Commonwealth of Virginia
Department of
Medical Assistance Services

2023 External Quality Review Technical Report—Commonwealth Coordinated Care Plus (MLTSS)

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

VIRGINIA'S MEDICAID PROGRAM
DMAS
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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®,[1]	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CC	Community Coaching
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
CI	Confidence Interval
CIL	Center for Independent Living
CMH	Community Mental Health
CMHRS	Community Mental Health Rehabilitative Services
CMS	Centers for Medicare & Medicaid Services
CMU	Care Management Unit
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
CRMS	Care Management Solution
CSB	Community Services Board

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

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
DITP ..... Discrete Incentive Transitions Program
DMAS ..... Department of Medical Assistance Services
DNA ..... Deoxyribonucleic Acid
DOC ..... Department of Corrections
DSS ..... Department of Social Services
ED ..... Emergency Department
EDV ..... Encounter Data Validation
EDWS ..... Enterprise Data Warehouse System
EPS ..... Encounter Processing System
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
F/EA ..... Fiscal/Employer Agent
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
FICA ..... Federal Insurance Contributions Act
FIPS ..... Federal Information Processing Standards
FIT ..... Fecal Immunochemical Test
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®,[2] ..... Healthcare Effectiveness Data and Information Set
HHS ..... United States Department of Health and Human Services
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIV ..... Human Immunodeficiency Virus
HMO ..... Health Maintenance Organization

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

HPV ..... Human Papillomavirus
HRA ..... Health Risk Assessment
HSAG ..... Health Services Advisory Group, Inc.
I/DD ..... Intellectual and Developmental Disability
IACCT ..... Independent Assessment Certification and Coordination Team
ICT ..... Intensive Community Treatment
ID ..... Identification
IDSS ..... Interactive Data Submission System
IES ..... Individual Experience Survey
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
LANE ..... Lowest Acuity Non-emergent Emergency
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
LOCERI ..... Level of Care Review Instrument
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
MFT ..... Managed File Transfer
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
MRI ..... Magnetic Resonance Imaging
MRRV ..... Medical Record Review Validation
MY ..... Measurement Year
NA ..... Not Applicable
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/Expected
OB/GYN ..... Obstetrics and Gynecology
OBOT ..... Office-Based Opioid Treatment
OSR ..... Operational Systems Review
OTP ..... Opioid Treatment Program
OUD ..... Opioid Use Disorder
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Provider
PDI ..... Pediatric Quality Indicator
PDL ..... Preferred Drug List
PDSA ..... Plan-Do-Study-Act
PHA ..... Post-Hospital Assessment
PHE ..... Public Health Emergency
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PM ..... Performance Measure
PMV ..... Performance Measure Validation
PNC ..... Prenatal 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
SA	Service Authorization
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
SIS	Supports Intensity Scale
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
TCC	Transition of Care Coordinators
Tdap	Tetanus, Diphtheria Toxoids, and Acellular Pertussis
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 CMS.[1-1]

To meet this requirement, the Commonwealth of Virginia, DMAS, contracted with HSAG, as its EQRO, to perform the assessment and produce this report for EQR activities conducted during the period of January 1, 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 CCC Plus (MLTSS) program. 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 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 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 DMAS to ensure better continuity of care for members, operate with improved administrative efficiency,

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

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 CCC Plus (MLTSS) program. A comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each MCO are found in the results of each activity in sections 4 through 12 of this report and Section 13—Summary of MCO-Specific Strengths and Weaknesses. Detailed information about each activity's methodology is provided in Appendix B of this report. Table 1-2 identifies the EQR mandatory and optional activities included in this report.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities		
PIPs	The purpose of PIP validation is to validate PIPs that have the potential to affect and improve member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's PIP Summary Forms. These forms provided detailed information about the PIPs related to the steps completed and validated by HSAG for the 2023 validation cycle.	*Protocol 1.* Validation of Performance Improvement Projects
PMV	HSAG conducts the PMV for each MCO to assess the accuracy of PMs reported by the MCOs, determine the extent to which these measures follow State specifications and reporting requirements, and validate the data collection and	*Protocol 2.* Validation of Performance Measures

Activity	Description	CMS EQR Protocol
	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.	
Compliance With Medicaid and CHIP Managed Care Regulations	This activity determines the extent to which a Medicaid and CHIP MCO is in compliance with federal standards and associated state-specific requirements, when applicable. HSAG conducted full compliance reviews (called OSRs) that included all federal and state-specific requirements for the review period of July 1, 2021, through June 30, 2022.	*Protocol 3*. Review of Compliance with Medicaid and CHIP Managed Care Regulations
	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.	
Validation of Network Adequacy	The network adequacy validation activity validates MCO network adequacy using DMAS' network standards in its contracts with the MCOs. DMAS established time and distance standards for the following network provider types: primary care (adult and pediatric), OB/GYN, BH, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, and additional provider types that promote the objectives of the Medicaid program.	*Protocol 4*. Validation of Network Adequacy
Optional Activities		
EDV	HSAG conducts EDV, which includes an IS review/assessment of DMAS' and the MCOs' IS and processes to examine the extent to which DMAS' and the MCOs' IS infrastructures are likely to collect and process complete and accurate encounter data. HSAG also completes an administrative profile, which is an analysis of DMAS' electronic encounter data completeness, accuracy, and timeliness. This activity evaluates the extent to which the encounter data in DMAS' EPS database are complete, accurate, and submitted by the MCOs in a timely manner for encounters.	*Protocol 5.* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

Activity	Description	CMS EQR Protocol
CAHPS Analysis	This activity assesses member experience with an MCO and its providers and the quality of care members receive.	*Protocol 6.* Administration or Validation of Quality of Care Surveys
Calculation of Additional PMs	This activity calculates quality measures to evaluate the degree to which evidence-based treatment guidelines are followed, where indicated, and to assess the results of care. HSAG calculates one PM (selected by DMAS) for the Medicaid population stratified by geographic region and key demographic variables (race, gender, age, etc.).	*Protocol 7.* Calculation of Additional Performance Measures
ARTS Measurement Specification Development and Maintenance	HSAG identifies, when available, PMs from existing measure sets or develops PMs for the ARTS program.	*Protocol 7.* Calculation of Additional Performance Measures
Focus Studies	This activity provides information about the healthcare quality for a particular aspect of care across managed care in the Commonwealth or for subpopulations served by managed care within the Commonwealth. **Medicaid and CHIP Maternal and Child Health Focus Study**—HSAG conducts a focus study that provides quantitative information about PNC and associated birth outcomes among Medicaid recipients. **Child Welfare Focus Study**—HSAG conducts a Child Welfare Focus Study to evaluate healthcare utilization among children in foster care under the CCC Plus (MLTSS) program. **Dental Utilization in Pregnant Women Data Brief**—HSAG produces a data brief describing dental utilization among pregnant women enrolled in Medicaid.	*Protocol 9.* Conducting Focus Studies of Health Care Quality
Consumer Decision Support Tool	This activity provides information to help eligible members choose a Medicaid CCC Plus (MLTSS) 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	*Protocol 10.* Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans,

Activity	Description	CMS EQR Protocol
	healthcare quality and transparency and provide information to consumers to make informed decisions about their care within the CCC Plus (MLTSS) program. HSAG uses HEDIS and CAHPS data to compare MCOs to one another in key performance areas.	and Prepaid Ambulatory Health Plans
PWP	HSAG develops a methodology to calculate the MCO results for the PWP for DMAS. The 2023 PWP used HEDIS and non-HEDIS measures.	
QS Update	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.	Medicaid and CHIP Managed Care QS Toolkit

Virginia Managed Care Program Findings and Conclusions

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

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

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

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

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

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

Program Strengths		
Domain		**Conclusion**
	**Quality**	**Strength:** Overall, BH care and ARTS demonstrate a strength 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 demonstrated strength 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. **Strength:** Overall, the Maternal and Child Health focus study, FAMIS MOMS program results 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 outperforming 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 outperformed the national benchmarks in CY 2021. Additionally, the Medicaid Expansion

Program Strengths		
Domain		**Conclusion**
		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. **Strength:** The CCC Plus (MLTSS) program demonstrated strength in the Living With Illness domain. MCO performance showed strength 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. **Strength:** The CCC Plus (MLTSS) program also showed strengths within the Taking Care of Children domain. The MCOs demonstrated strength related to metabolic monitoring for children and adolescents on antipsychotics, as 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.
	**Access**	**Strength:** For the CCC Plus (MLTSS) program, the Child Welfare focus study demonstrated that children in foster care have higher rates of appropriate healthcare utilization than comparable controls (children not enrolled in child welfare systems) 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 20.8 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. **Strength:** The Child Welfare focus 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*

Program Strengths		
Domain		**Conclusion**
		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. The Child Welfare focus study results have some alignment with the CCC Plus (MLTSS) MCO PM results. The MCOs demonstrated strength within the Use of Opioids domain, as four of six MCOs' rates met or exceeded the 50th percentile for two of the three *Use of Opioids from Multiple Providers* PM indicators. Molina and VA Premier met or exceeded the 50th percentile for three of four (75.0 percent) measure rates that were compared to national benchmarks. Moreover, VA Premier had four of four (100.0 percent) of the measure rates exceeding the Virginia aggregate. **Strength:** An overall strength for the CCC Plus (MLTSS) program was found within the Access and Preventive Care domain. The MCOs demonstrated strength related to access to care, as all six MCOs' rates met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
+	**Timeliness**	**Strength:** CCC Plus (MLTSS) members' experience with receiving timely access to care and services was positive. 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.

Program Weaknesses		
Domain		**Conclusion**
−	**Quality**	Disparities were identified in the quality, accessibility, and timeliness of care and services for the CCC Plus (MLTSS) program members. 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

Program Weaknesses	
Domain	**Conclusion**
	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. The ARTS study and related PM results identify opportunities for the MCOs to focus interventions on reducing disparities in care and service delivery. **Weakness:** The ARTS study findings are supported by CCC Plus (MLTSS) PM results. Five of six MCOs' rates fell below the 50th percentile for the *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 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measures. **Weakness:** 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. **Weakness:** Members identified with chronic diseases within the CCC Plus (MLTSS) program also demonstrated opportunities for MCOs to improve receipt of recommended care and services. PM results indicate that 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.

Program Weaknesses		
Domain		**Conclusion**
–	**Access**	**Weakness:** The 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 have been 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 CCC Plus (MLTSS) PM results within the Behavioral Health domain. For *Follow-Up After Hospitalization for Mental Illness* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* PM indicators, none of the MCOs' rates met or exceeded the 50th percentile, reflecting an area of opportunity for improvement. This performance suggests that members have not received timely follow-up after hospitalizations for mental illness. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care. **Weakness:** The CCC Plus (MLTSS) program's 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*. The member experience survey results may indicate challenges in scheduling care and services with providers listed in MCO provider directories. The CCC Plus (MLTSS) PCP secret shopper survey revealed that overall, approximately 83 percent of providers 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 secret shopper survey 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 appointment, 16.0 percent were compliant with the one-day (i.e., 24 hours) standard for urgent primary care services. **Weakness:** The results of the CCC Plus (MLTSS) PCP secret shopper survey could indicate that members may not consistently have access

Program Weaknesses		
Domain		**Conclusion**
		to well-care and preventive services, resulting in lower rates in some MCO PM rates. For example, 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. This performance indicates members did not receive screenings according to recommended schedules.
–	**Timeliness**	**Weakness:** The CCC Plus (MLTSS) program's CAHPS 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for *Getting Care Quickly.* CCC Plus (MLTSS) PM results may align with the member experience survey results. Within the Taking Care of Children PM domain, all six MCOs have opportunities for improvement related to 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 indicator rates, as none of the MCOs' rates for these PM indicators met or exceeded 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. MCO performance is indicative of opportunities to increase PCP and OB/GYN assessment of children and adolescent BMI, counseling for nutrition, and counseling for physical activity.

Quality Strategy Recommendations for the Virginia Managed Care Program

The Virginia 2023–2025 QS is designed to improve the health outcomes of 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[1-2]

Program Recommendations	
Recommendation	**Associated Virginia 2023–2025 QS Objective, and Measure**
To improve program-wide performance in support **of Goal 5: Providing Whole-Person Care for Vulnerable Populations, Objective 5.1** and improve outcomes for members with chronic conditions, HSAG recommends that DMAS: • Work with MCOs to consider the health literacy of the population served and their capacity to obtain, process, and understand the need to manage and maintain their chronic conditions, 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 rates in controlling high blood pressure, including members diagnosed with diabetes. In addition, HSAG recommends that DMAS monitor the MCOs to ensure implementation of interventions that address disparities and reflect identified opportunities for improvement.	**Objective 5.1:** Improve Outcomes for Members With Chronic Conditions **Measure 5.1.1.5:** Controlling High Blood Pressure
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 consider the MCO opportunities related to measures within the Behavioral Health domain: • Work with the MCOs to identify best practices for ensuring follow-up care is completed for members hospitalized for mental illness. HSAG recommends that the MCOs identify and implement interventions based on completed root cause analyses which identified barriers their members experience in accessing care and services to monitor cardiovascular disease in members diagnosed with cardiovascular disease and schizophrenia. Additionally, HSAG recommends that MCOs evaluate providers' barriers to the use of first-line psychosocial care for children and adolescents on antipsychotics, then implement targeted interventions to address these barriers.	**Objective 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness **Measure 5.4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Measure 5.4.1.10:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
To improve the accuracy of provider information available to members in support of **Goal 4: Strengthen the Health of Families and Communities**, **Objectives 4.1** and **4.2** and	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members

[1-2] 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.

Program Recommendations	
improve accessibility 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 providers' 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 that the offices have a plan in place for educating new staff in the event of staff turnover.	**Measure 4.1.1.2:** Child and Adolescent Well-Care Visits **Measure 4.1.1.3:** Childhood Immunization Status **Measure 4.1.1.4:** Immunizations for Adolescents **Measure 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents **Objective 4.2:** Improve Outcomes for Maternal and Infant Members **Measure: 4.2.1.4:** Well-Child Visits in the First 30 Months of Life

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[2-1]

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
Total Served	2,194,813

**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. The Optima and VA Premier MCOs merged under the Optima name during CY 2023. The six MCOs contracted with DMAS on December 31, 2023, are displayed in Table 2-2.

Table 2-2—CCC Plus (MLTSS) 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 through 04/01/2024

[2-1] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Feb 20, 2024.

MCO	Profile Description	MCO NCQA Accreditation Status
HealthKeepers	HealthKeepers is a Virginia HMO affiliated with Anthem Blue Cross Blue Shield, a publicly owned, for-profit corporation that operates as a multistate healthcare company, headquartered in Indianapolis, Indiana.	Accredited* through 03/09/2024 Health Equity through 11/15/2025 Health Equity Plus through 08/25/2026 LTSS through 03/09/2024
Molina	Molina is a Medicaid/FAMIS Plus program offered by Molina Health, Inc., conducting business in Virginia since 1972. Molina is headquartered in Scottsdale, Arizona.	Accredited* through 11/01/2026 Electronic Clinical Data Health Equity through 02/20/2027 LTSS 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 Health Equity through 07/08/2025 LTSS 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.*[2-2]

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

[2-2] National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: Dec 12, 2023.

MCO CCC Plus (MLTSS) Enrollment Characteristics

Figure 2-1 through Figure 2-5 display the CCC Plus (MLTSS) program enrollment characteristics. Table 2-3 through

Table 2-7 display the MCO and CCC Plus (MLTSS) program overall enrollment characteristics. Data contained in these tables and figures are from DMAS' Cardinal Care Medicaid/FAMIS Enrollment dashboard.[2-3]

Figure 2-1—CCC Plus (MLTSS) Program CY 2023 MCO Eligibility Categories

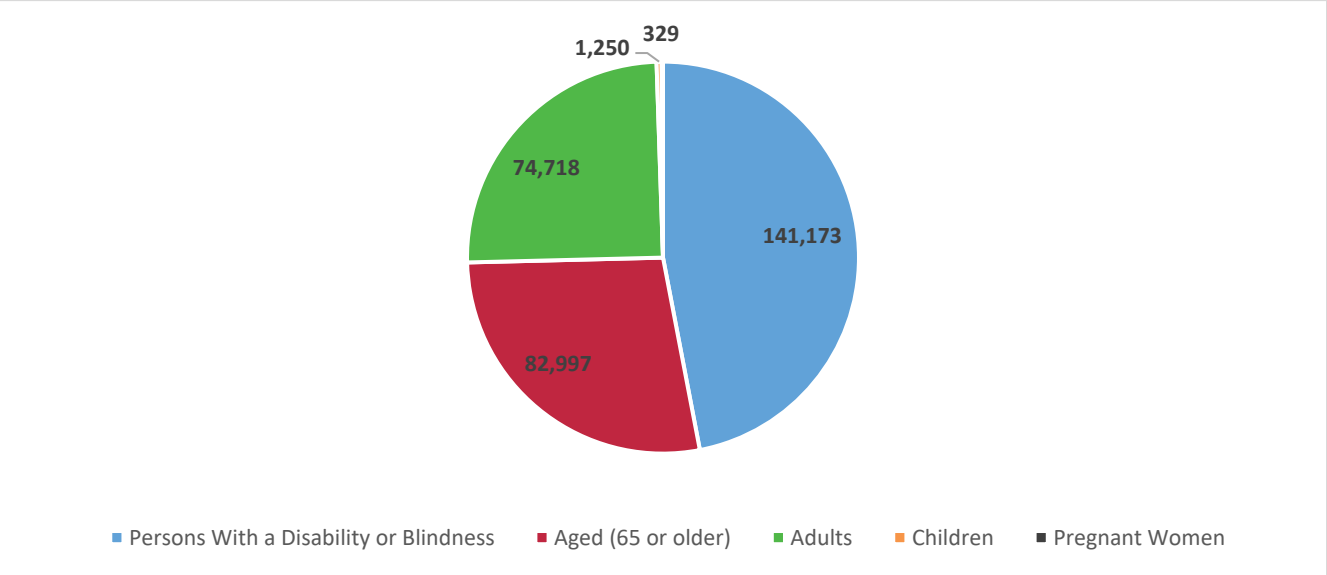


Table 2-3—CCC Plus (MLTSS) Program CY 2023 MCO Eligibility Categories[2-4]

Category	Aetna	HealthKeepers	Molina	Optima*	United	All
Overall Total	48,125	85,789	29,355	95,567	41,631	300,467
Persons With a Disability or Blindness	22,133	39,083	11,794	50,745	17,418	141,173
Aged (65 or older)	13,573	24,725	10,186	22,853	16,069	82,997
Adults	12,258	21,408	7,266	21,364	8,013	74,718
Children	112	500	56	512	70	1,250
Pregnant Women	49	73	53	93	61	329

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

2-3 Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 14, 2023.

2-4 Ibid.

Figure 2-2—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Race[2-5]

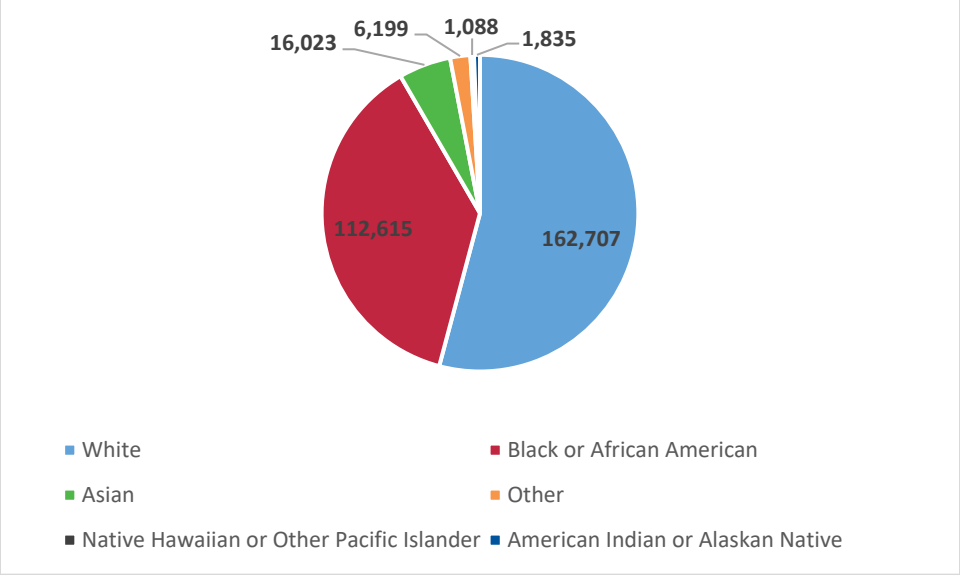


Table 2-4—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Race[2-6]

Category	Aetna	HealthKeepers	Molina	Optima	United	All
White	26,692	45,133	15,579	52,664	22,639	162,707
Black or African American	17,399	31,064	11,493	1,466	14,776	112,615
Asian	2,576	6,797	938	2,656	3.056	16,023
Other	1,000	1,898	1,038	1,532	731	6,199
Native Hawaiian or Other Pacific Islander	164	354	119	302	149	1,088
American Indian or Alaskan Native	294	543	188	530	280	1,835

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

2-5 Ibid.
2-6 Ibid.

Figure 2-3—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Ethnicity[2-7]

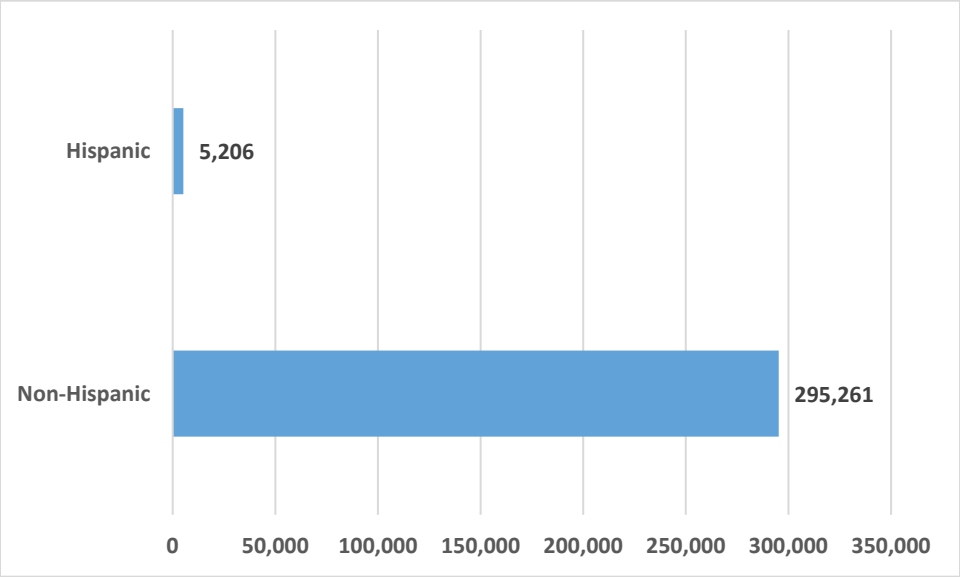


Table 2-5—CCC Plus (MLTSS) Program CY 2023 MCO Categories by Ethnicity[2-8]

Category	Aetna	HealthKeepers	Molina	Optima	United	All
Non-Hispanic	47,312	84,194	28,809	94,101	40,845	295,261
Hispanic	813	1,595	546	1,466	786	5,206

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

2-7 Ibid.
2-8 Ibid.

Figure 2-4—CCC Plus (MLTSS) Program CY 2023 MCO Percentage by Gender[2-9]

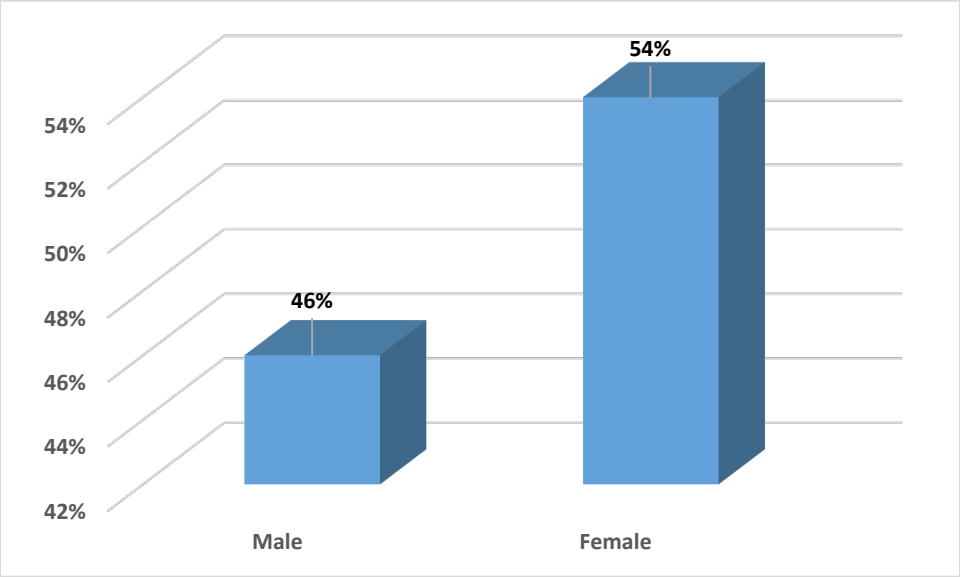


Table 2-6—CCC Plus (MLTSS) Program CY 2023 MCO Percentage by Gender[2-10]

Category	Aetna	HealthKeepers	Molina	Optima	United	All
Male	45%	45%	51%	46%	44%	46%
Female	55%	55%	49%	54%	56%	54%

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

2-9 Ibid.
2-10 Ibid.

Figure 2-5—CCC Plus (MLTSS) Program CY 2023 MCO Enrollment by Age Group[2-11]

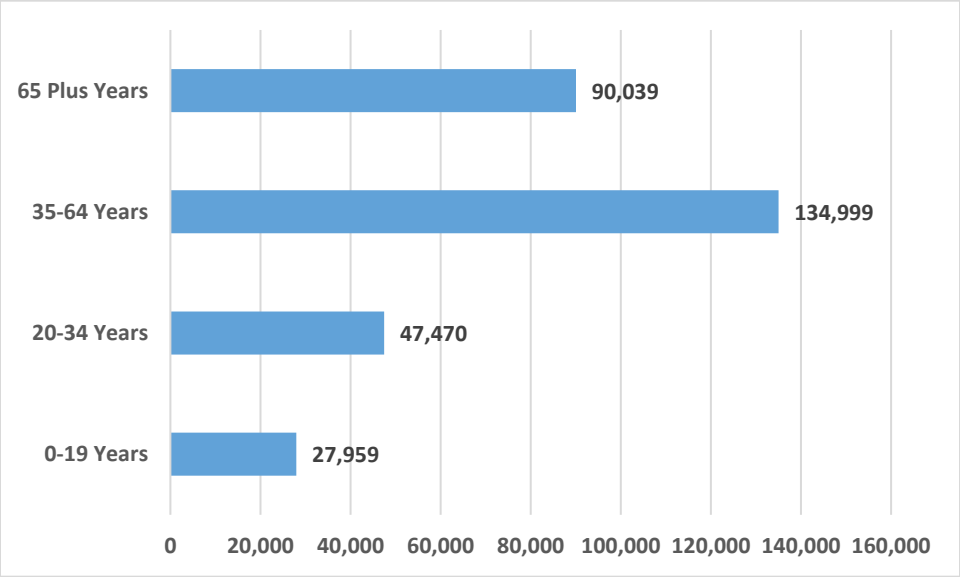


Table 2-7—CCC Plus (MLTSS) Program CY 2023 MCO Enrollment by Age Group[2-12]

Category	Aetna	HealthKeepers	Molina	Optima	United	All
0–19 Years	3,387	9,211	1,832	11,219	2,310	27,959
20–34 Years	7,249	13,774	5,470	15,903	5,074	47,470
35–64 Years	22,816	36,057	14,051	45,003	17,072	134,999
65+ Years	14,673	26,747	8,002	23,442	17,175	90,039

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

CCC Plus (MLTSS) Program

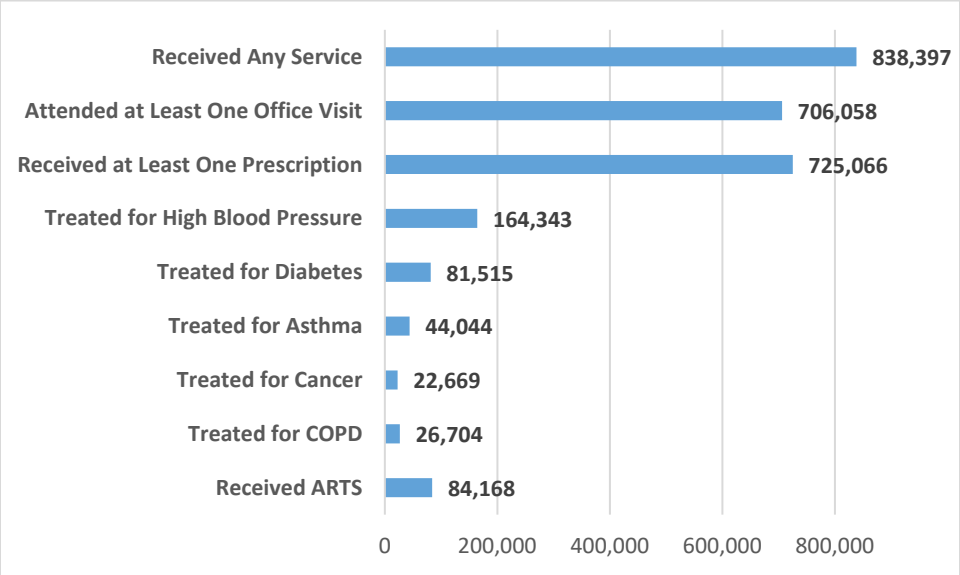
The CCC Plus (MLTSS) program's focus is to improve the quality of, access to, and efficiency of healthcare and services and supports for individuals residing in facilities and in-home and community-based settings. The CCC Plus (MLTSS) program approaches care delivery through a person-centered program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

Medicaid expansion coverage began in Virginia on January 1, 2019, and is administered through a comprehensive system of care. Medicaid expansion provides coverage for eligible individuals, including

2-11 Ibid.
2-12 Ibid.

adults ages 19 through 64 who are not Medicare eligible, who have income from 0 percent to 138 percent of the FPL, and who are not already eligible for a mandatory coverage group (i.e., children, caretaker adults, pregnant women, individuals over the age of 65, and individuals who are blind or have a disability). Males accounted for 46 percent of the Medicaid expansion population and 54 percent were female. Figure 2-6 displays services received by Medicaid expansion members since January 2019. Enrollment and service data were obtained from the August 1, 2023, Medicaid expansion data, which include all Medicaid program populations.[2-13] Data in Table 2-8 through Table 2-11 and Figure 2-6 through Figure 2-9 were obtained from the August 1, 2023, enrollment data.[2-14]

Figure 2-6—CY 2023 Medicaid Expansion Service Provision



[2-13] Ibid.

