, Keeping Kids Healthy, and Taking Care of Women categories.
Weaknesses and Recommendations	
	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.

## Performance Withhold Program

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 (Acute) PWP. The SFY 2023 PWP assessed CY 2022 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2023 PWP, the Medallion 4.0 (Acute) MCOs could earn all or a portion of their 1 percent quality withhold based on performance for seven NCQA HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators). The SFY 2023 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures and receiving a reportable audit status on the AHRQ PDI and CMS Adult Core Set PMs. For detailed information related to the PWP, please see the SFY 2023 PWP Methodology on DMAS' website.<sup>3-18</sup>

<sup>3-18</sup> Health Services Advisory Group, Inc. *SFY 2023 Performance Withhold Program Methodology*. Available at: <https://www.dmas.virginia.gov/media/4807/va-egro-sfy-2023-pwp-methodology-f2.pdf>. Accessed on: Oct 31, 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 MCOs 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:** No confidence in reported results. 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*.

## ***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 2023 validation, the MCOs progressed to reporting baseline data, QI strategies, and interventions. The validation findings for each MCO are provided below.

## ***Validation Findings***

### **Aetna**

In 2023, Aetna submitted its baseline data and interventions for the following PIPs for validation: *Ensuring Timeliness of Prenatal Visits* 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

<b>Ensuring Timeliness of Prenatal Visits</b>			
PIP Topic	Ensuring Timeliness of Prenatal Visits		
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	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 in the organization.		
Description of Data Obtained	Administrative using claims and encounters and medical record review following HEDIS hybrid data collection specifications		
Validation Scores	<table border="1"> <tr> <td>Overall Score: 100%</td> <td>Critical Elements Score: 100%</td> </tr> </table>	Overall Score: 100%	Critical Elements Score: 100%
Overall Score: 100%	Critical Elements Score: 100%		
Validation Status/Confidence Level	<i>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.</i>		
<b>Tobacco Use Cessation in Pregnant Women</b>			
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	Percentage of pregnant women who are screened for tobacco use.		
Description of Data Obtained	Administrative data extracted from Inovalon Quality Spectrum		
Validation Scores	<table border="1"> <tr> <td>Overall Score: 100%</td> <td>Critical Elements Score: 100%</td> </tr> </table>	Overall Score: 100%	Critical Elements Score: 100%
Overall Score: 100%	Critical Elements Score: 100%		
Validation Status/Confidence Level	<i>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.</i>		

Aetna met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. Aetna reported its baseline rate and the QI activities conducted. Aetna completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-2 and Table 4-3 display the PIP intervention summaries.

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

<b>Intervention</b>	<b>Intervention Status</b>
Care Management will outreach members within 15 days of receiving the monthly Maternal Care report.	New and in progress



Intervention	Intervention Status
Care management will outreach identified pregnant members and assist them during the prenatal screening process.	New and in progress
Care management will focus on ensuring that members have an OB/GYN provider and will follow up with members within 15 days of making an appointment referral that accommodates the member's schedule.	New and in progress
Care management will focus on ensuring that members have an OB/GYN provider and will follow up with members within 15 days of making an appointment referral that accommodates the member's schedule.	New and in progress

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

Intervention	Intervention Status
A fax blast was sent to all three provider types: OB/GYNs, family practitioners, and general practitioners. The fax blast included provider talking points and member resources for tobacco use cessation.	New and in progress
A fax blast was sent to all three provider types: OB/GYNs, family practitioners, and general practitioners. The fax blast contained information on the correct codes to submit to indicate that the counseling was completed.	New and in progress
A fax blast was sent to all three provider types: OB/GYNs, family practitioners, and general practitioners. The fax blast included information on smoking cessation programs and pharmaceutical treatment options for providers to educate their pregnant members.	New and in progress

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	Aetna progressed to subsequent PIP stages, successfully collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	<b>Weakness:</b> None identified
	<b>Recommendations:</b> NA

## HealthKeepers

In 2023, HealthKeepers submitted its baseline data and interventions for the following 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

<b>Timeliness of Prenatal Care</b>			
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 the enrollment start date, or within 42 days of enrollment in the organization		
Description of Data Obtained	Administrative using claims and encounters		
Validation Scores	<table border="1"> <tr> <td>Overall Score: 100%</td> <td>Critical Elements Score: 100%</td> </tr> </table>	Overall Score: 100%	Critical Elements Score: 100%
Overall Score: 100%	Critical Elements Score: 100%		
Validation Status/Confidence Level	<i>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.</i>		
<b>Tobacco Use Cessation in Pregnant Women</b>			
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 Measures	<p>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.</p> <p>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, and if the screen was positive for smoking, subsequently received counseling/advice for smoking cessation.</p>		

Tobacco Use Cessation in Pregnant Women		
Description of Data Obtained	Administrative using claims and encounters	
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 met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its baseline rate and the QI activities conducted. HealthKeepers completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-6 and Table 4-7 display the PIP intervention summaries.

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



Intervention	Intervention Status
Send informative and educational text messages to members regarding timely prenatal visits as a reminder to make an appointment with their obstetrics (OB) provider.	New and in progress
Generated HEDIS tags in PointClickCare (Collective Medical) using identified Gap in Care report to alert care coordinators of HEDIS gaps and generate a return report from PointClickCare overlaying gaps with emergency room visits in real time.	New and in progress
Provide education to members on the value of prenatal visits by informing them of the doula benefit via flyers and text messages.	New and in progress
Developed a report that identifies members with SDOH needs, including pregnant members, for care coordinators/care managers to outreach the members and assist with addressing the identified SDOH needs.	New and in progress
Extended Pay for Quality Provider Incentive Programs for providers. This program allows the providers to earn incentives for closing gaps in care earlier in the year to allow for additional gap closures. Hired an additional OB practice consultant to increase participation in the Obstetric Quality Incentive Program (OBQIP) that incentivizes providers for improving maternal performance indicators, including timely prenatal care.	New and in progress
Added the <i>Timeliness of Prenatal Care</i> measure to the Provider Incentive Category II program to encourage providers to use the correct codes for billing.	New and in progress

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

Intervention	Intervention Status
Informative and/or educational text messages via mPulse to members regarding timely prenatal visits as a reminder to make an appointment with their OB and educate members on tobacco cessation.	New and in progress
OB practice consultants meet with providers in the OBQIP provider incentive program to close prenatal and postpartum gaps in care. Consultants encourage providers to refer members to 1-800-QUIT-NOW or to the care management team for other resources.	New and in progress
Care coordinators and case managers educate members regarding the dangers of smoking and tobacco use, the different forms of tobacco use such as vaping, and the different modalities for cessation, including support groups.	New and in progress

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	HealthKeepers progressed to subsequent PIP stages, successfully collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	<b>Weakness:</b> None identified
	<b>Recommendations:</b> NA

**Molina**

In 2023, Molina submitted its baseline data and interventions for the following 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

**Table 4-9—PIP Aim Statements and Validation 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?



Timeliness of Prenatal Care		
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 with Molina Complete Care as defined by the HEDIS <i>PPC</i> measure specifications.	
Description of Data Obtained	Administrative using claims and encounters	
Validation Scores	<i>Overall Score: 100%</i>	<i>Critical Elements Score: 100%</i>
Validation Status/Confidence Level	<i>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.</i>	
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 Measures	The percentage of pregnant members as defined by the HEDIS <i>PPC</i> measure specifications who have quit smoking or use of tobacco products while pregnant during the measurement period.	
Description of Data Obtained	Administrative using claims and encounters and pharmacy data	
Validation Scores	<i>Overall Score: 100%</i>	<i>Critical Elements Score: 100%</i>
Validation Status/Confidence Level	<i>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.</i>	

Molina met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its baseline rate and the QI activities conducted. Molina completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-10 and Table 4-11 display the PIP intervention summaries.

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

Intervention	Intervention Status
Member outreach. The outreach allows for additional support to be incorporated to ensure that multiple attempts are made to reach members and their assigned providers to collect and update information for the purposes of education, provider alignment, and appointment scheduling.	New and in progress



Intervention	Intervention Status
Provider quality meetings are conducted with education provided on available resources, coding, required documentation, data sharing, and scheduling members for timely appointments.	New and in progress

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

Intervention	Intervention Status
Member outreach. The MCO uses various tools to identify alternative methods of communication or contact information and will target all prenatal members after three attempts have been made by the healthcare service team.	New and in progress

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	Molina successfully progressed to subsequent PIP stages, collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	<b>Weakness:</b> None identified
	<b>Recommendations:</b> NA

**Optima**

In 2023, Optima submitted its baseline data and interventions for the following 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

**Table 4-13—PIP Aim Statements and Validation 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	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.

Timeliness of Prenatal Care		
Description of Data Obtained	Administrative using claims and encounters and medical record review following HEDIS hybrid data collection specifications	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Validation Status/Confidence Level	<i>Met/High Confidence/Confidence in reported PIP results:</i> All critical evaluation elements were <i>Met</i> , and 80 to 100 percent of all evaluation elements were <i>Met</i> 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 Measures	The percentage of identified non-smoking pregnant members during the measurement period.	
Description of Data Obtained	Administrative data using electronic health records	
Validation Scores	Overall Score: 100%	Critical Elements Score: 100%
Validation Status/Confidence Level	<i>Met/High Confidence/Confidence in reported PIP results:</i> All critical evaluation elements were <i>Met</i> , and 80 to 100 percent of all evaluation elements were <i>Met</i> across all steps.	

Optima met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its baseline rate and the QI activities conducted. HealthKeepers completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-14 and Table 4-15 display the PIP intervention summaries.

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



Intervention	Intervention Status
Increase case management efforts and utilize the maternity assessment for pregnant Medallion 4.0 (Acute) members. The Partners in Pregnancy team receives a monthly member enrollment list from DMAS. Based on this list, the Partners in Pregnancy team outreaches members and completes a maternity assessment.	New and in progress
The MCO utilizes Ovia (a digital application) so members can have real-time access to pregnancy information at their own pace. The Ovia information is posted on the Optima website for easy access. Ovia also provides the MCO with a monthly list of Medallion 4.0 (Acute) members who accessed the pregnancy topic in the application.	New and in progress

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

Intervention	Intervention Status
<p>Increase case management efforts and utilize the maternity assessment to identify pregnant smokers. The Partners in Pregnancy team receives a monthly member enrollment list from DMAS. Based on this list, the PIP team outreaches members and completes a maternity assessment. This assessment includes a question about smoking: “Do you smoke?”</p> <p>Optima’s analytics team provides a monthly report from the JIVA application that includes the number of completed assessments and the number of members who answered “Yes” to the question “Do you smoke?”</p> <p>The Partners in Pregnancy team offers educational materials to these identified pregnant members who smoke.</p>	<p>New and in progress</p>
<p>Offer Emmi educational videos that are easily accessible.</p> <p>Optima sends the Emmi video links to pregnant Medallion 4.0 (Acute) members on a schedule based on trimester.</p> <p>The member registers for the Emmi video and will be able to access Tobacco Cessation videos. The Emmi vendor can identify members who accessed the educational videos and viewed the videos assigned. The Emmi vendor also provides a monthly report to Optima.</p>	<p>New and in progress</p>

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Optima successfully progressed to subsequent PIP stages, collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> None identified</p> <p><b>Recommendations:</b> NA</p>

## United

In 2023, United submitted its baseline data and interventions for the following 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

Timeliness of Prenatal Care		
PIP Topic	Timeliness of Prenatal Care	
PIP Aim Statement	Targeted interventions 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 (Acute) population?	
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.	
Description of Data Obtained	Administrative using claims and encounters	
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 <i>Met</i> , and 80 to 100 percent of all evaluation elements were <i>Met</i> across all steps.	
Tobacco Use Cessation in Pregnant Women		
PIP Topic	Tobacco Use Cessation in Pregnant Women	
PIP Aim Statement	Targeted interventions supported by the Virginia UnitedHealthcare Medallion Plan and focused on member engagement-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 Measures	The percentage of pregnant women using tobacco who received smoking cessation services.	
Description of Data Obtained	Administrative using claims and encounters and telephone service center data	
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 <i>Met</i> , and 80 to 100 percent of all evaluation elements were <i>Met</i> across all steps.	

United met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. The MCO reported its baseline rate and the QI activities conducted. The MCO completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-18 and Table 4-19 display the PIP intervention summaries.

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



Intervention	Intervention Status
Redesigning the maternity program to focus on identifying healthy pregnant members with no prenatal care upon enrollment into the health plan and conduct case management outreach to encourage these members to complete prenatal care visits at recommended intervals.	New and in progress

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

Intervention	Intervention Status
Define and implement a process to integrate claims and other data sources to identify and capture more pregnant members who are current tobacco users or who have a history of tobacco use into the case management process for member outreach and follow-up by a case manager.	New and in progress

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	United successfully progressed to subsequent PIP stages, collecting data and initiating interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> None identified</p> <p><b>Recommendations:</b> NA</p>

**VA Premier**

In 2023, VA Premier submitted its baseline data and interventions for the following PIPs for validation: *Timeliness of Prenatal Visits* 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 the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

<b>Timeliness of Prenatal Care</b>	
PIP Topic	Timeliness of Prenatal Visits
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 the enrollment start date, or within 42 days of enrollment in the organization.
Description of Data Obtained	Administrative using claims and encounters
Validation Scores	<i>Overall Score: 75%</i> <i>Critical Elements Score: 67%</i>
Validation Status/Confidence Level	<i>Low Confidence in reported PIP results: All critical evaluation elements were Met, and one or more critical evaluation elements were Partially Met.</i>
<b>Tobacco Use Cessation in Pregnant Women</b>	
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 Measures	The percentage of tobacco use cessation in pregnant members.
Description of Data Obtained	Administrative using electronic health records
Validation Scores	<i>Overall Score: 94%</i> <i>Critical Elements Score: 89%</i>
Validation Status/Confidence Level	<i>Low Confidence in reported PIP results: All critical evaluation elements were Met, and one or more critical evaluation elements were Partially Met.</i>

VA Premier had opportunities for improvement identified within this stage for both PIPs. For the *Timeliness of Prenatal Visits* PIP, the baseline data were not reported correctly, and for both PIP topics, the MCO did not provide a copy of the QI tools that were used. All these elements were critical in the validation tool and impacted the overall scores and validation status. VA Premier did identify barriers through a causal/barrier analysis process and initiate appropriate interventions to address these barriers.



Table 4-22 and Table 4-23 display the PIP intervention summaries.

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



Intervention	Intervention Status
Pregnancy incentive-based prenatal care program and early identification of pregnancy with outreach.	New and in progress
Transportation through Verida.	New and in progress
Obstetrics (OB) registration program.	New and in progress

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

Intervention	Intervention Status
Referrals to community resources and to the internal SDOH social work team. Trained outreach team as community health workers.	New and in progress
Education to prenatal members by member outreach and case management.	New and in progress
Doula program.	New and in progress

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	Although opportunities for improvement were identified and not addressed in the resubmission of the PIPs, VA Premier’s PIPs were found to methodologically sound and created a foundation for the MCO to progress to subsequent PIP stages—collecting data and implementing interventions that address the identified barriers.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The MCO did not address all validation feedback and did not make the necessary corrections in the final resubmitted PIPs, which resulted in the overall validation status for each PIP of <i>Partially Met</i>.</p> <p><b>Recommendations:</b> With VA Premier no longer serving members as of July 1, 2023, and this being the last validation cycle for the <i>Timeliness of Prenatal Visits</i> and <i>Tobacco Use Cessation in Pregnant Members</i> PIPs, HSAG has no recommendations.</p>

## ***Recommendations***

As the MCOs continue with their PIPs, progress to reporting remeasurement data, and work toward improving outcomes, HSAG has the following recommendations:

- The MCOs should revisit their causal/barrier analyses at least annually to ensure timely and accurate identification and prioritization of barriers and opportunities for improvement.
- The MCOs should keep interventions focused on the prioritized barriers and consider making fundamental changes.
- When developing interventions, the MCOs should consider collaborating with external organizations and SMEs.
- The MCOs should use PDSA cycles to test interventions on a small scale before expanding to larger populations. The MCOs should select intervention effectiveness measures that directly monitor intervention impact and evaluate measure results quickly. The intervention evaluation results should drive next steps for interventions and determine whether they should be adopted, adapted, or abandoned, or whether continued testing is needed.
- The MCOs should discuss and address barriers to PIP progress with their internal teams and/or HSAG to determine methods on how to overcome any identified barriers.
- The MCOs should continue to reference the PIP Completion Instructions as additional steps of the PIP process are completed. This will help ensure that all documentation requirements have been addressed.
- The MCOs should apply lessons learned and HSAG's validation feedback to their PIPs and other QI projects.

## 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 3-3, displays, by MCO, the HEDIS MY 2022 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 Children’s Preventive Care domain, Aetna displayed strong performance for the <i>Well-Child Visits in the First 30 Months of Life— Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, Aetna displayed strong performance for the <i>Asthma Medication Ratio—Total</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	Within the Behavioral Health domain, Aetna displayed strong performance with four PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile, with the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> PM indicators meeting or exceeding the 90th percentile.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna:</p> <ul style="list-style-type: none"> <li>• <i>Childhood Immunization Status—Combination 3</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i></li> <li>• <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i></li> </ul> <p><b>Recommendations:</b> HSAG recommends that Aetna conduct a root cause analysis or focus study for these PMs within the Children’s Preventive Care, Women’s Health, and Access to Care domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG</p>

**Weaknesses and Recommendations**

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 for the <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i> and <i>HbA1c Poor Control (&gt;9.0%)</i> PM indicators, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	Within the Behavioral Health domain, HealthKeepers displayed strong performance for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total, and Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment</i> PM indicators, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.

**Weaknesses and Recommendations**

	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rate fell at or below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and was determined to be an opportunity for improvement for HealthKeepers:</p> <ul style="list-style-type: none"> <li>• <i>Eye Exam for Patients With Diabetes—Total</i></li> </ul>
	<p><b>Recommendations:</b> HSAG recommends that HealthKeepers conduct a root cause analysis or focus study for this PM within the Care for Chronic Conditions domain 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.</p>



**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	
	<p>Within the Care for Chronic Conditions domain, Molina displayed strong performance for the <i>Asthma Medication Ratio—Total</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.</p>
	<p>Within the Behavioral Health domain, four of Molina’s PM indicators met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total</i>, <i>30-Day Follow-Up—Total</i>, and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of</i></p>

Strengths	
	<i>SUD Treatment PM indicators met or exceeded the 75th percentile, and the Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment PM indicator met or exceeded the 90th percentile.</i>

**Weaknesses and Recommendations**

	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina:</p> <ul style="list-style-type: none"> <li>• <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i></li> <li>• <i>Breast Cancer Screening</i></li> <li>• <i>Cervical Cancer Screening</i></li> <li>• <i>Child and Adolescent Well-Care Visits—Total</i></li> <li>• <i>Childhood Immunization Status—Combination 3</i></li> <li>• <i>Blood Pressure Control for Patients With Diabetes—Total</i></li> <li>• <i>Eye Exam for Patients With Diabetes—Total</i></li> <li>• <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%) and HbA1c Poor Control (&gt;9.0%)</i></li> <li>• <i>Controlling High Blood Pressure</i></li> <li>• <i>Follow-Up After ED for Mental Illness—30-Day Follow-Up—Total</i></li> <li>• <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i></li> <li>• <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i></li> </ul> <p><b>Recommendations:</b> HSAG recommends that Molina conduct a root cause analysis or focus study for these PMs within the Access to Care, Children’s Preventive Care, Behavioral Health, 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.</p>
---	--






## 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 Children’s Preventive Care domain, Optima’s rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicator.
	Optima’s performance within the Behavioral Health domain identified three PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The <i>Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment</i> PM indicator met or exceeded the 75th percentile, and the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> PM indicators met or exceeded the 90th percentile.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:</p> <ul style="list-style-type: none"> <li>• <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i></li> <li>• <i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i></li> </ul>

### Weaknesses and Recommendations

**Recommendations:** HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Behavioral Health, and Women’s Health 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 for the <i>Child and Adolescent Well-Care Visits—Total</i> PM indicator, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	United’s performance within the Behavioral Health domain identified four PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. The <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> , and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> PM indicators met or exceeded the 75th percentile.

### Weaknesses and Recommendations



**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 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*
- *Eye Exam for Patients With Diabetes—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*

**Recommendations:** HSAG recommends that United conduct a root cause analysis or focus study for these PMs within the Access to Care, Care for Chronic Conditions, 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 for the *Hemoglobin A1c Control for Patients With Diabetes— HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* PM indicators, with the MCO’s

Strengths	
	rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	Within the Behavioral Health domain, VA Premier’s rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> , and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> PM indicators.

Weaknesses and Recommendations	
	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:</p> <ul style="list-style-type: none"> <li>• <i>Adult’s Access to Preventive/Ambulatory Health Services—Total</i></li> <li>• <i>Cervical Cancer Screening</i></li> <li>• <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i></li> <li>• <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i></li> </ul> <p><b>Recommendations:</b> With VA Premier no longer serving members as of July 1, 2023, HSAG has no recommendations. With the VA Premier MCO merging with the Optima MCO, HSAG recommends that Optima consider conducting a root cause analysis or focus study for these PMs within the Access to Care, Children’s Preventive Care, Behavioral Health, and Women’s Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima also consider analyzing the 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.</p>

## 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*, February 2023 (EQR Protocol 3).<sup>6-1</sup>

### 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.

---

<sup>6-1</sup> 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*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-egr-protocols.pdf>. Accessed on: Dec 27, 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—OSR Standard Assigned CMS Categories**

Standard	SFY 2021–2022	Access	Quality	Timeliness
<b>Provider Network Management</b>				
V. Adequate Capacity and Availability of Services	✓	✓	✓	✓
VIII. Provider Selection	✓	✓	✓	✓
IX. Subcontractual Relationships and Delegation	✓	✓	✓	✓
<b>Member Services and Experiences</b>				
II. Member Rights and Confidentiality	✓		✓	
III. Member Information	✓		✓	
IV. Emergency and Poststabilization Services	✓	✓	✓	✓
VI. Coordination and Continuity of Care	✓	✓	✓	✓



Standard	SFY 2021–2022	Access	Quality	Timeliness
VII. Coverage and Authorization of Services	✓	✓	✓	✓
XIII. Grievance and Appeal Systems	✓	✓	✓	✓
<b>Managed Care Operations</b>				
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 (Acute) OSR Standards and Scores**

CFR		Compliance Reviews Standard Name	Aetna		
			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%
<b>TOTAL SCORE</b>					<b>93.2%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.</p>

### HealthKeepers



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

**Table 6-3—HealthKeepers’ Medallion 4.0 (Acute) 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	Adequate Capacity and Availability of Services			80.0%

	CFR	Compliance Reviews	HealthKeepers		
		Standard Name	2019	2020	2021
	438.207				
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%
<b>TOTAL SCORE</b>					<b>92.6%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.</p>


## Molina

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

**Table 6-4—Molina’s Medallion 4.0 (Acute) OSR Standards and Scores**

	CFR	Compliance Reviews	Molina		
		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			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%
<b>TOTAL SCORE</b>					<b>93.2%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

**Weaknesses and Recommendations**



**Recommendations:** MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.



**Optima**

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

**Table 6-5—Optima’s Medallion 4.0 (Acute) 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%
<b>TOTAL SCORE</b>					<b>94.4%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.</p>

### United



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

**Table 6-6—United’s Medallion 4.0 (Acute) OSR Standards and Scores**

	CFR	Compliance Reviews Standard Name	United		
			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%

	CFR	Compliance Reviews Standard Name	United		
			2019	2020	2021
XV.	441.58 Section 1905 of the SSA	EPSDT Services			87.5%
<b>TOTAL SCORE</b>					<b>96.3%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.</p>

### VA Premier



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

**Table 6-7—VA Premier’s Medallion 4.0 (Acute) OSR Standards and Scores**

	CFR	Compliance Reviews Standard Name	VA Premier		
			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%

	CFR	Compliance Reviews Standard Name	VA Premier		
			2019	2020	2021
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 Section 1905 of the SSA	EPSDT Services			62.5%
<b>TOTAL SCORE</b>					<b>88.9%</b>

### Strengths, Weaknesses, and Recommendations

Strengths	
	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.</p> <p><b>Recommendations:</b> MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 External Quality Review Technical Report—Medallion 4.0 dated March 2022.</p>

### DMAS Intermediate Sanctions Applied

During 2023, 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**

MCO/Vendor	Compliance Action
United CAP	UHC was placed under a CAP due to the MCO’s subcontracted vendor requesting DMAS portal access for offshore servicing. Access to the DMAS portal was never granted to the subcontracted vendor, and no member PHI was accessed from an offshore location.



## 7. Cardinal Care Program Readiness Reviews

### Cardinal Care Readiness Review

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department’s FFS and managed care programs and effectively combine the CCC Plus and Medallion 4.0 programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. 42 CFR §438.66(d)(1) describes the circumstances wherein a state must conduct readiness reviews of MCOs using desk reviews and, at the state’s option, on-site reviews. In accordance with the regulation, a state must assess the readiness of each MCO with which it contracts when the MCO will provide or arrange for the provision of covered benefits to new eligibility groups.

DMAS contracted with HSAG to conduct readiness reviews for the Cardinal Care program that focused on the MCOs’ ability and capacity to comply with the Cardinal Care contract requirements and the 2020 Medicaid and CHIP Managed Care Final Rules.<sup>7-1</sup> The primary objective was to assess the ability and capacity of the MCOs to satisfactorily perform the new Model of Care contract requirements. In addition, HSAG assessed the ability and capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in the Cardinal Care MCO contract.

The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4), which are presented in Table 7-1. The key program areas were divided into three readiness review components—Operations/Administration, Service Delivery, and Information Systems Management—and each component was assessed using a variety of tools, staff interviews, and/or requested data and document submissions.

**Table 7-1—Readiness Review Focus Areas**

Readiness Review Areas
<b>Operations/Administration</b>
Administrative Staffing and Resources
Delegation and Oversight
Member and Provider Communications
Grievance and Appeals
Member Services and Outreach
Provider Network Management
Program Integrity/Compliance

<sup>7-1</sup> Medicaid and CHIP Managed Care Final Rules. Available at: <https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html>. Accessed on: Dec 27, 2023.

Readiness Review Areas	
<b>Service Delivery</b>	
Case Management/Care Coordination/Service Planning	
Quality Improvement	
Utilization Review	
<b>Financial Management*</b>	
Financial Reporting and Monitoring	
Financial Solvency	
<b>Information Systems Management</b>	
Claims Management	
Encounter Data Management	
Enrollment Information Management	
*Financial reporting and monitoring and financial solvency readiness standards were out of the scope of HSAG's readiness review process and were conducted by DMAS.	

The MCO Cardinal Care program readiness review results are displayed in the following tables.

### Aetna

Table 7-2 presents a summary of Aetna's Cardinal Care program readiness review results.

**Table 7-2—Aetna's Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	19	1	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>131</b>	<b>1</b>	<b>99.2%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		8	8	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III CAP Review Results		1	1	0	100%
<b>Comprehensive Total</b>		<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*Score includes Phase II and Phase II CAP element review scores.

## HealthKeepers

Table 7-3 presents a summary of HealthKeepers Cardinal Care program readiness review results.

**Table 7-3—HealthKeepers’ Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	19	0	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>131</b>	<b>0</b>	<b>99.2%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		13	13	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III Cap Review Results		1	1	0	100%
<b>CAP Review Results Total</b>		<b>14</b>	<b>14</b>	<b>0</b>	<b>100%</b>
<b>Comprehensive Total</b>		<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*Score includes Phase II and Phase II CAP element review scores.

## Molina

Table 7-4 presents a summary of Molina’s Cardinal Care program readiness review results.

**Table 7-4—Molina’s Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	20	0	100%
XVI	Model of Care	107	107	0*	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>132</b>	<b>8</b>	<b>100%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		87	87	0	100%
Phase II CAP Review Results		7	7	0	100%
Phase III CAP Review Results		0	0	0	100%
<b>Comprehensive Total</b>		<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*Score includes Phase II and Phase II CAP element review scores.

## Optima

Table 7-5 presents a summary of Optima’s Cardinal Care program readiness review results.

**Table 7-5—Optima’s Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	19	1	95.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	4	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>131</b>	<b>1</b>	<b>99.2%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		4	4	0	100%
Phase II CAP Review Results		0	0	0	100%
Phase III CAP Review Results		2	2	0	100%
<b>Comprehensive Total</b>		<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.  
 Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.  
 Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.  
 \*Score includes Phase II and Phase II Corrective Action Plan element review scores.

## United

Table 7-6 presents a summary of United’s Cardinal Care program readiness review results.

**Table 7-6—United’s Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number <i>Met</i>	Number <i>In Progress</i>	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	18	2	90.0%
XVI	Model of Care	107	105	2	98.1%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>128</b>	<b>4</b>	<b>97.0%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		56	56	0	100%
Phase II CAP Review Results		1	1	0	100%
Phase III CAP Review Results		4	3	0	100%
<b>Comprehensive Total</b>		<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.  
 Number *Met* = The total number of elements within each standard that supported readiness.  
 Number *Not Met* = The total number of elements within each standard that did not support readiness.



Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*Score includes Phase II and Phase II Corrective Action Plan element review

## VA Premier

Table 7-7 presents a summary of VA Premier’s Cardinal Care program readiness review results.

**Table 7-7—VA Premier’s Cardinal Care Program Readiness Review Standards and Scores**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number Met	Number In Progress	Score
<b>OSR Results</b>					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%
III	Member Information	21	21	0	100%
IV	Emergency and Poststabilization Services	12	12	0	100%
V	Adequate Capacity and Availability of Services	18	18	0	100%
VI	Coordination and Continuity of Care	9	9	0	100%
VII	Coverage and Authorization of Services	20	20	0	100%
VII	Provider Selection	5	5	0	100%
IX	Subcontractual Relationships and Delegation	4	4	0	100%
X	Practice Guidelines	3	3	0	100%
XI	Health Information Systems	6	6	0	100%
XII	Quality Assessment and Performance Improvement	6	6	0	100%
XIII	Grievance and Appeal Systems	29	29	0	100%
XIV	Program Integrity	12	12	0	100%
XV - A	EPSDT Services	8	8	0	100%
<b>OSR Total</b>		<b>167</b>	<b>167</b>	<b>0</b>	<b>100%</b>
<b>Phase III Readiness Review Results*</b>					
XV	Network Adequacy	20	18	2	90.0%
XVI	Model of Care	107	107	0	100%
XVII	Organizational Structure, Operations, and Systems	5	5	0	100%
<b>Readiness Review Total</b>		<b>132</b>	<b>130</b>	<b>2</b>	<b>98.5%</b>
<b>Readiness Review CAP Review Results</b>					
Phase I CAP Review Results		6	6	0	100%
Phase II CAP Review Results		7	7	0	100%

Standard	Requirements/Elements Assessed			
	Number of Elements	Number <i>Met</i>	Number <i>In Progress</i>	Score
Phase III CAP Review Results	2	2	0	100%
<b>Comprehensive</b>	<b>299</b>	<b>299</b>	<b>0</b>	<b>100%</b>

Number of Elements = The total number of requirements included as part of each standard that were reviewed for readiness.

Number *Met* = The total number of elements within each standard that supported readiness.

Number *Not Met* = The total number of elements within each standard that did not support readiness.

Comprehensive Total = 2021 OSR and 2023 Readiness Review Results. The Comprehensive Total Number *Met* was calculated by adding the OSR *Deeming* elements, the *Met* elements, and the *DMAS-approved CAPs*.

\*Score includes Phase II and Phase II Corrective Action Plan element review scores.

## 8. Secret Shopper Surveys

### Prenatal Care Secret Shopper Survey

#### *Overview*

This section presents HSAG's MCO-specific results and conclusions of the Prenatal Care Secret Shopper Survey conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. The methodology for each activity can be found in Appendix B—Technical Methods of Data Collection and Analysis—MCOs.

#### *Objectives*

DMAS contracted with HSAG to conduct a secret shopper telephone survey of appointment availability to collect information on members' access to prenatal care services under the VA Medicaid managed care program. For purpose of this survey, a secret shopper will pose as a patient to evaluate the validity of provider information (e.g., accurate location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

The primary purpose of the secret shopper survey is to collect appointment availability information among prenatal care providers enrolled with the Virginia Medicaid MCOs. Specific survey objectives include the following:

- Determine whether prenatal care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker's data.
- Determine whether prenatal care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled prenatal care service location for prenatal care services during the first, second, and third trimesters of pregnancy.

#### *Statewide Results*

Survey findings support specific opportunities for improving the quality of prenatal care provider data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 95 percent (n=1,758) of overall cases were unable to be reached, did not offer prenatal care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date.

## General Recommendations

- Overall, HSAG was unable to reach approximately 36.0 percent (n=663) of the sampled cases. Callers noted that a key nonresponse reason involved reaching a disconnected phone number (12.5 percent). Approximately 11.8 percent (n=218) of the cases reached a voicemail or had an extended hold time.<sup>8-1</sup> Additionally, 3.6 percent (n=67) of the cases reached a nonmedical facility. While conducting the survey calls, callers noted that a high percentage of sampled numbers connected to nonapproved, out-of-state locations not included in the study (i.e., providers practicing outside of Virginia in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Since DMAS' enrollment broker supplied HSAG with the prenatal care provider data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). While the data provided by the enrollment broker were slightly more accurate than the historical data provided by the MCOs, HSAG identified areas in which the data can still be improved.
- Although the provider type and specialty were indicative of prenatal care services, a total of 547 respondents (29.7 percent) indicated that the provider location did not provide such services. Additionally, 11.4 percent (n=210) of respondents indicated that the address for the sampled location was incorrect. HSAG recommends that the enrollment broker verify that its provider data correctly identifies the location's address and appropriate provider type and specialty.
- Survey results indicated that only 4.7 percent of respondents (n=86) accepting new patients offered first, second, or third trimester appointments. Reasons that appointments were not offered by the providers' offices included offices requiring preregistration, personal information, review of medical records, or not accepting new patients for the requested trimester. HSAG identified considerations due to the nature of a secret shopper survey (i.e., requiring preregistration or personal information to schedule, VA Medicaid ID eligibility verification, and requiring completion of a questionnaire or interview) and separated those considerations from those not related to the nature of a secret shopper survey (e.g., requiring a medical record review or gestational age requiring physician approval, or schedule/calendar not available). Those considerations not related to the nature of a secret shopper survey present opportunities to remove barriers applicable to any VA Medicaid member attempting to schedule prenatal care appointments. HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices' requirements to ensure that these considerations for scheduling appointments do not unduly burden members' ability to access prenatal care and to streamline the process of scheduling new patient appointments within the first (seven-day), second (seven-day), or third (three-day) trimester appointment standards.
- To further evaluate data inconsistencies, HSAG recommends that DMAS consider conducting an NVS to evaluate the MCOs' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the MCOs' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the MCO-submitted data and the online provider directory, a secret or revealed call would be placed to the provider location to verbally confirm the directory information and request appointment

---

<sup>8-1</sup> Some barriers to reaching the office (e.g., reaching voicemail) are unique to the secret shopper process. To maintain the secret nature of the survey, callers posed as new members but were instructed not to leave voicemails. As such, survey results may not represent response rates for members who are willing to provide personal information or leave voicemail messages.

availability. Additionally, DMAS could consider providing the enrollment broker data to the MCOs to investigate differences in provider information.

- In coordination with ongoing outreach and network management activities, DMAS and/or the MCOs should review provider office procedures for ensuring that appointment availability standards are being met, address questions or educate providers and office staff members on DMAS’ standards, and incorporate appointment availability standards into educational materials.

### MCO-Specific Results

#### Aetna

Table 8-1 shows the outcome of Aetna’s secret shopper survey calls compared to all MCOs combined.

**Table 8-1—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Aetna	144 (55.8%)	23 (8.9%)	3 (1.2%)	1 (0.4%)	1 (0.4%)	6 (2.3%)	11 (4.3%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-2 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-3 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-2—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Aetna	16.7%	15.8%	14.9%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.



**Table 8-3—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*
Aetna	83.3%	20.0%	0.0%	0.0%	66.7%	16.7%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	Of the cases reached, 8.9 percent of the provider locations did not offer prenatal care services. Of the cases that were accepting new patients, 83.3 percent offered a first trimester appointment date.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 258 provider locations surveyed, 55.8 percent could not be reached. Of the cases reached, 16.7 percent accepted Aetna, 15.8 percent accepted VA Medicaid, and 14.9 percent accepted new patients. Of the cases that were accepting new patients, none offered a second trimester appointment, and 66.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, 16.7 percent were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Aetna’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Aetna and request that Aetna provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Aetna, including panel capacity to accept new patients.</p>

## HealthKeepers

Table 8-4 shows the outcome of HealthKeepers’ secret shopper survey calls compared to all MCOs combined.

**Table 8-4—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
HealthKeepers	95 (28.5%)	117 (35.1%)	20 (6.0%)	3 (0.9%)	4 (1.2%)	40 (12.0%)	17 (5.1%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-5 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-6 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-5—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
HealthKeepers	26.9%	25.6%	23.9%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.

**Table 8-6—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard	Cases Offered an Appointment	Appointments in Compliance With Standard	Cases Offered an Appointment	Appointments in Compliance With Standard
HealthKeepers	61.1%	0.0%	20.0%	20.0%	7.1%	0.0%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.



**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	No strengths were identified for HealthKeepers.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 333 provider locations surveyed, 28.5 percent could not be reached. Of the cases reached, 35.1 percent did not offer prenatal care services, 26.9 percent accepted HealthKeepers, 25.6 percent accepted VA Medicaid, and 23.9 percent accepted new patients. Of the cases that were accepting new patients, 61.1 percent offered a first trimester appointment, 20.0 percent offered a second trimester appointment, and 7.1 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that HealthKeepers’ provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with HealthKeepers and request that HealthKeepers provide updates or confirmation that the data has been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with HealthKeepers, including panel capacity to accept new patients.</p>

**Molina**

Table 8-7 shows the outcome of Molina’s secret shopper survey calls compared to all MCOs combined.

**Table 8-7—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Molina	115 (36.6%)	126 (40.1%)	11 (3.5%)	2 (0.6%)	0 (0.0%)	32 (10.2%)	9 (2.9%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-8 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-9 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-8—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Molina	21.6%	20.6%	20.6%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.



**Table 8-9—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*
Molina	23.1%	33.3%	36.4%	25.0%	11.8%	0.0%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	No strengths were identified for Molina.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 314 provider locations surveyed, 36.6 percent could not be reached. Of the cases reached, 40.1 percent did not offer prenatal care services, 21.6 percent accepted Molina, 20.6 percent accepted VA Medicaid, and 20.6 percent accepted new patients. Of the cases that were accepting new patients, 23.1 percent offered a first trimester appointment, 36.4 percent offered a second trimester appointment, and 11.8 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 33.3 percent were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 25.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Molina’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Molina and request that Molina provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Molina, including panel capacity to accept new patients.</p>

### Optima

Table 8-10 shows the outcome of Optima’s secret shopper survey calls compared to all MCOs combined.

**Table 8-10—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does Not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Optima	117 (38.4%)	86 (28.2%)	13 (4.3%)	1 (0.3%)	4 (1.3%)	38 (12.5%)	15 (4.9%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-11 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-12 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-11—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Optima	30.9%	30.3%	28.2%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.



**Table 8-12—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*
Optima	60.0%	0.0%	10.0%	50.0%	22.2%	0.0%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	No strengths were identified for Optima.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 305 provider locations surveyed, 38.4 percent could not be reached. Of the cases reached, 28.2 percent did not offer prenatal care services, 30.9 percent accepted Optima, 30.3 percent accepted VA Medicaid, and 28.2 percent accepted new patients. Of the cases that were accepting new patients, 60.0 percent offered a first trimester appointment, 10.0 percent offered a second trimester appointment, and 22.2 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 50.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Optima’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Optima and request that Optima provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Optima, including panel capacity to accept new patients.</p>

**United**

Table 8-13 shows the outcome of United’s secret shopper survey calls compared to all MCOs combined.

**Table 8-13—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
United	129 (35.2%)	97 (26.5%)	7 (1.9%)	19 (5.2%)	4 (1.1%)	54 (14.8%)	19 (5.2%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-14 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-15 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-14—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
United	40.5%	32.5%	30.8%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.



**Table 8-15—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*
United	48.0%	16.7%	13.6%	0.0%	15.4%	0.0%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	No strengths were identified for United.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 366 provider locations surveyed, 35.2 percent could not be reached. Of the cases reached, 26.5 percent did not offer prenatal care services, 40.5 percent accepted United, 32.5 percent accepted VA Medicaid, and 30.8 percent accepted new patients. Of the cases that were accepting new patients, 48.0 percent offered a first trimester appointment, 13.6 percent offered a second trimester appointment, and 15.4 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 16.7 percent were compliant with the seven-calendar-day standard. None of the second or third trimester appointments were compliant with DMAS’ wait time standards of seven calendar days and three business days.</p> <p><b>Why the weakness exists:</b> These findings suggest that United’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with United and request that United provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with United, including panel capacity to accept new patients.</p>



### VA Premier

Table 8-16 shows the outcome of VA Premier’s secret shopper survey calls compared to all MCOs combined.

**Table 8-16—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Prenatal Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
VA Premier	63 (23.5%)	98 (36.6%)	21 (7.8%)	1 (0.4%)	2 (0.7%)	51 (19.0%)	15 (5.6%)
<b>All MCOs<sup>2</sup></b>	<b>663 (36.0%)</b>	<b>547 (29.7%)</b>	<b>75 (4.1%)</b>	<b>27 (1.5%)</b>	<b>15 (0.8%)</b>	<b>221 (12.0%)</b>	<b>86 (4.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-17 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-18 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-17—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
VA Premier	33.7%	33.2%	32.2%
<b>All MCOs</b>	<b>29.6%</b>	<b>27.3%</b>	<b>26.0%</b>

\*The denominator includes cases reached.



**Table 8-18—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	First Trimester		Second Trimester		Third Trimester	
	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*	Cases Offered an Appointment	Appointments in Compliance With Standard*
VA Premier	52.0%	30.8%	0.0%	0.0%	7.7%	50.0%
<b>All MCOs</b>	<b>52.0%</b>	<b>15.1%</b>	<b>14.7%</b>	<b>21.4%</b>	<b>17.3%</b>	<b>10.5%</b>

\*The denominator includes cases reached, accepting new patients, and offering an appointment date.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	No strengths were identified for VA Premier.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 268 provider locations surveyed, 23.5 percent could not be reached. Of the cases reached, 36.6 percent did not offer prenatal care services, 33.7 percent accepted VA Premier, 33.2 percent accepted VA Medicaid, and 32.2 percent accepted new patients. Of the cases that were accepting new patients, 52.0 percent offered a first trimester appointment, none offered a second trimester appointment, and 7.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 30.8 percent were compliant with the seven-calendar-day standard. No cases were offered a second trimester appointment within the seven-calendar day standard. For cases that were offered a third trimester appointment, 50.0 percent were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that VA Premier ‘s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> VA Premier is no longer serving members as of July 1, 2023; therefore, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis and providing updates or confirmation that the MCO’s merged network data have been updated as appropriate. Additionally, Optima should confirm the merged MCO’s appointment availability and scheduling procedures with DMAS, including panel capacity to accept new patients.</p>

## PCP Secret Shopper Survey

### Overview

This section presents HSAG's MCO-specific results and conclusions of the PCP Secret Shopper Survey conducted for the MCOs. It provides a discussion of the MCOs' overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. The methodology for each activity can be found in Appendix B Technical Methods of Data Collection and Analysis—MCOs.

### Objectives

DMAS contracted HSAG to conduct a secret shopper telephone survey of appointment availability to collect information on members' access to primary care services under the VA Medicaid managed care program. A secret shopper is a person employed to pose as a patient to evaluate the quality of customer service or the validity of information (e.g., location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

The primary purpose of the secret shopper survey was to collect appointment availability information among PCPs enrolled with the VA Medicaid MCOs to address the following survey objectives:

- Determine whether primary care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker's data.
- Determine whether primary care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled primary care service location for urgent and routine primary care services.

### Statewide Results

Survey findings support specific opportunities for improving the quality of PCP data and streamlining the new patient appointment scheduling process for VA Medicaid members. Approximately 83 percent (n=2,101) of overall cases were unable to be reached, did not offer primary care services, were not at the sampled location, did not accept the requested MCO, did not accept VA Medicaid, were not accepting new patients, or were unable to offer an appointment date to the caller.

## General Recommendations

- Overall, HSAG was unable to reach approximately 37 percent of the sampled cases. Callers noted that key nonresponse reasons involved reaching a voicemail or an extended hold time.<sup>8-2</sup> Approximately 11.5 percent (n=290) of the cases had disconnected phone numbers. Additionally, 6.6 percent (n=167) of the cases reached a nonmedical facility. While conducting the survey calls, callers noted that a high percentage of sampled numbers connected to nonapproved, out-of-state locations (i.e., providers practicing outside of Virginia in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Since DMAS' enrollment broker supplied HSAG with the PCP data used for this survey, HSAG recommends that DMAS work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). While the data provided by the enrollment broker was slightly more accurate than the historical data provided by the MCOs, HSAG identified areas in which the data can still be improved.
- Approximately 22 percent of the respondents indicated that the provider location did not provide such services. Additionally, approximately 8 percent of respondents indicated that the address for the sampled location was incorrect. HSAG recommends that the enrollment broker verify that its provider data correctly identifies the location's address and appropriate provider type and specialty.
- Survey results indicated that less than 17 percent of respondents accepting new patients offered routine or urgent care appointments. Reasons that appointments were not offered by the providers' offices included offices requiring preregistration, personal information, review of medical records, or that a scheduling calendar was not available to schedule an appointment. HSAG identified considerations due to the nature of a secret shopper survey (i.e., requiring preregistration or personal information to schedule, VA Medicaid ID eligibility verification, and requiring completion of a questionnaire or interview) and separated those considerations from those not related to the nature of a secret shopper survey (e.g., requiring a medical record review or schedule/calendar not available). Those considerations not related to the nature of a secret shopper survey present opportunities to remove barriers applicable to any VA Medicaid member attempting to schedule a primary care appointment. HSAG recommends that DMAS and the MCOs consider conducting a review of the provider offices' requirements to ensure that these considerations to scheduling appointments do not unduly burden members' ability to access primary care and to streamline the process of scheduling new patient appointments within the routine (30-day) and urgent (one-day) appointment standards.
- To further evaluate data inconsistencies, HSAG recommends that DMAS consider conducting an NVS to evaluate the MCOs' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the MCOs' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the MCO-submitted data and the online provider directory, a secret or revealed call would be placed to the provider location to verbally confirm the directory information and request appointment availability. Additionally, DMAS could consider providing the enrollment broker data to the MCOs to investigate differences in provider information.

---

<sup>8-2</sup> Some barriers to reaching the office (e.g., reaching voicemail) are unique to the secret shopper process. To maintain the secret nature of the survey, callers posed as new members but were instructed not to leave voicemails. As such, survey results may not represent response rates for members who are willing to provide personal information or leave voicemail messages.

- In coordination with ongoing outreach and network management activities, DMAS and/or the MCOs should review provider office procedures for ensuring that appointment availability standards are being met, address questions or educate providers and office staff members on DMAS’ standards and incorporate appointment availability standards into educational materials.

## MCO-Specific Results

### Aetna

Table 8-19 shows the outcome of Aetna’s secret shopper survey calls compared to all MCOs combined.

**Table 8-19—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Aetna <sup>1</sup>	234 (56.0%)	40 (9.6%)	7 (1.7%)	2 (0.5%)	6 (1.4%)	19 (4.5%)	10 (2.4%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-20 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-21 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-20—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Aetna	20.1%	19.0%	15.8%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\* The denominator includes cases reached.

**Table 8-21—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
Aetna	28.6	50.0	40.0	0.0
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>

<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	Of the cases reached, 9.6 percent of the provider locations did not offer primary care services.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 418 provider locations surveyed, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients. Of the provider locations accepting new patients, 28.6 percent and 40.0 percent offered a routine and urgent visit appointment, respectively. For routine appointments, 50.0 percent of the routine visit appointments offered were compliant with DMAS’ 30-day appointment availability compliance standard. None of the urgent visit appointments offered were compliant with DMAS’ 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Aetna’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Aetna and request that Aetna provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Aetna, including panel capacity to accept new patients.</p>

## HealthKeepers

Table 8-22 shows the outcome of HealthKeepers' secret shopper survey calls compared to all MCOs combined.

**Table 8-22—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
HealthKeepers	160 (37.0%)	99 (22.9%)	24 (5.5%)	10 (2.3%)	21 (4.8%)	0 (0.0%)	93 (21.5%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-23 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-24 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-23—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
HealthKeepers	45.4%	41.8%	34.1%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\* The denominator includes cases reached.

**Table 8-24—Percentage of Calls Offered an Appointment and in Compliance With Standards**

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
HealthKeepers	100.0	71.4	100.0	25.0
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>



<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.



**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Of the provider locations accepting new patients, 100.0 percent offered a routine and urgent visit appointment. Additionally, 71.4 percent of the routine visit appointments offered were compliant with DMAS’ 30-day appointment availability compliance standard.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 433 provider locations surveyed, 37.0 percent could not be reached. Of the cases reached, 22.9 percent did not offer primary care services, 45.4 percent accepted HealthKeepers, 41.8 percent accepted VA Medicaid, and 34.1 percent accepted new patients. For urgent visits, 25.0 percent of the urgent visit appointments offered were compliant with DMAS’ 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that HealthKeepers’ provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with HealthKeepers and request that HealthKeepers provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with HealthKeepers, including panel capacity to accept new patients.</p>

### Molina

Table 8-25 shows the outcome of Molina’s secret shopper survey calls compared to all MCOs combined.

**Table 8-25—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Molina	156 (38.0%)	98 (23.9%)	5 (1.2%)	5 (1.2%)	32 (7.8%)	9 (2.2%)	97 (23.7%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-26 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-27 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-26—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Molina	56.3%	54.3%	41.7%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\*The denominator includes cases reached.

**Table 8-27—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
Molina	91.7	88.6	91.4	5.7
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>

<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Of the provider locations accepting new patients, 91.7 percent and 91.4 percent offered a routine and urgent visit appointment, respectively. Additionally, 88.6 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standards.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 410 provider locations surveyed, 38.0 percent could not be reached. Of the cases reached, 23.9 percent did not offer primary care services, 56.3 percent accepted Molina, 54.3 percent accepted VA Medicaid, and 41.7 percent accepted new patients. 5.7 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Molina's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Molina and request that Molina provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Molina, including panel capacity to accept new patients.</p>

### Optima

Table 8-28 shows the outcome of Optima’s secret shopper survey calls compared to all MCOs combined.

**Table 8-28—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
Optima	129 (31.3%)	77 (18.7%)	20 (4.9%)	22 (5.3%)	18 (4.4%)	83 (20.1%)	34 (8.3%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-29 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-30 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-29—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
Optima	55.5%	47.7%	41.3%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\*The denominator includes cases reached.

**Table 8-30—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
Optima	31.0	77.8	27.1	6.3
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>

<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Of the cases reached, 18.7 percent of the provider locations did not offer primary care services. Additionally, 77.8 percent of the routine visit appointments offered were compliant with DMAS’ 30-day appointment availability compliance standards.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 412 provider locations surveyed, 31.3 percent could not be reached. Of the cases reached, 55.5 percent accepted Optima, 47.7 percent accepted VA Medicaid, and 41.3 percent accepted new patients. Of the provider locations accepting new patients, 31.0 percent and 27.1 percent offered a routine and urgent visit appointment, respectively. For urgent visits, 6.3 percent of the urgent visit appointments offered were compliant with DMAS’ 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that Optima’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with Optima and request that Optima provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with Optima, including panel capacity to accept new patients.</p>

**United**

Table 8-31 shows the outcome of United’s secret shopper survey calls compared to all MCOs combined.

**Table 8-31—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
United	154 (33.8%)	143 (31.4%)	6 (1.3%)	12 (2.6%)	19 (4.2%)	26 (5.7%)	77 (16.9%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-32 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-33 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-32—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
United	44.5%	40.5%	34.2%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\*The denominator includes cases reached.

**Table 8-33—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
United	72.5	82.8	76.2	12.5
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>

<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Of the provider locations accepting new patients, 72.5 percent and 76.2 percent offered a routine and urgent visit appointment, respectively. 82.8 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standards.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 455 provider locations surveyed, 33.8 percent could not be reached. Of the cases reached, 31.4 percent did not offer primary care services, 44.5 percent accepted United, 40.5 percent accepted VA Medicaid, and 34.2 percent accepted new patients. 12.5 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that United's provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers' offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that DMAS share those files with United and request that United provide updates or confirmation that the data have been updated as appropriate. Additionally, DMAS can confirm appointment availability and scheduling procedures with United, including panel capacity to accept new patients.</p>



### VA Premier

Table 8-34 shows the outcome of VA Premier’s secret shopper survey calls compared to all MCOs combined.

**Table 8-34—Secret Shopper Survey Call Outcomes by MCO and VA Medicaid**

MCO	Provider Location Could not be Reached <sup>1</sup>	Provider Location Does not Offer Primary Care Services <sup>2</sup>	Provider Location not Accepting MCO <sup>2</sup>	Provider Location not Accepting VA Medicaid <sup>2</sup>	Provider Location not Accepting New Patients <sup>2</sup>	Other Limitation to Scheduling Appointment	Appointment Available <sup>3</sup>
VA Premier	95 (24.1%)	95 (24.1%)	30 (7.6%)	4 (1.0%)	18 (4.6%)	18 (4.6%)	110 (27.9%)
<b>All MCOs<sup>2</sup></b>	<b>928 (36.8%)</b>	<b>552 (21.9%)</b>	<b>92 (3.6%)</b>	<b>55 (2.2%)</b>	<b>114 (4.5%)</b>	<b>155 (6.1%)</b>	<b>421 (16.7%)</b>

<sup>1</sup>The denominator includes the total number of survey cases.

<sup>2</sup>The denominator includes cases reached.

<sup>3</sup>The denominator includes cases reached and accepting new patients.

Table 8-35 shows the percentage of survey respondents that accepted the MCO, VA Medicaid, and were accepting new patients. Table 8-36 shows the percentage of calls that were offered an appointment and the percentage of those appointments within the compliance standards.

**Table 8-35—MCO, VA Medicaid, and New Patient Acceptance Rates**

MCO	Accepting MCO*	Accepting VA Medicaid*	Accepting New Patients*
VA Premier	50.2%	48.8%	42.8%
<b>MCO Total</b>	<b>46.7%</b>	<b>43.3%</b>	<b>36.1%</b>

\*The denominator includes cases reached.

**Table 8-36—Percentage of Calls Offered an Appointment and in Compliance With Standards**



MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>	Cases Offered an Appointment Rate (%) <sup>1</sup>	Appointments in Compliance With Standards Rate (%) <sup>2</sup>
VA Premier	92.9	61.5	80.6	25.9
<b>All MCOs</b>	<b>74.0</b>	<b>74.5</b>	<b>72.3</b>	<b>16.0</b>

<sup>1</sup>The denominator includes cases reached and accepting new patients.

<sup>2</sup>The denominator includes cases reached, accepting new patients, and offering an appointment.

**Strengths, Weaknesses, and Recommendations**

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

Strengths	
	<p>Of the provider locations accepting new patients, 92.9 percent and 80.6 percent offered a routine and urgent visit appointment, respectively.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Of the 394 provider locations surveyed, 24.1 percent could not be reached. Of the cases reached, 24.1 percent did not offer primary care services, 50.2 percent accepted VA Premier, 48.8 percent accepted VA Medicaid, and 42.8 percent accepted new patients. 61.5 percent of the routine visit appointments offered were compliant with DMAS’ 30-day appointment availability compliance standard. 25.9 percent of the urgent visit appointments offered were compliant with DMAS’ 24-hour appointment availability compliance standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that VA Premier’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold time of five minutes for the secret shopper survey; however, this may indicate that the providers’ offices were facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> VA Premier is no longer serving members as of July 1, 2023; therefore, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. Since VA Premier merged with Optima, HSAG recommends that Optima consider conducting a root cause analysis and providing updates or confirmation that the MCO’s merged network data have been updated as appropriate. Additionally, Optima should confirm the merged MCO’s appointment availability and scheduling procedures with DMAS, including panel capacity to accept new patients.</p>

## 9. Encounter Data Validation

### Overview

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCOs to accurately and effectively monitor and improve the quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to DMAS' overall management and oversight of its Medicaid managed care program. Results of the EDV study will be included in the 2024 External Quality Review Technical Report.

## 10. 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, an assessment of how effectively the MCOs have addressed the recommendations for QI made by HSAG during the previous year can be found in Appendix E. 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 (Acute) Medicaid managed care population to obtain information on the levels of experience of adult Medicaid members and parents/caretakers of child Medicaid members. For the Medallion 4.0 (Acute) 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 10-1 and Table 10-2 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared Aetna’s 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Aetna were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-1—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Aetna**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	60.3%	58.3%
<i>Rating of All Health Care</i>	53.6%	53.5%

	2022	2023
Rating of Personal Doctor	65.4%	70.7%
Rating of Specialist Seen Most Often	59.5% <sup>+</sup>	66.7% <sup>+</sup>
<b>Composite Measures</b>		
Getting Needed Care	73.6% <sup>+</sup>	76.2%
Getting Care Quickly	73.1% <sup>+</sup>	76.7% <sup>+</sup>
How Well Doctors Communicate	85.7% <sup>+</sup>	91.1%
Customer Service	83.8% <sup>+</sup>	88.1% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

Aetna’s 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Aetna’s 2023 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.</p> <p><b>Recommendations:</b> HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.</p>

**Table 10-2—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: Aetna**

	2022	2023
<b>Global Ratings</b>		
Rating of Health Plan	74.0%	70.9%
Rating of All Health Care	66.9%	66.0%
Rating of Personal Doctor	75.8%	74.7%

	2022	2023
<i>Rating of Specialist Seen Most Often</i>	65.9% <sup>+</sup>	65.4% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	82.8%	83.1%
<i>Getting Care Quickly</i>	85.3%	85.5%
<i>How Well Doctors Communicate</i>	91.2%	95.2%
<i>Customer Service</i>	88.0% <sup>+</sup>	85.3% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

Aetna’s 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Aetna’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Aetna’s 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.</p> <p><b>Recommendations:</b> HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.</p>

### HealthKeepers

Table 10-3 and Table 10-4 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared HealthKeepers’ 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for HealthKeepers were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-3—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: HealthKeepers**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	63.1%	52.8%
<i>Rating of All Health Care</i>	53.8% <sup>+</sup>	48.1%
<i>Rating of Personal Doctor</i>	65.3%	59.7%
<i>Rating of Specialist Seen Most Often</i>	78.0% <sup>+</sup>	63.0% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	84.7% <sup>+</sup>	84.9% <sup>+</sup>
<i>Getting Care Quickly</i>	84.4% <sup>+</sup>	80.9% <sup>+</sup>
<i>How Well Doctors Communicate</i>	89.2% <sup>+</sup>	92.9% <sup>+</sup>
<i>Customer Service</i>	86.2% <sup>+</sup>	91.4% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

HealthKeepers’ 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

<b>Strengths</b>	
	HealthKeepers’ 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
<b>Weaknesses and Recommendations</b>	
	<p><b>Weakness:</b> HealthKeepers’ 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for <i>Rating of Health Plan</i>.</p> <p><b>Recommendations:</b> HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as an 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 recommends that HealthKeepers continue to monitor the measure to ensure a significant decrease in the score over time does not continue to occur.</p>



**Table 10-4—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: HealthKeepers**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	74.8%	73.5%
<i>Rating of All Health Care</i>	74.4%	70.9%
<i>Rating of Personal Doctor</i>	71.2%	73.6%
<i>Rating of Specialist Seen Most Often</i>	71.4% <sup>+</sup>	82.7% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	85.3%	83.7%
<i>Getting Care Quickly</i>	84.0%	85.1%
<i>How Well Doctors Communicate</i>	92.7%	92.3%
<i>Customer Service</i>	88.5% <sup>+</sup>	89.7% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

HealthKeepers’ 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

<b>Strengths</b>	
	HealthKeepers’ 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
<b>Weaknesses and Recommendations</b>	
	<p><b>Weakness:</b> HealthKeepers’ 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.</p> <p><b>Recommendations:</b> HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.</p>

## Molina

Table 10-5 and Table 10-6 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared Molina’s 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Molina were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-5—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Molina**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	60.1%	57.3%
<i>Rating of All Health Care</i>	56.6%	59.2%
<i>Rating of Personal Doctor</i>	66.9%	68.1%
<i>Rating of Specialist Seen Most Often</i>	65.9% <sup>+</sup>	65.0%
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	83.4% <sup>+</sup>	83.3%
<i>Getting Care Quickly</i>	76.1% <sup>+</sup>	76.7%
<i>How Well Doctors Communicate</i>	93.8%	93.7%
<i>Customer Service</i>	88.0% <sup>+</sup>	88.9%

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

▲ Statistically significantly higher in 2023 than in 2022.


▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

## Strengths, Weaknesses, and Recommendations

Molina’s 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

<b>Strengths</b>	
	Molina’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.

### Weaknesses and Recommendations



**Weakness:** Molina’s 2023 top-box scores were not statistically significantly lower than the 2023 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 10-6—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: Molina**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	67.3%	68.6%
<i>Rating of All Health Care</i>	68.1%	69.4%
<i>Rating of Personal Doctor</i>	75.0%	72.1%
<i>Rating of Specialist Seen Most Often</i>	71.7%	75.6% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	82.4%	74.0% ▼
<i>Getting Care Quickly</i>	86.8%	79.0% ▼
<i>How Well Doctors Communicate</i>	94.4%	91.2% ▼
<i>Customer Service</i>	89.2%	78.6% ▼

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

Molina’s 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

#### Strengths



Molina’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.

**Weaknesses and Recommendations**



**Weakness:** Molina’s 2023 top-box scores were statistically significantly lower than the 2022 top-box scores and the 2022 NCQA child Medicaid national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

**Recommendations:** HSAG recommends that Molina conduct root cause analyses of the 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 recommends that Molina continue to monitor the measures to ensure significant decreases in the scores over time do not continue to occur.

**Optima**

Table 10-7 and Table 10-8 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared Optima’s 2023 adult Medicaid CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for Optima were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-7—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: Optima**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	64.3%	64.1% <sup>+</sup>
<i>Rating of All Health Care</i>	64.3% <sup>+</sup>	52.4% <sup>+</sup>
<i>Rating of Personal Doctor</i>	67.7% <sup>+</sup>	71.4% <sup>+</sup>
<i>Rating of Specialist Seen Most Often</i>	62.5% <sup>+</sup>	64.1% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	78.4% <sup>+</sup>	83.1% <sup>+</sup>
<i>Getting Care Quickly</i>	82.2% <sup>+</sup>	86.1% <sup>+</sup>
<i>How Well Doctors Communicate</i>	93.1% <sup>+</sup>	95.2% <sup>+</sup>
<i>Customer Service</i>	85.3% <sup>+</sup>	81.0% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

Optima’s 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and there were no differences observed.

Strengths	
	Optima’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Optima’s 2023 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.</p> <p><b>Recommendations:</b> HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.</p>

**Table 10-8—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: Optima**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	71.3%	74.9%
<i>Rating of All Health Care</i>	70.8%	70.0%
<i>Rating of Personal Doctor</i>	77.9%	78.6%
<i>Rating of Specialist Seen Most Often</i>	76.8% <sup>+</sup>	79.5% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	84.4% <sup>+</sup>	84.1% <sup>+</sup>
<i>Getting Care Quickly</i>	84.0% <sup>+</sup>	81.9% <sup>+</sup>
<i>How Well Doctors Communicate</i>	95.9%	96.8%
<i>Customer Service</i>	89.2% <sup>+</sup>	88.2% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

## Strengths, Weaknesses, and Recommendations

Optima’s 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	Optima’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, <i>How Well Doctors Communicate</i> .
Weaknesses and Recommendations	
	<p><b>Weakness:</b> Optima’s 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified.</p> <p><b>Recommendations:</b> HSAG recommends that Optima continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.</p>

## United

Table 10-9 and Table 10-10 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared United’s 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2022 CAHPS scores for United were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-9—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: United**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	56.2%	69.5% ▲
<i>Rating of All Health Care</i>	47.8% <sup>+</sup>	59.6% <sup>+</sup>
<i>Rating of Personal Doctor</i>	60.0% <sup>+</sup>	66.0%
<i>Rating of Specialist Seen Most Often</i>	58.5% <sup>+</sup>	67.9% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	76.8% <sup>+</sup>	80.2% <sup>+</sup>
<i>Getting Care Quickly</i>	80.6% <sup>+</sup>	82.9% <sup>+</sup>
<i>How Well Doctors Communicate</i>	90.9% <sup>+</sup>	89.5% <sup>+</sup>
<i>Customer Service</i>	84.8% <sup>+</sup>	88.2% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

## Strengths, Weaknesses, and Recommendations

United’s 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United’s 2023 top-box score was statistically significantly higher than the 2022 top-box score and NCQA adult Medicaid national average for one measure, <i>Rating of Health Plan</i> .
Weaknesses and Recommendations	
	<p><b>Weakness:</b> United’s 2023 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.</p> <p><b>Recommendations:</b> HSAG recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.</p>

**Table 10-10—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: United**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	70.6%	68.3%
<i>Rating of All Health Care</i>	75.5% <sup>+</sup>	76.4%
<i>Rating of Personal Doctor</i>	74.1%	66.4%
<i>Rating of Specialist Seen Most Often</i>	80.0% <sup>+</sup>	50.0% <sup>+</sup> ▼
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	74.5% <sup>+</sup>	79.8% <sup>+</sup>
<i>Getting Care Quickly</i>	76.1% <sup>+</sup>	81.5% <sup>+</sup>
<i>How Well Doctors Communicate</i>	91.9%	89.4%
<i>Customer Service</i>	82.3% <sup>+</sup>	90.4% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.