[2-14] 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: Feb 20, 2024.

Table 2-8—CY 2023 Medicaid Expansion Service Provision

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/

Figure 2-7—CY 2023 Medicaid Expansion Percentage by Age Category

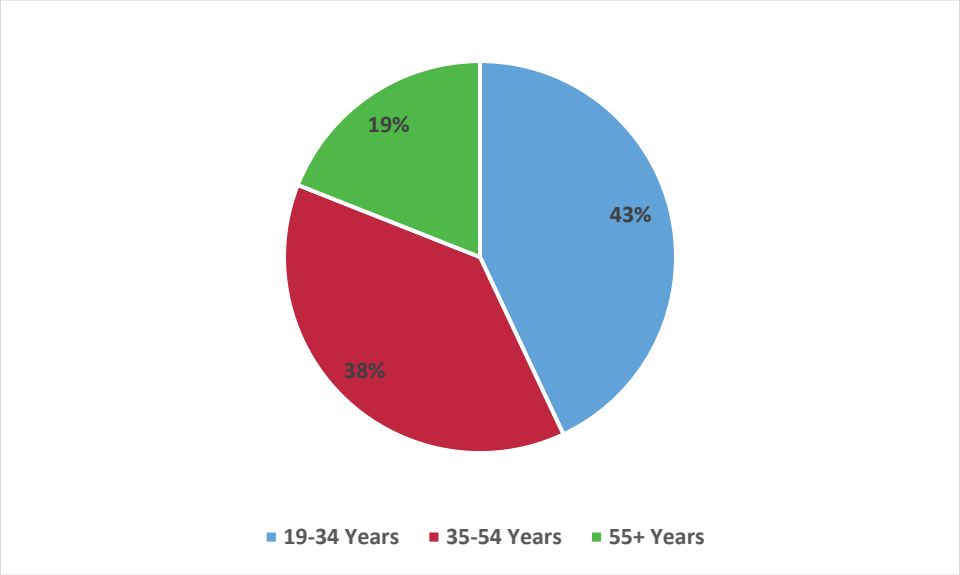


Table 2-9—CY 2023 Medicaid Expansion Percentage by Age Category

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

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

Figure 2-8—Medicaid Expansion Members by FPL Category

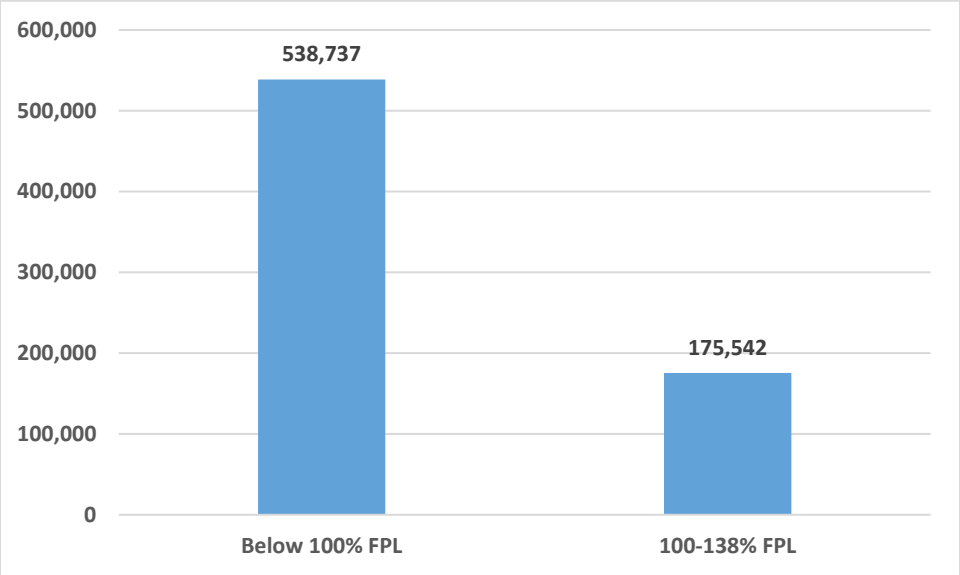


Table 2-10—Medicaid Expansion Members by FPL Category

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

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

Figure 2-9—Medicaid Expansion Members by Medicaid Region

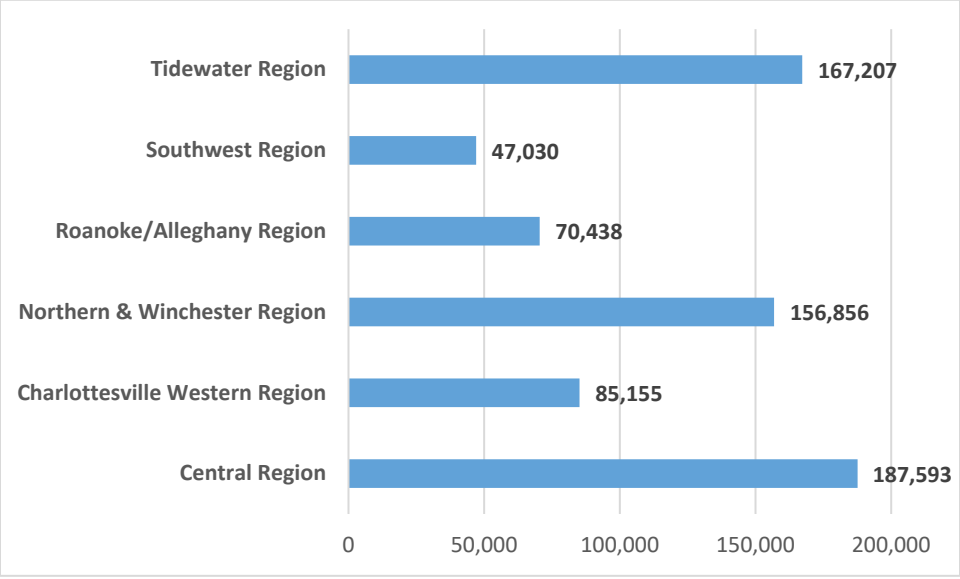


Table 2-11—Medicaid Expansion Members by Medicaid Region

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/

The CCC Plus (MLTSS) program is an integrated delivery model that includes physical health, BH and SUD services, and LTSS. The CCC Plus (MLTSS) program incentivizes community living and promotes innovation and value-based payment strategies. The CCC Plus (MLTSS) program priorities are displayed in Table 2-12.

Table 2-12—CCC Plus (MLTSS) Priorities

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

COVID-19 Response

The 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.

DMAS implemented flexibilities for care and services for members receiving LTSS in addition to the flexibilities allowed for all members. DMAS also allowed flexibilities for specific face-to-face visit requirements and other HCBS requirements. 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 2-13 describes the LTSS and other flexibilities allowed by DMAS during 2023.[2-15]

[2-15] Virginia Department of Medical Assistance Services. COVID-19 Response. Available at: https://www.dmas.virginia.gov/covid-19-response/. Accessed on: Dec 12, 2023.

Table 2-13—COVID-19 Flexibilities and Waivers[2-16]

Waivers
Members who received less than one service per month were not discharged from an HCBS waiver. Any member with a significant change that requested an increase in support due to changes in medical condition and/or changes in natural supports was required to have an in-person visit.
Legally responsible individuals (parents of children under age 18 and spouses) were allowed to provide personal care/personal assistance services for reimbursement. This flexibility was active until November 11, 2023.
Personal care, respite, and companion aides hired by an agency were permitted to provide services prior to receiving the standard 40-hour training. CE/CC was provided through video conferencing for individuals who had the technological resources and ability to participate with remote CE/CC staff via virtual platforms.
In-home support services were delivered via an electronic method or telehealth. Group day services were provided through video conferencing for individuals who had the technological resources and ability to participate with remote group day staff members via virtual platforms.
Reinstatement of requirements for waiver service providers and MCOs to perform visits face-to-face as required by regulations.
Residential providers were permitted to not comply with the HCBS settings requirement at 42 CFR §441.301(c)(4)(vi)(D) that individuals were able to have visitors of their choosing at any time.
Waived the requirements at 42 CFR §483.35(d) (with the exception of 42 CFR §483.35[d][1][i]), which required that an SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under 42 CFR §483.35(d).
Allowed beneficiaries to receive monthly monitoring when services were furnished on a less than monthly basis. This flexibility was active until November 11, 2023.
Appeals
For all appeals filed during the state of emergency, Medicaid members will automatically keep their coverage. This flexibility is continuing under a 1902(e)(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.

[2-16] Ibid.

Care and Services
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 the 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 permitted 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.
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 noncompliance 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 Agency'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 including appeals and EDI. 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 service authorization information, including dates of the health risk assessment and the completion of the individualized care plan. CRMS also houses level of care and preadmission screening documentation 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

Care coordination is the centerpiece of the CCC Plus (MLTSS) program. Every member is impacted in some way by care coordination. Each CCC Plus (MLTSS) member is assigned an MCO-dedicated care coordinator who works with the member and the member's provider(s) to ensure timely access to appropriate, high-quality care. The CCC Plus (MLTSS) model of care uses person-centered care coordination for all members, which involves using methods to identify, assess, and stratify certain populations; the model also uses comprehensive health risk assessments, individualized care planning, and interdisciplinary care team involvement to ensure competent care through seamless transitions between levels of care and care settings. DMAS care coordination requirements extend to all geographic areas, populations, and services within the managed care environment.

Training, Support, and Oversight of Care Coordination

The value of care coordination continues to demonstrate its worth with DMAS' most vulnerable members in the CCC Plus (MLTSS) program. The DMAS CMU continued to offer specialized training opportunities for the care coordinators. Topics were selected that related to DMAS projects, agency efforts, and identified care coordinator needs based on questions and concerns, and that supported member clinical needs as well as community resources. DMAS partnered with the Department on Aging to host several focus groups for the awareness and promotion of collaboration with the No Wrong Door program. Guest speakers included the Ombudsman and Advocacy Office, the Alzheimer's Association, and Virginia Housing experts. In addition, DMAS Integrated Care collaborated with other DMAS units regarding needed educational opportunities related to the waiver, screenings, BH, maternal and child health, and other areas as identified.

CMU continued to offer webinars twice a month for the CCC Plus (MLTSS) care coordinators. Depending on the urgency of the topic, and guest speakers' availability, more sessions could be offered each month. Webinar topics were carefully selected, and SMEs were invited to cover

certain topics that were helpful to the care coordinators in fulfilling the expectations of the CCC Plus (MLTSS) contract requirements. Many topics were related to waiver services and requirements but there were also topics that were more general such as BH resources, or crisis services and working with challenging members, etc. These webinars were scheduled weekly or less frequently depending on unit resources and needs. The following is a list of the ongoing efforts and resources provided for the continued development and success of the care coordinators:

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

Although these webinars were dedicated to CCC Plus (MLTSS) care coordinators, all MCO care coordinators, including Medallion 4.0 (Acute) staff members, were invited to attend as the topic applied to their requirements. Some topics were applicable for Medallion 4.0 (Acute) clinical staff members even if requirements differed between the two programs such as community resources, dealing with critically ill members, best practices, etc. Training topics and meeting agendas were emailed to over 750 care coordinators each week, with an average of 500 participants on each call. Training topics included:

- Care coordinator back to basics
- Federal Medicaid continuous coverage requirement: Resuming normal operations
- LOCERI CRMS (follow-up)
- DITP
- Critical incidents and care coordination follow-up
- DMAS Quality Strategy
- Multisystemic therapy and functional family therapy
- Communication, more than words
- IES implementation

- LTSS enrollment and disenrollment
- Prevention of falls
- LTSS screening
- CILs in Virginia
- Overview of the Children's Services Act
- Suicide awareness and prevention
- Celebrating and learning from care coordination
- Level of care review (LOCERI)
- Patient pay and DMAS-225 basics
- ARTS for the care coordinators
- Early intervention
- Virginia Navigator: a best-practice

The DMAS CMU continued to oversee care coordination provided through the MCOs and provide training and support to the MCO care coordinators.

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

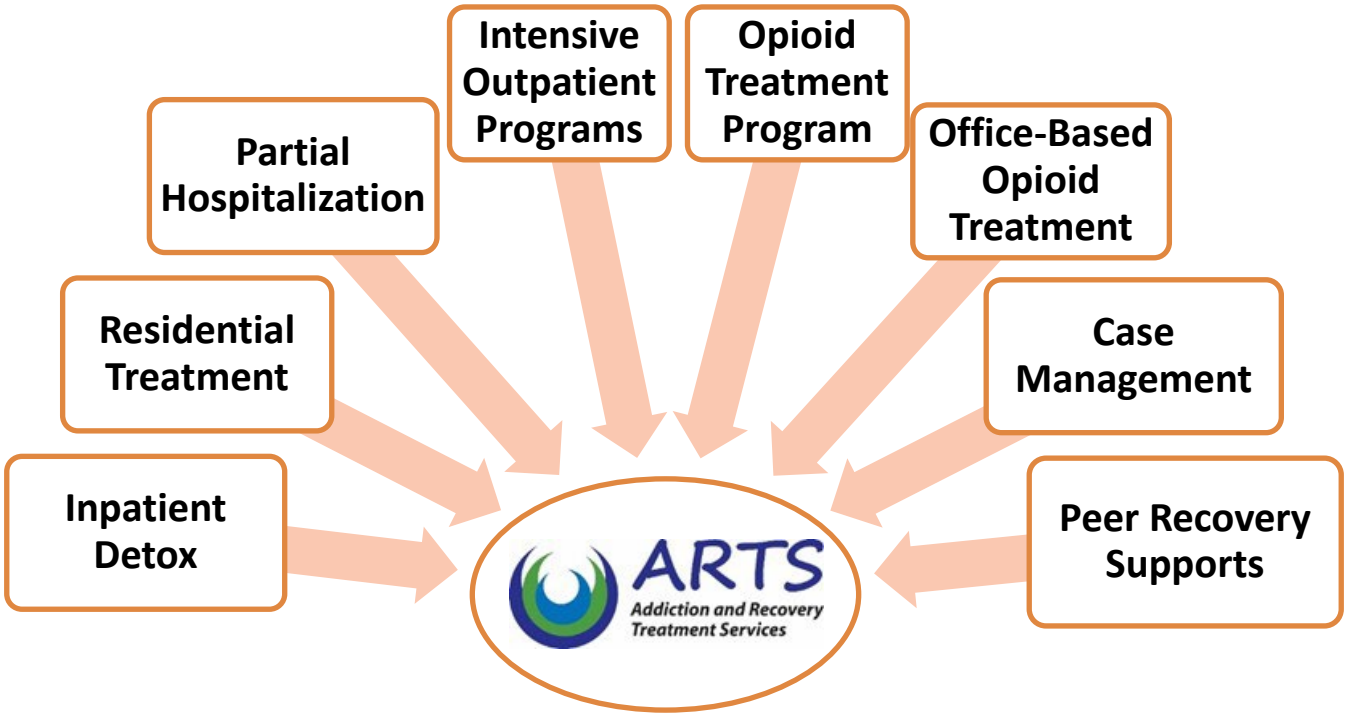
ARTS[2-17]

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

[2-17] 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.

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.



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).[2-18] 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:

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

[2-18] 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.

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).
- 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.

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 percentage change from 2019 through 2022 of buprenorphine waivered prescribers was 80.8 percent.

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 waivered prescribers was 80.8 percent. The rate of pharmacies with any prescription for buprenorphine increased 43.9 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 2-14 demonstrates the increase in ARTS providers by provider type.

Table 2-14—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

Addiction Provider Type	# of Providers Before ARTS (2017)	# of Providers in 2020	# of Providers in 2022
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 services 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).

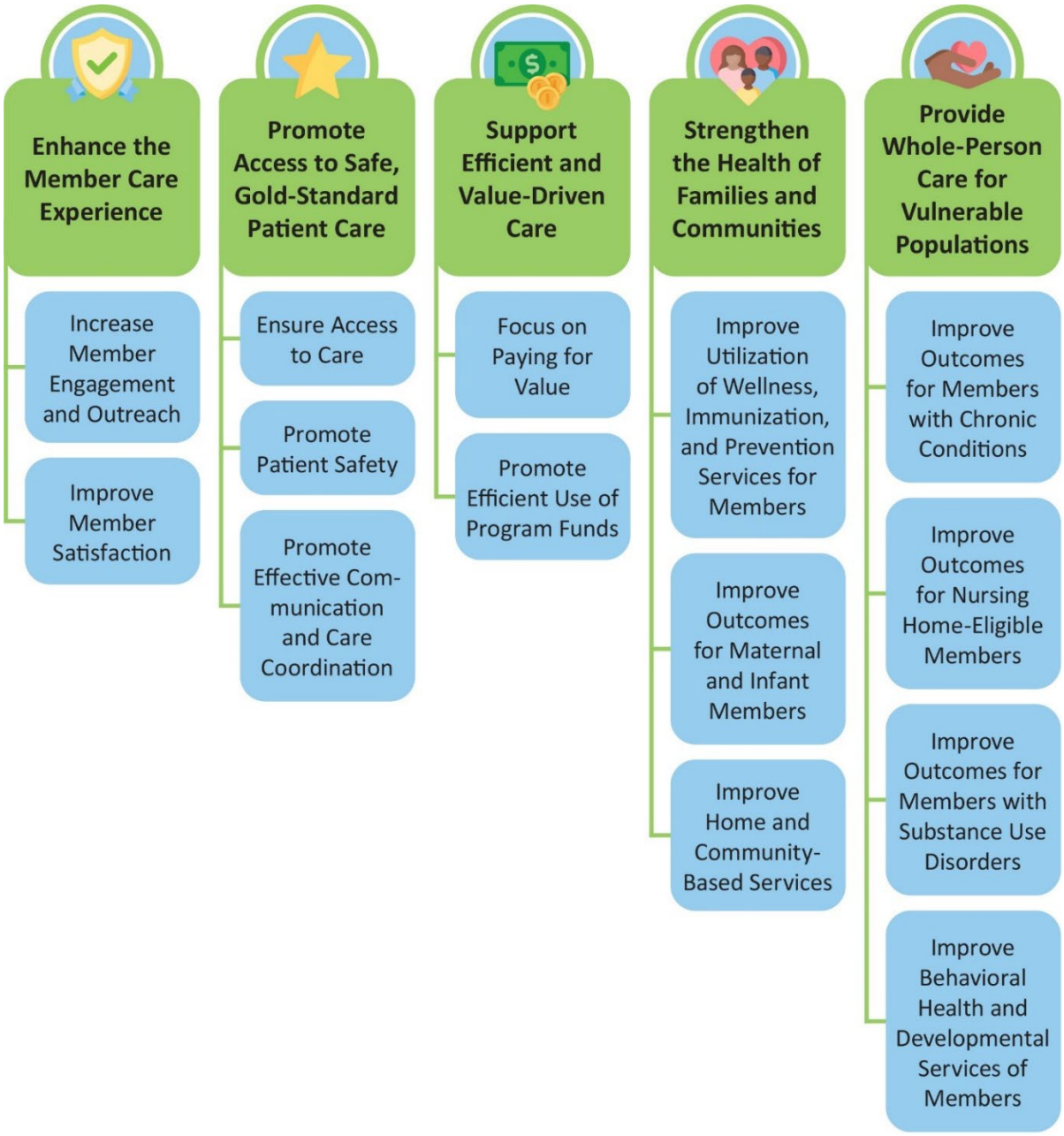
Between SFY 2020 and SFY 2021, the number of members with an ED visit increased. There were 45.4 SUD-related ED visits per 1,000 members in SFY 2021, a 5.6 percent increase from the prior year. Also, there were 9.7 OUD-related ED visits per 1,000 members in SFY 2021, a 15.5 percent increase from the 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 2-15 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 2-15—DMAS Quality Initiatives Driving Improvement

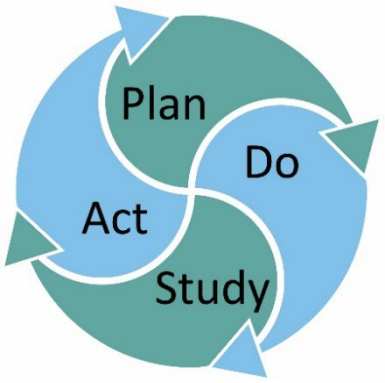
Virginia 2023–2025 QS Goal/Objective/Metric	DMAS Quality Initiative
Goal 5.: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders **Metric 5.3.1.2:** Follow-Up After Emergency Department Visit for Substance Use	DMAS was awarded 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.
Goal 5.: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders **Metric 5.3.1.2:** Follow-Up After Emergency Department Visit for Substance Use	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.

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

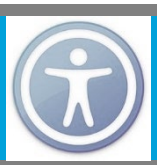
In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the CCC Plus (MLTSS) program.

Definitions

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

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.[1]



Access

CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2]

Timeliness

NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[3] NCQA further states that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care.

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

MCO Comparative and Statewide Aggregate PIP Results

PIP Highlights

In 2023, the MCOs continued the HEDIS-based DMAS-selected topics of *Ambulatory Care (AMB)—Emergency Department (ED) Visits* and *Follow-Up After Discharge* (following the *Transitions of Care—TRC*) specifications. 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	
+	Four of the six MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a *High Confidence* 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.
Weaknesses and Recommendations	
−	**Weakness:** Two of the six MCOs have opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and effectively evaluating the effectiveness of each individual intervention.
	Recommendations: The MCOs should ensure that all validation feedback is addressed. The MCOs should define the performance indicators correctly and ensure that the measurement data for the performance indicators are calculated and reported accurately. The MCOs should develop methodologically sound processes for evaluating the effectiveness of each intervention and ensure that the evaluation data are calculated and reported correctly in the PIP Submission Form. The MCOs should ensure that the status or next steps for each intervention are data-driven decisions.

Table 3-1—PIP Baseline Performance Results

	PIP Baseline Rate					
PIP Topic	**Aetna**	**Health Keepers**	**Molina**	**Optima**	**United**	**VA Premier**
AMB-ED Visits	1,083.05 visits/1,000 member years	8,141.9 visits/1,000 member years	675.72 visits/ 1,000 member years	1,000.32 visits/1,000 member years	1,152.54 visits/1,000 member years	62.41 visits/1,000 member years
Follow-Up After Discharge	64.39%	67.30%	63.27%	49.40%	70.34%	45.59%

MCO Comparative and Statewide Aggregate PMV Results

To evaluate the MCOs' managed care performance in Virginia, DMAS used a subset of HEDIS and non-HEDIS measures to track and trend MCO performance and to establish benchmarks for improving the health of MCO populations. To evaluate the accuracy of reported PM data, HSAG conducted, on a subset of PMs and all quality withhold measures, non-HEDIS PMV for the measurement period of January 1, 2022, through December 31, 2022. Table 3-2 highlights the overall strengths and weaknesses identified by PM domain.

PMV Highlights

The PMV highlights are included in Table 3-2.

Table 3-2—PM Strengths and Weaknesses

Domain	Strengths	Weaknesses
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.	All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures.
		Four of the six MCOs' rates fell below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measures.

Domain	Strengths	Weaknesses
Behavioral Health	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.	Five of the six MCOs' rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* measure. All six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* 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.
	Five of the six MCOs' rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measures met or exceeded the 50th percentile.	
Taking Care of Children	Five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total F*and *Blood Glucose and Cholesterol Testing—Total* PM indicators.	All six 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.
Living With Illness	MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing*	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.

Domain	Strengths	Weaknesses
	Cessation PM indicator, and five of six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* PM indicators.	
	Five of six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators.	
Use of Opioids	Four of six MCOs' rates met or exceeded the 50th percentile for *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* PM indicators.	Five of six MCOs' rates fell below the 50th percentile for *Use of Opioids from Multiple Providers—Multiple Prescribers* measure indicator.
		Three of six MCOs' rates fell below the 50th percentile for *Use of Opioids at High Dosage—Total* measure indicator.

To ensure that HEDIS rates were accurate and reliable, DMAS required each MCO to undergo an NCQA HEDIS Compliance Audit™.[3-1] Each MCO contracted with an NCQA LO to conduct the HEDIS audit. Additionally, HSAG reviewed the MCOs' FARs, IS compliance tools, and the IDSS files approved by each MCO's LO. HSAG found that the MCOs' IS and processes were compliant with the applicable IS standards and the HEDIS reporting requirements for the key CCC Plus (MLTSS) Medicaid measures for HEDIS MY 2022.

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

- *Blood Pressure Control for Patients With Diabetes*
- *Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*
- *Eye Exam for Patients With Diabetes*
- *Follow-Up After Emergency Department Visit for Substance Use*
- *Follow-Up After Emergency Department Visit for Mental Illness*
- *Heart Failure Admission Rate (Per 100,000 Member Months)*
- *Hemoglobin A1c Control for Patients With Diabetes*

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

- *Initiation and Engagement of Substance Use Disorder Treatment*

HSAG contracted with ALI Consulting Services, LLC, for assistance with the validation of the PMs listed above. Using the validation methodology and protocols described in Appendix B, HSAG validated results for each PM. The CMS PMV protocol identifies two possible validation designations for PMs: *Reportable (R)*—measure data were compliant with DMAS specifications, and the data were valid as reported; or *Do Not Report (DNR)*—measure data were materially biased. HSAG's validation results for each MCO are summarized in Table 3-3, with all rates validated as *Reportable (R)*.

Table 3-3—HSAG MCO PMV Results

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier
Blood Pressure Control for Patients With Diabetes						
Blood Pressure Control for Patients with Diabetes	58.88%	51.82%	41.36%	54.74%	68.37%	58.39%
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)*						
40–64 Years	39.00	69.72	73.41	82.03	94.68	75.30
65+ Years	26.82	75.77	66.21	81.24	87.58	69.24
Total	38.39	71.49	72.47	81.92	91.69	73.75
Eye Exam for Patients With Diabetes						
Eye Exam for Patients With Diabetes	53.04%	55.72%	39.90%	51.58%	62.04%	54.26%
Follow-Up After Emergency Department (ED) Visit for Substance Use						
7-Day Follow-Up—Total	35.47%	29.42%	25.26%	36.13%	26.74%	24.79%
30-Day Follow-Up—Total	49.90%	42.93%	36.48%	49.29%	42.92%	40.10%
Follow-Up After ED Visit for Mental Illness						
7-Day Follow-Up—Total	40.28%	42.94%	36.96%	40.39%	39.39%	37.62%
30-Day Follow-Up—Total	54.03%	59.00%	51.36%	53.72%	52.43%	55.13%
Heart Failure Admission Rate (Per 1000,000 Member Months)*						
18–64 Years	65.56	96.86	60.75	73.43	130.37	125.17
65+ Years	114.00	200.32	80.92	177.26	230.36	228.80
Total	76.00	117.37	62.38	82.86	163.69	143.46
Hemoglobin A1c (HbA1c) Control for Patients With Diabetes						
*HbA1c Poor Control (>9.0%)**	34.55%	37.71%	59.12%	52.31%	28.47%	41.12%
HbA1c Control (<8.0%)	55.96%	50.36%	35.04%	41.12%	62.77%	49.64%
Initiation and Engagement of Substance Use Disorder Treatment						
Initiation of IET—Total—Total	48.51%	52.13%	54.94%	47.98%	45.75%	49.47%
Engagement of IET—Total—Total	16.11%	16.23%	17.50%	14.80%	11.04%	16.39%

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

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

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

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

MCO Comparative and Statewide Aggregate HEDIS Results

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

Table 3-4 displays, by MCO, the HEDIS MY 2022 measure rate results compared to NCQA's Quality Compass®,[3-2] national Medicaid HMO percentiles for the HEDIS MY 2021 50th percentiles and the Virginia aggregate, which represents the average of all six MCOs' measure rates weighted by the eligible population. Gray-shaded boxes indicate MCO PM rates that were at or above the 50th percentile. Rates indicating better performance than the Virginia aggregate rates are represented in burgundy font.

Table 3-4—MCO Comparative and Virginia Aggregate HEDIS MY 2022 Measure Results

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Access and Preventive Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	**86.67%**	**89.06%**	77.67%	85.29%	**90.23%**	84.78%	**86.44%**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis							
Total	39.18%	43.63%	**57.87%**	**55.56%**	30.42%	**48.75%**	**45.65%**
Breast Cancer Screening							

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

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Total	**48.43%**	**51.16%**	43.00%	44.76%	**58.41%**	36.91%	**46.76%**
Cervical Cancer Screening							
Total	**47.93%**	**47.45%**	40.39%	**45.74%**	**45.50%**	42.58%	**45.47%**
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	**71.82%**	**82.14%**	63.79%	64.14%	68.57%	69.23%	**71.01%**
Postpartum Care	**61.82%**	**75.00%**	41.38%	53.03%	**67.14%**	54.40%	**60.20%**
Use of Imaging Studies for Low Back Pain							
Total	64.80%	65.20%	65.70%	**67.28%**	**67.19%**	**67.55%**	**66.26%**
Behavioral Health							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia							
Total	65.17%	66.22%	58.06%	**66.45%**	**69.44%**	**70.21%**	**66.36%**
Antidepressant Medication Management							
Effective Acute Phase Treatment	60.49%	61.62%	58.79%	60.57%	**67.12%**	**65.71%**	**62.36%**
Effective Continuation Phase Treatment	44.84%	**46.84%**	43.34%	44.66%	**51.65%**	**48.30%**	**46.70%**
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia							
Total	61.29%	**67.14%**	NA	60.87%	**73.53%**	63.64%	**64.60%**
Follow-Up After Emergency Department Visit for Substance Use							
7-Day Follow-Up—Total	**35.47%**	29.42%	25.26%	**36.13%**	26.74%	24.79%	**29.89%**
30-Day Follow-Up—Total	**49.90%**	42.93%	36.48%	**49.29%**	42.92%	40.10%	**43.85%**
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	**40.28%**	**42.94%**	36.96%	**40.39%**	39.39%	37.62%	**39.93%**
30-Day Follow-Up—Total	54.03%	**59.00%**	51.36%	53.72%	52.43%	**55.13%**	**54.90%**
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Total	**30.99%**	**33.57%**	22.14%	**32.13%**	**29.58%**	21.38%	**29.00%**
30-Day Follow-Up—Total	**52.56%**	**59.02%**	43.64%	**56.16%**	**54.55%**	41.02%	**52.02%**
Diagnosed Mental Health Disorders							
Total	**59.40%**	**57.99%**	54.74%	**57.75%**	54.43%	**57.45%**	**57.37%**
Diagnosed Substance Use Disorders							
Alcohol disorder—Total	**6.93%**	**6.53%**	**9.67%**	5.62%	6.15%	4.79%	**6.19%**

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Opioid disorder—Total	**6.65%**	**6.85%**	**8.93%**	4.64%	5.45%	**6.78%**	**6.31%**
Other or unspecified drugs—Total	**8.71%**	**8.15%**	**12.10%**	6.79%	7.21%	6.87%	**7.81%**
Any disorder—Total	**15.81%**	**15.09%**	**21.00%**	12.53%	13.91%	13.55%	**14.57%**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics							
Total	NA	35.71%	NA	36.25%	NA	**41.27%**	**37.18%**
Taking Care of Children							
Child and Adolescent Well-Care Visits							
Total	42.92%	**50.54%**	36.02%	43.36%	39.30%	39.54%	**44.15%**
Childhood Immunization Status							
Combination 3	NA	**68.47%**	NA	**73.97%**	NA	62.22%	**64.63%**
Immunizations for Adolescents							
Combination 1 (Meningococcal; Tetanus, Diphtheria Toxoids and Acellular Pertussis [Tdap])	**81.71%**	**83.94%**	73.45%	79.35%	71.43%	78.47%	**79.96%**
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	**32.93%**	**33.33%**	30.09%	29.97%	29.46%	28.47%	**30.96%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	**51.94%**	47.83%	**53.66%**	47.23%	**55.06%**	**56.81%**	**50.78%**
Cholesterol Testing—Total	**36.43%**	31.00%	**50.00%**	32.82%	**38.20%**	**38.34%**	**34.87%**
Blood Glucose and Cholesterol Testing—Total	**35.66%**	29.83%	**46.34%**	31.49%	**38.20%**	**37.41%**	**33.69%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
Body Mass Index (BMI) Percentile Documentation—Total	**71.53%**	**70.56%**	61.56%	63.75%	**72.75%**	66.67%	**67.97%**
Counseling for Nutrition—Total	**67.88%**	**64.23%**	47.45%	52.55%	**65.45%**	60.10%	**60.34%**
Counseling for Physical Activity—Total	**59.61%**	**54.99%**	40.15%	42.58%	**59.61%**	**52.80%**	**51.75%**
Well-Child Visits in the First 30 Months of Life							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	NA	**30.51%**	NA	NA	NA	NA	**18.66%**

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	**71.43%**	**70.95%**	NA	57.78%	NA	53.57%	**63.11%**
Living With Illness							
Asthma Medication Ratio							
Total	**71.47%**	**69.25%**	**74.73%**	63.37%	66.67%	**69.34%**	**68.30%**
Blood Pressure Control for Patients With Diabetes							
Total	**58.88%**	51.82%	41.36%	54.74%	**68.37%**	**58.39%**	**56.55%**
Eye Exam for Patients With Diabetes							
Total	53.04%	**55.72%**	39.90%	51.58%	**62.04%**	54.26%	**54.27%**
Hemoglobin A1c Control for Patients With Diabetes							
HbA1c Control (<8.0%)	**55.96%**	**50.36%**	35.04%	41.12%	**62.77%**	49.64%	**50.10%**
*HbA1c Poor Control (>9.0%)**	**34.55%**	**37.71%**	59.12%	52.31%	**28.47%**	41.12%	**40.72%**
Controlling High Blood Pressure							
Total	54.99%	52.07%	37.71%	51.58%	**67.88%**	**58.15%**	**55.31%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications							
Total	**83.56%**	82.04%	79.11%	80.20%	**85.18%**	**84.97%**	**82.49%**
Medical Assistance With Smoking and Tobacco Use Cessation							
Advising Smokers and Tobacco Users to Quit	**79.18%**	76.40%	77.83%	**84.49%**	74.39%	**81.25%**	**78.45%**
Discussing Cessation Medications	55.10%	**60.89%**	57.89%	**69.02%**	49.18%	**60.57%**	**57.94%**
Discussing Cessation Strategies	45.53%	**50.84%**	**46.70%**	**52.20%**	38.24%	**49.72%**	**45.96%**
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation							
Systemic Corticosteroid	**80.79%**	**68.67%**	**78.89%**	56.84%	**78.51%**	51.45%	**66.61%**
Bronchodilator	**85.88%**	**81.33%**	**87.41%**	67.60%	**86.74%**	61.31%	**76.29%**
Use of Opioids							
Use of Opioids at High Dosage*							
Total	**3.93%**	5.47%	8.48%	**4.99%**	5.76%	**4.48%**	**5.13%**
Use of Opioids from Multiple Providers*							
Multiple Prescribers	24.36%	**20.66%**	**18.12%**	25.63%	**19.48%**	**19.09%**	**21.29%**

Performance Measure	Aetna	Health Keepers	Molina	Optima	United	VA Premier	Virginia Aggregate
Multiple Pharmacies	3.68%	**1.53%**	**1.36%**	2.78%	**1.46%**	**1.78%**	**2.07%**
Multiple Prescribers and Multiple Pharmacies	2.81%	**1.16%**	**1.09%**	1.95%	**0.95%**	**1.39%**	**1.53%**
Utilization							
Ambulatory Care—Emergency Department (ED) Visits*							
Emergency Department (ED) Visits—Total	1,083.05	1,096.40	1,132.40	**1,063.44**	1,152.54	**1,017.40**	**1,079.89**
Initiation and Engagement of Substance Use Disorder Treatment							
Initiation of SUD Treatment	48.51%	**52.13%**	**54.94%**	47.98%	45.75%	49.47%	**49.83%**
Engagement of SUD Treatment	**16.11%**	**16.23%**	**17.50%**	14.80%	11.04%	**16.39%**	**15.42%**
Inpatient Utilization—General Hospital/Acute Care[1]							
Total Discharges per 1,000 Member Months (Total Inpatient)	159.67	196.12	191.05	211.67	229.10	239.13	**207.36**
Total Average Length of Stay (Total Inpatient)	7.27	7.53	6.73	7.71	7.20	7.09	**7.34**
Total Discharges per 1,000 Member Months (Medicine)	101.97	127.32	132.30	147.48	157.02	168.08	**140.84**
Total Average Length of Stay (Medicine)	5.95	6.20	5.78	6.64	5.77	5.66	**6.04**
Total Discharges per 1,000 Member Months (Surgery)	52.63	63.86	53.47	58.10	67.73	66.65	**61.49**
Total Average Length of Stay (Surgery)	10.21	10.48	9.40	10.88	10.78	10.92	**10.60**
Total Discharges per 1,000 Member Months (Maternity)	6.51	6.36	5.86	8.26	6.48	6.28	**6.73**
Total Average Length of Stay (Maternity)	3.29	3.50	3.38	3.44	3.24	4.10	**3.53**
Plan All-Cause Readmissions*							
Observed Readmissions	13.13%	12.76%	**11.11%**	**11.95%**	**11.07%**	**11.59%**	**12.08%**
O/E Ratio Total	1.0732	1.0547	**0.9344**	**0.9694**	**0.9059**	**0.9655**	**0.9956**

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

[1] Rates for utilization measures do not indicate better or worse performance and are displayed for information only. Therefore, comparisons to the 50th percentiles and Virginia aggregates were not performed.

NA indicates that the MCO followed the specifications, but the denominator was too small to report a valid rate.

Note: *MCO measure rates indicating better performance than the Virginia aggregate are represented in bold burgundy.*

Indicates that the HEDIS MY 2022 rate was at or above the 50th percentile.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Access and Preventive Care domain, the MCOs demonstrated strength related to access to care, as all six MCOs' rates met or exceeded the 50th percentile related to the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
+	The MCOs demonstrated strength within the Behavioral Health 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* PM indicators. In addition, follow-up care for BH conditions represented a strength, as five of six MCOs' rates met or exceeded the 50th percentile for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* PM indicators.
+	Within the Taking Care of Children domain, the MCOs demonstrated strength related to metabolic monitoring for children and adolescents on antipsychotics, as 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.
+	MCO performance within the Living With Illness domain showed strength 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. Aetna and United demonstrated the highest performance with nine of the 12 (75.0 percent) measure rates meeting or exceeding the 50th percentile.
+	The MCOs demonstrated strength within the Use of Opioids domain, as four of six MCOs' rates met or exceeded the 50th percentile for two of the three *Use of Opioids from Multiple Providers* PM indicators. Molina and VA Premier met or exceeded the 50th percentile for three of four (75.0 percent) measure rates that were compared to national benchmarks. Moreover, VA Premier had four of four (100.0 percent) of the measure rates exceeding the Virginia aggregate.
Weaknesses and Recommendations	
−	**Weakness:** 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—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. Aetna, HealthKeepers, and VA Premier demonstrated the lowest performance in the Access and Preventive Care domain, falling below the 50th percentile for six of seven (85.7 percent) measure rates within the domain. This performance

Weaknesses and Recommendations	
	indicates members did not receive screenings according to recommended schedules. Cancer screening can improve outcomes and early detection, reduce the risk of dying, and lead to a greater range of treatment options and lower healthcare costs.[3-3] Prolonged delays in screening may lead to delayed diagnoses, poor health consequences, and an increase in cancer disparities among women already experiencing health inequities.[3-4] MCO performance suggests that members are not receiving timely prenatal care and postpartum care, which can reduce the risk of pregnancy complications. Timely and adequate prenatal care and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants.[3-5] Evidence shows that unnecessary or routine imaging (x-ray, MRI, CT scans) for low back pain is not associated with improved outcomes. It also exposes patients to unnecessary harm, such as radiation and further unnecessary treatment. MCO performance suggests members did not consistently receive appropriate treatment for low back pain. Avoiding imaging for patients when there is no indication of an underlying condition can prevent unnecessary harm and unintended consequences to patients and can reduce healthcare costs.[3-6]
	Recommendations: HSAG recommends that the MCOs consider the health literacy of the population served and their capacity to obtain, process, and understand the need to complete recommended cancer screenings and to make appropriate health decisions. 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. Additionally, HSAG recommends the MCOs analyze the factors that contributed to the higher usage of imaging studies when not clinically appropriate for a particular age group, ZIP Code, etc. HSAG recommends that the MCOs implement appropriate interventions to increase screening rates, improve pregnancy care, and reduce unnecessary low back pain-related imaging studies due to the low rates for the four measures.
–	**Weakness:** Within the Behavioral Health domain, for *Follow-Up After Hospitalization for Mental Illness* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* PM indicators, none of the MCOs' rates met or exceeded the 50th percentile, reflecting an area of opportunity for improvement.

[3-3] National Committee for Quality Assurance. Breast Cancer Screening. Available at: https://www.ncqa.org/hedis/measures/breast-cancer-screening/. Accessed on: Dec 27, 2023.
[3-4] 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. Accessed on: Nov 8, 2023.
[3-5] National Committee for Quality Assurance. Prenatal and Postpartum Care. Available at: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/. Accessed on: Oct 27, 2023.
[3-6] National Committee for Quality Assurance. Use of Imaging Studies for Low Back Pain. Available at: https://www.ncqa.org/hedis/measures/use-of-imaging-studies-for-low-back-pain/. Accessed on: Oct 27, 2023.

Weaknesses and Recommendations	
	This performance suggests members have not received timely follow-up after hospitalizations for mental illness. Individuals hospitalized for mental health disorders often do not receive adequate follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes and decrease the likelihood of re-hospitalization and the overall cost of outpatient care.[3-7] Additionally, MCO performance related to the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure indicator demonstrates that first-line psychosocial interventions were underutilized which may result in children and adolescents incurring unnecessary risks associated with antipsychotic medications.[3-8]
	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[3-9] materials to identify potential new strategies to increase member access, engage providers, and leverage data to ensure members receive timely follow-up care. Furthermore, HSAG recommends that the MCOs identify factors contributing to underutilization of first-line psychosocial interventions for children and adolescents. Based on these factors, MCOs should leverage their annual QAPIs to determine appropriate areas of focus to improve the utilization of such interventions, and to track the effectiveness of programs the MCOs implement to improve in this area.
−	**Weakness:** Within the Taking Care of Children domain, all six MCOs have opportunities for improvement related to 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 indicator rates, as none of the MCOs' rates for these PM indicators met or exceeded the 50th percentile. Vaccines are a safe and effective way to protect adolescents against potential deadly diseases.[3-10] 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

3-7 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: Oct 27, 2023.

3-8 National Committee for Quality Assurance. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Available at: https://www.ncqa.org/hedis/measures/use-of-first-line-psychosocial-care-for-children-and-adolescents-on-anti-psychotics/ Accessed on: Dec 13, 2023.

3-9 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.

3-10 National Committee for Quality Assurance. Immunizations for Adolescents. Available at: https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/. Accessed on: Oct 27, 2023.

Weaknesses and Recommendations	
	vaccines at a rate in line with national benchmarks. CDC has identified significant increases in childhood obesity over the last three decades, and research shows that monitoring of weight problems in children and adolescents is important to reduce risks of becoming obese and developing related diseases.[3-11] MCO performance is indicative of opportunities to increase PCP and OB/GYN assessment of children and adolescent BMI, counseling for nutrition, and counseling for physical activity.
	Recommendations: Considering the recurring MCO opportunities related to measures within the Taking Care of Children domain, HSAG continues to recommend that the MCOs 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, MCOs should evaluate providers' barriers to completing BMI assessments, counseling for nutrition, and counseling for physical activity, then implement targeted interventions to address these barriers.
	**Weakness:** Within the Living With Illness 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* PM indicators, reflecting areas of opportunity for improvement. Proper diabetes management is essential to control blood glucose, reduce risks for complications, and prolong life. With support from healthcare providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, and being physically active.[3-12] Uncontrolled hypertension increases individuals' risk of heart disease and stroke, which are the leading causes of death in the United States.[3-13,3-14] MCO performance below the 50th percentile indicates some members with diabetes and hypertension are not receiving appropriate care to support optimal health.
	Recommendations: HSAG recommends that the MCOs evaluate the impact of interventions from the prior year, which led to improved outcomes for members with diabetes and hypertension, then consider the potential to expand these successful interventions to support members in better managing both chronic conditions. MCOs may also consider enhancing provider education, leveraging the American Diabetes Association *2022 Focus on Diabetes Impact Report*[3-15] as a resource.

[3-11] National Committee for Quality Assurance. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC). Available at: https://www.ncqa.org/hedis/measures/weight-assessment-and-counseling-for-nutrition-and-physical-activity-for-children-adolescents/. Accessed on: Dec 13, 2023.

[3-12] National Committee for Quality Assurance. Comprehensive Diabetes Care. Available at: https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/. Accessed on: Dec 20, 2023.

[3-13] Fryar CD, Ostchega Y, Hales CM, et al. Hypertension Prevalence and Control Among Adults: United States, 2015–2016. NCHS Data Brief. 2017;(289):1-8. National Center for Health Statistics.

[3-14] Kochanek KD, Murphy SL, Xu J,et al. Deaths: Final Data for 2017. National Vital Statistics Reports, 68(9). Hyattsville, MD: National Center for Health Statistics; 2019.

[3-15] 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. Accessed on: Dec 12, 2023.

Weaknesses and Recommendations	
–	**Weakness:** Five of six MCOs' rates fell below the 50th percentile for the *Use of Opioids from Multiple Providers—Multiple Prescribers* measure indicator, reflecting an area for improvement. Studies show that individuals who receive opioids from four or more prescribers or pharmacies have a higher likelihood of opioid-related overdose death than those who receive opioids from one prescriber or one physician.[3-16] MCO performance is indicative of opportunities for providers and pharmacies to coordinate care to better manage opioid prescribing patterns.
	Recommendations: HSAG continues to recommend that the MCOs conduct a root cause analysis or focus study to determine why there is a higher proportion of members receiving prescriptions for opioids from multiple prescribers. Upon identification of a root cause, HSAG recommends that the MCOs implement appropriate interventions to help reduce the proportion of members who may be considered high risk for opioid overuse and misuse. MCOs should consider tracking all interventions and progress toward improvement, within their annual QAPIs.

Compliance With Standards Monitoring

DMAS conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2021, HSAG conducted MCO compliance review activities for the CCC Plus (MLTSS) program. During 2022, DMAS monitored the MCOs' implementation of federal and Commonwealth requirements and CAPs from the 2021 compliance reviews.

Operational Systems Reviews

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	Overall Score
I.	438.56	Enrollment and Disenrollment: Requirements and Limitations*	100%	100%	100%	100%	100%	85.7%	97.6%
II.	438.100 438.224	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%

[3-16] National Committee for Quality Assurance. Use of Opioids from Multiple Providers. Available at: https://www.ncqa.org/hedis/measures/use-of-opioids-from-multiple-providers/. Accessed on: Oct 27, 2023.

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
V.	438.206 438.207	Assurance of Adequate Capacity and Availability of Services	77.8%	72.2%	77.8%	61.1%	83.3%	50.0%	70.4%
VI.	438.208	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
VII.	438.210	Coverage and Authorization of Services	100%	100%	95.0%	95.0%	100%	100%	98.3%
VIII.	438.214	Provider Selection	100%	100%	100%	100%	100%	100%	100%
IX.	438.230	Subcontractual Relationships and Delegation	75.0%	100%	100%	75.0%	50.0%	75.0%	79.2%
X.	438.236	Practice Guidelines	100%	100%	100%	100%	100%	100%	100%
XI.	438.242	Health Information Systems**	100%	100%	100%	100%	100%	100%	100%
XII.	438.330	Quality Assessment and Performance Improvement	100%	66.7%	100%	83.3%	100%	100%	91.7%
XIII	438.228	Grievance and Appeal Systems	86.2%	82.8%	86.2%	96.6%	93.1%	75.9%	86.8%
XIV.	438.608	Program Integrity	100%	100%	100%	100%	100%	100%	100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services	62.5%	62.5%	62.5%	87.5%	87.5%	62.5%	70.8%
TOTAL SCORE			**92.2%**	**91.0%**	**92.2%**	**92.2%**	**95.2%**	**86.2%**	**91.5%**

** Added in the 2020 Medicaid Managed Care Rule effective December 14, 2020.*

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia *2022 External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

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.[3-17] 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 Rules 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
OSR Results*									
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 and Availability of Services	100%	100%	100%	100%	100%	100%	100%

[3-17] Medicaid and CHIP Managed Care Final Rules. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on: Dec 15, 2023.

Standard	CFR	Standard Name	Aetna	HealthKeepers	Molina	Optima	United	VA Premier	Overall Score
OSR Results*									
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%
		OSR Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Readiness Review Results**									
Network Adequacy			95.0%	95.0%	100%	95.0	90.0%	90.0%	94.2%
Model of Care			100%	100%	100%	100%	98.1%	100%	99.7%
Organizational Structure, Operations, and Systems			100%	100%	100%	100%	100%	100%	100%
		Readiness Review Total	**99.2%**	**99.2%**	**100%**	**99.2%**	**97.0%**	**98.5%**	
Readiness Review CAP Review Results									
Phase I CAP Review Results			100%	100%	100%	100%	100%	100%	100%
Phase II CAP Review Results			100%	100%	100%	100%	100%	100%	100%
Phase III CAP Review Results			100%	100%	100%	100%	100%	100%	100%
		Comprehensive Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

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*.
*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).[3-18] 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.

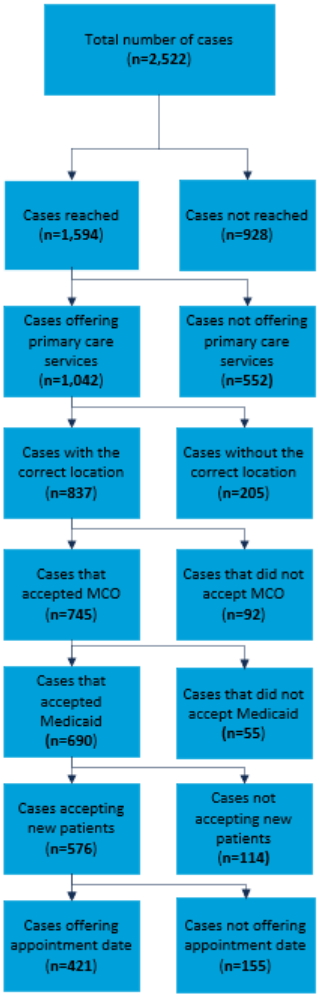
[3-18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 15, 2023.

Primary Care Provider Secret Shopper Surveys

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 3-1.

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

MCO	Denominator[1]	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%
MCO Total	**1,594**	**46.7%**	**43.3%**	**36.1%**

[1] The denominator includes cases responding to the survey.

As shown in Figure 3-2 and Figure 3-3, 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 3-2—New Patient Appointment Availability

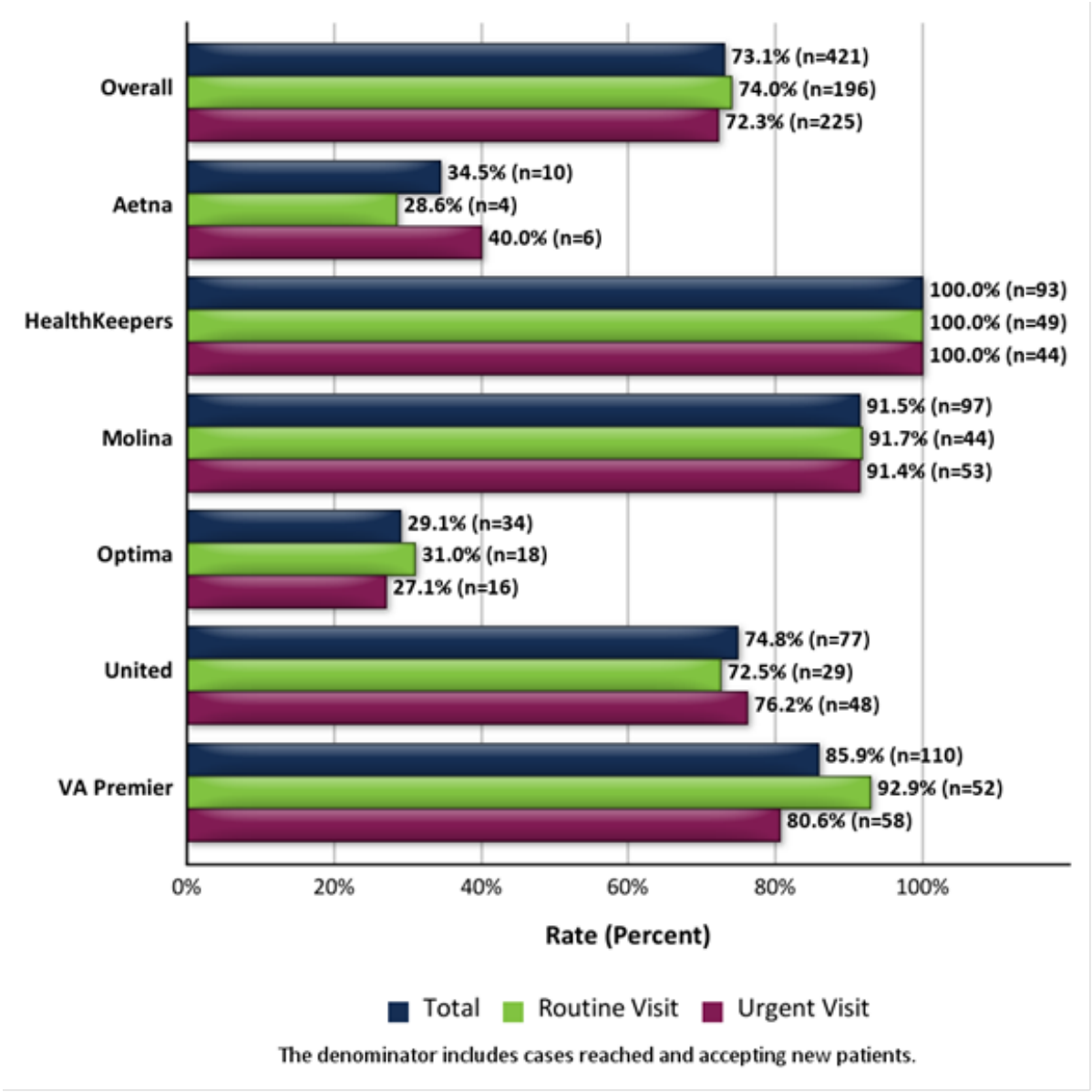
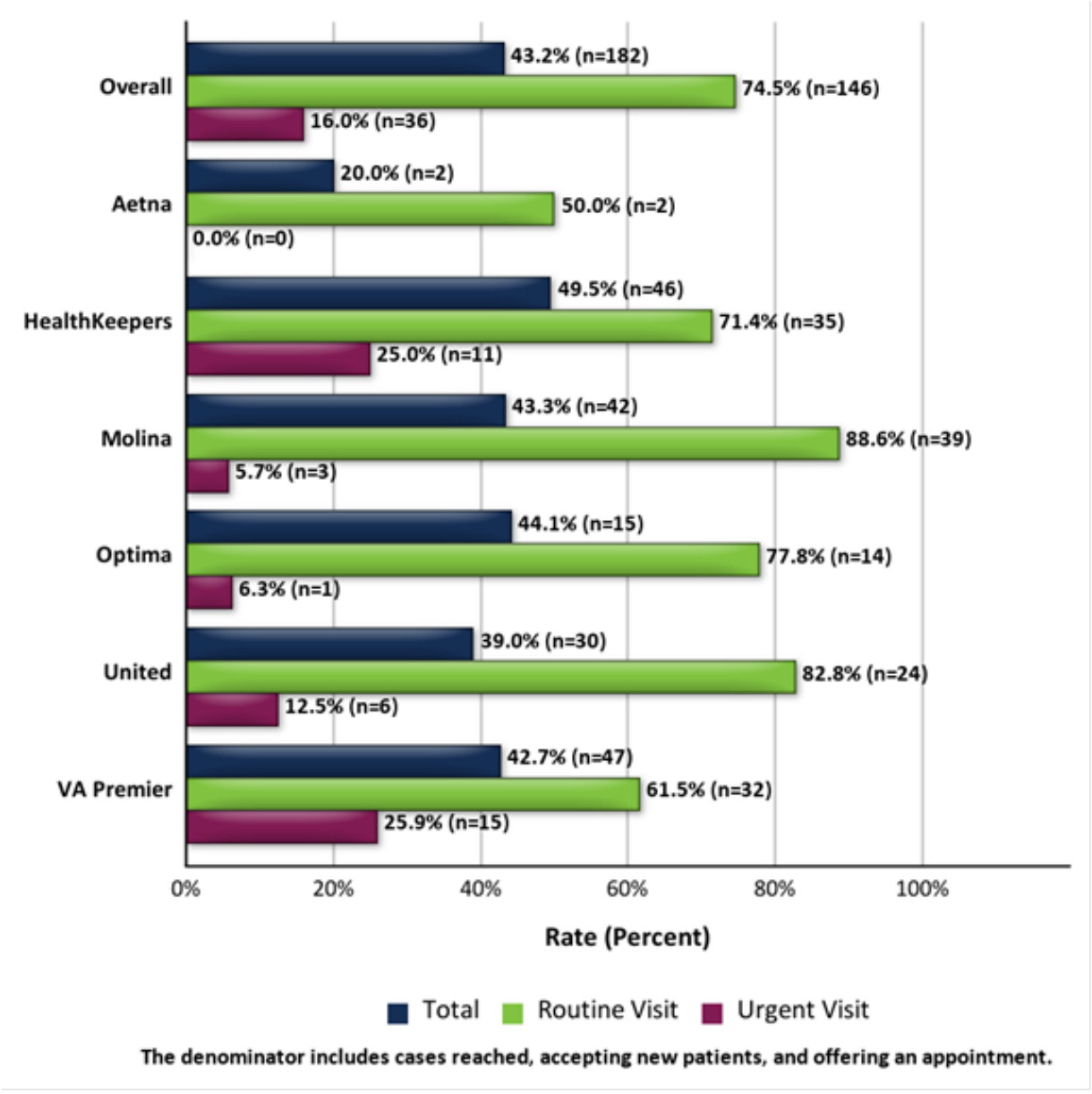


Figure 3-3—Appointments Meeting Compliance Standards



Strengths, Weaknesses, and Recommendations

Weaknesses and Recommendations	
–	**Weakness:** 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.
	Recommendations: 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.
Weaknesses and Recommendations	
–	**Weakness:** 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.
	Recommendations: 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.

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.

Other Surveys Conducted

DMAS also conducted the following member experience surveys:

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

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

Statewide Aggregate CAHPS Results

Adult Medicaid

Table 3-8 and Table 3-9 present the 2023 top-box scores for each MCO and the CCC Plus (MLTSS) 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 CCC Plus (MLTSS) program were also compared to the 2022 NCQA adult Medicaid national averages.

Table 3-8—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*
CCC Plus (MLTSS) Program	66.6%	65.4%	58.8%	58.0%	70.5%	71.8%	72.6%	68.9%
Aetna	63.2%	67.8%	53.6%	51.5%	68.1%	68.1%	73.4%	71.1%
HealthKeepers	67.8%	67.0%	61.5%	59.5%	69.2%	73.2%	74.5%	66.7%
Molina	56.9%	61.5%	56.5%	56.2%	70.4%	67.9%	69.5%	68.1%
Optima	69.1%	68.1%	63.1%	61.8%	72.3%	75.7%	77.7%	74.4%
United	68.0%	63.8%	56.5%	62.8%	69.7%	69.8%	66.9%	68.3%
VA Premier	67.4%	60.7%	56.3%	55.9%	72.0%	70.9%	67.6%	64.8%

+ 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.

Table 3-9—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*
CCC Plus (MLTSS) Program	85.7%	83.3%	85.8%	82.6%▼	93.1%	93.4%	90.4%	91.2%
Aetna	82.6%	80.5%	82.4%	83.1%	92.7%	93.8%	89.1%	87.4%
HealthKeepers	86.0%	82.5%	85.1%	84.9%	92.8%	94.9%	90.6%	93.3%
Molina	84.4%	81.1%	80.8%	77.2%	91.6%	91.0%	87.9%	86.2%
Optima	84.5%	86.2%	86.5%	84.8%	94.7%	92.7%	92.8%	92.6%
United	81.9%	84.5%	81.7%	81.7%	93.2%	93.5%	90.8%	87.8%
VA Premier	90.1%	83.6%▼	90.6%	79.2%▼	92.5%	92.7%	89.5%	93.0%

+ 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.