▼ Statistically significantly lower in 2023 than in 2022.



Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.



## Strengths, Weaknesses, and Recommendations

United’s 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	United’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> United’s 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for <i>Rating of Personal Doctor</i>.</p> <p><b>Weakness:</b> United’s 2023 top-box score was statistically significantly lower than the 2022 top-box score and the 2022 NCQA child Medicaid national average for <i>Rating of Specialist Seen Most Often</i>.</p> <p><b>Recommendations:</b> HSAG recommends that United conduct root cause analyses of the 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 recommends that United continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.</p>

## VA Premier

Table 10-11 and Table 10-12 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores, respectively, for the global ratings and composite measures. A trend analysis was performed that compared VA Premier’s 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 CAHPS scores for VA Premier were compared to the 2022 NCQA adult and child Medicaid national averages.

**Table 10-11—Comparison of 2022 and 2023 Adult Medicaid CAHPS Results: VA Premier**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	69.5%	58.4% ▼
<i>Rating of All Health Care</i>	58.8% <sup>+</sup>	60.0%
<i>Rating of Personal Doctor</i>	64.0%	68.2%
<i>Rating of Specialist Seen Most Often</i>	62.5% <sup>+</sup>	70.1% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	85.2% <sup>+</sup>	82.2% <sup>+</sup>

	2022	2023
<i>Getting Care Quickly</i>	79.0% <sup>+</sup>	80.1% <sup>+</sup>
<i>How Well Doctors Communicate</i>	93.7% <sup>+</sup>	92.8% <sup>+</sup>
<i>Customer Service</i>	94.9% <sup>+</sup>	89.4% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

VA Premier’s 2023 adult Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	VA Premier’s 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> VA Premier’s 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, <i>Rating of Health Plan</i>.</p> <p><b>Recommendations:</b> As a result of VA Premier merging with Optima during CY 2023, HSAG has no recommendations. HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.</p>

**Table 10-12—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: VA Premier**

	2022	2023
<b>Global Ratings</b>		
<i>Rating of Health Plan</i>	78.8%	80.5%
<i>Rating of All Health Care</i>	72.8%	76.2%
<i>Rating of Personal Doctor</i>	77.2%	77.1%
<i>Rating of Specialist Seen Most Often</i>	71.2% <sup>+</sup>	71.7% <sup>+</sup>
<b>Composite Measures</b>		
<i>Getting Needed Care</i>	79.7% <sup>+</sup>	86.3%

	2022	2023
Getting Care Quickly	85.9% <sup>+</sup>	82.8%
How Well Doctors Communicate	92.5%	93.7%
Customer Service	82.9% <sup>+</sup>	82.5% <sup>+</sup>

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

▲ Statistically significantly higher in 2023 than in 2022.



▼ Statistically significantly lower in 2023 than in 2022.

Cells highlighted in orange represent rates that are statistically significantly higher than the 2022 NCQA Medicaid national averages.

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Strengths, Weaknesses, and Recommendations

VA Premier’s 2023 child Medicaid CAHPS scores were compared for statistically significant differences and revealed the following summary results:

Strengths	
	VA Premier’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, <i>Rating of Health Plan</i> .
Weaknesses and Recommendations	
	<p><b>Weakness:</b> VA Premier’s 2023 top-box scores were not statistically significantly lower than the 2022 top-box scores or NCQA child Medicaid national averages for any measure; therefore, no weaknesses were identified</p> <p><b>Recommendations:</b> As a result of VA Premier merging with Optima during CY 2023, HSAG has no recommendations. HSAG encourages the merged Optima MCO to review the VA Premier results and implement actions to address member experience issues, as appropriate.</p>

# 11. ARTS Measure Specification Development and Maintenance

## Overview

Beginning in contract year 2019–2020, DMAS contracted with HSAG, as its EQRO, to identify appropriate existing PMs and to develop new measure specifications, where necessary, for the ARTS benefit as mandated in the CMS Section 1115 Demonstration, “Building and Transforming Coverage, Services, and Supports for a Healthier Virginia.” The Special Terms and Conditions of the 1115 Demonstration Waiver require DMAS to monitor the MCOs at least once per year through the EQRO. The ARTS benefit, which was launched in 2017, provides treatment for members with SUDs in Virginia.<sup>11-1</sup> The goals of the ARTS benefit include increasing initiation and engagement in SUD treatment, reducing overdose deaths, and improving access to care for all Medicaid-eligible members with SUD.<sup>11-2</sup> HSAG, in conjunction with DMAS, developed PMs using administrative data for the evaluation of DMAS’ ARTS benefit. The 2022 ARTS Measure Report presented the CY 2020 and CY 2021 ARTS measure rates for the eight measures described in Table 11-1.

**Table 11-1—ARTS Measures**

Measure and Indicators
<i>Concurrent Prescribing of Naloxone and High-Dose Opioids</i>
<i>Naloxone Use for High Risk of Overdose—Naloxone Use for Diagnosed Opioid Use Disorder, Naloxone Use for History of Chronic Opioid Use, Naloxone Use for Concurrent Benzodiazepine and Opioid Use, and Naloxone Use for History of Overdose</i>
<i>Treatment of Hepatitis C for Those With Hepatitis C and SUD</i>
<i>Treatment of HIV for Those With HIV and SUD</i>
<i>Preferred Office-Based Addiction Treatment (OBAT) Compliance—Alcohol or Drug Screening, Counseling from an OBAT Provider, Family Planning, Prescription for Naloxone from OBAT Provider, Prescription for Naloxone, Testing for Human Immunodeficiency Virus (HIV)/Hepatitis C, Initiation of Medication for Opioid Use Disorder (OUD), Concurrent Pharmacotherapy and Care Coordination, Rapid Plasma Reagin (RPR) Testing, and Annual Tuberculosis (TB) Testing</i>
<i>Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis, Members Identified as having OUD who Initiated OUD Treatment, and Members who Initiated OUD Treatment who Also Engaged in OUD Treatment</i>
<i>Cascade of Care for Members With Hepatitis C—Prevalence of Hepatitis C, Received Direct-Acting Antiviral (DAA) Treatment for Hepatitis C, Completed DAA Treatment for Hepatitis C, and Achieved Sustained Virologic Response (SVR)</i>
<i>Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and Received Antiretroviral Therapy</i>

<sup>11-1</sup> Virginia DMAS. Addiction and Recovery Treatment Services (ARTS). Available at: <https://www.dmas.virginia.gov/providers/addiction-and-recovery-treatment-services>. Accessed on: Oct 31, 2023.

<sup>11-2</sup> Centers for Medicare & Medicaid Services Department of Health & Human Services. Building and Transforming Coverage, Services, and Supports for a Healthier Virginia. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf>. Accessed on: Oct 31, 2023.

## Findings

Table 11-2 presents the Virginia Medicaid total denominators (displayed as Denom) and rates for all study indicators for CY 2020 and CY 2021. Please note, the table also includes rates for all measure stratifications (i.e., Pharmacotherapy, Other Treatment, and Both Pharmacotherapy and Other Treatment) for the *Cascade of Care for Members With OUD—Members Identified as Having OUD who Initiated OUD Treatment* study indicator.

**Table 11-2—Study Indicator Rates for the Virginia Medicaid Total Population, CY 2020 and CY 2021**

Measure	CY 2020		CY 2021	
	Denom	Rate	Denom	Rate
<b>Concurrent Prescribing of Naloxone and High-Dose Opioids</b>				
<i>Concurrent Prescribing of Naloxone and High-Dose Opioids</i>	3,404	49.9%	3,306	51.4%
<b>Naloxone Use for High Risk of Overdose</b>				
<i>Naloxone Use for Diagnosed Opioid Use Disorder</i>	26,263	35.1%	38,510	39.2%
<i>Naloxone Use for History of Chronic Opioid Use</i>	2,663	66.6%	2,293	68.0%
<i>Naloxone Use for Concurrent Benzodiazepine and Opioid Use</i>	3,140	57.5%	2,851	58.3%
<i>Naloxone Use for History of Overdose</i>	1,956	37.6%	2,397	43.7%
<b>Treatment of Hepatitis C for Those With Hepatitis C and SUD</b>				
<i>Treatment of Hepatitis C for Those With Hepatitis C and SUD</i>	3,809	29.1%	4,420	31.9%
<b>Treatment of HIV for Those With HIV and SUD</b>				
<i>Treatment of HIV for Those With HIV and SUD</i>	1,104	64.9%	1,303	62.5%
<b>Preferred OBAT Compliance</b>				
<i>Alcohol or Drug Screening: 8+ Screenings</i>	9,492	55.0%	12,788	69.6%
<i>Counseling from an OBAT Provider</i>	9,492	94.2%	12,788	91.0%
<i>Family Planning</i>	4,004	42.6%	5,220	44.1%
<i>Prescription for Naloxone from OBAT Provider</i>	9,492	36.7%	12,788	37.6%
<i>Prescription for Naloxone</i>	9,492	51.1%	12,788	54.4%
<i>Testing for HIV/Hepatitis C</i>	9,492	20.8%	12,788	23.2%
<i>Initiation of Medication for OUD</i>	9,492	20.6%	12,788	19.3%
<i>Concurrent Pharmacotherapy and Care Coordination</i>	9,492	16.9%	12,788	15.4%
<i>RPR Testing</i>	9,492	1.3%	12,788	1.5%
<i>Annual TB Testing</i>	9,492	3.3%	12,788	4.9%
<b>Cascade of Care for Members With OUD</b>				
<i>High-Risk Members With OUD Diagnosis</i>	67,799	3.8%	87,229	5.1%
<i>Members Identified as Having OUD who Initiated OUD Treatment: Pharmacotherapy</i>	2,565	25.0%	4,485	31.2%
<i>Members Identified as Having OUD who Initiated OUD Treatment: Other OUD Treatment</i>	2,565	25.9%	4,485	25.8%

Measure	CY 2020		CY 2021	
	Denom	Rate	Denom	Rate
<i>Members Identified as Having OUD who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment</i>	2,565	11.4%	4,485	12.8%
<i>Members who Initiated OUD Treatment who Also Engaged in OUD Treatment</i>	1,013	49.4%	1,983	40.7%
<b>Cascade of Care for Members With Hepatitis C</b>				
<i>Prevalence of Hepatitis C</i>	873,579	0.2%	1,073,812	0.2%
<i>Received DAA Treatment for Hepatitis C</i>	1,842	38.3%	1,871	46.1%
<i>Completed DAA Treatment for Hepatitis C</i>	705	90.8%	862	91.3%
<i>Achieved SVR</i>	705	24.5%	862	30.7%
<b>Cascade of Care for Members With HIV</b>				
<i>Received HIV Care</i>	4,938	41.3%	6,213	37.3%
<i>Retained in HIV Care</i>	4,938	68.2%	6,213	66.1%
<i>Received Antiretroviral Therapy</i>	4,938	63.9%	6,213	68.9%

## Conclusions

Study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. However, NIH also reports that substance use has increased since the onset of the COVID-19 PHE,<sup>11-3</sup> so these findings may also reflect an increased incidence of SUD.

Several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021. Additionally, among members who had an initiation visit with an OBAT provider, 91.0 percent of members received counseling from an OBAT provider during the measurement year, and nearly 70 percent of members received eight or more alcohol or drug screenings during the measurement year. However, the percentage of members receiving counseling from an OBAT provider declined by 3.2 percentage points from CY 2020 to CY 2021. Please note that during the COVID-19 PHE, DMAS allowed for flexibilities to not discontinue a member’s medication for OUD if they were not able to engage in counseling.

Study findings show that engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD

<sup>11-3</sup> National Institutes of Health: National Institute on Drug Abuse. COVID-19 and Substance Use. Available at: <https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use>. Accessed on: Oct. 31, 2023.



treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the COVID-19 PHE, since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE.

Seven study indicators assessed the receipt of naloxone, a medication to reverse opioid overdose, which can help reduce overdose deaths. These indicators demonstrated that the prescribing of naloxone to reduce overdose deaths has been consistent or has improved across CY 2020 and CY 2021, in alignment with ARTS benefit goals. However, there are opportunities for improvement among specific populations. Most members who receive opioids through the healthcare system are receiving naloxone. In CY 2021, 51.4 percent of members prescribed high-dose opioids received naloxone, and this rate improved by 1.5 percentage points from CY 2020 to CY 2021. Additionally, 68.0 and 58.3 percent of members with a history of chronic opioid use and concurrent benzodiazepine and opioid use, respectively, received naloxone. However, naloxone receipt is notably lower among other members at high risk of overdose. Only 39.2 percent of members diagnosed with OUD received naloxone. The rate of naloxone receipt among members receiving OBAT services was substantially higher at 54.4 percent, but still low compared to other high-risk populations. Additionally, only 43.7 percent of members with a history of overdosing received naloxone, though this rate improved by 6.1 percentage points from CY 2020 to CY 2021.

Several study indicators assessed utilization of care for physical health conditions among members, with a focus on care for hepatitis C and HIV. These indicators found low rates for initiation of care but high rates for retention in care. Additionally, most rates related to care for physical health conditions improved from CY 2020 to CY 2021. Among members with SUD, 31.9 percent of members diagnosed with hepatitis C initiated antiviral therapy for hepatitis C, and 62.5 percent of members diagnosed with HIV were dispensed an antiretroviral therapy medication within 30 days of their first HIV diagnosis. Treatment for members with hepatitis C and SUD improved by 2.8 percentage points from CY 2020 to CY 2021, while treatment for members with HIV and SUD declined by 2.4 percentage points. In CY 2021, 91.3 percent of members who received DAA treatment completed it; however, only 46.1 percent of members diagnosed with hepatitis C received DAA treatment at all. While the rates of hepatitis C diagnosis and DAA treatment completion were consistent across CY 2020 and CY 2021, the rate of initiating DAA treatment and achieving SVR increased by 7.8 and 6.2 percentage points, respectively, from CY 2020 to CY 2021. Among members diagnosed with HIV, only 37.3 percent received HIV care within 30 days of diagnosis, while 66.1 percent were retained in HIV care for at least three months, and 68.9 percent received antiretroviral therapy within three months of initial HIV diagnosis.

In addition to the total Virginia Medicaid rates, the 2022 ARTS Measure Report evaluated PM rates stratified by demographics, region, delivery system, eligibility group, managed care program, and MCO. Among rates stratified by age category, members 12 to 21 years of age were consistently less likely to receive naloxone and OUD treatment compared to members in other age categories. Additionally, members 65 years of age and older were consistently less likely to initiate or be retained in hepatitis C and HIV care. However, these findings may reflect services billed to Medicare or medications received in institutionalized settings, such as skilled nursing facilities, not being captured in Medicaid administrative data. Rates for male and female members were generally similar. Rate differences among racial/ethnic groups varied across study indicators. However, Asian members prescribed high-dose opioids or with diagnosed OUD were less likely to receive naloxone than other racial/ethnic groups. Asian members at high risk of OUD were also almost half as likely to be diagnosed with OUD than members in other racial/ethnic groups. Additionally, White members were more likely to receive



treatment for hepatitis C than Black/African American members. The Central region had the highest rate of OUD diagnoses yet some of the lowest rates for initiation of pharmacotherapy and other treatment. The Southwest region had the highest rate of hepatitis C diagnoses but the lowest rates for initiation and completion of DAA treatment. The Roanoke/Alleghany region had the lowest rates for receipt of antiretroviral therapy among members with HIV.

Study indicator rates by delivery system varied, since the denominator for FFS members was typically small. Many study indicators had large increases in their denominators driven by an increase in Medicaid Expansion members from CY 2020 to CY 2021, and this increase in Medicaid Expansion sometimes drove overall changes in rates. Also of note, Dual Eligible members were consistently less likely to receive treatment for hepatitis C and HIV; however, this finding may reflect services billed to Medicare or medications received in institutionalized settings, such as skilled nursing facilities, not being captured in Medicaid administrative data. For MCO, Aetna and Molina tended to have lower rates of naloxone prescription compared to other MCOs. Molina also had the highest rate of OUD diagnoses, yet had relatively low rates for initiation of pharmacotherapy, initiation of other OUD treatment, and engagement in OUD treatment.

## 12. Focus Studies

### Overview

#### Medicaid and CHIP Maternal and Child Health Focus Study

The contract year 2021–2022 Medicaid and CHIP Maternal and Child Health 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 (e.g., preterm births, low birth weight) are associated with births paid by Virginia Medicaid?
- What maternal health outcomes (e.g., depression) are associated with births paid by Virginia Medicaid?
- What health disparities exist in birth outcomes for births paid by Virginia Medicaid?

The Medicaid and CHIP 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 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 (Acute) 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 12-1 presents the birth outcomes study indicator results by Medicaid delivery system within each measurement period (i.e., CY 2019, CY 2020, and CY 2021).

**Table 12-1—Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Delivery System, CY 2019–CY 2021**

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
<b>FFS</b>							
Births with Early and Adequate Prenatal Care	76.4%	2,357	65.0%	1,881	64.8%	2,320	60.2%
<i>Births with Inadequate Prenatal Care*</i>	NA	693	19.1%	562	19.4%	962	24.9%
<i>Births with No Prenatal Care*</i>	NA	193	5.3%	117	4.0%	176	4.6%
Preterm Births (<37 Weeks Gestation)*	9.4%	488	12.8%	334	11.0%	413	10.5%

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	457	12.0%	280	9.3%	338	8.6%
<b>Managed Care</b>							
Births with Early and Adequate Prenatal Care	76.4%	20,035	73.2%	20,364	72.7%	21,460	74.3%
<i>Births with Inadequate Prenatal Care*</i>	NA	4,350	15.9%	4,089	14.6%	4,144	14.4%
<i>Births with No Prenatal Care*</i>	NA	495	1.8%	417	1.5%	509	1.8%
Preterm Births (<37 Weeks Gestation)*	9.4%	2,775	9.7%	2,834	9.7%	2,914	10.0%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	2,613	9.1%	2,699	9.2%	2,736	9.4%

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

Overall, women enrolled in managed care had better outcomes than women in the FFS population in CY 2021, with the exception of the *Newborns with Low Birth Weight (<2,500 grams)* study indicator rate. The CY 2021 managed care rate for the *Newborns with Low Birth Weight (<2,500 grams)* indicator exceeded the national benchmark 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 2021 rate for women in FFS continued to improve from prior measurement periods and outperformed the national benchmark for *Newborns with Low Birth Weight (<2,500 grams)*.

Table 12-2 presents the birth outcomes study indicator results by Medicaid program for each measurement period.

**Table 12-2—Overall Birth Outcomes Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2019–CY 2021**

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
<b>Medicaid for Pregnant Women</b>							
Births with Early and Adequate Prenatal Care	76.4%	16,028	73.1%	13,737	72.4%	11,493	73.9%
<i>Births with Inadequate Prenatal Care*</i>	NA	3,451	15.7%	2,839	15.0%	2,337	15.0%
<i>Births with No Prenatal Care*</i>	NA	393	1.8%	241	1.3%	239	1.5%
Preterm Births (<37 Weeks Gestation)*	9.4%	2,173	9.5%	1,750	8.9%	1,460	9.3%

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	2,062	9.0%	1,699	8.6%	1,333	8.5%
<b>Medicaid Expansion</b>							
Births with Early and Adequate Prenatal Care	76.4%	1,462	70.9%	3,249	73.8%	5,031	77.5%
<i>Births with Inadequate Prenatal Care*</i>	NA	330	16.0%	578	13.1%	722	11.1%
<i>Births with No Prenatal Care*</i>	NA	74	3.6%	90	2.0%	154	2.4%
Preterm Births (<37 Weeks Gestation)*	9.4%	261	12.1%	544	11.9%	733	11.2%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	235	10.9%	463	10.1%	707	10.8%
<b>FAMIS MOMS</b>							
Births with Early and Adequate Prenatal Care	76.4%	1,626	77.2%	1,564	76.8%	1,382	78.1%
<i>Births with Inadequate Prenatal Care*</i>	NA	292	13.9%	261	12.8%	219	12.4%
<i>Births with No Prenatal Care*</i>	NA	28	1.3%	11	0.5%	12	0.7%
Preterm Births (<37 Weeks Gestation)*	9.4%	168	7.7%	163	7.8%	161	9.0%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	158	7.2%	150	7.2%	145	8.1%
<b>Other Aid Categories<sup>†</sup></b>							
Births with Early and Adequate Prenatal Care	76.4%	3,276	66.9%	3,695	66.9%	5,874	65.9%
<i>Births with Inadequate Prenatal Care*</i>	NA	970	19.8%	973	17.6%	1,828	20.5%
<i>Births with No Prenatal Care*</i>	NA	193	3.9%	192	3.5%	280	3.1%
Preterm Births (<37 Weeks Gestation)*	9.4%	661	12.9%	711	12.3%	973	10.8%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	615	12.0%	667	11.5%	889	9.9%

\*a lower rate indicates better performance for this indicator.

NA indicates there is not an applicable national benchmark for this indicator.

† Other Aid Categories includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS programs.

Overall, the FAMIS MOMS program demonstrated strength, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* study indicators exceeding the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program also had *Preterm Births (<37 Weeks Gestation)* and *Newborns with Low Birth Weight (<2,500 grams)* rates that exceeded the national benchmarks in CY 2021. Additionally, the Medicaid Expansion program’s rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 to exceed the national benchmark in CY 2021. Conversely, the Other Aid Categories rates for all three study indicators fell below the national benchmarks for all three measurement periods.

Table 12-3 presents the maternal health outcomes study indicator results by Medicaid delivery system within each measurement period (i.e., CY 2019, CY 2020, and CY 2021).

**Table 12-3—Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births by Delivery System, CY 2021**

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
<b>FFS</b>			
<i>Postpartum ED Utilization*</i>	316	3,916	8.1%
<i>Postpartum Ambulatory Care Utilization</i>	1,576	3,916	40.2%
<i>Prenatal Maternal Depression Screening</i>	15	3,916	0.4%
<i>Postpartum Maternal Depression Screening</i>	113	3,916	2.9%
<b>Managed Care</b>			
<i>Postpartum ED Utilization*</i>	4,311	29,116	14.8%
<i>Postpartum Ambulatory Care Utilization</i>	15,448	29,116	53.1%
<i>Prenatal Maternal Depression Screening</i>	1,623	29,116	5.6%
<i>Postpartum Maternal Depression Screening</i>	2,138	29,116	7.3%

\*a lower rate indicates better performance for this indicator.

Table 12-4 presents the maternal health outcomes study indicator results by Medicaid program for each measurement period.

**Table 12-4—Overall Maternal Health Outcomes Study Indicator Findings Among Singleton Births by Medicaid Program, CY 2021**

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
<b>Medicaid for Pregnant Women</b>			
<i>Postpartum ED Utilization*</i>	2,175	15,682	13.9%
<i>Postpartum Ambulatory Care Utilization</i>	8,301	15,682	52.9%
<i>Prenatal Maternal Depression Screening</i>	709	15,682	4.5%
<i>Postpartum Maternal Depression Screening</i>	1,147	15,682	7.3%

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
<b>Medicaid Expansion</b>			
<i>Postpartum ED Utilization*</i>	905	6,548	13.8%
<i>Postpartum Ambulatory Care Utilization</i>	3,265	6,548	49.9%
<i>Prenatal Maternal Depression Screening</i>	387	6,548	5.9%
<i>Postpartum Maternal Depression Screening</i>	485	6,548	7.4%
<b>FAMIS MOMS</b>			
<i>Postpartum ED Utilization*</i>	191	1,785	10.7%
<i>Postpartum Ambulatory Care Utilization</i>	855	1,785	47.9%
<i>Prenatal Maternal Depression Screening</i>	48	1,785	2.7%
<i>Postpartum Maternal Depression Screening</i>	109	1,785	6.1%
<b>Other Aid Categories<sup>†</sup></b>			
<i>Postpartum ED Utilization*</i>	1,198	9,017	17.1%
<i>Postpartum Ambulatory Care Utilization</i>	4,603	9,017	51.0%
<i>Prenatal Maternal Depression Screening</i>	494	9,017	5.5%
<i>Postpartum Maternal Depression Screening</i>	510	9,017	5.7%

\*a lower rate indicates better performance for this indicator.

† Other Aid Categories includes all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS programs

Births to women in the FAMIS MOMS program had the lowest rates of *Postpartum Ambulatory Care Utilization*, *Prenatal Maternal Health Screening*, and *Postpartum Maternal Depression Screening* for CY 2021. Additionally, the Medicaid for Pregnant Women program had the highest rate of *Postpartum Ambulatory Care* and had some of the highest rates for *Prenatal Maternal Depression Screening* and *Postpartum Maternal Depression Screening* for CY 2021.

## Foster Care Focus Study

In contract year 2021–2022, HSAG conducted the seventh annual Child Welfare Focus Study to determine the extent to which members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) received the expected preventive and therapeutic medical care under a managed care service delivery program compared to members not in a child welfare program and receiving Medicaid managed care benefits during MY 2021 (i.e., January 1, 2021–December 31, 2021). While historically the Foster Care Focus Study evaluated healthcare utilization among members in the study populations, for this year’s focus study, DMAS requested that HSAG also evaluate timely access to care for members who transitioned into or out of the foster care program. For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner.



Additionally, DMAS requested that HSAG evaluate disparities in healthcare utilization and timely access to care based on demographic factors (i.e., age, sex, race, region, and MCO). Federal regulations require state Medicaid agencies to incorporate a plan to identify, evaluate, and reduce health disparities as part of their managed care state QS.<sup>12-1</sup> DMAS' QS is committed to monitoring health disparities to inform QI efforts and ensure that Virginia Medicaid members have access to high-quality care. DMAS' QS defines health disparities as differences in health outcomes between groups within a population.<sup>12-2</sup> The 2021–22 Child Welfare Focus Study presents study indicator results stratified by member demographics and assesses whether health disparities were statistically significant.

A policy statement published in 2015 by AAP outlined a significant number of barriers in providing adequate and timely health services to children in foster care.<sup>12-3</sup> 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 health and BH providers,<sup>12-4</sup> necessitating levels of care coordination and follow-up beyond those expected for most children and adolescents. These physical health and BH conditions create additional challenges for youth aging out of the foster care system who are unable to find a permanent home and must navigate the transition into adulthood and adult healthcare.<sup>12-5</sup> 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 child welfare program.

## Healthcare Utilization Findings

For alignment with other quality initiatives, healthcare utilization measures were based on CMS' Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2021 Reporting or custom measure specifications. The healthcare utilization analysis assessed 20 measures, representing 34 study indicators, across six domains:

- Primary Care
- Oral Health
- Behavioral Health
- Substance Use
- Respiratory Health
- Service Utilization

---

<sup>12-1</sup> CMS. CMS External Quality Review (EQR) Protocols. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Nov 8, 2023.

<sup>12-2</sup> Commonwealth of Virginia DMAS. 2022–2022 Quality Strategy. Available at: <https://www.dmas.virginia.gov/media/2649/2020-2022-dmas-quality-strategy.pdf>. Accessed on: Nov 8, 2023.

<sup>12-3</sup> 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: Nov 8, 2023.

<sup>12-4</sup> Deutsch SA, Lynch A, Zlotnik S, et.al. Mental health, behavioral and developmental issues for youth in foster care. *Current Problems in Pediatric and Adolescent Health Care*. 2015; 45:292–297.

<sup>12-5</sup> 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.



Table 12-5 through Table 12-7 present study indicator results for the children in foster care, children receiving adoption assistance, and former foster care members study populations and their associated controls. *P*-values indicate whether the rate differences between the study population and their controls are statistically significant.

**Table 12-5—Healthcare Utilization Study Indicator Results for Children in Foster Care and Controls**

Measure	Children in Foster Care Rate	Controls Rate	<i>p</i>
<b>Primary Care</b>			
<i>Child and Adolescent Well-Care Visits</i>	64.8%	54.7%	<0.001*
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i>	63.8%	60.0%	0.46
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	79.7%	75.8%	0.31
<b>Oral Health</b>			
<i>Annual Dental Visit</i>	70.6%	52.4%	<0.001*
<i>Preventive Dental Services</i>	64.6%	45.6%	<0.001*
<i>Oral Evaluation, Dental Services</i>	63.5%	44.5%	<0.001*
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	35.0%	20.8%	<0.001*
<i>Topical Fluoride for Children—Dental Services</i>	28.3%	16.0%	<0.001*
<i>Topical Fluoride for Children—Oral Health Services</i>	2.4%	2.1%	0.43
<b>Behavioral Health</b>			
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	64.2%	59.7%	0.56
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	92.9%	81.5%	0.25
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i>	38.0%	35.7%	0.67
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	89.2%	68.4%	0.01*
<i>Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up</i>	78.1%	66.4%	0.04*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up</i>	88.6%	81.8%	0.13
<i>Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up</i>	93.0%	90.2%	0.43
<i>Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up</i>	96.5%	96.5%	1.00
<i>Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up</i>	98.2%	97.2%	0.70
<b>Substance Use</b>			
<i>Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up</i>	0.0%	0.0%	NC

Measure	Children in Foster Care Rate	Controls Rate	p
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment<sup>^</sup></i>	39.7%	50.0%	0.39
<i>Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment<sup>^</sup></i>	20.7%	16.7%	0.77
<b>Respiratory Health</b>			
<i>Asthma Medication Ratio</i>	85.7%	80.2%	0.48
<b>Service Utilization</b>			
<i>Ambulatory Care Visits</i>	88.9%	89.7%	0.33
<i>ED Visits</i>	24.8%	31.5%	<0.001*
<i>Inpatient Visits</i>	4.5%	4.4%	0.82
<i>Behavioral Health Encounters—ARTS</i>	1.9%	0.7%	<0.001*
<i>Behavioral Health Encounters—CMH Services</i>	38.8%	21.7%	<0.001*
<i>Behavioral Health Encounters—RTC Services</i>	4.4%	2.6%	<0.001*
<i>Behavioral Health Encounters—Therapeutic Services</i>	10.4%	5.9%	<0.001*
<i>Behavioral Health Encounters—Traditional Services</i>	67.8%	53.8%	<0.001*
<i>Behavioral Health Encounters—Total</i>	71.0%	57.5%	<0.001*
<i>Overall Service Utilization</i>	92.1%	93.0%	0.18

\* Indicates that the rates are statistically different between the children in foster care and controls.

NC indicates that the p-value could not be calculated since both numerators were zero.

P-values were calculated using Chi-square tests and Fisher’s exact tests to quantify the relationship between foster care status and numerator compliance. Measure 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.

<sup>^</sup> MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

**Table 12-6—Healthcare Utilization Study Indicator Results for Children Receiving Adoption Assistance and Controls**

Measure	Children in Foster Care Rate	Controls Rate	p
<b>Primary Care</b>			
<i>Child and Adolescent Well-Care Visits</i>	47.1%	48.2%	0.17
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i>	50.0%	65.3%	0.61
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>	71.0%	72.9%	0.82
<b>Oral Health</b>			
<i>Annual Dental Visit</i>	53.2%	50.8%	0.003*
<i>Preventive Dental Services</i>	48.3%	45.0%	<0.001*
<i>Oral Evaluation, Dental Services</i>	47.2%	44.0%	<0.001*
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	23.7%	19.6%	<0.001*

Measure	Children in Foster Care Rate	Controls Rate	p
<i>Topical Fluoride for Children—Dental Services</i>	19.4%	16.2%	<0.001*
<i>Topical Fluoride for Children—Oral Health Services</i>	1.4%	1.2%	0.46
<b>Behavioral Health</b>			
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	59.7%	52.0%	0.25
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	80.0%	67.4%	0.13
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i>	34.1%	34.6%	0.90
<i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	59.3%	65.3%	0.41
<i>Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up</i>	51.4%	58.1%	0.12
<i>Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up</i>	62.9%	74.3%	0.005*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up</i>	73.1%	81.0%	0.03*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up</i>	86.1%	91.5%	0.05*
<i>Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up</i>	91.0%	94.0%	0.19
<b>Substance Use</b>			
<i>Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up</i>	0.0%	25.0%	0.40
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment<sup>^</sup></i>	54.1%	30.0%	0.03*
<i>Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment<sup>^</sup></i>	8.1%	10.0%	1.00
<b>Respiratory Health</b>			
<i>Asthma Medication Ratio</i>	86.1%	71.4%	0.001*
<b>Service Utilization</b>			
<i>Ambulatory Care Visits</i>	81.4%	83.6%	<0.001*
<i>ED Visits</i>	16.1%	24.1%	<0.001*
<i>Inpatient Visits</i>	2.8%	2.4%	0.12
<i>Behavioral Health Encounters—ARTS</i>	0.4%	0.5%	0.08
<i>Behavioral Health Encounters—CMH Services</i>	14.0%	14.2%	0.76
<i>Behavioral Health Encounters—RTC Services</i>	2.7%	1.9%	<0.001*
<i>Behavioral Health Encounters—Therapeutic Services</i>	5.0%	4.3%	0.03*
<i>Behavioral Health Encounters—Traditional Services</i>	50.3%	42.4%	<0.001*
<i>Behavioral Health Encounters—Total</i>	51.6%	44.9%	<0.001*
<i>Overall Service Utilization</i>	84.1%	86.7%	<0.001*

\* Indicates that the rates are statistically different between the adoption assistance children and controls.

P-values were calculated using Chi-square tests and Fisher’s exact tests to quantify the relationship between adoption assistance status and numerator compliance. Measure 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

^ MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

**Table 12-7—Healthcare Utilization Study Indicator Results for Former Foster Care Members and Controls**

Measure	Children in Foster Care Rate	Controls Rate	p
<b>Primary Care</b>			
<i>Child and Adolescent Well-Care Visits</i>	19.6%	17.4%	0.37
<b>Oral Health</b>			
<i>Annual Dental Visit</i>	32.1%	27.2%	0.21
<i>Preventive Dental Services</i>	22.5%	20.1%	0.48
<i>Oral Evaluation, Dental Services</i>	24.1%	20.7%	0.34
<i>Topical Fluoride for Children—Dental or Oral Health Services</i>	4.5%	4.2%	0.86
<i>Topical Fluoride for Children—Dental Services</i>	4.1%	3.2%	0.59
<i>Topical Fluoride for Children—Oral Health Services</i>	0.0%	0.0%	NC
<b>Behavioral Health</b>			
<i>Antidepressant Medication Management—Effective Acute Phase Treatment</i>	33.3%	42.1%	0.19
<i>Antidepressant Medication Management—Effective Continuation Phase Treatment</i>	13.5%	20.0%	0.21
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>	26.9%	33.3%	0.50
<i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i>	48.6%	26.7%	0.21
<b>Substance Use</b>			
<i>Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up</i>	5.0%	14.3%	0.56
<i>Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^</i>	47.0%	45.8%	0.88
<i>Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^</i>	12.0%	13.9%	0.70
<b>Respiratory Health</b>			
<i>Asthma Medication Ratio</i>	69.2%	66.7%	1.00
<b>Service Utilization</b>			
<i>Ambulatory Care Visits</i>	62.3%	66.9%	0.01*
<i>ED Visits</i>	44.3%	38.5%	<0.001*
<i>Inpatient Visits</i>	10.4%	9.6%	0.48
<i>Behavioral Health Encounters—ARTS</i>	5.8%	4.5%	0.08
<i>Behavioral Health Encounters—CMH Services</i>	10.1%	6.3%	<0.001*
<i>Behavioral Health Encounters—RTC Services</i>	5.0%	2.5%	<0.001*

Measure	Children in Foster Care Rate	Controls Rate	p
<i>Behavioral Health Encounters—Therapeutic Services</i>	4.1%	2.9%	0.06
<i>Behavioral Health Encounters—Traditional Services</i>	34.2%	30.9%	0.04*
<i>Behavioral Health Encounters—Total</i>	35.6%	31.9%	0.02*
<i>Overall Service Utilization</i>	74.7%	75.4%	0.66

\* Indicates that the rates are statistically different between the former foster children and controls.

NC indicates that the p-value could not be calculated since both numerators were zero.

P-values were calculated using Chi-square tests and Fisher’s exact tests to quantify the relationship between former foster care status and numerator compliance. Measure 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.

^ MY 2021 rates were recalculated for the 2022–23 Child Welfare Focus Study; therefore, these rates will not match the MY 2021 rates presented in the 2021–22 Child Welfare Focus Study.

This study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services; and Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively), the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points), and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points). Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children in foster care had lower rates compared to controls for only four study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment, Ambulatory Care Visits, ED Visits, and Overall Service Utilization*. For *Initiation of AOD Treatment*, children in foster care had a higher rate than controls during MY 2019 but a lower rate than controls in MY 2020. However, the rate for children in foster care increased from 29.1 percent to 40.8 percent from MY 2020 to MY 2021, and the gap between children in foster care and controls reduced from 16.7 to 7.3 percentage points. Additionally, the rate for children in foster care for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator was lower than controls during MY 2020 but higher than controls during MY 2021, indicating improvement in AOD treatment engagement as well. For the *ED Visits* study indicator, the rate for children in foster care was 6.7 percentage points lower than the rate for controls, which could reflect better management of health conditions for children in foster care. For the *Ambulatory Care Visits* and *Overall Service Utilization* indicators, the rate difference between children in foster care and controls was less than 1 percentage point, and the rates for children in foster care were very high for both indicators.

Among children in foster care, four study indicator rates increased, while 13 study indicator rates decreased from MY 2020 to MY 2021, and seven study indicator rates increased, while eight study indicator rates decreased from MY 2019 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator (by 8.7 percentage points), the *Annual Dental Visit* indicator (by 8.5 percentage points), and the *Preventive Dental Services* indicator (by 7.4 percentage points). Among controls for children in



foster care, 13 study indicator rates increased, while four study indicator rates decreased from MY 2020 to MY 2021, and eight study indicator rates increased, while nine study indicator rates decreased from MY 2019 to MY 2022. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. For instance, from March 2020 to May 2020, most elective procedures and outpatient visits were cancelled or postponed nationwide.<sup>12-6</sup> Additionally, utilization of ambulatory care services remained below expected rates into early 2021, and rates for Medicaid enrollees were slower to rebound after COVID-19 outbreaks than commercial, Medicare Advantage, and Medicare fee-for-service (FFS) enrollees.<sup>12-7</sup> Despite the nationwide decline in healthcare utilization, six of the MY 2020 to MY 2021 rate declines were by less than 3 percent.

This study demonstrated that children receiving adoption assistance have higher rates of appropriate healthcare utilization than comparable controls for 47 percent of study indicators in MY 2021 compared to 60 percent of study indicators in MY 2020. Study findings show that children receiving adoption assistance had higher rates than controls for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio*, *Inpatient Visits*, and four out of six *Behavioral Health Encounters* study indicators. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, children receiving adoption assistance had lower rates compared to controls for the three Primary Care domain study indicators, most Behavioral Health domain study indicators, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*. The largest differences were for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* study indicator (by 15.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.4 percentage points). However, for eight study indicators, the rates for children receiving adoption assistance were less than 3 percentage points lower than the controls. Additionally, the *ED Visits* rate for children receiving adoption assistance was 8.0 percentage points lower than controls, which may indicate that health conditions for children receiving adoption assistance are being better managed.

Among children receiving adoption assistance, four study indicator rates increased, while 12 study indicator rates decreased from MY 2020 to MY 2021. The largest declines from MY 2020 to MY 2021 were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 15.0 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 8.9 percentage points). The *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator also declined by 33.0 percentage points; however, the denominator is very small, so rate changes across time are expected to be larger. Among controls for children receiving adoption assistance, nine study indicator rates increased, while nine study indicator rates decreased from MY 2020 to MY 2021. Some declines in rates may be attributable to the COVID-19 pandemic during MY 2020 and MY 2021. Despite

---

<sup>12-6</sup> 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](https://jada.ada.org/article/S0002-8177(21)00417-7/pdf). Accessed on: Nov 8, 2023.

<sup>12-7</sup> Mafi JN, Craff M, Vangala S. *Trends in US Ambulatory Care Patterns During the COVID-19 Pandemic, 2019-2021*. Journal of the American Medical Association. 2022. Available at: <https://jamanetwork.com/journals/jama/fullarticle/2788140>. Accessed on: Nov 8, 2023.

the nationwide decline in healthcare utilization, four of the rate declines among children in adoption assistance were by less than 3 percent.

This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for 64 percent of study indicators in MY 2021 compared to 45 percent of study indicators in MY 2020. Study findings show that former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, all Oral Health domain study indicators, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Asthma Medication Ratio*, *ED Visits*, *Inpatient Visits*, and all *Behavioral Health Encounters* study indicators. Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2021, former foster care members had lower rates compared to controls for the *Antidepressant Medication Management* study indicators, the *Initiation and Engagement of AOD Abuse or Dependence Treatment* study indicators, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for the *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment* study indicator (by 11.9 percentage points), the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator (by 9.3 percentage points), and the *Antidepressant Medication Management—Effective Acute Phase Treatment* study indicator (by 8.8 percentage points).

Among former foster care members, all study indicator rates except *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* increased from MY 2020 to MY 2021. However, the *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* study indicator only declined by 0.9 percentage points. Among controls for former foster care members, all study indicator rates except two (i.e., *Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*) also increased from MY 2020 to MY 2021.

### Timely Access to Care Findings

For the timely access to care analysis, HSAG developed custom measures to determine the extent to which children newly enrolled in the foster care program and children who aged out of the foster care program were able to access healthcare services in a timely manner. HSAG assessed 3 measures, representing 10 study indicators. Table 12-8 contains the timely access to care study indicator results for children newly enrolled in foster care and members who aged out of foster care.

**Table 12-8—Timely Access to Care Study Indicator Results for Children Newly Enrolled in Foster Care and Members Who Aged Out of Foster Care**

Measure	Denominator	Numerator	Rate
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members</i>	1,699	1,464	86.2%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members</i>	1,699	747	44.0%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members</i>	1,699	1,534	90.3%
<i>Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members</i>	1,699	677	39.9%



Measure	Denominator	Numerator	Rate
<i>Timely Access to Care for Members Who Aged Out of Foster Care— Timely Access to Primary Care for Members Who Aged Out of Foster Care</i>	179	125	69.8%
<i>Timely Access to Care for Members Who Aged Out of Foster Care— Timely Access to Dental Care for Members Who Aged Out of Foster Care</i>	179	62	34.6%
<i>Timely Access to Care for Members Who Aged Out of Foster Care— Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care</i>	179	133	74.3%
<i>Timely Access to Care for Members Who Aged Out of Foster Care— Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care</i>	179	54	30.2%
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care— Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care</i>	179	58	32.4%
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care— Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care with a Behavioral Health Diagnosis</i>	142	56	39.4%

The SFY 2021–2022 study found that 86.2 percent of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care. Therefore, most children in foster care are receiving timely access to primary care; however, there may be some room for improvement in meeting State guidelines. Additionally, 44.0 percent of new foster care members had a visit with a dental provider within 30 days after or 90 days prior to entering foster care, and most of these children also had a visit with a PCP. Study indicators also assessed timely access to care for members who aged out of foster care. Findings demonstrate that 69.8 percent of members who aged out of foster care in the year prior to the measurement year had a visit with a PCP during the measurement year. Similar to new foster care members, 34.6 percent of members who aged out of foster care had a visit with a dental practitioner during the measurement year, and most of these members also had a visit with a PCP. Additionally, most members who aged out of foster care had a BH diagnosis, and 39.4 percent of these members with a BH diagnosis had a visit with an MHP during the measurement year.

## Health Disparities Findings

HSAG assessed health disparities among members in child welfare programs based on key demographic factors (i.e., race, age, gender, MCO, and region) for both the healthcare utilization measures and the timely access to care measures. For the healthcare utilization measures, HSAG also assessed health disparities among each group of controls and compared results to the study populations. Table 12-9 contains the count and percentage of healthcare utilization study indicators for which a health disparity was identified by member characteristic (e.g., age category) for each analysis.

**Table 12-9—Count and Percentage of Study Indicators With a Health Disparity**

Disparity Type and Analysis	Count of Study Indicators	Percent of Study Indicators
<b>Age Category*</b>		
<i>Healthcare Utilization: Children in Foster Care</i>	17	64.4%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	14	53.8%
<i>Healthcare Utilization: Former Foster Care Members</i>	1	6.3%
<i>Timely Access to Care</i>	4	100.0%
<b>Sex</b>		
<i>Healthcare Utilization: Children in Foster Care</i>	6	21.4%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	7	25.0%
<i>Healthcare Utilization: Former Foster Care Members</i>	7	29.2%
<i>Timely Access to Care</i>	6	60.0%
<b>Race</b>		
<i>Healthcare Utilization: Children in Foster Care</i>	2	7.1%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	9	32.1%
<i>Healthcare Utilization: Former Foster Care Members</i>	7	29.2%
<i>Timely Access to Care</i>	0	0.0%
<b>Region</b>		
<i>Healthcare Utilization: Children in Foster Care</i>	19	67.9%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	22	78.6%
<i>Healthcare Utilization: Former Foster Care Members</i>	7	29.2%
<i>Timely Access to Care</i>	7	70.0%
<b>MCO</b>		
<i>Healthcare Utilization: Children in Foster Care</i>	13	46.4%
<i>Healthcare Utilization: Children Receiving Adoption Assistance</i>	15	53.6%
<i>Healthcare Utilization: Former Foster Care Members</i>	5	20.8%
<i>Timely Access to Care</i>	7	70.0%

\* Only includes study indicators for which there is more than one age category.

### Children in Foster Care

Among children in foster care, 17 study indicators demonstrated disparities across age categories. These disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. For example, BH conditions are more likely to be diagnosed later in life, so rates for the *Behavioral Health Encounters* indicators are expected to be higher among older children. However, for other measures, such as *Child and Adolescent Well-Care Visits*, older children were less likely to have a well-care visit despite Virginia state guidelines that children in foster care should have an annual well-child visit up to age 18.<sup>12-8</sup> Additionally, for the

<sup>12-8</sup> Virginia Department of Social Services. Child and Family Services Manual: Identifying Services To Be Provided. 2021. Available at: [https://www.dss.virginia.gov/files/division/dfs/fc/intro\\_page/guidance\\_manuals/fc/07\\_2021/section\\_12\\_identifying\\_services\\_to\\_be\\_provided.pdf](https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2021/section_12_identifying_services_to_be_provided.pdf). Accessed on: Nov 8, 2023.

*Follow-Up for Hospitalization After Mental Illness—7-Day Follow-Up* indicator, the rate for children in foster care 14 years of age or older was lower than the rate for controls as well as all other age categories. Six study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit, ED visit, inpatient visit, and BH encounter with RTC services, while male members were more likely to have a BH encounter with ARTS or therapeutic services. Only two study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a BH encounter with ARTS compared to other racial groups, while White members were less likely, and members in the Other racial group were less likely to have a BH encounter with therapeutic services. These disparities were not seen among controls. There were also some disparities identified across regions and MCOs; however, no region or MCO performed consistently better or worse across study indicators.

### **Children Receiving Adoption Assistance**

Since children receiving adoption assistance is the largest group among the child welfare populations, and *p*-value calculations are influenced by sample size, statistical tests to identify health disparities were most sensitive for this population. Among children receiving adoption assistance, 14 study indicators demonstrated disparities across age categories. Like the findings for children in foster care, these disparities were typically seen among the controls as well, and sometimes reflect the relevance of certain services to specific age categories. However, for other measures, such as Child and Adolescent Well-Care Visits and Annual Dental Visit, older children receiving adoption assistance were less likely to have a well-care visit and annual dental visit compared to younger children. Seven study indicators demonstrated disparities between males and females. Female members were more likely to have an annual dental visit and follow-up visits after hospitalizations or ED visits for mental illness, while male members were more likely to have any BH encounter and BH encounters with CMH, therapeutic, or traditional services.

Nine study indicators demonstrated disparities between racial groups. Black or African American members were more likely to have a well-care visit, oral evaluation, topical fluoride treatment, inpatient visit, and any BH encounter except ARTS compared to other racial groups, while White members were less likely to have a well-care visit, oral evaluation, and any BH encounter except ARTS and CMH services. However, White members on antipsychotics were more likely to have metabolic monitoring. Additionally, children receiving adoption assistance in the Other racial group were less likely to have a BH encounter with CMH or traditional services. Some of these disparities were seen among controls. There were also some disparities identified across regions and MCOs. For example, members in the Northern & Winchester region were less likely to have a well-care visit, any of the services in the Oral Health domain (e.g., annual dental visit, preventive dental services), ambulatory care visit, and BH encounter compared to members in other regions, and members enrolled with Aetna and Molina were less likely to have a well-care visit, any of the services in the Oral Health domain, and an ambulatory care visit compared to members enrolled with other MCOs. Additionally, members enrolled with Aetna were less likely to have a BH encounter.

### **Former Foster Care Members**

Among former foster care members, only the Overall Service Utilization study indicator demonstrated disparities across age categories, whereby members 23 to 26 years of age were less likely to have an ambulatory care visit, ED visit, inpatient visit, or BH encounter compared to members 19 to 22 years of age. This disparity was not seen among controls. Seven study indicators demonstrated disparities

between males and females. Female members were more likely to have a well-care visit, annual dental visit, ambulatory care visit, ED visit, inpatient visit, any BH encounter, and BH encounters with traditional services.

Seven study indicators demonstrated disparities between racial groups. Black or African American former foster care members were more likely to have an oral evaluation or BH encounter with therapeutic services and less likely to initiate AOD treatment or have an ambulatory care visit compared to members in other racial groups, while White former foster care members were less likely to receive an oral evaluation, topical fluoride treatment, or BH encounter with therapeutic services. Additionally, among members with a diagnosis of major depression who were treated with antidepressant medication, Black or African American members were less likely to remain on an antidepressant medication treatment for at least 12 weeks, while White members were more likely. This finding was not seen among controls. For region and MCO, the only notable finding was that former foster care members in the Tidewater region were less likely to have an annual dental visit, preventive dental services, and oral evaluation compared to members in other regions.

## ***Dental Utilization in Pregnant Women Focus Study***

As a supplement to the Medicaid and CHIP Maternal and Child Health 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.<sup>12-9</sup> During 2023, 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 with deliveries from January 1 through December 31, 2022 (i.e., CY 2022). 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).<sup>12-10</sup> 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 timely prenatal care
- Relationship between dental utilization and postpartum ED utilization for non-traumatic dental-related services
  - For this analysis, HSAG also evaluated the top primary diagnoses for the ED visit and timing of the ED visit in relation to the delivery.
- Relationship between dental utilization and postpartum ambulatory care utilization

---

<sup>12-9</sup> 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/>.

<sup>12-10</sup> The analysis only includes paid claims. All zero-paid claims were excluded.

Overall, HSAG identified 37,260 deliveries from January 1 through December 31, 2022. Of the 37,260 deliveries, 3,922 were to women less than 21 years of age and 33,338 were to women 21 years of age and older.

Table 12-10 displays the count of deliveries from the study population that received preconception dental services (Num), the percentage of deliveries from the study population that received preconception dental services (Rate), and percentage of deliveries wherein preconception dental services were received (Percent of Num) for each age group, stratified by dental service category. Please note that a delivery is counted once for each applicable dental service category; thus, the same delivery may be included in more than one dental service category. Women who were continuously enrolled for six months prior to conception and had a conception date later than January 1, 2022, are included in the results.

**Table 12-10—Distribution of Women With Preconception Dental Utilization, by Dental Service Category**

Dental Service Category	Less Than 21 Years of Age			21 Years of Age and Older		
	Num*	Rate	Percent of Num	Num*	Rate	Percent of Num
Any Dental Service	142	21.42%	100.00%	637	12.43%	100.00%
Adjunctive General Services	61	9.20%	42.96%	114	2.23%	17.90%
Diagnostic Services	127	19.16%	89.44%	553	10.79%	86.81%
Endodontics	15	2.26%	10.56%	73	1.42%	11.46%
Oral and Maxillofacial Surgery	26	3.92%	18.31%	161	3.14%	25.27%
Periodontics	S	S	S	61	1.19%	9.58%
Preventive Services	106	15.99%	74.65%	270	5.27%	42.39%
Prosthodontics	0	0.00%	0.00%	S	S	S
Restorative	46	6.94%	32.39%	265	5.17%	41.60%

*\*Because a woman may have had more than one dental service during the preconception period, the count of deliveries for each dental service category may not sum to the overall number of deliveries among women with any dental service. 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.*

As shown in Table 12-10, women less than 21 years of age received preconception dental services in 21.42 percent (n=142) of deliveries, while women 21 years of age and older received preconception dental services in 12.43 percent (n=637) of deliveries. Of the deliveries among women less than 21 years of age who received preconception dental services, 54.93 percent also received dental services during the perinatal period. Of the deliveries among women 21 years of age and older who received preconception dental services, 57.14 percent also received dental services during the perinatal period.

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,<sup>12-11</sup> LIFC, or Other Medicaid<sup>12-12</sup>); managed care program (i.e., Medallion 4.0 [Acute], CCC Plus [MLTSS], or FAMIS); and delivery system (i.e., managed care or FFS). Table 12-11 presents the count of deliveries from the study population (Denom), the percentage of deliveries from the study population (Percent of Denom), the count of deliveries from the study population wherein perinatal dental services were received (Num), and percentage of deliveries that received any perinatal dental services (Rate) for each group, stratified by Medicaid program, managed care program, and delivery system as of the woman’s date of delivery.

**Table 12-11—Distribution of Women With Perinatal Dental Utilization, by Medicaid Program at Time of Delivery**

Stratification	Less Than 21 Years of Age				21 Years of Age and Older			
	Denom	Percent of Denom	Num	Rate	Denom	Percent of Denom	Num	Rate
Any Program	3,922	100.00%	1,010	25.75%	33,338	100.00%	6,938	20.81%
<b>Medicaid Program</b>								
Medicaid for Pregnant Women	952	24.27%	177	18.59%	12,192	36.57%	2,616	21.46%
Medicaid Expansion	533	13.59%	142	26.64%	7,417	22.25%	1,566	21.11%
FAMIS MOMS	448	11.42%	103	22.99%	5,300	15.90%	1,337	25.23%
LIFC	116	2.96%	S	S	4,054	12.16%	813	20.05%
Other Medicaid	1,823	46.48%	562	30.83%	3,064	9.19%	574	18.73%
Not Enrolled	50	1.27%	S	S	1,311	3.93%	32	2.44%
<b>Medicaid Managed Care Program</b>								
Medallion 4.0 (Acute)	2,948	75.17%	824	27.95%	23,195	69.58%	5,141	22.16%
CCC Plus (MLTSS)	73	1.86%	S	S	927	2.78%	252	27.18%

<sup>11-11</sup> 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.

<sup>11-12</sup> 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 Department of Corrections, which are included in the Not Enrolled category.



Stratification	Less Than 21 Years of Age				21 Years of Age and Older			
	Denom	Percent of Denom	Num	Rate	Denom	Percent of Denom	Num	Rate
FAMIS	492	12.54%	125	25.41%	4,959	14.87%	1,287	25.95%
Not Enrolled	50	1.27%	S	S	1,311	3.93%	32	2.44%
<b>Medicaid Delivery System</b>								
Managed Care	3,513	89.57%	978	27.84%	29,081	87.23%	6,680	22.97%
FFS	359	9.15%	S	S	2,946	8.84%	226	7.67%
Not Enrolled	50	1.27%	S	S	1,311	3.93%	32	2.44%

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.

As shown in Table 12-11, most of the study population was covered by managed care regardless of age, with 89.57 percent (n=3,513) of deliveries to women less than 21 years and 87.23 percent (n=29,081) of deliveries to women 21 years of age and older covered by managed care. Deliveries covered by managed care for women less than 21 years of age had higher rates of receiving any perinatal dental service (27.84 percent) compared to women 21 years of age and older age (22.97 percent). Of note, deliveries covered by FFS had low rates of receiving perinatal dental services for women 21 years of age and older (7.67 percent). Within the managed care program, similar distributions were seen between women less than 21 years of age and women 21 years of age and older, with 75.17 percent (n=2,948) of deliveries covered by Medallion 4.0 (Acute) for women less than 21 years of age and 69.58 percent (n=23,195) for women 21 years of age and older. Women less than 21 years of age had higher rates of receiving any perinatal dental services compared to women 21 years of age and older for Medallion (Acute) 4.0 (27.95 percent compared to 22.16 percent). For deliveries covered by FAMIS, women less than 21 years of age had similar rates of receiving any perinatal dental services compared to women 21 years of age and older (25.41 percent and 25.95 percent, respectively). Additionally, approximately 46 percent (n=1,823) of deliveries to women less than 21 years of age were enrolled in the Other Medicaid program, with 30.83 percent (n=562) receiving any perinatal dental services. For women 21 years of age and older, most deliveries were to women enrolled in Medicaid for Pregnant Women (36.57 percent; n=12,192), with 21.46 percent (n=2,616) receiving any perinatal dental services. Of note, the highest rate (25.23 percent) of receiving any perinatal dental service for the 21 years of age and older group was for women enrolled with FAMIS MOMS.

The length of time a woman was continuously enrolled in Medicaid during pregnancy may have also contributed to the ability to obtain perinatal dental services through the SFC program. Of the overall study population, 72.26 percent (n=2,834) of women less than 21 years of age and 71.61 percent (n=23,872) of women 21 years of age and older were continuously enrolled in Medicaid for at least 90 days prior to and including the day of the delivery. Among the deliveries for continuously enrolled women, 29.25 percent (n=829) of women less than 21 years of age and 23.17 percent (n=5,531) of women 21 years of age and older received one or more dental services during the perinatal period. In contrast, 16.64 percent (n=181) of women less than 21 years of age and 14.86 percent (n=1,407) of



women 21 years of age and older who were not continuously enrolled for at least 90 days prior to and including the day of delivery received perinatal dental services.

HSAG performed a statistical analysis related to the association of the receipt of prenatal dental health services and birth outcomes. Table 12-12 presents the total number of deliveries among continuously enrolled women (Denom) and the number (Num) and percentage (Rate) of deliveries with any dental service during the prenatal period, by birth outcome. Additionally, Table 12-12 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 12-12—Prenatal Dental Utilization and Birth Outcomes Chi-Square Analysis—Any Dental Services**

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
<b>Preterm Births (&lt;37 Weeks Gestation)*</b>						
Any Dental Services	682	50	7.33%	4,534	385	8.49% ↓
No Dental Services	3,240	279	8.61%	28,798	2,865	9.95%
<b>Newborns With Low Birth Weight (&lt;2,500 grams)*</b>						
Any Dental Services	682	51	7.48% ↓	4,532	323	7.13% ↓
No Dental Services	3,240	326	10.06%	28,794	2,701	9.38%
<b>Births With Adequate Prenatal Care</b>						
Any Dental Services	648	482	74.38% ↑	4,357	3,380	77.58% ↑
No Dental Services	3,102	2,143	69.08%	27,543	20,572	74.69%
<b>Postpartum ED Utilization for Non-Traumatic Dental Services*</b>						
Any Dental Services	681	S	S	4,532	13	0.29%
No Dental Services	3,191	S	S	27,495	89	0.32%

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
<b>Postpartum Ambulatory Care Utilization</b>						
Any Dental Services	681	449	65.93% ↑	4,532	3,098	68.36% ↑
No Dental Services	3,191	1,825	57.19%	27,495	15,283	55.58%

\*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.

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 12-12 shows that women less than 21 years of age had statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for four of the birth outcomes: *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, *Postpartum ED Utilization for Non-Traumatic Dental Services*, and *Postpartum Ambulatory Care Utilization*. The percentage of deliveries for *Newborns With Low Birth Weight (<2,500 grams)* was significantly lower for those who received at least one prenatal dental service (7.48 percent) compared to those who received no prenatal dental services (10.06 percent). For measures with non-suppressed rates, *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates (74.38 percent and 65.93 percent, respectively) compared to women who received no dental services (69.08 percent and 57.19 percent, respectively).

For women 21 years of age and older, there were statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for four of the birth outcomes: *Preterm Births (<37 Weeks Gestation)*, *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. The percentages of deliveries for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one prenatal dental service (8.49 percent and 7.13 percent, respectively) compared to those who received no prenatal dental services (9.95 percent and 9.38 percent, respectively). For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates (77.58 percent and 68.36 percent, respectively) compared to women who received no dental services (74.69 percent and 55.58 percent, respectively).

Table 12-13 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. Additionally, Table 12-13 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 12-13—Prenatal Dental Utilization and Birth Outcomes Correlation Analysis—Preventive Dental Services**

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
<b>Preterm Births (&lt;37 Weeks Gestation)*</b>						
Preventive Services	500	34	6.80%	2,203	152	6.90% ↓
No Preventive Services	3,422	295	8.62%	31,129	3,098	9.95%
<b>Newborns With Low Birth Weight (&lt;2,500 grams)*</b>						
Preventive Services	500	39	7.80%	2,202	123	5.59% ↓
No Preventive Services	3,422	338	9.88%	31,124	2,901	9.32%
<b>Births With Adequate Prenatal Care</b>						
Preventive Services	476	354	74.37% ↑	2,128	1,686	79.23% ↑
No Preventive Services	3,274	2,271	69.36%	29,772	22,266	74.79%
<b>Postpartum ED Utilization for Non-Traumatic Dental Services*</b>						
Preventive Services	499	S	S	2,202	S	S
No Preventive Services	3,373	S	S	29,825	99	0.33%
<b>Postpartum Ambulatory Care Utilization</b>						
Preventive Services	499	334	66.93% ↑	2,202	1,508	68.48% ↑
No Preventive Services	3,373	1,940	57.52%	29,825	16,873	56.57%

\*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.

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 12-13 shows that women less than 21 years of age had statistically significant differences in rates for deliveries that received preventive dental services versus those that did not receive any





preventive 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* and *Postpartum Ambulatory Care Utilization* was significantly higher for those who received at least one preventive service (74.37 percent and 66.93 percent, respectively) compared to those who did not receive any preventive services (69.36 percent and 57.52 percent, respectively).

For women 21 years of age and older, there were statistically significant differences in rates for deliveries that received any preventive services versus those that did not receive any preventive services for four of the birth outcomes: *Preterm Births (<37 Weeks Gestation)*, *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*. The rates for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one preventive dental service (6.90 percent and 5.59 percent, respectively) compared to those who did not receive any preventive dental services (9.95 percent and 9.32 percent, respectively). For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one preventive dental service had significantly higher rates (79.23 percent and 68.48 percent, respectively) compared to women who did not receive any preventive dental services (74.79 percent and 56.57 percent, respectively).

## 13. Summary of MCO-Specific Strengths and Weaknesses

### Aetna

**Table 13-1—Overall Conclusions for Aetna: Quality, Access, and Timeliness**

Strengths Related to Quality	
	Aetna demonstrated strength within the Children’s Preventive Care domain. Members were able to access providers for preventive and well-care visits, resulting in children receiving care according to the EPSDT and Bright Futures schedules. Aetna displayed strong performance for the <i>Well-Child Visits in the First 30 Months of Life— Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	Within the Care for Chronic Conditions domain, Aetna displayed strong performance for the <i>Asthma Medication Ratio—Total</i> PM indicator, with the MCO’s rate meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. Aetna’s performance results for this indicator demonstrate that providers are monitoring care for asthma using evidence-based guidelines.
Strengths Related to Access and Timeliness	
	Aetna demonstrated strength in providing care and follow-up for members diagnosed with BH disorders and SUDs, indicating the MCO had processes in place to monitor care and services and ensure appropriate follow-up was conducted so that members were connected with care. Within the Behavioral Health domain, Aetna displayed strong performance with four PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile, with the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> PM indicators meeting or exceeding the 90th percentile.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Aetna:</p> <ul style="list-style-type: none"> <li>• <i>Childhood Immunization Status—Combination 3</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i></li> <li>• <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i></li> </ul>

**Weaknesses and Recommendations**

These results align with the results of the prenatal care secret shopper survey results. Of the 258 provider locations surveyed, 55.8 percent could not be reached. Of the cases reached, 16.7 percent accepted Aetna, 15.8 percent accepted VA Medicaid, and 14.9 percent accepted new patients. Of the cases that were accepting new patients, none offered a second trimester appointment, and 66.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, 16.7 percent were compliant with the three-business-day standard.

**Why the weakness exists:** These findings suggest that Aetna’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate the providers’ offices are facing delays due to staffing shortages and workforce issues.

**Recommendations:** HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation that the data have been updated as appropriate. Additionally, Aetna should review appointment availability and scheduling procedures, including panel capacity to accept new patients and provide an update to DMAS of its findings. HSAG also recommends that Aetna conduct a root cause analysis or focus study for these PMs within the Children’s Preventive Care, Women’s Health, and Access to Care 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.



**Weakness:** The results of the PCP secret shopper survey also identified concerns with the accuracy of the information provided to members regarding PCPs, their locations, and contact information. The secret shopper survey revealed that of the 418 provider locations surveyed, 56.0 percent could not be reached. Of the cases reached, 20.1 percent accepted Aetna, 19.0 percent accepted VA Medicaid, and 15.8 percent accepted new patients.