Strengths, Weaknesses, and Recommendations

Strengths	
+	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*.
+	Aetna's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for *Rating of Health Plan*.
+	HealthKeepers' 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for *Getting Care Quickly* and *Customer Service*.
+	Optima's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly,* and *Customer Service*.
+	United's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Rating of All Health Care*.
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Customer Service*.

Weaknesses and Recommendations	
−	**Weakness:** VA Premier's 2023 top-box score was statistically significantly lower than the 2022 top-box score for *Getting Needed Care*.
−	**Weakness:** The 2023 top-box scores for the CCC Plus (MLTSS) program and VA Premier were statistically significantly lower than the 2022 top-box scores for *Getting Care Quickly.*
	Recommendations: HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that the MCOs continue to monitor the measures to ensure significant decreases in scores over time do not continue to occur.

Child Medicaid

Table 3-10 and Table 3-11 present the 2023 top-box scores for each MCO and the CCC Plus (MLTSS) 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 CCC Plus (MLTSS) program were also compared to the 2022 NCQA child Medicaid national averages.

Table 3-10—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
CCC Plus (MLTSS) Program	65.6%	65.5%	66.1%	63.9%	75.6%	75.8%	72.3%	72.4%
Aetna	66.1%	63.9%	62.5%	62.3%	73.1%	72.6%	64.5%	69.2%
HealthKeepers	65.9%	65.3%	63.9%	60.4%	72.3%	70.4%	71.1%	71.4%
Molina	45.2%+	59.0%+	66.7%+	56.5%+	76.2%+	60.6%+	75.0%+	60.0%+
Optima	70.2%	68.8%	70.8%	66.2%	81.6%	81.4%	75.0%	75.5%
United	65.0%	62.5%	65.2%+	70.3%+	78.6%+	78.8%+	83.7%+	76.1%+
VA Premier	67.0%	65.9%	66.0%	68.0%	74.2%	82.8%▲	70.7%	74.3%

+ 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 3-11—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
CCC Plus (MLTSS) Program	84.3%	83.3%	87.6%	85.6%	93.8%	94.7%	87.2%	88.5%
Aetna	81.8%	81.7%	82.9%	85.5%	92.7%	95.8%	84.6%+	89.6%+
HealthKeepers	83.1%	82.0%	86.4%	83.6%	92.2%	92.4%	87.2%+	87.2%
Molina	72.6%+	82.0%+	86.5%+	81.3%+	94.1%+	97.6%+	80.3%+	85.7%+
Optima	85.3%	85.9%	89.0%	85.9%	95.9%	95.8%	93.1%+	89.7%+
United	90.7%+	81.7%+	85.4%+	87.1%+	91.6%+	92.0%+	85.9%+	89.3%+
VA Premier	87.8%	84.4%	90.5%	89.0%+	94.7%	96.9%	84.8%+	89.5%+

+ 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.

Strengths, Weaknesses, and Recommendations

Strengths	
+	The 2023 top-box scores for Molina and VA Premier were statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.

Strengths	
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 top-box score for *Rating of Personal Doctor.*

Weaknesses and Recommendations	
−	**Weakness:** The 2023 top-box scores for the CCC Plus (MLTSS) program, Aetna, HealthKeepers, and United were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*.
	Weakness: The 2023 top-box scores for the CCC Plus (MLTSS) program, Aetna, and HealthKeepers were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of All Health Care*.
	Weakness: HealthKeepers' top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Personal Doctor.*
	Recommendations: HSAG recommends that the MCOs conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG recommends that the MCOs continue to monitor the measures to ensure that significant decreases in scores over time do not continue to occur.

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 Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual.*[3-19] Table 3-12 displays the CY 2022 *MLTSS-8* PM results stratified by Medicaid managed care program, Medicaid delivery system, MCO, geographic region, and select demographics (i.e., age, gender, and race).

Table 3-12—*MLTSS-8* PM Results

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Virginia Total	4,578	33.70%	67.61%	0.50
Medicaid Program				
CCC Plus (MLTSS)	3,742	31.11%	67.90%	0.46

[3-19] 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*
Medallion 4.0 (Acute)	86	79.07%	57.92%	1.37
More than One Medicaid Program	147	64.63%	53.74%	1.20
Medicaid Delivery System				
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
MCO				
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
Geographic Region				
Central	1,192	35.82%	66.51%	0.54
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*
Age				
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

Stratifications	Facility Admissions	Observed Rate	Expected Rate	O/E Ratio*
Gender				
Male	2,000	35.10%	66.82%	0.53
Female	2,578	32.62%	68.22%	0.48
Race				
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).*

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.

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.[3-20] 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

[3-20] 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.

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

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 CCC Plus (MLTSS) MCOs. The CCC Plus (MLTSS) Consumer Decision Support Tool demonstrates how the Virginia Medicaid CCC Plus (MLTSS) MCOs compared to one another in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 3-13. Please refer to Appendix B for the detailed methodology used for this tool.

Table 3-13—CCC Plus (MLTSS) Consumer Decision Support Tool–Performance Ratings

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

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

Table 3-14 displays the CCC Plus (MLTSS) 2023 Consumer Decision Support Tool results for each MCO.

Table 3-14—2023 Consumer Decision Support Tool Results

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

**This rating includes all categories, as well as how the member feels about their MCO, their MCO's customer service, and the healthcare they received.*
***Data for Optima also include data for members enrolled in VA Premier in 2022.*
—Indicates the CCC Plus (MLTSS) MCO did not have enough data to receive a rating.

Strengths, Weaknesses, and Recommendations

Strengths	
+	HealthKeepers demonstrated the strongest performance by achieving the Highest Performance level for the Behavioral Health and Taking Care of Children categories; High Performance for the Overall Rating category; and Average Performance for the Doctors' Communication, Access and Preventive Care, and Living With Illness categories.
+	Aetna also demonstrated strong performance by achieving the High Performance level for the Behavioral Health and Taking Care of Children categories, and the Average Performance level for the Overall Rating, Doctors' Communication, Access and Preventive Care, and Living With Illness categories.
Weaknesses	
−	Molina demonstrated the lowest performance by achieving the Lowest Performance level for Overall Rating and Behavioral Health, and never performing above the Low Performance level.

Performance Withhold Program

In 2023, DMAS contracted with HSAG to establish, implement, and maintain a scoring mechanism for 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 CCC Plus (MLTSS) 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.[3-21]

[3-21] Health Services Advisory Group, Inc. *SFY 2023 Performance Withhold Program Methodology*. Available at: https://www.dmas.virginia.gov/media/4807/va-eqro-sfy-2023-pwp-methodology-f2.pdf. Accessed on: Oct 31, 2023.

4. Validation of Performance Improvement Projects

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

Objective

As part of the Commonwealth's QS, each 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 2023 submissions, the MCOs updated and completed Steps 1 through 8 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: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. 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

Ambulatory Care—Emergency Department Visits	
PIP Topic	Ambulatory Care—Emergency Department Visits
PIP Aim Statement	Do targeted interventions decrease emergency department visits for the eligible population?

Ambulatory Care—Emergency Department Visits		
Performance Indicator Measure	The percentage of members in the entire eligible population aligned with the HEDIS *AMB* measure specifications and who had more than one ED visit within the measurement period.	
Description of Data Obtained	Administrative data 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.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of members who were hospitalized and had an ambulatory follow-up visit with a PCP or licensed provider within 30 days of discharge?	
Performance Indicator Measure	The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge.	
Description of Data Obtained	Administrative data 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.	

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 *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
Case manager educates the member on availability of 24-hour nurse line services and ED/ER utilization during each phone contact.	New and in progress

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

Intervention	Intervention Status
Implementation of an automated alerts process using Med Compass when a member is admitted to or discharged from an inpatient facility.	New and in progress

Intervention	Intervention Status
Initiate a Transition of Care Coordinators (TCC) contact for members with ED criteria of three visits in 90 days and/or ER visit after a fall.	New and in progress
Care manager conducts a post-discharge follow-up call to members who met intervention criteria and have a RAP score of 49.9 or less (low risk) to remind members of follow-up visit and answer any post-discharge questions.	New and in progress
If the member has a risk assessment profile (RAP) score of greater than 50, the TCC will call the member while in the hospital, assist with a discharge plan as appropriate, and follow-up on discharge date to transition to care management for post-discharge follow-up.	New and in progress

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	
–	**Weakness:** None identified.
	Recommendations: NA

HealthKeepers

In 2023, HealthKeepers submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-4 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

Ambulatory Care—Emergency Department Visits	
PIP Topic	Ambulatory Care—Emergency Department Visits
PIP Aim Statement	Do targeted interventions decrease the percentage of ED visits that do not result in an inpatient encounter?
Performance Indicator Measure	The percentage of ED encounters during the measurement period that did not result in an inpatient stay.
Description of Data Obtained	Administrative data using claims and encounters

Ambulatory Care—Emergency Department Visits		
Validation Scores	*Overall Score:* 88%	*Critical Elements Score:* 89%
Validation Status/Confidence Level	*Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met*.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of inpatient discharges that had an ambulatory follow-up visit within 30-days?	
Performance Indicator Measure	The percentage of discharges where the member had an ambulatory follow-up visit within 30-days of discharge.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 88%	*Critical Elements Score:* 89%
Validation status/Confidence Level	*Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met*.	

HealthKeepers reported its baseline data and there were opportunities for improvement identified related to reporting data accurately in the data table and in the narrative summary of results. HealthKeepers completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicator; however, for the *Follow-up After Discharge* PIP, the MCO did not provide the date the intervention was initiated for all interventions documented. Table 4-5 and Table 4-6 display the PIP intervention summaries.

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

Intervention	Intervention Status
Collaborative Insights Process provides seamless coordination of transitions of care through the emergency room, inpatient, and discharge planning for members. This intervention will provide community inpatient providers with available member resources that promote health maintenance in the community and encourage primary care utilization to reduce emergency room utilization and inpatient readmissions.	New and in progress

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

Intervention	Intervention Status
Dispatch Health is a full-service, in-home care continuum that provides medical services and addresses social needs in a member's home in the Central and Nova areas. Dispatch Health will provide Bridge care visits post-hospitalization within 24–72	New and in progress

Intervention	Intervention Status
hours of discharge. If a member lives in the service area, care coordinators educate the member and hospital discharge planner on Dispatch Health and Bridge care and will refer the member to Bridge care prior to the hospital discharge if the member gives consent.	
Collaborative Insights Process provides seamless coordination of transitions of care through the emergency room, inpatient, and discharge planning for members. This intervention will provide community inpatient providers with available member resources that promote health maintenance in the community and encourage primary care utilization to reduce emergency room utilization and inpatient readmissions.	New and in progress

Strengths, Weaknesses, and Recommendations

Strengths	
+	HealthKeepers' PIPs are methodologically sound and created the foundation for HealthKeepers to progress to subsequent PIP stages. The MCO initiated interventions that have the potential to positively impact performance indicator results and outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** Opportunities for improvement exist for the MCO to calculate and report performance indicator data accurately in the data table and in the narrative summary of results.
	Recommendations: The MCO must ensure that the data reported in the submission form are calculated and reported correctly. The MCO should implement internal quality checks prior to submitting the PIP for the annual validation.

Molina

In 2023, Molina submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-7 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-7—PIP Aim Statements and Validation Results: Molina

Ambulatory Care—Emergency Department Visits	
PIP Topic	Ambulatory Care—Emergency Department Visits

Ambulatory Care—Emergency Department Visits		
PIP Aim Statement	Do targeted member education and engagement interventions reduce the rate of ED visits that do not result in an inpatient stay?	
Performance Indicator Measure	The percentage of ED visits that did not result in an inpatient stay during the measurement period.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 88%	*Critical Elements Score:* 89%
Validation Status/Confidence Level	*Partially Met/Low Confidence in reported PIP results*: One or more critical evaluation elements were *Partially Met*.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of inpatient discharges for members 18 years of age and older that had an ambulatory follow up visit within 30-days of discharge?	
Performance Indicator Measure	The percentage of members provided patient engagement and follow-up service within 30-days after inpatient discharge during the measurement period	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 94%	*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.	

For the *AMB-ED Visits* PIP, Molina had an opportunity for improvement related to reporting the correct number of visits per 1,000 in the narrative summary of results. For the *Follow-up After Discharge* PIP, the MCO needs to ensure that it addresses factors that threaten the validity of the data reported. Molina completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicator. Table 4-8 and Table 4-9 display the PIP intervention summaries.

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

Intervention	Intervention Status
Provider Quality Meetings. The MCO will share a list of frequent ED utilizers to target for outreach and support and provide education on the measurement requirements. Targeted meeting based on the list, will includes action items, actionable data, and resources to	New and in progress

Intervention	Intervention Status
promote engagement and intervention activities.	
Care coordinators outreach members to provide support, raise awareness, and address any social needs of the members to help them navigate the health system through connecting members with PCPs and providers with extended hours and/or urgent care facilities to reduce ED visits.	New and in progress

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

Intervention	Intervention Status
Targeted member outreach by Healthcare Services Team. Outreach includes appointment scheduling assistance, educating members on the importance of timely care, and offering additional support for areas of concern. Members who are identified as "Unable to Contact" are sent to the designated team to help identify alternate contact information. Research is completed in various settings to identify contact information. Letters are also mailed when no additional information has been collected. In conjunction with research for the members who cannot be contacted, the assigned PCP is outreached to help identify additional contact information as well.	New and in progress
Provider Quality Meetings. Provider quality meetings are conducted to engage providers and provide actionable data. The QI department is conducting outreach to support provider groups with scheduling new member appointments. QI and network departments are working with members to update providers as directed by members when members express having a PCP, but they are assigned to a different provider. Outreach was conducted to raise awareness of the importance of primary	New and in progress

Intervention	Intervention Status
care services and completion of preventative screenings to increase the number of members completing wellness and preventative screenings.	

Strengths, Weaknesses, and Recommendations

Strengths	
+	Molina developed methodologically sound projects and successfully progressed to subsequent PIP stages. The MCO initiated interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** For the *AMB-ED* PIP, Molina has an opportunity for improvement related to reporting correct data in the narrative summary of results.
	Recommendations: The MCO must ensure that the data reported in the submission form are calculated and reported correctly. Molina should implement internal quality checks prior to submitting the PIP for the annual validation.
−	**Weakness:** For the *Follow-Up After Discharge* PIP, Molina did not address all documentation requirements for data analysis and interpretation of results.
	Recommendations: The MCO should ensure it addresses whether there are factors that threaten the validity and comparability of the data annually.

Optima

In 2023, Optima submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-10 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

Table 4-10—PIP Aim Statements and Validation Results: Optima

Ambulatory Care—Emergency Department Visits		
PIP Topic	Ambulatory Care—ED Visits	
PIP Aim Statement	Do targeted interventions decrease the percentage of ED visits during the measurement period?	
Performance Indicator Measure	The percentage of utilization of emergency department visits among Optima Health Community Care enrolled members.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores:	Overall Score: 100%	Critical Elements Score: 100%

Ambulatory Care—Emergency Department Visits		
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.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of discharges for which the member had a 30-day follow-up visit (can include outpatient visits, telephone visits, transitional care services, and e-visits/virtual check-ins) during the measurement period?	
Performance Indicator Measure	The percentage of follow-up after hospital discharge amongst Optima Health Community Care (OHCC)-enrolled members.	
Description of Data Obtained	Administrative data 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.	

Optima met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. Optima reported its baseline rate and the QI activities conducted. Optima completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-11 and Table 4-12 display the PIP intervention summaries.

Table 4-11—Intervention Summary for *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
Identify providers with the lowest acuity non-emergent emergency department (LANE) visits. The business analyst uses claims with LANE top 10 diagnoses and the National Provider Identifier (NPI) number of the PCPs and practice to identify opportunities for educating the providers. The Network Management team provides education with newsletters and email blasts. Education includes reminders about other options for care for members.	New and in progress
Provide case management and education to LANE members. Using specific reports, the transition care coordinator (TCC) completes a triggering event encounter (TEE) and sends a reminder to the care coordinator (CC) to complete a TEE in the specified time frame. The TCC sets a reminder to follow up on TEE completion within the specified time frame. TCC completes telephone call and reminder to CC to complete a Face-to-Face TEE assessment with the member. During the assessment, services are identified,	New and in progress

Intervention	Intervention Status
education is provided to the member to mitigate high ED utilization, and referrals are generated as appropriate.	
Identify transportation issues. The business analyst pulls data from claims, and the data are reviewed and discussed by the LANE subcommittee and Clinical Efficiency Committee to identify opportunities for improvement.	New and in progress

Table 4-12—Intervention Summary for *Ambulatory Care*—Follow-Up After Hospital Discharge

Intervention	Intervention Status
TCCs work with members, the members' care coordinators, and the treatment team to facilitate safe and effective treatment that supports the appropriate next level of care that prevents over- or under-utilization of services and improves member outcomes.	New and in progress
An assessment is initiated for each admission. The assessment is used to document TCC activity.	New and in progress
The care plan will be transitioned to the care coordinator after the member is discharged from the acute facility.	New and in progress
The following are completed during the TCC assessment: • If after three calls the TCC is unable to contact the member, the TCC documents the attempts in the Discharge Planning Contact Log.	New and in progress
TCCs ensure members have a follow-up appointment scheduled, and if there are no appointments available within 30 days, the case coordinators assist the member in locating an alternative solution.	New and in progress

Strengths, Weaknesses, and Recommendations

Strengths	
+	Optima developed methodologically sound projects and successfully progressed to subsequent PIP stages. The MCO initiated interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

United

In 2023, United submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. 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: United

Ambulatory Care—Emergency Department Visits		
PIP Topic	Ambulatory Care—ED Visits	
PIP Aim Statement	Do targeted interventions decrease overall ED visits that do not result in an impatient stay during the measurement year?	
Performance Indicator Measure	The percentage of emergency department visits that did not result in an inpatient stay during the measurement period.	
Description of Data Obtained	Administrative data 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.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of patient engagements within 30-days after discharge?	
Performance Indicator Measure	The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30-days of discharge.	
Description of Data Obtained	Administrative data 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.	

United met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. United reported its baseline rate and the QI activities conducted. United 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 *Ambulatory Care—Emergency Department Visits*

Intervention	Intervention Status
For medically complex members, care managers review the Pre-Manage report daily to identify members who had an ED visit. Pre-Manage is a secure, web-based care management system that provides real-time information about patients receiving ED care.	New and in progress
Care managers outreach identified members within 24–48 business hours following ED alert or discharge notification.	New and in progress
Care managers complete ED follow-up script in Communication Care documentation platform. While on the phone with the member, the care manager reviews alternatives to ED care, identifies potential resource needs, and ensures appropriate follow-up care is scheduled.	New and in progress

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

Intervention	Intervention Status
A care manager or the vendor runs a discharge report to identify the number of discharges and number of post-hospital assessments (PHAs) and triggering event health risk assessments (HRAs) completed following an inpatient stay and ensure PHAs are completed within 72 hours of discharge.	New and in progress
The vendor manager reviews and analyzes the data to identify trends and barriers, then shares the results in monthly committee meetings. Pending results, a CAP will be implemented to address barriers to completing the PHAs.	New and in progress

Strengths, Weaknesses, and Recommendations

Strengths	
+	United developed methodologically sound projects and successfully progressed to subsequent PIP stages. The MCO initiated interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: NA

VA Premier

In 2023, VA Premier submitted its baseline data and interventions for the following PIPs for validation: *Ambulatory Care—Emergency Department Visits* and *Follow-Up After Discharge*. The topics selected by DMAS addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. Table 4-16 displays the PIP Aim, performance indicator measure, validation scores, and confidence level for each PIP.

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

Ambulatory Care—Emergency Department Visits		
PIP Topic	Ambulatory Care—ED Visits	
PIP Aim Statement	Do targeted inventions decrease the rate of emergency department utilization among members enrolled in the Virginia Premier Health Plan?	
Performance Indicator Measure	The percentage of emergency department visits in ambulatory care among members enrolled in the Commonwealth Coordinated Care (CCC) Plus program.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
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.	
Follow-Up After Discharge		
PIP Topic	Follow-Up After Discharge	
PIP Aim Statement	Do targeted interventions increase the percentage of discharges that have a follow-up visit within 30 days after an inpatient discharge during the measurement period	
Performance Indicator Measure	The percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge.	
Description of Data Obtained	Administrative data using claims and encounters	
Validation Scores	*Overall Score:* 100%	*Critical Elements Score:* 100%
Confidence Level	*Met/High Confidence/Confidence in reported PIP results:* All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all steps.	

VA Premier met 100 percent of the requirements in the Implementation stage, Steps 7 and 8. VA Premier reported its baseline rate and the QI activities conducted. VA Premier completed a causal/barrier analysis, prioritized the identified barriers, and initiated interventions that have the potential to impact the performance indicators. Table 4-17 and Table 4-18 display the PIP intervention summaries.

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

Intervention	Intervention Status
The Collective Medical report was developed by the medical director SME to identify low-acuity, non-emergent ED visits (LANE) diagnoses. Also, develop an ED cohort for initial ED visits and a cohort for three or more ED visits within 90 days. Developed a high ED utilizer report for 10 or more and 20 or more ED visits. This report helps the team identify those members utilizing the ED for LANE-specific diagnoses.	New and in progress
Implementation of high ED utilizer rounds. The care management team brings complex cases for members with five or more ED visits to determine the next approach or steps for managing these members.	New and in progress
Outreach to members to help educate them on when to use urgent care, PCP, and ED, and members are sent a "Where to Go" flyer.	New and in progress
Determine if the member has an assigned PCP and connect them to Member Services should they need to change their assigned provider.	New and in progress

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

Intervention	Intervention Status
Referrals to community resources and referrals to the internal SDOH work team.	New and in progress
TCC conducts outreach to members following the current transitions of care model.	New and in progress

Strengths, Weaknesses, and Recommendations

Strengths	
+	VA Premier developed methodologically sound projects and successfully progressed to subsequent PIP stages. The MCO initiated interventions that have the potential to impact performance indicator results and the desired outcomes for the project.
Weaknesses and Recommendations	
−	**Weakness:** None identified.
	Recommendations: With VA Premier no longer serving members as of July 1, 2023, and this being the last validation cycle for the *Ambulatory Care—ED Visits* and *Follow-up After Discharge* PIPs, HSAG has no recommendations.

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 Measure Sets, MLTSS PMs, 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.

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

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 Access and Preventive Care domain, Aetna displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile
+	Aetna's performance within the Behavioral Health domain identified seven PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Opioid disorder—Total, Other or unspecified drugs—Total,* and *Any disorder—Total* PM indicators met or exceeded the 90th percentile.
+	Aetna's performance within the Living With Illness domain identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio—Total* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile.
+	Aetna displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 50th percentile for the *Use of Opioids at High Dosage—Total* PM indicator.
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 Aetna: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening*

Weaknesses and Recommendations	
	• *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Use of Imaging Studies for Low Back Pain* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Aetna analyze its data and consider if there are disparities within its populations that contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

HealthKeepers

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

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

- *Medical Service Data (Claims/Encounters):* HSAG identified no concerns with HealthKeepers' claims system or processes.
- *Enrollment Data:* HSAG identified no concerns with HealthKeepers' eligibility system or processes.
- *Provider Data:* HSAG identified no concerns with HealthKeepers' provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with HealthKeepers' MRR processes.
- *Supplemental Data:* HSAG identified no concerns with HealthKeepers' supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with HealthKeepers' procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Access and Preventive Care domain, HealthKeepers displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021

Strengths	
	Medicaid HMO 90th percentile.
+	Within the Behavioral Health domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 50th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total, Antidepressant Medication Management—Effective Acute Phase Treatment,* and *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up—Total* PM indicators. The *Antidepressant Medication Management—Effective Continuation Phase Treatment* PM indicator ranked at or above the 75th percentile.
+	Within the Living With Illness domain, HealthKeepers displayed strong performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
+	Within the Use of Opioids domain, HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Use of Opioids from Multiple Providers—Multiple Pharmacies* PM indicators.

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 HealthKeepers: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Cervical Cancer Screening* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* • *Plan All-Cause Readmissions—Observed Readmissions—Total*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization 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 contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.

Molina

Molina's HEDIS auditor found that the MCO was fully compliant with all IS standards and determined that Molina submitted valid and reportable rates for all measures in the scope of the HEDIS 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 and processes.
- *Provider Data:* HSAG identified no concerns with Molina's provider data systems or processes.
- *Medical Record Review Process:* HSAG identified no concerns with Molina's MRR processes.
- *Supplemental Data:* HSAG identified no concerns with Molina's supplemental data systems and processes.
- *Data Integration:* HSAG identified no concerns with Molina's procedures for data integration and PM production.

Strengths, Weaknesses, and Recommendations

Strengths	
+	Within the Taking Care of Children domain, Molina displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
+	Within the Living With Illness domain, Molina ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total, Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators.
+	Molina displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Use of Opioids from Multiple Providers—Multiple Pharmacies* PM indicator.
Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Molina: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening*

Weaknesses and Recommendations	
	• *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Child and Adolescent Well-Care Visits—Total* • *Controlling High Blood Pressure* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
	Recommendations: HSAG recommends that Molina conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina 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.

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 Access and Preventive Care domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator.
+	Within the Taking Care of Children domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Child Immunization Status—Combination 3* PM indicator.
+	Within the Living With Illness domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total* and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies* PM indicators met or exceeded the 75th percentile, and *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators met or exceeded the 90th percentile.

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* • *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Use of Opioids from Multiple Providers—Multiple Prescribers* • *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

Weaknesses and Recommendations	
	Recommendations: HSAG recommends that Optima conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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.

United

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

HSAG determined that United followed the measure specifications and produced reportable rates for all 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 Access and Preventive Care domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
+	Within the Behavioral Health domain, United met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia Strategies* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
+	United's performance within the Living With Illness domain identified six PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total,*

Strengths	
	Controlling High Blood Pressure—Total, and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%),* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators met or exceeded the 90th percentile.
+	United displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator.

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: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Use of Imaging Studies for Low Back Pain* • *Child and Adolescent Well-Care Visits—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*
	Recommendations: HSAG recommends that United conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United 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.

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 Access and Preventive Care domain, VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
+	Within the Behavioral Health domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
+	Within the Taking Care of Children domain, VA Premier displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
+	Within the Living With Illness domain, VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,* and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies* and *Advising Smokers and Tobacco Users to Quit* PM indicators.

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 VA Premier: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* • *Well-Child Visits in the First 30 Months of Life— Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*
	Recommendations: 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 and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization 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.

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).[6-1]

Objectives

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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 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
Provider Network Management				
V. Adequate Capacity and Availability of Services	✓	✓	✓	✓
VIII. Provider Selection	✓	✓	✓	✓
IX. Subcontractual Relationships and Delegation	✓	✓	✓	✓
Member Services and Experiences				
II. Member Rights and Confidentiality	✓		✓	
III. Member Information	✓		✓	
IV. Emergency and Poststabilization Services	✓	✓	✓	✓
VI. Coordination and Continuity of Care	✓	✓	✓	✓

Standard	SFY 2021–2022	Access	Quality	Timeliness
VII. Coverage and Authorization of Services	✓	✓	✓	✓
XIII. Grievance and Appeal Systems	✓	✓	✓	✓
Managed Care Operations				
I. Enrollment and Disenrollment	✓	✓		✓
X. Practice Guidelines	✓		✓	
XI. Health Information Systems	✓	✓	✓	✓
XII. Quality Assessment and Performance Improvement	✓	✓	✓	✓
XIV. Program Integrity	✓	✓	✓	
XV. EPSDT Services	✓	✓	✓	✓

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

Aetna

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

Table 6-2—Aetna's CCC Plus (MLTSS) OSR Standards and Scores

	CFR	Compliance Reviews	Aetna		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			85.7%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			77.8%
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%

	CFR	Compliance Reviews	Aetna		
		Standard Name	2019	2020	2021
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			86.2%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**92.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
⊕	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
⊖	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

HealthKeepers

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

Table 6-3—HealthKeepers' CCC Plus (MLTSS) OSR Standards and Scores

	CFR	Compliance Reviews	HealthKeepers		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			72.2%
VI.	438.208	Coordination and Continuity of Care			100%

	CFR	Compliance Reviews	HealthKeepers		
		Standard Name	2019	2020	2021
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			66.7%
XIII.	438.228	Grievance and Appeal Systems			82.8%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**91.0%**

Strengths, Weaknesses, and Recommendations

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

Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

Molina

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

Table 6-4—Molina's CCC Plus (MLTSS) 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%

	CFR	Compliance Reviews	Molina		
		Standard Name	2019	2020	2021
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			77.8%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			95.9%
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			86.2%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**92.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

Optima

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

Table 6-5—Optima's CCC Plus (MLTSS) 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			61.1%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			95.0%
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			96.6%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			87.5%
TOTAL SCORE					**92.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.

Weaknesses and Recommendations	
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

United

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

Table 6-6—United's CCC Plus (MLTSS) OSR Standards and Scores

	CFR	Compliance Reviews	United		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			100%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			100%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			83.3%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			50.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			93.1%
XIV.	438.608	Program Integrity			100%
XV.	441.58 Section 1905 of the SSA	EPSDT Services			87.5%
TOTAL SCORE					**95.2%**

Strengths, Weaknesses, and Recommendations

Strengths	
+	Strengths were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

VA Premier

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

Table 6-7—VA Premier's CCC Plus (MLTSS) OSR Standards and Scores

	CFR	Compliance Reviews	VA Premier		
		Standard Name	2019	2020	2021
I.	438.56	Enrollment and Disenrollment			85.7%
II.	438.100 438.224	Member Rights and Confidentiality			100%
III.	438.10	Member Information			90.5%
IV.	438.114	Emergency and Poststabilization Services			100%
V.	438.206 438.207	Adequate Capacity and Availability of Services			50.0%
VI.	438.208	Coordination and Continuity of Care			100%
VII.	438.210	Coverage and Authorization of Services			100%
VIII.	438.214	Provider Selection			100%
IX.	438.230	Subcontractual Relationships and Delegation			75.0%
X.	438.236	Practice Guidelines			100%
XI.	438.242	Health Information Systems			100%
XII.	438.330	Quality Assessment and Performance Improvement			100%
XIII.	438.228	Grievance and Appeal Systems			75.9%
XIV.	438.608	Program Integrity			100%

	CFR	Compliance Reviews	VA Premier		
		Standard Name	2019	2020	2021
XV.	441.58 Section 1905 of the SSA	EPSDT Services			62.5%
TOTAL SCORE					**86.2%**

Strengths, Weaknesses, and Recommendations

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

Weaknesses and Recommendations	
−	**Weakness:** Weaknesses were discussed in the Virginia 2021 EQR Annual Technical Report dated April 2021.
	Recommendations: MCO follow-up on recommendations can be found in Appendix E in the Virginia 2022 *External Quality Review Technical Report—Commonwealth Coordinated Care Plus* dated March 2023.

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
Aetna CAP - 19927	Aetna encountered internal system issues which impacted CRMS SA data submission. As a result, Aetna developed a crosswalk of expected values to overcome the QNXT system limitations.
Aetna CAP - 19947	On May 27, 2021, Aetna submitted four 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 records in production. On August 27, 2021, Aetna failed to prevent such an incident from reoccurring and submitted four SA Medical files to CRMS Production without approval from DMAS. Aetna 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.

MCO/Vendor	Compliance Action
Optima CAP -19987	Optima entered a member into the DMAS Web Portal for LTSS Services prior to a valid level of care screening being conducted. Optima updated the processing of DMAS 80 forms, the Enrollment Change Request Form, and implemented a second-level review with a supervisor signature requirement.
UHC CAP - 20067	UHC's fiscal/employer agent (F/EA) 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.
UHC CAP - 20068	UHC approved an implementation that migrated its BetterOnline Web portal and website platform to the 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.
UHC CAP - 20070	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.
Optima CAP - 20071	Optima's F/EA 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.
Optima CAP - 20072	Optima approved an implementation that migrated its BetterOnline web portal and website platform to the 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.
Optima CAP - 20074	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.
Aetna CAP - 20076	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.

MCO/Vendor	Compliance Action
Aetna CAP - 20077	Aetna approved an implementation that migrated its BetterOnline Web portal and website platform to the 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.
Aetna CAP - 20078	Aetna's F/EA 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.
Anthem CAP - 20080	Anthem's F/EA 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.
Anthem CAP - 20081	Anthem approved an implementation that migrated its BetterOnline Web portal and website platform to the 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.
Anthem CAP - 20083	A process was implemented by the F/EA without DMAS' approval. The new process encouraged new attendants to submit DSS forms directly to DSS for processing. This change is in violation of contract requirements. The MCO sent notification with instructions to resume the correct procedure and reimbursed all impacted individuals.
UHC CAP - 20127	On October 27, 2021, a call was placed to Maximus. An individual who identified herself as a UHC agent remained on the line after a different UHC representative disconnected and requested that a member's CCC Plus (MLTSS) MCO be changed to UHC. The Maximus Customer Services representative informed the UHC representative that she could not be on the call and would need to disconnect so Maximus could speak with the member. The UHC representative used profanity and ended the call without allowing the member to participate in the call or be provided any services. UHC conducted a review of the issue and determined the individual was an independent contractor. Measures were put in place to ensure the contractor did not interact with UHC members in the future. UHC also implemented training to ensure calls are conducted to contractual protocols.
Anthem CAP - 20190	Anthem HealthKeepers Plus was noncompliant with payment cycle entry timeliness and payment cycle certification timeliness. The MCO discovered that a vendor was not recording payments as separate data elements. The MCO also implemented a job aid, quality control, and monitoring procedures to ensure data were being reported for the proper time frames.

MCO/Vendor	Compliance Action
Optima CAP - 20207	Optima inaccurately enrolled several members into the CCC Plus Waiver. The MCO conducted a root cause analysis which identified processes that created unnecessary opportunities for errors. A new team was created to specialize in waiver entries and receive focused training on policies and procedures. Quality controls and an audit tool were implemented for the entire waiver process.
Molina CAP - 20228	Molina inaccurately enrolled a member into the CCC Plus Waiver. Internal trainings were conducted with the staff who complete the portal updates. This training was completed by the LTSS director via a Microsoft Teams meeting with video on for accountability. Resources from DMAS were utilized and scenarios were reviewed. A root cause analysis determined the underlying cause was human error. The individual responsible received training and coaching, and random audits are being conducted on all members of the team.
Aetna CAP - 20348	Appropriate steps were not taken to contact a member upon enrollment that resulted in the DMAS portal not accurately reflecting the member's status. This resulted in overpayments of capitation rates. The MCO conducted formal performance counseling and introduced action plans for case managers handling this case. A full review of the entire NF population was entered into a dedicated database, and all discrepancies were reported to DMAS with a schedule for correction. Continued performance monitoring and spot check audits were implemented.
Molina CAP - 20367	Molina mistakenly made a coding error which caused generic medications to be paid in over 1,000 claims when the brand name medication is preferred on the PDL. This resulted in overpayments and members not receiving the medications assured in the PDL. The MCO identified paid claims for non-preferred medication. The monthly pharmacy operations surveillance program was updated to reflect monthly monitoring of paid claims for non-preferred generics and to randomly select prior authorizations to validate if payment should apply to brand and/or generic products.

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 Rule regulations.[7-1] 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
Operations/Administration
Administrative Staffing and Resources
Delegation and Oversight
Member and Provider Communications
Grievance and Appeals
Member Services and Outreach
Provider Network Management
Program Integrity/Compliance
Service Delivery
Case Management/Care Coordination/Service Planning

[7-1] Medicaid and CHIP Managed Care Final Rules. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html. Accessed on: Dec 18, 2023.

Readiness Review Areas
Quality Improvement
Utilization Review
Financial Management*
Financial Reporting and Monitoring
Financial Solvency
Information Systems Management
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
OSR Results					
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%
	OSR Total	**167**	**167**	**0**	**100%**

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
Phase III Readiness Review Results*					
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%
Readiness Review Total		**132**	131	**1**	99.2%
Readiness Review CAP Review Results					
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%
Comprehensive Total		**299**	**299**	**0**	**100%**

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
OSR Results					
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%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
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%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
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%
	Readiness Review Total	**132**	**131**	**0**	**99.2%**
Readiness Review CAP Review Results					
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%
	CAP Review Results Total	14	14	0	100%
	Comprehensive Total	**299**	**299**	**0**	**100%**

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
OSR Results					
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%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
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%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
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%
	Readiness Review Total	**132**	**132**	**8**	**100%**
Readiness Review CAP Review Results					
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%
	Comprehensive Total	**299**	**299**	**0**	**100%**

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
OSR Results					
I	Enrollment and Disenrollment	7	7	0	100%
II	Member Rights and Confidentiality	7	7	0	100%

Standard		Requirements/Elements Assessed			
		Number of Elements	Number *Met*	Number *In Progress*	Score
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%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
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%
	Readiness Review Total	**132**	**131**	**1**	**99.2%**
Readiness Review CAP Review Results					
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%
	Comprehensive Total	**299**	**299**	**0**	**100%**

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 *Met*	Number *In Progress*	Score
OSR Results					
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%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
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%
	Readiness Review Total	**132**	**128**	**4**	**97.0%**
Readiness Review CAP Review Results					
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%
	Comprehensive Total	**299**	**299**	**0**	**100%**

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
OSR Results					
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%
	OSR Total	**167**	**167**	**0**	**100%**
Phase III Readiness Review Results*					
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%
	Readiness Review Total	**132**	**130**	**2**	**98.5%**
Readiness Review CAP Review Results					
Phase I CAP Review Results		6	6	0	100%
Phase II CAP Review Results		7	7	0	100%
Phase III CAP Review Results		2	2	0	100%
	Comprehensive	**299**	**299**	**0**	**100%**

Number of Element*s* = 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 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.[8-1] 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 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 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 were 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 identify 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.

[8-1] 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 8-1 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[1]	Provider Location Does not Offer Primary Care Services[2]	Provider Location not Accepting MCO[2]	Provider Location not Accepting VA Medicaid[2]	Provider Location not Accepting New Patients[2]	Other Limitation to Scheduling Appointment	Appointment Available[3]
Aetna[1]	234 (56.0%)	40 (9.6%)	7 (1.7%)	2 (0.5%)	6 (1.4%)	19 (4.5%)	10 (2.4%)
All MCOs[2]	**928 (36.8%)**	**552 (21.9%)**	**92 (3.6%)**	**55 (2.2%)**	**114 (4.5%)**	**155 (6.1%)**	**421 (16.7%)**

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	20.1%	19.0%	15.8%
MCO Total	**46.7%**	**43.3%**	**36.1%**

* The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
Aetna	28.6	50.0	40.0	0.0
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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	
−	**Weakness:** 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. **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 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.
	Recommendations: 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.

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	45.4%	41.8%	34.1%
MCO Total	**46.7%**	**43.3%**	**36.1%**

* The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
HealthKeepers	100.0	71.4	100.0	25.0
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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 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.
Weaknesses and Recommendations	
−	**Weakness:** 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. **Why the weakness exists:** 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.
	Recommendations: 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.

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	56.3%	54.3%	41.7%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
Molina	91.7	88.6	91.4	5.7
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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 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 standard.
Weaknesses and Recommendations	
−	**Weakness:** 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. For urgent appointments, 5.7 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** 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.
	Recommendations: 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.

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	55.5%	47.7%	41.3%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
Optima	31.0	77.8	27.1	6.3
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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, 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 standard.
Weaknesses and Recommendations	
−	**Weakness:** 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. **Why the weakness exists:** 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.
	Recommendations: 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.

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	44.5%	40.5%	34.2%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
United	72.5	82.8	76.2	12.5
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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 provider locations accepting new patients, 72.5 percent and 76.2 percent offered a routine and urgent visit appointment, respectively. For routine visits, 82.8 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard.
Weaknesses and Recommendations	
−	**Weakness:** 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. For urgent visits, 12.5 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** 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.
	Recommendations: 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.

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

[1]The denominator includes the total number of survey cases.
[2]The denominator includes cases reached.
[3]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	50.2%	48.8%	42.8%
MCO Total	**46.7%**	**43.3%**	**36.1%**

*The denominator includes cases reached.

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

MCO	Routine Visits		Urgent Visits	
	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]	Cases Offered an Appointment Rate (%)[1]	Appointments in Compliance With Standards Rate (%)[2]
VA Premier	92.9	61.5	80.6	25.9
All MCOs	**74.0**	**74.5**	**72.3**	**16.0**

[1]The denominator includes cases reached and accepting new patients.
[2]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 provider locations accepting new patients, 92.9 percent and 80.6 percent offered a routine and urgent visit appointment, respectively.

Weaknesses and Recommendations	
−	**Weakness:** 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. For routine visits, 61.5 percent of the routine visit appointments offered were compliant with DMAS' 30-day appointment availability compliance standard. For urgent visits, 25.9 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standard. **Why the weakness exists:** 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.
	Recommendations: 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 has 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.

9. Encounter Data Validation

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 CCC Plus (MLTSS) 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 CCC Plus (MLTSS) 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 parents/caretakers of child Medicaid members enrolled in their respective MCOs.

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
Global Ratings		
Rating of Health Plan	63.2%	67.8%
Rating of All Health Care	53.6%	51.5%
Rating of Personal Doctor	68.1%	68.1%
Rating of Specialist Seen Most Often	73.4%	71.1%

	2022	2023
Composite Measures		
Getting Needed Care	82.6%	80.5%
Getting Care Quickly	82.4%	83.1%
How Well Doctors Communicate	92.7%	93.8%
Customer Service	89.1%	87.4%

▲ *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.

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 score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*.
Weaknesses and Recommendations	
−	**Weakness:** 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.
	Recommendations: HSAG recommends that Aetna monitor the measures to ensure significant decreases in scores over time do not occur.

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

	2022	2023
Global Ratings		
Rating of Health Plan	66.1%	63.9%
Rating of All Health Care	62.5%	62.3%
Rating of Personal Doctor	73.1%	72.6%
Rating of Specialist Seen Most Often	64.5%	69.2%
Composite Measures		
Getting Needed Care	81.8%	81.7%

	2022	2023
Getting Care Quickly	82.9%	85.5%
How Well Doctors Communicate	92.7%	95.8%
Customer Service	84.6%+	89.6%+

+ 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

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	
⊖	**Weakness:** Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan.*
	Weakness: Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of All Health Care*.
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis of the measures 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. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.

HealthKeepers

Table 10-3 and Table 10-4 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared HealthKeepers' 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
Global Ratings		
Rating of Health Plan	67.8%	67.0%
Rating of All Health Care	61.5%	59.5%
Rating of Personal Doctor	69.2%	73.2%
Rating of Specialist Seen Most Often	74.5%	66.7%
Composite Measures		
Getting Needed Care	86.0%	82.5%
Getting Care Quickly	85.1%	84.9%
How Well Doctors Communicate	92.8%	94.9%
Customer Service	90.6%	93.3%

▲ *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.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Getting Care Quickly*.
+	HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** HealthKeepers' 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.
	Recommendations: HSAG recommends that HealthKeepers monitor the measures to ensure significant decreases in scores over time do not occur.

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

	2022	2023
Global Ratings		
Rating of Health Plan	65.9%	65.3%
Rating of All Health Care	63.9%	60.4%
Rating of Personal Doctor	72.3%	70.4%
Rating of Specialist Seen Most Often	71.1%	71.4%
Composite Measures		
Getting Needed Care	83.1%	82.0%
Getting Care Quickly	86.4%	83.6%
How Well Doctors Communicate	92.2%	92.4%
Customer Service	87.2%+	87.2%

+ 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:

Strengths	
⊕	HealthKeepers' 2023 top-box scores were not statistically significantly higher than the 2022 top-box scores or the NCQA child Medicaid national averages for any measure; therefore, no strengths were identified.
Weaknesses and Recommendations	
⊖	**Weakness:** HealthKeepers' 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.

Molina

Table 10-5 and Table 10-6 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Molina's 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
Global Ratings		
Rating of Health Plan	56.9%	61.5%
Rating of All Health Care	56.5%	56.2%
Rating of Personal Doctor	70.4%	67.9%
Rating of Specialist Seen Most Often	69.5%	68.1%
Composite Measures		
Getting Needed Care	84.4%	81.1%
Getting Care Quickly	80.8%	77.2%
How Well Doctors Communicate	91.6%	91.0%
Customer Service	87.9%	86.2%

+ 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.

Strengths, Weaknesses, and Recommendations

Molina's 2023 adult 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 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 2022 top-box scores or NCQA adult Medicaid national averages for any measure; therefore, no weaknesses were identified.
	Recommendations: HSAG recommends that Molina monitor the measures to ensure significant decreases in scores over time do not occur.

Table 10-6—Comparison of 2022 and 2023 Child Medicaid CAHPS Results: Molina

	2022	2023
Global Ratings		
Rating of Health Plan	45.2%+	59.0%+
Rating of All Health Care	66.7%+	56.5%+
Rating of Personal Doctor	76.2%+	60.6%+
Rating of Specialist Seen Most Often	75.0%+	60.0%+
Composite Measures		
Getting Needed Care	72.6%+	82.0%+
Getting Care Quickly	86.5%+	81.3%+
How Well Doctors Communicate	94.1%+	97.6%+
Customer Service	80.3%+	85.7%+

+ 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.

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 score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.

Weaknesses and Recommendations	
−	**Weakness:** Molina'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

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

Optima

Table 10-7 and Table 10-8 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared Optima's 2023 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
Global Ratings		
Rating of Health Plan	69.1%	68.1%
Rating of All Health Care	63.1%	61.8%
Rating of Personal Doctor	72.3%	75.7%
Rating of Specialist Seen Most Often	77.7%	74.4%
Composite Measures		
Getting Needed Care	84.5%	86.2%
Getting Care Quickly	86.5%	84.8%
How Well Doctors Communicate	94.7%	92.7%
Customer Service	92.8%	92.6%

+ 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.

Strengths, Weaknesses, and Recommendations

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

Strengths	
+	Optima's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** 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.
	Recommendations: HSAG recommends that Optima monitor the measures to ensure significant decreases in scores over time do not occur.

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

	2022	2023
Global Ratings		
Rating of Health Plan	70.2%	68.8%
Rating of All Health Care	70.8%	66.2%
Rating of Personal Doctor	81.6%	81.4%
Rating of Specialist Seen Most Often	75.0%	75.5%
Composite Measures		
Getting Needed Care	85.3%	85.9%
Getting Care Quickly	89.0%	85.9%
How Well Doctors Communicate	95.9%	95.8%
Customer Service	93.1%+	89.7%+

+ 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.

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

United

Table 10-9 and Table 10-10 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared United's 2023 CAHPS scores to its corresponding 2022 CAHPS scores. In addition, the 2023 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
Global Ratings		
Rating of Health Plan	68.0%	63.8%
Rating of All Health Care	56.5%	62.8%
Rating of Personal Doctor	69.7%	69.8%
Rating of Specialist Seen Most Often	66.9%	68.3%
Composite Measures		
Getting Needed Care	81.9%	84.5%
Getting Care Quickly	81.7%	81.7%
How Well Doctors Communicate	93.2%	93.5%

	2022	2023
Customer Service	90.8%	87.8%

+ 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.

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 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*.
Weaknesses and Recommendations	
−	**Weakness:** 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.
	Recommendations: HSAG recommends that United monitor the measures to ensure significant decreases in scores over time do not occur.

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

	2022	2023
Global Ratings		
Rating of Health Plan	65.0%	62.5%
Rating of All Health Care	65.2%+	70.3%+
Rating of Personal Doctor	78.6%+	78.8%+
Rating of Specialist Seen Most Often	83.7%+	76.1%+
Composite Measures		
Getting Needed Care	90.7%+	81.7%+
Getting Care Quickly	85.4%+	87.1%+
How Well Doctors Communicate	91.6%+	92.0%+

	2022	2023
Customer Service	85.9%+	89.3%+

+ 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	
−	**Weakness:** United's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.
	Recommendations: HSAG recommends that United conduct a root cause analysis of the measure that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that United focus initiatives on raising the statistically significantly lower score and continue to monitor the measure to ensure there is not a significant decrease in the score over time.

VA Premier

Table 10-11 and Table 10-12 present the 2022 and 2023 MCO-specific adult and child Medicaid CAHPS top-box scores for the global ratings and composite measures. A trend analysis was performed that compared VA Premier's 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
Global Ratings		
Rating of Health Plan	67.4%	60.7%

	2022	2023
Rating of All Health Care	56.3%	55.9%
Rating of Personal Doctor	72.0%	70.9%
Rating of Specialist Seen Most Often	67.6%	64.8%
Composite Measures		
Getting Needed Care	90.1%	83.6%▼
Getting Care Quickly	90.6%	79.2%▼
How Well Doctors Communicate	92.5%	92.7%
Customer Service	89.5%	93.0%

+ 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.

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 score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *Customer Service*.
Weaknesses and Recommendations	
−	**Weakness:** VA Premier's 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for two measures, *Getting Needed Care* and *Getting Care Quickly*.
	Recommendations: 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.

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

	2022	2023
Global Ratings		
Rating of Health Plan	67.0%	65.9%

	2022	2023
Rating of All Health Care	66.0%	68.0%
Rating of Personal Doctor	74.2%	82.8%▲
Rating of Specialist Seen Most Often	70.7%	74.3%
Composite Measures		
Getting Needed Care	87.8%	84.4%
Getting Care Quickly	90.5%	89.0%+
How Well Doctors Communicate	94.7%	96.9%
Customer Service	84.8%+	89.5%+

+ 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.

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 top-box score for one measure, *Rating of Personal Doctor*. In addition, VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for one measure, *How Well Doctors Communicate*.
Weaknesses and Recommendations	
−	**Weakness:** VA Premier'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.
	Recommendations: 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.

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.[11-1] 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.[11-2] 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
Concurrent Prescribing of Naloxone and *High-Dose Opioids*
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*
Treatment of Hepatitis C for Those With Hepatitis C and SUD
Treatment of HIV for Those With HIV and SUD
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*
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*
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)*
Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and *Received Antiretroviral Therapy*

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

[11-2] 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
Concurrent Prescribing of Naloxone and High-Dose Opioids				
Concurrent Prescribing of Naloxone and High-Dose Opioids	3,404	49.9%	3,306	51.4%
Naloxone Use for High Risk of Overdose				
Naloxone Use for Diagnosed Opioid Use Disorder	26,263	35.1%	38,510	39.2%
Naloxone Use for History of Chronic Opioid Use	2,663	66.6%	2,293	68.0%
Naloxone Use for Concurrent Benzodiazepine and Opioid Use	3,140	57.5%	2,851	58.3%
Naloxone Use for History of Overdose	1,956	37.6%	2,397	43.7%
Treatment of Hepatitis C for Those With Hepatitis C and SUD				
Treatment of Hepatitis C for Those With Hepatitis C and SUD	3,809	29.1%	4,420	31.9%
Treatment of HIV for Those With HIV and SUD				
Treatment of HIV for Those With HIV and SUD	1,104	64.9%	1,303	62.5%
Preferred OBAT Compliance				
Alcohol or Drug Screening: 8+ Screenings	9,492	55.0%	12,788	69.6%
Counseling from an OBAT Provider	9,492	94.2%	12,788	91.0%
Family Planning	4,004	42.6%	5,220	44.1%
Prescription for Naloxone from OBAT Provider	9,492	36.7%	12,788	37.6%
Prescription for Naloxone	9,492	51.1%	12,788	54.4%
Testing for HIV/Hepatitis C	9,492	20.8%	12,788	23.2%
Initiation of Medication for OUD	9,492	20.6%	12,788	19.3%
Concurrent Pharmacotherapy and Care Coordination	9,492	16.9%	12,788	15.4%
RPR Testing	9,492	1.3%	12,788	1.5%
Annual TB Testing	9,492	3.3%	12,788	4.9%
Cascade of Care for Members With OUD				
High-Risk Members With OUD Diagnosis	67,799	3.8%	87,229	5.1%
Members Identified as Having OUD who Initiated OUD Treatment: Pharmacotherapy	2,565	25.0%	4,485	31.2%
Members Identified as Having OUD who Initiated OUD Treatment: Other OUD Treatment	2,565	25.9%	4,485	25.8%

Measure	CY 2020		CY 2021	
	Denom	Rate	Denom	Rate
Members Identified as Having OUD who Initiated OUD Treatment: Both Pharmacotherapy and Other Treatment	2,565	11.4%	4,485	12.8%
Members who Initiated OUD Treatment who Also Engaged in OUD Treatment	1,013	49.4%	1,983	40.7%
Cascade of Care for Members With Hepatitis C				
Prevalence of Hepatitis C	873,579	0.2%	1,073,812	0.2%
Received DAA Treatment for Hepatitis C	1,842	38.3%	1,871	46.1%
Completed DAA Treatment for Hepatitis C	705	90.8%	862	91.3%
Achieved SVR	705	24.5%	862	30.7%
Cascade of Care for Members With HIV				
Received HIV Care	4,938	41.3%	6,213	37.3%
Retained in HIV Care	4,938	68.2%	6,213	66.1%
Received Antiretroviral Therapy	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,[11-3] 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

[11-3] 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 overdose 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 Outcomes 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 CCC Plus (MLTSS) 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–CY2021

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
FFS							
Births with Early and Adequate Prenatal Care	76.4%	2,357	65.0%	1,881	64.8%	2,320	60.2%
*Births with Inadequate Prenatal Care**	*NA*	693	19.1%	562	19.4%	962	24.9%
*Births with No Prenatal Care**	*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%
Managed Care							
Births with Early and Adequate Prenatal Care	76.4%	20,035	73.2%	20,364	72.7%	21,460	74.3%
*Births with Inadequate Prenatal Care**	*NA*	4,350	15.9%	4,089	14.6%	4,144	14.4%
*Births with No Prenatal Care**	*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 outperformed the national benchmark but continued to underperform in comparison to 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
Medicaid for Pregnant Women							
Births with Early and Adequate Prenatal Care	76.4%	16,028	73.1%	13,737	72.4%	11,493	73.9%
*Births with Inadequate Prenatal Care**	*NA*	3,451	15.7%	2,839	15.0%	2,337	15.0%
*Births with No Prenatal Care**	*NA*	393	1.8%	241	1.3%	239	1.5%

Study Indicator	National Benchmark	CY 2019		CY 2020		CY 2021	
		Number	Percent	Number	Percent	Number	Percent
Preterm Births (<37 Weeks Gestation)*	9.4%	2,173	9.5%	1,750	8.9%	1,460	9.3%
Newborns with Low Birth Weight (<2,500 grams)*	9.7%	2,062	9.0%	1,699	8.6%	1,333	8.5%
Medicaid Expansion							
Births with Early and Adequate Prenatal Care	76.4%	1,462	70.9%	3,249	73.8%	5,031	77.5%
*Births with Inadequate Prenatal Care**	*NA*	330	16.0%	578	13.1%	722	11.1%
*Births with No Prenatal Care**	*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%
FAMIS MOMS							
Births with Early and Adequate Prenatal Care	76.4%	1,626	77.2%	1,564	76.8%	1,382	78.1%
*Births with Inadequate Prenatal Care**	*NA*	292	13.9%	261	12.8%	219	12.4%
*Births with No Prenatal Care**	*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%
Other Aid Categories†							
Births with Early and Adequate Prenatal Care	76.4%	3,276	66.9%	3,695	66.9%	5,874	65.9%
*Births with Inadequate Prenatal Care**	*NA*	970	19.8%	973	17.6%	1,828	20.5%
*Births with No Prenatal Care**	*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 outperforming 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 outperformed 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 underperformed in comparison to 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
FFS			
*Postpartum ED Utilization**	316	3,916	8.1%
Postpartum Ambulatory Care Utilization	1,576	3,916	40.2%
Prenatal Maternal Depression Screening	15	3,916	0.4%
Postpartum Maternal Depression Screening	113	3,916	2.9%
Managed Care			
*Postpartum ED Utilization**	4,311	29,116	14.8%
Postpartum Ambulatory Care Utilization	15,448	29,116	53.1%
Prenatal Maternal Depression Screening	1,623	29,116	5.6%
Postpartum Maternal Depression Screening	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
Medicaid for Pregnant Women			
*Postpartum ED Utilization**	2,175	15,682	13.9%

Study Indicator	CY 2021		
	Numerator	Denominator	Percent
Postpartum Ambulatory Care Utilization	8,301	15,682	52.9%
Prenatal Maternal Depression Screening	709	15,682	4.5%
Postpartum Maternal Depression Screening	1,147	15,682	7.3%
Medicaid Expansion			
*Postpartum ED Utilization**	905	6,548	13.8%
Postpartum Ambulatory Care Utilization	3,265	6,548	49.9%
Prenatal Maternal Depression Screening	387	6,548	5.9%
Postpartum Maternal Depression Screening	485	6,548	7.4%
FAMIS MOMS			
*Postpartum ED Utilization**	191	1,785	10.7%
Postpartum Ambulatory Care Utilization	855	1,785	47.9%
Prenatal Maternal Depression Screening	48	1,785	2.7%
Postpartum Maternal Depression Screening	109	1,785	6.1%
Other Aid Categories†			
*Postpartum ED Utilization**	1,198	9,017	17.1%
Postpartum Ambulatory Care Utilization	4,603	9,017	51.0%
Prenatal Maternal Depression Screening	494	9,017	5.5%
Postpartum Maternal Depression Screening	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[12-1]

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

[12-1] The Foster Care Focus Study is not limited to the CCC Plus (MLTSS) population.

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 quality strategy.[12-2] 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.[12-3] 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.[12-4] 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,[12-5] 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.[12-6] 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:

12-2 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.

12-3 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.

12-4 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.

12-5 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.

12-6 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.