Of the 15.8 percent of provider locations accepting new patients, 28.6 percent and 40.0 percent offered a routine and urgent visit appointment, respectively. Of the routine visit appointments offered, 50.0 percent were compliant with DMAS’ 30-day appointment availability compliance standards. None of the urgent visit appointments offered were compliant with DMAS’ 24-hour appointment availability compliance standards. The lack of availability of providers accepting new patients and appointments within DMAS’ contract time frames may impact members’ ability to access needed care and services, also resulting in lower PM rates.



### Weaknesses and Recommendations

**Why the weakness exists:** These findings suggest that Aetna’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate the providers’ offices are facing delays due to staffing shortages and workforce issues.

**Recommendations:** HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation that the data have been updated as appropriate. Additionally, Aetna should review appointment availability and scheduling procedures, including PCP panel capacity to accept new patients and provide an update to DMAS of its findings. HSAG recommends that Aetna consider provider education regarding access to care requirements.

## HealthKeepers

Table 13-2—Overall Conclusions for HealthKeepers: Quality, Access, and Timeliness

### Strengths Related to Quality



HealthKeepers also showed strength in ensuring members accessed care and services to manage their chronic conditions. Within the Care for Chronic Conditions domain, HealthKeepers displayed strong performance for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* PM indicators, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. HealthKeepers should review its processes and identify the successful interventions for members diagnosed with diabetes and determine if the interventions are appropriate to implement to impact the same member population in receiving eye exams, as the HEDIS MY 2022 PM rates fell at or below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile.


### Strengths Related to Access and Timeliness





HealthKeepers demonstrated strength in providing care and follow-up for members diagnosed with BH disorders and SUDs, indicating the MCO had processes in place to monitor care and services and ensure appropriate follow-up was conducted so that members were connected with care. Within the Behavioral Health domain, HealthKeepers displayed strong performance for the *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total*, *30-Day Follow-Up—Total*, and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM




**Strengths Related to Access and Timeliness**

	indicators, with the MCO’s rate exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
	Of the provider locations accepting new patients, 100.0 percent offered a routine and urgent visit appointment. Additionally, 71.4 percent of the routine visit appointments offered were compliant with DMAS’ 30-day appointment availability compliance standards.



**Weaknesses and Recommendations**

	<p><b>Weakness:</b> The results of the prenatal care secret shopper survey identified that of the 333 provider locations surveyed, 28.5 percent could not be reached. Of the cases reached, 35.1 percent did not offer prenatal care services, 26.9 percent accepted HealthKeepers, 25.6 percent accepted VA Medicaid, and 23.9 percent accepted new patients. Of the cases that were accepting new patients, 61.1 percent offered a first trimester appointment, 20.0 percent offered a second trimester appointment, and 7.1 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 20.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, none were compliant with the three-business-day standard.</p> <p><b>Why the weakness exists:</b> These findings suggest that HealthKeepers’ provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate the providers’ offices are facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HealthKeepers should review appointment availability and scheduling procedures, including panel capacity to accept new patients and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to prenatal care and improved maternal and infant outcomes.</p>
	<p><b>Weakness:</b> The results of the PCP secret shopper survey identified that of the 433 provider locations surveyed, 37.0 percent could not be reached. Of the cases reached, 22.9 percent did not offer primary care services, 45.4 percent accepted HealthKeepers, 41.8 percent accepted VA Medicaid, and 34.1 percent accepted new patients. Of the urgent visit appointments offered, 25.0 percent were compliant with DMAS’ 24-hour appointment availability compliance standards.</p> <p><b>Why the weakness exists:</b> These findings suggest that HealthKeepers’ provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The</p>

Weaknesses and Recommendations	
	<p>inability to reach providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate the providers' offices are facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HealthKeepers should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to preventive, well, and chronic care visits.</p>
	<p><b>Weakness:</b> For the CAHPS Survey, HealthKeepers' 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for <i>Rating of Health Plan</i>.</p> <p><b>Recommendations:</b> The lack of accuracy of provider information as well as limited appointment availability identified in the PCP secret shopper survey may also be reflected in the CAHPS score for <i>Rating of Health Plan</i>. HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as an area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measure to ensure a significant decrease in the score over time does not continue to occur.</p>

## Molina

Table 13-3—Overall Conclusions for Molina: Quality, Access, and Timeliness

Strengths Related to Quality	
	<p>Molina showed strength in ensuring members accessed care and services to screen for conditions and to receive timely monitoring of prescribed medications. This is demonstrated within the Care for Chronic Conditions domain where Molina displayed strong performance for the <i>Asthma Medication Ratio—Total PM</i> indicator, with the MCO's rate meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.</p>
Strengths Related to Access and Timeliness	
	<p>Molina demonstrated strength in providing care and follow-up for members diagnosed with BH disorders and SUDs, indicating the MCO had processes in place to monitor care and services and ensure appropriate follow-up was conducted so that members were connected with care. This was evidenced within the Behavioral Health domain where four of Molina's PM indicators met or</p>

**Strengths Related to Access and Timeliness**

exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total*, *30-Day Follow-Up—Total*, and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* PM indicators met or exceeded the 75th percentile, and the *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM indicator met or exceeded the 90th percentile.

**Weaknesses and Recommendations**



**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 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*
- *Blood Pressure Control for Patients With Diabetes—Total*
- *Eye Exam for Patients With Diabetes—Total*
- *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)*
- *Controlling High Blood Pressure*
- *Follow-Up After ED for Mental Illness—30-Day Follow-Up—Total*
- *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 to 30 Months—Two or More Well-Child Visits*

The results of the prenatal care secret shopper survey align with *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates. The survey results identified that of the 314 provider locations surveyed, 36.6 percent could not be reached. Of the cases reached, 40.1 percent did not offer prenatal care services, 21.6 percent accepted Molina, 20.6 percent accepted VA Medicaid, and 20.6 percent accepted new patients. Of the cases that were accepting new patients, 23.1 percent offered a first trimester appointment, 36.4 percent offered a second trimester appointment, and 11.8 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 33.3 percent were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 25.0 percent were compliant with the seven-calendar-day standard. For cases that were offered a third

**Weaknesses and Recommendations**

trimester appointment, none were compliant with the three-business-day standard.

In addition, the results of the PCP secret shopper survey also identified that of the 410 provider locations surveyed, 38.0 percent could not be reached. Of the cases reached, 23.9 percent did not offer primary care services, 56.3 percent accepted Molina, 54.3 percent accepted VA Medicaid, and 41.7 percent accepted new patients. Of the urgent visit appointments offered, 5.7 percent were compliant with DMAS’ 24-hour appointment availability compliance standards.

Aligning with the PM and secret shopper survey results, Molina’s member experience survey 2023 top-box scores were statistically significantly lower than the 2022 top-box scores and the 2022 NCQA child Medicaid national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.




**Recommendations:** HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, Molina should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved access to preventive, well, and chronic care visits.

HSAG also recommends that Molina conduct a root cause analysis or focus study for these PMs within the Access to Care, Children’s Preventive Care, Behavioral Health, 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.

In addition, 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 the scores over time do not continue to occur.

## Optima

**Table 13-4—Overall Conclusions for Optima: Quality, Access, and Timeliness**

Strengths Related to Quality	
	<p>Within the Children’s Preventive Care domain, Optima’s rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicator. These results indicate that Optima providers are providing care to children according to the EPSDT and Bright Futures schedules.</p>
Strengths Related to Access and Timeliness	
	<p>Optima demonstrated strength in providing care and follow-up for members diagnosed with BH disorders and SUDs, indicating the MCO had processes in place to monitor care and services and ensure appropriate follow-up was conducted so that members were connected with care. Optima’s performance within the Behavioral Health domain identified three PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The <i>Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment</i> PM indicator met or exceeded the 75th percentile, and the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> PM indicators met or exceeded the 90th percentile.</p>
Weaknesses and Recommendations	
	<p><b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima:</p> <ul style="list-style-type: none"> <li>• <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i></li> <li>• <i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase</i></li> <li>• <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i></li> </ul> <p>The results of the <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i> measure indicators aligned with the results of the prenatal care secret shopper survey, which found that of the 305 provider locations surveyed, 38.4 percent could not be reached. Of the cases reached, 28.2 percent did not offer prenatal care services, 30.9 percent accepted Optima, 30.3 percent accepted VA Medicaid, and 28.2 percent accepted new patients. Of the cases that were accepting new patients, 60.0 percent offered a first trimester appointment, 10.0 percent offered a second trimester appointment, and 22.2 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, none were compliant with the seven-calendar-day standard. For cases that were offered a second trimester appointment, 50.0 percent were compliant with the seven-calendar-day standard. For cases that</p>

**Weaknesses and Recommendations**

were offered a third trimester appointment, none were compliant with the three-business-day standard.

In addition, the results of the PCP secret shopper survey also found that of the 412 provider locations surveyed, 31.3 percent could not be reached. Of the cases reached, 55.5 percent accepted Optima, 47.7 percent accepted VA Medicaid, and 41.3 percent accepted new patients. Of the provider locations accepting new patients, 31.0 percent and 27.1 percent offered a routine and urgent visit appointment, respectively. Of the urgent visit appointments offered, 6.3 percent were compliant with DMAS' 24-hour appointment availability compliance standards.

**Recommendations:** HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, Optima should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care visits.

HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Behavioral Health, and Women's Health 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**

**Table 13-5—Overall Conclusions for United: Quality, Access, and Timeliness**

**Strengths Related to Quality**



Within the Children's Preventive Care domain, United displayed strong performance for the *Child and Adolescent Well-Care Visits—Total* PM indicator, with the MCO's rate exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. These results indicate that United network providers are providing care to children according to the EPSDT and Bright Futures schedules.



**Strengths Related to Quality**



For the CAHPS survey, United’s 2023 top-box score was statistically significantly higher than the 2022 top-box score and NCQA adult Medicaid national average for one measure, *Rating of Health Plan*.

**Strengths Related to Access and Timeliness**



United’s performance within the Behavioral Health domain identified four PM indicators that met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. The *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* and *Engagement of SUD Treatment* PM indicators met or exceeded the 75th percentile.

**Weaknesses and Recommendations**



**Weakness:** The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 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*
- *Eye Exam for Patients With Diabetes—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*

The results of the PCP secret shopper survey results identified that of the 455 provider locations surveyed, 33.8 percent could not be reached. Of the cases reached, 31.4 percent did not offer primary care services, 44.5 percent accepted United, 40.5 percent accepted VA Medicaid, and 34.2 percent accepted new patients. Of the urgent visit appointments offered, 12.5 percent were compliant with DMAS’ 24-hour appointment availability compliance standards.

**Recommendations:** HSAG recommends that United conduct a root cause analysis or focus study for these PMs within the Access to Care, Care for Chronic Conditions, 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.






HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG also recommends that the MCO request a copy of the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, United should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an



Weaknesses and Recommendations	
	<p>update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to screenings and preventive and chronic condition care.</p>
	<p><b>Weakness:</b> The results of the prenatal care secret shopper survey identified that of the 366 provider locations surveyed, 35.2 percent could not be reached. Of the cases reached, 26.5 percent did not offer prenatal care services, 40.5 percent accepted United, 32.5 percent accepted VA Medicaid, and 30.8 percent accepted new patients. Of the cases that were accepting new patients, 48.0 percent offered a first trimester appointment, 13.6 percent offered a second trimester appointment, and 15.4 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 16.7 percent were compliant with the seven-calendar-day standard. None of the second or third trimester appointments were compliant with DMAS’ wait time standards of seven calendar days and three business days, respectively.</p> <p><b>Why the weakness exists:</b> These findings suggest that United’s provider data may not include the most updated information regarding provider contact information, specialties, contract status, and acceptance of new patients. The inability to reach the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate the providers’ offices are facing delays due to staffing shortages and workforce issues.</p> <p><b>Recommendations:</b> HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that the MCO request a copy of the analytic flat files from the prenatal care secret shopper survey and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, United should review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care.</p>
	<p><b>Weakness:</b> For the CAHPS Survey, United’s 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for <i>Rating of Personal Doctor</i>. United’s 2023 top-box score was statistically significantly lower than the 2022 top-box score and the 2022 NCQA child Medicaid national average for <i>Rating of Specialist Seen Most Often</i>.</p> <p><b>Recommendations:</b> 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.</p>

## VA Premier

**Table 13-6—Overall Conclusions for VA Premier: Quality, Access, and Timeliness**

Strengths Related to Quality	
	VA Premier showed strength in ensuring members accessed care and services, following evidence-based guidelines for chronic conditions. VA Premier’s performance within the Care for Chronic Conditions domain was strong, with the <i>Hemoglobin A1c Control for Patients With Diabetes— HbA1c Control (&lt;8.0%)</i> and <i>HbA1c Poor Control (&gt;9.0%)</i> PM indicator rates meeting or exceeding NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
	VA Premier’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, <i>Rating of Health Plan</i> . The Child CAHPS score in this measure indicate that overall, members are able to receive care and services as needed.
Strengths Related to Access and Timeliness	
	VA Premier demonstrated strength in providing care and follow-up for members diagnosed with BH disorders and SUDs, indicating the MCO had processes in place to monitor care and services and ensure appropriate follow-up was conducted so that members were connected with care. Within the Behavioral Health domain, VA Premier’s rates met or exceeded NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total</i> and <i>30-Day Follow-Up—Total</i> , and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> PM indicators.
Weaknesses and Recommendations	
	<p><b>Weakness:</b> There are opportunities for improvement in VA Premier’s implementation of PIPs. Although opportunities for improvement were identified and not addressed in the resubmission of the PIPs, VA Premier’s PIPs were found to be methodologically sound and created a foundation for the MCO to progress to subsequent PIP stages—collecting data and implementing interventions that address the identified barriers. The MCO did not address all validation feedback and did not make the necessary corrections in the final resubmitted PIPs, which resulted in a <i>Partially Met</i> overall validation status for each PIP.</p> <p><b>Recommendations:</b> With VA Premier merging with Optima and no longer serving members as of July 1, 2023, and this being the last validation cycle for the <i>Timeliness of Prenatal Visits</i> and <i>Tobacco Use Cessation in Pregnant Members</i> PIPs, HSAG has no additional recommendations.</p>
	<b>Weakness:</b> The following HEDIS MY 2022 PM rates fell below NCQA’s Quality Compass HEDIS MY 2021 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for VA Premier:

## Weaknesses and Recommendations


- *Adult’s Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *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*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator results align with the results of the prenatal care secret shopper survey, which identified that of the 268 provider locations surveyed, 23.5 percent could not be reached. Of the cases reached, 36.6 percent did not offer prenatal care services, 33.7 percent accepted VA Premier, 33.2 percent accepted VA Medicaid, and 32.2 percent accepted new patients. Of the cases that were accepting new patients, 52.0 percent offered a first trimester appointment, none offered a second trimester appointment, and 7.7 percent offered a third trimester appointment. For cases that were offered a first trimester appointment, 30.8 percent were compliant with the seven-calendar-day standard. For cases that were offered a third trimester appointment, 50.0 percent were compliant with the three-business-day standard.

In addition, the results of the PCP secret shopper survey also identified that of the 394 provider locations surveyed, 24.1 percent could not be reached. Of the cases reached, 24.1 percent did not offer primary care services, 50.2 percent accepted VA Premier, 48.8 percent accepted VA Medicaid, and 42.8 percent accepted new patients. Of the routine visit appointments offered, 61.5 percent were compliant with DMAS’ 30-day appointment availability compliance standards. Of the urgent visit appointments offered, 25.9 percent were compliant with DMAS’ 24-hour appointment availability compliance standards. The lack of accuracy in providers’ information and appointment availability may have impacted the member’s ability to access screenings, well-child visits, and preventive and ambulatory visits.

**Recommendations:** With VA Premier merging with Optima, HSAG has no recommendations for VA Premier. HSAG provides DMAS with the analytic flat files from the telephone survey. HSAG recommends that Optima request a copy of these files from the prenatal care and PCP secret shopper surveys and use the files to provide updates or confirmation to DMAS that the data have been updated as appropriate. Additionally, HSAG recommends that Optima review appointment availability and scheduling procedures, including panel capacity to accept new patients, and provide an update to DMAS of its findings. Initiatives focused on improving the accuracy of the provider data may result in improved member access to care.

HSAG also recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access to Care, Children’s Preventive Care,

Weaknesses and Recommendations	
	Behavioral Health, and Women’s Health domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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.
	<p><b>Weakness:</b> For the CAHPS Survey, VA Premier’s adult 2023 top-box score was statistically significantly lower than the 2022 top-box score for one measure, <i>Rating of Health Plan</i>.</p> <p><b>Recommendations:</b> With VA Premier merging with Optima and no longer serving members as of July 1, 2023, HSAG has no additional recommendations.</p>

## 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
1a	The state submitted its EQR technical report by April 30th.	Cover Page
1b	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	Table of Contents
1c	Produce a searchable PDF to enable stakeholders to review topics of interest and facilitate use of the reports for topic-specific analyses.	Entire Report
1d	Use the names of the MCEs when referring to plan performance. Findings and comparisons should refer to MCEs by name in order to facilitate transparency and stakeholder understanding of specific plan performance.	Entire Report
2	<p>All eligible Medicaid and Children’s Health Insurance Program (CHIP) plans are included in the report.</p> <p><i>TIPS: Identify the MCPs subject to EQR by plan name, MCP type, managed care authority, and population(s) served in an introduction, executive summary, or appendix. Explain MCE exclusions (overall or by mandatory or optional EQR activity) by providing context on MCE mergers, acquisitions, or terminations. §438.364(a)</i></p>	Pages 1-1 – 1-2
3a	<p>Required elements are included in the report: The technical report must summarize findings on quality, access, and timeliness of care for each MCO, PIHP, PAHP, and PCCM entity that provides benefits to Medicaid and CHIP enrollees.</p> <p><i>TIPS: Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 and 2 CFR 438.364(a)(1) were 1. Aggregated, 2. analyzed, and 3. conclusions were drawn about the MCP’s ability to furnish services. These findings should reflect a comparison to the domains of quality, timeliness, and access to the healthcare services furnished by the MCO, PIHP, PAHP, or PCCM entity.</i></p>	Pages 1-5 – 1-10 Sections 3 – 13
3b	<p>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]) 42 CFR 438.364[a][1], and §438.364[a][3]), furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.</p> <p><i>TIPS:</i></p> <ul style="list-style-type: none"> <li>• <i>Include a chart outlining each MCP’s strengths and weaknesses for each EQR activity and designate a quality, timeliness, and access domain.</i></li> </ul>	Sections 3 – 13 Section 13

	Required Elements	Page Number
	<ul style="list-style-type: none"> <li>Highlight substantive findings concerning the extent to which each MCP is furnishing high quality, timely, and appropriate access to health care services. Findings should focus on the specific strengths and weaknesses the EQRO identified, rather than on numerical ratings or validation scores obtained under the EQRO's review methodology.</li> </ul>	
3c	<p>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 and 42 CFR 438.364(a)(4), to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP enrollees.</p> <p><b>TIPS:</b></p> <ul style="list-style-type: none"> <li>Consider connecting EQR findings to the quality strategy goals and objectives, particularly in sections of the report that assess the state's overall performance of the quality, timeliness, and access to health care services; when discussing strengths and weaknesses of a MCP or activity; or when discussing the basis of performance measures or PIPs. Note when goals in the quality strategy are considered in EQR activities and which goals they are. Describe the relationship between goals in the state's quality strategy and the four mandatory EQR activities.</li> </ul>	Pages 1-10 – 1-12
3d	<p>Recommend improvements for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM Entity. §438.310(c)(2) and 2 CFR 438.364(a)(4)</p> <p><b>TIPS:</b></p> <ul style="list-style-type: none"> <li>Include recommendations for each MCP. Recommendations should share the EQRO's understanding of why the weakness exists and suggest steps for how the MCP—potentially in concert with the state—can best address the issue. If the cause for the weakness is unclear or unknown, the EQRO should suggest how the MCP and/or state can identify the cause.</li> <li>When determining recommendations, EQROs should consider whether the suggested actions are within the authority of the MCP (or state).</li> </ul>	Sections 3 – 13
3e	Summarize results across all MCEs and provide state-level recommendations for performance improvement.	Pages 1-5 – 1-10 Section 3
3f	<p>Ensure methodologically appropriate, comparative information about all MCPs in accordance with 42 CFR 438.364(a)(5).</p> <p><b>TIPS:</b></p> <ul style="list-style-type: none"> <li>Aggregate findings across MCPs for each EQR activity and show comparisons.</li> <li>Provide context for the individual MCP to make it easier for stakeholders to understand the results of the review and more readily determine whether issues are localized or systemic.</li> </ul>	Section 3 Appendix B
3f	<p>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. §438.364(a)(6)</p> <p><b>TIPS:</b></p>	Appendix E



	Required Elements	Page Number
	<ul style="list-style-type: none"> <li>State the prior year finding and describe the assessment of each MCP’s approach to addressing the recommendation or findings issued by the state or EQRO in the previous year’s EQR technical report. This is not a restatement of a response or rebuttal to the recommendation by the MCP or state.</li> <li>Document assessments with the same specificity used when reporting on initial findings.</li> </ul>	
3g	<p>The information included in the technical report must not disclose the identity or other protected health information of any patient. 2 CFR 438.364(d)</p> <p><b>TIPS:</b></p> <ul style="list-style-type: none"> <li>Ensure the technical report is consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 C.F.R. §431 Subpart F and § 457.1110).</li> <li>Ensure that MCPs comply with HIPAA and all other federal and state laws concerning confidentiality and disclosure.</li> <li>Ensure that EQR-related data collection and reporting activities are consistent with HIPAA requirements.</li> </ul>	Entire Report
3h	An assessment of the MCO, PIHP, PAHP, or PCCM entity information system as part of the validation process. §438.242	Pages 5-1 – 5-2
	The EQRO can address these plan level reporting requirements via tables or appendices to the aggregate report or prepare separate aggregate reports by type of MCP if appropriate.	
4	<p>Validation of performance improvement projects (PIPs):</p> <p>A description of <b>PIP interventions</b> associated with each state-required PIP topic that were underway during the preceding 12 months, and the following for the validation of PIPs: <b>objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.</b> §438.358(b)(1)(i) and 2 CFR 438.364(a)(2)(iiv)</p> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>Provide a validation of all PIPs underway during the 12-month period preceding the EQR review, regardless of the phase of the PIP’s implementation. States often link the timeframe under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.</li> </ul>	
4a	<p>Validation of performance improvement projects (PIPs):</p> <ul style="list-style-type: none"> <li><b>Interventions</b> The technical report must include a description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle. §438.330(d)</li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>For states with many MCPs and PIPs, provide an appendix or link to each plan-level report, an appendix in an aggregate report, or a separate PIP-report that compiles the PIPs applicable to all or a group of plans. Present this information in a cohesive way that allows for brevity in the sections that describe data analysis and conclusions.</li> <li>Note that a table listing all PIP interventions will not alone be considered as methodologically appropriate comparative information, as the table simply</li> </ul>	Pages 4-4 – 4-16



	Required Elements	Page Number
	<i>organizes information, but does not compare or draw conclusions from the information presented.</i>	
4b	<p>Validation of performance improvement projects (PIPs):</p> <ul style="list-style-type: none"> <li><b>Objectives</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li><i>Provide the state or EQRO’s objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO. The state may also include the objective or aim statement for each PIP to satisfy this criterion for the PIP validation activity.</i></li> </ul>	Pages 4-1 – 4-2 Appendix B
4c	<p>Validation of performance improvement projects (PIPs):</p> <ul style="list-style-type: none"> <li><b>Technical methods of data collection and analysis</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li><i>Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</i></li> </ul>	Pages 4-2 – 4-16 Appendix B
4d	<p>Validation of performance improvement projects (PIPs):</p> <ul style="list-style-type: none"> <li><b>Description of data obtained:</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li><i>Based upon the collection efforts above, describe the types of data obtained – information system extracts, documents, answers to questions in data collection tools, and others – to explain the nature of the data collected and analyzed.</i></li> </ul>	Pages 4-1 – 4-16 Appendix B
4e	<p>Validation of performance improvement projects (PIPs):</p> <ul style="list-style-type: none"> <li><b>Conclusions drawn from the data</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li><i>Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.</i></li> </ul>	Page 3–2 Pages 4-1 – 4-16
5	<p>Validation of performance measures (2 CFR 438.358(b)(1)(ii)): The technical report must include information on the validation of each MCO’s, PIHP’s, PAHP’s, or PCCM entity’s performance measures for each MCO, PIHP, PAHP, and PCCM entity performance measure calculated by the state during the preceding 12 months. Include a description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.</p> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li><i>Provide a validation of all performance measures in use during the 12-month period preceding the EQR review, regardless of the phase of the performance measure’s implementation.</i></li> </ul>	

	Required Elements	Page Number
	<ul style="list-style-type: none"> <li>States often link the timeframe under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.</li> </ul>	
5a	Validation of performance measure validation (PMV): <ul style="list-style-type: none"> <li><b>Objectives</b></li> </ul> <b>CONSIDERATIONS:</b> <ul style="list-style-type: none"> <li>Provide the state or EQRO’s objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO.</li> </ul>	Pages 3-3 – 3-12 Page 5-1 Appendix B
5b	Validation of performance measure validation (PMV): <ul style="list-style-type: none"> <li><b>Technical methods of data collection and analysis</b></li> </ul> <b>CONSIDERATIONS:</b> <ul style="list-style-type: none"> <li>Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</li> </ul>	Appendix B
5c	Validation of performance measure validation (PMV): <ul style="list-style-type: none"> <li><b>Description of data obtained</b></li> </ul> <b>CONSIDERATIONS:</b> <ul style="list-style-type: none"> <li>Based upon the collection efforts above, describe the types of data obtained – information system extracts, documents, answers to questions in data collection tools, and others – to explain the nature of the data collected and analyzed.</li> </ul>	Page 5-1 Appendix B
5d	Validation of performance measure validation (PMV): <ul style="list-style-type: none"> <li><b>Conclusions drawn from the data.</b></li> </ul> <b>CONSIDERATIONS:</b> <ul style="list-style-type: none"> <li>Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.</li> </ul>	Pages 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 <b>on a review, conducted within the previous three-year period</b> , 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. The technical report must provide MCP results for the following 11 Subpart D and QAPI standards: 42 CFR 438.206, 457.1230(a), Availability of services 42 CFR 438.207, 457.1230(b), Assurances of adequate capacity and services 42 CFR 438.208, 457.1230(c) Coordination and continuity of care 42 CFR 438.210, 457.1230(d), Coverage and authorization of services 42 CFR 438.214, 457.1233(a), Provider selection 42 CFR 438.224, 457.1230(c), Confidentiality 42 CFR 438.228, 457.1260, Grievance and appeals system 42 CFR 230, 457.1233(b), Subcontractual relationships and delegation 42 CFR 438.236, 457.1233(c), Practice guidelines 42 CFR 438.242, 457.1233(d), Health information system 42 CFR 438.330, 457.1240(b), QAPI.	

	Required Elements	Page Number
	<p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>For each of the 10 Subpart D standards and individual QAPI standard, ensure that the method of compliance review clearly links the EQRO’s activities to the standard under review. Further, ensure that a clear compliance determination is made and recorded for each standard for each plan. A best practice is to list a compliance score of a numerical or semi-quantitative nature.</li> <li>EQROs that assess domains, standards, and requirements that do not neatly overlap with the regulatory standards should provide a clear crosswalk of their activities to the standards under review. As a best practice, the technical report may include a table outlining the timeline for reviewing all standards for MCPs across the three-year review period.</li> </ul> <p>Additional information that needs to be included for compliance is listed in the rows below:</p>	
6a	<p>Review for compliance:</p> <ul style="list-style-type: none"> <li><b>Objectives</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>Provide the state or EQRO’s objective for conducting the mandatory activity itself, including the general approach or methods of validation used by the EQRO.</li> </ul>	Page 6-1 Appendix B
6b	<p>Review for compliance:</p> <ul style="list-style-type: none"> <li><b>Technical methods of data collection and analysis</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>Provide a description of how data was obtained by the EQRO to conduct the validation activity. If a collection tool is used, providing an example of the format of the tool, or questions asked, in an appendix is a best practice. Further, describe how data is analyzed to connect the data requested to the analytical methods that eventually support the conclusions drawn with those data and analyses.</li> </ul>	Page 6-2 Appendix B
6c	<p>Review for compliance:</p> <ul style="list-style-type: none"> <li><b>Description of data obtained</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>This requirement does not apply to the compliance review activity (Protocol 3).</li> </ul>	Appendix B
6d	<p>Review for compliance:</p> <ul style="list-style-type: none"> <li><b>Conclusions drawn from the data</b></li> </ul> <p><b>CONSIDERATIONS:</b></p> <ul style="list-style-type: none"> <li>Having employed the process of data collection and validation using the types and nature of the data received, provide conclusions relevant to the mandatory activity.</li> </ul>	Pages 3-12 – 3-15 Pages 6-3 – 6-10
7	<p><b>Each remaining activity</b> included in the technical report must include a <b>description of the activity</b> and the following information:</p>	
7a.1	<p>Optional activities: Secret Shopper Survey</p> <p><b>Objectives;</b></p>	Page 8-1 Page 8-15 Appendix B

	Required Elements	Page Number
7b.1	Optional activities: <b>Technical methods of data collection and analysis;</b>	Appendix B
7c.1	Optional activities: <b>Description of data obtained; and</b>	Appendix B
7d.1	Optional activities: <b>Conclusions drawn from the data.</b>	3-19 – 3-30 8-1 – 8-28
7a.2	Optional activities: Encounter Data Validation <b>Objectives;</b>	
7b.2	Optional activities: <b>Technical methods of data collection and analysis;</b>	
7c.2	Optional activities: <b>Description of data obtained; and</b>	
7d.1	Optional activities: <b>Conclusions drawn from the data.</b>	
7a.3	Optional activities: Member Experience of Care Survey • <b>Objectives;</b>	Page 10-1 Appendix B
7b.3	Optional activities: • <b>Technical methods of data collection and analysis;</b>	Page 10-1 Appendix B
7c.3	Optional activities: • <b>Description of data obtained; and</b>	Page 10-1 Appendix B
7d.3	Optional activities: • <b>Conclusions drawn from the data.</b>	Pages 3-31 – 3-35
7a.4	Optional activities: Calculation of Additional PM Results <b>Objectives;</b>	Appendix B
7b.4	Optional activities: <b>Technical methods of data collection and analysis;</b>	Appendix B
7c.4	Optional activities: <b>Description of data obtained; and</b>	Appendix B
7d.4	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 3-36 – 3-38
7a.5	Optional activities: ARTS Measurement Specification Development and Maintenance <b>Objectives;</b>	Page 3-38
7b.5	Optional activities: <b>Technical methods of data collection and analysis;</b>	Page 3-38
7c.5	Optional activities: <b>Description of data obtained; and</b>	Page 3-38
7d.5	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 11-2 – 11-5
7a.6	Optional activities: Medicaid and CHIP Maternal and Child Health Focus Study <b>Objectives;</b>	Page 12-1 Appendix B

	Required Elements	Page Number
7b.6	Optional activities: <b>Technical methods of data collection and analysis;</b>	Appendix B
7c.6	Optional activities: <b>Description of data obtained; and</b>	Appendix B
7d.6	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 12-1 – 12-5
7a.7	Optional activities: Child Welfare Focus Study <b>Objectives;</b>	Pages 12-5 – 12-6
7b.7	Optional activities: <b>Technical methods of data collection and analysis;</b>	Appendix B
7c.7	Optional activities: <b>Description of data obtained; and</b>	Appendix B
7d.7	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 12-6 – 12-17 Appendix B
7a.8	Optional activities: Dental Utilization in Pregnant Women Data Brief <b>Objectives;</b>	Page 12-17 Appendix B
7b.8	Optional activities: <b>Technical methods of data collection and analysis;</b>	Pages 12-17 – 12-18 Appendix B
7c.8	Optional activities: <b>Description of data obtained; and</b>	Pages 12-18 – 12-18 Appendix B
7d.8	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 12-18 – 12-24
7a.9	Optional activities: Consumer Decision Support Tool <b>Objectives;</b>	Pages 3-38 – 3-39 Appendix B
7b.9	Optional activities: <b>Technical methods of data collection and analysis;</b>	Pages 3-38 – 3-39 Appendix B
7c.9	Optional activities: <b>Description of data obtained; and</b>	Pages 3-38 – 3-39 Appendix B
7d.9	Optional activities: <b>Conclusions drawn from the data.</b>	Pages 3-39 – 3-40
7a.10	Optional activities: Performance Withhold Program <b>Objectives;</b>	Page 3-40 Appendix B
7b.10	Optional activities: <b>Technical methods of data collection and analysis;</b>	Page 3-40 Appendix B
7c.10	Optional activities: <b>Description of data obtained; and</b>	Page 3-40 Appendix B
7d.10	Optional activities: <b>Conclusions drawn from the data.</b>	Page 3-40

## 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
- Readiness Review
- PCP Secret Shopper Methodology
- PNC Provider Secret Shopper Survey Methodology
- Encounter Validation Methodology
- Member Experience of Care Survey Methodology
- MCO Comparative and Statewide Calculation of Additional Performance Measure Results
- Medicaid and CHIP Maternal and Child Health Focus Study Methodology
- Child Welfare Focus Study Methodology
- Dental Utilization in Pregnant Women Focus Study Methodology
- Consumer Decision Support Tool Methodology
- Performance Withhold Program Methodology

### PIP Validation Approach and Methodology

The purpose of PIP validation is to ensure that PIPs are conducted in a manner that is consistent with the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.<sup>B-1</sup> For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.<sup>B-2</sup> HSAG's PIP validation process includes two key components:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCOs design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., topic supported by data, Aim statement, population, sampling techniques, performance indicator measure, and data collection methodology)

---

<sup>B-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Aug 22, 2023.

<sup>B-2</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Aug 22, 2023.



is based on sound methodological principles and can reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate, and indicators used have the capability to achieve statistically significant and sustained improvement.

2. HSAG evaluates the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process; analysis of data; and identification and prioritization of barriers and subsequent development of relevant, actionable interventions. Through this component, HSAG evaluates how well the MCO improves its rates by implementing effective processes (i.e., barrier analyses, intervention, and evaluation of results).

### **PIP Submission Form**

HSAG developed a PIP Submission Form that MCOs use to document each required step, as well as accompanying instructions to aid them in addressing all documentation requirements. The accompanying instructions describe the requirements for each step in the process and explain step by step how to document and complete the PIP Submission Form.

### **PIP Validation Tool**

HSAG designed its PIP Validation Tool, which it uses to validate the submitted PIPs. The PIP Validation Tool corresponds to the PIP Submission Form. For each submitted PIP, HSAG completed the validation tool and submitted it to the MCO and DMAS as formal feedback and the validation tool will be part of the MCO-specific PIP report.

### **PIP Validation Methodology**

HSAG's approach to assessing the PIP methodology and documentation of the validation findings provides a consistent, structured process and a mechanism that gives the MCOs specific detailed feedback and recommendations for the PIP. HSAG performs the following nine PIP validation steps:

- Step I: Review the Selected PIP Topic
- Step II: Review the PIP Aim Statement
- Step III: Review the Identified PIP Population
- Step IV: Review the Sampling Method
- Step V: Review the Selected PIP Variables and Performance Measures
- Step VI: Review the Data Collection Procedures
- Step VII: Review the Data Analysis and Interpretation of PIP Results
- Step VIII: Assess the Improvement Strategies
- Step IX: Assess the Likelihood That Significant and Sustained Improvement Occurred

HSAG used its standardized scoring methodology within the PIP Validation Tool to rate each MCO's compliance with each of the nine steps. The PIP Validation Tool includes, for each required validation step, a set of evaluation elements. Each element receives a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed* based on the MCO's documentation and performance indicator outcomes. Once all elements have been scored, HSAG rates and reported the overall validity and reliability of the PIP findings as one of the following:



- *Met*: High confidence/confidence in the reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.
- *Partially Met*: Low confidence in the reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: No confidence in the reported PIP results. All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all steps, or one or more critical evaluation elements were *Not Met*.

HSAG has designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must receive a *Met* score. Given the importance of critical elements to the scoring methodology, any critical element that receives a score of *Not Met* will result in an overall PIP validation rating of *Not Met*.

HSAG assigns each PIP an overall percentage score for all evaluation elements (including critical elements), calculating the overall score by dividing the total number of elements scored as *Met* by the sum 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 then assigns a level of confidence to the validated PIP.

### PIP Technical Assistance

HSAG provides ongoing PIP technical assistance to the MCOs and DMAS that includes training on how to complete the PIP Submission Form, quality improvement science tools, logically linking interventions that have the potential to impact the performance indicator outcomes with priority barriers, and evaluation of interventions to aid MCOs in making data driven decisions.

## 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 performance measures (42 CFR §438.358[b][1][ii]). HSAG, in conjunction with ALI Consulting Services, LLC, conducted PMV for DMAS, validating the data collection and reporting processes used to calculate the performance measure rates by the MCOs in accordance with 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 (Acute) 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 (Acute) program for CY 2021. DMAS identified a set of performance measures that the MCOs were required to calculate and report.

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

**Table B-1—CY 2022 Medallion 4.0 (Acute) 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 performance measure data collected by the MCO and determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure. A performance measure-specific review was performed on a subset of Medallion 4.0 (Acute) MCO performance measures, all part of quality withhold performance measures, to evaluate the accuracy of reported performance measure data. PMV results provided DMAS with MCO-specific performance measure designations to additional information for MCO quality withhold payments.

## 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 performance measures that were selected by DMAS for validation.

HSAG then prepared a document request letter that was submitted to the MCOs outlining the steps in the PMV process. The document request letter included a request for source code/software programming or process steps used to generate the performance measure data element values for each performance measure, a completed 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 performance measures 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 performance measures. The ISCAT supplemented the information included in the Roadmap and addresses data collection and reporting specifics of non-HEDIS measures. HSAG used responses from the Roadmap and ISCAT to complete the pre-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 performance measures reported using the hybrid method. In addition, HSAG requested that the MCOs submit the following documentation for review: medical record abstraction tools and instructions, training materials for 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 performance measure. HSAG followed NCQA’s guidelines to validate the integrity of the MRRV processes used by the MCOs and determined if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for performance measures**—The MCOs that calculate the performance measures using internally developed source code will be required to submit source code for each performance measure being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the performance measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the performance measure and assessing the degree of bias (if any). MCOs that do not use source code were required to submit documentation describing the steps taken for performance measure calculation. If the MCOs outsourced programming for HEDIS performance measure production to an outside vendor, the MCOs were required to submit the vendor’s NCQA performance measure certification reports.
- **Supporting documentation**—HSAG requested documentation that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, performance measure 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 (Acute) and CCC Plus (MLTSS) 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 performance measures. The purpose of the PMV, required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation**—This session was designed to be interactive with key MCO staff so that the validation team obtains a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and can evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain if written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes**—The evaluation includes a review of the 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 performance measures. Key staff may include executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generation of the performance measures. HSAG used these interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—This session included a review of the IS and evaluation of processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

HSAG performed additional validation using 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 performance measures to verify that the MCOs have system documentation that supports that the MCO appropriately includes records for performance measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error, and as a result no additional cases related to that issue may be reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—At the end of each 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 performance measure rates submitted by the MCOs to DMAS and followed up with each MCO on any outstanding issues identified during the documentation review and/or during the 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 (Acute) for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. CMS EQR Protocol 2 identifies possible validation results for performance measures, defined in Table B-2.

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

Designation	Description
Reportable (R)	Performance measure 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 performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of errors detected within each audit element. It is possible for an audit element to receive a validation result of DNR when the impact of even a single error associated with that element biased the reported performance measure rate by more than 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 performance measure DNR.

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

**Table B-3—Performance Measure List for SFY 2023**

Performance Measure	Specifications	Method*
<i>Asthma Admission Rate (Per 100,000 Member Months)</i>	AHRQ PDI	Admin
<i>Blood Pressure Control for Patients With Diabetes</i>	HEDIS MY 2022	Hybrid
<i>Child and Adolescent Well-Care Visits</i>	HEDIS MY 2022	Admin
<i>Childhood Immunization Status—Combination 3</i>	HEDIS MY 2022	Hybrid
<i>Eye Exam for Patients With Diabetes</i>	HEDIS MY 2022	Hybrid
<i>Follow-Up After ED Visit for Mental Illness</i>	HEDIS MY 2022	Admin
<i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes</i>	HEDIS MY 2022	Hybrid
<i>Prenatal and Postpartum Care</i>	HEDIS MY 2022	Hybrid

\* The 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:
<b>Activity 1:</b>	<b>Establish Compliance Thresholds</b>
	<p>Conducted before the review to assess compliance with federal managed care regulations and DMAS contract requirements:</p> <ul style="list-style-type: none"> <li>a. HSAG and DMAS participated in virtual meetings to determine the timing and scope of the reviews, as well as scoring strategies.</li> <li>b. HSAG collaborated with DMAS to develop monitoring tools, record review tools, report templates, agendas, and set review dates.</li> <li>c. HSAG submitted all materials to DMAS for review and approval.</li> <li>d. HSAG conducted training for all reviewers to ensure consistency in scoring across the MCOs.</li> </ul>
<b>Activity 2:</b>	<b>Perform Preliminary Review</b>
	<ul style="list-style-type: none"> <li>• 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.</li> <li>• HSAG confirmed a primary MCO contact person for the review and assigned</li> </ul>



For this protocol activity,	HSAG completed the following activities:
	<p>HSAG reviewers to participate.</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> </ul>
<b>Activity 3:</b>	<b>Conduct MCO Review</b>
	<ul style="list-style-type: none"> <li>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.</li> <li>HSAG requested, collected, and reviewed additional documents, as needed.</li> <li>At the close of the virtual review, HSAG provided MCO staff members and DMAS personnel an overview of preliminary findings.</li> </ul>
<b>Activity 4:</b>	<b>Compile and Analyze Findings</b>
	<ul style="list-style-type: none"> <li>HSAG used the CY 2020–2021 DMAS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities.</li> <li>HSAG analyzed the findings and calculated final scores based on DMAS-approved scoring strategies.</li> <li>HSAG determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.</li> </ul>
<b>Activity 5:</b>	<b>Report Results to DMAS</b>
	<ul style="list-style-type: none"> <li>HSAG populated the DMAS-approved report template.</li> <li>HSAG submitted the draft report to DMAS for review and comment.</li> <li>HSAG incorporated the DMAS comments, as applicable, and submitted the draft report to the MCO for review and comment.</li> </ul>

For this protocol activity,	HSAG completed the following activities:
	<ul style="list-style-type: none"> <li>• HSAG incorporated the MCO’s comments, as applicable, and finalized the report.</li> <li>• 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 <i>Not Met</i>).</li> <li>• HSAG distributed the final report to the MCO and DMAS.</li> </ul>

### **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	✓	✓	✓

# Cardinal Care Program Readiness Review Methodology

## Introduction

DMAS is the single state agency that administers the Medicaid managed care program in the Commonwealth of Virginia. In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department’s FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program will achieve a single streamlined system of care that links seamlessly with the FFS program. The Cardinal Care program will ensure an efficient and well-coordinated Virginia Medicaid delivery system that provides high-quality, equitable care to its members, and adds value for its providers and the Commonwealth.

The transition to Cardinal Care is planned for January 1, 2023. Cardinal Care will merge the CCC Plus (MLTSS) program and the Medallion 4.0 (Acute) program and rebrand the Medicaid program as the Cardinal Care program. Table B-7 contains a list of the MCOs that will serve the members enrolled in the Cardinal Care program. The transition to the Cardinal Care program will retain the MCOs that served the members prior to the program transition.

**Table B-7—Cardinal Care Program MCOs**

MCOs
Aetna
HealthKeepers
Molina
Optima
United
VA Premier

## Federal Readiness Review Requirements

42 CFR §438.66 describes the state monitoring requirements, including MCO readiness reviews, when states implement a managed care program or when an MCO entity currently contracting with the state will provide or arrange for the provision of covered benefits to new eligibility groups. The regulation further states that the readiness review must be started at least three months prior to the contract effective date and that the results must be submitted to CMS for approval.

HSAG conducts readiness reviews for each of the MCOs to evaluate the MCOs’ ability and capacity to comply with the federal and State Medicaid Cardinal Care program requirements. The readiness reviews rely heavily on reviewing real-time data and processes and assessing the MCOs’ preparedness to fulfill future functions required for the success of the Cardinal Care program. The readiness reviews conducted by HSAG assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions outlined in CMS requirements and provisions in the Commonwealth’s contract with the MCOs.

The readiness reviews standards completed by HSAG are based on CMS requirements and are conducted in compliance with the CMS EQR *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, October 2019.<sup>3</sup> HSAG utilizes the protocol to guide the review of each MCO and assess each MCO's ability to meet the readiness review requirements and report on the findings.

## Objectives

The primary objective of the Cardinal Care program readiness reviews conducted by HSAG is to assess the ability and the capacity of the MCOs to perform satisfactorily in key operational and administrative functions, service delivery, and systems management. The readiness review includes a robust review of the MCOs' administrative, operational, and function capacities to fully implement the Cardinal Care program requirements by January 2023. The MCOs are expected to remediate deficiencies that HSAG and DMAS deem critical prior to the January 2023, program implementation.

To accomplish these objectives, HSAG, in collaboration with DMAS, defines the scope of the review by conducting an evaluation and prioritization of the following:

- Commonwealth of Virginia Cardinal Care program MCO contractual requirements
- 2020 Federal Managed Care Final Rule readiness review requirements

## Readiness Review Process

As required in 42 CFR §438.66(d), HSAG's readiness review process includes an assessment of the ability and capacity of the MCOs to perform satisfactorily, specifically in relation to the Cardinal Care program requirements, in the following required functional and organizational areas:

- Operations/administration
  - Administrative staffing and resources
  - Delegation and oversight of MCO entity responsibilities
  - Enrollee and provider communications
  - Grievances and appeals
  - Member services and outreach
  - Provider network management
  - Program integrity/compliance
- Service delivery, including
  - Case management/care coordination/service planning
  - Quality improvement
  - Utilization review
- Systems management, including
  - Claims management

---

<sup>B-3</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, October 2019. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf> Accessed on: May 4, 2022.

- Encounter data
- Enrollment information management

HSAG uses the results of the MCOs' 2021 CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs to reduce MCOs' and DMAS' burden and duplication of review activities. The readiness review include a focus on:

- 2021 MCO OSR identified deficiencies (Not Met) and implementation of corrective action plans
- MCO operational and administrative changes implemented for the Cardinal Care program requirements
- Updated policies and procedures that reflect the MCO Cardinal Care contract requirements
- Anticipated staffing changes
- System changes

### **Model of Care Readiness Review**

HSAG's readiness review process includes a readiness review of the MCOs' readiness to implement the DMAS Model of Care for the following populations:

- CCC Plus Waiver members receiving PDN
- Children receiving PDN through EPSDT
- Ventilator-dependent members (by setting)

The review includes the DMAS requirement that the MCOs' implementation plans for the Model of Care includes:

- Strategy for how members will be identified—new and current
- Staffing plan and care manager assignment process or procedure
- Process for how the care manager will follow the member through transitions
- Summary of updated MCO contract Model of Care policies and procedures
- Clinical documentation and alerts procedure
- Care management policies and procedures to ensure Model of Care requirements have been updated to reflect the Cardinal Care program Model of Care requirements

HSAG conducts follow-up with the MCOs to ensure all gaps or deficiencies that have the potential to impact the ability of the MCO to be ready to serve the Cardinal Care population on the go-live date are satisfactorily addressed.

### **Technical Methods of Data Collection**

The HSAG readiness review methodology aligns with the guidelines and processes set forth in CMS' *EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, October 2019. Utilizing the CMS EQR protocol, HSAG will assess each MCO's readiness to serve the Cardinal Care program members, compliance with the Medicaid Managed Care Rule requirements, and the MCO's contract requirements. HSAG reports on the findings.

## Planning Review Activities

This methodology document represents the initial planning activities for the readiness review. Upon DMAS' approval of the methodology and high-level timeline, HSAG will proceed with creating the readiness review tools with the Cardinal Care program requirements. HSAG will utilize results and findings from the 2021 CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs. HSAG will collaborate with DMAS regarding the standards and elements included in the desk review tools for the Cardinal Care program readiness review. HSAG will develop an MCO kick-off readiness review webinar. The webinar will contain an overview of the HSAG readiness review processes, timeline, documentation submission requirements, and the readiness review tools.

## Description of Data Obtained

To assess the MCOs' compliance with the CMS Final Rule requirements and the MCOs' readiness to implement the Cardinal Care program requirements as defined in the MCO contracts, HSAG will review information from a wide range of written documents including, but not limited to, the following:

- Results of the CCC Plus (MLTSS) 2021 OSRs
- Results of the Medallion 4.0 (Acute) 2021 OSRs
- MCO CAPs and follow-up activities
- MCO updates specific to the Cardinal Care program requirements including:
  - Updated policies, procedures, and processes specific to the Cardinal Care program
  - Organizational staffing plans and organization structure
  - Call Center and claims processing staffing plans
  - Training and coordination schedule and curriculum
  - Cardinal Care program Model of Care requirements
  - Member information updated with Cardinal Care program information and requirements
  - Provider information updated with Cardinal Care program benefits and requirements
  - Provider, subcontractor, and vendor contracts as applicable to Cardinal Care program requirements
  - MCO websites
  - Network data and information
  - Narrative and/or data reports across performance and content areas focused on the Cardinal Care program requirements

HSAG will obtain additional information for the readiness review through virtual discussions and interviews with the MCOs' key staff members and subject matter experts, as necessary.

## Communication With the MCOs

HSAG will establish early communication with the MCOs through written notice of the readiness reviews and dates for the kick-off webinars. HSAG will manage ongoing communications with the MCOs and provide technical assistance throughout the readiness review process. HSAG will schedule interviews of MCO staff, if determined necessary, to ensure implementation of the MCOs' Cardinal Care program implementation plans. DMAS will be provided for review and approval all MCO-wide communications.



## Document Submission

HSAG will require the MCOs to populate the focused readiness review tools with supporting documentation (evidence of readiness) and upload the source documents to the secure HSAG Virginia SharePoint site or the HSAG SAFE site on or before the desk review tool submission deadline. MCOs will be required to highlight or annotate compliant information within submissions to streamline the review purposes.

## How Data Were Aggregated and Analyzed

The evaluation phase will consist of a desk review of documentation submitted by the MCOs, virtual staff interviews, as necessary, and the assignment of readiness review scores.

## Desk Review Process

Upon receipt of the desk review tools, the MCOs will have three weeks to submit the completed desk readiness review tool and supporting documentation. Upon receipt of the desk review materials, the HSAG review team will conduct the desk reviews.

The HSAG project leader will conduct training of the readiness review team. The training for the reviewers is intended to ensure quality and consistency with the ratings, maintain review process efficiencies, and provide DMAS and the MCOs with actionable feedback. The HSAG review team will conduct in-depth desk reviews that include MCO submitted documentation and results of the previous CCC Plus (MLTSS) and Medallion 4.0 (Acute) OSRs. The reviewers are required to have the preliminary desk review findings and lists of follow-up items and interview questions prepared for any MCO follow-up conference calls or virtual meeting reviews that are needed.

## How Conclusions Were Drawn

From a review of documents, observations, and interviews with key staff members during the readiness review, the HSAG reviewers assign a score for each element and an aggregate score for each standard in the Readiness Review Evaluation Tool. Each element will be given a score of *Met* or *Not Met*.

HSAG's scoring is based upon the following:

- **MET** indicates full compliance or readiness defined as **all of** the following:
  - All documentation was present and updated to include Cardinal Care program requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) contained sufficient information to ascertain how the MCO met this requirement.
  - The documentation included appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members provided responses consistent with the policies and/or processes described in documentation.

- **NOT MET** indicates noncompliance defined as **any of** the following:
  - A substantive portion of the documentation was not updated with Cardinal Care program requirements, was unclear, or contained conflicting information that did not address the regulatory and/or contractual requirements.
  - The documentation (whether it was a policy, procedure, diagram, or some other form of communication) did not contain the information needed to ascertain how the MCO met this requirement.
  - The documentation did not have the appropriate identification that signified the functional area(s) or organization(s) responsible for carrying out the specifics outlined in the document.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory and/or contractual provisions.
  - For those elements with multiple components, key components of the element could be identified; and, if the reviewer was unable to assess the MCO's ability and capacity to meet the requirement based upon the information submitted, any deficiencies identified could result in an overall finding of *Incomplete* regardless of the findings noted for the remaining components.

If the MCO receives a **NOT MET** score for an element and is required to submit a CAP prior to Cardinal Care program implementation, HSAG's criteria for evaluating the sufficiency of the CAPs include:

- The completeness of the CAP in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The appropriateness of the timeline for correcting the deficiency.

CAPs that do not meet the above criteria will require resubmission to HSAG and technical assistance calls with the MCO, as needed, until the CAPs are approved.

From the scores HSAG reviewers assign for each of the requirements, HSAG calculates a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards.

## Deliverables

The readiness reviews deliverables will include:

- Approved timeline
- Review tools and scoring methodology
- Kick-off readiness review webinar with the MCOs
- MCO-specific readiness review reports
- Corrective action plan templates

Throughout the readiness review process, HSAG will provide technical assistance as requested or when a need is identified.

HSAG will produce MCO-specific reports and forward the reports to DMAS for initial review. Upon DMAS' approval of the reports, HSAG will finalize the reports and distribute to the MCOs along with CAP templates for the MCOs to complete and submit back to HSAG for review. HSAG will review and evaluate the MCO CAP submissions, make recommendations for acceptance of CAPs, and review follow-up documentation submitted by the MCOs to show evidence of implementation of the CAPs.

HSAG will conduct regular monitoring and follow-up to ensure MCO readiness review requirements have been met prior to the Cardinal Care program implementation date (January 2023). HSAG will work closely with DMAS regarding any identified concerns that indicate an MCO may not meet the federal and DMAS requirements to go live with the Cardinal Care program on January 1, 2023.

## Encounter Data Validation Methodology

### Overview

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCOs to accurately and effectively monitor and improve the quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to DMAS' overall management and oversight of its Medicaid managed care program.

### Methodology

During SFY 2022–2023, DMAS contracted with HSAG to conduct an EDV study. In alignment with CMS EQR Protocol 5. *Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023,<sup>B-4</sup> HSAG conducted the following two core evaluation activities:

- IS review—assessment of DMAS' and the MCOs' information systems and processes.
- Comparative analysis—analysis of DMAS' electronic encounter data completeness and accuracy through a comparison between DMAS' electronic encounter data and the data extracted from the MCOs' claims payment data systems.

HSAG conducted the EDV study for the six Medallion 4.0 (Acute) MCOs displayed in Table B-8.

---

<sup>B-4</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: June 20, 2023.

**Table B-8—Medallion 4.0 (Acute) MCOs**

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

### Information Systems Review

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

#### Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DMAS. Documents requested for review included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, work group meeting minutes, and DMAS’ current encounter data submission requirements, among others. The information obtained from this review is important for developing a targeted questionnaire to address important topics of interest to DMAS.

#### Stage 2—Development and Fielding of a Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the MCOs’ most recent ISCA collected through CMS *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.<sup>B-5</sup> This process allows the IS review activity to be coordinated across projects, preventing duplication and minimizing the impact on the MCOs. HSAG then developed a questionnaire customized in collaboration with DMAS to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Lastly, since HSAG conducted an IS review two years ago, this review included specific topics of interest to DMAS. For example, HSAG included DMAS staffing and encounter quality monitoring reports for MCOs’ subcontractors as focus areas in the questionnaire.

#### Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DMAS and MCO information technology personnel to clarify any questions from the questionnaire responses. Overall, the IS review

<sup>B-5</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: June 20, 2023.

allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

## Comparative Analysis

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to DMAS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' claims payment data systems. This step corresponds to another important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data. In this activity, HSAG developed a data requirements document requesting encounter data from both DMAS and the MCOs. To help the MCOs prepare data for the EDV study, HSAG added a section regarding data extraction tips to the data requirements document. A follow-up technical assistance session occurred approximately one week after distributing the data requirements document to the MCOs, thereby allowing the MCOs time to review and prepare their questions for the session.

HSAG used data from both DMAS and the MCOs with dates of service between January 1, 2022, and December 31, 2022, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represent the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters with MCO adjustment/paid dates on or before April 30, 2023, and submitted to DMAS on or before May 31, 2023. This anchor date allowed enough time for the encounters in the study period to be submitted, processed, and available for evaluation in the DMAS data warehouse.

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

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields were present on the file and had values in those fields.
- Percentage of valid values—The values included were the expected values (e.g., valid ICD-10 codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DMAS' data warehouse and the MCOs' data submitted to HSAG.

Based on the preliminary file review results, HSAG generated a report that highlighted major findings requiring the MCOs to resubmit data, as needed.

Once HSAG received and processed the final set of data from DMAS and each MCO, HSAG conducted a series of comparative analyses, which were divided into two analytic sections. First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in DMAS' data warehouse (record omission).
- The number and percentage of records present in DMAS' data warehouse but not in the MCOs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table B-9. The analyses focused on an element-level comparison for each data element.

**Table B-9—Key Data Elements for Comparative Analysis**

Key Data Elements	Professional	Institutional	Pharmacy
Member ID	✓	✓	✓
Detail Service From Date	✓	✓	✓
Detail Service To Date	✓		✓
Header Service From Date		✓	
Header Service To Date		✓	
Billing Provider NPI	✓	✓	✓
Rendering Provider NPI	✓		
Attending Provider NPI		✓	
Servicing Provider Taxonomy Code	✓	✓	
Prescribing Provider NPI			✓
Referring Provider Number/NPI	✓	✓	
Primary Diagnosis Code	✓	✓	
Secondary Diagnosis Codes	✓	✓	
Procedure Code	✓	✓	
Procedure Code Modifiers	✓	✓	
Surgical Procedure Codes		✓	
NDC	✓	✓	✓
Drug Quantity	✓	✓	✓
Revenue Code		✓	
DRG		✓	
Type of Bill Codes		✓	
Header Paid Amount	✓	✓	
Header TPL Paid Amount	✓	✓	
Detail Paid Amount	✓	✓	✓
Detail TPL Paid Amount	✓	✓	✓
MCO Received Date (i.e., the date when the MCOs received claims from providers)	✓	✓	✓
MCO Paid Date	✓	✓	✓

For the matching records between DMAS’ data and the MCOs’ data from the first step, HSAG then evaluated the element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs’ submitted files but not in DMAS’ data warehouse (element omission).
- The number and percentage of records with values present in DMAS’ data warehouse but not in the MCOs’ submitted files (element surplus).



- The number and percentage of records with values missing from both DMAS' data warehouse and the MCOs' submitted files (element missing values).

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and DMAS' data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCOs' submitted files and DMAS' data warehouse (element accuracy).

For the records present in both DMAS' data and the MCOs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (all-element accuracy).

Additionally, results were stratified by subcontractor as needed to provide a better understanding of the aggregate results by distinguishing data anomalies that may only pertain to a specific subcontractor.

## 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 CCC Plus (MLTSS) MCOs (Aetna, HealthKeepers, Molina, Optima, United, and VA Premier) with their MCO and healthcare.

### *Technical Methods of Data Collection*

For the CCC Plus (MLTSS) 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.<sup>B-6</sup> 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 and United 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

---

<sup>B-6</sup> Aetna, HealthKeepers, Molina, Optima, United, and VA Premier administered the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set to their child Medicaid populations. For purposes of this report, the child Medicaid CAHPS results presented for the MCOs represent the CAHPS results for their general child populations (i.e., general child CAHPS results).



followed to select members and distribute surveys.<sup>B-7</sup> These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. Each MCO provided HSAG with its NCQA Summary Reports of adult and child Medicaid CAHPS survey results (i.e., summary report produced by NCQA of calculated CAHPS results) and raw data files for purposes of reporting.

The CAHPS 5.1H Surveys include a set of standardized items (40 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with the Children with Chronic Conditions measurement set) that assess members' perspectives on care. For the MCOs, the CAHPS survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite scores. The global ratings reflected members' overall experience with their health plan, all health care, 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 were "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 survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered from January to May 2022 for the CCC Plus (MLTSS) MCOs.

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. For the CAHPS 5.1H Adult Medicaid Health Plan Survey, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 10, 19, 23, and 28. For the CAHPS 5.1H Child Medicaid Health Plan Survey with the CCC measurement set, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 25, 40, 44, and 49. Eligible members included the entire sample minus ineligible members. For the adult population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated. For the child population, ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

---

<sup>B-7</sup> Aetna and HealthKeepers contracted with CSS; and Molina, Optima, United, and VA Premier contracted with SPH Analytics to conduct the CAHPS survey administration, analysis, and reporting of survey results for their respective adult and child Medicaid populations.

## How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the FY 2022 top-box scores were compared to their corresponding FY 2021 top-box scores to determine whether there were statistically significant differences. Statistically significant differences are noted with directional triangles. Scores that were statistically significantly higher in FY 2022 than FY 2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2022 than FY 2021 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, the 2022 top-box scores for each MCO and the statewide aggregate were compared to the 2021 NCQA Medicaid national averages.<sup>B-8,B-9,B-10</sup> 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.

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.

## 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-10.

**Table B-10—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains**

	Quality	Timeliness	Access
<b>Global Ratings</b>			
<i>Rating of Health Plan</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Personal Doctor</i>	✓		

<sup>B-8</sup> For the NCQA 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.

<sup>B-9</sup> National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA, September 2021.

<sup>B-10</sup> NCQA national averages were not available for 2022 at the time this report was prepared; therefore, 2021 national data are presented.

	Quality	Timeliness	Access
<i>Rating of Specialist Seen Most Often</i>	✓		
<b>Composite Measures</b>			
<i>Getting Needed Care</i>	✓		✓
<i>Getting Care Quickly</i>	✓	✓	
<i>How Well Doctors Communicate</i>	✓		
<i>Customer Service</i>	✓		

## PCP Secret Shopper Methodology

### Overview

DMAS contracted with HSAG, to conduct a secret shopper telephone survey of appointment availability to collect information on members’ access to primary care services under the VA Medicaid managed care program. A secret shopper is a person employed to pose as a patient to evaluate the quality of customer service or the validity of information (e.g., location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

HSAG evaluated appointment availability information among PCPs enrolled with the Virginia Medicaid MCOs to address the following survey objectives:

- Determine whether primary care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker’s data.
- Determine whether primary care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled primary care service location for urgent and routine primary care services.

HSAG used a DMAS-approved survey script to complete calls to all sampled provider locations during January and February 2023, recording survey responses in an electronic data collection tool.

### Eligible Population

The eligible population included PCPs actively enrolled with one or more Virginia Medicaid MCO as of November 1, 2022. Using DMAS-approved data request materials, the DMAS enrollment broker identified providers potentially eligible for survey inclusion and submitted the PCP data files to HSAG. The enrollment broker was asked to ensure that the PCP data included out-of-state providers contracted to serve Virginia Medicaid managed care members (i.e., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Eligible PCPs were identified based on the PCP flag, provider specialty, and whether they accepted new patients. Provider types and specialties considered for the study included, but were not limited to the following:

- Provider type: MD, DO, Nurse Practitioner, Physician Assistant
- Provider specialties: Primary Care, Family Medicine, General Practice, Internal Medicine, Geriatric Medicine, Adolescent Medicine, Pediatrics, Preventive Medicine

HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, telephone number, provider name, and service street address. HSAG standardized provider address data to align with the United States Postal Service Coding Accuracy Support System to identify potential data concerns with street addresses and to facilitate deduplication.

## ***Sampling Approach***

The following random sampling approach was used to generate a list of primary care service locations (i.e., “cases”) from each MCO for inclusion in the survey:

- **Step 1:** HSAG assembled the sample frame using records from all primary care service locations identified for each MCO.<sup>B-11</sup>
  - Out-of-state service locations with service addresses in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington, DC were included in the sample frame.
  - In order to minimize the number of repeat phone calls to providers, HSAG identified service locations using unique telephone numbers.
- **Step 2:** HSAG used the sample frame to determine a statistically valid number of unique service locations based on a 95 percent confidence level and  $\pm 5$  percent margin of error.
- **Step 3:** The calculated sample size for each MCO was proportionately split across the six regional geographic area assignments based on the number of providers in the sample frame for each region. The sample size calculated at the region level was used for sampling the providers equally among urgent and non-urgent appointment scenarios. The six regional geographic area assignments are listed below:
  - Region 1: Tidewater
  - Region 2: Central
  - Region 3: Western/ Charlottesville
  - Region 4: Roanoke/ Alleghany
  - Region 5: Southwest
  - Region 6: Northern/ Winchester

## ***Telephone Survey Process***

HSAG’s secret shopper callers collected survey responses using a standardized script approved by DMAS. Callers were instructed to conduct the survey as though they had moved to the area and were trying to arrange an appointment for themselves or a family member. Due to the secret shopper nature

---

<sup>B-11</sup> Provider locations may be included in the eligible population for the prenatal care and PCP survey if the provider location is identified as having providers meeting the criteria for prenatal care providers and PCPs.

of the calls, callers may have improvised during actual calls as needed. Callers were instructed not to leave voicemail messages or schedule appointments.

Callers made two attempts to contact each survey case during standard business hours (i.e., 9:00 a.m. to 5:00 p.m. Eastern Time).<sup>B-12</sup> If the caller was put on hold at any point during the call, they waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical provider, practice, or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the caller was put on hold for more than five minutes or the call was answered by an automated voicemail or answering service that prevented the caller from speaking with office staff).