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

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	*p*
Primary Care			
Child and Adolescent Well-Care Visits	64.8%	54.7%	<0.001*
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	63.8%	60.0%	0.46
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	79.7%	75.8%	0.31
Oral Health			
Annual Dental Visit	70.6%	52.4%	<0.001*
Preventive Dental Services	64.6%	45.6%	<0.001*
Oral Evaluation, Dental Services	63.5%	44.5%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	35.0%	20.8%	<0.001*
Topical Fluoride for Children—Dental Services	28.3%	16.0%	<0.001*
Topical Fluoride for Children—Oral Health Services	2.4%	2.1%	0.43
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	64.2%	59.7%	0.56
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	92.9%	81.5%	0.25
Metabolic Monitoring for Children and Adolescents on Antipsychotics	38.0%	35.7%	0.67
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	89.2%	68.4%	0.01*
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	78.1%	66.4%	0.04*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	88.6%	81.8%	0.13
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	93.0%	90.2%	0.43

Measure	Children in Foster Care Rate	Controls Rate	p
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	96.5%	96.5%	1.00
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	98.2%	97.2%	0.70
Substance Use			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	0.0%	NC
*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^*	39.7%	50.0%	0.39
*Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^*	20.7%	16.7%	0.77
Respiratory Health			
Asthma Medication Ratio	85.7%	80.2%	0.48
Service Utilization			
Ambulatory Care Visits	88.9%	89.7%	0.33
ED Visits	24.8%	31.5%	<0.001*
Inpatient Visits	4.5%	4.4%	0.82
Behavioral Health Encounters—ARTS	1.9%	0.7%	<0.001*
Behavioral Health Encounters—CMH Services	38.8%	21.7%	<0.001*
Behavioral Health Encounters—RTC Services	4.4%	2.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	10.4%	5.9%	<0.001*
Behavioral Health Encounters—Traditional Services	67.8%	53.8%	<0.001*
Behavioral Health Encounters—Total	71.0%	57.5%	<0.001*
Overall Service Utilization	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.
^ 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
Primary Care			
Child and Adolescent Well-Care Visits	47.1%	48.2%	0.17
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	50.0%	65.3%	0.61

Measure	Children in Foster Care Rate	Controls Rate	*p*
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	71.0%	72.9%	0.82
Oral Health			
Annual Dental Visit	53.2%	50.8%	0.003*
Preventive Dental Services	48.3%	45.0%	<0.001*
Oral Evaluation, Dental Services	47.2%	44.0%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	23.7%	19.6%	<0.001*
Topical Fluoride for Children—Dental Services	19.4%	16.2%	<0.001*
Topical Fluoride for Children—Oral Health Services	1.4%	1.2%	0.46
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	59.7%	52.0%	0.25
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	80.0%	67.4%	0.13
Metabolic Monitoring for Children and Adolescents on Antipsychotics	34.1%	34.6%	0.90
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	59.3%	65.3%	0.41
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	51.4%	58.1%	0.12
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	62.9%	74.3%	0.005*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	73.1%	81.0%	0.03*
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	86.1%	91.5%	0.05*
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	91.0%	94.0%	0.19
Substance Use			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	0.0%	25.0%	0.40
*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^*	54.1%	30.0%	0.03*
*Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^*	8.1%	10.0%	1.00
Respiratory Health			
Asthma Medication Ratio	86.1%	71.4%	0.001*
Service Utilization			
Ambulatory Care Visits	81.4%	83.6%	<0.001*
ED Visits	16.1%	24.1%	<0.001*
Inpatient Visits	2.8%	2.4%	0.12
Behavioral Health Encounters—ARTS	0.4%	0.5%	0.08
Behavioral Health Encounters—CMH Services	14.0%	14.2%	0.76

Measure	Children in Foster Care Rate	Controls Rate	p
Behavioral Health Encounters—RTC Services	2.7%	1.9%	<0.001*
Behavioral Health Encounters—Therapeutic Services	5.0%	4.3%	0.03*
Behavioral Health Encounters—Traditional Services	50.3%	42.4%	<0.001*
Behavioral Health Encounters—Total	51.6%	44.9%	<0.001*
Overall Service Utilization	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
Primary Care			
Child and Adolescent Well-Care Visits	19.6%	17.4%	0.37
Oral Health			
Annual Dental Visit	32.1%	27.2%	0.21
Preventive Dental Services	22.5%	20.1%	0.48
Oral Evaluation, Dental Services	24.1%	20.7%	0.34
Topical Fluoride for Children—Dental or Oral Health Services	4.5%	4.2%	0.86
Topical Fluoride for Children—Dental Services	4.1%	3.2%	0.59
Topical Fluoride for Children—Oral Health Services	0.0%	0.0%	NC
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment	33.3%	42.1%	0.19
Antidepressant Medication Management—Effective Continuation Phase Treatment	13.5%	20.0%	0.21
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	26.9%	33.3%	0.50
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	48.6%	26.7%	0.21
Substance Use			
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up	5.0%	14.3%	0.56
*Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment^*	47.0%	45.8%	0.88
*Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment^*	12.0%	13.9%	0.70
Respiratory Health			

Measure	Children in Foster Care Rate	Controls Rate	*p*
Asthma Medication Ratio	69.2%	66.7%	1.00
Service Utilization			
Ambulatory Care Visits	62.3%	66.9%	0.01*
ED Visits	44.3%	38.5%	<0.001*
Inpatient Visits	10.4%	9.6%	0.48
Behavioral Health Encounters—ARTS	5.8%	4.5%	0.08
Behavioral Health Encounters—CMH Services	10.1%	6.3%	<0.001*
Behavioral Health Encounters—RTC Services	5.0%	2.5%	<0.001*
Behavioral Health Encounters—Therapeutic Services	4.1%	2.9%	0.06
Behavioral Health Encounters—Traditional Services	34.2%	30.9%	0.04*
Behavioral Health Encounters—Total	35.6%	31.9%	0.02*
Overall Service Utilization	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 39.7 percent from MY 2020 to MY 2021, and the gap between children in foster care and controls reduced from 16.7 to 10.3 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.[12-7] 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.[12-8] 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.

12-7 Choi SE, Simon L, Basu S, Barrow JR. *Changes in dental care use patterns due to COVID-19 among insured patients in the United States*. Journal of the American Dental Association. 2021. Available at: https://jada.ada.org/article/S0002-8177(21)00417-7/pdf. Accessed on: Nov 8, 2023.

12-8 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.

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 16.9 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 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, *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment*, *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, *Initiation and Engagement of AOD Drug Abuse or Dependence Treatment—Engagement of AOD Treatment*, *Ambulatory Care Visits*, and *Overall Service Utilization*. The largest differences were for 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
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care for New Foster Care Members	1,699	1,464	86.2%
Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members	1,699	747	44.0%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members	1,699	1,534	90.3%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members	1,699	677	39.9%
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	179	125	69.8%
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	179	62	34.6%
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	179	133	74.3%
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	179	54	30.2%
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	179	58	32.4%
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	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
Age Category*		
Healthcare Utilization: Children in Foster Care	17	64.4%
Healthcare Utilization: Children Receiving Adoption Assistance	14	53.8%
Healthcare Utilization: Former Foster Care Members	1	6.3%
Timely Access to Care	4	100.0%
Sex		
Healthcare Utilization: Children in Foster Care	6	21.4%
Healthcare Utilization: Children Receiving Adoption Assistance	7	25.0%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	6	60.0%
Race		
Healthcare Utilization: Children in Foster Care	2	7.1%
Healthcare Utilization: Children Receiving Adoption Assistance	9	32.1%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	0	0.0%
Region		
Healthcare Utilization: Children in Foster Care	19	67.9%
Healthcare Utilization: Children Receiving Adoption Assistance	22	78.6%
Healthcare Utilization: Former Foster Care Members	7	29.2%
Timely Access to Care	7	70.0%
MCO		
Healthcare Utilization: Children in Foster Care	13	46.4%
Healthcare Utilization: Children Receiving Adoption Assistance	15	53.6%
Healthcare Utilization: Former Foster Care Members	5	20.8%
Timely Access to Care	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.[12-9] Additionally, for the *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.

[12-9] 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. Accessed on: Nov 8, 2023.

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[12-10]

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.[12-11] 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).[12-12] 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

[12-10] The Dental Utilization in Pregnant Women Focus Study is not limited to the CCC Plus (MLTSS) population.
[12-11] 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-andservices/dental/pregnant-women/.
[12-12] The analysis only includes paid claims. All zero-paid claims were excluded.

- 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

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,[12-13] LIFC, or Other Medicaid[12-14]), 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%
Medicaid Program								
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%

[12-13] 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.

[12-14] 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
Medicaid Managed Care Program								
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%
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%
Medicaid Delivery System								
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 12-12, 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
Preterm Births (<37 Weeks Gestation)*						
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%
Newborns With Low Birth Weight (<2,500 grams)*						
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%
Births With Adequate Prenatal Care						
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%

	Less Than 21 Years of Age			21 Years of Age and Older		
	Denom	Num	Rate	Denom	Num	Rate
Postpartum ED Utilization for Non-Traumatic Dental Services*						
Any Dental Services	681	*S*	*S*	4,532	13	0.29%
No Dental Services	3,191	*S*	*S*	27,495	89	0.32%
Postpartum Ambulatory Care Utilization						
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 12-13 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
Preterm Births (<37 Weeks Gestation)*						
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%
Newborns With Low Birth Weight (<2,500 grams)*						
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%
Births With Adequate Prenatal Care						
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%
Postpartum ED Utilization for Non-Traumatic Dental Services*						
Preventive Services	499	*S*	*S*	2,202	*S*	*S*
No Preventive Services	3,373	*S*	*S*	29,825	99	0.33%
Postpartum Ambulatory Care Utilization						
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 in providing care and follow-up for members diagnosed with BH and substance use disorders indicating the MCO had processes in place to monitor care and services and to ensure appropriate follow-up was conducted so that members were connected with care. Aetna's performance within the Behavioral Health domain identified seven PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. The *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up* and *30-Day Follow-Up—Total, Diagnosed Mental Health Disorders—Total, Diagnosed Substance Use Disorders—Alcohol disorder—Total, Opioid disorder—Total, Other or unspecified drugs—Total,* and *Any disorder—Total* PM indicators met or exceeded the 90th percentile.
⊕	Aetna also showed strength in ensuring members accessed care and services to screen for conditions and to receive timely monitoring of prescribed medications. Aetna's performance within the Living With Illness domain identified three PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Asthma Medication Ratio—Total* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicator met or exceeded the 90th percentile.
⊕	Aetna further displayed strength in providing care when prescribing opioids, ensuring that members who may be at high risk for opioid overuse or misuse are identified and monitored to ensure use is conducted with care. Aetna demonstrated strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 50th percentile for the *Use of Opioids at High Dosage—Total* PM indicator.
⊕	Overall, adult members rated their experience with Aetna as high; however, for child member representatives, the opposite was true. Aetna's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of Health Plan*. However, Aetna's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*. Aetna has an opportunity to apply these processes used in working with adult members to how it manages MCO contacts with parents and guardians of child members.

Strengths Related to Access and Timeliness	
+	PM results identified that adult members were able to access providers for preventive and well-care visits. This may have contributed to the high member experience survey response related to *Rating of Health Plan.* Within the Access and Preventive Care domain, Aetna displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
+	The majority of providers identified by Aetna as PCPs were confirmed to provide primary care services and verified that the provider was contracted with Aetna to provide care and services to Medicaid members. Of the PCPs surveyed in the secret shopper survey, 90.4 percent offered primary care services to Aetna CCC Plus (MLTSS) members.

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 Aetna: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Use of Imaging Studies for Low Back Pain* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*
	Recommendations: HSAG recommends that Aetna conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization 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:** Of the 418 provider locations surveyed as part of the secret shopper initiative, 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. Fifty percent of the routine visit appointments offered were compliant with DMAS' 30-day

Weaknesses and Recommendations	
	appointment availability compliance standards. None of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standards. **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 the providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that 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 Aetna request the file from DMAS use the file data to correct inaccuracy, validate provider information and data, and provide DMAS updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Aetna review and update provider appointment availability and the ability of members to schedule appointments within contractual time frames and providers accepting new patients. HSAG recommends that the MCO provide confirmation to DMAS that it has corrected and is in compliance with contractual appointment availability and scheduling procedures, including panel capacity to accept new patients.

HealthKeepers

Table 13-2—Overall Conclusions for HealthKeepers: Quality, Access, and Timeliness

Strengths Related to Quality	
⊕	HealthKeepers showed strength in ensuring members accessed care and services to screen for conditions and in providing support to members identified as needing assistance to quit smoking or use of tobacco products. Within the Living With Illness domain, HealthKeepers displayed strong performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile.
⊕	HealthKeepers demonstrated strength in providing care and follow-up for members diagnosed with BH and substance use disorders, indicating that the MCO had processes in place to monitor care and service delivery and prescribing patterns for members. This is supported by the results within the Use of Opioids domain, with HealthKeepers ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Use of Opioids from Multiple Providers—Multiple Pharmacies* PM indicator.

Strengths Related to Access and Timeliness	
+	HealthKeepers PM results indicate that members are connected with their PCPs and able to access care for preventive, well-care, and coordination of care. HealthKeepers' processes are reflected within the Access and Preventive Care domain, wherein HealthKeepers displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, meeting or exceeding NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile. This result also aligns with the high rates in smoking and tobacco use cessation measures and screening for diabetes measures for members receiving BH medications.
+	HealthKeepers scored well in the PCP secret shopper survey conducted by HSAG related to members' ability to schedule appointments. 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.
+	Results in the access to care, BH, and chronic illness PMs support that, overall, members are able to access care when needed. The ability to access care was also reflected in the HealthKeepers' 2023 top-box score that was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Getting Care Quickly*. In addition, HealthKeepers' 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for *Customer Service*.

Weaknesses and Recommendations	
−	**Weakness:** Opportunities for improvement exist for the MCO to calculate and report performance indicator data accurately in the data table and in the narrative summary of results when conducting PIPs.
	Recommendations: HSAG recommends that the MCO ensure that the data reported in the submission form are calculated and reported correctly. HSAG recommends that the MCO implement internal quality checks prior to submitting the PIP for the annual HSAG validation process.
−	**Weakness:** Although there was positive performance in many access to care and screening PMs, 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 HealthKeepers: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Cervical Cancer Screening* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*

Weaknesses and Recommendations	
	• *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* • *Plan All-Cause Readmissions—Observed Readmissions—Total*
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization 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 contributed to lower performance for a particular race or ethnicity, age group, ZIP Code, etc.
−	**Weakness:** HSAG found during the secret shopper survey of PCPs 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. **Why the weakness exists:** 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 times of five minutes for the secret shopper survey; however, this may indicate that 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 HealthKeepers request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that HealthKeepers provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that HealthKeepers implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients.
−	**Weakness:** HealthKeepers' 2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national averages for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. These results may reflect and align with the results of the PCP secret shopper survey that found inaccuracies in provider information and ability to schedule appointments.
	Recommendations: HSAG recommends that HealthKeepers conduct a root cause analysis of the study indicator in conjunction with actions taken related to primary care secret shopper survey results that have been identified as an area of low performance. This type of analysis is used to

Weaknesses and Recommendations	
	investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.

Molina

Table 13-3—Overall Conclusions for Molina: Quality, Access, and Timeliness

Strengths Related to Quality	
+	Molina's PM results indicate that in most cases members are connected with their PCPs and able to access care for preventive, well-care, and coordination of care. Within the Taking Care of Children domain, Molina displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile.
+	Results in the access to care, BH, and chronic illness PMs support that, overall, members are able to access care when needed. Within the Living With Illness domain, Molina ranked at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Asthma Medication Ratio—Total, Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators.
Strengths Related to Access and Timeliness	
+	Molina displayed strong performance within the Use of Opioids domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Use of Opioids from Multiple Providers—Multiple Pharmacies* PM indicator.
+	The PCP secret shopper survey found that 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. The primary care secret shopper survey results support the PMV findings that members are able to access providers for well-care, screening, and managing conditions such as smoking and tobacco cessation.
Weaknesses and Recommendations	
−	**Weakness:** PIP validation results identified that for the *AMB-ED* PIP, Molina has an opportunity for improvement related to reporting correct data in the narrative summary of results. In addition, for the *Follow-Up After*

Weaknesses and Recommendations	
	Discharge PIP, Molina did not address all documentation requirements for data analysis and interpretation of results.
	Recommendations: HSAG recommends that the MCO ensure that the data reported in the submission form are calculated and reported correctly. HSAG recommends that Molina implement internal quality checks prior to submitting the PIP for the annual validation. HSAG also recommends that Molina ensure it addresses whether there are factors that threaten the validity and comparability of the data annually.
	**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: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Child and Adolescent Well-Care Visits—Total* • *Controlling High Blood Pressure* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*
	Recommendations: Although Molina members are able to access some well-care, preventive, and screening appointments with PCPs, HSAG recommends that Molina conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina 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 PCP secret shopper survey results found 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,

Weaknesses and Recommendations	
	5.7 percent were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** 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 times of five minutes for the secret shopper survey; however, this may indicate that 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 Molina request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that Molina provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Molina implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients.

Optima

Table 13-4—Overall Conclusions for Optima: Quality, Access, and Timeliness

Strengths Related to Quality	
⊕	Within the Taking Care of Children domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Child Immunization Status—Combination 3* PM indicator. Although the MCO performed well in ensuring children received recommended vaccinations according to the Bright Futures and EPSDT schedule, the MCO's initiatives are not having a similar impact on ensuring children receive well and preventive care according to the same preventive health schedules. The MCO should consider whether any interventions used to ensure children are vaccinated can be replicated to ensure children also receive recommended well visits.
⊕	Optima has implemented effective procedures for ensuring that members receiving medications to manage BH diagnosis receive necessary screenings to identify and treat associated chronic illnesses. Providers are also identifying and providing resources to assist members in reducing or eliminating the use of smoking and tobacco products. These findings are supported by Optima's results within the Living With Illness domain, wherein Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. For the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Total* and *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*

Strengths Related to Quality	
	PM indicators, Optima met or exceeded the 75th percentile, and for the *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit* and *Discussing Cessation Medications* PM indicators, Optima met or exceeded the 90th percentile.

Strengths Related to Access and Timeliness	
+	PM results and CAHPS adult survey results indicate that members have access to preventive care and are getting care when needed. Within the Access and Preventive Care domain, Optima met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 90th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator. This rate aligns with the results of the CAHPS survey which found that Optima's 2023 top-box scores were statistically significantly higher than the 2022 NCQA adult Medicaid national averages for five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Weaknesses and Recommendations	
−	**Weakness:** The following HEDIS MY 2021 PM rates fell below NCQA's Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile and were determined to be opportunities for improvement for Optima: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* • *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Use of Opioids from Multiple Providers—Multiple Prescribers* • *Well-Child Visits in the First 15 Months to 30 Months—Two or More Well-Child Visits* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*

Weaknesses and Recommendations	
	Recommendations: A significant number of PMs were below the NCQA Quality Compass HEDIS MY 2020 Medicaid HMO 25th percentile. In consideration of the results of the PCP secret shopper survey, access to network providers may also be impacting these PM results. HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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. HSAG also recommends that Optima conduct a review to identify best practices for providing care and services that fall in these care domains and identify best practices that will increase these PM rates.
−	**Weakness:** 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. **Why the weakness exists:** 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 times of five minutes for the secret shopper survey; however, this may indicate that 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 Optima request a copy of the file from DMAS and review it for accuracy and completeness. HSAG recommends that Optima provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that Optima implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients. HSAG recommends that Optima review best practices for ensuring members are able to schedule appointments and to access recommended or needed care and services within the timelines outlined in Optima's contract with DMAS.

United

Table 13-5—Overall Conclusions for United: Quality, Access, and Timeliness

Strengths Related to Quality	
	United has implemented effective procedures for ensuring that members receiving medications to manage BH diagnosis receive necessary screenings to identify and treat associated chronic illnesses. These findings are supported by United's results within the Behavioral Health domain. United met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia Strategies* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
	United's performance within the Living With Illness domain identified six PM indicators that met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile or 90th percentile. The *Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, Controlling High Blood Pressure—Total,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* PM indicators met or exceeded the 75th percentile, and the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%),* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* PM indicators met or exceeded the 90th percentile. These findings related to managing chronic conditions indicate that United has developed procedures to ensure that members are assisted in receiving recommended care and services for their chronic condition.
	United's processes for ensuring members with chronic conditions are managed and are receiving recommended services may also have an impact on ensuring members do not experience readmissions. United displayed strong performance within the Utilization domain, ranking at or above NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Plan All-Cause Readmissions—O/E Ratio—Total* PM indicator.
	United's 2023 top-box score was statistically significantly higher than the 2022 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*. This rating may reflect members' satisfaction with their ability to receive care that allows them to manage their chronic conditions.
Strengths Related to Access and Timeliness	
	Within the Access and Preventive Care domain, United displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM indicator, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 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 United: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* • *Use of Imaging Studies for Low Back Pain* • *Child and Adolescent Well-Care Visits—Total* • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies*
	Recommendations: HSAG recommends that United conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United 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. HSAG recommends that United consider its effective practices that have resulted in high PM rates for some chronic illness measures and determine whether a similar impact could be derived for care associated with these measures.
−	**Weakness:** 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. **Why the weakness exists:** 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 providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that 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 United request a copy of

Weaknesses and Recommendations	
	the file from DMAS and review it for accuracy and completeness. HSAG recommends that United provide DMAS with updates or confirmation that the data have been updated as appropriate. Additionally, HSAG recommends that United implement processes to confirm appointment availability and appointment scheduling procedures with providers to ensure contract requirements are met, including requirements for panel capacity and providers who are accepting new patients.
−	**Weakness:** United's 2023 top-box score was statistically significantly lower than the 2022 NCQA child Medicaid national average for one measure, *Rating of Health Plan*.
	Recommendations: HSAG recommends that United conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that United focus initiatives on raising the statistically significantly lower score and continue to monitor the measure to ensure there is not a significant decrease in the score over time. In addition, there may be an opportunity to review initiatives that resulted in the positive score in the Adult *Rating of All Health Care* measure.

VA Premier

Table 13-6—Overall Conclusions for VA Premier: Quality, Access, and Timeliness

Strengths Related to Quality	
+	VA Premier implemented effective procedures for ensuring that members receive and adhere to medications to manage their BH diagnosis. These findings are supported by VA Premier's results within the Behavioral Health domain. VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* PM indicators.
+	Within the Taking Care of Children domain, VA Premier displayed strong performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* and *Blood Glucose and Cholesterol Testing—Total* PM indicators, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile. This aligns with VA Premier's results within the Living With Illness domain wherein VA Premier met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 75th percentile for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Medical Assistance With Smoking and Tobacco Use*

Strengths Related to Quality	
	Cessation—Discussing Cessation Strategies and *Advising Smokers and Tobacco Users to Quit* PM indicators. The MCO should review its processes for ensuring members receive these screenings and determine if any best practices could be used to improve other PM indicator rates.
+	VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *Customer Service*. VA Premier's 2023 top-box score was statistically significantly higher than the 2022 top-box score for one measure, *Rating of Personal Doctor*. In addition, VA Premier's 2023 top-box score was statistically significantly higher than the 2022 NCQA child Medicaid national average for *How Well Doctors Communicate*.
Strengths Related to Access and Timeliness	
+	Within the Access and Preventive Care domain, VA Premier displayed strong performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total* PM, which met or exceeded NCQA's Quality Compass HEDIS MY 2021 Medicaid HMO 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 VA Premier: • *Ambulatory Care—ED Visits—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care* • *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* • *Childhood Immunization Status—Combination 3* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* • *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* • *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* • *Use of Imaging Studies for Low Back Pain* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

Weaknesses and Recommendations	
	• *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*
	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 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, 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 members' access to care. HSAG recommends that Optima conduct a root cause analysis or focus study for these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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. HSAG recommends that Optima consider its effective practices that have resulted in high PM rates for some BH measures and determine whether a similar impact could be derived for care associated with these measures.
−	**Weakness:** PCP secret shopper survey results 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, and 25.9 percent of the urgent visit appointments offered were compliant with DMAS' 24-hour appointment availability compliance standards. **Why the weakness exists:** 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 providers could be affected by the limited hold times of five minutes for the secret shopper survey; however, this may indicate that the providers offices are facing delays due to staffing shortages and workforce issues.
	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 the analytic flat files from the PCP secret shopper survey and use the files to provide updates or confirmation to DMAS that the data

Weaknesses and Recommendations	
	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 members' access to care.
−	**Weakness:** VA Premier's 2023 top-box scores were statistically significantly lower than the 2022 top-box scores for two measures, *Getting Needed Care* and *Getting Care Quickly*.
	Recommendations: These results may align with the low PM results in some of the women's health and children's health measures. With VA Premier merging with Optima and no longer serving members as of July 1, 2023, HSAG has no additional recommendations.

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 Document
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 Document
2	All eligible Medicaid and Children's Health Insurance Program (CHIP) plans are included in the report. *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)*	Page 2 Each Section
3a	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. *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.*	Sections 3 – 13
3b	Required elements are included in the report: An assessment of the strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) 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. *TIPS:* • *Include a chart outlining each MCP's strengths and weaknesses for each EQR activity and designate a quality, timeliness, and access domain.*	Sections 3 – 13

	Required Elements	Page Number
	• *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.*	
3c	Required elements are included in the report: Describe how the state can target goals and objectives in the quality strategy, under 42 CFR §438.340 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. *TIPS:* • *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.*	Pages 1-11 – 1-12
3d	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) *TIPS:* • *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.* • *When determining recommendations, EQROs should consider whether the suggested actions are within the authority of the MCP (or state).*	Section 13
3e	Summarize results across all MCEs and provide state-level recommendations for performance improvement.	Section 3
3f	Ensure methodologically appropriate, comparative information about all MCPs in accordance with 42 CFR 438.364(a)(5). *TIPS:* • *Aggregate findings across MCPs for each EQR activity and show comparisons.* • *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.*	Section 3 Appendix B
3f	Assess the degree to which each MCP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. §438.364(a)(6) *TIPS:*	Appendix E

	Required Elements	Page Number
	• *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.* • *Document assessments with the same specificity used when reporting on initial findings.*	
3g	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) *TIPS:* • *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).* • *Ensure that MCPs comply with HIPAA and all other federal and state laws concerning confidentiality and disclosure.* • *Ensure that EQR-related data collection and reporting activities are consistent with HIPAA requirements.*	Entire Report
3h	An assessment of the MCO, PIHP, PAHP, or PCCM entity information system as part of the validation process. §438.242	Section 8 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	**Validation of performance improvement projects (PIPs):** A description of **PIP interventions** associated with each state-required PIP topic that were underway during the preceding 12 months, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.** §438.358(b)(1)(i) and 2 CFR 438.364(a)(2)(iiv) *CONSIDERATIONS:* • *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.*	
4a	Validation of performance improvement projects (PIPs): • **Interventions** 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) *CONSIDERATIONS:* • *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.* • *Note that a table listing all PIP interventions will not alone be considered as methodologically appropriate comparative information, as the table simply organizes information, but does not compare or draw conclusions from the information presented.*	Section 4 Pages 4-4 – 4-16

	Required Elements	Page Number
4b	Validation of performance improvement projects (PIPs): • **Objectives** *CONSIDERATIONS:* • *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.*	Section 4 Page 4-1
4c	Validation of performance improvement projects (PIPs): • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *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.*	Appendix B
4d	Validation of performance improvement projects (PIPs): • **Description of data obtained;** *CONSIDERATIONS:* • *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.*	Appendix B
4e	Validation of performance improvement projects (PIPs): • **Conclusions drawn from the data** *CONSIDERATIONS:* • *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.*	Section 4 Pages 4-3 – 4-17
5	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. *CONSIDERATIONS:* • *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.* • *States often link the timeframe under review to a corresponding measurement or performance period such as state or federal fiscal year, or calendar year.*	

	Required Elements	Page Number
5a	Validation of performance measure validation (PMV): • **Objectives** *CONSIDERATIONS:* • *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.*	Page 5-1 Appendix B
5b	Validation of performance measure validation (PMV): • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *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.*	Appendix B
5c	Validation of performance measure validation (PMV): • **Description of data obtained** *CONSIDERATIONS:* • *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.*	Appendix B
5d	Validation of performance measure validation (PMV): • **Conclusions drawn from the data.** *CONSIDERATIONS:* • *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.*	Pages 5-2 – 5-11
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report including information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. 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. *CONSIDERATIONS:*	

	Required Elements	Page Number
	• *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.* • *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.* Additional information that needs to be included for compliance is listed in the rows below:	
6a	Review for compliance: • **Objectives** *CONSIDERATIONS:* • *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.*	Page 6-1 Appendix B
6b	Review for compliance: • **Technical methods of data collection and analysis** *CONSIDERATIONS:* • *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.*	Appendix B
6c	Review for compliance: • **Description of data obtained** CONSIDERATIONS: • *This requirement does not apply to the compliance review activity (Protocol 3).*	Section 6 Appendix B
6d	Review for compliance: • **Conclusions drawn from the data** *CONSIDERATIONS:* • *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.*	Pages 6-2 – 6-10
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a.1	Optional activities: Secret Shopper Survey **Objectives;**	Page 8-1 Appendix B

	Required Elements	Page Number
7b.1	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.1	Optional activities: **Description of data obtained; and**	Page 8-1 Appendix B
7d.1	Optional activities: **Conclusions drawn from the data.**	Pages 8-1 – 8-14
7a.2	Optional activities: Encounter Data Validation **Objectives;**	
7b.2	Optional activities: **Technical methods of data collection and analysis;**	
7c.2	Optional activities: **Description of data obtained; and**	
7d.1	Optional activities: **Conclusions drawn from the data.**	
7a.3	Optional activities: Member Experience of Care Survey • **Objectives;**	Page 10-1
7b.3	Optional activities: • **Technical methods of data collection and analysis;**	Appendix B
7c.3	Optional activities: • **Description of data obtained; and**	Appendix B
7d.3	Optional activities: • **Conclusions drawn from the data.**	Pages 10-1 – 10-14
7a.4	Optional activities: Calculation of Additional PM Results **Objectives;**	Page 3-31 Appendix B
7b.4	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.4	Optional activities: **Description of data obtained; and**	Appendix B
7d.4	Optional activities: **Conclusions drawn from the data.**	Pages 3-31 – 3-33
7a.5	Optional activities: ARTS Measurement Specification Development and Maintenance **Objectives;**	Pages 3-33 – 3-34 Page11-1 Appendix B
7b.5	Optional activities: **Technical methods of data collection and analysis;**	Page 11-1 – 11-2 Appendix B
7c.5	Optional activities: **Description of data obtained; and**	Page 3-33 – 3-34 Page 11-1 – 11-3 Appendix B
7d.5	Optional activities: **Conclusions drawn from the data.**	NA

	Required Elements	Page Number
7a.6	Optional activities: Medicaid and CHIP Maternal and Child Health Focus Study **Objectives;**	Page 12-1 Appendix B
7b.6	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.6	Optional activities: **Description of data obtained; and**	Appendix B
7d.6	Optional activities: **Conclusions drawn from the data.**	Pages 12-1 – 12-5
7a. 7	Optional activities: Child Welfare Focus Study **Objectives;**	Pages 12-5 – 12-6 Appendix B
7b.7	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.7	Optional activities: **Description of data obtained; and**	Appendix B
7d.7	Optional activities: **Conclusions drawn from the data.**	Pages 12-6 – 12-17
7a.8	Optional activities: Dental Utilization in Pregnant Women Data Brief **Objectives;**	Pages 12-17 – 12-18
7b.8	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.8	Optional activities: **Description of data obtained; and**	Appendix B
7d.8	Optional activities: **Conclusions drawn from the data.**	Pages 12-18 – 12-24
7a.9	Optional activities: Consumer Decision Support Tool **Objectives;**	Page 3-34 Appendix B
7b.9	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.9	Optional activities: **Description of data obtained; and**	Appendix B
7d.9	Optional activities: **Conclusions drawn from the data.**	Pages 3-34 – 3-35
7a.10	Optional activities: Performance Withhold Program **Objectives;**	Page 3-36 Appendix B
7b.10	Optional activities: **Technical methods of data collection and analysis;**	Appendix B
7c.10	Optional activities: **Description of data obtained; and**	Page 3-36 Appendix B
7d.10	Optional activities: **Conclusions drawn from the data.**	Page 3-36

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
- Encounter Data Validation Methodology
- Member Experience of Care Survey Methodology
- MCO Comparative and Statewide Calculation of Additional Performance Measure Results
- Prenatal Care and Birth Outcomes Focus Study Methodology
- Foster Care 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.[B-1] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[B-2] 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) is based on sound methodological principles and can reliably measure outcomes. Successful

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 22, 2023.

[B-2] 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.

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 Me*t: 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 Me*t.

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. Title 42 of the 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 the CMS publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*.[B-3]

DMAS is responsible for administering the Medicaid program and CHIP in the Commonwealth of Virginia. DMAS refers to its CHIP program as FAMIS. The CCC Plus (MLTSS) program is an integrated managed care delivery model that includes medical services, nursing, personal care, and behavioral (mental) health services. DMAS contracted with six privately owned MCOs to provide services to

[B-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf.Accessed on: Nov 17, 2023.

members enrolled in the CCC Plus (MLTSS) program for CY 2022. DMAS identified a set of performance measures that the MCOs were required to calculate and report.

The purpose of the PMV was to assess the accuracy of performance measures reported by the CCC Plus (MLTSS) MCOs and to determine the extent to which performance measures reported by the MCOs followed State specifications and reporting requirements. Table B-2 displays the CCC Plus (MLTSS) MCOs that were included in the PMV.

Table B-2—CY 2022 CCC Plus (MLTSS) 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 measure-specific review was performed on a subset of CCC Plus (MLTSS) MCO performance measures, all part of quality withhold measures, to evaluate the accuracy of reported performance measure data. PMV results provided DMAS with MCO-specific performance measure designations to additional information for MCO quality withhold payments.

Technical Methods of Data Collection

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

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

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

Based on the scope of the validation, HSAG assembled a validation team based on the full complement of skills required for validating the specific performance measures and conducting the PMV for each MCO. The team was composed of a lead auditor and several team members.

Description of Data Obtained

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data HSAG reviewed and how HSAG analyzed these data:

- **Roadmap and ISCAT**—The MCOs submitted a Roadmap for HSAG's review that was to be completed as part of the NCQA HEDIS audit process. HSAG completed a thorough review of the Roadmap, which includes MCO operational and organizational structure; data systems and data reporting structure and processes; and additional information related to HEDIS audit standards. Additionally, the MCOs completed and submitted an ISCAT for HSAG's review of the performance measures. The ISCAT supplemented the information included in the Roadmap and addresses data collection and reporting specifics of non-HEDIS measures. HSAG used responses from the Roadmap and ISCAT to complete the pre-on-site assessment of information systems.
- **Medical record documentation**—The MCOs were responsible for completing the medical records review section within the Roadmap for the measures reported using the hybrid method. In addition, HSAG requested that the MCOs submit the following documentation for review: medical record abstraction tools and instructions, training materials for medical record review staff members, and policies and procedures outlining the processes for monitoring the accuracy of the abstractions performed by the review staff members. HSAG conducted over-read of 16 records from the hybrid sample for each performance measure. HSAG followed NCQA's guidelines to validate the integrity of the MRRV processes used by the MCOs and determined if the findings impact the audit results for any performance measure rate.
- **Source code (programming language) for performance measures**—The MCOs that calculate the performance measures using internally developed source code will be required to submit source code for each performance measure being validated. HSAG will complete a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DMAS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs that do not use source code were required to submit documentation describing the steps taken for performance measure calculation. If the MCOs outsourced programming for HEDIS measure production to an outside vendor, the MCOs were required to submit the vendor's NCQA measure certification reports.
- **Supporting documentation**—HSAG requested documentation that provides additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, measure certification reports, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

How Data Were Aggregated and Analyzed

During the on-site visit, HSAG collected additional information to compile PMV findings using several methods including interviews, system demonstration, review of data output files that identify numerator and denominator compliance, observation of data processing, and review of data reports. The on-site was combined for the Medallion 4.0 (Acute) and CCC Plus (MLTSS) programs. The on-site strategies included:

- **Opening meetings**—These meetings included introductions of the validation team and key MCO staff involved in the calculation or reporting of the performance measures. The purpose of the PMV, required documentation, basic meeting logistics, and queries to be performed will be discussed.
- **Review of ISCAT and Roadmap documentation**—This session was designed to be interactive with key MCO staff so that the validation team obtains a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and can evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain if written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes**—The evaluation includes a review of the information systems, focusing on the processing of claims, processing of enrollment and disenrollment data. HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculation of the performance measures. Key staff may include executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generation of the performance measures. HSAG used these interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- **Overview of data integration and control procedures**—This session included a review of the information systems and evaluation of processes used to collect, calculate, and report the performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  HSAG performed additional validation using PSV to further validate the data output files. PSV is a review technique used to confirm that the information from the primary source matches the data output file used for reporting. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCOs have system documentation that supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome is determined based on the type of error. For example, the review of one case may be sufficient in detecting a programming language error, and as a result no additional cases related to that issue may be reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—At the end of each on-site visit, HSAG summarized preliminary findings, discuss follow-up items, and revisit the documentation requirements for any post-on-site activities.

How Conclusions Were Drawn

After the on-site visit, HSAG reviewed final performance measure rates submitted by the MCOs to DMAS and followed up with each MCO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issue identified from the rate review was communicated to the MCO as a corrective action that must be addressed as soon as possible so that the rate could be revised before the PMV report was issued.

HSAG prepared a separate PMV report for CCC Plus (MLTSS) for each MCO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS PMV protocol identifies possible validation results for performance measures, defined in Table B-3 below.

Table B-3—Validation Results and Definitions for Performance Measures

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

According to the CMS EQR PMV protocol, the validation result for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of errors detected within each audit element. It is possible for an audit element to receive a validation result of DNR when the impact of even a single error associated with that element biased the reported performance measure rate by more than five percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of "Reportable" (R).

Any corrective action that cannot be implemented in time is noted in the MCO's PMV report under "Recommendations". If the corrective action is closely related to accurate rate reporting, HSAG may render a particular measure DNR.

Table B-4 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-4—Performance Measure List for SFY 2023

Performance Measure	Specifications	Method*
Blood Pressure Control for Patients With Diabetes	HEDIS MY 2022	Hybrid
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)	Adult Core Set	Admin
Eye Exam for Patients With Diabetes	HEDIS MY 2022	Hybrid
Follow-Up After Emergency Department Visit for Substance Use	HEDIS MY 2022	Admin
Follow-up After Emergency Department Visit for Mental Illness	HEDIS MY 2022	Admin

Performance Measure	Specifications	Method*
Heart Failure Admission Rate	Adult Core Set	Admin
Hemoglobin A1c Control for Patients With Diabetes	HEDIS MY 2022	Hybrid
Initiation and Engagement of Substance Use Disorder Treatment	HEDIS MY 2022	Admin

* 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-5 describes the standards and associated regulations and requirements reviewed for each standard during the OSRs.

Table B-5—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	Federal Requirements Included	Standard	Federal Requirements Included
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-6 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table B-6—Protocol Activities Performed for Assessment of Compliance With Regulations

For this protocol activity,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Conducted before the review to assess compliance with federal managed care regulations and DMAS contract requirements: a. HSAG and DMAS participated in virtual meetings to determine the timing and scope of the reviews, as well as scoring strategies. b. HSAG collaborated with DMAS to develop monitoring tools, record review tools, report templates, agendas, and set review dates. c. HSAG submitted all materials to DMAS for review and approval. d. HSAG conducted training for all reviewers to ensure consistency in scoring across the MCOs.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted an MCO training webinar to describe HSAG's processes and allow the MCOs the opportunity to ask questions about the review process and MCO expectations. • HSAG confirmed a primary MCO contact person for the review and assigned HSAG reviewers to participate. • No less than 60 days prior to the scheduled date of the review, HSAG notified the MCO in writing of the request for desk review documents via email delivery of a desk review form, the compliance monitoring tool, and a webinar review agenda. The desk review request included instructions for organizing and preparing the documents to be submitted. Thirty days prior to the review, the MCO provided data files from which HSAG chose sample grievance, appeal, and denial cases to be reviewed. HSAG provided the final samples to the MCOs via HSAG's SAFE site. No less than 30 days prior to the scheduled review, the MCO provided documentation for the desk review, as requested. • Examples of documents submitted for the desk review and compliance review consisted of the completed desk review form, the compliance monitoring tool with the MCO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The HSAG review team reviewed all documentation submitted prior to the scheduled virtual review and prepared a request for further documentation and an interview guide to use during the webinar.

For this protocol activity,	HSAG completed the following activities:
Activity 3:	**Conduct MCO Review**
	• During the review, HSAG met with the MCO's key staff members to obtain a complete picture of the MCO's compliance with Medicaid and CHIP managed care regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCO's performance. • HSAG requested, collected, and reviewed additional documents, as needed. • At the close of the virtual review, HSAG provided MCO staff members and DMAS personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2020–2021 DMAS-approved Compliance Review Report Template to compile the findings and incorporate information from the compliance review activities. • HSAG analyzed the findings and calculated final scores based on DMAS-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.
Activity 5:	**Report Results to DMAS**
	• HSAG populated the DMAS-approved report template. • HSAG submitted the draft report to DMAS for review and comment. • HSAG incorporated the DMAS comments, as applicable, and submitted the draft report to the MCO for review and comment. • HSAG incorporated the MCO's comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of Not Met). • HSAG distributed the final report to the MCO and DMAS.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory

- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (grievances and appeals)
- Interviews with key MCO staff members conducted virtually

How Data Were Aggregated and Analyzed

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

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

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

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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services provided by the MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality and timeliness of, or access to care and services provided by the MCOs. Table B-7 depicts assignment of the standards to the domains of care.

Table B-7—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-8 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-8—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 the 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*, February 2023.[B-4] 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.

[B-4] 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.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

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
  - 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.

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.[B-5]
  - 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 ±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 are 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).[B-6] 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).

[B-5] 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.

[B-6] 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.

- 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[B-7] of request.
- Appointments for routine visits (e.g., annual well-check appointment) shall be scheduled within 30 calendar days of request.

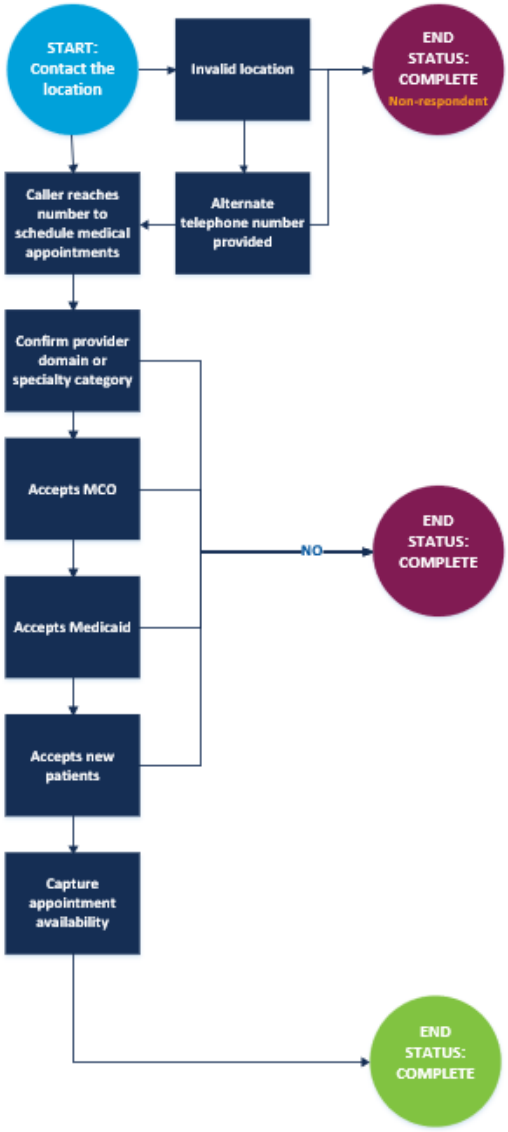
HSAG collected the following information pertaining to provider data accuracy:

- 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-1 outlines the decision stop points throughout the survey.

[B-7] 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-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

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,[B-8] 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 CCC Plus (MLTSS) MCOs displayed in Table B-9.

Table B-9—CCC Plus (MLTSS) 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

[B-8] 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: Dec 18, 2023.

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.[B-9] 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 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.

[B-9] 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.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 18, 2023.

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-10. The analyses focused on an element-level comparison for each data element.

Table B-10—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	✓		

Key Data Elements	Professional	Institutional	Pharmacy
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.[B-10] 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, Molina 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 2023.

Each MCO was responsible for contracting with an NCQA-certified survey vendor to conduct CAHPS surveys of the MCO's adult and child Medicaid populations on the MCO's behalf. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed to select members and distribute surveys.[B-11] 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

[B-10] 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).

[B-11] 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.

the Children with Chronic Conditions measurement set) that assess adult members' and parents'/caretakers' of child 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 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. 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 (adult population only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

How Data Were Aggregated and Analyzed

HSAG performed a trend analysis of the results in which the FY 2023 top-box scores were compared to their corresponding FY 2022 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 2023 than FY 2022 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in FY 2023 than FY 2022 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, the 2023 top-box scores for each MCO and the statewide aggregate were compared to the 2022 NCQA Medicaid national averages.[B-12,B-13,B-14] 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-11.

Table B-11—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

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

B-12 For the NCQA Medicaid national averages, the source for the data contained in this publication is Quality Compass® 2022 data and is used with the permission of the National Committee for Quality Assurance (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. Quality Compass is a registered trademark of NCQA.

B-13 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA, September 2022.

B-14 NCQA national averages were not available for 2023 at the time this report was prepared; therefore, 2022 national data are presented.

MCO Comparative and Statewide Calculation of Additional Performance Measure Results[B-15]

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.* [B-16]

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 Medicaid eligible individuals. DMAS supplied SAS® data sets extracted by claims' paid dates. [B-17] 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.

[B-15] Note: This methodology is presented as it appeared in the final report for this activity.
[B-16] 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.
[B-17] SAS is a registered trademark of the SAS Institute, Inc.

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-12 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-12—Medicaid Program, Medicaid Delivery System, MCO, Geographic Region, Age Group, and Gender Stratification Values

Stratification	Values
Medicaid Program	• CCC Plus (MLTSS) • Medallion 4.0 (Acute) • More than One Medicaid Program
Medicaid Delivery System	• FFS • Managed Care • More than One Delivery System
MCO	• Aetna Better Health of Virginia (Aetna) • HealthKeepers, Inc. (HealthKeepers) • Molina Complete Care of Virginia, LLC (Molina) • Optima Health (Optima) • UnitedHealthcare of the Mid-Atlantic, Inc. (United) • Virginia Premier Health Plan, Inc. (VA Premier) • More than One MCO
Geographic Regions	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater • Unknown

Stratification	Values
Age Groups	• 18–44 • 45–64 • 65–74 • 75–84 • 85+ • Total
Gender	• Male • Female

For results stratified by race, DMAS provided race categories; however, to increase the utility of these rates, the original race categories were combined into larger groupings as shown in Table B-13. Table B-13 presents the *MLTSS-8* performance measure race stratifications that were reported by HSAG with a crosswalk to DMAS' race categories.

Table B-13—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.

ARTS Measurement Specification Development and Maintenance

Objectives

DMAS contracted with HSAG, as its EQRO, to identify appropriate existing performance measures and to develop new measure specifications, where necessary, for the ARTS benefit as mandated in the Special Terms and Conditions of CMS Section 1115 Demonstration, "Building and Transforming Coverage,

Services, and Supports for a Healthier Virginia." The Special Terms and Conditions require that DMAS monitor the MCOs at least once per year through the EQRO. HSAG, in conjunction with DMAS, developed performance measures using administrative data for the evaluation of DMAS' ARTS benefit.

Technical Methods of Data Collection

HSAG utilized Medicaid administrative claims and encounters data as well as member, provider, enrollment, and laboratory data supplied by DMAS. DMAS provided claims and encounters paid through June 30, 2022, during July 2022, resulting in a six-month data runout from the end of CY 2021 to data extraction.

Description of Data Obtained

Study data included administrative claims and encounters, as well as demographic, eligibility, enrollment, and laboratory data to examine services received by Virginia Medicaid members. Measure calculations utilized data up to three years prior to the measurement year.

How Data Were Aggregated and Analyzed

Measures

HSAG calculated the Virginia Medicaid total population rates for the following eight measures and 27 study indicators, as displayed in Table B-14.

Table B-14—ARTS Measures

Measure and Indicators
Concurrent Prescribing of Naloxone and *High-Dose Opioids*
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*
Treatment of Hepatitis C for Those With Hepatitis C and SUD
Treatment of HIV for Those With HIV and SUD
Preferred OBAT Compliance—Alcohol or Drug Screening, Counseling from an OBAT Provider, Family Planning, Prescription for Naloxone from OBAT Provider, Prescription for Naloxone, Testing for HIV/Hepatitis C, Initiation of Medication for OUD, Concurrent Pharmacotherapy and Care Coordination, RPR Testing, and *Annual TB Testing*
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*
Cascade of Care for Members With Hepatitis C—Prevalence of Hepatitis C, Received DAA Treatment for Hepatitis C, Completed DAA Treatment for Hepatitis C, and *Achieved SVR*
Cascade of Care for Members With HIV—Received HIV Care, Retained in HIV Care, and *Received Antiretroviral Therapy*

HSAG calculated all measures in alignment with the performance measure specifications developed by HSAG and DMAS.

Stratified Rates

For every performance measure, HSAG also calculated rates stratified by member characteristics. For the Medicaid total population, HSAG calculated rates stratified by the following characteristics:

- Age Category
  - Varies by measure
- Sex
  - Male and Female
- Race/Ethnicity
  - Asian, Black/African American, Hispanic, Southeast Asian/Pacific Islander, White, and More Than One Race/Other/Unknown
- Geographic Region of Residence
  - Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, Southwest, Tidewater, and Unknown
- Medicaid Delivery System
  - FFS, Managed Care, and More Than One Delivery System
- Eligibility Group
  - ABD; Dual Eligible; FAMIS Children; Medicaid Expansion; Pregnant Women; Other Non-Disabled Adults; Other Low Income Children; and Other Eligibility Groups

For the Virginia managed care total population, HSAG calculated rates stratified by the following characteristics:

- Managed Care Program
  - Medallion 4.0 (Acute), CCC Plus (MLTSS), and More Than One Managed Care Program
- MCO
  - Aetna; HealthKeepers; Molina; Optima; UnitedHealthcare; VA Premier; and More Than One MCO

For the Medicaid delivery system, managed care program, and MCO stratifications, HSAG assigned categories based on whether the member met the measure's continuous enrollment requirements for that category (e.g., whether the member was continuously enrolled in managed care for each measure). If a member was not continuously enrolled in any category or was continuously enrolled in multiple categories, they were assigned to the More Than One category (e.g., More Than One Delivery System). For stratifying rates by eligibility group, HSAG worked with DMAS to group Medicaid aid categories and benefit package codes into eligibility groups and assigned eligibility group based on enrollment during the measurement year, as described Table B-15.

Table B-15—Eligibility Group Definitions

Eligibility Group	Definition[B-18]
ABD	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 018, 020, 011, 012, 021, 022, 024, 025, 028, 029, 031, 032, 038, 039, 040, 041, 042, 044, 045, 048, 049, 051, 052, 058, 059, 060, 061, 062, 068. Excludes Dual Eligible members.
Dual Eligible	Members enrolled for any length of time during the measurement year in Medicare based on any one or combination of the following benefit packages: 01010200, 01010300, 01010400, 01052000, 01052001.
Medicaid Expansion	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 100, 101, 102, 103, 106. Excludes Dual Eligible members.
Pregnant Women	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 005, 091, 097, 110, 111. Excludes Dual Eligible members.
FAMIS Children	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 006, 007, 008, 009, 010, 014. Excludes Dual Eligible members.
Other Low Income Children	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 064, 072, 075, 076, 079, 082, 085, 086, 088, 090, 091, 092, 093, 094, 098, 099. Excludes Dual Eligible members.
Other Non-Disabled Adults	Members continuously enrolled for the measurement year in any one or combination of the following aid categories: 065, 066, 067, 070, 077, 078, 081, 083. Excludes Dual Eligible members.

B-18 To be continuously enrolled for the measurement year, members could not have more than one gap in enrollment during the measurement year or any gap longer than 31 days during the measurement year. Additionally, members had to be enrolled on December 31 of the measurement year.

Eligibility Group	Definition[B-18]
Other Eligibility Groups	Members who did not meet any of the other eligibility group criteria or who were enrolled in multiple eligibility groups.

In addition to member-based stratifications, HSAG also calculated measure-specific stratifications for select measures, where applicable (e.g., the *90 ≤ MME per Day < 120* and *MME per Day ≥ 120* rates for the *Concurrent Prescribing of Naloxone and High-Dose Opioids* measure).

How Conclusions Were Drawn

For the total and stratified findings for the study indicators during CY 2020 and CY 2021, HSAG highlighted changes and differences in rates greater than 1.0 percentage point for total rates and greater than 5.0 percentage points for stratified rates. However, for select measures with large rate changes across most stratifications, HSAG highlighted stratifications with rate changes that differed notably from the trend in the total population.

Medicaid and CHIP Maternal and Child Health Focus Study Methodology

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) funding to serve pregnant women with incomes up to 200 percent[B-19] 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 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).

[B-19] A standard disregard of 5 percent FPL is applied if the woman's income is slightly above the FPL.

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-16 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-16—Study Indicators†

Indicator	Denominator	Numerator
Birth Outcomes		
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).
Births with Inadequate Prenatal Care	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.
Births with No Prenatal Care	Number of singleton, live births paid by Virginia Medicaid during the measurement period	Number of singleton, live births with no prenatal care.
Preterm Births (<37 Weeks Gestation)*	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: • Preterm: Less than 37 weeks – Late preterm: 34–36 weeks – Moderate preterm: 32–33 weeks – Very preterm: 28–31 weeks – Extremely preterm: <28 weeks

Indicator	Denominator	Numerator
Newborns with Low Birth Weight (<2,500 grams)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: • Overall low birth weight: <2,500 grams – Moderately low birth weight: 1,500 grams–2,499 grams – Very low birth weight: <1,500 grams
Maternal Health Outcomes		
Postpartum Emergency Department (ED) Utilization	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.
Postpartum Ambulatory Care Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 90 days of delivery.
Prenatal Screening, Brief Intervention, and Referral to Treatment (SBIRT)	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: • HCPCS Codes: – H0049 – H0050 – G0396 – G0397 • CPT Codes: – 99408 – 99409
Postpartum SBIRT	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.

Indicator	Denominator	Numerator
Prenatal Maternal Depression Screening	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: • Managed Care Codes: – 96127 – 96160 – 96161 – 99401 – 99402 – 99403 – 99404 – G0444 – G9000 – G9001 • FFS Codes: – 96127 – 96169 – 96161
Postpartum Maternal Depression Screening	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.

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

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

Where applicable, HSAG will compare the study indicators to national benchmarks. HSAG will use the Healthy People 2030 goals,[B-20] using data derived from CDC, NCHS, and NVSS, for the *Births with Early and Adequate Prenatal Care* and *Preterm Births (<37 Weeks Gestation)* study indicators, and will

[B-20] Healthy People 2030. Pregnancy and Childbirth. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available at: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth. Accessed on: Dec 13, 2023.

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.

Study Indicator Stratifications

HSAG will stratify the CY 2021 study indicator rates by the categories listed in Table B-17, 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-17—Study Indicator Stratifications

Stratification	Category Values
Medicaid Program at Delivery^	• Medicaid for Pregnant Women (Eligibility categories 091, 097) • Medicaid Expansion (Eligibility categories 100, 101, 102, 103, 106, and 108) • FAMIS MOMS (Eligibility category 005) • Other Aid Categories (will include all other births not covered by Medicaid for Pregnant Women, Medicaid Expansion, and FAMIS MOMS; will exclude births to women in Plan First [aid category: 080] and incarcerated individuals [aid category: 109])
Medicaid Delivery System at Delivery	• FFS • Managed Care
Managed Care Program at Delivery	• Medallion 4.0 (Acute) (will include FAMIS MOMS and FAMIS Children) • CCC Plus (MLTSS)
Managed Care Organization (MCO) at delivery	• 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. (Virginia Premier)

Stratification	Category Values
Length of Continuous Enrollment Prior to Delivery	• ≤ 30 Days • 31–90 Days • 91–180 Days • > 180 Days
Trimester of Prenatal Care Initiation *Note: Defined from the birth registry data.*	• First Trimester • Second Trimester • Third Trimester • No Prenatal Care • Unknown
Managed Care Region of Maternal Residence *Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.*	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Maternal Race/Ethnicity *Note: Defined from the birth registry data*	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

**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-17 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-17 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-17 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.[B-21] 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-18.

Table B-18—Member-Level Data File

Demographic Category	Category Values
Singleton Birth Indicator	• Singleton • Multiple
Medicaid Program at Delivery	• Medicaid for Pregnant Women • Medicaid Expansion • FAMIS MOMS • Other Aid Categories
Comparative Analysis Population Group	• Study Population • Comparison Group • NA
Medicaid Delivery System at Delivery	• FFS • Managed Care

[B-21] 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
MCO at Delivery	• Aetna • HealthKeepers • Molina • Optima • United • Virginia Premier
MCO Enrollment	• Not enrolled with an MCO prior to delivery (e.g., FFS) • Enrolled with one MCO prior to delivery • Enrolled with more than one MCO prior to delivery
Continuous Enrollment	• The number of days continuously enrolled in Virginia Medicaid
Length of Continuous Enrollment Prior to Delivery	• ≤ 30 Days • 31–90 Days • 91–180 Days • > 180 Days • Not continuously enrolled prior to delivery
Maternal Gravidity *Note: Defined from the birth registry data.*	• The number of pregnancies, including the current pregnancy
Trimester of Prenatal Care Initiation	• First Trimester • Second Trimester • Third Trimester • No Prenatal Care • Unknown
Managed Care Region of Maternal Residence *Note: Defined from the birth registry data using the county of residence at the time of delivery, grouped into regions using the Virginia managed care regions.*	• Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater • Unknown/Missing

Demographic Category	Category Values
Maternal Race/Ethnicity *Note: Defined from the birth registry data as non-Hispanic race (i.e., White, non-Hispanic), with Hispanic women of any race reported in the Hispanic category.*	• White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown
Maternal Age at Delivery	• 15 Years and Younger • 16–17 Years • 18–20 Years • 21–24 Years • 25–29 Years • 30–34 Years • 35–39 Years • 40–44 Years • 45 Years and Older • Unknown
Maternal Citizenship Status *Note: Defined from DMAS' demographic data.*	• U.S. Citizen (Citizenship Status = "C", "N") • Documented immigrant (Citizenship Status = "E", "I", "P", "R") • Undocumented immigrant (Citizenship Status = "A") • Other (Citizenship Status = "V")
Emergency Only Benefits	• Emergency Only Benefits • NA
Maternal Asthma[B-22]	• Asthma • No Asthma • NA
Maternal Diabetes[B-23]	• Diabetes • No Diabetes • NA

B-22 Identification of asthma will use administrative data sources; therefore, this stratification will not be applied to women without Medicaid enrollment prior to delivery.
B-23 Identification of 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
Maternal Gestational Diabetes[B-24]	• Gestational Diabetes • No gestational diabetes • NA
Prenatal Care (PNC) Index	• Adequate Plus PNC • Adequate PNC • Intermediate PNC • Inadequate PNC • Missing Info
Gestational Age	• Preterm: Less than 37 weeks • Late preterm: 34–36 weeks • Moderate preterm: 32–33 weeks • Very preterm: 28–31 weeks • Extremely preterm: <28 weeks • Term: 37–41 weeks • Late Term: 41 weeks • Full Term: 39–40 weeks • Early Term: 37–38 weeks • Post Term: > 42 weeks
Birth Weight	• Moderately Low • Very Low • Not Low • Missing
Method of Delivery *Note: Defined from the birth registry data.*	• C-Section Delivery • Vaginal Delivery • Missing
Postpartum ED Utilization *Note: Only ED services up to 90 days after delivery will be considered.*	• Yes • No
Postpartum Ambulatory Care Utilization *Note: Only ambulatory care services up to 90 days after delivery will be considered.*	• Yes • No

B-24 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
Received Prenatal SBIRT *Note: Only SBIRT evaluations received between the LMP and delivery date will be considered.*	• Yes • No
Received Postpartum SBIRT *Note: Only SBIRT evaluation received on or between 7 and 84 days after delivery will be considered.*	• Yes • No
Received Prenatal Maternal Depression Screening *Note: Only maternal depression screenings received between the LMP and delivery date will be considered.*	• Yes • No
Received Postpartum Maternal Depression Screening *Note: Only maternal depression screenings received on or between 7 and 84 days after delivery will be considered.*	• Yes • No

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[B-25]

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 I.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.

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.

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

- 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-19.

Table B-19—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
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+)^
Oral Health
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)
Behavioral Health
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)^

Measure and Indicators
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)^
Substance Use
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)
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits
ED Visits
Inpatient Visits
Behavioral Health Encounters—Total, ARTS, CMH Services, RTC Services, Therapeutic Services, and Traditional Services
Overall Service Utilization

^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.
**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.*
†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-20.

Table B-20—Timely Access to Care Measure Indicators

Measure and Indicators
Timely Access to Care for New Foster Care Members—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

Measure and Indicators
Dental Care for New Foster Care Members, and Timely Access to Primary Care and Dental Care for New Foster Care Members
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, 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
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 and Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis
Timely Access to Behavioral Health Care for New Foster Care Members—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
Timely Access to Behavioral Health Care for Members Receiving Adoption Assistance—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®,[B-26] 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

[B-26] Quality Compass® is a registered trademark of NCQA.

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.

Dental Utilization in Pregnant Women Data Brief Methodology[B-27]

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.

[B-27] Note: This methodology is presented as it appeared in the final report for this activity.

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).[B-28]

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.[B-29] HSAG will exclude non-live births from the deliveries using the *Non-Live Birth Value Set* for the *Prenatal and Postpartum Care* measure.[B-30] 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).

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.[B-31]

[B-28] 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.

[B-29] 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.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1681155105. Accessed on: Apr 10, 2023.

[B-30] Ibid.

[B-31] 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.

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:[B-32]

- 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-21.