## Survey Indicators

HSAG classified survey indicators into domains that consider provider data accuracy and appointment availability by MCO. Provider data accuracy was evaluated based on survey responses. In general, matched information received a “Yes” response and nonmatched information received a “No” response. For data collected on the first available appointment, the average wait time was calculated based on call date and earliest appointment date. HSAG also assessed appointment availability in relation to DMAS’ primary care appointment standards for urgent and routine care:

- Appointments for urgent symptomatic visits (e.g., sore throat without a fever) shall be scheduled within 24 hours<sup>B-13</sup> of request.
- Appointments for routine visits (e.g., annual well-check appointment) shall be scheduled within 30 calendar days of request.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location’s identification as offering services for the designated provider domain or specialty category
- Affiliation with the requested MCO

---

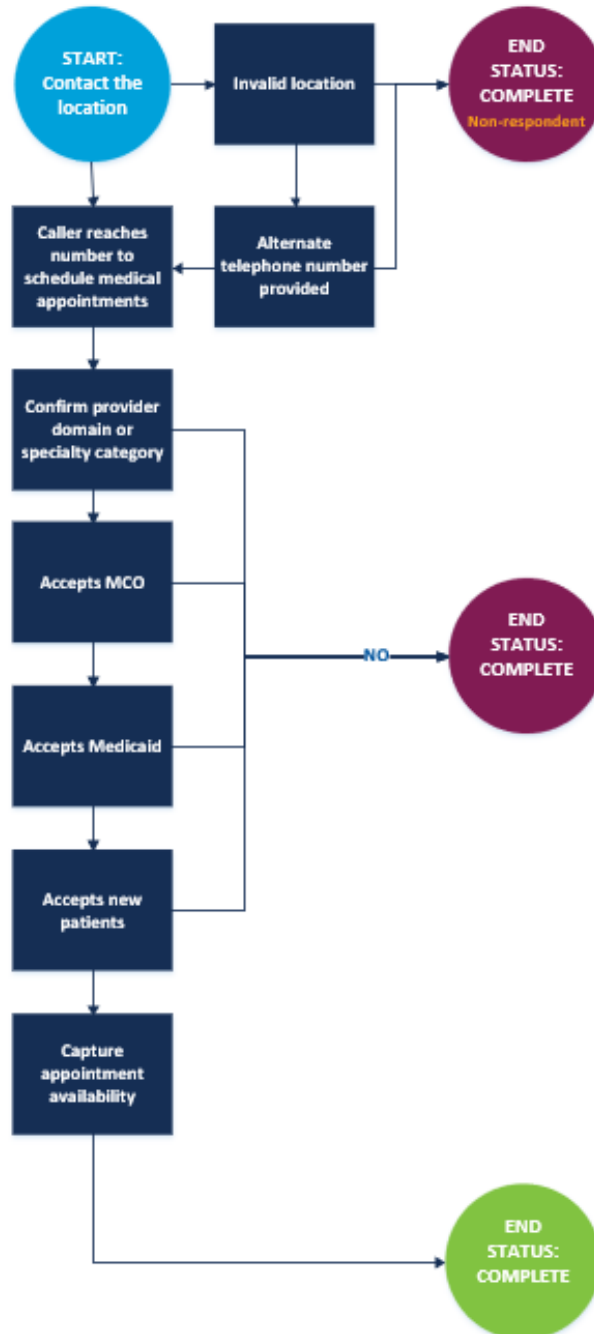
<sup>B-12</sup> HSAG did not consider a call attempted when the caller reached an office outside of the office’s usual business hours. For example, if the caller reached a recording that stated that office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The caller attempted to contact the office up to two times outside of the known lunch hour.

<sup>B-13</sup> For the purposes of the secret shopper survey, HSAG assumed appointments were within the standards if they were scheduled within one business day since follow-up with urgent care or emergency clinics cannot be assessed.

- Accuracy of accepting VA Medicaid managed care

Figure B-1 outlines the decision stop points throughout the survey.

**Figure B-1—Survey Decision Stop Points**



HSAG collected the following access-related information when calling sampled locations:

- Information on whether the location accepted new patients
- Date until the next available new patient appointment for an urgent or routine visit at the sampled service location with any individual practitioner at the sampled service location
- Any considerations to scheduling an appointment; this included the service location requiring:
  - Personal information or preregistration with the practice
  - Patients to complete a questionnaire
  - A review of the member’s medical records
  - Verification of the member’s insurance eligibility

## MCO Comparative and Statewide Calculation of Additional Performance Measure Results <sup>B-14</sup>

### ***Performance Overview***

Virginia DMAS contracts with HSAG to calculate one performance measure as part of the Task J—Performance Measure Calculation activity. For the CY 2022 performance measure calculation activity, DMAS requested that HSAG calculate the *MLTSS-8* performance measure. This document provides an overview of the methodology for the CY 2022 *MLTSS-8* performance measure rate calculation.

### ***Performance Measure***

For the CY 2022 performance measure calculation, HSAG calculated the *MLTSS-8* performance measure, which measures the proportion of long-term facility stays (i.e., stays at least 101 days long) among members 18 years of age and older that resulted in a successful transition to the community (i.e., the member was in the community for 60 or more days). HSAG followed the 2022 CMS *Medicaid MLTSS Measures Technical Specifications and Resource Manual*. <sup>B-15</sup>

### ***Performance Period***

In 2023, HSAG calculated the *MLTSS-8* measure rates for CY 2022 using data collected by DMAS and submitted to HSAG.

### ***Data Collection***

The *MLTSS-8* performance measure was calculated using administrative data sources, including demographic, enrollment, professional claims/encounters, and institutional claims/encounters, for

---

<sup>B-14</sup> Note: This methodology is presented as it appeared in the final report for this activity.

<sup>B-15</sup> 2022 Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual. Available at: <https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf>. Accessed on: Oct 19, 2023.



Medicaid eligible individuals. DMAS supplied SAS® data sets extracted by claims’ paid dates. <sup>B-16</sup> HSAG retrieved the data files from DMAS’ SFTP site.

HSAG used SAS software to perform all analytics. Upon receiving the data, HSAG confirmed the reasonability and completeness of the data.

### Performance Measure Calculation

HSAG developed SAS program code to calculate the measure rates following the performance measure specifications. A lead analyst and validation analyst independently calculated the *MLTSS-8* measure rates. The lead analyst produced the production programming code to generate the results and output for DMAS. In parallel with the work that was performed by the lead analyst, the validation analyst created a separate code and confirmed the rates generated by the lead analyst. The Director overseeing performance measure calculations performed a final review of the rates, which included a rate review by the Chief Data Officer, as necessary. Prior to the rate deliverable submission, HSAG reviewed the final output for appropriate formatting and numerical reasonability.

HSAG calculated a Virginia total measure rate and stratified results by Medicaid Program, Medicaid Delivery System, MCO, and managed care geographic region using FIPS codes. In addition, rates were stratified by age, race, and gender. Table B-11 presents the *MLTSS-8* performance measure rate stratifications and values for Medicaid Program, Medicaid Delivery System, MCO, geographic region, age group, and gender.

**Table B-11—Medicaid Program, Medicaid Delivery System, MCO, Geographic Region, Age Group, and Gender Stratification Values**

Stratification	Values
Medicaid Program	<ul style="list-style-type: none"> <li>• CCC Plus (MLTSS)</li> <li>• Medallion 4.0 (Acute)</li> <li>• More than One Medicaid Program</li> </ul>
Medicaid Delivery System	<ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> <li>• More than One Delivery System</li> </ul>
MCO	<ul style="list-style-type: none"> <li>• Aetna Better Health of Virginia (Aetna)</li> <li>• HealthKeepers, Inc. (HealthKeepers)</li> <li>• Molina Complete Care of Virginia, LLC (Molina)</li> <li>• Optima Health (Optima)</li> <li>• UnitedHealthcare of the Mid-Atlantic, Inc. (United)</li> <li>• Virginia Premier Health Plan, Inc. (VA Premier)</li> <li>• More than One MCO</li> </ul>

<sup>B-16</sup> SAS is a registered trademark of the SAS Institute, Inc.

Stratification	Values
Geographic Regions	<ul style="list-style-type: none"> <li>• Central</li> <li>• Charlottesville/Western</li> <li>• Northern &amp; Winchester</li> <li>• Roanoke/Alleghany</li> <li>• Southwest</li> <li>• Tidewater</li> <li>• Unknown</li> </ul>
Age Groups	<ul style="list-style-type: none"> <li>• 18–44</li> <li>• 45–64</li> <li>• 65–74</li> <li>• 75–84</li> <li>• 85+</li> <li>• Total</li> </ul>
Gender	<ul style="list-style-type: none"> <li>• Male</li> <li>• Female</li> </ul>

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-12. Table B-12 presents the *MLTSS-8* performance measure race stratifications that were reported by HSAG with a crosswalk to DMAS’ race categories.

**Table B-12—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
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

Once rates were generated, HSAG produced a single Microsoft Excel workbook containing numerator, denominator, and rate results. HSAG denoted measure 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 also provided DMAS with a member-level file that included the member’s demographic information, risk adjustment information, and a numerator flag.

# Medicaid and CHIP Maternal and Child Health Focus Study Methodology<sup>B-17</sup>

## Project Overview

DMAS has contracted with HSAG since SFY 2015–2016, as their EQRO, to conduct an annual focus study that will provide quantitative information about prenatal care and associated birth outcomes among women with births paid by Title XIX or Title XXI, which includes the Medicaid, FAMIS MOMS, and Medicaid Expansion programs. The SFY 2021–2022 (Contract Year 1) Task I.1 Medicaid Maternal and Child Health Focus Study will address the following study questions:

- To what extent do women with births paid by Virginia Medicaid receive early and adequate prenatal care during pregnancy?
- What clinical outcomes (e.g., preterm births, low birth weight) are associated with births paid by Virginia Medicaid?
- What maternal health outcomes (e.g., depression) are associated with births paid by Virginia Medicaid?
- What health disparities exist in maternal and birth outcomes for births paid by Virginia 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 2021, regardless of whether the births occurred in Virginia. Births paid by Virginia Medicaid were assigned to one of four full-scope Medicaid program categories based on the mother's enrollment in the program at the time of delivery:

- 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 FAMIS MOMS program uses Title XXI (CHIP Demonstration Waiver) funding to serve pregnant women with incomes up to 200 percent<sup>B-18</sup> of the FPL and provides benefits similar to Medicaid through the duration of pregnancy and for 60 days postpartum.
- The “Other Aid Categories” include births paid by Medicaid or CHIP that do not fall into the three main categories of Medicaid for Pregnant Women, Medicaid Expansion, or FAMIS MOMS. Other Aid Categories include LIFC (parents and caretaker adults), disabled individuals, Medicaid Children, Foster Children and Former Foster Youth, Adoption Assistance Children, FAMIS Children, FAMIS

---

<sup>B-17</sup> Note: This methodology is presented as it appeared in the final report for this activity.

<sup>B-18</sup> A standard disregard of 5 percent FPL is applied if the woman's income is slightly above the FPL.

Prenatal Coverage, presumptively eligible individuals, and others. Other Aid Categories excludes births to women in Plan First, incarcerated individuals, and emergency only benefits.

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 immediately before or on the day of the delivery, and these individuals typically did not have access to Medicaid coverage and benefits earlier in their pregnancy, these births will be evaluated separately. Additionally, births to women enrolled in the FAMIS Prenatal Coverage program, which launched on July 1, 2021, will be included in the “Other Aid Categories” eligible population for this study. HSAG will also evaluate these births separately and provide DMAS with informational only results regarding this program for DMAS’ internal use.

## 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 2021. HSAG will submit the Finder’s File to DMAS with instructions for conducting two types of data linkages. DMAS will work with the VDH to obtain the birth registry data and conduct the following data linkages:

- DMAS will use probabilistic data linking to match HSAG’s list of women eligible for the study to birth registry records.
- 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 2021 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-13 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. Please note that the Maternal Health Outcome measures listed below will not be calculated for the emergency only population.

**Table B-13—Study Indicators†**

Indicator	Denominator	Numerator
<b>Birth Outcomes</b>		
<b>Births with Early and Adequate Prenatal Care</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with an Adequacy of Prenatal Care Utilization Index (i.e., the Kotelchuck Index) score greater than or equal to 80 percent, which includes the Adequate Plus category (greater than or equal to 110 percent).
<b>Births with Inadequate Prenatal Care</b>	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.
<b>Births with No Prenatal Care</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with no prenatal care.
<b>Preterm Births (&lt;37 Weeks Gestation)*</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: <ul style="list-style-type: none"> <li>• Preterm: Less than 37 weeks               <ul style="list-style-type: none"> <li>– Late preterm: 34–36 weeks</li> <li>– Moderate preterm: 32–33 weeks</li> <li>– Very preterm: 28–31 weeks</li> <li>– Extremely preterm: &lt;28 weeks</li> </ul> </li> </ul>
<b>Newborns with Low Birth Weight (&lt;2,500 grams)</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: <ul style="list-style-type: none"> <li>• Overall low birth weight: &lt;2,500 grams               <ul style="list-style-type: none"> <li>– Moderately low birth weight: 1,500 grams–2,499 grams</li> <li>– Very low birth weight: &lt;1,500 grams</li> </ul> </li> </ul>
<b>Maternal Health Outcomes</b>		
<b>Postpartum Emergency Department (ED) Utilization</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ED services within 90 days of delivery.
<b>Postpartum Ambulatory Care Utilization</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 90 days of delivery.

Indicator	Denominator	Numerator
<b>Prenatal Screening, Brief Intervention, and Referral to Treatment (SBIRT)</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received an SBIRT evaluation during pregnancy.  The following codes are used to define an SBIRT evaluation: <ul style="list-style-type: none"> <li>• HCPCS Codes:               <ul style="list-style-type: none"> <li>– H0049</li> <li>– H0050</li> <li>– G0396</li> <li>– G0397</li> </ul> </li> <li>• CPT Codes:               <ul style="list-style-type: none"> <li>– 99408</li> <li>– 99409</li> </ul> </li> </ul>
<b>Postpartum SBIRT</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received an SBIRT evaluation on or between 7 and 84 days after delivery.  The same SBIRT codes used for the Prenatal SBIRT measure will be used for the Postpartum SBIRT measure.
<b>Prenatal Maternal Depression Screening</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received a screening for depression during pregnancy.  The following codes are used to define maternal depression screening: <ul style="list-style-type: none"> <li>• Managed Care Codes:               <ul style="list-style-type: none"> <li>– 96127</li> <li>– 96160</li> <li>– 96161</li> <li>– 99401</li> <li>– 99402</li> <li>– 99403</li> <li>– 99404</li> <li>– G0444</li> <li>– G9000</li> <li>– G9001</li> </ul> </li> <li>• FFS Codes:               <ul style="list-style-type: none"> <li>– 96127</li> <li>– 96169</li> <li>– 96161</li> </ul> </li> </ul>

Indicator	Denominator	Numerator
<b>Postpartum Maternal Depression Screening</b>	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of women who received a screening for depression on or between 7 and 84 days after delivery.  The same maternal depression screening codes used for the Prenatal Maternal Depression Screening measure will be used for the Postpartum Maternal Depression Screening measure.

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

<sup>\*</sup>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,<sup>B-19</sup> 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 2021 CMS Core Set benchmarks, if available, for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator.

HSAG will also present CY 2021 birth outcome study indicator results compared to historical results (i.e., CY 2019 and CY 2020), when available. Please note, HSAG will re-calculate historical study indicator results for the Other Aid Categories to include births to women in the LIFC program given that LIFC was previously reported separately for CY 2019 and CY 2020. For CY 2021, 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 *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.

<sup>B-19</sup> 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: Apr 13, 2022.



## Study Indicator Stratifications

HSAG will stratify the CY 2021 study indicator rates by the categories listed in Table B-14, on the page below. Please note, HSAG will re-calculate historical rates for the Medallion 4.0 (Acute) managed care program to include the FAMIS managed care program, given that FAMIS was previously reported separately for CY 2019 and CY 2020.

**Table B-14—Study Indicator Stratifications**

Stratification	Category Values
<b>Medicaid Program at Delivery<sup>^</sup></b>	<ul style="list-style-type: none"> <li>• Medicaid for Pregnant Women (Eligibility categories 091, 097)</li> <li>• Medicaid Expansion (Eligibility categories 100, 101, 102, 103, 106, and 108)</li> <li>• FAMIS MOMS (Eligibility category 005)</li> <li>• Other Aid Categories (will include all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS; will <u>exclude</u> births to women in Plan First [aid category: 080] and incarcerated individuals [aid category: 109])</li> </ul>
<b>Medicaid Delivery System at Delivery</b>	<ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> </ul>
<b>Managed Care Program at Delivery</b>	<ul style="list-style-type: none"> <li>• Medallion 4.0 (Acute) (will include FAMIS MOMS and FAMIS Children)</li> <li>• CCC Plus (MLTSS)</li> </ul>
<b>Managed Care Organization (MCO) at delivery</b>	<ul style="list-style-type: none"> <li>• Aetna Better Health of Virginia (Aetna)</li> <li>• HealthKeepers, Inc. (HealthKeepers)</li> <li>• Molina Complete Care (Molina)*</li> <li>• Optima Health (Optima)</li> <li>• UnitedHealthcare of the Mid-Atlantic, Inc. (United)</li> <li>• Virginia Premier Health Plan, Inc. (Virginia Premier)</li> </ul>
<b>Length of Continuous Enrollment Prior to Delivery</b>	<ul style="list-style-type: none"> <li>• ≤ 30 Days</li> <li>• 31–90 Days</li> <li>• 91–180 Days</li> <li>• &gt; 180 Days</li> </ul>

Stratification	Category Values
<p><b>Trimester of Prenatal Care Initiation</b></p> <p><i>Note: Defined from the birth registry data.</i></p>	<ul style="list-style-type: none"> <li>• First Trimester</li> <li>• Second Trimester</li> <li>• Third Trimester</li> <li>• No Prenatal Care</li> <li>• Unknown</li> </ul>
<p><b>Managed Care Region of Maternal Residence</b></p> <p><i>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.</i></p>	<ul style="list-style-type: none"> <li>• Central</li> <li>• Charlottesville/Western</li> <li>• Northern &amp; Winchester</li> <li>• Roanoke/Alleghany</li> <li>• Southwest</li> <li>• Tidewater</li> </ul>
<p><b>Maternal Race/Ethnicity</b></p> <p><i>Note: Defined from the birth registry data</i></p>	<ul style="list-style-type: none"> <li>• White, Non-Hispanic</li> <li>• Black, Non-Hispanic</li> <li>• Asian, Non-Hispanic</li> <li>• Hispanic, Any Race</li> <li>• Other/Unknown</li> </ul>

\*Where appropriate, HSAG will compare the CY 2021 results for Molina Complete Care to the CY 2019 and CY 2020 results for Magellan Complete Care of Virginia.

^ Please note that the Emergency-Only program will be displayed separately within the report.

In addition to the study indicator results and trending, HSAG will present the study indicator results stratified by MCO (Medallion 4.0 [Acute] and CCC Plus [MLTSS] combined), including MCO study indicator results stratified by demographics within the Findings Section of the report. HSAG will present program-specific (Medallion 4.0 [Acute] and CCC Plus [MLTSS]) 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: Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, or Other Aid Categories.
- The comparison group will include women enrolled in any of the four Medicaid programs (i.e., Medicaid for Pregnant Women, Medicaid Expansion, FAMIS MOMS, or Other Aid Categories) 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 four 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 2021 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 prenatal care initiation. Please refer to the category values defined in Table B-14 for more information regarding these stratifications.

### **Emergency Only Benefits**

For the emergency only benefits study indicator results, HSAG will stratify the CY 2021 results by maternal race/ethnicity, maternal age at delivery, and managed care region of maternal residence. Additionally, HSAG will compare the CY 2021 study indicators to the CY 2019 and 2020 study indicator results for the women covered by emergency only benefits. Please refer to the category values defined in Table B-14 for more information regarding these stratifications.

### **FAMIS Prenatal Coverage**

For the FAMIS Prenatal Coverage study indicator results for DMAS' internal use, HSAG will stratify the CY 2021 results by Medicaid delivery system, MCO, maternal race/ethnicity, maternal age at delivery, managed care region of maternal residence, length of continuous enrollment prior to delivery, and trimester of prenatal care initiation. Please refer to the category values defined in Table B-14 for more information regarding these stratifications. HSAG will provide DMAS with these results in an Excel spreadsheet.

## ***Health Disparities Analysis***

For the Maternal Race/Ethnicity stratification group, HSAG will perform an analysis to identify positive and negative health disparities for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* measures. For each stratified rate, the reference group will be the aggregated rate for all other stratifications within the stratification group (i.e., the rate for the White, Non-Hispanic group will be compared to the aggregate of all other race/ethnicity stratifications). The *p*-value of the coefficient from the logistic regression will be used to identify statistically significant differences when comparing the stratified rates to the reference groups.

For this report, a health disparity will be defined as a stratified rate with a  $p$ -value of the coefficient of the logistic regression that is less than 0.005.<sup>B-20</sup> When analyzing a given stratification, HSAG will classify the rate in one of the following three categories based on the preceding analyses:

- **Better Rate**
  - The  $p$ -value of the coefficient of the logistic regression is less than 0.005 and the stratified rate is higher or more favorable than the rate for the reference group. In other words, the reference group shows a health disparity compared to the stratification being evaluated.
- **Worse Rate**
  - The  $p$ -value of the coefficient of the logistic regression is less than 0.005 and the stratified rate is lower or less favorable than the rate for the reference group. In other words, the stratification being evaluated showed a health disparity compared to the reference group.
- **Similar Rate**
  - The  $p$ -value of the coefficient of the logistic regression is greater than or equal to 0.005. This means no health disparities are identified when the stratification was compared to the reference group.

### Member-Level Data File

HSAG will produce a member-level data file and Excel spreadsheet that DMAS can use for internal purposes. The member-level data file will include all data elements listed in Table B-15.

**Table B-15—Member-Level Data File**

Demographic Category	Category Values
<b>Singleton Birth Indicator</b>	<ul style="list-style-type: none"> <li>• Singleton</li> <li>• Multiple</li> </ul>
<b>Medicaid Program at Delivery</b>	<ul style="list-style-type: none"> <li>• Medicaid for Pregnant Women</li> <li>• Medicaid Expansion</li> <li>• FAMIS MOMS</li> <li>• Other Aid Categories</li> </ul>
<b>Comparative Analysis Population Group</b>	<ul style="list-style-type: none"> <li>• Study Population</li> <li>• Comparison Group</li> <li>• Not Applicable (NA)</li> </ul>
<b>Medicaid Delivery System at Delivery</b>	<ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> </ul>
<b>MCO at Delivery</b>	<ul style="list-style-type: none"> <li>• Aetna Better Health of Virginia (Aetna)</li> <li>• HealthKeepers, Inc. (HealthKeepers)</li> </ul>

<sup>B-20</sup> A  $p$ -value of the coefficient of the logistic regression less than 0.005 was chosen due to the anticipated large eligible populations for the measures.

Demographic Category	Category Values
	<ul style="list-style-type: none"> <li>• Molina Complete Care (Molina)</li> <li>• Optima Health (Optima)</li> <li>• UnitedHealthcare of the Mid-Atlantic, Inc. (United)</li> <li>• Virginia Premier Health Plan, Inc. (Virginia Premier)</li> </ul>
<b>MCO Enrollment</b>	<ul style="list-style-type: none"> <li>• Not enrolled with an MCO prior to delivery (e.g., FFS)</li> <li>• Enrolled with one MCO prior to delivery</li> <li>• Enrolled with more than one MCO prior to delivery</li> </ul>
<b>Continuous Enrollment</b>	<ul style="list-style-type: none"> <li>• The number of days continuously enrolled in Virginia Medicaid</li> </ul>
<b>Length of Continuous Enrollment Prior to Delivery</b>	<ul style="list-style-type: none"> <li>• ≤ 30 Days</li> <li>• 31–90 Days</li> <li>• 91–180 Days</li> <li>• &gt; 180 Days</li> <li>• Not continuously enrolled prior to delivery</li> </ul>
<b>Maternal Gravidity</b> <i>Note: Defined from the birth registry data.</i>	<ul style="list-style-type: none"> <li>• The number of pregnancies, including the current pregnancy</li> </ul>
<b>Trimester of Prenatal Care Initiation</b>	<ul style="list-style-type: none"> <li>• First Trimester</li> <li>• Second Trimester</li> <li>• Third Trimester</li> <li>• No Prenatal Care</li> <li>• Unknown</li> </ul>
<b>Managed Care Region of Maternal Residence</b> <i>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.</i>	<ul style="list-style-type: none"> <li>• Central</li> <li>• Charlottesville/Western</li> <li>• Northern &amp; Winchester</li> <li>• Roanoke/Alleghany</li> <li>• Southwest</li> <li>• Tidewater</li> <li>• Unknown/Missing</li> </ul>
<b>Maternal Race/Ethnicity</b> <i>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.</i>	<ul style="list-style-type: none"> <li>• White, Non-Hispanic</li> <li>• Black, Non-Hispanic</li> <li>• Asian, Non-Hispanic</li> <li>• Hispanic, Any Race</li> <li>• Other/Unknown</li> </ul>
<b>Maternal Age at Delivery</b>	<ul style="list-style-type: none"> <li>• 15 Years and Younger</li> </ul>

Demographic Category	Category Values
	<ul style="list-style-type: none"> <li>• 16–17 Years</li> <li>• 18–20 Years</li> <li>• 21–24 Years</li> <li>• 25–29 Years</li> <li>• 30–34 Years</li> <li>• 35–39 Years</li> <li>• 40–44 Years</li> <li>• 45 Years and Older</li> <li>• Unknown</li> </ul>
<p><b>Maternal Citizenship Status</b></p> <p><i>Note: Defined from DMAS’ demographic data.</i></p>	<ul style="list-style-type: none"> <li>• U.S. Citizen (Citizenship Status = “C”, “N”)</li> <li>• Documented immigrant (Citizenship Status = “E”, “I”, “P”, “R”)</li> <li>• Undocumented immigrant (Citizenship Status = “A”)</li> <li>• Other (Citizenship Status = “V”)</li> </ul>
<p><b>Emergency Only Benefits</b></p>	<ul style="list-style-type: none"> <li>• Emergency Only Benefits</li> <li>• NA</li> </ul>
<p><b>Maternal Asthma<sup>B-21</sup></b></p>	<ul style="list-style-type: none"> <li>• Asthma</li> <li>• No Asthma</li> <li>• NA</li> </ul>
<p><b>Maternal Diabetes<sup>B-22</sup></b></p>	<ul style="list-style-type: none"> <li>• Diabetes</li> <li>• No Diabetes</li> <li>• NA</li> </ul>
<p><b>Maternal Gestational Diabetes<sup>B-23</sup></b></p>	<ul style="list-style-type: none"> <li>• Gestational Diabetes</li> <li>• No gestational diabetes</li> <li>• NA</li> </ul>
<p><b>Prenatal Care (PNC) Index</b></p>	<ul style="list-style-type: none"> <li>• Adequate Plus PNC</li> <li>• Adequate PNC</li> <li>• Intermediate PNC</li> <li>• Inadequate PNC</li> <li>• Missing Info</li> </ul>

<sup>B-21</sup> Identification of asthma will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

<sup>B-22</sup> Identification of diabetes will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.

<sup>B-23</sup> 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
<p><b>Gestational Age</b></p>	<ul style="list-style-type: none"> <li>• Preterm: Less than 37 weeks               <ul style="list-style-type: none"> <li>– Late preterm: 34–36 weeks</li> <li>– Moderate preterm: 32–33 weeks</li> <li>– Very preterm: 28–31 weeks</li> <li>– Extremely preterm: &lt;28 weeks</li> </ul> </li> <li>• Term: 37–41 weeks               <ul style="list-style-type: none"> <li>– Late Term: 41 weeks</li> <li>– Full Term: 39–40 weeks</li> <li>– Early Term: 37–38 weeks</li> </ul> </li> <li>• Post Term: &gt; 42 weeks</li> </ul>
<p><b>Birth Weight</b></p>	<ul style="list-style-type: none"> <li>• Moderately Low</li> <li>• Very Low</li> <li>• Not Low</li> <li>• Missing</li> </ul>
<p><b>Method of Delivery</b></p> <p><i>Note: Defined from the birth registry data.</i></p>	<ul style="list-style-type: none"> <li>• C-Section Delivery</li> <li>• Vaginal Delivery</li> <li>• Missing</li> </ul>
<p><b>Postpartum ED Utilization</b></p> <p><i>Note: Only ED services up to 90 days after delivery will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p><b>Postpartum Ambulatory Care Utilization</b></p> <p><i>Note: Only ambulatory care services up to 90 days after delivery will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p><b>Received Prenatal SBIRT</b></p> <p><i>Note: Only SBIRT evaluations received between the LMP and delivery date will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p><b>Received Postpartum SBIRT</b></p> <p><i>Note: Only SBIRT evaluation received on or between 7 and 84 days after delivery will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>
<p><b>Received Prenatal Maternal Depression Screening</b></p> <p><i>Note: Only maternal depression screenings received between the LMP and delivery date will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>



Demographic Category	Category Values
<p><b>Received Postpartum Maternal Depression Screening</b></p> <p><i>Note: Only maternal depression screenings received on or between 7 and 84 days after delivery will be considered.</i></p>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> </ul>

## Deliverables

For the 2021–2022 Medicaid Maternal and Child Health Focus Study, HSAG will provide DMAS with the following deliverables:

- HSAG will present the findings of this focus study in a formal report for DMAS to share with stakeholders. HSAG will apply suppression (i.e., suppress numerators and denominators fewer than 11) to the version of the report that is made 508-compliant. A non-suppressed version of the report will be provided to DMAS for internal purposes.
- HSAG will provide a member-level analytic dataset as an Excel spreadsheet with an accompanying data dictionary.
- HSAG will supply a supplemental Excel spreadsheet that provides additional stratifications not included in the report, including FAMIS Prenatal Coverage study indicators.
- A corresponding PowerPoint slide deck will be produced based upon the report and delivered to DMAS. At DMAS’ request, HSAG will present the slides at the quarterly MCO Quality Collaborative meeting that occurs in the calendar quarter after delivery of the final report.

## Child Welfare Focus Study Methodology<sup>B-24</sup>

### Objectives

DMAS has contracted with HSAG since SFY 2015–2016 to conduct a focus study that assesses healthcare utilization among members in child welfare programs receiving medical services through MCOs. The SFY 2022–2023 (Contract Year 2) Task 1.2 Child Welfare Focus Study assessed how healthcare utilization among members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) compared to utilization among members not in child welfare programs and receiving Medicaid managed care benefits and to national benchmarks, where applicable. Additionally, the 2022–2023 study assessed timely access to care for members who transitioned into or out of the foster care program and identified disparities in healthcare utilization and timely access to care based on demographic factors.

<sup>B-24</sup> Note: This methodology is presented as it appeared in the final report for this activity.

## **Technical Methods of Data Collection**

HSAG extracted information needed for the study from administrative claims and encounter data, as well as member, provider, eligibility, and enrollment data received from DMAS. In addition, DMAS supplied HSAG with dental encounter data during the measurement period from the Medicaid DBM, DentaQuest. A six-month data run-out period was allowed between the end of the measurement period and data extraction; data extraction began July 1, 2023.

## **Description of Data Obtained**

Study data included administrative claims and encounters, as well as demographic, eligibility, and enrollment data to examine services received by members for MY 2022.

## **How Data Were Aggregated and Analyzed**

### **Healthcare Utilization Analysis**

For the healthcare utilization analysis, HSAG identified the eligible populations for each child welfare program using the specific program's aid category to determine member enrollment at any point during the measurement period:

- **Children in Foster Care**—All children enrolled in Medicaid under 18 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category “076” for children in foster care.
- **Children Receiving Adoption Assistance**—All children enrolled in Medicaid under 18 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category “072” for children in the adoption assistance program.
- **Former Foster Care Members**—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2022, and identified by DMAS as enrolled in Medicaid under the aid category “070” for young adults formerly in foster care.

Selected study indicators assess demographic characteristics among the eligible populations for any length of Medicaid enrollment during the measurement period. For study indicators assessing healthcare utilization, the eligible populations were limited to members enrolled in the Medallion 4.0 (Acute) or CCC Plus (MLTSS) managed care programs with any MCO or a combination of MCOs during the measurement year, with enrollment gaps totaling no more than 45 days. This approach ensured that these members were continuously enrolled and covered by Medicaid for study indicators assessing healthcare utilization. Additionally, HSAG matched this group of continuously enrolled members to controls meeting the same age and enrollment criteria and sharing similar demographic and health characteristics to determine the final study populations and controls.

To determine the extent to which children in foster care, children receiving adoption assistance, and former foster care members who were continuously enrolled with one or more MCOs throughout the study period utilized healthcare services, HSAG assessed 20 measures, representing 32 study indicators, across six domains, as displayed Table B-16.

**Table B-16—Healthcare Utilization Measure Indicators**

Measure and Indicators
<b>Primary Care</b>
Child and Adolescent Well-Care Visits (WCV)
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)^ and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)^
<b>Oral Health</b>
Annual Dental Visit (ADV)
Preventive Dental Services (PDENT-CH)
Oral Evaluation, Dental Services (OEV-CH)
Topical Fluoride for Children—Dental or Oral Health Services (TFL-CH)
<b>Behavioral Health</b>
Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–A) and Effective Continuation Phase Treatment (AMM–C)*
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up (FUH)
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up (FUM)
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM)^
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up, Two-Month Follow-Up, Three-Month Follow-Up, Six-Month Follow-Up, and Nine-Month Follow-Up (ADD)^
<b>Substance Use</b>
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA)†
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment (IET–I) and Engagement of SUD Treatment (IET–E)
<b>Respiratory Health</b>
Asthma Medication Ratio (AMR)
<b>Service Utilization</b>
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—Total, ARTS, CMH Services, RTC Services, Therapeutic Services, and Traditional Services
Overall Service Utilization

<sup>^</sup>Indicates these study indicators were not calculated for former foster care members as the measure indicators are not applicable to members 19 to 26 years of age.

<sup>\*</sup>Indicates these study indicators were only calculated for former foster care members as the measure indicators are only applicable to members 18 years of age and older.

<sup>†</sup>Indicates these study indicators were only calculated for the former foster care members, as the denominators for the children in foster care and the children receiving adoption assistance members are historically very small.

### Timely Access to Care Analysis

For the timely access to care analysis, HSAG worked with DMAS to develop custom measure specifications to assess timely access to care for members who transitioned into or out of the foster care or adoption assistance programs during the measurement year. These members were continuously enrolled in Medallion 4.0 (Acute) or CCC Plus (MLTSS) managed care programs with any MCO or a combination of MCOs during the follow-up period for assessing timely care. These populations were not matched to controls.

HSAG assessed five measures, representing 16 study indicators, as displayed in Table B-17.

**Table B-17—Timely Access to Care Measure Indicators**

Measure and Indicators
<i>Timely Access to Care for New Foster Care Members</i> —Timely Access to Primary Care for New Foster Care Members, Timely Access to Dental Care for New Foster Care Members, Timely Access to Primary Care or Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Care for New Foster Care Members
<i>Timely Access to Care for Members Who Aged Out of Foster Care</i> —Timely Access to Primary Care for Members Who Aged Out of Foster Care, Timely Access to Dental Care for Members Who Aged Out of Foster Care, Timely Access to Primary Care or Dental Care for Members Who Aged Out of Foster Care, and Timely Access to Primary Care and Dental Care for Members Who Aged Out of Foster Care
<i>Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care</i> —Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis
<i>Timely Access to Behavioral Health Care for New Foster Care Members</i> —Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members, Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members With a Behavioral Health Diagnosis, Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members, and Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members With a Behavioral Health Diagnosis
<i>Timely Access to Behavioral Health Care for Members Receiving Adoption Assistance</i> —Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members and Timely Access to Behavioral Health Care Within 1 Year for New Adoption Assistance Members With a Behavioral Health Diagnosis

### Health Disparities Analysis

HSAG assessed health disparities among members in child welfare programs based on key demographic factors (i.e., race, age, gender, MCO, and region) for both the healthcare utilization measures and the timely access to care measures. For the healthcare utilization measures, HSAG also

assessed health disparities among each group of controls and compared results to the study populations. HSAG identified health disparities using logistic regression models that predict numerator compliance and compare the results of each demographic stratification to a reference group. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model). The reference groups consisted of members in any other stratification (e.g., the reference group for members in Tidewater was all other members not in the Tidewater region).

## How Conclusions Were Drawn

For the Healthcare Utilization and Timely Access to Care analyses, HSAG compared MY 2022 study indicator rates to NCQA's Quality Compass<sup>®</sup> B-25 national Medicaid HMO percentiles, when available, to provide additional context for indicator results.

Additionally, to assess whether indicator rates were statistically different between the study populations and their matched controls, HSAG calculated  $p$ -values to determine the association between program status (e.g., membership in the foster care program) and numerator compliance. For indicators for which all contingency table cell sizes (i.e., the number of numerator-positive and numerator-negative members for each group) were greater than or equal to 5, HSAG calculated  $p$ -values using Chi-square tests. For indicators with small contingency table cell sizes, HSAG used Fisher's exact test because Fisher's exact test is more accurate than the Chi-square test when cell sizes are small. A  $p$ -value less than 0.05 was considered statistically significant.

For the Health Disparities analysis, the  $p$ -value for the demographic group's coefficient in the logistic regression model was used to identify statistically significant health disparities between the demographic groups and their reference groups. HSAG excluded comparisons for which disparities could not be determined because the logistic regression model could not be calculated (e.g., denominators were too small to ensure a reliable model).

For this report, a  $p$ -value less than 0.05 indicated a health disparity. When analyzing a given demographic group, HSAG classified the stratified rate in one of the following three categories based on the preceding analyses:

- Higher Rate
  - The  $p$ -value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was higher than the rate for the reference group.
- Lower Rate
  - The  $p$ -value for the coefficient in the logistic regression model was less than 0.05, indicating a health disparity, and the stratified rate for the demographic group was lower than the rate for the reference group.
- Similar Rate

The  $p$ -value for the coefficient in the logistic regression model was greater than or equal to 0.05. This means no health disparity was identified when the stratification was compared to the reference group.

---

B-25 Quality Compass<sup>®</sup> is a registered trademark of NCQA.

## Dental Utilization in Pregnant Women Data Brief Methodology<sup>B-26</sup>

### Overview

DMAS contracted with HSAG to conduct the 2022–2023 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 Smiles for Children 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 the VDH. If vital statistics data are not received by August 4, 2023, HSAG will use the member enrollment and eligibility, and claims/encounter data files provided by DMAS in July 2023 for the analysis.

### Measurement Period

HSAG will assess the utilization of dental services during the preconception, prenatal, and postpartum periods for women with deliveries during CY 2022 (i.e., January 1, 2022, through December 31, 2022).<sup>B-27</sup>

### Eligible Population

If vital statistics data are received by August 4, 2023, HSAG will use vital statistics data to identify deliveries to women during CY 2022. 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* measure in the FFY 2023 CMS Adult and Child Core Set of Health Care Quality Measures.<sup>B-28</sup> HSAG will exclude non-live births from the deliveries using the *Non-Live Birth Value Set* for the *Prenatal and Postpartum Care* measure.<sup>B-29</sup> Additionally, if vital statistics data are not available, HSAG will not be able to complete analyses that depend on information that is only available in the vital statistics data (e.g., study indicators and stratifications utilizing Kotelchuck Index score).

---

<sup>B-26</sup> Note: This methodology is presented as it appeared in the final report for this activity.

<sup>B-27</sup> A women’s pregnancy would begin during March 2021 for a live birth delivered on January 1, 2022. Therefore, all women with deliveries beginning in CY 2022 would have been eligible for the VA Smiles for Children program, contingent upon their enrollment in Medicaid or FAMIS MOMS.

<sup>B-28</sup> 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 2023 Reporting, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1681155105>. Accessed on: Apr 10, 2023.

<sup>B-29</sup> Ibid.



HSAG will include women of any age at the time of conception in the analysis but will calculate rates separately for women 21 years of age and older and women under 21 years of age. 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.<sup>B-30</sup>

## Study Indicators

### Dental Utilization

HSAG will use the dental encounter data to determine which dental services, if any, were utilized during the member’s preconception, pregnancy, or postpartum period, using the following code sets:<sup>B-31</sup>

- Any Dental Service Code Set
- Adjunctive Services Code Set
- Diagnostic Services Code Set
- Endodontics Code Set
- Oral & Maxillofacial Surgery Code Set
- Periodontics Code Set
- Preventive Services Code Set
- Prosthodontics Code Set
- Restorative Code Set

### Dental Utilization Stratifications

HSAG will stratify the CY 2022 dental utilization study indicator rates by the categories listed in Table B-18.

**Table B-18—Dental Utilization Study Indicator Stratifications**

Stratification	Description/Values
Medicaid Program	The Medicaid Program the woman was enrolled with on the date of delivery: <ul style="list-style-type: none"> <li>• FAMIS MOMS (Eligibility category 005)</li> <li>• Medicaid for Pregnant Women (Eligibility categories 091, 097)</li> </ul>

<sup>B-30</sup> Historically, the VA Smiles for Children program covered most dental services for children under 21 years of age and pregnant women aged 21 years and older through their pregnancy and postpartum period. Starting July 1, 2021, the VA Smiles for Children program also began covering comprehensive dental services for adults, aged 21 years and older, who are receiving full Medicaid benefits. 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>.

<sup>B-31</sup> 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* Excel File.



Stratification	Description/Values
	<ul style="list-style-type: none"> <li>• Medicaid Expansion (Aid categories 100, 101, 102, 103, 106, and 108)</li> <li>• LIFC (Aid category 081)</li> <li>• 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])</li> <li>• Not Enrolled</li> </ul>
Managed Care Program	<ul style="list-style-type: none"> <li>• Medallion 4.0 (Acute)</li> <li>• CCC Plus (MLTSS)</li> <li>• FAMIS</li> <li>• Not Enrolled</li> </ul>
Medicaid Delivery System	<ul style="list-style-type: none"> <li>• FFS</li> <li>• Managed Care</li> <li>• Not Enrolled</li> </ul>
Perinatal Timing of Dental Service	<p>The perinatal timing of the utilization of dental services. The following categories will be presented:</p> <ul style="list-style-type: none"> <li>• Preconception period: the defined lookback period prior to conception (e.g., 3 months, 6 months)*</li> <li>• 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)</li> <li>• Postpartum period: through six months postpartum**</li> <li>• Perinatal period: anytime during the prenatal and postpartum periods defined above</li> </ul>
Continuous Enrollment During Dental Service	<p>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.</p>
Age	<p>The age of the woman on the date of delivery. The following age groups will be presented:</p> <ul style="list-style-type: none"> <li>• 20 and Under</li> <li>• 21 and Older (21–24, 25–29, 30–34, 35–39, 40 and Older)</li> </ul>
Race/Ethnicity	<p>The race/ethnicity of the woman. The following race/ethnicity categories will be presented:</p> <ul style="list-style-type: none"> <li>• White, Non-Hispanic</li> </ul>

Stratification	Description/Values
	<ul style="list-style-type: none"> <li>• Black, Non-Hispanic</li> <li>• Asian, Non-Hispanic</li> <li>• Hispanic, Any Race</li> <li>• Other/Unknown</li> </ul>
Managed Care Region of Residence	<p>The region of the woman’s residence at the time of delivery. The following regions will be presented:</p> <ul style="list-style-type: none"> <li>• Central</li> <li>• Charlottesville/Western</li> <li>• Northern &amp; Winchester</li> <li>• Roanoke/Alleghany</li> <li>• Southwest</li> <li>• Tidewater</li> </ul>
Prenatal Care***	<ul style="list-style-type: none"> <li>• Received Prenatal Care</li> <li>• Did Not Receive Prenatal Care</li> </ul>
Trimester of Prenatal Care Initiation***	<ul style="list-style-type: none"> <li>• First Trimester</li> <li>• Second Trimester</li> <li>• Third Trimester</li> <li>• No Prenatal Care</li> <li>• Unknown</li> </ul>
Adequacy of Prenatal Care***	<ul style="list-style-type: none"> <li>• Adequate Prenatal Care (i.e., Kotelchuck Index score greater than or equal to 80 percent, which includes the Adequate Plus category [greater than or equal to 110 percent])</li> <li>• Intermediate Prenatal Care (i.e., Kotelchuck Index score less than 80 percent and greater than or equal to 50 percent)</li> <li>• Inadequate Prenatal Care (i.e., Kotelchuck Index score less than 50 percent)</li> </ul>

\* Since dental coverage for non-pregnant adult members began July 1, 2021, HSAG will assess appropriate time frames for the preconception period after receiving the administrative data for this measurement year.

\*\* Starting July 1, 2022, coverage of postpartum benefits was expanded from 60 days to one year postpartum. However, HSAG will only receive complete claims/encounter data through May 2023 for this report. Therefore, HSAG will only be able to assess services for up to six months postpartum for deliveries during CY 2022. Additionally, HSAG will caveat in the report that that postpartum data for deliveries at the end of CY 2022 may be less complete, and women with deliveries prior to April 2022 may have had a gap in coverage between the end of their 60 days postpartum coverage and the expansion of postpartum benefits in July 2022.

\*\*\* For stratifications that are new to this year’s analysis, HSAG will evaluate the appropriateness of these approaches based on the data received and modify the stratifications as needed with DMAS’ approval.

## 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 whether there is a significant difference between members with any dental services and members with no dental services for each of the birth outcomes listed below, HSAG will use Pearson’s chi-square test of significance. HSAG will use a *p*-value <0.05 to identify significant associations.

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 prenatal care

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), newborns with low birth weight (<2,500 grams), and timely prenatal care.

Table B-19 presents details into the birth outcomes that HSAG will assess for this data brief.

**Table B-19—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: <ul style="list-style-type: none"> <li>• Preterm: Less than 37 weeks</li> <li>• Late preterm: 34–36 weeks</li> <li>• Moderate preterm: 32–33 weeks</li> <li>• Very preterm: 28–31 weeks</li> <li>• Extremely preterm: &lt;28 weeks</li> </ul>
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: <ul style="list-style-type: none"> <li>• Overall low birth weight: &lt;2,500 grams</li> <li>• Moderately low birth weight: 1,500 grams–2,499 grams</li> <li>• Very low birth weight: &lt;1,500 grams</li> </ul>

Indicator	Denominator	Numerator
<p>Postpartum ED Utilization for Non-Traumatic Dental Services</p>	<p>Number of singleton, live births paid by Virginia Medicaid during the measurement period.</p>	<p>Number of postpartum women who utilized ED services (<u>ED Visits Code Set</u>) for either of the following within 60 days of delivery:</p> <ul style="list-style-type: none"> <li>• A primary diagnosis of a non-traumatic dental condition (<u>Non-Traumatic Dental Conditions Code Set</u>)</li> <li>• A primary diagnosis for other non-traumatic dental conditions (<u>Other Non-Traumatic Dental Cond Code Set</u>) with a secondary diagnosis of non-traumatic dental conditions (<u>Non-Traumatic Dental Cond Code Set</u>)</li> </ul> <p>For this indicator, HSAG will stratify rates by race/ethnicity, region, and MCO. Additionally, HSAG will provide additional information on the most common diagnoses for these visits and when the visits occur during the postpartum period.</p>
<p>Postpartum Ambulatory Care Utilization</p>	<p>Number of singleton, live births paid by Virginia Medicaid during the measurement period.</p>	<p>Number of postpartum women who utilized ambulatory care services within 60 days of delivery. Ambulatory visits are identified as:</p> <ul style="list-style-type: none"> <li>• An ambulatory outpatient visit (<u>Ambulatory Outpatient Visits Code Set</u>)</li> <li>• A telephone visit (<u>Telephone Visits Code Set</u>) or online assessment (<u>Online Assessments Code Set</u>)</li> <li>• Any one of the following: <ul style="list-style-type: none"> <li>– An ED visit (<u>ED Code Set</u>)</li> <li>– An ED procedure code (<u>ED Procedure Code Set</u>) with an ED POS code (<u>ED POS Code Set</u>)</li> </ul> </li> </ul>

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

### **Deliverables**

HSAG will present the findings of the dental utilization analysis in a data brief by October 1, 2023. Additionally, HSAG will apply suppression (i.e., suppress numerators and denominators fewer than 11) to the version of the report that is made 508-compliant. A non-suppressed version of the report will be provided to DMAS for internal purposes.

## **Consumer Decision Support Tool Methodology**

### **Objectives**

DMAS contracted with HSAG to analyze MY 2022 HEDIS results, including MY 2022 CAHPS data from six Virginia Medallion 4.0 (Acute) MCOs for presentation in the 2023 Virginia Medallion 4.0 (Acute) Consumer Decision Support Tool. The Consumer Decision Support Tool analysis helps support DMAS’ public reporting of MCO performance information. Please note that due to the merger of Optima and VA Premier during CY 2023, HSAG combined the results for Optima and VA Premier for the 2023 Consumer Decision Support Tool.

### **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 2022. The *HEDIS MY 2022 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS MY 2022 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

### **Reporting Categories**

The Medallion 4.0 (Acute) 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 2023 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 their overall health care.

- **Doctors' Communication:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and the overall ratings of personal doctors.
- **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 substance use.
- **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 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 (Acute) 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-20 lists the 39 measure indicators, 9 CAHPS and 30 HEDIS, and their associated weights.<sup>B-32</sup> Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally in the derivation of the final results. Please see the Comparing MCO Performance section for more details.

---

<sup>B-32</sup> The following measures were removed from the 2023 Consumer Decision Support Tool analysis due to half or more of the MCOs having *Not Applicable (NA)* statuses: *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)*, *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies*, *Adult Medicaid—Getting Needed Care (CAHPS Composite)*, and *Adult Medicaid—Getting Care Quickly (CAHPS Composite)*.

**Table B-20—Medallion 4.0 (Acute) Consumer Decision Support Tool Reporting Categories, Measures, and Weights**

Measures	Measure Weight
<b>Overall Rating<sup>B-33</sup></b>	
<i>Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)</i>	1
<i>Child Medicaid—Rating of Health Plan (CAHPS Global Rating)</i>	1
<i>Adult Medicaid—Rating of All Health Care (CAHPS Global Rating)</i>	1
<i>Child Medicaid—Rating of All Health Care (CAHPS Global Rating)</i>	1
<b>Doctors' Communication</b>	
<i>Child Medicaid—How Well Doctors Communicate (CAHPS Composite)</i>	1
<i>Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)</i>	1
<i>Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)</i>	1
<b>Getting Care</b>	
<i>Child Medicaid—Getting Needed Care (CAHPS Composite)</i>	1
<i>Child Medicaid—Getting Care Quickly (CAHPS Composite)</i>	1
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	
<i>20–44 Years</i>	1/3
<i>45–64 Years</i>	1/3
<i>65+ Years</i>	1/3
<i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total</i>	1
<i>Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total</i>	1
<i>Follow-Up After ED Visit for Mental Illness</i>	
<i>7-Day Follow-Up—Total</i>	1/2
<i>30-Day Follow-Up—Total</i>	1/2
<i>Initiation and Engagement of SUD Treatment</i>	
<i>Initiation of SUD Treatment—Total</i>	1/2
<i>Engagement of SUD Treatment—Total</i>	1/2
<b>Keeping Kids Healthy</b>	
<i>Childhood Immunization Status—Combination 3</i>	1
<i>Well-Child Visit in the First 30 Months of Life</i>	

<sup>B-33</sup> To calculate the Overall Rating category, all 39 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating reporting category are exclusive to the reporting category.



Measures	Measure Weight
<i>Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i>	1
<i>Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits</i>	1
<b>Child and Adolescent Well-Care Visits</b>	
<i>3–11 Years</i>	1
<i>12–17 Years</i>	1
<i>18–21 Years</i>	1
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>	
<i>Initiation Phase</i>	1/2
<i>Continuation and Maintenance Phase</i>	1/2
<i>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total</i>	1
<b>Living With Illness</b>	
<b>HbA1c Control for Patients with Diabetes</b>	
<i>HbA1c Control (&lt;8.0 Percent)</i>	1/4
<i>HbA1c Poor Control (&gt;9.0 Percent)</i>	1/4
<i>Blood Pressure Control for Patients with Diabetes</i>	1/4
<i>Eye Exam for Patients with Diabetes</i>	1/4
<i>Controlling High Blood Pressure</i>	1
<i>Asthma Medication Ratio—Total<sup>B-34</sup></i>	1
<b>Antidepressant Medication Management</b>	
<i>Effective Acute Phase Treatment</i>	1/2
<i>Effective Continuation Phase Treatment</i>	1/2
<b>Taking Care of Women</b>	
<i>Breast Cancer Screening</i>	1
<i>Cervical Cancer Screening</i>	1
<b>Prenatal and Postpartum Care</b>	
<i>Timeliness of Prenatal Care</i>	1
<i>Postpartum Care</i>	1

<sup>B-34</sup> This measure is not required in the Medallion 4.0 (Acute) 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.

## Missing Values

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

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

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

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

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

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

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

## Comparing MCO Performance

HSAG computed six summary scores for each MCO, as well as the summary mean values for the MCOs as a group. Each score was a standardized score where higher values represented more favorable performance. Summary scores for the six reporting categories (Overall Rating, Doctors' Communication, Getting Care, Keeping Kids Healthy, Living With Illness, and Taking Care of Women) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

1. HEDIS rates were extracted from the auditor-locked IDSS data sets and HSAG calculated the CAHPS rates using the NCQA CAHPS member-level data files. To calculate a rate for a CAHPS measure, HSAG converted each individual question by assigning the top-box responses (i.e., "Usually/Always," "9/10," and "Yes," where applicable) to a 1 for each individual question, as described in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. All other non-missing responses were assigned a value of 0. HSAG then calculated the percentage of respondents with a

top-box response (i.e., a 1). For composite measures, HSAG calculated the composite rate by taking the average percentage for each question within the composite.

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

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

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

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

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

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

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

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

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

- For MCOs with an *NA* status, or *NR* or *BR* audit results, HSAG used the average variance of the non-missing rates across all MCOs. This ensured that all rates reflected some level of variability, rather than simply omitting the missing variances in subsequent calculations.
- HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
- Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category weighting.
- HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
- For each MCO  $k$ , HSAG calculated the category variance,  $CV_k$  as:

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

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

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  $d_k = \text{MCO } k \text{ score} - \text{group mean}$ .
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:

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

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

Additionally, due to the merger of Optima and VA Premier, HSAG combined results for Optima and VA Premier for MY 2022. HSAG employed the following methodology to combine the results:

The formula for computing the combined mean ( $\bar{X}_c$ ) for each measure is:

$$\bar{X}_c = \frac{n_1 \bar{X}_1 + n_2 \bar{X}_2}{n_1 + n_2}$$

where:  $n_1$  = Number of members in the eligible population for Optima  
 $n_2$  = Number of members in the eligible population for VA Premier  
 $\bar{X}_1$  = Mean of measure for Optima population  
 $\bar{X}_2$  = Mean of measure for VA Premier population

The formula for computing the combined variance is as follows:

$$S_c^2 = \frac{m_1 [S_1^2 + (\bar{X}_1 - \bar{X}_c)^2] + m_2 [S_2^2 + (\bar{X}_2 - \bar{X}_c)^2]}{m_1 + m_2}$$

where:  $S_1^2$  = Variance of Optima population  
 $S_2^2$  = Variance of VA Premier population

$m_1$  = Number of members in Optima’s denominator

$m_2$  = Number of members in VA Premier’s denominator

If the measure was reported using the hybrid methodology, then the hybrid sample was used as  $m_i$  for the calculation of  $S_c^2$ . If the measure was reported using the administrative methodology, then the eligible population was used as  $m_i$  for the calculations of  $S_c^2$ .<sup>B-35</sup>

### 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-21, on the next page, shows how the Medallion 4.0 (Acute) Consumer Decision Support Tool results were displayed:

**Table B-21—Medallion 4.0 (Acute) Consumer Decision Support Tool—Performance Ratings**

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

<sup>B-35</sup> When combining the data for Optima and VA Premier, if both MCOs had a rate with an NA status, HSAG used the NA status for the combined rate.

## Performance Withhold Program Methodology

### Objectives

DMAS contracted with HSAG as their EQRO to establish, implement, and maintain a scoring mechanism for the managed care PWP, also referred to as the “quality withhold.” For the SFY 2023 PWP, MCOs’ performance is evaluated on seven NCQA HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures (two measure indicators). The EQRO is responsible for collecting MCOs’ audited HEDIS measure rates, the AHRQ PDI measure rates, and CMS Adult Core Set measure rates from DMAS. The EQRO will derive PWP scores for each measure and calculate the portion of the 1 percent quality withhold earned back for each MCO.

The following sections provide the PWP calculation methodology for the SFY 2023. 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 seven HEDIS measures (14 measure indicators), one AHRQ PDI measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators) for the PWP indicated in Table B-22.

**Table B-22—PWP Measures**

Indicator	Measure Specification	Required Reporting Method
<i>Asthma Admission Rate (per 100,000 Member Months [MM])*</i>	AHRQ PDI	Administrative
<i>Child and Adolescent Well-Care Visits—Total</i>	HEDIS	Administrative
<i>Childhood Immunization Status—Combination 3</i>	HEDIS	Hybrid
<i>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total*</i>	CMS Adult Core Set	Administrative
<i>Comprehensive Diabetes Care Composite— Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, HbA1c Control (&lt;8.0%)—Total and HbA1c Poor Control (&gt;9.0%)—Total* B-36</i>	HEDIS	Hybrid
<i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	HEDIS	Administrative

<sup>B-36</sup> Starting with HEDIS MY 2022, the Comprehensive Diabetes Care measure has been removed and three new measures have been established. For the purposes of the PWP, the measures will be combined as a composite measure and weighted similar to the other measures.

Indicator	Measure Specification	Required Reporting Method
<i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	HEDIS	Administrative
<i>Heart Failure Admission Rate (per 100,000 MM)—Total*</i>	CMS Adult Core Set	Administrative
<i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment and Engagement of SUD Treatment</i>	HEDIS	Administrative
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i>	HEDIS	Hybrid

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

### Performance Period

The SFY 2023 PWP assesses CY 2022 performance measure data (i.e., the performance measures will be calculated following HEDIS MY 2022, AHRQ’s PDI Technical Specifications [July 2021], and CMS FFY 2023 Adult Core Set Specifications that use a CY 2022 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in SFY 2023 (i.e., the 1 percent of capitation payments withheld from July 1, 2022, through June 30, 2023).<sup>B-37</sup>

### Technical Methods of Data Collection and Description of Data Obtained

The HEDIS IDSS files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS measure rates will be provided to the EQRO by the MCOs. DMAS will contract with their EQRO to validate the AHRQ PDI measure and the two CMS Adult Core Set measures in accordance with *CMS EQR Protocols: Protocol 2. Validation of Performance Measures*, October 2019.<sup>B-38</sup> Following the performance measure validation, the EQRO will provide the true, audited rates for the AHRQ PDI and CMS Adult Core Set measures to DMAS.

<sup>B-37</sup> Per the technical measure specifications, the Asthma Admission Rate is reported per 100,000 population. However, this measure should be reported per 100,000 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).

<sup>B-38</sup> Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS External Quality Review (EQR) Protocols. 2019:57-114. Available at: <https://www.medicaid.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf>. Accessed on: Nov 3, 2023



## How Data Were Aggregated and Analyzed

### PWP Calculation

The following sections provide a detailed description and examples of the PWP scoring and quality withhold funds model for the SFY 2023 PWP (i.e., the initial performance year). With receipt of audited HEDIS measure rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back.

Only measure rates with a “Reportable (R)” (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) will be included in the PWP calculation. Measure 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. Measure 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 measure).

### SFY 2023 PWP

As indicated above, SFY 2023 PWP will use the MCOs’ audited HEDIS MY 2022 and validated CY 2022 AHRQ PDI and CMS FFY 2023 CMS Adult Core Set performance measure data. Table B-23 shows the percentage of withhold associated with each performance measure indicator.

**Table B-23—SFY 2023 PWP Measure Weights**

Indicator	Measure Weight
<i>Asthma Admission Rate (per 100,000 MM)*</i>	10%
<i>Child and Adolescent Well-Care Visits—Total</i>	10%
<i>Childhood Immunization Status—Combination 3</i>	10%
<i>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total*</i>	10%
<i>Comprehensive Diabetes Care Composite— Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, HbA1c Control (&lt;8.0%)—Total and HbA1c Poor Control (&gt;9.0%)—Total*</i>	10%
<i>Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	10%
<i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i>	10%
<i>Heart Failure Admission Rate (per 100,000 MM)—Total*</i>	10%

Indicator	Measure Weight
<i>Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment and Engagement of SUD Treatment</i>	10%
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care</i>	10%

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

## Scoring Methods

The next several sections describe the PWP calculation method for the SFY 2023 PWP.

### Indicator Partial Score

For SFY 2023, the AHRQ PDI and CMS Adult Core Set measure scoring will be based on whether the MCO reported valid HEDIS MY 2022 (i.e., CY 2022) measure rates to NCQA in the required reporting method as indicated in Table B-24. Due to the planned transition to Cardinal Care, beginning with the SFY 2024 PWP and forwards, DMAS will attempt to set benchmarks for determining the Cardinal Care MCO performance scores for the AHRQ PDI and CMS Adult Core Set measures, based on available data from SFY 2023.

**Table B-24—Audit Designations (AHRQ PDI and CMS Adult Core Set)**

Audit Designation	
Eligible for Points	Ineligible for Points
<i>Reportable (R)</i>	<i>Do Not Report (DNR)</i>
	<i>Not Applicable (NA)</i>
	<i>No Benefit (NR)</i>

As indicated in Table B-24, only measures with a “*Reportable (R)*” audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) will be included in the PWP calculation for the AHRQ PDI and CMS Adult Core Set measures. Measure rates with the following audit results will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure):

- “*Do Not Report (DNR)*” audit result (i.e., the calculated rate was materially biased)
- “*Not Applicable (NA)*” audit result (i.e., the plan was not required to report the measure)
- “*No Benefit (NR)*” audit result (i.e., the measure was not reported because the plan did not offer the required benefit)

The performance scores for the HEDIS measures 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-25

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 measure score, and no scores will be dropped.

**Table B-25—PWP HEDIS Indicator Scoring**

Criteria for Each Indicator	Score
MCO's rate is below the 25th percentile	0.00
MCO's rate is at or above the 25th percentile but below the 50th percentile	Between 0.00 and 1.00
MCO's rate is at or above the 50th percentile	1.00

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 quality improvement. The partial score for each measure 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 and CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning improvement bonus points for future iterations of the PWP, if applicable.

For the SFY 2023 PWP, MCOs that failed to meet the 50th percentile in CY 2021 (i.e., HEDIS MY 2021 data) for a HEDIS indicator may be eligible to earn an improvement bonus if an indicator rate demonstrates substantial improvement from CY 2021.<sup>B-39</sup> 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 2021 and the following is true:

<sup>B-39</sup> HSAG will use the HEDIS MY 2021 Combined Aggregate files (i.e., the MCO's standard NCQA HEDIS submission) as a comparison to the HEDIS MY 2022 data submissions.

$$|MCO \text{ Current Rate} - MCO \text{ CY 2021 Rate}| \geq \left\lceil \left\lfloor \frac{(50th \text{ Percentile} - 25th \text{ Percentile})}{5} \right\rfloor \right\rceil$$

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 2021 rate;
- The MCO reported the indicator rate in both the current year and CY 2021;
- The MCO’s reported indicator rate was below the 50th percentile in CY 2021;
- 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 2021 to hybrid in the current year); and
- 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 of the criteria for improvement bonus determinations, then the MCO will receive an improvement bonus for that indicator.

### High Performance Bonus

For the AHRQ PDI and CMS Adult Core Set measure indicators, DMAS will determine an appropriate method of assigning high performance bonus points for future iterations of the PWP, if applicable.

For the SFY 2023 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 2021. Each indicator rate that ranks above the 66.67th percentile for the current year and CY 2021 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).

### How Conclusions Were Drawn

#### Scoring Model Example

Table B-26 and Table B-27, on the two next pages, provide examples of how indicator partial scores will be determined, by MCO. All data presented in the tables below (both measure rates and percentile values) are mock data and do not represent actual data or results.

**Table B-26—Indicator Partial Score Calculations—HEDIS Measures**  
(Example Using Mock Data)

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
<b>Child and Adolescent Well-Care Visits</b>				
Total	55.55%	44.28%	54.26%	1.00
<b>Childhood Immunization Status</b>				

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
Combination 3	73.82%	65.45%	70.68%	1.00
<b>Comprehensive Diabetes Care Composite</b>				
Blood Pressure Control for Patients With Diabetes—Total	53.00%	50.23%	54.55%	0.64
Eye Exam for Patients With Diabetes—Total	42.68%	41.77%	52.00%	0.09
HbA1c Control (<8.0%)—Total	54.74%	44.11%	51.22%	1.00
HbA1c Poor Control (<9.0%)—Total*	50.70%	45.55%	38.66%	0.00
<b>Follow-Up After ED Visit for Substance Use</b>				
7-Day Follow-Up—Total	6.94%	6.25%	9.73%	0.20
30-Day Follow-Up—Total	11.04%	9.89%	15.25%	0.21
<b>Follow-Up After ED Visit for Mental Illness</b>				
7-Day Follow-Up—Total	46.22%	29.21%	35.49%	1.00
30-Day Follow-Up—Total	58.92%	43.17%	51.45%	1.00
<b>Initiation and Engagement of SUD Treatment</b>				
Initiation of SUD Treatment	42.26%	39.25%	41.99%	1.00
Engagement of SUD Treatment	11.16%	9.53%	11.01%	1.00
<b>Prenatal and Postpartum Care</b>				
Timeliness of Prenatal Care—Total	78.01%	78.10%	83.76%	0.00
Postpartum Care—Total	64.70%	59.38%	65.69%	0.84

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

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

**Table B-27—Indicator Partial Score Calculations—AHRQ PDI and CMS Adult Core Set Measures (Example Using Mock Data)**

Indicator	Audit Designation*	Met Reporting Requirements	Indicator Partial Score
<b>Asthma Admission Rate (per 100,000 MM)</b>			
Total	R	Yes	1.00
<b>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)</b>			
Total	R	Yes	1.00
<b>Heart Failure Admission Rate (per 100,000 MM)</b>			

Indicator	Audit Designation*	Met Reporting Requirements	Indicator Partial Score
Total	NA	No	0.00

\*Audit designations include: Reportable (R); Do Not Report (DNR); Not Applicable (NA); No Benefit (NR).

The indicator partial scores for the HEDIS measures 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* 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 and CMS Adult Core Set measures, the *Asthma Admission Rate—Total* indicator receives an indicator partial score of 1.00 because the audit designation was “Reportable (R).”

Table B-28 provides an example of how the improvement bonus scores will be determined by MCO based on performance for the current year and CY 2021 for the HEDIS measures. Improvement bonus determinations for the AHRQ PDI and CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

**Table B-28—Indicator Improvement Bonus Score Calculations—HEDIS Measures**  
(Example Using Mock Data)

Indicator	CY 2021 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
<b>Child and Adolescent Well-Care Visits</b>							
Total	50.85%	55.55%	4.70%	2.00%	Y	Y	0.25
<b>Childhood Immunization Status</b>							
Combination 3	71.29%	73.82%	2.53%	1.05%	N	Y	0.00
<b>Comprehensive Diabetes Care Composite</b>							
Blood Pressure Control for Patients With Diabetes—Total	53.25%	53.00%	-0.25%	0.86%	Y	N	0.00
Eye Exam for Patients With Diabetes—Total	44.27%	42.68%	-1.59%	2.05%	Y	N	0.00
HbA1c Control (<8.0%)—Total	57.41%	54.74%	-2.67%	1.42%	N	N	0.00
HbA1c Poor Control (>9.0%)—Total*	52.26%	50.70%	-1.56%	-1.38%	Y	Y	0.25
<b>Follow-Up After ED Visit for Substance Use</b>							
7-Day Follow-Up—Total	5.66%	6.94%	1.28%	0.70%	Y	Y	0.25
30-Day Follow-Up—Total	11.42%	11.04%	-0.38%	1.07%	Y	N	0.00

Indicator	CY 2021 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
<b>Follow-Up After ED Visit for Mental Illness</b>							
7-Day Follow-Up—Total	45.12%	46.22%	1.10%	1.26%	N	N	0.00
30-Day Follow-Up—Total	59.67%	58.92%	-0.75%	1.66%	N	N	0.00
<b>Initiation and Engagement of SUD Treatment</b>							
Initiation of SUD Treatment	41.68%	42.26%	0.58%	0.55%	N	Y	0.00
Engagement of SUD Treatment	11.11%	11.16%	0.05%	0.30%	Y	N	0.00
<b>Prenatal and Postpartum Care</b>							
Timeliness of Prenatal Care—Total	77.62%	78.01%	0.39%	1.13%	Y	N	0.00
Postpartum Care—Total	60.58%	64.70%	4.12%	1.26%	Y	Y	0.25

†A measure indicator is eligible for an improvement bonus if the indicator rate was below the 50th percentile in CY 2021 and the indicator rate demonstrated substantial improvement from CY 2021.

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

Table B-29, on the next page, provides an example of how the high performance bonus scores will be determined, by MCO, based on performance for the current year and CY 2021 for the HEDIS measures. Once the high performance bonus scores are determined, the indicator partial score, the improvement bonus score, and high performance bonus score (i.e., 0.00 or 0.25) will be summed to obtain the final indicator score. High performance bonus determinations for the AHRQ PDI and CMS Adult Core Set measures will be evaluated for future iterations of the PWP.

**Table B-29—High Performance Bonus Score Calculations—HEDIS Measures  
(Example Using Mock Data)**

Indicator	CY 2021 Rate	CY 2021 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					Prior Year	Current Year	Points Earned
<b>Child and Adolescent Well-Care Visits</b>							
Total	50.85%	59.49%	55.55%	60.34%	N	N	0.00
<b>Childhood Immunization Status</b>							
Combination 3	71.29%	73.72%	73.82%	72.75%	N	Y	0.00
<b>Comprehensive Diabetes Care Composite</b>							
Blood Pressure Control for Patients With Diabetes—Total	53.25%	56.12%	53.00%	57.89%	N	N	0.00



Indicator	CY 2021 Rate	CY 2021 66.67th Percentile	Current Year Rate	Current Year 66.67th Percentile	High Performance Bonus		
					Prior Year	Current Year	Points Earned
<i>Eye Exam for Patients With Diabetes—Total</i>	44.27%	57.16%	42.68%	58.02%	N	N	0.00
<i>HbA1c Control (&lt;8.%)—Total</i>	57.41%	53.48%	54.74%	54.51%	Y	Y	0.25
<i>HbA1c Poor Control (&gt;9.0%)—Total*</i>	52.26%	33.23%	50.70%	34.15%	N	N	0.00
<b>Follow-Up After ED Visit for Substance Use</b>							
<i>7-Day Follow-Up—Total</i>	5.66%	10.85%	6.94%	11.01%	N	N	0.00
<i>30-Day Follow-Up—Total</i>	11.42%	15.30%	11.04%	15.75%	N	N	0.00
<b>Follow-Up After ED Visit for Mental Illness</b>							
<i>7-Day Follow-Up—Total</i>	45.12%	44.56%	46.22%	45.77%	Y	Y	0.25
<i>30-Day Follow-Up—Total</i>	59.67%	54.66%	58.92%	55.79%	Y	Y	0.25
<b>Initiation and Engagement of SUD Treatment</b>							
<i>Initiation of SUD Treatment</i>	41.68%	47.00%	42.26%	48.04%	N	N	0.00
<i>Engagement of SUD Treatment</i>	11.11%	12.16%	11.16%	12.13%	N	N	0.00
<b>Prenatal and Postpartum Care</b>							
<i>Timeliness of Prenatal Care—Total</i>	77.62%	85.59%	78.01%	86.37%	N	N	0.00
<i>Postpartum Care—Total</i>	60.58%	67.82%	64.70%	68.36%	N	N	0.00

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

Table B-30 shows the measure level score calculations for each MCO by determining the average of the indicator level scores for each measure.

**Table B-30—Measure Level Score Calculations**  
**(Example Using Mock Data)**

Indicator	Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	Measure Level Score
<b>Asthma Admission Rate (Per 100,000 MM)*</b>					
<i>Total</i>	1.00	NE	NE	1.00	<b>1.00</b>
<b>Child and Adolescent Well-Care Visits</b>					
<i>Total</i>	1.00	0.25	0.00	1.25	<b>1.25</b>
<b>Childhood Immunization Status</b>					
<i>Combination 3</i>	1.00	0.00	0.00	1.00	<b>1.00</b>

Indicator	Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	Measure Level Score
<b>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)*</b>					
Total	1.00	NE	NE	1.00	<b>1.00</b>
<b>Comprehensive Diabetes Care Composite</b>					
Blood Pressure Control for Patients with Diabetes—Total	0.64	0.00	0.00	0.64	<b>0.56</b>
Eye Exam for Patients with Diabetes—Total	0.09	0.00	0.00	0.09	
HbA1c Control (<8.0 Percent)—Total	1.00	0.00	0.25	1.25	
HbA1c Poor Control (>9.0 Percent)—Total*	0.00	0.25	0.00	0.25	
<b>Follow-Up After ED Visit for Substance Use</b>					
7-Day Follow-Up—Total	0.20	0.25	0.00	0.45	<b>0.33</b>
30-Day Follow-Up—Total	0.21	0.00	0.00	0.21	
<b>Follow-Up After ED Visit for Mental Illness</b>					
7-Day Follow-Up—Total	1.00	0.00	0.25	1.25	<b>1.25</b>
30-Day Follow-Up—Total	1.00	0.00	0.25	1.25	
<b>Heart Failure Admission Rate (per 100,000 MM)*</b>					
Total	0.00	NE	NE	0.00	<b>0.00</b>
<b>Initiation and Engagement of SUD Treatment</b>					
Initiation of SUD Treatment	1.00	0.00	0.00	1.00	<b>1.00</b>
Engagement of SUD Treatment	1.00	0.00	0.00	1.00	
<b>Prenatal and Postpartum Care</b>					
Timeliness of Prenatal Care—Total	0.00	0.00	0.00	0.00	<b>0.55</b>
Postpartum Care—Total	0.84	0.25	0.00	1.09	

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data. NE indicates the measure is not eligible for an Improvement Bonus or High Performance Bonus.

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

As shown above, the *Follow-Up After ED Visit for Substance Use* measure level score (0.33) was obtained by averaging the indicator level scores for *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* (0.45 and 0.21 respectively).

Table B-31 provides an example of how the percentage of the quality withhold is derived (i.e., overall withhold earned) based on the ten measure level scores calculated above. The percentage of the quality withhold that the MCO is eligible to earn back is calculated by multiplying the measure level score with the applicable measure weight and then summing the measure 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-31—Percentage Withhold Earned  
(Example Using Mock Data)**

Indicator	Measure Level Score	Weight	Measure Withhold Earned	Overall Withhold Earned
<i>Asthma Admission Rate (per 100,000 MM)</i>	1.00	10.00%	10.00%	<b>79.33%</b>
<i>Child and Adolescent Well-Care Visits</i>	1.25	10.00%	12.50%	
<i>Childhood Immunization Status</i>	1.00	10.00%	10.00%	
<i>COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)</i>	1.00	10.00%	10.00%	
<i>Comprehensive Diabetes Care Composite</i>	0.56	10.00%	5.58%	
<i>Follow-Up After ED Visit for Substance Use</i>	0.33	10.00%	3.30%	
<i>Follow-Up After ED Visit for Mental Illness</i>	1.25	10.00%	12.50%	
<i>Heart Failure Admission Rate (per 100,000 MM)</i>	0.00	10.00%	0.00%	
<i>Initiation and Engagement of SUD</i>	1.00	10.00%	10.00%	
<i>Prenatal and Postpartum Care</i>	0.55	10.00%	5.45%	

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

### 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-32—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
<b>MCO</b>	\$735,790,000.00	\$7,357,900.00	79.33%	\$5,836,654.18

Please note that the numbers in the table have been rounded for display purposes. Calculations will be based off unrounded data.

As shown in Table B-32, the one percent at risk amount for the example MCO is \$7,357,900.00. The MCO earned 79.33 percent of the quality withhold through the review of the HEDIS, AHRQ PDI, and CMS Adult Core Set measure indicator rates, thus the MCO is eligible to receive \$5,836,654.18 of the quality withhold according to the following equation:

$$\text{Final Withhold Earned Back Amount} = (\text{Maximum At Risk Amount} \times \text{Percentage Withhold Earned})$$

# PNC Provider Secret Shopper Methodology

## Overview

DMAS contracted with HSAG, to conduct a secret shopper telephone survey of appointment availability to collect information on members' access to primary care services under the VA Medicaid managed care program. A secret shopper is a person employed to pose as a patient to evaluate the quality of customer service or the validity of information (e.g., location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor.

HSAG evaluated appointment availability information among PCPs enrolled with the Virginia Medicaid MCOs to address the following survey objectives:

- Determine whether primary care service locations accept patients enrolled with the MCOs and the degree to which this information aligns with the enrollment broker's data.
- Determine whether primary care service locations accept new VA Medicaid patients for the requested MCO.
- Determine appointment availability at the sampled primary care service location for urgent and routine primary care services.

HSAG used a DMAS-approved survey script to complete calls to all sampled provider locations during January and February 2023, recording survey responses in an electronic data collection tool.

## Eligible Population

The eligible population included PCPs actively enrolled with one or more Virginia Medicaid MCO as of November 1, 2022. Using DMAS-approved data request materials, the DMAS enrollment broker identified providers potentially eligible for survey inclusion and submitted the PCP data files to HSAG. The enrollment broker was asked to ensure that the PCP data included out-of-state providers contracted to serve Virginia Medicaid managed care members (i.e., providers practicing in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, and Washington, DC). Eligible PCPs were identified based on the PCP flag, provider specialty, and whether they accepted new patients. Provider types and specialties considered for the study included, but were not limited to the following:

- Provider type: MD, DO, Nurse Practitioner, Physician Assistant
- Provider specialties: Primary Care, Family Medicine, General Practice, Internal Medicine, Geriatric Medicine, Adolescent Medicine, Pediatrics, Preventive Medicine

HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, telephone number, provider name, and service street address. HSAG standardized provider address data to align with the United States Postal Service Coding Accuracy Support System to identify potential data concerns with street addresses and to facilitate deduplication.

## Sampling Approach

The following random sampling approach was used to generate a list of primary care service locations (i.e., “cases”) from each MCO for inclusion in the survey:

- **Step 1:** HSAG assembled the sample frame using records from all primary care service locations identified for each MCO.<sup>B-40</sup>
  - Out-of-state service locations with service addresses in Kentucky, Maryland, North Carolina, Tennessee, West Virginia, or Washington, DC were included in the sample frame.
  - In order to minimize the number of repeat phone calls to providers, HSAG identified service locations using unique telephone numbers.
- **Step 2:** HSAG used the sample frame to determine a statistically valid number of unique service locations based on a 95 percent confidence level and  $\pm 5$  percent margin of error.
- **Step 3:** The calculated sample size for each MCO was proportionately split across the six regional geographic area assignments based on the number of providers in the sample frame for each region. The sample size calculated at the region level was used for sampling the providers equally among urgent and non-urgent appointment scenarios. The six regional geographic area assignments are listed below:
  - Region 1: Tidewater
  - Region 2: Central
  - Region 3: Western/ Charlottesville
  - Region 4: Roanoke/ Alleghany
  - Region 5: Southwest
  - Region 6: Northern/ Winchester

## Telephone Survey Process

HSAG’s secret shopper callers collected survey responses using a standardized script approved by DMAS. Callers were instructed to conduct the survey as though they had moved to the area and were trying to arrange an appointment for themselves or a family member. Due to the secret shopper nature of the calls, callers may have improvised during actual calls as needed. Callers were instructed not to leave voicemail messages or schedule appointments.

Callers made two attempts to contact each survey case during standard business hours (i.e., 9:00 a.m. to 5:00 p.m. Eastern Time).<sup>B-41</sup> If the caller was put on hold at any point during the call, they waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at

---

<sup>B-40</sup> Provider locations may be included in the eligible population for the prenatal care and PCP survey if the provider location is identified as having providers meeting the criteria for prenatal care providers and PCPs.

<sup>B-41</sup> HSAG did not consider a call attempted when the caller reached an office outside of the office’s usual business hours. For example, if the caller reached a recording that stated that office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The caller attempted to contact the office up to two times outside of the known lunch hour.

a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical provider, practice, or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the caller was put on hold for more than five minutes or the call was answered by an automated voicemail or answering service that prevented the caller from speaking with office staff).

## **Survey Indicators**

HSAG classified survey indicators into domains that consider provider data accuracy and appointment availability by MCO. Provider data accuracy was evaluated based on survey responses. In general, matched information received a “Yes” response and nonmatched information received a “No” response. For data collected on the first available appointment, the average wait time was calculated based on call date and earliest appointment date. HSAG also assessed appointment availability in relation to DMAS’ primary care appointment standards for urgent and routine care:

- Appointments for urgent symptomatic visits (e.g., sore throat without a fever) shall be scheduled within 24 hours<sup>B-42</sup> of request.
- Appointments for routine visits (e.g., annual well-check appointment) shall be scheduled within 30 calendar days of request.

HSAG collected the following information pertaining to provider data accuracy:

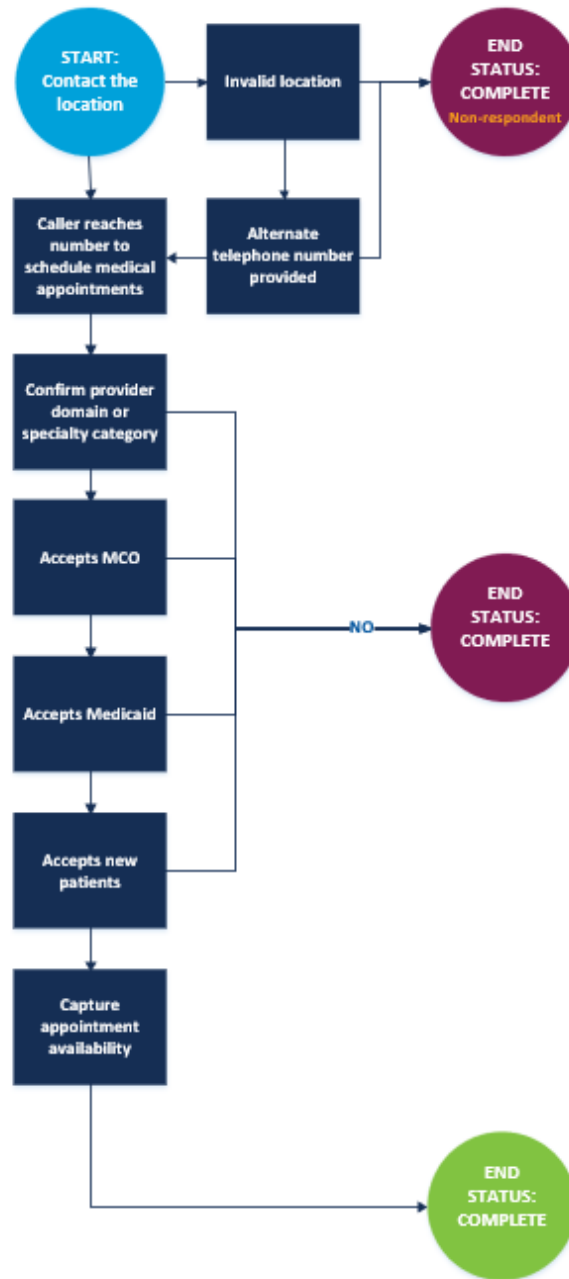
- Telephone number
- Address
- Provider location’s identification as offering services for the designated provider domain or specialty category
- Affiliation with the requested MCO
- Accuracy of accepting VA Medicaid managed care

Figure B-2 outlines the decision stop points throughout the survey.

---

<sup>B-42</sup> For the purposes of the secret shopper survey, HSAG assumed appointments were within the standards if they were scheduled within one business day since follow-up with urgent care or emergency clinics cannot be assessed.

**Figure B-2—Survey Decision Stop Points**



HSAG collected the following access-related information when calling sampled locations:

- Information on whether the location accepted new patients
- Date until the next available new patient appointment for an urgent or routine visit at the sampled service location with any individual practitioner at the sampled service location
- Any considerations to scheduling an appointment; this included the service location requiring:
  - Personal information or preregistration with the practice



- Patients to complete a questionnaire
- A review of the member's medical records
- Verification of the member's insurance eligibility

## Appendix C. MCO Best and Emerging Practices

Table C-1 identifies the MCOs’ self-reported best and emerging practices.

**Table C-1—DMAS’ Best and Emerging Practices**

Best and Emerging Practices
<p><b>Topic/Title:</b> Partnership for Petersburg</p> <p><b>Description:</b> In August of 2022, Governor Glenn Youngkin announced a transformative program called “Partnership for Petersburg.” This program has been focused on bringing together public and private resources to help the City of Petersburg and its residents, who have experienced negative health, public safety, education, and economic outcomes. One component of this plan is to improve the health of Petersburg’s residents by increasing access to preventative screenings, promoting awareness of primary care and addressing prenatal health disparities by connecting Petersburg residents with medical and social services. DMAS Focus Areas: 1. Improve Petersburg maternal and infant health outcomes. 2. Provide Primary Care Services, Mobile Health Clinics, and Community Events 3. Expand School-Based Clinic Services through the Crimson Clinic Information Request Submitted Response 4. Establish Community-Based Health Literacy Hubs. DMAS’s Key Collaborators and Partners: Medicaid MCOs (Aetna, Anthem, Molina, Optima and United), Central Virginia Health Services, Crimson Clinic, Crater Health District, Bon Secours Southside Regional Hospital, Petersburg City Public Schools, DentaQuest, Conexus, Petersburg Sheriff’s Office, VDH, and the Department of Social Services.</p>
<p><b>Topic/Title:</b> Improving Timely Health Care for Children and Youth in Foster Care - Affinity Group</p> <p><b>Description:</b> DMAS co-led a collaborative, interagency, quality improvement “affinity group” with support and technical assistance from CMS and Mathematica. Representatives from DMAS were joined by representatives from the Virginia Department of Social Services (VDSS), local Departments of Social Services (LDSS), and contracted health plans to design and implement data-driven quality improvement pilot projects to improve timely health services for children and youth in foster care.</p> <p>The Affinity Group worked with stakeholders to understand the full scope of the process, and then developed, tested, and collected data around a variety of pilot interventions in order to identify changes that would lead to improvement in the rate of the specific health care service being measured (<i>initial comprehensive medical examination within 30 days of a child entering foster care</i>). By the end of the 2-year Affinity Group, the team was able to identify barriers to accessing timely health care services for the foster care member population, as well as utilize data to demonstrate the success of several pilot tests that improved the identified process measures and outcome measures of the project.</p> <p>The most successful interventions identified were several iterations of warm handoffs of new foster care member information between VDSS or LDSS agencies and DMAS or the assigned MCO care coordinators, for MCOs to support the scheduling and completion of comprehensive health care visits within the first 30 days of placement. One 9-month pilot test with Bedford County Department of Social Services resulted in an improvement in MCO successful outreach to members in Bedford from an average of 52 days down to 2 days after entering foster care.</p>

**Best and Emerging Practices**

The team then scaled the pilot up statewide and tested a less labor-intense process while continuing to see improvement, though not as significant (down to an average of 28 days). Outcome measures for both warm handoff pilots discussed also improved, with 100% of members in Bedford County receiving initial medical examinations within 30 days of entering custody for the final 7 months of the test.

DMAS plans to continue to utilize the general structure and tools of the Affinity Group to continue working with DSS and contracted MCOs on identified quality improvement projects. DMAS will host these projects through the regularly scheduled Foster Care Partnership workgroup meetings moving forward.

**Topic/Title:** Newborn Bot Enrollment

**Description:** Description: The Newborn Enrollment process now incorporates newborn auto enrollment using an automated process in the form of a “newborn bot”. Yes. The expectation is that the bot will process newborn enrollments from hospital through the Medicaid enrollment process. However, currently the bot is an attended bot. The newborn enrollment unit is moving toward an unattended bot which will be able to process more cases per day. Cases not processed through the bot are captured in an exception file which flags cases where there is a redetermination or where a case change has been made. Messaging for members remains the same for now for families to call CoverVA or work with LDSS to enroll their newborns.

**Topic/Title:** ARTS Internal Metrics Dashboard Improvements

**Description:** The ARTS team has worked with DMAS’ Healthcare Analytics Division to make improvements to the ARTS dashboard so that it can provide information similar to the internal dashboard used by DMAS staff for mental health disorder services. This allows ARTS team more capability to do real time data analysis and quality assurance/improvement work.

**Topic/Title:** OBAT Managed Care Committee

**Description:** The ARTS team has worked with internal and external stakeholders to begin holding regularly scheduled meetings with the Managed Care Organizations (MCOs) to discuss any issues with Medicaid members accessing OBAT services and medications. These meetings have provided opportunities for DMAS and the MCOs to discuss successes and challenges, including improving access and capacity issues. MCOs have reported that these meetings are valuable and insightful and are helping to improve members’ experiences accessing OBAT services.

**Topic/Title:** CMS Infant Well-Child Visit Learning Collaborative

**Description:** The learning collaborative offers technical assistance to state Medicaid and Children’s Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners,

DMAS and its partners are receiving technical assistance in designing and implementing a quality improvement project aimed at identifying ways to increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and will conclude in

Best and Emerging Practices	
December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.	
<b>Topic/Title:</b> Baby Steps Virginia	
<b>Description:</b> Baby Steps Virginia is the vehicle with which Virginia Medicaid brings together sister agencies, other key partners and stakeholders and the voice of the member with the focus of improving maternal health outcomes, eliminate racial disparity in outcomes and maternal mortality. Baby Steps Virginia incorporates awareness of issues like social determinants of health (SDOH), barriers to care, and member/provider engagement.	
<b>Here are some current Baby Step VA successes</b>	
<ul style="list-style-type: none"> <li>• Three CMS affinity groups (quality improvement) targeting child, foster care youth and maternal health improvement plans</li> <li>• LRCD Affinity Group – Reducing Low Risk Cesarean Delivery</li> <li>• Outreach events to support pregnant, postpartum and parenting families</li> </ul>	
<b>Topic/Title:</b> Community Doula Program	
<b>Description:</b> Description: To date, 125 doulas have received state certification. Of the 125 state-certified doulas, 90 are approved and enrolled as Medicaid Doula Providers. There have been 107 doula-supported births to Medicaid members and over 304 birthing families have received doula services through Virginia Medicaid. Feedback continues to be positive from families who have received care and support from a doula. DMAS continues to focus on increasing the network of doula providers, community and provider engagement, and data. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant people with the goal of improving maternal and infant health outcomes, reducing infant and maternal mortality, and helping to address racial and health disparities. More information is available about doulas, the state certification process, and the Medicaid doula benefit, on the <a href="#">DMAS website</a> .	

Table C-2 identifies the MCOs’ self-reported best and emerging practices. The narrative within the table was provided by the MCOs and has not been altered by HSAG except for minor formatting.

**Table C-2—MCOs’ Best and Emerging Practices**

MCO	Best and Emerging Practices
Aetna	<p><b>Topic/Title:</b> Vital Decisions</p> <p><b>Description:</b> A national clinician-guided telehealth services vendor that collaborates with and supports members with making decisions about advance care planning. The service helps individuals, and their families think through, communicate, and document their preferences to ensure their care is aligned with their wishes – now and in the future as their medical situation changes.</p> <p><b>Topic/Title:</b> New Moms Box</p>

MCO	Best and Emerging Practices
	<p><b>Description:</b> A care package that contains a variety of products and educational material to help new mothers adjust to life and care for their new baby while also reinforcing the importance of care management to drive healthier outcomes.</p> <p><b>Topic/Title:</b> Social Care Team</p> <p><b>Description:</b> The Social Care Team is a field team that proactively outreaches members who score as high-risk via our partner’s predictive analytics tool. After completing a SDOH screening, the team identifies appropriate and timely resources based on the member’s needs and follows up with members and service providers to support loop closure for all members. Data and reporting from the Social Care Team influences relationships, investments in programs, and health equity strategies that they pursue. The program is designed to increase engagement and satisfaction, decrease ED visits and readmissions, and improve HEDIS scores and overall health outcomes.</p> <p><b>Topic/Title:</b> Readmission Avoidance Program (RAP)</p> <p><b>Description:</b> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p> <p><b>Topic/Title:</b> Pyx</p> <p><b>Description:</b> An app that increases member engagement with the Health Plan and steers to the right resources/assistance. Members receive personalized assistance to find resources, activities to reduce the feeling of loneliness and social isolation, and companionship of having someone to talk to when they need it. Additional features include a 24/7 chatbot, screenings for loneliness, depression, SDOH, self-management tips, and Health Plan resources, such as 24/7 member services and nurse line.</p>
<p><b>HealthKeepers</b></p>	<p><b>Topic/Title:</b> Obstetric Quality Incentive Program (OBQIP) and Program Consultants</p> <p><b>Description:</b> OBQIP offers incentives to OB Providers to provide quality and efficient care while keeping Members’ healthcare needs primary. OB Providers are prohibited from encouraging Member selection or deselection and from discriminating against Members based on location, ethnicity, culture, race, religion, disability, political belief, sex, age, socioeconomic status, health status, or medical history. OB Providers are also prohibited from withholding or preventing medically necessary services from being delivered to Anthem HealthKeepers Plus Members. The Program is not intended to limit the OB Providers’ judgment in treating Members or to limit their ability to discuss available treatment options with Members. OBQIP does not discriminate against OB Providers who provide service to any Member; any ethnic, cultural, or socioeconomic groups in particular geographic locations; or groups with specific medical conditions. The program is supported by OB Practice Consultants who provide in person and virtual support for Medicaid OB maternity providers.</p>

MCO	Best and Emerging Practices
	<p><b>Topic/Title:</b> Embedded Care Coordination Department Social Services Program</p> <p><b>Description:</b> The DSS/Anthem Embedded Care Coordination program aims to strengthen the relationship between DSS, CSA and MCO and to better serve Anthem foster and former foster care members with a focus on whole person care. Anthem HealthKeepers Plus care coordinators from the foster care team are embedded in DSS offices two to three days a week, providing face to face support to DSS and CSA workers. Key areas of support include assisting with transportation, addressing SDOH needs, connecting members to PCPs, dentists, and other specialty BH and PH treatment providers, and attending FPM/FAPT meetings. They also serve as a resource in walking members through the IACCT process and assist with securing RTC placements.</p> <p>Expected outcomes include a decrease in ER utilization, increased use of PCP services, and to increase DSS knowledge of care coordination and the benefits offered by Anthem HealthKeepers Plus.</p> <p><b>Topic/Title:</b> Gold Card Program</p> <p><b>Description:</b> Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly responsive to assisting with emergent member needs. Data is reviewed quarterly to determine a provider’s continued participation and support the ongoing development of an optimized network.</p> <p><b>Topic/Title:</b> Life Skill Building Program</p> <p><b>Description:</b> A partnership with select quality CMHRS providers in which an integrated care approach is utilized with identified complex populations (sickle cell/foster care/former foster care) and general population high needs/high-cost PH members where specialized high touch services are offered for a period to assist with coordination of whole person needs and navigation of barriers. Key components include enhanced engagement, coaching, creativity in addressing member needs with a focus on integrated care and SDOH, provider collaboration, assistance with healthcare system navigation, community resource engagement and crisis intervention.</p> <p><b>Topic/Title:</b> HEDIS Pay for Quality Program (P4Q)</p> <p><b>Description:</b> This is a program that offers annual incentives to PCPs to close HEDIS care gaps. This program includes admin-only, PCP-based HEDIS measures. It is intended to complement our PCP VBP program and transition</p>

MCO	Best and Emerging Practices
	<p>providers into a VB contract. The program incentive program was extended from 3 months to the last 6 months of the year as a strategy to close more gaps in care</p>
<p><b>Molina</b></p>	<p><b>Topic/Title:</b> Pay for Quality (P4Q) Program</p> <p><b>Description:</b> Description: For 2023, Molina selected a set of quality measures aligning with the state quality strategy and performance withhold program to include in an incentive program, P4Q. Molina will pay in-network primary care group practices a dollar amount to incentivize competition of preventative care and follow up appointments. This will be paid out per member after the primary care group achieves enough appointments within the designated measure to meet the 50th percentile benchmark for their assigned panel.</p> <p><b>Topic/Title:</b> Clinic Day</p> <p><b>Description:</b> Molina partnered with network providers by holding clinic day events for its members to schedule new and/or existing member appointments, arrange transportation service and performing reminder calls. Molina’s approach included identification of members with active care gaps, increasing access to healthcare with in-network PCPs, providing health education and rewarding members for their participation in connection to completion of health actions.</p> <p>This contributed to improved overall health outcomes and experiences, reduced administrative burden on provider office staff, decreased no-show rates, and improved member/provider experience.</p> <p>The Clinic Day offered a fun way to encourage members to:</p> <ul style="list-style-type: none"> <li>• Obtain needed health services</li> <li>• Improve health outcomes</li> <li>• Improve HEDIS score/close care gaps</li> <li>• Improve member/provider experience</li> <li>• Meet and interact with Molina team members</li> </ul> <p><b>Topic/Title:</b> Provider Network and Quality Partnership</p> <p><b>Description:</b> Molina’s Quality and Provider Networking teams work collaboratively with target provider groups within each state region to build relationships, eliminate barriers to care, educate providers within the health plan to improve member health outcomes and overall patient satisfaction.</p> <p><b>Topic/Title:</b> Direct Scheduling</p> <p><b>Description:</b> Molina Healthcare has partnered to offer a direct appointment scheduling solution to our provider groups to assist with outreaching members with gaps in care. Provider groups can select specific days, times and specific care gaps/preventative screenings that Molina Representatives can schedule Molina Healthcare members. This reduces member call duration and hold times for appointment scheduling versus contacting the practice directly and serves as a reminder for preventative care that may have been forgotten. It decreases member</p>



MCO	Best and Emerging Practices
	<p>frustration and abrasion, increases member confidence in the provider group and health plan, and increases positive health outcomes while alleviating the administrative burden and staffing challenges faced by many practices.</p> <p>This partnership is leveraged for clinic day participation to help with timely scheduling of events, improving provider practice participation by eliminating outreach staff barriers and unused appointment blocks.</p>
Optima	<p><b>Topic/Title:</b> Justice Care Coordination Program</p> <p><b>Description:</b> Justice Care Coordination program aims to ensure that justice-involved individuals are informed about the services and resources available to treat mental illness and substance use disorders. The members receive aid in navigating and coordinating their benefits while under state supervision before entry into or upon discharge from jail or prison to prevent recidivism and relapse. The Justice Care Coordinators collaborate with community partners and stakeholders to increase awareness and remove the stigma around mental illness and substance use disorders for justice-involved individuals while encouraging them to invest in their overall health.</p> <p><b>Topic/Title:</b> Tribal Care Coordination</p> <p><b>Description:</b> Tribal Care Coordination program aims to decrease barriers to treatment for individuals of Indian/Native American/Tribal descent. Our goal is to reduce the reluctance of the Native American/Tribal members to use providers available to them under their Medicaid benefits despite their use of the Indian healthcare system. We aim to connect this population to providers sensitive to their cultural needs.</p> <p><b>Topic/Title:</b> UHS Telehealth Program</p> <p><b>Description:</b> This program expands telehealth access of BH follow up treatment to members who are discharged from the Emergency Department (ED) and inpatient stays. For members at Sentara Hospitals, the hospital staff in the ED are able to use this telehealth program to schedule appointments for members in the ED.</p> <p><b>Topic/Title:</b> BH Coaching Program</p> <p><b>Description:</b> BH Coaching seeks to intervene when members are feeling “stuck” or distressed. The BH coaches provide interventions that will assist members in gaining longer-term benefits from changing their health behavior, stave off functional decline, and minimize the onset or exacerbation of chronic conditions. BH Coaching supports clinical management and helps members maximize health and overall functioning by building self-care capacity, long-term health behavior changes, and the functional resilience necessary to sustain or regain independent living.</p> <p><b>Topic/Title:</b> Peer Support Program</p>

MCO	Best and Emerging Practices
	<p><b>Description:</b> This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members’ social support systems, hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery.</p> <p><b>Topic/Title:</b> Mental Health Group</p> <p><b>Description:</b> This group includes BH team members and the focus are developing trainings to share with the BH team and internal partners. Topics have included: trauma-informed care practices, sex trafficking and the impact on members, gambling addiction, and the importance of peer support training. This group also participates in community events, sharing mental health issues impacting the community.</p> <p><b>Topic/Title:</b> Quality Accreditation Team</p> <p><b>Description:</b> Quality Committee Governance and Oversight</p> <p>Optima Health has updated and enhanced its governance structure. The quality committees facilitate and evaluate quality improvement activities carried out across various departments within the organization. There was a coordinated effort for subcommittee reporting.</p> <p>As of 07/01/2023, the committees have been integrated for efficiencies. There are three subcommittees reporting to the Corporate Quality Improvement Committee (QIC). These three subcommittees include:</p> <ul style="list-style-type: none"> <li>• Physician Leadership Committee (PLC) –responsible for the development, implementation, and management of quality and utilization improvement processes, and for providing overall direction to health plan staff and providers on the appropriate use of covered services.</li> <li>• Quality Performance Improvement Committee (QPIC) (newly formed) – responsible for the strategic oversight of improving quality measures and member experience and advancing clinical excellence through the provision of compassionate member-centered care.</li> <li>• Policies and Procedure (P&amp;P) Committee - responsible to ensure policies and their outcomes support the mission, values, and strategic goals of the organization.</li> </ul> <p>These three subcommittees have 10 reporting committees which include internal and external physicians.</p>

MCO	Best and Emerging Practices
	<p>To improve awareness of organizational activities, the frequency of meetings increased from quarterly to every other month.</p> <p>As the overarching committee, the Quality Improvement Committee (QIC) is the foundation of the Quality Improvement Program (QIP). The QIC assists the Health Plan leadership in overseeing, maintaining, and supporting the QIP and Work Plan activities. The committee is to ensure that the plan remains accountable and compliant with state regulators, NCQA, CMS, and other regulatory bodies for the covered services.</p> <p>Emerging Practices:</p> <ul style="list-style-type: none"> <li>• Formal Committee charters for all subcommittees</li> <li>• Process Maps</li> </ul> <p><b>Topic/Title:</b> Quality Member Safety/Contractual and Regulatory Team</p> <p><b>Description:</b> Alignment of critical incident criteria across all lines of business. Developed a single assessment/referral tool for critical incident reporting which is easily accessible in the electronic case management system for internal use.</p> <p><b>Topic/Title:</b> Welcoming Baby Program/Community Health Worker Outreach</p> <p><b>Description:</b> Use of Certified Community Health workers to support maternal health. Welcoming Baby and Watch Me Grow Outreach programming for connections to community resources, one-on-one supportive services, telephonic &amp; face-to-face, incentives &amp; events. Specialized training to:</p> <ul style="list-style-type: none"> <li>• Address social needs</li> <li>• Enhance health literacy</li> <li>• Outreach, screening, educate, refer</li> </ul> <p><b>Topic/Title:</b> Member Recertification Specialty Team</p> <p><b>Description:</b> Use of a specialty team to support the member recertification process. An unwinding application assistance program to include telephonic and in-person assistance, collaboration with DSS, and connection to CoverVA and CommonHelp. Programming and training specialized to:</p> <ul style="list-style-type: none"> <li>• Provide customized/individual application assistance</li> <li>• Use of SDOH data to drive member engagement</li> </ul> <p><b>Topic/Title:</b> Use of Community Health Workers</p> <p><b>Description:</b> Use of Certified Community Health Workers (CHW) to support member onboarding, outreach, and education. Outreach and education programming to include telephonic and in-person assistance, connection to</p>

MCO	Best and Emerging Practices
	<p>community and faith-based resources, wrap-around services, and community events. Programming and training specialized to:</p> <ul style="list-style-type: none"> <li>• Address social needs</li> <li>• Promote health equity</li> <li>• Foster Cultural Competence</li> <li>• Enhance health literacy</li> <li>• Improve health screenings</li> <li>• Reduce care gaps</li> </ul> <p><b>Topic/Title:</b> Chronic Care Management Program</p> <p><b>Description:</b> Chronic Care Management is a program administered by Optima health that provides the following:</p> <ol style="list-style-type: none"> <li>A. Telephonic engagement from a Registered Nurse to help the member in managing Diabetes, Asthma Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Heart Disease, Heart Failure, and Cancer.</li> <li>B. Assistance with helping members find and establish a relationship with a Primary Care Provider, Transportation, and connection to other inter-services offered through Optima Health.</li> <li>C. Develop a care plan and follow up with members to address barriers to them receiving care.</li> <li>D. Print member education materials.</li> <li>E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care.</li> </ol> <p><b>Topic/Title:</b> Population Health - IVR and Educational Video Campaigns</p> <p><b>Description:</b> EMMI IVR call campaigns are conducted monthly and EMMI educational videos are sent to members regarding gaps in care, primarily around diabetes management, immunizations, and blood pressure. The calls and videos provide education around focus measures and help to answer questions members may have otherwise asked their provider and aid in providing a response to any clarifying questions members may have. There is live call follow-up to members who were not engaged with the IVR call or may need further assistance. This is an effort to improve PWP measures for both M4 and CCCP.</p> <p><b>Topic/Title:</b> Population Health – Coaching and educational tools for members with Type II Diabetes</p> <p><b>Description:</b> Eligible members are provided the Dario App which provides multichannel engagement, coaching and free blood glucose monitors and test strips. Members engage with coaches and are encouraged to test their blood sugar</p>

MCO	Best and Emerging Practices
	<p>levels more frequently. Members have the ability to set reminders, use the in-app logbook, capture their weight and much more in the app.</p> <p><b>Topic/Title:</b> Population Health – Digital Health Apps that help members track ovulation, cycle, pregnancy and navigate the early years of parenthood.</p> <p><b>Description:</b> The Ovia App connects members to Registered Nurses for health coaching. The Ovia Fertility app allows members to view a personalized health summary and track their periods from fertility signs to menopause symptoms. Members can track their pregnancy journey, appointment reminders, nutrition, medications, vitamins, symptoms, sleep and more. Parenting allows members to track baby’s milestones and learn about parenting styles, breastfeeding and more.</p> <p><b>Topic/Title:</b> Population Health - Preventive Screening Kits</p> <p><b>Description:</b> The health plan collaborates with vendor partners to provide screening kits to members of both the CCC Plus and M4 product lines. Retina Labs performs in-home DREs. The vendor mail screening kits for A1c for diabetic members and FIT kits for colorectal cancer screening for members that have gaps in these measures. This is an effort to improve PWP measures as well as improve overall population health and member satisfaction by making the preventative screenings easily accessible.</p>
<p><b>United</b></p>	<p><b>Topic/Title:</b> Creating Communities of Health</p> <p><b>Description:</b> Addressing health disparities at the community level is vital to our mission of making the health system work better for everyone. Through a commitment to support the Governor’s Partnership for Petersburg initiative, we have strengthened and expanded our Creating Communities of Health strategy. Through this process, we have gained valuable insight into the importance of redefining the concept of a community to achieve improved health outcomes.</p> <p>Supporting Petersburg taught us that to effectively improve community health outcomes we must:</p> <ol style="list-style-type: none"> <li>1) Think differently about what a “community” is. It’s not just the people who live in a certain ZIP code. Or a handful of businesses. It’s the whole environment — the people, businesses, organizations, faith-based organizations, and health care systems that serve the community.</li> <li>2) Work with community leaders to identify community health needs to best collaborate on solutions, from improving systems and providing necessary resources to building physical spaces and empowering workforces, that increase access to health and social services.</li> <li>3) Acknowledge that the economic well-being of a community directly depends on the health of its people. A healthier community alleviates pressure on</li> </ol>

MCO	Best and Emerging Practices
	<p>overextended health systems. In turn, this can lower the cost of health care for everyone.</p> <p>4) Listen to, engage, and work with people throughout a community to build and support community specific solutions that remove social barriers to enable health and well-being.</p> <p><b>How we support our communities.</b> Taking on big challenges is a shared effort. We develop relationships with individuals and consult and collaborate with trusted organizations within a community to impact culturally responsive health and well-being.</p> <p><b>Data and analytics.</b> Every aspect of Creating Communities of Health — from identifying communities in need to how we invest money and resources — is informed by data analysis and community participation.</p> <p><b>Strengthening access for everyone.</b> Our efforts support better health access for everyone. This includes people with all types of medical coverage — from Medicare and Medicaid to employer-sponsored plans — and those who don't have insurance.</p> <p><b>Broad collaboration.</b> We partner with and listen to community organizations, local governments and private companies that reside in and serve the community. By combining our data analysis with their local insight, we can better support a community's biggest needs.</p> <p><b>Taking action to deliver results.</b> From building physical spaces to strengthening the community workforce and health systems, our focus is on investing in areas that will help communities grow and prosper.</p> <p><b>Topic/Title:</b> Housing + Health 2.0 – Continuums of Care</p> <p><b>Description:</b> Our Housing+Health strategy makes a difference in the lives of our members by working within existing systems to bring the functional components of the housing and health care systems closer together with integrated care management, behavioral health, and housing navigation support. Our dedicated housing navigators collaborate with local CBOs, housing partners and our care management team to 1) help <b>assess members' housing needs</b>, 2) <b>identify barriers</b> impacting housing stability, 3) help members <b>develop a housing stability plan</b>, and 4) <b>navigate members to community resources</b> that can address both long-term housing sustainability and short-term urgent housing barriers.</p> <p>To facilitate a case conference, we created a two-way member consent form to improve collaboration. Participating CoCs are now able to make immediate outreach to us upon discovering that our members need support. By matching our membership to the Homeless Management Information System (HMIS) database, we can identify our members who are actively receiving homelessness or housing</p>



MCO	Best and Emerging Practices
	<p>services. By leveraging the two-way release form, UnitedHealthcare can participate in a multidisciplinary approach to addressing needs (housing, behavioral health, justice-involved, medical, and vocational staff).</p> <p>Our case conferencing with the CoCs enables us to work with the agency providing services to locate, engage and provide a warm introduction to CHWs or behavioral health peers so we can ensure Medicaid benefits are accessible and understood. Current case conferencing data shows that we have conferenced on 75 families with 29 of them being sheltered since December 2022.</p> <p><b>Topic/Title:</b> One Pass</p> <p><b>Description:</b> To improve physical and mental well-being for our members and potentially reduce the risk of diseases, 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. UHC expanded this program to our CCC Plus population in support of the transition to Cardinal Care effective January 1, 2023. UHC also partners with in-network gyms/YMCAs for community events such as live cooking demonstrations complete with complimentary cookware and ingredients for featured recipes. Our pilot event was featured at the Petersburg Family YMCA. Over the last twelve months, we have accomplished a 500% increase in the number of Members using this benefit.</p> <p><b>Topic/Title:</b> Integrated Behavioral Health Home</p> <p><b>Description:</b> Our Integrated Behavioral Health Homes (IBHH) program is an innovative, integrated value-based program aimed at large outpatient community mental health centers (CMHCs). This program improves total cost of care by delivering key core services to attributed members, leveraging numerous BH and physical health quality and efficiency metrics and using comprehensive data sharing and technical support. By shifting the focus from the volume of services provided to the value of care delivered, the IBHH program enhances access to high-quality BH services. When compared to baseline data, the IBHH program drove between 25% and 40% improvement in Medication Adherence for Antidepressants, Antipsychotics, and Mood Stabilizers and a 30% reduction in inpatient admissions for members most vulnerable to crisis in the Commonwealth.</p> <p><b>Topic/Title:</b> Careforth</p> <p><b>Description:</b> UnitedHealthcare is partnering with Careforth to deliver caregiver support services to our family caregivers. Careforth focuses on engaging, empowering, educating and supporting caregivers. UHC understands that informal family caregivers are the safety net for our UHC members with complex needs who choose to remain living in the community rather than a nursing facility. Demands on caregivers are on the rise, and their own support needs are becoming more complicated. UnitedHealthcare recognizes the vital role caregivers play in supporting our members, often neglecting their own well-being. These vital</p>



MCO	Best and Emerging Practices
	<p>caregivers are often the “last mile” between an individual aging in a place of their choice and more costly options.</p>
<p>VA Premier</p>	<p><b>Topic/Title:</b> Health-Related Social Needs Team</p> <p><b>Description:</b> Developed a Health-Related Social Needs (HRSN) Team to support members with social needs that impact their health, such as housing, employment, and food scarcity. We combined the team of telephonic and field-based Housing Specialists and Social Workers to directly address members’ needs across the state.</p> <p><b>Topic/Title:</b> Case Conferencing with Homeless Shelters</p> <p><b>Description:</b> Established a process and a regular schedule with the Greater Richmond Continuum of Care (CoC) for homelessness, to conduct case conferencing on members who enter the shelter system.</p> <p><b>Topic/Title:</b> Personal ID Procurement</p> <p><b>Description:</b> Support members to obtain their identification documents, including state-issued photo ID, Social Security Card, and Birth Certificate. These present a barrier to applying for benefits, housing, and employment if they are missing. We assist members in getting their documents and cover the fees if needed.</p> <p><b>Topic/Title:</b> Financial Stability Planning Program</p> <p><b>Description:</b> Provide members with personal guidance to access benefits, education and training, and job search resources to improve their income and increase their independence.</p> <p><b>Topic/Title:</b> Welcoming Baby Program/ Community Health Worker Outreach</p> <p><b>Description:</b> Use of Certified Community Health workers to support maternal health. Welcoming Baby and Watch Me Grow Outreach programming for connections to community resources, one-on-one supportive services, telephone &amp; face to face, incentives &amp; events. Specialized training to:</p> <ul style="list-style-type: none"> <li>• Address social needs</li> <li>• Enhance health literacy</li> <li>• Outreach, screening, education, referral</li> </ul> <p><b>Topic/Title:</b> Chronic Care Management Program</p> <p><b>Description:</b> Chronic Care Management is a program that provides the following:</p>

MCO	Best and Emerging Practices
	<p>A. Assist member in managing Diabetes, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Heart Disease, Heart Failure, and Cancer via telephonic engagement from a Registered Nurse.</p> <p>B. Assist members to find and establish a relationship with a Primary Care Provider, transportation, and connection to other inter-services offered by the Health Plan.</p> <p>C. Develop a care plan and follow up with members to address barriers to receiving care.</p> <p>D. Print member education materials.</p> <p>E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care.</p> <p><b>Topic/Title:</b> Peer Support Specialist Program</p> <p><b>Description:</b> This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members’ social support systems, hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery.</p> <p><b>Topic/Title:</b> ARTS Transition of Care for all ASAM levels of care</p> <p><b>Description:</b> The ARTS Transition of Care team is primary for discharge planning for any member in ASAM levels of care. ARTS Care Coordinators (CC) manage all ASAM discharges to provide transition services for 14 days post discharge. In addition, the ARTS CC supports transitioning members throughout the ASAM outpatient continuum.</p> <p><b>Topic/Title:</b> UHS Telehealth Program</p> <p><b>Description:</b> This program expands telehealth access to Behavioral Health (BH) follow-up treatment to members who are discharged from the Emergency Department (ED) and inpatient stays. For members at Sentara Hospitals, the hospital staff in the ED rooms can use this telehealth program to schedule appointments for members in the ED.</p> <p><b>Topic/Title:</b> Edinburgh and 5’Ps Screening assessments for maternal population</p>

MCO	Best and Emerging Practices
	<p><b>Description:</b> BH Chronic Care Coordinators (CCC) administer the Edinburgh Postnatal Depression Scale for at-risk women receiving prenatal and postpartum care. Members with a positive screening are connected to appropriate maternal health providers for follow-up screening, monitoring, and treatment and ensure engagement. The BH CCC also utilize the 5 P’s (Parents, Peers, Partners, Past, and Present) Screening Tool for prenatal and postpartum women. This is a substance-use screening for at-risk women challenged with substance-use during pregnancy.</p> <p><b>Topic/Title:</b> Community Stabilization Team</p> <p><b>Description:</b> The goal of Community Stabilization Services is to stabilize the individual within the community and assist the individual and natural support system during the following: 1) initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care, if the appropriate level of care is identified but not immediately available for access 2) transitional step-down from a higher level of care, if the next level of care is identified but not immediately available or 3) diversion from a higher level of care. Community Stabilization Care Coordinators link/transition the individual to follow-up services and other needed resources to stabilize the individual within their community.</p> <p><b>Topic/Title:</b> Continuity of Care</p> <p><b>Description:</b> Behavioral Health and ARTS Inpatient Reviewers sends a notification at admission and discharge to the members’ Care Coordinator and/or BH/ARTS Transition of Care Coordinator to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission.</p>

## 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 2023–2025 QS’s goals and objectives. Note: The narrative within the Quality Initiatives section was provided by the MCO and has not been altered by HSAG except for minor formatting.

### Aetna

**Table D-1—Aetna’s QS Quality Initiatives**

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 1:</b> Enhance the Member Care Experience</p> <p><b>Objective 1.1:</b> Increase Member Engagement and Outreach</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Language Monitoring:</u> The Plan continues to conduct ongoing monitoring of membership population to assess and evaluate members’ language spoken to ensure member materials and services are available to meet members’ language needs and remain in alignment with Aetna’s health equity mission to assist members in obtaining personalized culturally and linguistically appropriate healthcare services.</p>	<p><b>Metric:</b> 1.1.1.2 Monitor Language and Disability Access Reports</p>
<p><b>Goal 1:</b> Enhance the Member Care Experience</p> <p><b>Objective 1.1:</b> Increase Member Engagement and Outreach</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Language Monitoring:</u> The Plan continues to conduct ongoing monitoring of membership population to assess and evaluate members’ language spoken to ensure member materials and services are available to meet members’ language needs and remain in alignment with Aetna’s health equity mission to assist members in obtaining personalized culturally and linguistically appropriate healthcare services.</p>	<p><b>Metric:</b> 1.1.1.3 Monitor Member Language Counts</p>
<p><b>Goal 1:</b> Enhance the Member Care Experience</p> <p><b>Objective 1.2:</b> Improve Member Satisfaction</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts</p>	<p><b>Metric:</b> 1.2.1.1 Rating of all Health Care</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>deep dives into barriers related to members not having a PCP, members’ ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	
<p><b>Goal 1:</b> Enhance the Member Care Experience <b>Objective 1.1:</b> Improve Member Satisfaction</p>	<p><b>Description of Quality Initiative:</b> <u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members’ ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	<p><b>Metric:</b> 1.2.1.2 Rating of Personal Doctor</p>
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care <b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b> <u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members’ ability to get urgent and</p>	<p><b>Metric:</b> 2.1.1.1 Getting Care Quickly</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members’ ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	<p><b>Metric:</b> 2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed</p>
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>HEDIS and CAHPS Workgroup:</u> Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members’ ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access</p>	<p><b>Metric:</b> 2.1.1.3 Getting Needed Care</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.3:</b> Promote Patient Safety</p>	<p><b>Description of Quality Initiative:</b>  <u>Improved Critical Incident Report Process and Data Management:</u>            Ongoing curriculum focused education and training for providers and care management staff, software application edits and additions for submission and management of reports, critical incident identification, and reporting process. Additionally, the Plan added a dedicated trainer to address CM urgent and ongoing training needs, which includes a curriculum</p>	<p><b>Metric:</b> 2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification</p>
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>	<p><b>Description of Quality Initiative:</b>  <u>HEDIS and CAHPS Workgroup:</u>            Multi-departmental workgroup that continuously looks for opportunities to improve member and provider satisfaction. The workgroup conducts deep dives into barriers related to members not having a PCP, members’ ability to get urgent and routine appointments as needed, obtaining needed information from Member Services, and having access to highly rated or specialty providers. The workgroup focuses on initiatives that encourage same-day scheduling, increasing utilization of telehealth services, improving communications between providers and members, and increasing member use of patient-centered medical homes.</p>	<p><b>Metric:</b> 2.3.1.1 How Well Doctors Communicate</p>



Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>BH/ARTS Preferred Provider Program:</u> Aetna-designed BH/ARTS Preferred Provider program for private and public providers that reduces administrative burdens for providers, allowing members to get access to care more quickly.</p> <p><u>Behavioral Health Clinical Liaison Team:</u> A best-in-class model that provides integrated Utilization Management and Care Management supports to members with BH/substance use disorder combined with high touch provider collaboration, connection, and training.</p>	<p><b>Metric:</b> 2.3.1.2 Service Authorizations</p>
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Readmission Avoidance Program (RAP):</u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p>	<p><b>Metric:</b> 3.1.1.1 Frequency of Potentially Preventable Admissions</p>
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Ambulatory Care – Emergency Department Visits Initiative:</u> Care Managers educating and reminding members about the availability of 24 hr. nurse line services and ED utilization during every contact.</p>	<p><b>Metric:</b> 3.1.1.3 Frequency of Potentially Preventable Emergency Department Visits</p>
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Readmission Avoidance Program (RAP):</u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p>	<p><b>Metric:</b> 3.1.1.3 Frequency of Potentially Preventable Readmissions</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Value Based Agreements:</u> Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.</p> <p><u>Provider Collaborated Outreach and Onsite Clinic Days:</u> QM collaborates with high-density provider offices to outreach members identified as not having completed a well-child visit or vaccines. Staff assists with scheduling appointment during planned clinic days for which Plan QM staff will be onsite.</p>	<p><b>Metric:</b> 3.1.1.4 Ambulatory Care</p>
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>AMB PIP Intervention:</u> Care manager educate members on availability of 24-hour Nurse Line services and ED/ER utilization during every contact.</p>	<p><b>Metric:</b> 3.1.1.5 Ambulatory Care: Emergency Department (ED) Visits</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Value Based Agreements:</u> Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.</p>	<p><b>Metric:</b> 4.1.1.1 Adults’ Access to Preventive/Ambulatory Health Services</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age</p>	<p><b>Metric:</b> 4.1.1.2 Child and Adolescent Well-Care Visits</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><u>Targeted Member Outreach:</u> Dedicated team outreaches parents/guardians of members in Petersburg area aged 0-20 years identified as being past due for a well-child visit and assists with scheduling appointments.</p> <p><u>Provider Collaborated Outreach and Onsite Clinic Days:</u> QM collaborates with high-density provider offices to outreach members identified as not having completed a well-child visit or vaccines. Staff assists with scheduling appointment during planned clinic days for which Plan QM staff will be onsite.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information</p>	<p><b>Metric:</b> 4.1.1.3 Child Immunization Status</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><u>CIS SMS Text Campaign:</u> Vendor initiated SMS text messaging to members identified as not having completed all age-appropriate recommended immunizations reminding them of importance of completing them.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><u>Ted E. Bear M.D. Wellness Club:</u> Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).</p> <p><u>HPV Vaccine Adherence Program:</u> Conducted live outreach calls to</p>	<p><b>Metric:</b> 4.1.1.4 Immunizations for Adolescents</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	members aged 9-13 years in Petersburg, identified as not having completed the HPV vaccine series with follow up educational flyers mailed to unable to reach members.	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>CVS Health Tags:</u> CVS Pharmacies attach messages to prescription bags that educates members about the importance of flu vaccination</p> <p><u>MS Hold Line Flu Shot Message:</u> When members call into plan, they will hear a recorded message reminding them to get their free flu shot.</p>	<p><b>Metric:</b> 4.1.1.5 Flu Vaccinations for Adults 18-64</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p>	<p><b>Metric:</b> 4.1.1.6 Topical Fluoride for Children</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health</p>	<p><b>Metric:</b> 4.1.1.7 Oral Evaluation, Dental Services</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p>issues and tips on how to keep the child safe and healthy.</p> <p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Preventive Screening Brochure:</u> A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.</p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p>	<p><b>Metric:</b> 4.1.1.8 Sealant Receipt of Permanent First Molars</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><u>Ted E. Bear M.D. Wellness Club:</u> Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child</p>	<p><b>Metric:</b> 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Well Woman Exam Incentive:</u> Eligible members can earn gift card for completing Pap Smear, Mammogram, Chlamydia Screening, Colorectal Cancer Screening, and Flu Vaccine.</p> <p><u>Moving On: Transitioning from Pediatrics to Primary Care:</u> Members between the ages of 18-20 years can earn a reward for completing preventive care services, adult medical screenings, weight management, and recommended vaccines.</p>	<p><b>Metric:</b> 4.1.1.10 Chlamydia Screening in Women Ages 16 to 20</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Birthday Mailers:</u> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><u>Ted E. Bear M.D. Wellness Club:</u> Kids program encompassing children ages newborn to 17 years that incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).</p>	<p><b>Metric:</b>4.1.1.11 Lead Screening in Children</p>



Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Maternity Incentive:</u> Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments.</p> <p><u>New Moms Box:</u> Value-added service offers eligible members who are pregnant through one year postpartum \$25 monthly to spend on over-the-counter items for themselves and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get a fee breast pump and 300 count free size one baby diapers delivered to their home after their baby is born.</p> <p><u>Postpartum Depression (PPD) Initiative:</u> BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members and encourage postpartum appointment adherence during virtual baby showers.</p> <p><u>Postpartum Text Campaign:</u> Women identified as having received prenatal or postnatal care in the last 18 months receive text alerts to reminding them of the importance of follow up care with their provider.</p>	<p><b>Metric:</b> 4.2.1.1 Prenatal and Postpartum Care: Postpartum Care</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Maternity Incentive:</u> Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments.</p> <p><u>New Moms Box:</u> Value-added service offers eligible members who are pregnant through one year postpartum \$25 monthly to spend on</p>	<p><b>Metric:</b> 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>over-the-counter items for themselves and their baby through CVS Pharmacy. New moms can also attend baby showers and earn prizes. Plus, new moms can get a fee breast pump and 300 count free size one baby diapers delivered to their home after their baby is born.</p> <p><u>Virtual Baby Showers</u>: Quarterly virtual baby shower for Medicaid members statewide that provide pregnant women an opportunity to celebrate their soon-to-be-arrival within the comfort and safety of their own homes. The Plan educates attendees with dietary, physical, and dental health recommendations.</p> <p><u>Timeliness of Prenatal Care PIP Intervention</u>: Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assist with scheduling first trimester prenatal appointments.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Maternity Incentive</u>: Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments.</p> <p><u>Benefits of Quitting: Tobacco Use Cessation in Pregnant Women</u>: Health Plan and American Cancer Society cobranded flyer that educates members about the benefits of quitting smoking/ tobacco cessation and the health risks of smoking during pregnancy.</p> <p><u>Timeliness of Prenatal Care PIP Intervention</u>: Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and</p>	<p><b>Metric:</b> 4.2.1.3 Live Births Weighing Less than 2,500 Grams</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>assist with scheduling first trimester prenatal appointments.</p> <p><i>Progeny:</i> A program that aims to improve NICU infant outcomes, decrease the cost of NICU care, and increase member and provider satisfaction. The program includes utilization and care management teams that monitor the baby telephonically from NICU admission and maintain consistent interaction with the hospital team through a care plan driven approach. The care management team connects with the family early in the hospital stay and continues to support them for the entire first year.</p> <p><i>Preeclampsia Prevention:</i> Provides high-risk pregnant members with a personalized prenatal care kit containing education about preeclampsia risk factors and low-dose aspirin and supports women to have conversations with their providers about their risk and steps they can take to reduce it.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><i>EPSDT Birthday Mailers:</i> Health education postcards mailed to members (parents) birth-20 years notifying them that they are due for a well child visit. Each postcard is age appropriate and lets parents know what they can expect at their child’s check-up and what they can do to prepare for the appointment. The mailers also include important education and other information related to age-appropriate health issues and tips on how to keep the child safe and healthy.</p> <p><i>Ted E. Bear M.D. Wellness Club:</i> Kids program encompassing children ages newborn to 17 years that</p>	<p><b>Metric:</b> 4.2.1.4 Well-Child Visits in the Frist 30 Months of Life</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>incentivizes parents to ensure their child completes an annual well-child check-up. Every child receives an enrollment age-appropriate gift and a gift card upon completion of well-child visits (gift cards vary based on age group).</p> <p><u>IWC Outreach:</u> Dedicated team outreaches parents/guardians of members aged 15 months identified as being past due for well-child visit and assists with scheduling appointments.</p> <p><u>National NBA:</u> Direct mail, SMS, emails, and live calls to members (0-30 months) identified as not having completed well-child visit.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Maternity Incentive:</u> Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments.</p> <p><u>Timeliness of Prenatal Care PIP Intervention:</u> Care managers outreach members within 15 days of receiving monthly Maternal Care Report to educate members about the importance of completing and assist with scheduling first trimester prenatal appointments. Additional CM follow up occurs within 15 days of making appointment referral.</p> <p><u>High Risk Pregnancy NBA:</u> Initiative that sends educational material to high-risk pregnant women informing them about gestational diabetes, hypertension, and preterm labor and how to stay healthy during pregnancy.</p>	<p><b>Metric:</b> 4.2.1.5 Low-Risk Cesarean Delivery</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Non-Traditional Provider Education:</u> Quality Management staff educate providers about how to write</p>	<p><b>Metric:</b> 4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Objective 4.3:</b> Improve Home and Community-Based Services</p>	<p>corrective action plans and publish Provider Newsletter articles educating community-based providers about trended review findings and helpful best practices and resources to aid in improving health outcomes for waiver members.</p>	<p>to Their Needs and Personal Goals</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Readmission Avoidance Program (RAP):</u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p> <p><u>Chronic Conditions Education Series:</u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p>	<p><b>Metric:</b> 5.1.1.1 Heart Failure Admission Rate</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Readmission Avoidance Program (RAP):</u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p> <p><u>Chronic Conditions Education Series:</u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p>	<p><b>Metric:</b> 5.1.1.2 Asthma Admission Rate</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p><u><i>Asthma/COPD Inhaler NBA:</i></u> Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u><i>Readmission Avoidance Program (RAP):</i></u> Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care Management to engage at the intensive level of care for 30-days post discharge.</p> <p><u><i>Chronic Conditions Education Series:</i></u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p> <p><u><i>Asthma/COPD Inhaler NBA:</i></u> Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.</p>	<p><b>Metric:</b> 5.1.1.3 COPD and Asthma in Older Adults’ Admission Rate</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u><i>Diabetes Incentive:</i></u> Members can earn a reward for completing their A1c blood test, blood pressure check, and dilated retinal exam.</p> <p><u><i>Diabetes Text Campaign:</i></u> Health education texts to members with diabetes encouraging them to complete their annual wellness exams and diabetes screening tests.</p> <p><u><i>Diabetes and Cholesterol Mailers:</i></u> Health Plan postcards mailed to members educating them on</p>	<p><b>Metric:</b> 5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>diabetes and cholesterol medication management.</p> <p><u>My ActiveHealth</u>: Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking.</p> <p><u>Primary Health Care Model for Adults</u>: Gender specific educational brochures educating members about the importance of completing recommended health screenings with PCP/Specialist.</p> <p><u>Moving On: Transitioning from Pediatrics to Primary Care</u>: Members between the ages of 18-20 years can earn a reward for completing preventive care services, adult medical screenings, weight management, and recommended vaccines.</p> <p><u>Chronic Conditions Education Series</u>: Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p> <p><u>CPT II Code Incentive</u>: Provider incentive of \$25 for submitting claims with CPT II codes for Diabetes A1c testing, blood pressure, and eye exams, prenatal and postpartum visits, and immunizations.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>My ActiveHealth</u>: Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking.</p>	<p><b>Metric:</b> 5.1.1.5 Controlling High Blood Pressure</p>



Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p><u><i>Chronic Conditions Education Series:</i></u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p> <p><u><i>Wellness Incentive:</i></u> Members can earn rewards for completing recommended screenings and annual wellness exams.</p> <p><u><i>CPT II Code Incentive:</i></u> Provider incentive of \$25 for submitting claims with CPT II codes for Diabetes A1c testing, blood pressure, and eye exams, prenatal and postpartum visits, and immunizations.</p> <p><u><i>Outreach Call Campaign:</i></u> Plan conducted live outreach call to members identified as not having completed a blood pressure screening and to discuss dietary recommendations and access to PCP.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p><u><i>My ActiveHealth:</i></u> Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking.</p> <p><u><i>Chronic Conditions Education Series:</i></u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p> <p><u><i>Asthma/COPD Inhaler NBA:</i></u> Multiple channels educating members</p>	<p><b>Metric:</b> 5.1.1.7 Asthma Medication Ratio: Ages 5 to 18 Years</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Residential Substance Use Disorder (SUD) Discharge Program:</u> Plan partners with residential treatment facilities to offer support with recovery planning, housing, transportation, food, workforce engagement, engagement with needed medical/psychiatric services for members returning to home community after discharge.</p> <p><u>National Opioid Use Disorder (OUD) Program:</u> Collaboration with providers to reduce opioid prescriptions/increase medication assisted treatment (MAT) by educating them about prescribing behavior and opportunities for member intervention, sharing member data so they can focus their outreach and engagement members with OUD in care management.</p> <p><u>Harm Reduction Coalitions:</u> Aetna donation to purchase supplies and educate communities around opioid use disorder and prevention.</p>	<p><b>Metric:</b> 5.3.1.1 Monitor Identification of Alcohol and Other Drug Services</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Community Health Workers Initiative:</u> Community Health Workers located throughout each region to link members to safe housing, local food markets, job opportunities and training, access to health care services, community-based resources, transportation, recreational activities, and other services</p> <p><u>Find Help Initiative:</u> Site used to provide resources and services for social determinants of health</p>	<p><b>Metric:</b> 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Annual DUR Program Initiative:</u> Program that targets outreach to providers prescribing over 90 milligram morphine equivalent (mme)/day. A list of members is shared along with a peer matched prescriber report card. This reporting shares information with the provider and highlights the importance of ensuring members have access to naloxone.</p>	<p><b>Metric:</b> 5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Residential Substance Use Disorder (SUD) Discharge Program:</u> Plan partners with residential treatment facilities to offer support with recovery planning, housing, transportation, food, workforce engagement, engagement with needed medical/psychiatric services for members returning to home community after discharge.</p> <p><u>Justice Integrated Care Pilot Program:</u> Program targeting members returning to the community, that includes an integrated care team to coordinate case management services, conduct health screenings, identify health-related social needs (HRSNs) and make closed loop referrals to community organizations that can address them and discuss participant needs through integrated weekly rounds. The team includes an Adult and Juvenile System of Care Administrators, Peer Support Specialists, Community Health Worker, and Sr. Clinical Strategist. The program will be expanded into other areas of the state.</p>	<p><b>Metric:</b> 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p><u><i>The High Utilizers of Virginia (HUV) Program:</i></u> Program emphasizing 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.</p> <p><u><i>Development of Behavioral Health Toolkits:</i></u> Educational publications specific to coping strategies, managing stress and decompensation, how to access services, helping members recognize symptoms, and how to access services – Distributed to inpatient facilities and schools.</p>	<p><b>Metric:</b> 5.4.1.1 Follow-Up After Hospitalization for Mental Illness</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u><i>The High Utilizers of Virginia (HUV) Program:</i></u> Program emphasizing 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</p>	<p><b>Metric:</b> 5.4.1.2 Follow-Up After Emergency Department for Mental Illness</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	among providers, reduce mental health admissions, general hospital admissions, ED visits, and overall cost of care for and among participants.	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>2023 Interactive Voice Response (IVR) Message Outreach Initiative:</u> IVR campaign educating members about the importance of follow up care for children prescribed ADHD/ADD Medications, within 30 days and throughout treatment is ongoing.</p> <p><u>ADHD Initiative:</u> Campaign that outreaches and educate providers, and parents/guardians based on new fill pharmacy reports to remind parents to set up follow up appointments and use of non-medication management education resources. The program also includes CM outreach to members how have started the initiation phase of the medication and are non-adherent to their medication with a 6-month rolling period.</p> <p><u>Member Educational Brochure:</u> Educational publication that includes behavioral therapies and how to access MyActive Health via the member portal.</p>	<p><b>Metric:</b> 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Transition Age Youth (TAY):</u> Targets members ages 16-29 years to reduce utilization of emergency services and inpatient admissions. The program is based on the Transition to Independence Process (TIP) Model, an evidence-supported practice that focuses on youth engagement, futures planning, and skill-building through a person-centered, strength-</p>	<p><b>Metric:</b> 5.4.1.4 Monitor Mental Health Utilization</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>based approach. Members who meet admissions thresholds benefit from focused care coordination, advanced engagement, connection with appropriate formal and informal services and natural and community support, as well as flexible individualized plans for treatment.</p> <p><u>Postpartum Depression (PPD) Initiative:</u> BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members and encourage postpartum appointment adherence during virtual baby showers.</p> <p><u>Richmond Behavioral Health Authority (RBHA) Enhanced Care Coordination (ECC) Initiative:</u> Value-based program with a community partner to provide enhanced care coordination to manage needs of adult members with co-morbid behavioral health and physical health needs. Includes review of claims history and authorizations to identify members with gaps in care. Aetna staff educate partner staff about covered benefits and formulary, as well as referrals to in-network providers as needed. Monthly rounds are held to coordinate care.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>The High Utilizers of Virginia (HUV) Program:</u> Program emphasizing 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</p>	<p><b>Metric:</b> 5.4.1.1 Follow-Up After Hospitalization for Mental Illness</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>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.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Flourish Health Partnership Initiative:</u> Program focuses on first episode psychosis and serious mental illness for members/enrollees ages 13-26 years to offer family systems therapy, in-person, and telehealth support, medication monitoring, and skills development.</p> <p><u>Prior Authorization Criteria Utilized:</u> Clinical Criteria for Antipsychotics in children less than 18 years of age</p>	<p><b>Metric:</b> 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Behavioral Health Case Management Member Engagement Initiative:</u> Program focused on engaging member, educating them about regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and address transportation, childcare, and other social determinants of health (SDOH) challenges/issues.</p> <p><u>DUR program Initiative:</u> Reviews and monitors children on concomitant antipsychotics and antidepressants</p> <p><u>Gaps in Care Reporting:</u> Plan generated gap in care reports with information on eligible members that</p>	<p><b>Metric:</b> 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics</p>



Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>are due or overdue for care and screening.</p> <p><u>High ED Utilizer Monitoring Initiative:</u> Identification of and outreach to educate high ED utilizers and members who utilize ED for conditions that could be treated at a lower level of care.</p> <p><u>Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:</u> Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1<sup>st</sup> atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence.</p> <p><u>CVS Pharmacy Advisor Program Initiative:</u> Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA antidepressants for members under 17 years old.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Chronic Conditions Education Series:</u> Quarterly virtual education sessions for members with chronic conditions. Each session is hosted by Health Plan staff or non-profit organization guest speaker relevant to the session topic and provides information and help tips about how to better manage chronic conditions.</p>	<p><b>Metric:</b> 5.4.1.7 Medial Assistance with Smoking and Tobacco Use Cessation</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Member Outreach Letters:</u> Outreach letters sent to members identified as having been prescribed</p>	<p><b>Metric:</b> 5.4.1.8 Antidepressant Medication Management</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
Developmental Services for Members	antidepressant medications to inform them of 90-day medication supply	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>EPSDT Periodicity Schedule:</u> Provider education about the EPSDT requirement to screen all children ages 12-20 years for depression, utilizing a validated, standardized screening tool.</p> <p><u>Postpartum Depression (PPD) Initiative:</u> BH and CM collaborate to conduct targeted outreach members identified as receiving prenatal or postnatal care in the last 18 months to educate them about PPD and how to identify symptoms and seek treatment. BH clinical liaisons also educate members and encourage postpartum appointment adherence during virtual baby showers.</p> <p><u>Postpartum Text Campaign:</u> Women identified as having received prenatal or postnatal care in the last 18 months receive text alerts to reminding them of the importance of follow up care with their provider.</p> <p><u>Provider Manual and Education/Training:</u> Includes guidance for screening depression, anxiety, post-traumatic stress disorder, through pediatric and adult tools. Providers are informed they can access these screenings utilizing our provider portal. Additionally, CM staff is trained on the use of screening tools and offers offer providers monthly virtual and recorded training on these tools.</p>	<p><b>Metric:</b> 5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Behavioral Health Case Management Member Engagement Initiative:</u> Program focused on engaging member, educating them about</p>	<p><b>Metric:</b> 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
<p>Developmental Services for Members</p>	<p>regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and address transportation, childcare, and other social determinants of health (SDOH) challenges/issues.</p> <p><u>Gaps in Care Reporting:</u> Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening.</p> <p><u>HEDIS Toolkit:</u> Comprehensive Plan-developed provider educational resource educating providers about HEDIS measure specifications, applicable coding, and tips. Our Toolkit is available on our website on the provider portal. The onsite and webinar practitioner HEDIS trainings also include instructions for how to use the HEDIS toolkit.</p> <p><u>High ED Utilizers Initiative:</u> Case managers continue to identify high ED utilizers and those members that use ED for conditions that could be treated at a lower level of care; outreach those members and their PCP/BH practitioner.</p> <p><u>Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:</u> Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1<sup>st</sup> atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence.</p> <p><u>CVS Pharmacy Advisor Program Initiative:</u> Geared to increase</p>	

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA antidepressants for members under 17 years old</p> <p><u>Medication Therapy Management Initiative:</u> Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>Behavioral Health Case Management Member Engagement Initiative:</u> Program focused on engaging member, educating them about regular screening, encouraging participation in Case Management. Includes support from CM to help schedule follow-up appointments and address transportation, childcare, and other social determinants of health (SDOH) challenges/issues.</p> <p><u>Gaps in Care Reporting:</u> Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening.</p> <p><u>HEDIS Toolkit:</u> Comprehensive Plan-developed provider educational resource educating providers about HEDIS measure specifications, applicable coding, and tips. Our Toolkit is available on our website on the provider portal. The onsite and webinar practitioner HEDIS trainings also include instructions for how to use the HEDIS toolkit.</p> <p><u>High ED Utilizers Initiative:</u> Case managers continue to identify high ED utilizers and those members that use ED for conditions that could be treated at a lower level of care;</p>	<p><b>Metric:</b> 5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</p>

Virginia QS Aim and Goal	Aetna’s Quality Initiative	Performance Metric
	<p>outreach those members and their PCP/BH practitioner.</p> <p><u>Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:</u> Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1<sup>st</sup> atypical script with follow-up monitoring and information on how to help members engage in other covered services that can mitigate metabolic impact of this therapy and improve adherence.</p> <p><u>CVS Pharmacy Advisor Program Initiative:</u> Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA antidepressants for members under 17 years old</p> <p><u>Medication Therapy Management Initiative:</u> Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><u>NBA Adherence Program Initiative:</u> Provides members with refill reminder leveraging channels such as IVR, SMS, and direct mail. Initiative utilizes predictive analytics to identify members who will be nonadherent to therapy. By sharing reminders, we equip members with the information to contact their pharmacy and fill the respective drug. Additionally, the PBM provides a drop in therapy notification to providers when nonadherence has been observed.</p>	<p><b>Metric:</b> 5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia</p>

## HealthKeepers

**Table D-2—HealthKeepers’ Quality Strategy Quality Initiatives**

Virginia QS Goals and Objectives	HealthKeepers’ Quality Initiative	Performance Metric
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Care</p> <p><b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan</p>	<p><b>Metric:</b> 2.1.1.9 Breast Cancer Screening</p> <p><i>Note: Not a DMAS QS Metric.</i></p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>EPSDT Birthday Reminders: Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90 days from the member’s birthday they have not had their Well Visit, we will send out another reminder to get services completed.</p>	<p><b>Metric:</b> 4.1.1.2 Child and Adolescent Well-Care Visits</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>EPSDT Co-Branding Initiative: Partnering with high volume providers to distribute reminders for overdue services. Co-Branded Birthday Reminders are sent out approximately 45-60 days before the members birthday to remind them to go in for services that are due. If after 90 days from the member’s birthday they have not had their Well Visit, we will send out another reminder to get services completed.</p>	<p><b>Metric:</b> 4.1.1.2 Child and Adolescent Well-Care Visits</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and</p>	<p><b>Description of Quality Initiative:</b></p> <p>EPSDT Birthday Reminders: Reminders are sent out approximately 45-60 days before the member’s birthday to remind them to go in for services that are due. If after 90 days</p>	<p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
Prevention Services for Members	<p>from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.</p> <p>Age Out Immunization Outreach: Targets members who need immunizations who have aged out AND members who are about to age out to get immunized in a timely manner</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Age Out Immunization Outreach: Targets members who need immunizations who have aged out and members who are about to age out to get immunized in a timely manner</p>	<p><b>Metric:</b> 4.1.1.4 Immunizations for Adolescents</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p> <p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	<p><b>Metric:</b> 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p>	<p><b>Metric:</b> 4.1.1.10 Chlamydia Screening in Women Ages 16 to 20</p>



Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b>            HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan</p>	<p><b>Metric:</b> 4.1.1.11 Lead Screening in Children</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b>            New Baby New Life Program: This program provides quality, culturally competent case management to pregnant Medicaid members during the prenatal and postpartum periods. At-risk pregnant members are supported by a dedicated OB Nurse Case Manager who encourages the member to take action to optimize the outcome of her pregnancy, prepare for the delivery and homecoming of her infant, and participate in her infant's care should a NICU stay be required. All members identified as pregnant and recently delivered, receive an educational packet with self-care booklets and additional resources. In addition, providers receive an educational packet as well.</p> <p>Program: The Availity Maternity HEDIS® Attestation Tool: Requires OB clinics to notify Anthem if an Anthem patient is pregnant during the check-in process. The notification occurs through a secure data file which links to the care management system and triggers for outbound calls to members for risk screening and enrollment in appropriate case management or care coordination services. The tool also includes HEDIS alerts to remind providers to schedule timely postpartum appointments. When an OB provider checks eligibility and the member is</p>	<p><b>Metric:</b> 4.2.1.2 Prenatal and Postpartum Care: Postpartum Care</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered.</p> <p>Program: 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.</p> <p>Program: My Advocate: is maternal health education by telephone, text message and by Smartphone app to pregnant women and postpartum women. Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. The application provides for live chats over the My Advocate™ Dashboard. This program uses the OB screener which allows for stratification of the member into low, mid, high. If they are ranked high-risk, they are assigned a CM.</p> <p>HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is faxed/distributed to health care providers.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>New Baby New Life Program: This program provides quality, culturally competent case management to pregnant Medicaid members during the prenatal and postpartum periods. At-risk pregnant members are supported by a dedicated OB Nurse Case Manager who encourages the member to take action to optimize the outcome of her pregnancy, prepare for the delivery and homecoming of her infant, and participate in her infant's care should a NICU stay be required. All members identified as</p>	<p><b>Metric:</b> 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>pregnant and recently delivered, receive an educational packet with self-care booklets and additional resources. In addition, providers receive an educational packet as well.</p> <p>The Availity Maternity HEDIS® Attestation Tool: Requires OB clinics to notify Anthem if an Anthem patient is pregnant during the check-in process. The notification occurs through a secure data file which links to the care management system and triggers for outbound calls to members for risk screening and enrollment in appropriate case management or care coordination services. The tool also includes HEDIS alerts to remind providers to schedule timely postpartum appointments. When a OB provider checks eligibility and the member is an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered.</p> <p>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.</p> <p>My Advocate: is maternal health education by telephone, text message and by Smartphone app to pregnant women and postpartum women. Pregnant/postpartum women are provided answers to their questions and directed to community and medical support if needed. The application provides for live chats over the My Advocate™ Dashboard. This program uses the OB screener which allows for stratification of the member</p>	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>into low, mid, high. If they are ranked high-risk, they are assigned a CM.</p> <p>HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is faxed/distributed to health care providers.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Visit Compliance Report: Monthly report that identifies the number of visits needed for compliancy.</p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed to healthcare providers.</p> <p>HEDIS Well Child and Immunizations Coding Tips Bulletin: This is a bulletin intended to provide coding guidance to health care providers for Well Child and Immunizations. This is faxed/distributed to health care providers.</p>	<p><b>Metric:</b> 4.2.1.4 Well-Child Visits in the First 30 Months of Life</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on Controlling Hypertension. Job aide includes education on Hypertension risk factors, how to manage high blood pressure. Smoking cessation information is provided</p>	<p><b>Metric:</b> 5.1.1.1 PQI 08: Heart Failure Admission Rate</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Description of Quality Initiative:</b></p> <p>Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in</p>	<p><b>Metric:</b> 5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
<p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p>educating members on the disease process of COPD (Chronic Obstructive Pulmonary Disease). Job aide includes education on Asthma disease process, medications such as the importance of maintenance/controller medications and rescue inhalers (bronchodilators), asthma action plan and information when to call 911, knowing triggers</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on the disease process of COPD (Chronic Obstructive Pulmonary Disease). Job aide includes education on COPD disease process, medications such as bronchodilators short and long acting, COPD action plan information and when to call 911, how to avoid triggers</p>	<p><b>Metric:</b> 5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>Care Coordination Outreach Healthwise Job Aides: Assisting Care Coordinators/Case Managers in educating members on the disease process of Diabetes. Job aide includes education on Diabetes disease process, most commonly prescribed medications, risk factors and prevention, A1c testing, diet and exercise, how to obtain a glucose meter</p> <p>CVS Health Tags Program: CVS provides written health messages and assistance from a Tech.</p> <p>HEDIS Cat II Coding Tips Bulletin: This is a bulletin intended to provide Cat II coding guidance. This is</p>	<p><b>Metric:</b> 5.1.1.4 Diabetes Care for Patients with Diabetes: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>faxed/distributed to health care providers, by the health plan.</p> <p>Zip Drug Program: Connects members to high-quality participating pharmacies to administer clinical services (such as BP screenings, A1c monitoring). Monitors members for adherence improvement, HEDIS gap closure, and cost-of-care reduction.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p> <p>CVS Health Tags Program: CVS provides written health messages and assistance from a Tech.</p> <p>Zip Drug Program: Connects members to high-quality participating pharmacies to administer clinical services (such as BP screenings, A1c monitoring). Monitors members for adherence improvement, HEDIS gap closure, and cost-of-care reduction.</p>	<p><b>Metric:</b> 5.1.1.5 Controlling High Blood Pressure</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the</p>	<p><b>Metric:</b> 5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	health plan as a resource for specific HEDIS Measures and Codes.	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p>Emergency Department Care Coordination Program: Anthem Inc, in partnership with DMAS and PointClickCare, is utilizing PreManage, a platform that connects all MCO's with hospital emergency room departments across the state via a two-portal interface allowing for the real-time sharing of member level information that our care coordinators use daily to drive member care. Via this portal Care Coordinators, ER staff and downstream providers share information, collaborate on care planning, and utilize actionable insights to improve outcomes for our members. Anthem Inc was identified as a forerunner in the initial full implementation and utilization of the product as well as playing a key role in the on boarding of downstream providers.</p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p>	<p><b>Metric:</b> 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use Disorders</p>



Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p> <p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	<p><b>Metric:</b> 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p>	<p><b>Description of Quality Initiative:</b></p> <p>Substance Use Disorder Medication Management with Medication Assisted Therapy: Provider Fax to promote continuity of Medication Assisted Therapy (MAT) through medication adherence and BH follow up care.</p>	<p><b>Metric:</b> 5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Gold Card Program: Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card</p>	<p><b>Metric:</b> 5.4.1.1 Follow-Up After Hospitalization for Mental Illness</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly responsive to assisting with emergent member needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network.</p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p> <p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Gold Card Program: Authorizations/registrations for specific CMHRS are waived for select proven quality providers. This serves as an incentive to our top-tier providers while motivating others to ensure they are providing quality services in an efficient manner. In addition, internal staffing opportunities are created for the effective management of those providers requiring extra attention. Gold card providers are forward thinking, creative and many are currently partnered with us on additional programs. They work closely with our care coordinators and are highly</p>	<p><b>Metric:</b> 5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>responsive to assisting with emergent member needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network.</p> <p>Emergency Department Care Coordination Program: Anthem Inc, in partnership with DMAS and PointClickCare, is utilizing PreManage, a platform that connects all MCO's with hospital emergency room departments across the state via a two-portal interface allowing for the real-time sharing of member level information that our care coordinators use daily to drive member care. Via this portal Care Coordinators, ER staff and downstream providers share information, collaborate on care planning, and utilize actionable insights to improve outcomes for our members.</p> <p>In partnership with Flourish Health members with SMI (serious mental illness) and SED (serious emotional disturbance) between the ages of 13 and 26 receive high touch in person support in combination with virtual therapeutic and psychiatric care empowering our members to achieve effective and lasting outcomes. Services offered include individual group and family therapy, medication management, mentorship and guidance, community resource navigation and 24/7 crisis support. In addition, a Fitbit wearable device with a mobile app to encourage a healthy lifestyle is provided. With the above programming in place engaged members will be supported and therefore better equipped to lead a quality life in the community with a</p>	

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>decrease in IP BH admission and ED utilization.</p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.</p> <p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.</p> <p>HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.</p>	<p><b>Metric:</b> 5.4.1.3 Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Description of Quality Initiative:</b></p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have</p>	<p><b>Metric:</b> 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
<p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p>enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p>	
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p>	<p><b>Metric:</b> 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>OB Practice Consultants meet with OBQIP providers in the OBQIP provider incentive program to close prenatal and postpartum gaps. Consultants encourage providers to refer members to 1-800-QuitNow or to the CM team for other resources.</p> <p>Care Coordinators and Case Managers educate members regarding the dangers of smoking and tobacco use, the different forms of tobacco use such as vaping, and the different modalities for cessation, including support groups.</p> <p>mPulse Text Messages: Informative and/or educational text messages via mPulse to members regarding timely prenatal visits, as a reminder to make an appointment with their OB and educate members on tobacco cessation.</p>	<p><b>Metric:</b> 5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Anti-Depressant New Start Behavioral Health Medication Management: Member: New Start Education: Analysis of pharmacy claims identify a new (first time) prescription for Depression medications: Member Live calls New Start education and Pharmacist outreach to members recently started on an anti-depressant medication to provide medication education, expectations, and address barriers to adherence.</p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p>	<p><b>Metric:</b> 5.4.1.8 Antidepressant Medication Management</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p>	<p><b>Metric:</b> 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Antipsychotic Medication Adherence Standalone Provider Fax: Targets members who are nonadherent to antipsychotic or bipolar medications; less than 80% PDC.</p> <p>Data Deep Dives: Data deep dives, are intensive and targeted analyses of</p>	<p><b>Metric:</b> 5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia</p>

Virginia QS Goals and Objectives	HealthKeepers' Quality Initiative	Performance Metric
	<p>specific HEDIS measures, that have enabled the Quality team to develop tailored, strategic interventions to improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.</p> <p>Member Outreach: Member Gap in Care outreach to refill medication, attend follow-up appointments and lab testing through Member email, telephone calls, and letters.</p>	

## Molina

**Table D-3—Molina’s Quality Strategy Quality Initiatives**

Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups by conducting monthly meetings, sharing of comprehensive gap reports, tactical strategies, provide support for member outreach and scheduling to new or existing patient to link members with providers as part of their care team, and coordination of care with our CM team with need is identified.</p>	<p><b>Metric:</b> 4.1.1.1 Adults’ Access to Preventive/Ambulatory Health Services</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Molina partners with CVS to promote sharing of education materials to help members clearing understand the importance of timely medication refills and usage.</p>	<p><b>Metric:</b> 5.1.1.7 Asthma Medication Ratio</p>



Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups to conduct monthly meetings, create a tactical workplan, share comprehensive gaps in care report, provide staffing support for member outreach when need is identified</p>	<p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Target member list of members who have a gap for preventative screenings to help drive outreach efforts, promote timely referrals and to create better outcomes. Molina has revised and revamp preventative screening materials to ensure accuracy and up to date information is shared</p>	<p><b>Metric:</b> Breast Cancer Screening</p> <p><b>Metric:</b> Cervical Cancer Screening</p> <p><b>Metric:</b> Colorectal Cancer Screening</p> <p><i>Note: Not DMAS QS metrics.</i></p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, educate them on CPT II codes, provide them support for member outreach. Molina uses home lab kit to ensure members have adequate access to screenings, once the kit is received it is complemented by an outreach call from the diabetic educate offer support, resources and education with health management skills. Members are provided assistance with scheduling diabetic exam and receive a blood pressure cuff to check and monitor their blood pressure as part of the program. Members will also receive a curated meal box</p>	<p><b>Metric:</b> 5.1.1.4 Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>

Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach.</p> <p>Partner with network providers, VDH and schools to participate in immunization campaign, provide education and materials, incentives and school supplies.</p>	<p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p> <p><b>Metric:</b> 4.1.1.4 Immunization for Adolescents</p> <p><b>Metric:</b> 4.1.1.11 Lead Screening in Children</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p>★ <b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p> <p>★ <b>Objective: 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with BH provider groups to share data and identify opportunities for improvement such as coding to ensure services are captured appropriately and timely to improve outcomes and reduce readmission.</p> <p>Molina host internal clinical rounds with the CMO and BH Medical Director, peer support, BH case management and TOC program to coordinate services for identified members, timely outreach, partner with BH providers to ensure timely referrals, monitor PointClickCare for diagnose and discharge data</p> <p>Target Pay for performance in progress to target BH providers for timely addressing BH quality measures in progress</p>	<p><b>Metric:</b> 5.3.1.2 – Follow up after Emergency Department visit for Alcohol and other drug Dependence Treatment – 7- and 30-days total</p> <p><b>Metric:</b> 5.4.1.2 - Follow up after Emergency Department visit for Mental Illness – 7- and 30-days total</p> <p><b>Metric:</b> 5.3.1.4 Initiation and Engagement for Alcohol and other drug Dependence Treatment</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p>★ <b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with both OB/GYN and network provider groups to conduct monthly meetings, send them gaps in care report for members in the prenatal measure, educate them on CPT II codes, provide them support for member outreach.</p>	<p><b>Metric:</b> 4.2.1.1 Prenatal and Postpartum Care</p>

Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
	<p>Compliant members receive incentives for timely completion of their prenatal and postpartum visits.</p> <p>High Risk members are referred to the High Risk OB team to provide timely support, education and resources to ensure a healthy pregnancy.</p> <p>Molina uses Lucina Analytics a data tool in conjunction with the pregnancy dashboard, which identifies of pregnancy early, which helps with getting members access to care more timely.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p>★ <b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI is working with family and pediatric network provider/ provider groups to conduct monthly meetings, share comprehensive gaps in care report targeting well child visits and provide support for member outreach.</p> <p>Target clinic day to outreach and tie to back-to-school events</p> <p>Member outreach to help with scheduling needs, provider education and share pertinent information about services and rewards that are available.</p>	<p><b>Metric:</b> 4.2.1.4 – Well child visits in the first 30 months after birth</p> <p><b>Metric:</b> Well child visit - Total</p> <p><i>Note: Not a Quality Strategy metric.</i></p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>Hosting Clinic days in provider’s offices to have an open day for appointments for members to get their services done.</p> <p>Champions Program: to target members who have A1c 8 and above to enroll in the program for management, resources, education and support.</p> <p>Members will receive a certificate based on their A1c outcomes.</p> <p>Vision Centers are incentivized to reach out to members, schedule them</p>	<p><b>Metric:</b> 5.1.1.4 Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>

Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
	<p>and complete the Dilated retinal eye exam.</p> <p>Blood Pressure cuffs sent to targeted members and telehealth visits are facilitated to capture required information.</p> <p>Members are sent home a HgA1c kit to complete.</p>	
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Hosting Clinic days in provider’s offices to have an open day for appointments for members to get their services done.</p>	<p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p> <p><b>Metric:</b> 4.1.1.4 Immunization for Adolescents</p> <p><b>Metric:</b> 4.2.1.4 – Well child visits in the first 30 months after birth</p> <p><b>Metric:</b> Well child visit – Total</p> <p><i>Note: Not a quality strategy metric.</i></p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI has partnered with CVS to conduct timely outreach calls and identify barriers preventing members from being adherent to medication.</p>	<p><b>Metric:</b> 5.1.1.7 Asthma Medication Ratio</p> <p><b>Metric:</b> 5.4.1.12 Adherence to Antipsychotic medications for individuals with Schizophrenia</p> <p><b>Metric:</b> 5.4.1.8 Antidepressant Medication Management</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p>Member outreach targeting kids before they turn two years old and helping them to schedule appointments to close the CIS measure gaps</p> <p>Molina leverages the postpartum care outreach activities to also provide education on immunizations and well child checkups.</p>	<p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p>

Virginia QS Aim and Goal	Molina’s Quality Initiative	Performance Metric
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Description of Quality Initiative:</b></p> <p>MHI has partnered with MRx vendor partner to do outreach calls and identify barriers preventing members to be medication adherent.</p>	<p><b>Metric:</b> 5.1.1.7 Asthma Medication Ratio</p> <p><b>Metric:</b> 5.4.1.12 Adherence to Antipsychotic medications for individuals with Schizophrenia</p> <p><b>Metric:</b> 5.4.1.8 Antidepressant Medication Management</p>

## Optima

Table D-4—Optima’s QS Quality Initiatives

Virginia QS Aim and Goal	Optima’s Quality Initiative	Performance Metric
<p><b>Goal:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 1.1:</b> Increase Member Engagement and Outreach</p>	<p><b>Description of Quality Initiative:</b></p> <p>Optima Health has a Culturally and Linguistically Appropriate Services (CLAS) program to strengthen the delivery of health care to culturally diverse populations. Optima Health has Alternative Language Options for Notices and Other Written Information.</p>	<p><b>Metric:</b> Monitor Member Language Counts</p>
<p><b>Goal:</b> Enhance the Member Care Experience</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant members</p>	<p><b>Description of Quality Initiative:</b></p> <p>1. <i>Timeliness of Prenatal Visits Among Pregnant Medallion 4.0 Members:</i> PIP intervention involving performing case management and educating members about the importance of timeliness of prenatal visits. Also offering a digital app for questions about pregnancy. 2. <i>Tobacco Cessation Among Pregnant Medallion 4.0 Members:</i> PIP intervention involving educating pregnant members about the importance of quitting smoking while pregnant as well as offering digital resources such as videos for maternity health and wellness.</p>	<p><b>Metric:</b> Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>

# United

**Table D-5—United’s QS Quality Initiatives**

Virginia QS Aim and Goal	United’s Quality Initiative	Performance Metric
<p><b>Goal 1:</b> Enhance the Member Care Experience</p> <p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 1.2:</b> Improve Member Satisfaction</p> <p><b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b></p> <ul style="list-style-type: none"> <li>• <i>Dr. Chat:</i> The UHC Doctor Chat App provides 24/7/365 virtual care for UnitedHealthcare Community Plan members. UHC Doctor Chat provides a real time option for members in lieu of the ER and helps reduce avoidable readmissions by offering an after-hours option for patients to ask questions about their post-discharge plan. UHC Doctor Chat can address acute care, chronic care, mental health, women's health and more.</li> <li>• <i>Addition of major health system:</i> UHC added the Riverside Health System in the Tidewater region, expanding member care access to six hospitals and nearly 1k primary and specialty care physicians. Additionally, tying this system to value fosters highly engaged providers to service members.</li> <li>• <i>Member/Provider Satisfaction:</i> UHC monitors provider and member satisfaction with services through various surveys, events, and forums – including CAHPS, Care Coordination and LTSS surveys, NPS surveys, and Member Advisory Committees (MAC), among others.</li> </ul>	<p><b>Metric:</b> 1.2.1.1 Enrollees’ Rating Q8-Rating of All Health Care</p> <p><b>Metric:</b> 2.1.1.1 Getting Care Quickly Q6</p> <p><b>Metric:</b> 2.1.1.3 Getting Needed Care</p>
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.1:</b> Ensure Access to Care</p>	<p><b>Description of Quality Initiative:</b></p> <p><i>Community Partnerships:</i> Collaboration and partnership with Federally Qualified Health Centers (FQHCs), health systems and other community entities to promote member self-care and facilitate</p>	<p><b>Metric:</b> 2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed</p> <p><b>Metric:</b> 2.1.1.3 Getting Needed Care</p>



Virginia QS Aim and Goal	United’s Quality Initiative	Performance Metric
<p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>	<p>support and assistance in scheduling preventative care.</p>	
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 3.1</b> Focus on Paying for Value</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><i>Community Plan Primary Care Provider Incentive Program:</i></p> <p>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. UHC additionally collaborates with providers and community entities to promote health fairs, clinic days, and other preventative care events.</p>	<p><b>Metric:</b> 3.1.1.4 Ambulatory Care</p> <p><b>Metric:</b> 4.1.1.1 Adults’ Access to Preventive/Ambulatory Health Services</p> <p><b>Metric:</b> 4.1.1.2 Child and Adolescent Well-Care Visits</p> <p><b>Metric:</b> 4.1.1.3 Childhood Immunization Status</p> <p><b>Metric:</b> 4.1.1.4 Immunizations for Adolescents</p> <p><b>Metric:</b> 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Description of Quality Initiative:</b></p> <p><i>AIM Infant Well Child Project:</i></p> <p>Collaboration project with DMAS to improve performance in attendance at well-child visits for members 0-15 moths: Northern Virginia, Winchester, Richmond and the Southwest were the areas of focus. The goal was to increase the % of members who have received 6+ visits by a minimum of 4% from baseline.</p>	<p><b>Metric:</b> 4.2.1.4 Well-Child Visits in the First 30 months of Life</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.4:</b> Improve Behavioral Health and</p>	<p><b>Description of Quality Initiative:</b></p> <p><i>Tobacco Use Cessation in Pregnant Women:</i></p> <p>PIP intervention involving engaging and educating pregnant members who have a history of current tobacco</p>	<p><b>Metric:</b> 5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation</p>



Virginia QS Aim and Goal	United’s Quality Initiative	Performance Metric
Developmental Services for Members	use. Care coordination staff assist with coordination of community resources and scheduling appointments.	

## VA Premier

Table D-6—VA Premier’s QS Quality Initiatives

Virginia QS Aim and Goal	VA Premier’s Quality Initiative	Performance Metric
<p><b>Goal 1:</b> Enhance the Member Care Experience</p> <p><b>Objective 1.2:</b> Improve Member Satisfaction</p>	<p><b>Description of Quality Initiative:</b></p> <p>UHS Telehealth Program            This program expands telehealth access to BH follow-up treatment to members who are discharged from ED and inpatient stays; and, for members at Sentara Hospitals, the hospital staff in the ED rooms can use this telehealth program to schedule appointments for Optima and legacy Virginia Premier members in ED.</p>	<p><b>Metric:</b> 1.2.1.1 Enrollees’ Ratings Q8-Rating of all Health Care</p>
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Objective 2.1:</b> Ensures Access to Care</p> <p><b>Objective 2.2:</b> Promote Patient Safety</p> <p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>	<p><b>Description of Quality Initiative:</b></p> <p>Peer Support Specialist Program            This program utilizes the real-life experiences of our peer support specialists to promote recovery and foster well-being among members with mental health and substance use disorders. The peer support specialists use recovery-oriented goals with members to help promote improvements in confidence, empowerment, and functioning. This approach to treatment supports the engagement of members through person-centered assessment and self-directed treatment planning that aims to increase members’ social support systems, hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery.</p>	<p><b>Metric:</b> 2.1.1.3 Getting Needed Care</p>

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
<p><b>Goal 3:</b> Support Efficient and Value-Driven Care</p> <p><b>Objective 3.1:</b> Focus on Paying for Value</p> <p><b>Objective 3.2:</b> Promote Efficient Use of Program Funds</p>	<p><b>Description of Quality Initiative:</b></p> <p>Community Stabilization Team</p> <p>The goal of Community Stabilization Services is to stabilize the individual within their community and assist the individual and natural support system during the following: 1) initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care if the appropriate level of care is identified but not immediately available for access 2) transitional step-down from a higher level of care if the next level of care is identified but not immediately available or 3) diversion from a higher level of care. Community Stabilization care coordinators link/transition the individual to follow-up services and other needed resources to stabilize the individual within the community.</p>	<p><b>Metric:</b> 3.2.1.1 Monitor Medical Loss Ratio</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve Utilization of Wellness, Immunization, and Prevention Services for members</p> <p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant members</p> <p><b>Objective 4.3</b> Improve Home and Community-Based Services</p>	<p><b>Description of Quality Initiative:</b></p> <p>Welcoming Baby Program/Community Health Worker Outreach</p> <p>Use of Certified Community Health workers to support maternal health. Welcoming Baby and Watch Me Grow Outreach programming for connections to community resources, one-on-one supportive services, telephonic and face-to-face, incentives &amp; events. Includes specialized staff training to:</p> <ul style="list-style-type: none"> <li>• Address social needs</li> <li>• Enhance health literacy</li> <li>• Outreach, screening, education, and referral</li> </ul>	<p><b>Metric:</b> 4.2.1.1 Prenatal and Postpartum Care: Postpartum Care</p> <p><b>Metric:</b> 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Description of Quality Initiative:</b></p> <p>Case Conferencing with Homeless Shelters</p> <p>Established a process and a regular schedule with the Greater Richmond</p>	<p><b>Metric:</b> 5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>

Virginia QS Aim and Goal	VA Premier's Quality Initiative	Performance Metric
<p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions</p> <p><b>Objective 5.2:</b> Improve Outcomes for Nursing Home Eligible Members</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders</p> <p><b>Objective 5.4:</b> Improve Behavior Health and Development Services of Members</p>	<p>Continuum of Care (CoC) for homelessness, to conduct case conferencing on members who enter the shelter system</p>	<p>Metric: 5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)</p> <p><b>Metric:</b> 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment</p> <p><b>Metric:</b> 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</p>

## Appendix E. Assessment of Follow-Up on Prior Recommendations

### DMAS Follow-Up on Prior Year Recommendations for the Medallion 4.0 (Acute) 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 CY 2022 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 (Acute)  
Program Overall**

Recommendation		
<b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations	<b>Objective: 5.4:</b> Improve Behavioral Health and Developmental Services for Members	<b>Measure 5.4.1.1:</b> Follow-Up After Hospitalization for Mental Illness
<p><b>HSAG Recommendation:</b> 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:</p> <ul style="list-style-type: none"> <li>• Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization.</li> <li>• Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data.</li> <li>• 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.</li> <li>• 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.</li> </ul>		
DMAS’ Response		
<p>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):</p> <ul style="list-style-type: none"> <li>• The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts: <ul style="list-style-type: none"> <li>– Implementation of evidence-based behavioral health care and building out of, Multisystemic Therapy, Functional Family Therapy, Assertive Community Treatment and implementation of</li> </ul> </li> </ul>		

**Recommendation**

4 crisis services based on the Crisis Now model, SAMHSA has identified as best practice. The implementation of these services is key to assisting individuals that are discharged from residential and hospital settings.

- DMAS has been instrumental in the planning and implementation of The Governor’s Right Help Right Now plan which aims to achieve the goal that all Virginians will, i) be able to access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor’s Right Help Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives: i) identifying service innovations and best practices in behavioral health services, this includes a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services; ii) identify and research evidence-based programs specific to youth and iii) assessment of health plan behavioral health network adequacy. The goal of DMAS in partnership with this plan is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia.
- A collaboration and partnership among health and human services state agencies in Virginia, came together to the Center for Evidence-Based Partnerships (CEP-VA) to assist in centralizing data, implementation work and collaboration around supporting and implementing evidence-based behavioral health services across Virginia agnostic of payer. The Center continues to support and analyze Virginia implementation of these services, and provide technical assistance and training to providers.
- DMAS’ Incentive Coordination and Economic Research (ICER) team included the measure Follow-Up After Emergency Department (ED) Visit for Mental Illness 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:

**Measure:** Follow-Up After Emergency Department (ED) Visit for Mental Illness

MY 2021: 7-Day: 45.34% 30-Day: 57.38%

MY 2022: 7-Day: 43.04% 30-Day: 55.53%

Identify any barriers to implementing initiatives: The ICER team identified no barriers.

**HSAG Assessment:**



**Recommendation**

**Goal 4:** Strengthen the Health of Families and Communities

**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members

**Measure 4.1.1.4:** Immunizations for Adolescents

Recommendation		
	<b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members	<b>Measure: 4.2.1.4:</b> Well-Child Visits in the First 30 Months of Life
<p><b>HSAG Recommendation:</b> 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:</p> <ul style="list-style-type: none"> <li>• Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules.</li> <li>• 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.</li> <li>• Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.</li> </ul>		
DMAS' Response		
<p>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 has improved its ability to track MCO required monthly data submissions</p> <p><b>Maternal and Child Health (MCH):</b></p> <ul style="list-style-type: none"> <li>• The new Cardinal Medallion 4.0 (M4) draft contract (now in RFP) includes requirement to incorporate American Academy of Pediatrics (AAP) and Bright Futures in its quality assurance activities. If implemented as written, the Contractor will be required to follow a long-term improvement plan relating to improving EPSDT indicators that will not exceed five (5) years. The contractor must implement interventions or strategies to address following criteria:             <ol style="list-style-type: none"> <li>1. Childhood immunization rates</li> <li>2. Well-child rates in all age groups</li> <li>3. Lead testing rates</li> <li>4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year</li> <li>5. Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis).</li> </ol> </li> <li>• MCOs are involved in our CMS Affinity Groups that targets increasing in well-child visit rates, immunizations, timeliness of care and increased access to quality care for children.</li> </ul> <p><b>ICER:</b> DMAS included the measures Child and Adolescent Well-Care Visits and Childhood Immunization Status in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p>		
<p>Identify any noted performance improvement as a result of initiatives implemented (if applicable):            PMV results showed:  <b>Measure:</b> Child and Adolescent Well-Care Visits            MY 2021: 46.57%            MY 2022: 50.27%  <b>Measure:</b> Childhood Immunization Status</p>		



**Recommendation**

MY 2021: 65.82%  
 MY 2022: 63.22

Identify any barriers to implementing initiatives: The ICER team identified no barriers.

**HSAG Assessment:**



**Recommendation**

**Goal 4:** Strengthen the Health of Families and Communities

**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

**HSAG Recommendation:** 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® 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.

**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):

**MCH:**

- Within the new DRAFT Cardinal M4 contract (now in RFP), MCOs will be required to conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO. Each PIP must include implementation of interventions to achieve improvement in the access to care, timeliness and quality of care, consistent with 42 CFR §430.330. The Contractor must identify benchmarks and set measurable achievable performance goals for each of its PIPs, which will be submitted to the Department for review and approval. In the first year of this Contract, one PIP shall be focused on maternal health. The due date for PIPs and validation must be in accordance with the process and methodology agreed upon by the Department and its EQRO agent. All PIP requirements will be located within the Cardinal Care Technical Manual.

**Recommendation**

- The new contract specifies measures to be used in DMAS' Performance Withhold Program (PWP) that include timeliness of prenatal care and timeliness of postpartum care. MCOs will have to report these measures, which will be validated by DMAS' EQRO.

**ICER:** DMAS included the measures Prenatal and Postpartum Care 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:

**Measure:** Prenatal and Postpartum Care

MY 2021: Timeliness of Prenatal Care: 73.00% Postpartum Care: 66.52%

MY 2022: Timeliness of Prenatal Care: 76.44% Postpartum Care: 66.76%

Identify any barriers to implementing initiatives: ICER identified no barriers.

**HSAG Assessment:**



## MCOs' Follow-Up on Prior Year Recommendations

From the findings of each MCO's performance for the CY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Medallion 4.0 (Acute) 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 Measure Validation		
<p><b>Goal 2:</b> Promote Access to Safe, Gold-Standard Patient Care</p> <p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Objective 2.1</b> Ensure Access to Care</p> <p><b>Objective 4.1</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p><b>Objective 5.1</b> Improve Outcomes for Members with Chronic Conditions</p>	<p><b>Measure 2.1.1.6:</b> Cervical Cancer Screening</p> <p><b>Measure 4.1.1.3:</b> Childhood Immunization Status</p> <p><b>Measure 5.1.1.5:</b> Controlling High Blood Pressure</p>

**Recommendation—Performance Measure Validation**

**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

**Why the weakness exists:**

**Recommendation:** 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.

**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 Health Plan conducted a health equities analysis to evaluate our membership population. The Plan also designated measure subject matter experts (SMEs) to complete deep dives into race, ethnicity, language, age group, and ZIP code for various measures to drive initiatives. The Health Plan also initiated the use of a Social Determinants of Health (SDOH) software application to assist in identifying specific needs in each region. The Health Plan engaged providers to increase coding and electronic data to capture services rendered. One member initiative implemented as a result of the analysis, includes targeted outreach to members aged 18-21 who were identified as non-compliant with preventative healthcare. One provider intervention included incentivizing for use of CPT2 codes.

**Measure:** *Cervical Cancer Screening*

2021: 47.93%

2022: 54.74%

**Measure:** *Childhood Immunization Status – Combination 3*

2021:52.55%

2022:58.88%

**Measure:** *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

2021:50.36%

2022:53.04%

**Measure:** *Controlling High Blood Pressure*

2021:48.66%

2022:53.53%

**Identify any barriers to implementing initiatives:**

Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.

**Recommendation—Performance Measure Validation**

**HSAG Assessment:**



**Recommendation—Member Experience of Care Survey – Adult Medicaid**

**Goal 1:** Enhance the Member Care Experience

**Objective 2.1:** Ensure Access to Care  
**Objective 2.3:** Promote Effective Communications and Care Coordination

**Measure 2.1.1.3:** Getting Needed Care  
**Measure 2.3.1.1:** How Well Doctors Communicate

**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*.

**Why the weakness exists:**

**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 causes analysis that focused on low performance related to Rating of Health Plan, All Health Care, and Specialist Seen Most Often. Based on the identified root causes, the Health Plan expanded its existing HEDIS and CAHPS workgroup to include additional member and provider facing staff. To identify potential opportunities, the Workgroup conducted deep dives into the barriers related to members not having a PCP, members ability to get urgent and routine appointments as needed, getting needed information from member services, and access to highly rated providers or specialists. Initiatives to improve, include working with providers to encourage same-day scheduling, increasing utilization of telehealth services, improving communication between providers, and working with members to increase use of patient-centered medical homes and member/patient communication with providers.
- Additional activities implemented included developing talking prompts during committees to solicit feedback and recommendations for improving access to care and communication between providers and settings, conducting an ad hoc appointment survey and implementing CAPs for those providers not meeting contractual requirements. The Plan also deployed a dedicated team to meet with providers to discuss performance related to access and communication and learned many provider offices are experiencing significant staff reduction. The Plan also conducted a CAHPS presentation at MAC meetings to educate members about CAHPS and discuss additional resources, including the 24-hour Nurse Line and telehealth.

**Recommendation—Member Experience of Care Survey – Adult Medicaid**

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Getting Needed Care—Medallion**

Adult MY2021: 73.6%

Adult MY2022: 76.2%

Child MY2021: 82.8%

Child MY2022: 83.1%

**Measure: Getting Care Quickly—Medallion**

Adult MY2021: 73.4%

Adult MY2022: 76.7%

Child MY2021: 85.3%

Child MY2022: 85.5%

**Measure: How Well Doctors Communicate—Medallion**

Adult MY2021: 85.7%

Adult MY2022: 91.1%

Child MY2021: 91.2%

Child MY2022: 95.2%

**Identify any barriers to implementing initiatives:**

Aetna Better Health of Virginia experienced challenges related to meeting or talking with some provider office staff due to many provider offices experiencing a significant decrease in office staff and/or hours.

**HSAG Assessment:**



**HealthKeepers**

**Table E-3—Prior Year Recommendations and Responses—HealthKeepers**

<b>Recommendation—Performance Measure Validation</b>		
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions?</p>	<p><b>Measure 5.1.1.4:</b> Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</p>
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p>	<p><b>Objective 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p>	<p><b>Measure 5.4.1.3:</b> Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p>		

**Recommendation—Performance Measure Validation**

	<p><b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members</p>	<p><b>Measure 4.2.1.1:</b> Prenatal and Postpartum Care: Postpartum Care  <b>Measure 4.2.1.2:</b> Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>
--	---	---

**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*

**Why the weakness exists:**

**Recommendation:** 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.

**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 Anthem Virginia Quality Management department completed the analysis of the HEDIS rates by convening a HEDIS RCA Work Group comprised of leaders from the following Anthem Virginia departments: QM, CM, Maternal Child Health Services, Managed Long Term Supports and Services, Provider Experience, BH, and included the plan Medical Director and BH Medical Director. This RCA work group analyzed rates and performed a Root Cause Analysis of HEDIS measures. The QM department includes the Director of QM, Clinical Quality Program Managers/Administrators and Quality Specialists.
- The following initiatives were implemented because of the root cause analysis for Comprehensive Diabetes Care-Eye Exams:
  - Identified PCP providers with DRE exam machines. Distributed Gap in Care report to the LTSS and Non LTSS teams to contact members of those providers who need a DRE exam to inform the member that they can have the exam performed in the PCP office.
  - CVS Health Tags: Messaging to targeted patients via CVS prescription bags and/or Pharmacist/Technician verbal reinforcement. Messages are surrounding Condition Management, Preventive Services, and Plan Benefit Awareness.
  - Generated tags in the Collective Medical ER system to alert Care Coordinators of HEDIS gaps. Care Coordinator works with member to remind them to complete Diabetic Eye Exam.
- The following initiatives were implemented because of the root cause analysis for Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase



**Recommendation—Performance Measure Validation**

- Provide education and reminders to parents/caregivers to get follow up appointments scheduled. Member letters updated to provide dates of when member is due to get appointment scheduled.
- Member incentive and engagement program designed to reward members with gift cards for completing recommended follow-up appointments, completing recommended screenings, and refilling prescribed medications with goal of improved HEDIS gap in care closures.
- Behavioral Health team educates pediatric PCP providers about the State approved Bravo services; this is a list of BH services authorized by the State to help children with a diagnosis of ADD.
- The following initiatives were implemented because of the root cause analysis for Postpartum Care
  - OBQIP Program: Recruited additional OB Practice Consultant to increase participation in program in rural areas and across the state.
  - Facilitated doula trainings in rural areas and has a focus to train doulas in more rural areas.
  - Implemented a CPT Category II Code Reimbursement program to decrease the need for record submissions and chart reviews, minimizing administrative burden on physicians and other healthcare professionals.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure CDC Eye Exams**

MY 2021: 44.53%

MY 2022: 45.01%

**Measure PPC Postpartum Care**

MY 2021: 65.69%

MY 2022: 79.26%

**Measure ADD Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase**

MY 2021: 37.11%

MY 2022: 44.54%

**Identify any barriers to implementing initiatives:**

- The barriers identified during the RCA for Comprehensive Diabetes Care-Eye Exam included:
  - Member must schedule a follow-up appointment with an ophthalmologist or optometrist after the test is ordered by the PCP or Endocrinologist making the member move from one practitioner (PCP or Endocrinologist) to a different practitioner (ophthalmologist or optometrist). Due to this, the member may not schedule the test because of the inconvenience of separate appointments and facilities.
  - Large volume providers have equipment to perform exam but may not be billing properly.
  - The members are not informed of the importance of an annual exam and the seriousness of the issues that early detection can save their eyesight.
  - Primary care providers may not be aware that their patient has not completed the exam.
  - Need for a provider reminder to schedule an exam.



**Recommendation—Performance Measure Validation**

- The barriers identified during the RCA for Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase included:
  - Behavioral & physical health providers may be uninformed that the follow-up within 30 days of initiation is monitored nationally utilizing specific timeframes. A member may be seen a few days after this timeframe and not be included in the numerator.
  - Members are not instructed by the providers to follow-up after initiation and the importance of a follow-up to make ensure the right dosage is prescribed and is effective.
  - Practitioners’ lack of awareness of clinical care guidelines and HEDIS® coding requirements. For example, behavioral & physical health providers may be unaware that the follow up within 30 days of initiation is monitored nationally utilizing specific timeframes.
  - Medication holidays during summer break can play a role in lowering HEDIS® scores during the continuation phase. If the behavioral issues occur primarily at school some physicians and parents may collectively decide to stop medications for the summer and restart when school is back in session.
  - SDOH concerns; members cannot attend appointments or have difficulties getting to pharmacy monthly due to lack of transportation.
  - Providers are not aware of services provided by the Plan.
  - Member caregivers are not aware of importance of follow up appointments.
- The barriers identified during the RCA for Postpartum Care included:
  - Lack of resources to meet member needs related to social drivers of health.
  - Challenges related to improving access to non-physician maternal healthcare providers (e.g., midwives, doulas); Doula benefit is not statewide.
  - Lack of providers that can meet enrollee’s cultural and linguistic needs.
  - Provider shortages in rural areas
  - Challenges with the allowance of global billing
  - Member is unable to get to visit due to availability of transportation.
  - Lack of awareness, by the new mother of the importance of the postpartum visit for themselves or their infant
  - Lack of awareness, by the new mother of the Medicaid benefit for transportation
  - Lack of awareness of the importance of the timing of the visit to assure wholesome health.
  - Lack of provider incentives to schedule the postpartum visit for the member.
  - Need for a provider reminder to schedule a postpartum visit.

**HSAG Assessment:**



**Recommendation—Member Experience of Care Survey – Child Medicaid**

**Goal 1:** Enhance the Member Care Experience

**Objective 1.2:** Improve Member Satisfaction

**Measure 1.2.1.2:** Rating of Personal Doctor

**Recommendation—Member Experience of Care Survey – Child Medicaid**

**Weakness:** 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*.

**Why the weakness exists:**

**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):**

The Anthem Virginia CAHPS Work Group, chaired by the Director of QM, consists of representatives from the following areas: Quality Management, Medicaid National Quality & Accreditation, Customer Care (Call Center), Government and Business Division (GBD) Quality Analytics, Provider Experience, and Medical Management meet monthly to review, analyze, and determine barriers and opportunities for improvement. The Anthem Virginia CAHPS Work Group held monthly meetings and performed a root cause analysis utilizing brainstorming techniques to identify the key drivers for member experience regarding the CAHPS questions. The survey vendor identified the rating of personal doctor to be the highest key driver for member satisfaction in the child survey followed by ease of getting needed care, tests, or treatment, got an appointment for urgent care as soon as needed, customer service provided information or help, and rating of specialist seen most often.

The following initiatives were implemented because of the root cause analysis:

- CAHPS Proxy Survey- after a review of the weekly claims data, a member outreach initiative is conducted to obtain their feedback regarding recent visits. Metrics are in place to avoid multiple outreaches within 90 days. The member feedback is shared with the providers.
- Revamp of Provider Education material - Elevance Health online learning course for Providers: Provider and community organization facing staff promote the “What Matters Most” education material.
- CAHPS playbook launched for education and resource for internal associates.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure**

MY 2021: 65.3%

MY 2022: 59.3%

**Identify any barriers to implementing initiatives:**

The barriers identified during the root cause analysis were:

- Physicians and office staff shortages
- Limited appointment availability

**Recommendation—Member Experience of Care Survey – Child Medicaid**

- Lack of transportation
- Physician offices no longer accepting new patients.
- Members may not be informed of the alternatives to urgent care.
- Physicians are not adhering to after-hours availability requirements.
- Physicians do not communicate clearly.
- Language barriers
- Assigned doctor not available.
- Generation gap between patient and physician.
- Providers rush visits and take too long to see the patient.
- Lack of provider awareness of tools available and how to use.

**HSAG Assessment:**



**Molina**

**Table E-4—Prior Year Recommendations and Responses—Molina**

**Recommendation—Performance Measure Validation**

**Goal 4:** Strengthen the Health of Families and Communities  
**Goal 2:** Promote Access to Safe, Gold-Standard Patient Care  
**Goal 5:** Providing Whole-Person Care for Vulnerable Populations

**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members  
**Objective 2.1:** Ensure Access to Care  
**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions  
**Objective 5.4:** Improve Behavioral Health and Developmental Services for Members  
**Objective 4.2:** Improve Outcomes for Maternal and Infant Members

**Measure 4.1.1.1:** Adults’ Access to Preventive/Ambulatory Health Services  
**Measure 2.1.1.9:** Breast Cancer Screening  
**Measure 2.1.1.6:** Cervical Cancer Screening  
**Measure 4.1.1.2:** Child and Adolescent Well-Care Visits  
**Measure 4.1.1.3:** Childhood Immunization Status  
**Measure 5.1.1.4:** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)  
**Measure 5.1.1.5:** Controlling High Blood Pressure  
**Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness

**Recommendation—Performance Measure Validation**

**Measure 5.4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication  
**Measure 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care  
**Measure 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care  
**Measure 4.2.1.4:** Well-Child Visits in the First 30 Months of Life

**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*
- *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*

**Why the weakness exists:**

**Recommendation:** 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.

**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—Performance Measure Validation**

- Enhanced Pay for Quality Program implemented in 2023
- Increased provider partnerships through meetings to have a tactical approach to identification of members with gaps in care and implement strategies.
- Distribution of monthly comprehensive scorecards
- Keona Direct Scheduling platform collaboration, providers are offered a platform scheduling option to eliminate staff burdens with scheduling, online scheduling option and self-scheduling
- Champions Blood Pressure and A1c program to promote disease management, healthy eating strategies, option to receive curated farm box, education and resource are shared. Upon completion member will receive a certificate of completion
- Prenatal and Postpartum care and smoking cessation in pregnant women incentive to reward for meeting scheduled appointments.
- Increase in Clinic Days, while working with providers to target members with gaps in care. Leverage direct scheduling to support scheduling of the members, target ped provides to include vaccine clinic and back to school supplies, target members with high volume of gaps in care, partner with eye care provider to complete diabetic eye exam.
- BH clinical rounds to review and target BH gaps in care, leverage peer support to provide support to members who have experience BH constraints.
- Identification of BH providers who are low performance to identify opportunities to provide education.
- Leverage PointClickCare software daily to identify members with BH diagnose, discharge notes and other pertinent information to create a target approach in outreaching members.
- Enhanced member rewards to target HEDIS measures for gap closure

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure:** Well Child Visit

2021: 36.7%

2022:38.4%

**Identify any barriers to implementing initiatives:**

Providers lack ability to timely schedule appointments, as scheduling was 2 months + out for appointments.

Low percentage of members who were connected with primary care.

**HSAG Assessment:**



**Optima**

**Table E-5—Prior Year Recommendations and Responses—Optima**

Recommendation—Performance Measure Validation		
<b>Goal 4:</b> Strengthen the Health of Families and Communities	<b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	<b>Measure 4.1.1.1:</b> Adults’ Access to Preventive/Ambulatory Health Services
<p><b>Weakness:</b> 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:</p> <ul style="list-style-type: none"> <li>• <b>Adults’ Access to Preventive/Ambulatory Health Services - Total</b></li> </ul> <p><b>Why the weakness exists:</b></p> <p><b>Recommendation:</b> HSAG recommends that Optima:</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>		
MCO’s Response		
<p><b>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):</b></p> <ul style="list-style-type: none"> <li>• Case Management engagement with members to assist in managing care, making appointments, and scheduling transportation</li> <li>• Birthday card mailings that includes a bookmarker that serves to remind members of the preventative health guidelines they should follow to achieve their personal best health</li> <li>• Provider Enablement provides data to VBC providers regarding preventative measures and discuss their performance/progress towards the goals</li> <li>• Network Management engagement</li> <li>• Includes appointment availability standards routinely in quarterly newsletters</li> <li>• Reviews standards and after-hours requirements with Providers during quarterly webinars</li> <li>• Review standards during individual Provider meetings with Network Educators</li> <li>• Population Health Assessment work group was 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 completed 7/2023.</li> </ul>		
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b></p> <p>PMV results showed:</p>		



**Recommendation—Performance Measure Validation**

**Measure: Adults’ Access to Preventive/Ambulatory Health Services - Total**

2021: 71.75%

2022: 67.82%

**Identify any barriers to implementing initiatives:**

- Decreased outpatient ambulatory or preventive care visits due to COVID-19 pandemic
- Lack of appointment availability in outpatient settings

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 2:** Promote Access to Safe, Gold-Standard Patient Care

**Objective 2.1:** Ensure Access to Care

**Measure 2.1.1.6:** Cervical Cancer Screening

**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:

- **Cervical Cancer Screening**

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- 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 sent to providers of members with cervical care gap
- Clinical Guidelines reviewed and Providers are notified of updated clinical guidelines via newsletter & provider website
- Articles in the Member Newsletters
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- Population Health Assessment work group was established 7/2022. NCQA standards and tools purchased to perform a comprehensive population health assessment to include but not limited to:



**Recommendation—Performance Measure Validation**

SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. Population Health Assessment completed 7/2023

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Cervical Cancer Screening**

2021: 48.66%

2022: 54.50%

**Identify any barriers to implementing initiatives:**

- No barriers identified. Measures showed significant improvement.
- Will continue with established initiatives

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 4:** Strengthen the Health of Families and Communities

**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members

**Measure 4.1.1.2:** Childhood Immunization Status

**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:

- **Childhood Immunization Status - Combination 3**

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- Childhood Immunization Incentive Program
- Emmi® patient engagement technology Well-Child & Immunizations IVR campaign

**Recommendation—Performance Measure Validation**

- Emmi® Manager utilization for educational videos
- Prealize Health predictive analytics 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
- Full time equivalent (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 identified
- 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 Q1 2023.
- Population Health Assessment work group was 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 completed 7/2023.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: *Childhood Immunization Status - Combination 3***

2021: 62.77%

2022: 63.75%

**Identify any barriers to implementing initiatives:**

- 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

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 5:** Providing Whole-Person Care for Vulnerable Populations

**Objective 5.1:** Improve Outcomes for members with Chronic Conditions

**Measure 5.1.1.4:** Comprehensive Diabetes Care: Hemoglobin A1c Control (<8%)

**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:

- **Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg)**

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- Diabetic Eye Exam incentive program
- Emmi® Manager utilization for educational videos
- Prealize Health 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 in Symphony/JIVA
- Pop Care Diabetic Eye Exam campaign
- BiolQ at-home A1c program
- Focus Care In-Home A1c testing and Diabetic Eye Exam
- HEDIS Blitz 4th Quarter Push CM 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 Q4 2022
- Dario: The Dario Pilot covers 1,500 Optima Health Plan Medallion 4.0 and CCC+ 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

**Recommendation—Performance Measure Validation**

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

Population Health Assessment work group was 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 completed 7/2023

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Comprehensive Diabetes Care - HbA1c Poor Control (>9.0%)**

2021: 52.80%

2022: 47.69%

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

**Measure: Eye Exam (Retinal) Performed**

2021: 43.55%

2022: 47.20%

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

**Measure: Blood Pressure Control (<140/90 mm Hg)**

2021: 49.64%

2022: 57.66%

**Identify any barriers to implementing initiatives:**

No barriers Identified

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 5:** Providing Whole-Person Care for Vulnerable Populations

**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions

**Measure 5.1.1.5:** Controlling High Blood Pressure

**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:

- **Controlling High Blood Pressure**

**Why the weakness exists:**

**Recommendation:** HSAG recommends that Optima:

**Recommendation—Performance Measure Validation**

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.

**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):**

- Chronic Care Management completes assessments for members who have diabetes. This assessment is conducted telephonically. Equipment and/or supplies to help manage members’ care are provided such as a glucometer, blood pressure cuff, or scale, if needed.
- Members are sent written education materials to give them reinforcement on how to best manage their diabetes
- HEDIS Blitz conducted annually to close care gaps
- Members receive an incentive for closing the care gap and obtaining preventative care
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: *Controlling High Blood Pressure***

2021: 47.69%

2022: 54.74%

**Identify any barriers to implementing initiatives:**

- No barriers identified.

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 5:** Providing Whole-Person Care for Vulnerable Populations

**Objective 5.4:** Improve Behavioral Health and Developmental Services for Members

**Measure 5.4.1.3:** Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

**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:

- ***Follow-up care for Children Prescribed ADHD Medication - Initiation Phase***

**Recommendation—Performance Measure Validation**

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic
- Care Coordination letters are sent to the member’s Primary Care Provider (PCP) and prescriber of atypical antipsychotic
- The goal is to ensure appropriate clinical monitoring of the member is being completed and reported
- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure:** *Follow-up care for Children Prescribed ADHD Medication - Initiation Phase*

2021: 31.17%

2022: 37.48%

**Identify any barriers to implementing initiatives:**

- No barriers Identified

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 4:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members

**Objective 4.2:** Improve Outcomes for Maternal and Infant Members

**Measure 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

**Recommendation—Performance Measure Validation**

**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:

- ***Prenatal and Postpartum Care - Timeliness of Prenatal Care and Postpartum Care***

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- 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
- Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/post-partum health.
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- Member Outreach Calls
- Emmi® Manager utilization for educational videos
- Prealize Health data utilized to identify members to refer to CM
- CM utilization of Tableau care gap report when engaging members
- CM 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



**Recommendation—Performance Measure Validation**

- 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+ and male members 18+ 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 9am to 9pm 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 was 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 completed 7/2023

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: *Prenatal and Postpartum Care - Timeliness of Prenatal Care***

2021: 69.59%

2022: 68.13%

PMV results showed:

**Measure: *Prenatal and Postpartum Care - Postpartum Care***

2021: 63.50%

2022: 61.07%

**Identify any barriers to implementing initiatives:**

- 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
- Coding discrepancies with the Bundled coding in Inovalon not capturing all prenatal visits in data pull

**Recommendation—Performance Measure Validation**

**HSAG Assessment:**



**Recommendation—Member Experience of Care Survey—Child**

<p><b>Goal 2:</b> Promote Access to Safe, Gold Standard Patient Care</p>	<p><b>Objective 2.1:</b> Ensure Access to Care</p> <p><b>Objective 2.2:</b> Promote Patient Safety</p> <p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>	<p><b>Measure 1.2.1.1:</b> Enrollees’ Ratings Q8 Ratings of all Health Care</p>
--	---	---

**Weakness:** Optima’s 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, Rating of Health Plan.

**Why the weakness exists:**

**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):**

- The Quality Satisfaction Committee (QSC) was re-established to ensure timely fielding of surveys and interventions are implemented
- Members receive reminders via social media, mail, & voice recordings to complete survey

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Top Box Score - Rating of Health Plan**

2021: 73.30%

2022: 72.50%

**Identify any barriers to implementing initiatives:**

- No barriers identified

**Recommendation—Member Experience of Care Survey—Child**

**HSAG Assessment:**



**United**

**Table E-6—Prior Year Recommendations and Responses—United**

**Recommendation—Performance Measure Validation**

**Goal 2:** Promote Access to Safe, Gold-Standard Patient Care  
**Goal 4:** Strengthen the Health of Families and Communities

**Objective 2.1:** Ensure Access to Care  
**Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members  
**Objective 4.2:** Improve Outcomes for Maternal and Infant Members

**Measure 2.1.1.6:** Cervical Cancer Screening  
**Measure 2.1.1.9:** Breast Cancer Screening  
**Measure 4.1.1.1:** Adult’s Access to Preventative/Ambulatory Health  
**Measure 4.2.1.1:** Prenatal and Postpartum Care: Postpartum Care  
**Measure 4.2.1.2:** Prenatal and Postpartum Care: Timeliness of Prenatal Care

**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**

**Why the weakness exists:**

**Recommendation:** 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.

**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—Performance Measure Validation**

UHC conducted root cause analysis and focus studies for these measures, including performance by race, ethnicity, gender, and region. The following initiatives were continued and further developed in areas noted with lower performance.

- Emails and monthly letter reminders to members to obtain annual wellness visit, breast and cervical cancer screenings, prenatal and postpartum care.
- Member outreach to educate, remind and assist members with scheduling an appointment for an open gap in care. Transportation for members was also arranged as needed.
- Healthy First Steps (HFS) program and Rewards – Comprehensive Case management services addressing SDOH, medical, and behavioral needs for mothers and infants.
- Member incentives for completing postpartum care visits.
- Assisted members with obtaining in-home & telehealth visits as needed.
- Increased provider incentives participating in Community Plan Primary Care Professional (CP-PCPi) program to close opportunities.
- Increased provider education, engagement and incentives through CP PCPi Incentive Program.
- Provider education through uhcprovider.com.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure 2.1.1.6: Cervical Cancer Screening**

2021: 46.47%

2022: 46.47%

**Measure 2.1.1.9: Breast Cancer Screening**

2021: 43.72%

2022: 46.46%

**Measure 4.1.1.1: Adult’s Access to Preventative/Ambulatory Health**

2021: 70.56%

2022: 67.67%

**Measure 4.2.1.1: Prenatal and Postpartum Care: Postpartum Care**

2021: 70.32%

2022: 79.32%

**Identify any barriers to implementing initiatives:**

During the COVID-19 national public health emergency, UHC determined members continued to have some hesitancy in returning to provider offices for preventative and follow-up care

**HSAG Assessment:**



Recommendation—Member Experience of Care Survey—Adult Medicaid		
<b>Goal 1:</b> Enhance the Member Care Experience	<b>Objective 1.2:</b> Improve Member Satisfaction	<b>Measure 1.2.1.1:</b> Enrollee’s Ratings Q8-Rating of all Health Care
<p><b>Weakness:</b> United’s 2022 top-box score was statistically significantly lower than the 2021 NCQA adult Medicaid national average for one measure, <i>Rating of All Health Care</i>.</p> <p><b>Why the weakness exists:</b></p> <p><b>Recommendation:</b> 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.</p>		
MCO’s Response		
<p><b>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):</b></p> <p>UHC conducted root cause analysis to investigate process deficiencies, identify causes, and potential improvement strategies. The following activities were continued and remain active. As a result of these initiatives, UHC’s 2023 score for this measure improved significantly.</p> <ul style="list-style-type: none"> <li>• Increased awareness and communications within all areas of the health plan on CAHPS and increased engagement of contributors in our QI activities.</li> <li>• Analyzed results and monitored trends in appeals and grievances, quality of care/quality of service (QOC/QOS), CAHPS and care management surveys.</li> <li>• UHC continues to regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and use 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.</li> <li>• UHC continues to survey providers on appointment availability. Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration.</li> <li>• Addressed trends in dissatisfaction with transportation services through vendor improvement action plans.</li> <li>• Offer provider education and improvement support, aligned with VBP programs.</li> <li>• Address network adequacy concerns by communicating requirements such as those for after-hours availability.</li> </ul>		
<p><b>Identify any noted performance improvement as a result of initiatives implemented (if applicable):</b></p> <p><b>Measure 1.2.1.1:</b> Enrollee’s Ratings Q8-Rating of all Health Care            2022: 47.8%            2023: 76.4%</p>		

**Recommendation—Member Experience of Care Survey—Adult Medicaid**

**Identify any barriers to implementing initiatives:**

UHC did not identify any barriers to implementing initiatives.

**HSAG Assessment:**



**Recommendation—Member Experience of Care Survey – Child Medicaid**

**Goal 2:** Promote Access to Safe, Gold-Standard Patient Care

**Objective 2.1:** Ensure Access to Care

**Measure 2.1.1.1:** Getting Care Quickly Q6

**Measure 2.1.1.3:** Getting Needed Care

**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*.

**Why the weakness exists:**

**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 conducted root cause analysis to investigate process deficiencies, identify causes, and potential improvement strategies. The following activities were continued and remain active. As a result of these initiatives, UHC’s 2023 score for these measures showed improvement.

- Increased awareness and communications within all areas of the health plan on CAHPS and increased engagement of contributors in our QI activities.
- Analyzed results and monitored trends in appeals and grievances, QOC/QOS, CAHPS and care management surveys.
- UHC continues to regularly assesses the accuracy of marketing materials and how well new members understand their benefits, services, and materials upon enrollment, and use 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 survey providers on appointment availability. Outreach and education continue to be provided to providers on scheduling best practices and how to improve access to routine/urgent care. We have fostered strong relationships with our providers via regular communications and collaboration.
- Addressed trends in dissatisfaction with transportation services through vendor improvement action plans.

**Recommendation—Member Experience of Care Survey – Child Medicaid**

- Offer provider education and improvement support, aligned with VBP programs.
- Address network adequacy concerns by communicating requirements such as those for after-hours availability.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

**Measure 2.1.1.1:** Getting Care Quickly Q6

2022:80.6%

2023: 81.5%

**Measure 2.1.1.3:** Getting Needed Care

2022:76.8%

2023: 79.8%

**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 Measure Validation**

**Goal 2:** Promote Access to Safe, Gold-Standard Patient Care

**Objective:** Ensure Access to Care, Promote Patient Safety

**Measure 2.1 and 2.2:** Adult’s Access to Preventive/Ambulatory Health Services

**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**

**Why the weakness exists:**

**Recommendation:** 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.



**Recommendation—Performance Measure 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):**

- Formalized Population Health Committee & workgroups established as part of the Quality Governance Structure
- NCQA Population Health Program (PHM) Standards and Readiness tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.
- Workgroups were established for each focus area of CAHPS to assess, research best practices, and pilot interventions to improve each area of focus
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Adult Access to Preventive/Ambulatory Health Services - Total**

2021: 72.46%

2022: 68.26%

**Identify any barriers to implementing initiatives:**

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. COVID along with the increased flu, and respiratory syncytial virus (RSV) still impacted member's ability to get in and see their primary care physicians.

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 4:** Strengthen the Health of Families and Communities

**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members

**Measure 4:** Childhood Immunization Status—Combination 3

**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:

- **Childhood Immunization Status—Combination 3**

**Why the weakness exists:**

**Recommendation—Performance Measure Validation**

**Recommendation:** 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.

**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):**

- Childhood Immunization Incentive Program
- Immunization Health Fairs across the State
- HEDIS Blitz conducted annually to close care gaps
- Provider Educational Outreach
- Hired a dedicated full-time employee to support EPSDT
- Data from the Virginia Immunization Information System (VIIS) is used to close gaps and referred to Case Management when appropriate
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- NCQA PHM Standards and Audit tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH (Social Determinants of Health), barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.
- A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Childhood Immunization Status – Combination 3**

2021: 59.37%

2022: 68.37%

**Identify any barriers to implementing initiatives:**

- No barriers identified

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 5:** Providing Whole-Person Care for Vulnerable Populations

**Objective 5.4:** Improve Behavioral Health and

**Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness

**Recommendation—Performance Measure Validation**

	Developmental Services for Members	
--	------------------------------------	--

**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:

- **Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total**

**Why the weakness exists:**

**Recommendation:** 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.

**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 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. Behavioral Health Inpatient Reviewers send notification at admission and discharge to member’s Care Coordinator (CC) and/or Transition Coordinator (TC) to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission
- Behavioral Health Inpatient Reviewers send notification at admission and discharge to member’s CC and/or Transition Coordinator to initiate discharge planning with the inpatient facility to identify and resolve barriers for safe and effective discharge, while initiating community-based services, as needed, to reduce the chance for member readmission
- A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

- **Measure: Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total**  
2021: 22.79%  
2022: 22.67%

- **Measure: Follow-Up After Hospitalization for Mental Illness—Total and 30-Day Follow-Up—Total**  
2021: 41.69%  
2022: 40.05%

**Recommendation—Performance Measure Validation**

**Identify any barriers to implementing initiatives:**

- Numerous unsuccessful outreach attempts to assist member with scheduling follow-up appointment post discharge

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 4:** Strengthen the Health of Families and Communities

**Objective 4.2:** Improve Outcomes for Maternal and Infant Members

**Measure 4.2:** Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care

**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:

- ***Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care***

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- Population Health Assessment work group was established 7/2022
- NCQA PHM Standards and Audit tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.
- A Maternal Health Incentive Program is in place to assist members and ensure they are getting their prenatal/post-partum care timely.
- A Care Coordination team is in place to assist at-risk pregnant members.
- Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/post-partum health.
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement.
- A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.

**Recommendation—Performance Measure Validation**

- An SDOH team has been established to address member needs

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

- **Measure: Prenatal and Postpartum Care—Timeliness of Prenatal Care**

2021: 74.45%

2022: 76.89%

**Identify any barriers to implementing initiatives:**

- No Barrier Identified

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

**Goal 4:** Strengthen the Health of Families and Communities

**Objective 4.2:** Improve Outcomes for Maternal and Infant Members

**Measure 4.2:** Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care

**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:

- ***Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care***

**Why the weakness exists:**

**Recommendation:** 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.

**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):**

- Population Health Assessment work group was established 7/2022
- NCQA PHM Standards and Audit tools were purchased to perform a comprehensive population health assessment to include but are not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc.
- A Maternal Health Incentive Program is in place to assist members and ensure they are getting their prenatal/post-partum care timely.

**Recommendation—Performance Measure Validation**

- A Care Coordination team is in place to assist at-risk pregnant members.
- Regional Baby Showers are conducted virtually which allows more members to participate. Educational materials are disseminated to the members on the importance of prenatal/post-partum health.
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement.
- A Performance Withhold Performance (PWP) team was established to monitor and track data trends with this measure and alert the organization when rates are dropping.
- An SDOH team has been established to address member needs.

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

- **Measure: Prenatal and Postpartum Care—Timeliness of Postpartum Care**  
2021: 68.86%  
2022: 72.51%

**Identify any barriers to implementing initiatives:**

- No Barriers Identified

**HSAG Assessment:**



**Recommendation—Performance Measure Validation**

<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p>	<p><b>Objective 4.1:</b> Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p>	<p><b>Measure 4.1:</b> 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</p>
---	---	---

**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:

- **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**

**Why the weakness exists:**

**Recommendation:** 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.

**Recommendation—Performance Measure 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):**

- Childhood Incentive Program established to incentivize member for obtaining preventative care
- Health fairs throughout the state of Virginia
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide
- Hired a dedicated full-time employee to support EPSDT
- Partnership with the Virginia Department of Health to increase access to appointments and provide education
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

- **Measure: Well-Child Visits in the First 30 Months of Life**

2021: 55.48%

2022: 51.41%

- **Measure: Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits**

2021: 65.09%

2022: 62.30%

**Identify any barriers to implementing initiatives:**

- Timely access to Primary Care Provider (PCP)

**HSAG Assessment:**



**Recommendation—Member Experience of Care Survey - Adult Medicaid**

**Goal 1:** Enhance the Member Care Experience

**Objective:** Improve Member Satisfaction

**Measure 1.2:** Rating of Personal Doctor

**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*.

**Why the weakness exists:**

**Recommendation:** 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.



**Recommendation—Member Experience of Care Survey - Adult Medicaid**

**MCO’s Response**

Describe initiatives implemented based on recommendations (include a summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation):

- The Quality Satisfaction Committee (QSC) was established to ensure timely fielding of surveys and interventions are implemented.
- Members receive reminders via social media, mail, & voice recordings to complete survey

**Identify any noted performance improvement as a result of initiatives implemented (if applicable):**

PMV results showed:

**Measure: Rating of Personal Doctor**

2021: 78.31%

2022: 81.76%

**Identify any barriers to implementing initiatives:**

- No barriers identified

**HSAG Assessment:**



## Appendix F. 2023–2025 Quality Strategy Status Assessment

### Quality Strategy

In accordance with 42 Code of Federal Regulations (CFR) §438.340, the Virginia Department of Medical Assistance Services (DMAS) implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the managed care organizations (MCOs) to Virginia Medicaid members under the Commonwealth Coordinated Care (CCC) Plus (Managed Long-Term Services and Supports [MLTSS]), Medallion 4.0 (Acute), and the Cardinal Care Medicaid managed care program. DMAS is the Commonwealth of Virginia’s single State agency that administers all Medicaid and Family Access to Medical Insurance Security (FAMIS) health insurance benefit programs in the Commonwealth. Medicaid is delivered to individuals through two models, managed care and fee-for-service (FFS). Table F-1 displays the average annual program enrollment during CY 2023.

**Table F-1—CY 2023 Average Annual Program Enrollment<sup>F-1</sup>**

Program	SFY 2023 Enrollment as of 08/01/2023*
Title XIX Medicaid	1,933,150
Title XXI CHIP	190,660
Medallion 4.0 (Acute)	1,605,199
CCC Plus (MLTSS)	300,467
Fee-for-Service	228,429
<b>Total Served</b>	<b>2,135,985</b>

*\*Point in time numbers. Categories are not intended to equal the total served.*

In June 2021, the Virginia General Assembly mandated that DMAS rebrand the Department’s FFS and managed care programs and effectively combine the CCC Plus (MLTSS) and Medallion 4.0 (Acute) programs under a single name, the Cardinal Care program. The combined program achieves a single streamlined system of care that links seamlessly with the FFS program. DMAS received Centers for Medicare & Medicaid Services (CMS) approval for an effective date of October 1, 2023, for the Cardinal Care program.

The Cardinal Care program will ensure an efficient, well-coordinated Virginia Medicaid delivery system that provides high-quality care to members and adds value for providers and the Commonwealth. The consolidated program will enable DMAS to ensure better continuity of care for members, operate with improved administrative efficiency, and strengthen the focus on the diverse and evolving needs of the populations served. The Cardinal Care program will continue to offer members the same programs and services and will not reduce or change any existing coverage. The overarching program will ensure a smoother transition for individuals whose healthcare needs evolve over time.

<sup>F-1</sup> 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 6, 2023.

Virginia’s 2023–2025 Quality Strategy 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. The Quality Strategy is intended to guide Virginia’s Medicaid managed care program by establishing clear goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured.

The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding MCOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DMAS will use the managed care infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, inclusive healthcare, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into five central goals:

1. Enhance the member care experience
2. Promote access to safe, gold-standard patient care
3. Support efficient and value-driven care
4. Strengthen the health of families and communities
5. Provide whole-person care for vulnerable populations

DMAS’ mission is to improve the health and well-being of Virginians through access to high-quality healthcare coverage. The Medicaid managed care program in Virginia is responsible for providing high-quality, innovative, and cost-effective healthcare to Medicaid enrollees.

DMAS contracted with six MCOs through September 30, 2023. In October 2023, the Optima and VA Premier MCOs merged under the Optima name. The five MCOs contracted with DMAS on December 31, 2023, are displayed in Table F-2. These MCOs pay for Medicaid benefits and services included in the Virginia Medicaid State plan, State statutes and administrative rules, and Medicaid policy and procedure manuals.

**Table F-2—CCC Plus (MLTSS) 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*





\*VA Premier and Optima merged during CY 2023.


## Goals and Objectives

The Virginia 2021–2023 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Virginia Medicaid managed care program. Refer to Appendix B for a detailed description of the objectives and performance measures (PMs) used to support each goal.

Virginia’s Quality Strategy identifies the following five goals and associated objectives:

**Table F-3—Quality Strategy Goals and Objectives**

Goals	Objectives
 <p><b>Goal 1:</b> Enhance the Member Care Experience</p>	<p><b>Objective 1.1:</b> Increase Member Engagement and Outreach</p>
	<p><b>Objective 1.2:</b> Improve Member Satisfaction</p>
 <p><b>Goal 2:</b> ★ Promote Access to Safe, Gold-Standard Patient Care ★</p>	<p><b>Objective 2.1:</b> Ensure Access to Care</p>
	<p><b>Objective 2.2:</b> Promote Patient Safety</p>
	<p><b>Objective 2.3:</b> Promote Effective Communication and Care Coordination</p>
 <p><b>Goal 3:</b> ★ Support Efficient and Value-Driven Care ★</p>	<p><b>Objective 3.1:</b> Focus on Paying for Value</p>
	<p><b>Objective 3.2:</b> Promote Efficient Use of Program Funds</p>
	<p><b>Objective 4.1:</b> Improve Utilization of Wellness, Immunization, and Prevention Services for Members</p>
	<p>★ <b>Objective 4.2:</b> Improve Outcomes for Maternal and Infant Members ★</p>

Goals	Objectives
<b>Goal 4:</b> Strengthen the Health of Families and Communities	<b>Objective 4.3</b> Improve Home and Community-Based Services
 <b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations	<b>Objective 5.1:</b> Improve Outcomes for Members with Chronic Conditions
	<b>Objective 5.2:</b> Improve Outcomes for Nursing Home Eligible Members
	<b>★ Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorders ★
	<b>★ Objective 5.4:</b> Improve Behavioral Health and Developmental Services of Members ★

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix B.

★ In alignment with Governor Glenn Youngkin’s identified priorities for the Medicaid program.

Each of the 14 objectives is tied to focused interventions used to drive improvements within, and, in many cases, across the goals and objectives set forth in the 2023–2025 Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

## Evaluation

DMAS uses several mechanisms to monitor and enforce MCO compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care enrollees. The following sections provide an overview of the key mechanisms DMAS uses to enforce these standards and to identify ongoing opportunities for improvement.

## Performance Measures

DMAS requires MCOs to report annually on patient quality, access, timeliness, and outcomes performance measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>F-2</sup> quality metrics, CMS Adult and Child Core Set of Health Care Quality Measures for Medicaid, Agency

<sup>F-2</sup> HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs), Consumer Assessment of Healthcare Providers and Systems (CAHPS®)<sup>F-3</sup> measures, and State-specified quality measures. The MCO performance measures align with the Quality Strategy’s goals of enhancing the members’ care experience, promoting access to safe, gold-standard patient care, supporting efficient and value-driven care, strengthening the health of families and communities, and providing whole-person care for vulnerable populations. DMAS assesses if MCO performance measures meet target objectives or improvement objectives.

## Medallion 4.0 (Acute)

### Progress

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities, in the Children’s Preventive Health domain, four 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. The Child Welfare Focus Study also demonstrated improvements towards Quality Strategy goals. The study found that children in foster care have higher rates of appropriate healthcare utilization than comparable controls for most study indicators in MY 2019, MY 2020, and MY 2021. Study findings show that MY 2021 rate differences between children in foster care and controls were greatest among the dental study indicators (*Annual Dental Visit; Preventive Dental Services; Oral Evaluation, Dental Services; and Topical Fluoride for Children—Dental or Oral Health Services* by 18.2, 19.0, 19.0, and 14.2 percentage points, respectively); the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure (by 20.4 percentage points); and the *Behavioral Health Encounters—CMH Services* indicator (by 17.1 percentage points).

Progress was made toward achieving DMAS’ Quality Strategy goal of providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five of six MCOs’ rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c control (<8.0%)* measure indicators.

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated improvement in the Maternal and Child Health Focus Study results, where the FAMIS MOMS program results demonstrated improvement, with rates for the *Births with Early and Adequate Prenatal Care, Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* study indicators outperforming the applicable national benchmarks for all three measurement periods. The Medicaid for Pregnant Women program had rates for the *Preterm Births (<37 Weeks Gestation)* study indicator that outperformed national benchmarks in CYs 2020 and 2021. and had rates for the *Newborns with Low Birth Weight (<2,500 grams)* study indicator that outperformed national benchmarks in CYs 2019, 2020, 2021. Additionally, the Medicaid Expansion program’s rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 and outperformed the national benchmark in CY 2021.

Progress toward achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders (SUDs) and improving behavioral health and developmental services for members was demonstrated with all six MCOs’ rates meeting or exceeding the 50th percentile for the

---

<sup>F-3</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).



*Follow-Up After Emergency Department (ED) Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total and Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment* PM indicators. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment and Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment* PM indicators.

Additional evidence of progress toward achieving the Quality Strategy goals was found in the *Cascade of Care for Members With Opioid Use Disorder (OUD)—High-Risk Members With OUD Diagnosis* indicator, which assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators showed that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. Of members diagnosed with OUD, 44.2 percent initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021.

## **Opportunities**

Opportunities for improvement in achieving the Quality Strategy goal of strengthening the health of families and communities in the Children's Preventive Health domain. Four of the six MCOs' rates fell below the 50th percentile for the *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 and Childhood Immunization Status—Combination 3* PM indicators.

The DMAS Quality Strategy goal of improving outcomes for maternal and infant health also demonstrated opportunities for improvement. All six MCOs' rates fell below the 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* PM indicators. In addition, the DMAS Quality Strategy goal of strengthening the health of families and communities also had opportunities for improvement in the Access to Care domain as all six MCOs' rates fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.

The Quality Strategy goal of promoting access to safe, gold-standard patient care also demonstrated opportunities for improvement in preventive screenings. While one MCO improved performance over the prior year, the overall MCO performance was below the 50th percentile for the *Cervical Cancer Screening* PM indicator. In addition, all six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* indicator.

Opportunities were also identified in achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations. Within the Care for Chronic Conditions domain, five of the six Medallion 4.0 (Acute) MCOs' rates fell below the 50th percentile for the *Eye Exam for Patients With Diabetes—Total* PM indicator. MCO performance below the 50th percentile indicates some members with diabetes are not receiving eye examinations as recommended to appropriately manage risks associated with diabetes.

Although progress was made overall in behavioral health and substance use quality goals, opportunities persist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs. The Addiction and Recovery Treatment Services (ARTS) study findings show that



engagement in OUD treatment may be declining. The *Cascade of Care for Members With OUD—Members who Initiated OUD Treatment who Also Engaged in OUD Treatment* indicator found that 40.7 percent of members who had initiated OUD treatment engaged in OUD treatment for six months following OUD diagnosis, and this rate declined by 8.7 percentage points from CY 2020 to CY 2021. However, the rate for CY 2021 may be especially impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), since this study indicator utilizes visits from the year prior to the measurement year. Therefore, many of these missed engagement visits were supposed to happen during 2020 after the onset of the PHE. The ARTS study findings are consistent with the overall Medallion 4.0 (Acute) PM results, with five of the six MCOs' rates falling below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators. Additionally, four of the six MCOs' rates fell below the 50th percentile for the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* PM indicator. This performance suggests that members have not received timely follow-up after ED visits and hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care.

## CCC Plus (MLTSS)

### Progress

Progress in achieving the DMAS Quality Strategy objective of improving outcomes for members with substance use disorders and improving behavioral health and substance use disorders. Overall, behavioral health (BH) care and ARTS demonstrated improvement for the CCC Plus (MLTSS) program. The ARTS study findings show that identification of members with SUD may be improving, in alignment with ARTS benefit goals. The *Cascade of Care for Members With OUD—High-Risk Members With OUD Diagnosis* indicator assessed identification of members with an OUD. Findings show that this rate increased from 3.8 percent to 5.1 percent from CY 2020 to CY 2021. In addition, several study indicators found that initiation of SUD treatment is increasing overall, though findings differ by type and timeliness of treatment. For example, 44.2 percent of members diagnosed with OUD initiated any OUD treatment (i.e., pharmacotherapy or other treatment) within 14 days of OUD diagnosis in CY 2021, and this rate increased by 4.7 percentage points from CY 2020. The rate change was driven by an increase in members initiating pharmacotherapy, for which the rate increased by 6.2 percentage points from CY 2020 to CY 2021. The emphasis and focus on the ARTS program may be driving improvement in BH measures.

The MCOs also demonstrated progress in achieving Quality Strategy goals and objectives within the Behavioral Health PM domain related to the use of medication to treat mental health conditions, as all six MCOs' rates met or exceeded the 50th percentile for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Diagnosed Substance Use Disorders—Opioid disorder—Total, Diagnosed Substance Use Disorders—Other or unspecified drugs—Total, and Diagnosed Substance Use Disorders—Any disorder—Total* PM indicators. In addition, five of the six MCOs' rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measure also met or exceeded the 50th percentile.

There was demonstrated progress toward achieving the DMAS Quality Strategy goal of strengthening the health of families and communities in the Access to Care domain Access and Preventive Care: All six MCOs' rates met or exceeded the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.

In alignment with the DMAS Quality Strategy goal of strengthening the health of families and communities and the Taking Care of Children domain, five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators.

Progress was made toward achieving DMAS' Quality Strategy goal of providing whole-person care for vulnerable populations in the Living With Illness domain—MCO performance showed improvement with five of six MCOs' rates having met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total*, *Eye Exam for Patients With Diabetes—Total*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total*, and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators.

## Opportunities

The DMAS Quality Strategy goal of strengthening the health of families and communities also demonstrated opportunities for improvement in the Access to Care and Preventive Care domain. within the Access and Preventive Care domain, cancer screenings for women, pregnancy care, and appropriate use of imaging studies for low back pain represent an area for opportunity Virginia-wide, as all reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*, and *Use of Imaging Studies for Low Back Pain* measures. Additionally, five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measure.

Opportunities exist in achieving the DMAS Quality Strategy objective of improving outcomes for members with SUDs and improving behavioral health and developmental services. Five of six MCOs' rates fell below the 50th percentile for *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total*, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and all three MCOs' rates without a small denominator fell below the 50th percentile for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures.

Opportunities also exist in the Taking Care of Children domain. All six CCC Plus (MLTSS) MCOs' rates for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* PM indicators fell below the 50th percentile. While the COVID-19 PHE contributed to a decline in routine pediatric vaccine ordering and doses administered, the MCOs' continued performance below the 50th percentile suggests children are not receiving vaccines at a rate in line with national benchmarks.

The MCOs did not meet improvement objectives for measures related to DMAS' goal to strengthen providing whole-person care for vulnerable populations in the Care for Chronic Conditions domain. Five

of the six MCOs' rates fell below the 50th percentile for the *Blood Pressure Control for Patients With Diabetes—Total* and *Controlling High Blood Pressure—Total* measures. MCO performance below the 50th percentile indicates that some members with diabetes and hypertension are not receiving appropriate care to support optimal health.

## CAHPS

DMAS requires the external quality review organization (EQRO) to administer a CAHPS survey according to the NCQA HEDIS Specifications for Survey measures. This activity assesses member experience with an MCO and its providers and the quality of care members receive. The standard survey instruments are the CAHPS 5.1H Child Medicaid Health Plan Survey and the 5.1H Adult Medicaid Health Plan Survey. CAHPS global ratings are for *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*. Additionally, CAHPS composite measures are *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

However, the CCC Plus (MLTSS) *Getting Care Quickly* indicator rate was statistically significantly lower in 2023 than in 2022.

### Medallion 4.0 (Acute) Adult Survey

In alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass<sup>®</sup>,<sup>F-4</sup> for the *Rating of Health Plan* Global indicator.

### Medallion 4.0 (Acute) Child Survey

The Medallion 4.0 (Acute) program's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Getting Care Quickly*. This represents an opportunity for improvement in relation to the Quality Strategy goal of Enhancing the Member Care Experience.

### CCC Plus (MLTSS) Child Survey

Also, in alignment with the DMAS Quality Strategy goal of promoting access to safe, gold-standard patient care, and the objective of ensuring access to care, the Medallion 4.0 (Acute) program Global child member CAHPS 5.1H Child Medicaid Health Plan Survey scores did not meet or exceed the national Medicaid benchmarks in the NCQA Quality Compass for any indicators. In addition, the Composite Top-Box Scores showed a Medallion 4.0 (Acute) statistically significantly lower rate in the *Getting Care Quickly* indicator than the 2022 NCQA Medicaid national average.

The CCC Plus (MLTSS) Global child member CAHPS 5.1H Child Medicaid Health Plan Survey rates were statistically significantly lower in the *Rating of Health Plan* and *Rating of All Health Care* indicators. The CCC Plus (MLTSS) Top-Box scores for the *How Well Doctors Communicate* indicator was statistically significantly higher than the 2022 NCQA Medicaid national average. The results

---

<sup>F-4</sup> Quality Compass<sup>®</sup> is a registered trademark of NCQA.

identify an opportunity for improvement for achieving Quality Strategy Goal 1: Enhance the Member Care Experience.

### **CCC Plus (MLTSS) Adult Survey**

Progress toward achieving the Quality Strategy goal of improving member satisfaction was demonstrated in the 2023 CAHPS results. The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*. The CAHPS survey results demonstrate members' overall satisfaction with aspects of the CCC Plus (MLTSS) program.

The CCC Plus (MLTSS) adult member CAHPS 5.1 Adult Medicaid Health Plan Survey scores met or exceeded the national Medicaid benchmarks in the NCQA Quality Compass® for the *Rating of Health Plan* and *Rating of Specialist Seen Most Often* Global indicators. The Composite Top-Box Scores showed CCC Plus (MLTSS) statistically significantly higher rate than the 2022 NCQA Medicaid national averages in the *Getting Care Quickly* and *Customer Service* indicators.

### **FAMIS Program Child Survey**

Although not a metric in the Quality Strategy, the FAMIS general child and CCC 2023 CAHPS scores in the Composite measure, *Customer Service*, identified a top-box score that was statistically significantly higher than the 2022 top-box score. However, the CCCs 2023 top-box scores were statistically significantly lower than the 2022 NCQA Child Medicaid national averages for two measures: *Rating of All Health Care* and *Getting Needed Care*. These results represent an opportunity for improvement for achieving Goal 1—Enhance the Member Care Experience.

### **External Quality Review (EQR) Activities**

As noted in the Quality Strategy, the EQRO plays a critical role in reporting MCOs' performance in several required areas (meaning federal regulations require that these activities be completed by the EQRO) and some optional areas (meaning that the State has elected to use the EQRO for these activities) under 42 CFR §§438.352 and 438.364.

### **Performance Evaluation and Improvement**

The final audit reports (FARs) issued by each MCO's independent auditor, were reviewed and it was identified that all MCOs were determined to be fully compliant with all applicable NCQA HEDIS information systems standards. Additionally, the MCO's independent audit determined that all reported rates were calculated in accordance with NCQA's specifications and no data collection or reporting concerns were identified.

Health Services Advisory Group, Inc. (HSAG) also conducted 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.

An ISCA was also conducted for each MCO, and the assessment indicated that the MCOs met the federal requirement of maintaining a health information system that collects, analyzes, integrates, and reports data.

### Performance Improvement Project (PIP) Validation

MCOs had an ongoing program of PIPs that intended to improve the care, services, and enrollee outcomes in each topic area. DMAS-approved MCO PIPs are listed below in Table F-4. DMAS and the EQRO facilitated regular PIP meetings with the MCOs to provide guidance and collaboration. The EQRO validated each MCO’s PIPs and provided results and findings for each MCO, along with recommendations for improvement.

**Table F-4—DMAS-Approved MCO PIPs**

Program	PIP Topic Area
Medallion 4.0 (Acute)	<i>Timeliness of Prenatal Care</i> rates for 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 the MCO as defined by the HEDIS MY 2022 <i>Prenatal and Postpartum Care (PPC)</i> Technical Specifications. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ <b>Improve Outcomes for Maternal and Infant Members.</b> ★)
Medallion 4.0 (Acute)	<i>Tobacco Use Cessation in Pregnant Women</i> rates for all pregnant women, as defined by the HEDIS MY 2022 PPC Technical Specifications, identified as smokers or tobacco users. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ <b>Improve Outcomes for Maternal and Infant Members</b> ★; and goal: Providing Whole Person Care for Vulnerable Populations; objective: Improve Behavioral Health and Developmental Services for Members.)
CCC Plus (MLTSS)	<i>Ambulatory Care—Emergency Department Visits</i> rates for the percentage of members in the entire eligible population aligned with the HEDIS MY 2022 Technical Specifications <i>Ambulatory Care (AMB)</i> measure specifications and who had more than one emergency department visit. (Quality Strategy goal: ★ <b>Support Efficient and Value-Driven Care</b> ★; objective: Focus on Paying for Value.)
CCC Plus (MLTSS)	<i>Follow-Up After Discharge</i> rates for the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. (Quality Strategy goal: ★ <b>Support Efficient and Value-Driven Care</b> ★; objective: Focus on Paying for Value.)

### Validation of Network Adequacy

HSAG will conduct the *EQR Protocol 4. Validation of Network Adequacy* activity beginning in calendar year 2024. In preparation for the task, HSAG identified that to assess appointment availability, DMAS established minimum standards to ensure members’ needs were sufficiently met. DMAS monitors the MCO’s compliance with these standards through regular reporting requirements outlined in the DMAS Managed Care Technical Manual. In addition, DMAS requires the MCOs to conduct various activities to



assess the adequacy of their networks as well as maintain provider and beneficiary data sets that allow monitoring of their networks' adequacy. DMAS requires MCOs to conduct:

- Geomapping to determine if provider networks meet quantitative time and distance standard
- Calculation of provider-to-enrollee ratios, by type of provider and geographic region
- Analysis of in-network and out-of-network utilization data to determine gaps in realized access
- Appointment availability and accessibility studies, including the proportion of in-network providers accepting new patients and the average wait time for an appointment
- Validation of provider directory information

In preparation for the 2024 Network Adequacy Validation task, HSAG obtained from DMAS a list of the State's quantitative network adequacy standards, by provider and plan type, as specified in the State's contract with the MCOs. DMAS has also provided a description of the network adequacy data and documentation that MCOs submit to the State to demonstrate compliance with network adequacy standards, including a list of the data and documentation submitted by the MCOs; the frequency with which the MCOs submit each type of data; formatting requirements for MCO data and documentation; DMAS standards for data completeness and accuracy, and DMAS data dictionaries and applicable companion guides.

### **Prenatal Care Secret Shopper Survey**

The prenatal care secret shopper survey provides indicators for MCO performance in relation to Goal 2: **★ Promote Access to Safe, Gold-Standard Patient Care ★**, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.2: **★ Improve Outcomes for Maternal and Infant Members ★**. HSAG conducts a prenatal care secret shopper survey of appointment availability to collect information on members' access to initial prenatal care services. For the Medallion 4.0 (Acute) program, 29.6 percent of offices contacted stated that the office accepted the VA Medicaid program, and 26.0 percent stated that the office accepted new patients. A first, second, and third trimester appointment date was provided 28.0 percent of the time. Of the appointments which were offered, 15.1 percent were compliant with DMAS wait time standards. There was a substantial difference in the percentage of appointments offered by trimester (i.e., first, second, or third). For cases that were offered a first trimester appointment, 15.1 percent (n=8) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a second trimester appointment, 21.4 percent (n=3) were compliant with the seven-calendar-day standard for prenatal care services. For cases that were offered a third trimester appointment, 10.5 percent (n=2) were compliant with the three-business-day standard for prenatal care services.

### **Primary Care Provider (PCP) Secret Shopper Survey**

HSAG also conducts a PCP secret shopper survey of appointment availability to collect information on members' access to primary care services. The primary care provider secret shopper survey provides indicators for MCO performance in relation to Goal 2: **★ Promote Access to Safe, Gold-Standard Patient Care ★**, Objective 2.1: Ensure Access to care, and Goal 4: Strengthen the Health of Families and Communities, Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members. For the Medallion 4.0 (Acute) program, 46.7 percent of offices contacted stated that the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 4.0

percent of calls were offered an appointment date for a routine appointment and 73.1 percent were offered an appointment date for an urgent or routine appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments.

For the CCC Plus (MLTSS) program, 46.7 percent stated the office accepted the MCO, 43.3 percent stated that the office accepted the VA Medicaid program, and 36.1 percent stated that the office accepted new patients. Survey results showed that 74.0 percent of calls were offered an appointment date for a routine appointment and 72.3 percent were offered an appointment date for an urgent appointment. Of the appointments which were offered, 74.5 percent met the DMAS standard of offering an appointment within 30 days for routine appointments. For urgent visit appointments offered, 16.0 percent met the DMAS standard of offering an appointment within one day for urgent appointments with rates.

### **Cardinal Care Program Readiness Reviews**

During 2022 and 2023, Cardinal Care program readiness reviews were conducted for all six MCOs. The readiness review included an assessment of all key program areas noted in 42 CFR §438.66(d)(4). The key program areas and related requirements were delineated between four separate readiness review components—Operations/Administration, Service Delivery, Information Systems Management, and Financial Management.

The readiness review process included federal and State-specific standards for 438.12—Prohibition on Provider Discrimination, 438.206—Availability of Services, 438.207—Assurances of Adequate Capacity and Services, and 438.214—Provider Selection. The review also contained federal standards and state-specific requirements for 438.230—Subcontractual Relationships and Delegation. Network adequacy was determined from a review of policies and procedures and a review of the MCOs' monthly and quarterly GeoAccess and other network reports, network contracting status, credentialing status, and network exception reports when network requirements were not met as a result of a lack of providers in the region, or the geographic area being determined a dearth county by DMAS. All network exception reports were approved by DMAS. MCO Cardinal Care program readiness review results indicated that the MCOs had adequate access and availability to serve members enrolled in the Cardinal Care program.

### **Compliance Monitoring**

During 2021 a compliance audit was conducted for each MCO to review compliance with federal regulations and state contract requirements. The comprehensive MCO compliance audit included all federal requirements and related state-specific requirements including:

- Enrollment and Disenrollment: 438.56
- Member Rights and Confidentiality: 438.100; 438.224
- Member Information: 438.10
- Emergency and Poststabilization Services: 438.114
- Assurance of Adequate Capacity and Availability of Services: 438.206; 438.207
- Coordination and Continuity of Care: 438.208



- Coverage and Authorization of Services: 438.210
- Provider Selection: 438.214
- Subcontractual Relationships and Delegation: 438.230
- Practice Guidelines: 438.236
- Health Information Systems (including ISCA): 438.242
- Quality Assessment and Performance Improvement: 438.330
- Grievance and Appeal Systems: 438.228
- Program Integrity: 438.608
- EPSDT Services: 441.58 Section 1905 of the SSA
- Assurances of Adequate Capacity and Services
- Coverage and Authorization of Services
- Provider Selection
- Enrollee Rights and Protection
- Grievance and Appeal Systems
- Quality Assessment and Performance Improvement
- Provider Selection
- Enrollee Rights and Protection

For the elements in standards that were not fully compliant, the MCOs were required to develop a corrective action plan which was reviewed by the EQRO and DMAS. Corrective action plans were approved when it was determined that the corrective action plan would bring the MCO into compliance with the requirements. DMAS provided ongoing monitoring of the implementation of the MCOs' corrective action plans.

### **Annual EQR Technical Reports**

To ensure DMAS' compliance with 42 CFR §438.364, aggregate technical reports were prepared and included all required components as outlined in the EQR protocols. Aggregated and analyzed data from the EQR activities was included, and conclusions were drawn with regard to the quality of, timeliness of, and access to health services furnished to MCO members. Conclusions were described in detail and actionable recommendations, as applicable, were provided. Additionally, based on the assessment, notable strengths were included so that the MCOs were able to build upon identified performance improvement and recommendations for identified Quality Strategy opportunities for improvement. The MCOs provided a summary of the quality improvement initiatives implemented as a result of the previous year's EQR recommendations. Quality Strategy performance metric rates were included as evidence of the extent to which those actions resulted in improvement in the Quality Strategy goals and objectives tied to quality, access, or timeliness of care and services.

### **Addressing Health Disparities**

During the VA 2021–2023 review period, DMAS continued to work diligently, in collaboration with the MCOs, to operationalize community engagement and health equity best practices and standards. To

meet Virginia’s Quality Strategy goal of providing whole-person care for vulnerable populations, DMAS and/or the MCOs implemented the following strategies to address health disparities:

- Partnership for Petersburg: In August of 2022, Governor Glenn Youngkin announced a transformative program called “Partnership for Petersburg.” This program has been focused on bringing together public and private resources to help the City of Petersburg and its residents, who have experienced negative health, public safety, education, and economic outcomes. One component of this plan is to improve the health of Petersburg’s residents by increasing access to preventative screenings, promoting awareness of primary care and addressing prenatal health disparities by connecting Petersburg residents with medical and social services. DMAS Focus Areas: 1. Improve Petersburg maternal and infant health outcomes. 2. Provide Primary Care Services, Mobile Health Clinics, and Community Events 3. Expand School-Based Clinic Services through the Crimson Clinic Information Request Submitted Response 4. Establish Community-Based Health Literacy Hubs. DMAS’s Key Collaborators and Partners: Medicaid MCOs (Aetna, Anthem, Molina, Optima and United), Central Virginia Health Services, Crimson Clinic, Crater Health District, Bon Secours Southside Regional Hospital, Petersburg City Public Schools, DentaQuest, Conexus, Petersburg Sheriff’s Office, VDH, and the Department of Social Services.
- CMS Infant Well-Child Visit Learning Collaborative: The learning collaborative offers technical assistance to state Medicaid and Children’s Health Insurance Program (CHIP) agencies and their partners (MCOs and other partners, DMAS and its partners are receiving technical assistance in designing and implementing a quality improvement project aimed at identifying ways increase participation in well-child visits. The collaborative initiated interventions with providers in Roanoke, Winchester, Tidewater Area, Petersburg, and Southwest Virginia. The initiative started in March 2021 and will conclude in December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.
  - Baby Steps Virginia: Baby Steps Virginia is the vehicle with which Virginia Medicaid brings together sister agencies, other key partners and stakeholders and the voice of the member with the focus of improving maternal health outcomes, eliminate racial disparity in outcomes and maternal mortality. Baby Steps Virginia incorporates awareness of issues like social determinants of health (SDOH), barriers to care, and member/provider engagement.
- Community Doula Program: To date, 125 doulas have received state certification. Of the 125 state-certified doulas, 90 are approved and enrolled as Medicaid Doula Providers. There have been 107 doula-supported births to Medicaid members and over 304 birthing families have received doula services through Virginia Medicaid. Feedback continues to be positive from families who have received care and support from a doula. DMAS continues to focus on increasing the network of doula providers, community and provider engagement, and data. The availability of state-certified Medicaid-approved doula providers within the Commonwealth means greater access to care and support for pregnant people with the goal of improving maternal and infant health outcomes, reducing infant and maternal mortality, and helping to address racial and health disparities.
- Improving Timely Health Care for Children and Youth in Foster Care—Affinity Group: developed, tested, and collected data around a variety of pilot interventions in order to identify changes that would lead to improvement in the rate of the specific health care service being measured (*initial comprehensive medical examination within 30 days of a child entering foster care*). By the end of the 2-year Affinity Group, the team was able to identify barriers to accessing timely health care services for the foster care member population, as well as utilize data to demonstrate the success of several pilot tests that improved the identified process measures and outcome measures of the project.

The most successful interventions identified were several iterations of warm handoffs of new foster care member information between VDSS or LDSS agencies and DMAS or the assigned MCO care coordinators, in order for MCOs to support the scheduling and completion of comprehensive health care visits within the first 30 days of placement. One 9-month pilot test with Bedford County Department of Social Services resulted in an improvement in MCO successful outreach to members in Bedford from an average of 52 days down to 2 days after entering foster care. The team then scaled the pilot up statewide and tested a less labor-intensive process while continuing to see improvement, though not as significant (down to an average of 28 days). Outcome measures for both warm handoff pilots discussed also improved, with 100% of members in Bedford County receiving initial medical examinations within 30 days of entering custody for the final 7 months of the test.

## MCO Cardinal Care Program Contract Language

DMAS included healthy equity requirements in the Cardinal Care program MCO contract. The MCO contract requires that the MCO consider the importance of health equity and disparities among populations in developing its various programs to provide services to members. The MCO must develop and maintain an annual report outlining its efforts to address health disparities for the managed care population. The contract also states that the MCO may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

The MCO contract also includes MCO requirements for the CMS 1115 demonstration for the 12-month postpartum coverage extension. Among the measures the demonstration evaluation includes is the advancement of health equity by reducing racial/ethnic and other disparities in maternal health coverage, access, and outcomes as well as infant health outcomes among postpartum Medicaid and CHIP enrolled women and infants.

Quality improvement requirements in the MCO contract state that the MCO's QI initiatives must be designed to help achieve the goals outlined in the Virginia Quality Strategy. Quality improvement requirements also state that DMAS is responsible for evaluating the quality of care provided to eligible enrollees in the contracted MCOs. DMAS partners with the MCOs and follows state, federal and DMAS policies to ensure that Medicaid members, both those receiving physical and mental health services, receive high quality cost-effective care, driven by innovation. The contract states that the care provided must meet standards for improving quality of care and services, access, transition of care, health disparities and timeliness.

MCOs are required to include in their quality assessment and performance improvement plan a description of the processes for collection and submission of performance measurement data, including any required by DMAS for identifying and analyzing objectives for servicing diverse memberships that includes but is not limited to analyzing significant health care disparities gaps.

The MCO contract includes additional requirements aimed at addressing and reducing healthcare disparities such as:

- **Doulas:** MCOs implementation of a community-based doula service. Doulas are community-based and trained to provide extended, culturally congruent support to families through pregnancy to include antepartum, intrapartum, during labor and birth, and up to one year postpartum. The community-based doulas provide an expanded set of services and play a crucial role in improving

outcomes and experiences for communities most affected by discrimination and disparities in health outcomes.

- **Enhanced Benefits:** Enhanced benefits are services offered by the Contractor to Members in excess of the Managed Care program’s covered services. The contract provides an example of an enhanced benefit as coverage by the MCO of services that address social determinants of health. For members with long-term care needs, enhanced benefits may include strategies to address social needs.
- **Community-Based Resources:** Strategies may include providing linkages to community-based resources and information on service providers and referrals (social needs are related to the conditions that make up the social determinants of health, including but not limited to housing, food, economic security, community and information supports, and personal goals.
- **Addressing Social Determinants of Health:** The MCO contract states that the MCO must develop programs, establish partnerships, and provide care coordination efforts that identify, address and track member needs across each of the five (5) key SDOH areas identified by the federal Office of Disease Prevention and Health Promotion’s, Healthy People 2020, including each of the Economic Stability subsections listed below:
  1. Economic Stability (access to employment, food security, housing);
  2. Education;
  3. Social and Community Context;
  4. Health and Health Care; and
  5. Neighborhood and Built Environment.

The MCO contract requires the submission of an annual report detailing how the MCO is identifying, addressing via programs and partnerships, and tracking each of the five key areas of SDOH.

### Other Medicaid Health Equity Initiatives

- Convening a quality collaborative to address best practices, review results of performance measures, and performance improvement projects that focused on health disparities.
- Working closely with the Virginia Commonwealth University Office of Health Equity (OHE) to identify health disparities and their root causes and to promote opportunities to be healthy. The work includes the development of programs and partnerships to empower racial and ethnic minority communities to promote awareness of health disparities.
- Working with the OHE Division of Multicultural Health and Community engagement in initiatives to identify approaches to eliminate health disparities through a focus on SDOH as a key strategy to eliminate health disparities that exist by socioeconomic status, race/ethnicity, geography, gender, immigrant status, and other social classifications.
- Producing an annual study of Medicaid and CHIP prenatal care and associated birth outcomes to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, geographic location, and disability status in birth outcomes.
- Working with MCOs in addressing the SDOH that are impacting members including:
  - Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
  - Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.

- Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid beneficiaries’ housing instability, transportation insecurity, food insecurity, and interpersonal violence.
- Identifying areas of high disparity to guide resources and to work with communities to address SDOH.
- Maintaining a resource platform accessible to members both online and through the MCO’s call center.
- Stratifying performance measure data to identify, evaluate, and reduce—to the extent practicable—health disparities based on age, race, ethnicity, sex, primary language, and disability status.
- Engaging and collaborating with internal and external stakeholders (providers, MCOs, other state agencies, members, etc.) to reduce health disparities and address health equity concerns.

## **Use of Sanctions**

DMAS may impose sanctions due to noncompliance with contract requirements or applicable federal or state laws. The types of intermediate sanctions that DMAS may impose on the MCO shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.702-708 and may include any of the following:

- Civil monetary penalties in the amounts specified in 42 CFR §438.704
- Appointment of temporary management for an MCO as provided in 42 CFR §438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollments, including automatic assignment, after the effective date of the sanction;
- Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or DMAS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur in accordance with 42 CFR §438.730; and
- Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

The following areas of noncompliance resulted in an MCO receiving a notice of corrective action:

- Internal system issues which impacted CRMS SA data submission. As a result, the MCO developed a crosswalk of expected values to overcome the QNXT system limitations.
- An MCO submitted four (4) SA Medical files with authorized decision dates ranging from July 23, 2017 through November 1, 2021 to CRMS Production without approval from DMAS. The files loaded or updated 84,819 files in production. On August 27, 2021, the MCO failed to prevent such an incident from reoccurring and submitted four (4) SA Medical files to CRMS Production without approval from DMAS. The MCO updated internal controls to prevent test files from being loaded into the production environment. Specific action items were added to incorporate the MFT process into the internal control process.
- An MCO entered a member into the DMAS Web Portal for LTSS Services prior to a valid level of care screening being conducted. The MCO updated DMAS 80 forms processing, the Enrollment Change Request Form, and implemented a second-level review with a supervisor signature requirement.



- An MCO's Fiscal/Employer Agent improperly withheld FICA tax from attendants' paychecks. As a result, the MCO conducted a thorough review of internal controls and developed a remedial process to resolve the payroll software issue and impact to members and their attendants.
- An MCO approved an implementation that migrated their web portal and website platform to their MyAccount platform without DMAS' approval. The MCO collaborated with DMAS to establish acceptable approval processes for the implementation of system changes that have the potential to significantly impact members.

## **Performance Withhold Program**

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for the Medallion 4.0 (Acute) and the CCC Plus (MLTSS) PWP. The SFY 2023 PWP assessed CY 2022 PM data to determine what portion, if any, of the MCOs' quality withhold would be earned back. For the SFY 2023 PWP, the Medallion 4.0 (Acute) MCOs could earn all or a portion of their one percent quality withhold based on performance for seven NCQA HEDIS measures (14 measure indicators), one Agency for Healthcare Quality (AHRQ) Pediatric Quality Indicator (PDI) measure (one measure indicator), and two CMS Adult Core Set measures (two measure indicators). The SFY 2023 PWP was based on comparisons to the NCQA Quality Compass national Medicaid HMO percentiles for all HEDIS measures and, receiving a reportable audit status on the AHRQ PDI and CMS Adult Core Set PMs.

## **Health Information Technology**

Virginia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. DMAS' modernized technology system allowed for increased data collection, analytics, oversight, and reporting functions for DMAS. The MES includes the Enterprise Data Warehouse System (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 MCOs with increased oversight and detail.

## **Quality Initiatives**

Virginia has developed a series of initiatives aligned closely to the Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These initiatives drive progress towards the Quality Strategy goals and objectives. These initiatives are discussed below.

### **Right Help, Right Now**

Governor Glenn Youngkin created *Right Help, Right Now* to reform Virginia's behavioral health system and to support individuals in crisis. The goal of *Right Help, Right Now* is to support Virginians before, during, and after a behavioral health crisis occurs. The *Right Help, Right Now* plan aims to ensure that there will be same-day care delivered through mobile crisis units and crisis centers in order to reduce overcrowding at emergency departments. By doing so, there will be less strain on law enforcement who can instead better serve the communities where they are needed. This will also serve to reduce the criminalization of mental health in Virginia. The *Right Help, Right Now* plan includes specialized

resources for individuals with substance use disorders or who have high risks of overdosing. Virginians should have immediate access to all the resources they need anytime and anywhere.

**The “Right Help, Right Now” Six Pillars:**



**Youth Mental Health Strategy**

Governor Glenn Youngkin unveiled the Youth Mental Health Strategy on the one-year anniversary of the *Right Help, Right Now* initiative. In 2023, according to Mental Health America, Virginia ranked 48th in the nation for youth mental health, which demands a collective and comprehensive approach to prioritize the health of the Commonwealth’s youngest and most vulnerable citizens. Children spend on average nearly five hours daily on social media; recent studies have suggested that children who spend more than a few hours per day on social media have double the risk of poor mental health.

Governor Glenn Youngkin is taking immediate action in year two of *Right Help, Right Now*. To better equip parents and support Virginia’s young people, Governor Glenn Youngkin, through budget proposals, legislation, and executive action, and the Youth Mental Health Strategy, will address critical components and harmful aspects of social media on Virginia’s youth. The strategy includes interventions in the following areas:

- Addictive and harmful aspects of social media on youth
- Inside Virginia schools—school-based mental health services for students
- In behavioral health care settings—family empowerment and rights

**Additional Developmental Disabilities Waiver Slots**

Governor Glenn Youngkin committed to enhance support for Virginians with developmental disabilities and their families. Included in the *Right Help, Right Now* initiative, Virginia is one step closer to the goal of providing enough priority one slots for everyone in urgent need of services by the end of the Governor’s term. Governor Glenn Youngkin announced an additional \$300 million over the biennium to fund enough priority one slots for every Virginian with a developmental disability on the waitlist for Medicaid Home and Community-Based Developmental Disability (DD) waiver slots.

These improvements give Virginians with disabilities the supports and services they need to live their best lives in their communities. Through these improvements, Virginians with disabilities are provided



supports and services they need to live their best lives in their communities. Secretary of Health and Human Resources John Littel stated that they have heard from Virginians and their families about the important difference a DD waiver can have in their life of the life of a loved one. Whether it be paying for in-home care or the kind of assistive technology that can help an individual avoid living in a hospital, nursing home, or other institution, these waivers can change lives. The waivers also cover services such as medical care, employment supports, assistance for community living, behavioral interventions, and other items like medical goods and assistive technology.

## **Baby Steps**

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 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.

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. During 2023 teams 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.

## **Behavioral Health Enhancement and Project BRAVO**

The Commonwealth is focused on improving behavioral health services. The vision for the Enhancement of Behavioral Health is to keep Virginians well and thriving in their communities, shift the system's current need to focus on crisis by investing in prevention and early intervention for mental health and substance use disorder (SUD) comorbidities, and support comprehensive alignment of services across the systems that serve Medicaid members. This includes efforts to reduce the burden on state psychiatric hospitals and EDs, with efforts including increasing use of mobile crisis response and reduction of emergency department utilization, as well as working to ensuring appropriate access to acute behavioral health services for foster care youths by working to carve in residential services into the managed care programs.

DMAS is also committed to the continued expansion of access to BRAVO services by implementing new services and engaging the communities to support these services. Project BRAVO is a comprehensive vision that details a "north star" continuum of services and a preliminary set of prioritized services to build out critical levels of care, including comprehensive crisis services.

Beginning in 2017, the Addiction and Recovery Treatment Services (ARTS) benefit provides treatment for members with SUDs across the state and provides access to addiction treatment services for all enrolled members in Medicaid, FAMIS, and FAMIS MOMS. A DMAS goal for the ARTS delivery system transformation includes ensuring that a full continuum of care is available, based on evidence-based practice, to effectively treat individuals with SUD.

This approach is expected to provide Medicaid members with access to the evidence-based care needed to achieve sustainable recovery. The MCOs work with DMAS, as required by contract, to

ensure that their members' care needs for SUD treatment and recovery are met and include care coordination, utilization review, and a robust array of services and treatment methods to address immediate and long-term physical, mental, and SUD service needs.

## **Foster Member and Provider Engagement**

DMAS has established the Medicaid Member Advisory Committee (MAC) in order to provide a formal method for members' voices to be included in the DMAS decision-making process and to inform DMAS change management strategies. The diverse committee is comprised of representatives from across the state and is entirely made up of Medicaid-enrolled individuals and individuals' authorized representatives. The MAC's purpose is to obtain the insight and recommendations of Virginia's Medicaid members in order to help the DMAS Medicaid Director improve the overall experience for all Virginia Medicaid applicants and members.

DMAS' provider committee is called the Medicaid Provider Managed Care Liaison Committee (MPMCLC). The MPMCLC meets quarterly to provide a forum for Medicaid providers, DMAS, and the MCOs to come together to discuss opportunities, provide feedback, and create alignment across Virginia's Medicaid managed care programs.

DMAS created the Civil Rights Coordinator position in November 2019 to ensure that individuals with limited English proficiency (LEP) and individuals with disabilities have meaningful access to programs and services. This position serves the critical function of ensuring continued compliance with federal and Commonwealth of Virginia civil rights requirements and ensures that internal and external stakeholders have language and disability access resources available to improve communications with LEP individuals and those with disabilities.

## **Value-Based Purchasing**

DMAS is focused on increasing the use of value-based purchasing arrangements with MCOs and providers. VBP includes a broad set of policies and strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial and nonfinancial incentives to the performance of various stakeholders serving Virginia Medicaid members. Movement toward and achievement of these goals is measured through a set of defined metrics evaluating quality, cost, and patient-centered care. There is no "one-size-fits-all" approach to VBP, and DMAS' efforts focus on a range of healthcare stakeholders, populations, and care events that are important to members, specifically highlighting chronic conditions, maternity care, behavioral health, and prevention.

## **Safe and Sound Task Force**

Virginia launched an initiative aimed at creating safe housing placements for children in foster care. The Safe and Sound Task Force brings together government agencies, the Virginia League of Social Services Executives, and other community partners to end the practice of children sleeping in local departments of social services, hotels, and emergency rooms. The initiative ensures that every child has a safe place to belong.

## Adult Dental Coverage

The comprehensive adult dental benefit became effective July 1, 2021. More than 960,000 members now have access to comprehensive dental benefits that make available each of the dental specialties. It was established on the premise that the dental treatment procedures would be prevention and control to keep the mouth disease free, and then restore it to healthy function. Beginning with preventive services will aid in improving systemic health concerns that may be in existence and prepare the patient for success with additional treatment that may be needed. The goal of additional treatment would focus on removing what cannot be saved and restoring what can be built around, therefore increasing longevity for any prosthetic appliances that may be in order.

## 12-Month Postpartum Coverage

DMAS' 1115 waiver amendment to extend 12 months postpartum coverage was approved by the federal government in November 2021, making Virginia one of the first states to provide guaranteed continuous full-benefit coverage across eligibility categories for a full 12 months postpartum. The expanded coverage enables Medicaid and FAMIS MOMS members to receive critical postpartum care for a full year postpartum, an important step in improving health outcomes for both women and their newborns.

## Perinatal Quality Collaborative

Funding for the Perinatal Quality Collaborative was provided for the Virginia Department of Health (VDH) to establish and administer a learning collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes through CQI, with an initial focus on pregnant women with a SUD and infants impacted by neonatal abstinence syndrome (NAS).

## 12-Month Contraceptive Coverage

In 2021, DMAS began covering a 12-month supply of contraception for Medicaid and FAMIS members. Medicaid members may pick up a full year's supply of contraception at a single visit to their pharmacy.

## Doula Project

To combat maternal morbidity and unintended consequences of pregnancy that result in life-altering health challenges, DMAS placed emphasis on the need for community doula care for women during the perinatal period, at labor and delivery, and during the postpartum period. According to the American Pregnancy Foundation, doulas serve to reduce the number of Cesarean sections, which increase the risk of maternal death by infection and hemorrhage and reduce the duration of labor by a quarter. Virginia Medicaid introduced a model of care to include doula services as a cost-saving measure and an effective way to improve health outcomes.

## Preventive Services for Adults

Starting in September 2022, all adult Medicaid members have access to preventive services, including screenings, check-ups, and counseling to support positive health outcomes. Under a policy, similar to

commercial insurance policies, preventive services are available to Medicaid members at no cost and without prior authorization from their doctor.

### Emergency Department Care Coordination

The Emergency Department Care Coordination (EDCC) program provides a single, statewide technology solution that connects all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration between physicians, other healthcare providers, and other clinical and care management personnel for patients receiving services in hospital EDs, for the purpose of improving the quality of patient care services. Real-time patient visit information from electronic health records is integrated with the Prescription Monitoring Program and the Advanced Health Directory. This sharing of information allows facilities, providers, and MCOs to identify patient-specific risks, create and share care coordination plans and other care recommendations, and access other clinically beneficial information related to patients receiving services in hospital EDs in the Commonwealth.

### Actions on EQR Recommendations

In accordance with 42 CFR §438.364(a)(4), the EQR technical report included recommendations for improving the quality of healthcare services furnished by each MCO contracted with DMAS to provide services to Virginia Medicaid members under Medallion 4.0 (Acute) and the CCC Plus (MLTSS) Medicaid managed care programs. These recommendations include how DMAS can target goals and objectives in the Quality Strategy to better support improvement in the quality and timeliness of, and access to health services furnished to Medicaid managed care members. Table F-5 and Table F-6 include the prior year Quality Strategy recommendations and actions taken by DMAS to support program improvement and progress in meeting the goals of the Quality Strategy.

**Table F-5—CCC Plus (MLTSS) Prior Year Recommendations and DMAS Responses**

2021–2022 EQRO Recommendations	DMAS Actions
<p><b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.3:</b> Improve Outcomes for Members with Substance Use Disorder</p> <p><b>Measure: 5.3.1.4:</b> Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</p> <p><b>Objective: 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p> <p><b>Measure 5.4.1.1:</b> Follow-Up After Hospitalization for Mental Illness</p> <p>To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS:</p>	<p>DMAS included the measure <i>Follow-Up After Emergency Department Visit for Substance Use</i> in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p> <p><b>Measure:</b> <i>Follow-Up After Emergency Department Visit for Substance Use</i></p> <p><b>MY 2021:</b> 7-Day: 11.44% 30-Day: 19.98%</p> <p><b>MY 2022:</b> 7-Day: 14.55% 30-Day: 22.57%</p>

2021–2022 EQRO Recommendations	DMAS Actions
<ul style="list-style-type: none"> <li>Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization.</li> <li>Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data.</li> <li>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.</li> <li>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.</li> </ul>	
<p><b>Goal:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective 5.1:</b> Improve Outcomes for Members With Chronic Conditions</p> <p><b>Measure: 5.1.1.4:</b> Comprehensive Diabetes Care: HbA1c Poor Control (&gt;9.0%)</p> <p>To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS:</p> <ul style="list-style-type: none"> <li>Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care.</li> <li>Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management.</li> <li>Require the MCOs to identify best practices to improve care and</li> </ul>	<p>DMAS included a <i>Comprehensive Diabetes Care measure that includes HbA1c Poor Control (&gt;9.0)</i> in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p> <p><b>Measure:</b> <i>Comprehensive Diabetes Care: HbA1c Poor Control (&gt;9.0%)</i></p> <p><b>MY 2021:</b> 51.42%</p> <p><b>MY 2022:</b> 47.39%</p>

2021–2022 EQRO Recommendations	DMAS Actions
services according to chronic care recommended guidelines.	

**Table F-6—Medallion 4.0 (Acute) Prior Year Recommendations and DMAS Responses**

2021–2022 EQRO Recommendations	DMAS Actions
<p><b>Goal:</b> Providing Whole-Person Care for Vulnerable Populations</p> <p><b>Objective: 5.4:</b> Improve Behavioral Health and Developmental Services for Members</p> <p><b>Measure 5.4.1.1:</b> Follow-Up After Hospitalization for Mental Illness</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization.</li> <li>• Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts: <ul style="list-style-type: none"> <li>– Implementation of evidence-based behavioral health care and building out of, Multisystemic Therapy, Functional Family Therapy, Assertive Community Treatment and implementation of 4 crisis services based on the Crisis Now model, SAMHSA has identified as best practice. The implementation of these services is key to assisting individuals that are discharged from residential and hospital settings.</li> <li>– DMAS has been instrumental in the planning and implementation of the Governor’s <i>Right Help Right Now</i> plan, which aims to achieve the goal that all Virginians will, i) be able to access behavioral health care when they need it; ii) have prevention and management services personalized to their needs, particularly for children, youth and families; iii) know who to call, who will help and where to go when in crisis; and iv) have paths to reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan. This year, in support of the Governor’s Right Help, Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has been working on the following initiatives: i) identifying service innovations and best practices in behavioral health services, this includes a specific focus on developing a new school-based behavioral health service for youth and researching best practice models for youth mental health residential treatment services; ii) identify and research evidence-based programs specific to youth and iii) assessment of health plan behavioral health network adequacy. The</li> </ul> </li> </ul>



2021–2022 EQRO Recommendations	DMAS Actions
	<p>goal of DMAS in partnership with this plan is to increase efficacy, access, and utilization of effective and appropriate behavioral health services for Medicaid members in Virginia.</p> <ul style="list-style-type: none"> <li>- A collaboration and partnership among health and human services state agencies in Virginia, came together to ( ) the Center for Evidence-Based Partnerships (CEP-VA) to assist in centralizing data, implementation work and collaboration around supporting and implementing evidence-based behavioral health services across Virginia agnostic of payer. The Center continues to support and analyze Virginia implementation of these services and provide technical assistance and training to providers.</li> <li>• DMAS' ICER team included the measure Follow-Up After Emergency Department (ED) Visit for Mental Illness in its PWP which provides an incentive to MCOs to increase performance and close gaps.</li> </ul> <p><b>Measure:</b> <i>Follow-Up After Emergency Department (ED) Visit for Mental Illness</i></p> <p><b>MY 2021:</b> 7-Day: 45.34% 30-Day: 57.38%</p> <p><b>MY 2022:</b> 7-Day: 43.04% 30-Day: 55.53%</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.1:</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members</p> <p><b>Measure 4.1.1.4:</b> Immunizations for Adolescents</p> <p><b>Objective 4.2:</b> ★ <b>Improve Outcomes for Maternal and Infant Members.</b> ★</p> <p><b>Measure: 4.2.1.4:</b> Well-Child Visits in the First 20 Months of Life</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Require the MCOs to identify best practices for ensuring children</li> </ul>	<p>DMAS has improved its ability to track MCO required monthly data submissions.</p> <p><b>MCH:</b></p> <ul style="list-style-type: none"> <li>• The new Cardinal M4 draft contract (now in RFP) includes a requirement to incorporate AAP and Bright Futures in its quality assurance activities. If implemented as written, the Contractor will be required to follow a long-term improvement plan relating to improving EPSDT indicators that will not exceed five (5) years. The contractor must implement interventions or strategies to address following criteria:             <ol style="list-style-type: none"> <li>1. Childhood Immunization rates</li> <li>2. Well-child rates in all age groups</li> <li>3. Lead testing rates</li> <li>4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year</li> <li>5. Improve the current tracking system for monitoring EPSDT corrective action referrals</li> </ol> </li> </ul>



2021–2022 EQRO Recommendations	DMAS Actions
<p>receive all preventive vaccinations and well-child services according to recommended schedules.</p> <ul style="list-style-type: none"> <li>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.</li> <li>Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.</li> </ul>	<p>(referrals based on the correction or amelioration of the diagnosis).</p> <ul style="list-style-type: none"> <li>MCOs are involved in the DMAS CMS Affinity Groups that targets increasing in well-child visit rates, immunizations, timeliness of care and increased access to quality care for children.</li> </ul> <p><b>ICER:</b> DMAS included the measures <i>Child and Adolescent Well-Care Visits and Childhood Immunization Status</i> in its PWP which provides an incentive to MCOs to increase performance and close gaps.</p> <p><b>Measure:</b> <i>Child and Adolescent Well-Care Visits</i>  <b>MY 2021:</b> 46.57%  <b>MY 2022:</b> 50.27%</p> <p><b>Measure:</b> <i>Childhood Immunization Status</i>  <b>MY 2021:</b> 65.82%  <b>MY 2022:</b> 63.22%</p>
<p><b>Goal 4:</b> Strengthen the Health of Families and Communities</p> <p><b>Objective 4.2:</b> ★ <b>Improve Outcomes for Maternal and Infant Members</b> ★</p> <p><b>Measure: 4.2.1.1:</b> Prenatal and Postpartum Care: Postpartum Care</p> <p><b>Measure: 4.2.1.2:</b> Prenatal and Postpartum Care: Timeliness of Prenatal Care</p> <p>To improve program-wide performance in support of Objective 4.2 and improve use of prenatal and postpartum care, HSAG recommends DMAS:</p> <ul style="list-style-type: none"> <li>Require the MCOs to identify access- and timeliness-related PM indicators such as the <i>Prenatal and Postpartum Care—Postpartum Care</i> and <i>Timeliness of Prenatal Care</i> PM indicators that fell below the NCQA Quality Compass national Medicaid HMO 50th percentile, and focus QI efforts on identifying the root cause and implementing interventions to improve access to care.</li> </ul>	<p><b>MCH:</b></p> <ul style="list-style-type: none"> <li>Within the new DRAFT Cardinal M4 contract (now in RFP), MCOs will be required to conduct annual Performance Improvement Projects (PIPs) for validation by the EQRO. Each PIP must include implementation of interventions to achieve improvement in the access to care, timeliness and quality of care, consistent with 42 CFR §430.330. The Contractor must identify benchmarks and set measurable achievable performance goals for each of its PIPs, which will be submitted to the Department for review and approval. In the first year of this Contract, one PIP shall be focused on maternal health. The due date for PIPs and validation must be in accordance with the process and methodology agreed upon by the Department and its EQRO agent. All PIP requirements will be located within the Cardinal Care Technical Manual.</li> <li>The new contract specifies measures to be used in DMAS’ Performance Withhold Program (PWP) that include timeliness of prenatal care and timeliness of postpartum care. MCOs will have to report these measures, which will be validated by DMAS’ EQRO.</li> </ul> <p><b>ICER:</b> DMAS included the measures <i>Prenatal and Postpartum Care</i> in its PWP which provides an</p>

2021–2022 EQRO Recommendations	DMAS Actions
<ul style="list-style-type: none"> <li>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.</li> <li>Require the MCOs to identify best practices to improve care and services according to evidence-based guidelines.</li> </ul>	<p>incentive to MCOs to increase performance and close gaps.</p> <p><b>Measure:</b> <i>Prenatal and Postpartum Care</i></p> <p><b>MY 2021:</b> <i>Timeliness of Prenatal Care: 73.00%</i> <i>Postpartum Care: 66.52%</i></p> <p><b>MY 2022:</b> <i>Timeliness of Prenatal Care: 76.44%</i> <i>Postpartum Care: 66.76%</i></p>

## Strengths and Recommendations

### Strengths

DMAS considers the Virginia 2023–2025 Quality Strategy to be its roadmap for the future. DMAS’ Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Virginia’s coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, and quality, satisfaction, and timeliness of services for Virginia Medicaid and CHIP members. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Virginia’s Medicaid managed care services. The Quality Strategy promotes 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 the Virginia Medicaid members. Additionally, DMAS’s initiatives tie to the Quality Strategy goals, and objectives. The Virginia Medicaid Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable.

DMAS conducts oversight of the MCOs in coordination with the Quality Strategy to promote accountability and transparency for improving health outcomes. DMAS has an MCO contract requirement that the MCO should be committed to quality improvement and its overall approach and specific strategies will be used to advance Virginia Medicaid’s Quality Strategy and incentive-based quality measures. In addition, each MCO is required to be NCQA accredited and to conduct HEDIS performance measure reporting.

## Recommendations

The EQRO has identified the following recommendations for the Quality Strategy:

To improve program-wide performance in support of **Goal 4: Strengthen the Health of Families and Communities, Objectives 4.1 and 4.2** and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS:

- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations that contributed to lower screening rates. Additionally, HSAG recommends that DMAS require the MCOs to analyze the factors that contributed to the higher usage of imaging studies when not clinically appropriate for a particular age group, ZIP Code, etc. MCOs should focus resources and implement appropriate interventions to increase the screening rates, pregnancy care and to reduce unnecessary low back pain-related imaging studies due to the low rates for the four measures.

To improve program-wide performance in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve adolescent well visits and adolescent immunizations for members under the age of 21 years, HSAG recommends DMAS, considering the recurring MCO opportunities related to measures within the Taking Care of Children domain:

- Work with the MCOs to identify best practices for ensuring adolescents receive all preventive vaccinations according to recommended schedules. HSAG recommends that the MCOs identify and implement new interventions based on their completed root cause analyses which identified barriers their members' parents and guardians have experienced in accessing care and services. Additionally, HSAG recommends that MCOs evaluate providers' barriers to completing BMI assessments, counseling for nutrition, and counseling for physical activity, then implement targeted interventions to address these barriers.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve access and timeliness of preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the survey (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identify the location's address and appropriate provider type and specialty. Additionally, DMAS may also consider requesting the MCOs to provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. Evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover.

To improve program-wide performance in support of **Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.4** and improve behavioral health and developmental services for members, HSAG recommends that DMAS:

- Work with the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization for mental illness and after emergency department visit for mental illness. HSAG also recommends that DMAS work with the MCOs to 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. Additionally, HSAG recommends that DMAS continue leveraging the CMS Improving Behavioral Health Follow-up Care Learning Collaborative<sup>F-5</sup> materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care.

To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities, Objective 4.1** and improve access and timeliness of well-child visits and preventive health care for members under the age of 21 years, and the timeliness of pregnancy related care, HSAG recommends that DMAS:

- Work with the enrollment broker to address the data deficiencies identified during the primary care provider and the prenatal care secret shopper surveys (e.g., incorrect or disconnected telephone numbers). Additionally, HSAG recommends that the enrollment broker verify that its provider data correctly identifies the location address and appropriate provider type and provider specialty. DMAS may also consider requesting that the MCOs provide evidence of training offered, by the MCO, to provider's offices regarding the MCO plan names and benefit coverage. MCO evidence should demonstrate that the office staff responsible for scheduling appointments have been educated on the MCO names and benefit coverage and the offices have a plan in place for educating new staff in the event of staff turnover. Accurate provider information, including provider specialties and contact information may result in improved access to care for members seeking well-care, preventive health, childhood immunizations, and pregnancy related care.
- Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended well-visits according to the EPSDT and Bright Futures schedule and to make appropriate health decisions. HSAG continues to recommend that DMAS monitor MCOs to ensure that the MCOs analyze their data and consider if there are disparities within the MCOs' populations.

## Quality Strategy Evaluation Methodology

### *Evaluation Methodology Description*

#### Review Period

The evaluation period focuses on the 12-month performance period of January 1, 2023–December 31, 2023.

---

<sup>F-5</sup> Centers for Medicare & Medicaid Services. Improving Behavioral Health Follow-up Care. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/behavioral-health-learning-collaborative/index.html>. Accessed on: Feb 26, 2024.

## Goals and Objectives

The Virginia 2023–2025 Quality Strategy identified goals and objectives that focus on process as well as achieving outcomes. Virginia’s Quality Strategy identifies the following five goals and fourteen associated objectives:

- Goal 1: Enhance the Member Care Experience:
  - Objective 1.1: Increase Member Engagement and Outreach
  - Objective 1.2: Improve Member Satisfaction
- Goal 2: ★ Promote Access to Safe, Gold-Standard Patient Care ★
  - Objective 2.1: Ensure Access to Care
  - Objective 2.2: Promote Patient Safety
  - Objective 2.3: Promote Effective Communication and Care Coordination
- Goal 3: ★ Support Efficient and Value-Driven Care ★
  - Objective 3.1: Focus on Paying for Value
  - Objective 3.2: Promote Efficient Use of Program Funds
- Goal 4: Strengthen the Health of Families and Communities
  - Objective 4.1: Improve Utilization of Wellness, Immunization, and Prevention Services for Members
  - Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members ★
  - Objective 4.3: Improve Home and Community-Based Services
- Goal 5: Providing Whole-Person Care for Vulnerable Populations
  - Objective 5.1: Improve Outcomes for Members with Chronic Conditions
  - Objective 5.2: Improve Outcomes for Nursing Home Eligible Members
  - Objective 5.3: ★ Objective 5.3: Improve Outcomes for Members with Substance Use Disorders ★
  - Objective 5.4: ★ Objective 5.4: Improve Behavioral Health and Developmental Services of Members ★

## Evaluation

HSAG conducts a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the managed care program. For DMAS, HSAG’s evaluation includes an assessment of managed care performance compared to national benchmarks; MCO target and improvement objectives; performance improvement initiatives; and an examination of strengths, opportunities for improvement, and recommendations to add, enhance, or modify quality initiatives aimed at improving service delivery, accessibility, and quality.

To evaluate the Quality Strategy, HSAG analyzes the following to determine performance and progress in achieving the goals of the DMAS Quality Strategy.

- HEDIS measures
- CAHPS surveys

- Core Set of Adult Health Care Quality Measures for Medicaid
- Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP
- State-specific measures
- Addressing health disparities
- Use of sanctions
- EQR activities, such as the following:
  - PIP validation
  - Network adequacy and availability validation
  - Compliance monitoring
  - Annual EQR technical reports
- MCO performance withholds of capitation payments
- Quality initiatives

The Quality Strategy evaluation provides critical information about the structure of the quality program and the process for improving health service quality, access, and timeliness, and whether the program is achieving its goals. When opportunities for improvement are identified, HSAG will work with DMAS and its contracted MCOs to identify the leading causes for stagnant or declining performance. HSAG also will work with DMAS to examine health policies that may impact, either positively or negatively, service delivery, accessibility, and quality of care and to refine its methodology and tools as needed based on lessons learned from the previous year’s evaluation.

## ***Evaluation Tool***

To track the progress of achieving goals and objectives outlined in the 2023–2025 Quality Strategy, HSAG tracks annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement. HSAG developed a Virginia Medicaid Goals Tracking Table. The table includes the metrics included in the 2023–2025 Virginia Quality Strategy and categorized by the State’s associated goals and objectives, along with baseline rates from measurement year (MY) 2020. The most recent MY rates are compared to baseline rates, targets, and improvement objectives.



## Quality Strategy Evaluation Virginia Medicaid Goals Tracking Table

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
<b>Goal 1:</b> Enhance the Member Care Experience	<b>Objective 1.1</b> Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	<b>Cover Virginia 2021:</b> Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088  <b>Cover Virginia 2021:</b> Calls Taken with Language Assistance Services: 50,902  <b>Medallion 4.0</b> Call Center Language Calls 2021: 7,551  <b>CCC Plus</b> Call Center Language Calls 2021: 545  <b>2021 DMAS Website</b> Translation Requests 2021: 3,489	Increase by X percent the Cover Virginia Spanish language calls taken by Spanish-speaking bilingual staff  Increase by X percent the Cover Virginia calls taken with language assistance by 2025  Increase by X percent the Medallion 4.0 call center language calls taken by 2025  Increase by X percent the CCC Plus call center language calls taken by 2025.  Increase by X percent the translation requests taken by 2025	
		1.1.1.2 Monitor Language and Disability Access Reports	DMAS	<ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase by X percent the Language and Disability Access report monitoring: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	



Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.1.1.3 Monitor Member Language Counts	DMAS	<ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	Increase by X percent the Member Language Counts reported <ul style="list-style-type: none"> <li>• Cardinal Care Program:</li> </ul>	
	Objective 1.2 Improve Member Satisfaction	1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> <li>• CCC Plus: 68.5%</li> <li>• Medallion 4.0: 75.7%</li> </ul> Adult: <ul style="list-style-type: none"> <li>• CCC Plus: 58.7%</li> <li>• Medallion 4.0: 55.8%</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>all Health Care</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Adult:</li> <li>• Child:</li> </ul>	
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> <li>• CCC Plus: 79.5%</li> <li>• Medallion 4.0: 77.7%</li> </ul> Adult: <ul style="list-style-type: none"> <li>• CCC Plus: 72.8%</li> <li>• Medallion 4.0: 68.0%</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>Personal Doctor</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Adult:</li> <li>• Child:</li> </ul>	
★ Goal 2: Promote Access to Safe, Gold-Standard Patient Care	Objective 2.1 Ensure Access to Care	2.1.1.1 Getting Care Quickly Q6	CAHPS – AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> <li>• CCC Plus: 89.7%</li> <li>• Medallion 4.0: 86.0%</li> </ul> Adult: <ul style="list-style-type: none"> <li>• CCC Plus: 85.0%</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Care Quickly</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Adult:</li> <li>• Child:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				<ul style="list-style-type: none"> <li>Medallion 4.0: 81.1%</li> </ul>		
		2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> <li>CCC Plus: %</li> <li>Medallion 4.0: %</li> </ul> Adult: <ul style="list-style-type: none"> <li>CCC Plus: %</li> <li>Medallion 4.0: %</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>Got Non-Urgent Appointment as Soon as Needed</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Adult:</li> <li>Child:</li> </ul>	
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: <ul style="list-style-type: none"> <li>CCC Plus: 87.3%</li> <li>Medallion 4.0: 84.6%</li> </ul> Adult: <ul style="list-style-type: none"> <li>CCC Plus: 86.1%</li> <li>Medallion 4.0: 82.9%</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>Getting Needed Care</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Adult:</li> <li>Child:</li> </ul>	
	<b>Objective 2.2</b> Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3% <sup>1</sup> Short-Term Nursing Facility: 7.1% <sup>1</sup> CCC Plus Waiver Members: 1.9% <sup>1</sup>	Decrease the prevalence percentage of LTSS members with pressure ulcers by 2025: <ul style="list-style-type: none"> <li>Long-Term Nursing Facility:</li> <li>Short-Term Nursing Facility:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>CCC Plus Waiver Members:</li> </ul>	
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	<ul style="list-style-type: none"> <li>CCC Plus Waiver w/o PDN: 694</li> <li>CCC Plus Waiver: 26</li> <li>CCC Plus Waiver W PDN: 30</li> <li>DD Waiver: 9</li> <li>Emerging Vulnerable: 349</li> <li>Minimal Need: 107</li> <li>Nursing Facility: 446</li> <li>Other: 732</li> <li>Total: 2,393<sup>2</sup></li> </ul>	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025: <ul style="list-style-type: none"> <li>CCC Plus Waiver w/o PDN:</li> <li>CC Plus Waiver:</li> <li>DD Waiver:</li> <li>Emerging Vulnerable:</li> <li>Minimal Need:</li> <li>Nursing Facility:</li> <li>Other:</li> <li>Total:</li> </ul>	
	<b>Goal 2.3</b> Promote Effective Communication and Care Coordination	2.3.1.1 How Well Doctors Communicate	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: <ul style="list-style-type: none"> <li>CCC Plus: 93.9%</li> <li>Medallion 4.0: 93.7%</li> </ul> Adult: <ul style="list-style-type: none"> <li>CCC Plus: 94.2%</li> <li>Medallion 4.0: 93.3%</li> </ul>	Increase the Cardinal Care annual CAHPS overall Rating of <i>How Well Doctors Communicate</i> to perform at or above the CAHPS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Adult:</li> <li>Child:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.3.1.2 Service Authorizations	DMAS <a href="https://www.dmas.virginia.gov/data/mco-service-authorization-performance/">https://www.dmas.virginia.gov/data/mco-service-authorization-performance/</a>	2022 Fourth Quarter MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
★ Goal 3: Support Efficient and Value-Driven Care	Objective 3.1 Focus on Paying for Value	3.1.1.1 Frequency of Potentially Preventable Admissions	DMAS Clinical Efficiency Measures	Clinical Efficiency Measures 2021 CCC Plus: 2.942	Decrease by 10% Potentially Preventable Admissions: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.2 Frequency of Emergency Department Visits	DMAS Clinical Efficiency Measure	Clinical Efficiency Measures 2021 CCC Plus: 43.08	Decrease by 1% the Potentially Preventable, Avoidable, and/or Medically Unnecessary Emergency Department Visits: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.3 Frequency of Potentially Preventable Readmissions	DMAS Clinical Efficiency Measure	2021 CCC Plus: 18.77%	Decrease by 8% Potentially Preventable Readmissions Within 30 Days: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus: 77.45</li> <li>Medallion 4.0:</li> </ul>	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.5 Ambulatory Care: Emergency (ED) Visits	DMAS Clinical Efficiency Measures NCQA HEDIS (AMB) CMS Child Core Set: AMB-CH	Clinical Efficiency Measures <ul style="list-style-type: none"> <li>2021 CCC Plus: 43.08</li> </ul> HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus: 77.45%</li> <li>Medallion 4.0: NR</li> </ul> Child Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0</li> </ul>	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program HEDIS:</li> <li>Cardinal Care Program Child Core Set:</li> <li>Less than 1 Year:</li> <li>1-9 Years:</li> <li>10-19 Years:</li> <li>Total:</li> </ul> Decrease the CMS Child Core Set Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program HEDIS:</li> <li>Cardinal Care Program Child Core Set:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>Less than 1 Year:</li> <li>1-9 Years:</li> <li>10-19 Years:</li> <li>Total:</li> </ul>	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Decrease by X% the number of nursing facility y days without minimum RN hours. <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.7 Total Nurse Staffing Hours Per Resident Day (RN, LPN, CAN) – Case-Mix Adjusted	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements. <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.8 Percentage of Long-Stay Resident with a Urinary Tract Infection (UTI)	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul>	
		3.1.1.9 Number of Hospitalizations per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays that occurred among	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					long-stay residents of a nursing home. <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		3.1.1.10 Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Decrease by X% the number of outpatient ED visits that occurred among long-stay residents of a nursing home.	
		3.1.1.11 Percentage of Long-Stay High-Risk Residents with Pressure Ulcers	DMAS VBP Reporting Team CMS Nursing Home Compare	NF VBP Program 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> </ul>	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	
	<b>Objective 3.2</b> Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials <a href="https://www.dmas.virginia.gov/data/mco-financials/">https://www.dmas.virginia.gov/data/mco-financials/</a>	<ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Maintain MLR XXXX	
<b>Goal 4:</b> Strengthen the Health of Families and Communities	<b>Objective 4.1</b> Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services	NCQA HEDIS (AAP)	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus: 87.12%</li> <li>Medallion 4.0: 72.75%</li> </ul>	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus: 39.86%</li> <li>Medallion 4.0: 46.57%</li> </ul>	Increase the HEDIS Child and Adolescent Well-Care Visits measure rate to perform at or above	



Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Child Core Set <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program:</li> </ul> Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• 3-11 Years:</li> <li>• 12-17 Years:</li> <li>• 18-21 Years:</li> <li>• Total:</li> </ul>	
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) <ul style="list-style-type: none"> <li>• Combo 3</li> </ul> Child Core Set: CIS-CH	HEDIS MY 2020 <ul style="list-style-type: none"> <li>• CCC Plus: 65.58%</li> <li>• Medallion 4.0: 65.82%</li> </ul> Child Core Set <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program:</li> </ul> Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program:</li> </ul>	
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) <ul style="list-style-type: none"> <li>• Combo 1</li> </ul>	HEDIS MY 2020 Combo 1	Increase the HEDIS Immunization for	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
			<ul style="list-style-type: none"> <li>Combo 2</li> <li>Child Core Set: IMA-CH</li> </ul>	<ul style="list-style-type: none"> <li>CCC Plus: 64.10%</li> <li>Medallion 4.0: %</li> <li>Combo 2</li> <li>CCC Plus: 26.02%</li> <li>Medallion 4.0: %</li> <li>Child Core Set</li> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Combo 1:</li> <li>Combo 2:</li> </ul> <p>Increase the CMS Child Core Set Child and Adolescent Well-Care Visits measure rate to perform at or above the CMCS 50th percentile by 2025: Cardinal Care Program:</p> <ul style="list-style-type: none"> <li>Combo 1:</li> <li>Combo 2:</li> </ul>	
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	<p>CAHPS 2021: ND Adult Core Set</p> <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Increase the CAHPS Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CAHPS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul> <p>Increase the CMS Adult Core Set Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CMCS 50<sup>th</sup> percentile by 2025:</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul>	
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0: Child Core Set</li> <li>CCC Plus:</li> <li>Medallion 4.0: CMS 416 2021</li> </ul>	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025:  <i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i> <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program:</li> </ul> <i>Note: Need to determine target for a CMS 416 measure.</i>	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0: Child Core Set</li> <li>CCC Plus:</li> <li>Medallion 4.0: CMS 416 2021</li> </ul>	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<p><i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i></p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> <p>Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <p><i>Note: Need to determine target for a CMS 416 measure.</i></p>	
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0: CMS 416 2021</li> </ul>	<p>Increase the HEDIS Sealant Receipt on Permanent First Molars measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <p><i>Note: MY 2023 Year 1 measure – percentile rankings may not be available.</i></p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> <p>Increase the CMS Child Core Set Sealant Receipt of</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Permanent First Molars measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <i>Note: Need to determine target for a CMS 416 measure.</i>	
		4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA HEDIS (WCC) CMS Child Core Set (WCC-CH)	HEDIS MY 2020 CCC Plus: <ul style="list-style-type: none"> <li></li> </ul>	Increase the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>BMI Percentile Documentation</li> <li>Counseling for Nutrition</li> <li>Counseling for Physical Activity</li> </ul> Increase the CMS Child Core Set Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program – Total:</li> <li>• BMI Percentile Documentation</li> <li>• Counseling for Nutrition</li> <li>• Counseling for Physical Activity</li> </ul>	
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 <ul style="list-style-type: none"> <li>• CCC Plus: NR</li> <li>• Medallion 4.0: NR</li> </ul> Child Core Set <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	Increase the HEDIS Chlamydia Screening in Women Ages 16-20 measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> </ul> <i>Note: HEDIS measure age is 16-24 Years.</i>  Increase the CMS Child Core Set Chlamydia Screening in Women Ages 16-20 Years measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program – Total:</li> </ul>	
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 <ul style="list-style-type: none"> <li>• CCC Plus: NR</li> </ul>	Increase the HEDIS Lead Screening in Children measure rate	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				<ul style="list-style-type: none"> <li>Medallion 4.0: NR</li> <li>Child Core Set</li> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
	<p>★ Objective 4.2 Improve Outcomes for Maternal and Infant Members</p>	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care <ul style="list-style-type: none"> <li>CCC Plus: NR</li> <li>Medallion 4.0: 66.52%</li> </ul> Adult Core Set Postpartum Care <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Increase the CMS Adult Core Set Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the CMCS 50th percentile by 2025:	



Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA HEDIS (PPC) Child Core Set: PPC-CH	HEDIS MY 2020 Timeliness of Prenatal Care <ul style="list-style-type: none"> <li>CCC Plus: NR</li> <li>Medallion 4.0: 73.00%</li> </ul> Adult Core Set Timeliness of Prenatal Care <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Increase the CMS Child Core Set Prenatal and Postpartum Care: Postpartum Care measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		4.2.1.3 Live Births Weighing Less than 2,500 Grams	Child Core Set: LBW-CH CDC Wonder State Vital Records	CMS 2021 Child Core Set Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Live Births Weighing Less than 2,500 Grams measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	<p>HEDIS MY 2020</p> <ul style="list-style-type: none"> <li>• CCC Plus: 71.81%</li> <li>• Medallion 4.0: 72.10%</li> </ul> <p>Child Core Set</p> <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• First 15 Months:</li> <li>• 15-30 Months</li> </ul> <p>Increase the CMS Child Core Set Well-Child Visits in the First 30 Months of Life measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• First 15 Months:</li> <li>• 15-30 Months</li> </ul>	
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	<p>Child Core Set</p> <p>CMS 2021 Reported Rate— CDC Wonder Data:</p>	<p>Decrease the CMS Child Core Set Low-Risk Cesarean Delivery measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program – Total:</li> </ul> <p><i>Note: Lower rate is better.</i></p>	
	<b>Objective 4.3</b> Improve Home	4.3.1.1 Number and Percent of Waiver	QMR	<p><b>FY22</b> Q1: 86.0%</p>	<p>Increase the number and percent of waiver</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
	and Community-Based Services	Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals		Q2: 50% Q3: 53%	individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		4.3.1.2 Number and Percent of Individuals Who Received Services in the Scope Specified in the Service Plan	QMR	<b>FY22</b> Q1: 97.0% Q2: 100% Q3: 100%	Increase the number and percent of individuals who received services in the scopes specified in their service plan by 5% by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
<b>Goal 5:</b> Providing Whole-Person Care for Vulnerable Populations	<b>Objective 5.1</b> Improve Outcomes for Members with Chronic Conditions	5.1.1.1 PQI 08: Heart Failure Admission Rate	Adult Core Set: PQI08-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <i>Note: Lower rate is better.</i>	
		5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2025:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <i>Note: Lower rate is better.</i>	
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus: 41.04%</li> <li>Medallion 4.0:</li> </ul>	Decrease the CMS Adult Core Set Asthma in Older Adults' Admission measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <i>Note: Lower rate is better.</i>	
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus: 51.42%</li> <li>Medallion 4.0: 41.04%</li> </ul> Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the HEDIS Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Increase the CMS Adult Core Set Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	<p>HEDIS MY 2020</p> <ul style="list-style-type: none"> <li>CCC Plus: 48.07%</li> <li>Medallion 4.0: 46.91%</li> </ul> <p>Adult Core Set</p> <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> <p>Increase the CMS Adult Core Set Controlling High Blood Pressure measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years	NCQA HEDIS (AAB) CMS Child Core Set: AAB-CH	<p>HEDIS MY 2020</p> <ul style="list-style-type: none"> <li>CCC Plus: 47.93%</li> <li>Medallion 4.0: NR</li> </ul> <p>Child Core Set</p> <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>3 Months to 17 Years:</li> <li>18- 64 Years:</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>65 Years and older:</li> <li>Total:</li> </ul> <p><i>Note: Recommend dropping the 18-64, 65 years and older, and total.</i></p> <p>Increase the CMS Child Core Set Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> <li>3 Months to 17 Years:</li> </ul>	
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	<p>HEDIS MY 2020</p> <ul style="list-style-type: none"> <li>CCC Plus: 63.62%</li> <li>Medallion 4.0: 71.00%</li> </ul> <p>Child Core Set</p> <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> <p>Increase the CMS Child Core Set Asthma Medication Ratio: Age 5 to 18</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Years measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
	<b>Objective 5.2</b> Improve Outcomes for Nursing Home Eligible Members	5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly)	NCQA HEDIS (DAE)	HEDIS MY 2020: CCC Plus: 14.88%	Decrease the HEDIS Use of High-Risk Medications in Older Adults (Elderly) measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul> <i>Note: Lower rate is better.</i>	
	★ <b>Objective 5.3</b> Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	<ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the percentage of members with Identification of Alcohol and Other Drug Services by 5% by 2025.	
		5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use	NCQA HEDIS (FUA) Child Core Set: FUA-CH	HEDIS MY 2020 CCC Plus <ul style="list-style-type: none"> <li>7-Day: 11.44%</li> <li>30-Day: 19.98%</li> </ul> Medallion 4.0: <ul style="list-style-type: none"> <li>7-Day: 13.92%</li> <li>30-Day: 21.88%</li> </ul> Child Core Set CCC Plus	Increase the HEDIS Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul>	



Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				<ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul> Medallion 4.0: <ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul>	Increase the CMS Child Core Set Follow-Up After Emergency Department Visit for Substance Use measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer	NCQA HEDIS (OHD) Adult Core Set: OHD-AD	HEDIS MY 2020 <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul> Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Decrease the HEDIS Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Decrease the CMS Adult Core Set Use of Opioids at High Dosage in Persons Without Cancer measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		5.3.1.4 Initiation and Engagement of	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus:	Increase the HEDIS Initiation and Engagement of	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Substance Use Disorder Treatment		<ul style="list-style-type: none"> <li>Initiation: 46.41%</li> <li>Engagement: 12.51%</li> </ul> Medallion 4.0: <ul style="list-style-type: none"> <li>Initiation:</li> <li>Engagement:</li> </ul> Adult Core Set CCC Plus: <ul style="list-style-type: none"> <li>Initiation:</li> <li>Engagement:</li> </ul> Medallion 4.0: <ul style="list-style-type: none"> <li>Initiation:</li> <li>Engagement:</li> </ul>	Substance Use Disorder Treatment measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul> Increase the CMS Adult Core Set Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus</li> <li>Medallion 4.0:</li> </ul>	Increase the CMS Adult Core Measure rate Use of Pharmacotherapy for Opioid Use Disorder measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Total:</li> </ul>	
	□ <b>Goal: 5.4</b> Improve Behavioral	5.4.1.1 Follow-Up After Hospitalization for Mental Illness	NCQA HEDIS (FUH) Adult Core Set: FUH-AD Child Core Set: FUH-CH	HEDIS MY 2020 CCC Plus <ul style="list-style-type: none"> <li>7-Day: 30.77%</li> </ul>	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
	<p>Health and Developmental Services for Members</p>			<ul style="list-style-type: none"> <li>• 30-Day: 54.12%</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>• 7-Day: 35.63%</li> <li>• 30-Day: 56.84%</li> </ul> <p>Adult Core Set CCC Plus</p> <ul style="list-style-type: none"> <li>• 7-Day:</li> <li>• 30-Day:</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>• 7-Day:</li> <li>• 30-Day:</li> </ul> <p>Child Core Set CCC Plus</p> <ul style="list-style-type: none"> <li>• 7-Day:</li> <li>• 30-Day:</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>• 7-Day:</li> <li>• 30-Day:</li> </ul>	<p>measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program 6 Years and Older</li> <li>• Within 7 Days</li> <li>• Within 30 Days</li> </ul> <p>Increase the CMS Adult Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program – 18 and Older:</li> <li>• Within 7 Days</li> <li>• Within 30 Days</li> </ul> <p>Increase the CMS Child Core Set Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025:</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					<ul style="list-style-type: none"> <li>Cardinal Care Program ages 6-17 Years:</li> <li>Within 7 Days</li> <li>Within 30 Days</li> </ul>	
		5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness	NCQA HEDIS (FUM) Adult Core Set: FUM-AD Child Core Set: FUM-CH	<p>HEDIS MY 2020 CCC Plus</p> <ul style="list-style-type: none"> <li>7-Day: 47.03%</li> <li>30-Day: 62.83%</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>7-Day: 45.34%</li> <li>30-Day: 57.38%</li> </ul> <p>Adult Core Set CCC Plus</p> <ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul> <p>Child Core Set CCC Plus</p> <ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul> <p>Medallion 4.0:</p> <ul style="list-style-type: none"> <li>7-Day:</li> <li>30-Day:</li> </ul>	<p>Increase the HEDIS Follow-Up After Emergency Department Visit for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program 6 Years and Older</li> <li>Within 7 Days</li> <li>Within 30 Days</li> </ul> <p>Increase the CMS Adult Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program – 18 and Older:</li> <li>Within 7 Days</li> <li>Within 30 Days</li> </ul> <p>Increase the CMS Child Core Set Follow-</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program ages 6-17 Years:</li> <li>• Within 7 Days</li> <li>• Within 30 Days</li> </ul>	
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus <ul style="list-style-type: none"> <li>• Initiation:</li> <li>• Continuation:</li> </ul> Medallion 4.0 <ul style="list-style-type: none"> <li>• Initiation: 45.20%</li> <li>• Continuation: 58.61%</li> </ul> Child Core Set CCC Plus: <ul style="list-style-type: none"> <li>• Initiation:</li> <li>• Continuation:</li> </ul> CCC Plus: <ul style="list-style-type: none"> <li>• Initiation:</li> <li>• Continuation:</li> </ul>	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program – Ages 6-12 Years</li> <li>• Initiation Phase:</li> <li>• Continuation and Maintenance Phase:</li> </ul> Increase the CMS Child Core Set Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program – Ages 6-12 Years</li> <li>• Initiation Phase:</li> <li>• Continuation and Maintenance Phase:</li> </ul>	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	Increase the percentage of members receiving mental health services by X% by 2025.	
		5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA HEDIS (APP) Child Core Set: APP-CH	HEDIS MY 2020 <ul style="list-style-type: none"> <li>• CCC Plus: 43.71%</li> <li>• Medallion 4.0: 69.58%</li> </ul> Child Core Set <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	Increase the HEDIS Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program – Ages 1-17 Years</li> </ul> Increase the CMS Child Core Set Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Ages 1-17 Years</li> </ul>	
		5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA HEDIS (APM) CMS Child Core Set: APM-CH	HEDIS MY 2020 CCC Plus: <ul style="list-style-type: none"> <li>Blood Glucose Testing—Total: 41.33</li> <li>Cholesterol Testing—Total: 28.59%</li> <li>Blood Glucose and Cholesterol Testing—Total: 27.05%</li> </ul> Medallion 4.0: NR Child Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Ages 1-17 Years</li> </ul> Increase the CMS Child Core Set Metabolic Monitoring for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program – Ages 1-17 Years</li> </ul>	
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure	



Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 3 Months – 17 Years</li> <li>• 18 – 64 Years</li> <li>• 65 and Older</li> <li>• Total</li> </ul> Increase the CMS Adult Core Set Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 18-64 Years</li> <li>• 65 and Older</li> </ul>	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus: <ul style="list-style-type: none"> <li>• Effective Acute Phase Treatment: 61.11%</li> <li>• Effective Continuation Phase: 48.29%</li> </ul> Medallion 4.0:	Increase the HEDIS Antidepressant Medication Management measure rate to perform at or above the HEDIS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 18 and Older</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				<ul style="list-style-type: none"> <li>Effective Acute Phase Treatment: 57.12%</li> <li>Effective Continuation Phase: 42.02%</li> </ul> Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<ul style="list-style-type: none"> <li>Effective Acute Phase Treatment</li> <li>Effective Continuation Phase Treatment</li> </ul> Increase the CMS Adult Core Set Antidepressant Medication Management measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>18 – 64 Years</li> <li>65 and Older</li> <li>Total</li> <li>Effective Acute Phase Treatment</li> <li>Effective Continuation Phase Treatment</li> </ul>	
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	Increase the CMS Adult Core Set Screening for Depression and Follow-Up Plan: Ages 18 and Older measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>Cardinal Care Program</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA HEDIS (SSD) CMS Adult Core Set: SSD-AD	<p>HEDIS MY 2020:</p> <ul style="list-style-type: none"> <li>• CCC Plus: 77.18%</li> <li>• Medallion 4.0: NR</li> </ul> <p>Adult Core Set</p> <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 18 to 64 Years</li> </ul> <p>Increase the CMS Adult Core Set Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 18 – 64 Years</li> </ul>	
		5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA HEDIS (HPCMI) CMS Adult Core Set: HPCMI-AD	<p>HEDIS MY 2020</p> <ul style="list-style-type: none"> <li>• CCC Plus:</li> <li>• Medallion 4.0</li> </ul> <p>Adult Core Set</p> <ul style="list-style-type: none"> <li>• CCC Plus:</li> </ul>	<p>Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) measure rate</p>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				<ul style="list-style-type: none"> <li>Medallion 4.0:</li> </ul>	<p>to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>18 to 75 Years</li> </ul> <p>Increase the CMS Adult Core Set Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) measure rate to perform at or above the CMCS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>18 – 64 Years</li> <li>65 – 75 Years</li> </ul>	
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	<p>HEDIS MY 2020:</p> <ul style="list-style-type: none"> <li>CCC Plus: 69.50%</li> <li>Medallion 4.0: NR</li> </ul> <p>Adult Core Set</p> <ul style="list-style-type: none"> <li>CCC Plus:</li> <li>Medallion 4.0:</li> </ul>	<p>Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2025:</p> <ul style="list-style-type: none"> <li>Cardinal Care Program</li> <li>18 to 39 Years</li> </ul>	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Adult Core Set Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the CMCS 50th percentile by 2025: <ul style="list-style-type: none"> <li>• Cardinal Care Program</li> <li>• 18 – 39 Years</li> </ul>	

<sup>1</sup> DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.

<sup>2</sup> MCO critical incident data reported to DMAS for calendar year 2021.

\*The baseline measure rate is the final validated 2021 HEDIS, performance measure rate or CAHPS reported in the 2021 Annual Technical Report and posted to the DMAS website.

\*\*Target established in the CY2021 PWP Methodology.

\*\*\*The baseline measure rate is the final validated 2020 HEDIS rate reported in the 2021 Annual Technical Report and posted to the DMAS website.

^The baseline measure rate is the final 2021 rate calculated by HSAG for the PWP.

^^The baseline measure rate is the final 2021 rate reported by DMAS for the Quality Management Review.

^^^The baseline measure rate is the final 2021 rate reported by the DMAS Finance Team

▲ Statistically significantly higher in 2020 than in 2019.

▼ Statistically significantly lower in 2020 than in 2019.

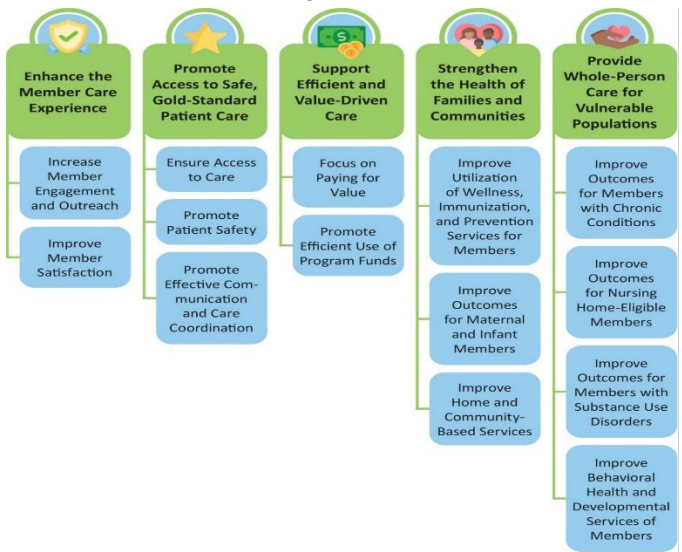
★ These goals are inclusive of Governor Glenn Youngkin’s identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.

# Appendix G. Medallion 4.0 (Acute) Program 2023 Snapshot

## Virginia Medicaid Background

DMAS administers the Medallion 4.0 (Acute) program, which includes the Virginia Medicaid program and FAMIS, the Commonwealth's CHIP program.

## Virginia's 2023–2025 Quality Strategy Goals and Objectives



## Medallion 4.0 (Acute) 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 accredited  
 \*\*NCQA Health Plan, Health Equity, LTSS, and Electronic Clinical Data Accredited  
 Note: Optima and VA Premier merged during CY 2023

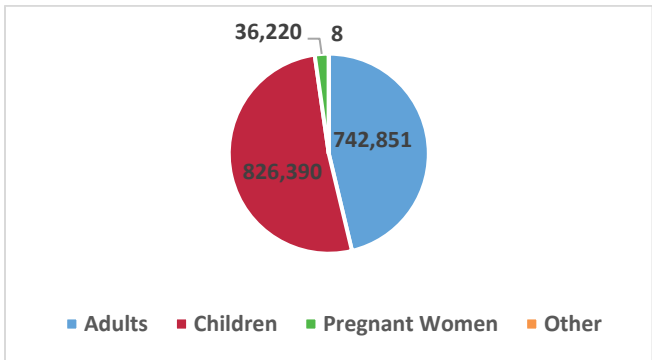
## Medallion 4.0 (Acute) Program Enrollment

### CY 2023 Average Annual Program Enrollment

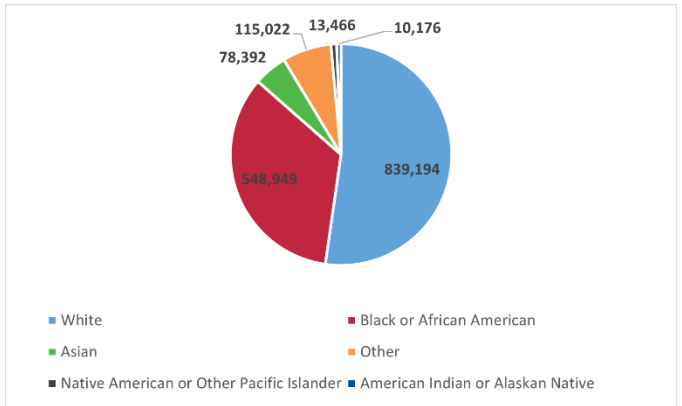
Program	SFY 2023 Enrollment as of 07/1/2023
Medallion 4.0	1,670,831

## Medallion 4.0 (Acute) Program Demographics

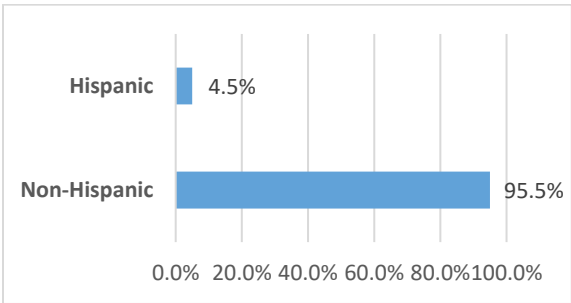
### Eligibility Categories



### Categories by Race

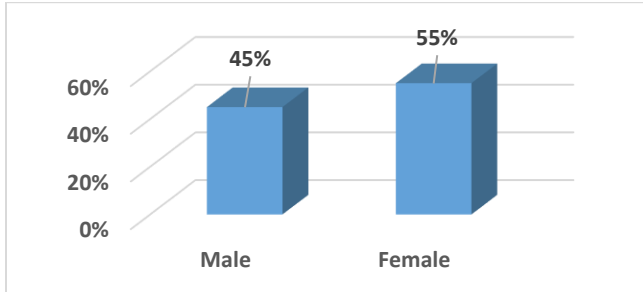


### Categories by Ethnicity

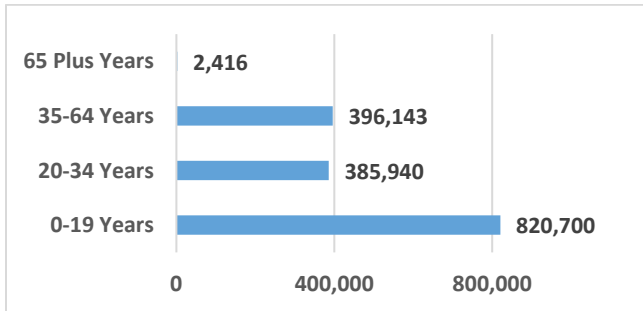


### Medallion 4.0 Program Demographics

Percentage by Gender

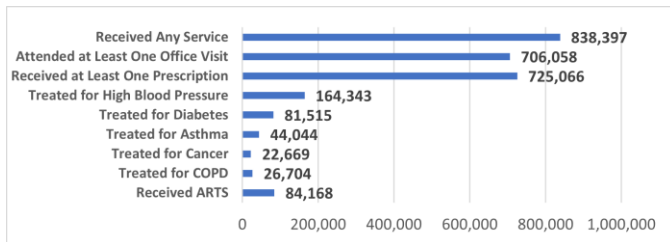


Enrollment by Age Group

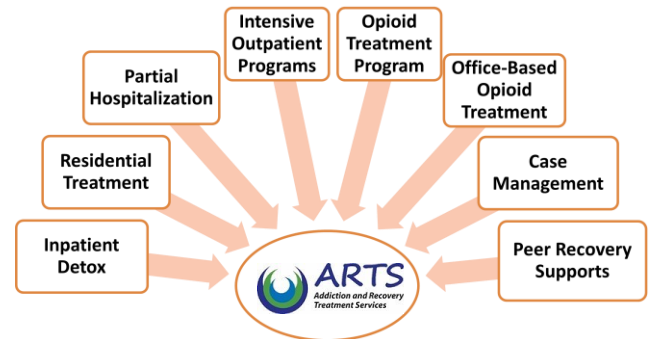
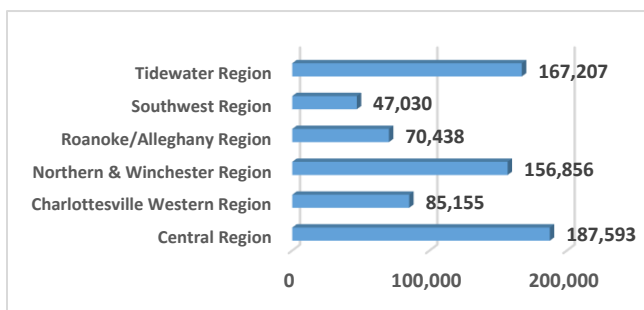


### Medicaid Expansion

Medicaid Expansion Service Provision



### Medicaid Expansion Members by Medicaid Region



### ARTS Benefit Outcomes SFY 2020, 2021, and First Half of 2022

- Over 116,000 Medicaid members had a diagnosed SUD in SFY 2021, an increase of 14.3% from SFY 2020.
- Use of ARTS services increased 24% between SFY 2020 and 2021.
- MOUD treatment rates increased from 64% in SFY 2020 to 78% in SFY 2021.
- Among members who used ARTS services in SFY 2021, only 9% utilized residential treatment, with an average length of stay of 15.5 days.
- 27% of members with an OUD-related ED visit received MOUD treatment within 7 days of the visit, and 37% within 30 days of the visit.
- Of members discharged from residential treatment, 54% received MOUD within 30 days of discharge.
- OUD-related overdoses per 100,000 Medicaid members increased 25% between SFY 2020 and SFY 2021. However, overdose rates decreased during the first two quarters of SFY 2022.

### Provider Network Expansion Supported Through ARTS

- The percentage change from 2019 through 2022 of buprenorphine waived prescribers was 80.8%.
- The percentage change of pharmacies with any prescription for buprenorphine increased 43.9%.

### Increase in Providers of ARTS Services

Addiction Provider Type	Number of Providers before ARTS (2017)	# of Providers in 2020	# of Providers in 2022
Inpatient Detox	N/A	51	70
Residential Treatment	4	123	95
Partial Hospitalization Programs	N/A	41	40
Intensive Outpatient Programs	49	252	209
Opioid Treatment Programs	6	40	43
Preferred Office-Based Addiction Treatment Providers	N/A	154	200
Outpatient Practitioners Billing for ARTS Services	1,087	5,089	6,184



### 2023 Statewide Aggregate PIP Results

**PIP Topics:**

- Timeliness of Prenatal Care
- Tobacco Cessation in Pregnant Women

<b>Strengths</b>	Five of the six MCOs received 100% validation scores across all evaluation elements for Steps 1 through 8 and were assigned a <i>High Confidence</i> level for both PIPs. These MCOs calculated and reported baseline data accurately and implemented targeted interventions that addressed the identified barriers and developed sound methodologies for evaluating the effectiveness for each intervention.
<b>Weakness</b>	One MCO had opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and providing the quality improvement processes used to identify and prioritize barriers.

### Compliance With Standards Monitoring Results

The MCOs' 2021 compliance with federal requirements scores, for the three-year cycle, ranged from 88.9% to 96.3%. All six MCOs received a 100% compliance score for the following standards:

Standards
Emergency and Poststabilization Services
Coordination and Continuity of Care
Provider Selection
Practice Guidelines
Health Information Systems
Program Integrity

### Cardinal Care Program Readiness Review Results

MCO Cardinal Care program readiness review results ranged from 90.0% to 100%. MCOs remediated readiness review identified deficiencies resulting in all six MCOs' final readiness reviews scores achieving 100%.

### Performance Measure Validation Results

Domain	Strengths
<b>Children's Preventive Care</b>	Four of six MCOs' rates met or exceeded the 50th percentile for the <i>Child and Adolescent Well-Care Visits—Total</i> and <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits</i> PM indicators.

<b>Care for Chronic Conditions</b>	Five of six MCOs' rates met or exceeded the 50th percentile for the <i>Asthma Medication Ratio—Total</i> and <i>Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (&lt;8.0%)</i> measure indicators.
<b>Behavioral Health</b>	All six MCOs' rates met or exceeded the 50th percentile for the <i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total, 30-Day Follow-Up—Total, and Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment</i> PM indicators. Additionally, five of six MCOs' rates met or exceeded the 50th percentile for the <i>Antidepressant Medication Management—Effective Acute Phase Treatment</i> and <i>Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment</i> PM indicators.
<b>Domain</b>	<b>Opportunities for Improvement</b>
<b>Children's Preventive Care</b>	Four of the six MCOs' rates fell below the 50th percentile for the <i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits and Childhood Immunization Status—Combination 3</i> PM indicators.
<b>Women's Health</b>	All six MCOs' rates fell below the 50th percentile for the <i>Breast Cancer Screening and Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> PM indicators.  Five of the six MCOs' rates fell below the 50th percentile for the <i>Cervical Cancer Screening</i> PM indicator.
<b>Access to Care</b>	All six MCOs' rates fell below the 50th percentile for the <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> PM indicator.
<b>Care for Chronic Conditions</b>	Five of the six MCOs' rates fell below the 50th percentile for the <i>Eye Exam for Patients With Diabetes—Total</i> PM indicator.
<b>Behavioral Health</b>	Five of the six MCOs' rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total, and Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total</i> measure indicators. Additionally, four of the six MCOs' rates fell below the 50th percentile for the <i>Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total</i> PM indicator.

### Primary Care Provider Secret Shopper Survey Results

#### New Patient Acceptance Rates

	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
MCO Total	46.7%	43.3%	36.1%

#### New Patient Appointment Availability

	Routine Visit	Urgent Visit	Total
MCO Total	74.0%	72.3%	73.1%

#### New Patient Appointments Meeting Compliance Standards

	Routine Visit	Urgent Visit	Total
MCO Total	74.5%	16.0%	43.2%

### Prenatal Care Provider Secret Shopper Survey Results

#### New Patient Acceptance Rates

	Accepting MCO	Accepting VA Medicaid	Accepting New Patients
MCO Overall	29.6%	27.3%	26.0%

#### New Patient Appointment Availability

	First Trimester	Second Trimester	Third Trimester	Total
MCO Overall	52.0%	14.7%	17.3%	28.0%

#### Appointments Meeting Compliance Standards

	First Trimester	Second Trimester	Third Trimester	Total
MCO Overall	15.1%	21.4%	10.5%	15.1%

#### After-Hours and Weekend Appointment Availability

	After-Hours Availability	Weekend Availability
MCO Overall	4.6%	2.3%

### Medicaid Member Experience of Care Survey Results

	Adult 2022	Adult 2023	Child 2022	Child 2023
<b>Global Top-Box Scores</b>				
Rating of Health Plan	63.4%	58.9%	74.1%	74.2%
Rating of All Health Care	56.6%	54.0%	72.6%	71.7%
Rating of Personal Doctor	65.2%	66.5%	74.7%	74.7%
Rating of Specialist Seen Most Often	66.3%	65.7%	73.0%	74.6%
<b>Composite Top-Box Scores</b>				
Getting Needed Care	81.1%	82.2%	82.5%	83.4%
Getting Care Quickly	80.2%	81.1%	83.9%	83.4%
How Well Doctors Communicate	91.0%	92.8%	93.2%	93.5%
Customer Service	87.5%	88.0%	86.8%	87.1%

Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Medicaid Member Experience of Care Survey Results

#### Strengths

##### 2023 Medicaid top-box score results:

- Adult—United’s 2023 top-box score was statistically significantly higher than the 2022 top-box score and the 2022 NCQA adult Medicaid national average for *Rating of Health Plan*.
- Child—VA Premier’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*.
- Child—Optima’s 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.

#### Opportunities for Improvement

##### 2023 Medicaid top-box score results:

- Adult—HealthKeepers’ 2023 top-box score was statistically significantly lower than the 2022 NCQA adult Medicaid national average for *Rating of Health Plan*.
- Adult—VA Premier’s 2023 top-box score was statistically significantly lower than the 2022 top-box score for *Rating of Health Plan*.
- Child—United’s 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. Additionally, United’s 2023 top box score for *Rating of Specialist Seen Most Often* was statistically significantly lower than the 2022 top-box score.
- Child—Molina’s 2023 top-box scores were statistically significantly lower than the 2022 top-box scores and the 2022 NCQA child Medicaid national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.
- Child—Medallion 4.0 (Acute) Program’s 2023 top-box score is statistically significantly lower than the 2022 NCQA child Medicaid national average for *Getting Care Quickly*.

### FAMIS Member Experience of Care Survey Results

	General Child 2022	General Child 2023	CCC 2022	CCC 2023
Rating of Health Plan	70.5%	72.7%	65.1%	65.9%
Rating of All Health Care	71.9%	67.0% <sup>+</sup>	62.8%	56.4%
Rating of Personal Doctor	77.4%	78.8%	73.7%	74.8%
Rating of Specialist Seen Most Often	69.4% <sup>+</sup>	73.9% <sup>+</sup>	68.6%	63.9% <sup>+</sup>
<b>Composite Top-Box Scores</b>				
Getting Needed Care	83.3% <sup>+</sup>	83.3% <sup>+</sup>	82.3%	76.2%
Getting Care Quickly	84.8% <sup>+</sup>	90.7% <sup>+</sup>	85.9%	87.7% <sup>+</sup>
How Well Doctors Communicate	95.2%	93.7% <sup>+</sup>	95.6%	92.2%
Customer Service	83.4% <sup>+</sup>	95.0% <sup>+</sup> ▲	82.8% <sup>+</sup>	89.3% <sup>+</sup>

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

▼ Statistically significantly lower in 2023 than in 2022.

▲ Cells highlighted in gray represent rates that are statistically significantly lower than the 2022 NCQA Medicaid national averages.

### Performance Measure Calculation Results

HSAG calculated the *Medicaid Managed Long-Term Services and Supports (MLTSS) Successful Transition after Long-Term Facility Stay* performance measure following the 2022 CMS *Medicaid MLTSS Measures Technical Specifications and Resource Manual*. The 2022 Virginia Medicaid total and the CCC Plus program results were:

Stratification	Facility Admissions	Observed Rate	Expected Rate	Observed-to-Expected (O/E) Ratio
Virginia Total	4,578	33.70%	67.61%	0.50
CCC Plus (MLTSS)	3,742	31.11%	67.90%	0.46
Medallion 4.0 (Acute)	86	79.07%	57.92%	1.37
Fee-for-Service	166	18.07%	74.93%	0.24
Managed care	3,975	33.38%	67.16%	0.50

### Medicaid Maternal Child and Health Focus Study

The Medicaid and CHIP 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).

#### Strengths

- Overall, women enrolled in managed care had better outcomes than women in the FFS population in CY 2021, with the exception of the *Newborns with Low Birth Weight (<2,500 grams)* study indicator rate.
- The CY 2021 managed care rate for the *Newborns with Low Birth Weight (<2,500 grams)* indicator exceeded the national benchmark but continued to fall below the national benchmark for the *Births with Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* indicators.
- Overall, the FAMIS MOMS program demonstrated strength, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* study indicators exceeding the applicable national benchmarks for all three measurement periods.
- The FAMIS MOMS program demonstrated strength, with rates for the *Births with Early and Adequate Prenatal Care*, *Preterm Births (<37 Weeks Gestation)*, and *Newborns with Low Birth Weight (<2,500 grams)* study indicators exceeding the applicable national benchmarks for all three measurement periods.
- The Medicaid for Pregnant Women program *Preterm Births (<37 Weeks Gestation)* and *Newborns with Low Birth Weight (<2,500 grams)* rates exceeded the national benchmarks in CY 2021.

- The Medicaid Expansion program's rate for the *Births with Early and Adequate Prenatal Care* study indicator improved from CY 2020 to exceed the national benchmark in CY 2021.

#### Opportunities for Improvement

- Births to women in the FAMIS MOMS program had the lowest rates of *Postpartum Ambulatory Care Utilization*, *Prenatal Maternal Health Screening*, and *Postpartum Maternal Depression Screening* for CY 2021.

### Dental Utilization in Pregnant Women Dental Brief

The Dental Utilization in Pregnant Women Focus Study (Dental Brief) included all women 21 years of age or older with deliveries during CY 2022. The Dental Brief was designed to assess dental utilization and birth outcomes among pregnant women covered by Virginia Medicaid or the FAMIS MOMS program through the Smiles for Children (SFC) program that was administered by DentaQuest.

#### Strengths

- The percentage of deliveries for *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization* was significantly higher for those who received at least one preventive service compared to those who did not receive any preventive.
- The rates for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one preventive dental service compared to those who did not receive any preventive dental services.
- For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates compared to women who received no dental services.
- Deliveries covered by managed care for women less than 21 years of age had higher rates of receiving any perinatal dental service compared to women 21 years of age and older age.
- For women 21 years of age and older, there were statistically significant differences in rates for deliveries that received any dental services versus those that received no dental services for four of the birth outcomes: *Preterm Births (<37 Weeks Gestation)*, *Newborns With Low Birth Weight (<2,500 grams)*, *Births With Adequate Prenatal Care*, and *Postpartum Ambulatory Care Utilization*.
- The percentages of deliveries for *Preterm Births (<37 Weeks Gestation)* and *Newborns With Low Birth Weight (<2,500 grams)* were significantly lower for those who received at least one prenatal dental service compared to those who received no prenatal dental services.
- For *Births With Adequate Prenatal Care* and *Postpartum Ambulatory Care Utilization*, women who received at least one prenatal dental service had significantly higher rates compared to women who received no dental services.

#### Opportunities for Improvement

- Deliveries covered by FFS had low rates of receiving perinatal dental services for women 21 years of age and older.



### Foster Care 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 2021.

#### Strengths

##### Children in Foster Care

- 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 across all three measurement years (MY 2019, MY 2020, MY 2021).
- The SFY 2021–22 Child Welfare Focus Study found that 86.2% of new foster care members had a visit with a PCP within 30 days after or 90 days prior to entering foster care.
- Rate differences between children in foster care and the control group were greatest among dental measures, where the rates of annual dental visits, preventive dental services, oral evaluation, dental services, and topical fluoride among children in foster care were 14.2 to 19.0 percentage points higher than the rates for the control group.
- Rate differences between children in foster care and the control group for the *Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics* measure was 20.4 percentage points higher than the control group.
- Rate differences between children in foster care and the control group for the *Behavioral Health Encounters—CMH Services* indicator was 17.1 percentage points higher than the rates of the control group.
- For the *ED Visits* study indicator, the rate for children in foster care was 6.7 percentage points lower than the rate for the control group.
- 44% of new foster care members had a visit with a dental provider within 30 days after or 90 days prior to entering foster care, and most of these children also had a visit with a PCP.

##### Children Receiving Adoption Assistance

- Children receiving adoption assistance had higher rates than the control group for all six Oral Health domain study indicators, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Asthma Medication Ratio*, *Inpatient Visits*, and four out of six *Behavioral Health Encounters* study indicators.

##### Former Foster Care Members

- Former foster care members had higher rates of appropriate healthcare utilization than comparable control group for 64% of study indicators in MY 2021 compared to 45% of study indicators in MY 2020.

- Former foster care members had higher rates than controls for *Child and Adolescent Well-Care Visits*, all Oral Health domain study indicators, *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*, *Asthma Medication Ratio*, *ED Visits*, *Inpatient Visits*, and all *Behavioral Health Encounters* study indicators.
- 69.8% of members who aged out of foster care in the year prior to the measurement year had a visit with a PCP during the measurement year. 34.6% of members who aged out of foster care had a visit with a dental practitioner during the measurement year, and most of these members also had a visit with a PCP.

#### Opportunities for Improvement

##### Disparities

- Black or African American members were more likely to have a behavioral health encounter with ARTS compared to other racial groups, while White members were less likely, and members in the Other racial group were less likely to have a behavioral health encounter with therapeutic services.
- Black or African American members were more likely to have a well-care visit, oral evaluation, topical fluoride treatment, inpatient visit, and any behavioral health encounter except ARTS compared to other racial groups, while White members were less likely to have a well-care visit, oral evaluation, and any behavioral health encounter except ARTS and CMH services.

##### Children Receiving Adoption Assistance

- During MY 2021, children receiving adoption assistance had lower rates compared to the control group for the three Primary Care domain study indicators and most Behavioral Health domain study indicators, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*. The largest differences were for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* study indicator (by 15.3 percentage points) and the *Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up* study indicator (by 11.4 percentage points).
- Children receiving adoption assistance had higher rates of appropriate healthcare utilization than the comparable control group for 47% of study indicators in MY 2021 compared to 60% of study indicators in MY 2020.

##### Children in Foster Care

- During MY 2021, children in foster care had lower rates compared to the control group for four study indicators: *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *Ambulatory Care Visits*, *ED Visits*, and *Overall Service Utilization*.
- The largest declines from MY 2020 to MY 2021 were for the *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* indicator (by 8.7 percentage points), the *Annual Dental Visit* indicator (by 8.5 percentage points), and the *Preventive Dental Services* indicator (by 7.4 percentage points).

**Consumer Decision Support Tool**

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

**Consumer Decision Support Tool**

MCO	Overall Rating*	Doctors' Communication	Getting Care
Aetna	★★★★★	★★★★★	★★★★★
HealthKeepers	★★★★★	★★	★★★★★
Molina	★	★★★	★
Optima**	★★★★★	★★★★★	★★★
United	★★★★★	★	★★★

MCO	Keeping Kids Healthy	Living With Illness	Taking Care of Women
Aetna	★★★	★★★★★	★★★★★
HealthKeepers	★★★★★	★★	★★★★★
Molina	★	★	★
Optima**	★	★★★	★★★
United	★★★★★	★★★★★	★★★★★

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

\*\*Data for Optima also include data for members enrolled in VA Premier in 2022.