Table B-21—Dental Utilization Study Indicator Stratifications

Stratification	Description/Values
Medicaid Program	The Medicaid Program the woman was enrolled with on the date of delivery: • FAMIS MOMS (Eligibility category 005) • Medicaid for Pregnant Women (Eligibility categories 091, 097) • Medicaid Expansion (Aid categories 100, 101, 102, 103, 106, and 108) • LIFC (Aid category 081) • Other Medicaid (will include all other births not covered by FAMIS MOMS, Medicaid for Pregnant Women, Medicaid Expansion, and LIFC; will exclude births to women in Plan First [aid category: 080] and DOC [aid category: 109]) • Not Enrolled

[B-32] 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
Managed Care Program	• Medallion 4.0 (Acute) • CCC Plus (MLTSS) • FAMIS • Not Enrolled
Medicaid Delivery System	• Fee-for-Service (FFS) • Managed Care • Not Enrolled
Perinatal Timing of Dental Service	The perinatal timing of the utilization of dental services. The following categories will be presented: • Preconception period: the defined lookback period prior to conception (e.g., 3 months, 6 months)* • 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) • Postpartum period: through six months postpartum** • Perinatal period: anytime during the prenatal and postpartum periods defined above
Continuous Enrollment During Dental Service	Dental service utilization occurred for members continuously enrolled in any Medicaid program for a minimum of 90 days prior to, and including, the date of delivery.
Age	The age of the woman on the date of delivery. The following age groups will be presented: • 20 and Under • 21 and Older (21–24, 25–29, 30–34, 35–39, 40 and Older)
Race/Ethnicity	The race/ethnicity of the woman. The following race/ethnicity categories will be presented: • White, Non-Hispanic • Black, Non-Hispanic • Asian, Non-Hispanic • Hispanic, Any Race • Other/Unknown

Stratification	Description/Values
Managed Care Region of Residence	The region of the woman's residence at the time of delivery. The following regions will be presented: • Central • Charlottesville/Western • Northern & Winchester • Roanoke/Alleghany • Southwest • Tidewater
Prenatal Care***	• Received Prenatal Care • Did Not Receive Prenatal Care
Trimester of Prenatal Care Initiation***	• First Trimester • Second Trimester • Third Trimester • No Prenatal Care • Unknown
Adequacy of Prenatal Care***	• 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]) • Intermediate Prenatal Care (i.e., Kotelchuck Index score less than 80 percent and greater than or equal to 50 percent) • Inadequate Prenatal Care (i.e., Kotelchuck Index score less than 50 percent)

** 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-22 presents details into the birth outcomes that HSAG will assess for this data brief.

Table B-22—Birth Outcomes Analysis

Indicator	Denominator	Numerator
Preterm Births (<37 Weeks Gestation)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by gestational estimate category: • Preterm: Less than 37 weeks • Late preterm: 34–36 weeks • Moderate preterm: 32–33 weeks • Very preterm: 28–31 weeks • Extremely preterm: <28 weeks
Newborns with Low Birth Weight (<2,500 grams)	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of singleton, live births by low birth weight category: • Overall low birth weight: <2,500 grams • Moderately low birth weight: 1,500 grams–2,499 grams • Very low birth weight: <1,500 grams
Postpartum ED Utilization for Non-Traumatic Dental Services	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ED services (ED Visits Code Set) for either of the following within 60 days of delivery: • A primary diagnosis of a non-traumatic dental condition (Non-Traumatic Dental Conditions Code Set)

Indicator	Denominator	Numerator
		• A primary diagnosis for other non-traumatic dental conditions (Other Non-Traumatic Dental Cond Code Set) with a secondary diagnosis of non-traumatic dental conditions (Non-Traumatic Dental Cond Code Set) 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.
Postpartum Ambulatory Care Utilization	Number of singleton, live births paid by Virginia Medicaid during the measurement period.	Number of postpartum women who utilized ambulatory care services within 60 days of delivery. Ambulatory visits are identified as: • An ambulatory outpatient visit (Ambulatory Outpatient Visits Code Set) • A telephone visit (Telephone Visits Code Set) or online assessment (Online Assessments Code Set) • Any one of the following: – An ED visit (ED Code Set) – An ED procedure code (ED Procedure Code Set) with an ED POS code (ED POS Code Set)
Births with Early and Adequate 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 MCOs serving the CCC Plus (MLTSS) population for presentation in the 2023 CCC Plus (MLTSS) Consumer Decision Support Tool. The CCC Plus (MLTSS) 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 MCO's 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 CCC Plus (MLTSS) 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, general child, and children with chronic conditions CAHPS measures on consumer perceptions of the overall rating of the MCO, MCO customer service, and their overall health care.
- **Doctors' Communication**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding how well their doctors communicate and the overall ratings of personal doctors and specialists seen most often. This category also includes children with chronic conditions CAHPS composites and question summary rates related to family centered care for children with chronic conditions. Additionally, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access and Preventive Care**: Includes adult, general child, and children with chronic conditions CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and

how quickly they received that care. Additionally, this category assesses a HEDIS measure related to adults' access to care and children with chronic conditions CAHPS question summary rates related to access to prescription medications. Additionally, this category includes HEDIS measures on how well MCOs perform related to preventive screenings for breast cancer and cervical cancer, as well as appropriate treatment for acute bronchitis/bronchiolitis and low back pain.

- **Behavioral Health**: Includes HEDIS measures that assess how often members remain on medications, appropriate care for members with SUD, and follow-up services for mental illness and substance use.
- **Taking Care of Children**: Includes HEDIS measures regarding how often preventive services and appropriate treatment are provided to child members (e.g., immunizations, well-child/well-care visits, weight assessment and counseling for nutrition and physical activity, and metabolic monitoring for children and adolescents on antipsychotics).
- **Living With Illness**: Includes HEDIS measures related to the appropriate treatment for people who have chronic conditions (e.g., diabetes, high blood pressure, COPD). In addition, this category includes HEDIS measures that assess medication management for people with asthma and schizophrenia or bipolar disorder.

Measures Used in Analysis

DMAS, in collaboration with HSAG, chose measures for this year's CCC Plus (MLTSS) Consumer Decision Support Tool based on a number of factors. In an effort to align with the PWP, the HEDIS measures evaluated as part of the PWP are included in this analysis, as well as many measures required by the CCC Plus Technical Manual for Reporting.[B-33] Per NCQA specifications, the CAHPS 5.1H Adult Medicaid Health Plan Survey instrument was used for the adult population and the CAHPS 5.1H Child Survey with Children with Chronic Conditions item set was used for the child population.

Table B-23 lists the 63 measure indicators, 27 CAHPS and 36 HEDIS, and their associated weights.[B-34] Weights are applied when calculating the category summary scores and the confidence intervals to ensure that all measures contribute equally to the derivation of the final results. Please see the Comparing MCO Performance section for more details.

[B-33] Virginia Department of Medical Assistance Services. CCC Plus Technical Manual. Version 2.35.

[B-34] 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: *General Child Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Customer Service (CAHPS Composite)*, *Children with Chronic Conditions Medicaid—Coordination of Care for Children with Chronic Conditions (CAHPS Question Summary Rates)*, *Children with Chronic Conditions Medicaid—Access to Specialized Services (CAHPS Composite)*, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—3 Months–17 Years*, *Childhood Immunization Status—Combination 3, Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*.

Table B-23—CCC Plus (MLTSS) Consumer Decision Support Tool Reporting Categories, Measures, and Weights

Measures	Measure Weight
Overall Rating[B-35]	
Adult Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
General Child Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Health Plan (CAHPS Global Rating)	1
Adult Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
General Child Medicaid—Rating of All Health Care (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Health Care (CAHPS Global Rating)	1
Adult Medicaid—Customer Service (CAHPS Composite)	1
Doctors' Communication	
Adult Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
General Child Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—How Well Doctors Communicate (CAHPS Composite)	1
Adult Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
General Child Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Personal Doctor (CAHPS Global Rating)	1
Adult Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	1
General Child Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Rating of Specialist Seen Most Often (CAHPS Global Rating)	1
Children with Chronic Conditions Medicaid—Family Centered Care: Personal Doctor Who Knows Child (CAHPS Composite)	1
Medical Assistance With Smoking and Tobacco Use Cessation	
Advising Smokers and Tobacco Users to Quit	1/3
Discussing Cessation Medications	1/3

[B-35] To calculate the Overall Rating category, all 63 CAHPS and HEDIS measures are included in the analysis. Please note that the CAHPS measures listed in the Overall Rating category are exclusive to the reporting category.

Measures	Measure Weight
Discussing Cessation Strategies	1/3
Access and Preventive Care	
Adult Medicaid—Getting Needed Care (CAHPS Composite)	1
General Child Medicaid—Getting Needed Care (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Getting Needed Care (CAHPS Composite)	1
Adult Medicaid—Getting Care Quickly (CAHPS Composite)	1
General Child Medicaid—Getting Care Quickly (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Getting Care Quickly (CAHPS Composite)	1
Children with Chronic Conditions Medicaid—Access to Prescription Medicines (CAHPS Question Summary Rates)	1
Adults' Access to Preventive/Ambulatory Health Services	
20–44 Years	1/3
45–64 Years	1/3
65+ Years	1/3
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	
18–64 Years	1/2
65+ Years	1/2
Use of Imaging Studies for Low Back Pain	
18–64 Years	1/2
65–75 Years	1/2
Breast Cancer Screening	1
Cervical Cancer Screening	1
Behavioral Health	
Initiation and Engagement of SUD Treatment	
Initiation of SUD Treatment—Total	1/2
Engagement of SUD Treatment—Total	1/2
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total	1
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	1
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	1

Measures	Measure Weight
Antidepressant Medication Management	
Effective Acute Phase Treatment	1/2
Effective Continuation Phase Treatment	1/2
Taking Care of Children	
Immunizations for Adolescents—Combination 2	1
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	1
Child and Adolescent Well-Care Visits	
3–11 Years	1
12–17 Years	1
18–21 Years	1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile Documentation—Total	1/3
Counseling for Nutrition—Total	1/3
Counseling for Physical Activity—Total	1/3
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	1
Living With Illness	
HbA1c Control for Patients with Diabetes	
HbA1c Control (<8.0%)	1/4
HbA1c Poor Control (>9.0%)	1/4
Blood Pressure Control for Patients with Diabetes	1/4
Eye Exam for Patients with Diabetes	1/4
Controlling High Blood Pressure	1
Asthma Medication Ratio—Total	1
Pharmacotherapy Management of COPD Exacerbation	
Systemic Corticosteroid	1/2
Bronchodilator	1/2
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	1

Measures	Measure Weight
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1

Missing Values

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

- *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 half of the plans or more had an *NR*, *BR*, or *NA* for any measure, then the measure was excluded from the analysis.

For MCOs with 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, Access and Preventive Care, Behavioral Health, Taking Care of Children, and Living With Illness) were calculated from MCO scores on selected HEDIS measures and CAHPS questions and composites.

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

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

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

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

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

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

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

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

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

3. 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.
4. HSAG computed the MCO composite mean for each CAHPS and HEDIS measure.
5. Each MCO mean (CAHPS or HEDIS) was standardized by subtracting the mean of the MCO means and dividing by the standard deviation of the MCO means to give each measure equal

weight toward the category rating. If the measures were not standardized, a measure with higher variability would contribute disproportionately toward the category weighting.

6. HSAG summed the standardized MCO means, weighted by the individual measure weights to derive the MCO category summary measure score.
7. For each MCO *k*, HSAG calculated the category variance, CV_k as:

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

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

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

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

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

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

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

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

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 ($\overline{X}_c$) for each measure is:

$$\overline{X}_c = \frac{n_1 \overline{X}_1 + n_2 \overline{X}_2}{n_1 + n_2}$$

where: n_1 = Number of members in the eligible population for Optima
n_2 = Number of members in the eligible population for VA Premier
$\overline{X}_1$ = Mean of measure for Optima population
$\overline{X}_2$ = Mean of measure for VA Premier population

The formula for computing the combined variance is as follows:

$$S_c^2 = \frac{m_1\left[S_1^2 + \left(\overline{X}_1 - \overline{X}_c\right)^2\right] + m_2\left[S_2^2 + \left(\overline{X}_2 - \overline{X}_c\right)^2\right]}{m_1 + m_2}$$

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.[B-36]

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-24 shows how the CCC Plus (MLTSS) Consumer Decision Support Tool displays results were displayed:

Table B-24—CCC Plus (MLTSS) Consumer Decision Support Tool–Performance Ratings

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

[B-36] 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.

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

Performance Withhold Program Methodology

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-25 on the next page.

Table B-25—PWP Measures

Indicator	Measure Specification	Required Reporting Method
*Asthma Admission Rate (per 100,000 Member Months [MM])**	AHRQ PDI	Administrative
Child and Adolescent Well-Care Visits—Total	HEDIS	Administrative
Childhood Immunization Status—Combination 3	HEDIS	Hybrid
*COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total**	CMS Adult Core Set	Administrative

Indicator	Measure Specification	Required Reporting Method
Comprehensive Diabetes Care Composite— Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, HbA1c Control (<8.0%)—Total and *HbA1c Poor Control (>9.0%)—Total** [B-37]	HEDIS	Hybrid
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS	Administrative
*Heart Failure Admission Rate (per 100,000 MM)—Total**	CMS Adult Core Set	Administrative
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment and *Engagement of SUD Treatment*	HEDIS	Administrative
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	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).[B-38]

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: A*

[B-37] 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.

[B-38] 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).

Mandatory EQR-Related Activity, February 2023.[B-39] Following the PMV, the EQRO will provide the true, audited rates for the AHRQ PDI and CMS Adult Core Set measures to DMAS.

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-26 shows the percentage of withhold associated with each performance measure indicator.

Table B-26—SFY 2023 PWP Measure Weights

Indicator	Measure Weight
*Asthma Admission Rate (per 100,000 MM)**	10%
Child and Adolescent Well-Care Visits—Total	10%
Childhood Immunization Status—Combination 3	10%
*COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total**	10%
Comprehensive Diabetes Care Composite—Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, HbA1c Control (<8.0%)—Total and *HbA1c Poor Control (>9.0%)—Total**	10%

[B-39] 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.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Nov 3, 2023.

Indicator	Measure Weight
Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	10%
*Heart Failure Admission Rate (per 100,000 MM)—Total**	10%
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment and *Engagement of SUD Treatment*	10%
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	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-27 on the next page. 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-27—Audit Designations (AHRQ PDI and CMS Adult Core Set)

Audit Designation	
Eligible for Points	**Ineligible for Points**
Reportable (R)	*Do Not Report (DNR)*
	Not Applicable (NA)
	No Benefit (NR)

As indicated in Table B-27, 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-28 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-28—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.[B-40] 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:

$$|MCO\ Current\ Rate - MCO\ CY\ 2021\ Rate| \geq \left|\left[\frac{(50th\ Percentile - 25th\ Percentile)}{5}\right]\right|$$

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-29 and Table B-30, 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.

[B-40] 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.

Table B-29—Indicator Partial Score Calculations—HEDIS Measures
(Example Using Mock Data)

Indicator	Current Year Rate	25th Percentile	50th Percentile	Indicator Partial Score
Child and Adolescent Well-Care Visits				
Total	55.55%	44.28%	54.26%	1.00
Childhood Immunization Status				
Combination 3	73.82%	65.45%	70.68%	1.00
Comprehensive Diabetes Care Composite				
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
Follow-Up After ED Visit for Substance Use				
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
Follow-Up After ED Visit for Mental Illness				
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
Initiation and Engagement of SUD Treatment				
Initiation of SUD Treatment	42.26%	39.25%	41.99%	1.00
Engagement of SUD Treatment	11.16%	9.53%	11.01%	1.00
Prenatal and Postpartum Care				
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-30—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
Asthma Admission Rate (per 100,000 MM)			
Total	R	Yes	1.00
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)			
Total	R	Yes	1.00
Heart Failure Admission Rate (per 100,000 MM)			
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-31 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-31—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†
Child and Adolescent Well-Care Visits							
Total	50.85%	55.55%	4.70%	2.00%	Y	Y	0.25
Childhood Immunization Status							
Combination 3	71.29%	73.82%	2.53%	1.05%	N	Y	0.00
Comprehensive Diabetes Care Composite							
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

Indicator	CY 2021 Rate	Current Year Rate	Rate Difference	Substantial Improvement Value	Below 50th Percentile in Prior Year	Met Substantial Improvement	Improvement Bonus†
*HbA1c Poor Control (>9.0%)—Total**	52.26%	50.70%	-1.56%	-1.38%	Y	Y	0.25
Follow-Up After ED Visit for Substance Use							
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
Follow-Up After ED Visit for Mental Illness							
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
Initiation and Engagement of SUD Treatment							
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
Prenatal and Postpartum Care							
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-32 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-32—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
Child and Adolescent Well-Care Visits							
Total	50.85%	59.49%	55.55%	60.34%	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
Childhood Immunization Status							
Combination 3	71.29%	73.72%	73.82%	72.75%	N	Y	0.00
Comprehensive Diabetes Care Composite							
Blood Pressure Control for Patients With Diabetes—Total	53.25%	56.12%	53.00%	57.89%	N	N	0.00
Eye Exam for Patients With Diabetes—Total	44.27%	57.16%	42.68%	58.02%	N	N	0.00
HbA1c Control (<8.%)—Total	57.41%	53.48%	54.74%	54.51%	Y	Y	0.25
*HbA1c Poor Control (>9.0%)—Total**	52.26%	33.23%	50.70%	34.15%	N	N	0.00
Follow-Up After ED Visit for Substance Use							
7-Day Follow-Up—Total	5.66%	10.85%	6.94%	11.01%	N	N	0.00
30-Day Follow-Up—Total	11.42%	15.30%	11.04%	15.75%	N	N	0.00
Follow-Up After ED Visit for Mental Illness							
7-Day Follow-Up—Total	45.12%	44.56%	46.22%	45.77%	Y	Y	0.25
30-Day Follow-Up—Total	59.67%	54.66%	58.92%	55.79%	Y	Y	0.25
Initiation and Engagement of SUD Treatment							
Initiation of SUD Treatment	41.68%	47.00%	42.26%	48.04%	N	N	0.00
Engagement of SUD Treatment	11.11%	12.16%	11.16%	12.13%	N	N	0.00
Prenatal and Postpartum Care							
Timeliness of Prenatal Care—Total	77.62%	85.59%	78.01%	86.37%	N	N	0.00
Postpartum Care—Total	60.58%	67.82%	64.70%	68.36%	N	N	0.00

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

Table B-33 shows the measure level score calculations for each MCO by determining the average of the indicator level scores for each measure.

Table B-33—Measure Level Score Calculations
(Example Using Mock Data)

Indicator	Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	Measure Level Score
Asthma Admission Rate (Per 100,000 MM)*					
Total	1.00	NE	NE	1.00	**1.00**

Indicator	Indicator Level Score	Improvement Bonus	High Performance Bonus	Final Indicator Score	Measure Level Score
Child and Adolescent Well-Care Visits					
Total	1.00	0.25	0.00	1.25	**1.25**
Childhood Immunization Status					
Combination 3	1.00	0.00	0.00	1.00	**1.00**
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)*					
Total	1.00	NE	NE	1.00	**1.00**
Comprehensive Diabetes Care Composite					
Blood Pressure Control for Patients with Diabetes—Total	0.64	0.00	0.00	0.64	**0.56**
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	
Follow-Up After ED Visit for Substance Use					
7-Day Follow-Up—Total	0.20	0.25	0.00	0.45	**0.33**
30-Day Follow-Up—Total	0.21	0.00	0.00	0.21	
Follow-Up After ED Visit for Mental Illness					
7-Day Follow-Up—Total	1.00	0.00	0.25	1.25	**1.25**
30-Day Follow-Up—Total	1.00	0.00	0.25	1.25	
Heart Failure Admission Rate (per 100,000 MM)*					
Total	0.00	NE	NE	0.00	**0.00**
Initiation and Engagement of SUD Treatment					
Initiation of SUD Treatment	1.00	0.00	0.00	1.00	**1.00**
Engagement of SUD Treatment	1.00	0.00	0.00	1.00	
Prenatal and Postpartum Care					
Timeliness of Prenatal Care—Total	0.00	0.00	0.00	0.00	**0.55**
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-34 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-34—Percentage Withhold Earned
(Example Using Mock Data)

Indicator	Measure Level Score	Weight	Measure Withhold Earned	Overall Withhold Earned
Asthma Admission Rate (per 100,000 MM)	1.00	10.00%	10.00%	**79.33%**
Child and Adolescent Well-Care Visits	1.25	10.00%	12.50%	
Childhood Immunization Status	1.00	10.00%	10.00%	
COPD or Asthma in Older Adults Admission Rate (per 100,000 MM)	1.00	10.00%	10.00%	
Comprehensive Diabetes Care Composite	0.56	10.00%	5.58%	
Follow-Up After ED Visit for Substance Use	0.33	10.00%	3.30%	
Follow-Up After ED Visit for Mental Illness	1.25	10.00%	12.50%	
Heart Failure Admission Rate (per 100,000 MM)	0.00	10.00%	0.00%	
Initiation and Engagement of SUD	1.00	10.00%	10.00%	
Prenatal and Postpartum Care	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-35—PWP Funds Allocation
(Example Using Mock Data)

MCO Name	Total Capitation Payment	Maximum At-Risk Amount (1% Withhold)	Percentage Withhold Earned	Final Withhold Earned Back Amount
MCO	$735,790,000.00	$7,357,900.00	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-35, 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:

$$Final\ Withhold\ Earned\ Back\ Amount = (Maximum\ At\ Risk\ Amount \times Percentage\ Withhold\ Earned)$$

Appendix C. MCO Best and Emerging Practices

Table C-1 identifies DMAS' best and emerging practices.

Table C-1—DMAS' Best and Emerging Practices

Best and Emerging Practices
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 December 2023. Initiatives have focused on enrollment processes (newborn), member education, consistent messaging across MCOs regarding enrollment.
Topic/Title: Baby Steps Virginia **Description:** 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. **Baby Step VA successes-** • Three CMS affinity groups (quality improvement) targeting child, foster care youth and maternal health improvement plans • LRCD Affinity Group – Reducing Low Risk Cesarean Delivery • Outreach events to support pregnant, postpartum and parenting families
Topic/Title: Community Doula Program **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-

Best and Emerging Practices
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 DMAS website.
Topic/Title: Nursing Facility Value Based Purchasing Program **Description:** A value-based performance payment program incentivizing improved quality of care in VA nursing facilities for Medicaid members. The NF VBP program began in July 2022 and is currently focused on both providing resources for and rewarding improvements in staffing and avoidance of negative care events.

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	**Topic/Title:** Vital Decisions **Description:** 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. **Topic/Title:** New Moms Box **Description:** 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. **Topic/Title:** Social Care Team **Description:** 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.

MCO	Best and Emerging Practices
	Topic/Title: Readmission Avoidance Program (RAP) **Description:** 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. **Topic/Title:** Pyx **Description:** An app that increases member engagement with the Health Plan and steerage to the right resources/assistance. Members receive personalized assistance to find resources, activities to reduce 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.
HealthKeepers	**Topic/Title:** Obstetric Quality Incentive Program (OBQIP) and Program Consultants **Description:** 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. **Topic/Title:** Embedded Care Coordination Department Social Services Program **Description:** 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. 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.

MCO	Best and Emerging Practices
	Topic/Title: Gold Card Program **Description:** 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. **Topic/Title:** Life Skill Building Program **Description:** 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. **Topic/Title:** Valued Relationship Inc. (VRI) **Description:** Engage Educate Empower (E3 Pilot) focuses targeted live messaging to members identified as having a gap in care via a report that we share monthly. Member that are part of this pilot receive personalized gap in care education and support via a live person that communicates with them through their PERS Device. HEDIS Measures address: HbA1C, Diabetic retinal exam, controlling BP, Statin Therapy, and colorectal cancer screening. In addition to monthly messaging on various topics such as medication adherence, fall prevention, and education on levels of care (ER, Urgent Care, and Telehealth) **Topic/Title:** HEDIS Pay for Quality Program (P4Q) **Description:** 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 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
Molina	**Topic/Title:** Pay for Quality (P4Q) Program **Description:** 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

MCO	Best and Emerging Practices
	group achieves enough appointments within the designated measure to meet the 50th percentile benchmark for their assigned panel. **Topic/Title:** Clinic Day **Description:** 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. 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. The Clinic Day offered a fun way to encourage members to: • Obtain needed health services • Improve health outcomes • Improve HEDIS score/close care gaps • Improve member/provider experience • Meet and interact with Molina team members **Topic/Title:** Provider Network and Quality Partnership **Description:** 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. **Topic/Title:** Direct Scheduling **Description:** 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 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. 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.

MCO	Best and Emerging Practices
Optima	**Topic/Title:** Justice Care Coordination Program **Description:** 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. **Topic/Title:** Tribal Care Coordination **Description:** 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. **Topic/Title:** UHS Telehealth Program **Description:** 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. **Topic/Title:** BH Coaching Program **Description:** 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. **Topic/Title:** Peer Support Program **Description:** 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,

MCO	Best and Emerging Practices
	hopefulness for recovery, awareness of early warning signs of problems, and improvement in taking responsibility for wellness and their recovery. **Topic/Title:** Mental Health Group **Description:** 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. **Topic/Title:** Quality Accreditation Team • CCC Plus: ☒ • Medallion 4.0: ☒ **Description:** Quality Committee Governance and Oversight 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. 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: • 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. • 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. • Policies and Procedure (P&P) Committee - responsible to ensure policies and their outcomes support the mission, values, and strategic goals of the organization. These three subcommittees have 10 reporting committees which include internal and external physicians. To improve awareness of organizational activities, the frequency of meetings increased from quarterly to every other month. 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

MCO	Best and Emerging Practices
	compliant with state regulators, NCQA, CMS, and other regulatory bodies for the covered services. • Formal Committee charters for all subcommittees • Process Maps **Topic/Title:** Quality Member Safety/Contractual and Regulatory Team **Description:** As of 7/1/2023, newly implemented, dedicated team for Quality Management Reviews (QMRs). **Topic/Title:** Quality Member Safety/Contractual and Regulatory Team **Description:** 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. **Topic/Title:** Member Recertification Specialty Team **Description:** 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: • Provide customized/individual application assistance · • Use of SDOH data to drive member engagement **Topic/Title:** Use of Community Health Workers **Description:** 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 community and faith-based resources, wrap-around services, and community events. Programming and training specialized to: • Address social needs • Promote health equity· • Foster Cultural Competence • Enhance health literacy • Improve health screenings • Reduce care gaps **Topic/Title:** Chronic Care Management Program

MCO	Best and Emerging Practices
	Description: Chronic Care Management is a program administered by Optima health that provides the following: 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. 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. C. Develop a care plan and follow up with members to address barriers to them receiving care. D. Print member education materials. E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care. **Topic/Title:** Population Health - IVR and Educational Video Campaigns **Description:** 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. **Topic/Title:** Population Health – Coaching and educational tools for members with Type II Diabetes **Description:** 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 levels more frequently. Members have the ability to set reminders, use the in-app logbook, capture their weight and much more in the app. **Topic/Title: Population Health** – Digital Health Apps that help members track ovulation, cycle, pregnancy and navigate the early years of parenthood. **Description:** 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,

MCO	Best and Emerging Practices
	medications, vitamins, symptoms, sleep and more. Parenting allows members to track baby's milestones and learn about parenting styles, breastfeeding and more. **Topic/Title:** Population Health - Preventive Screening Kits **Description:** 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.
United	**Topic/Title:** Creating Communities of Health – **Description:** 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. Supporting Petersburg taught us that to effectively improve community health outcomes we must: 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. 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. 3) Acknowledge that the economic well-being of a community directly depends on the health of its people. A healthier community alleviates pressure on overextended health systems. In turn, this can lower the cost of health care for everyone. 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. *How we support our communities.* 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.

MCO	Best and Emerging Practices
	Data and analytics. 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. *Strengthening access for everyone.* 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. *Broad collaboration.* 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. *Taking action to deliver results.* 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. **Topic/Title:** Housing + Health 2.0 – Continuums of Care **Description:** 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 **assess members' housing needs,** 2) **identify barriers** impacting housing stability, 3) help members **develop a housing stability plan**, and 4) **navigate members to community resources** that can address both long-term housing sustainability and short-term urgent housing barriers. 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 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). 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. **Topic/Title:** One Pass **Description:** To improve physical and mental well-being for our members and potentially reduce the risk of diseases, UHC offers an enhanced benefit to

MCO	Best and Emerging Practices
	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. **Topic/Title:** Integrated Behavioral Health Home **Description:** 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. **Topic/Title:** Careforth **Description:** 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 caregivers are often the “last mile” between an individual aging in a place of their choice and more costly options.
VA Premier	**Topic/Title:** Health-Related Social Needs Team **Description:** 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. **Topic/Title:** Case Conferencing with Homeless Shelters

MCO	Best and Emerging Practices
	Description: 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. **Topic/Title:** Personal ID Procurement **Description:** 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. **Topic/Title:** Financial Stability Planning Program **Description:** Provide members with personal guidance to access benefits, education and training, and job search resources to improve their income and increase their independence. **Topic/Title:** Chronic Care Management Program **Description:** Chronic Care Management is a program that provides the following: 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. 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. C. Develop a care plan and follow up with members to address barriers to receiving care. D. Print member education materials. E. Assist members with obtaining a scale, blood pressure cuff, or glucometer to help manage care. **Topic/Title:** Peer Support Specialist Program **Description:** 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.

MCO	Best and Emerging Practices
	Topic/Title: ARTS Transition of Care for all ASAM levels of care **Description:** 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. **Topic/Title:** UHS Telehealth Program **Description:** 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. **Topic/Title:** Edinburgh and 5'Ps Screening assessments for maternal population **Description:** 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. **Topic/Title:** Community Stabilization Team **Description:** 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. **Topic/Title:** Continuity of Care **Description:** 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.

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 Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Increase Member Engagement and Outreach	**Description of Quality Initiative:** *Language Monitoring:* 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.	**Metric:** 1.1.1.2 Monitor Language and Disability Access Reports
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Increase Member Engagement and Outreach	**Description of Quality Initiative:** *Language Monitoring:* 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	**Metric:**1.1.1.3 Monitor Member Language Counts

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	linguistically appropriate healthcare services.	
Goal 1: Enhance the Member Care Experience **Objective 1.2:** Improve Member Satisfaction	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* 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.	**Metric:**1.2.1.1 Rating of all Health Care
Goal 1: Enhance the Member Care Experience **Objective 1.1:** Improve Member Satisfaction	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* 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	**Metric:**1.2.1.2 Rating of Personal Doctor

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: 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.	**Metric:** 2.1.1.1 Getting Care Quickly
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: 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	**Metric:** 2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup:* 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.	**Metric:** 2.1.1.3 Getting Needed Care
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Description of Quality Initiative:**	**Metric:** 2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 2.3: Promote Patient Safety	*Improved Critical Incident Report Process and Data Management:* 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	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.3:** Promote Effective Communication and Care Coordination	**Description of Quality Initiative:** *HEDIS and CAHPS Workgroup*: 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.	**Metric:** 2.3.1.1 How Well Doctors Communicate
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Description of Quality Initiative:** *BH/ARTS Preferred Provider Program:* Aetna-designed BH/ARTS Preferred Provider	**Metric:** 2.3.1.2 Service Authorizations

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 2.3: Promote Effective Communication and Care Coordination	program for private and public providers that reduces administrative burdens for providers, allowing members to get access to care more quickly. *Behavioral Health Clinical Liaison Team:* 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.	
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* 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.	**Metric:** 3.1.1.1 Frequency of Potentially Preventable Admissions
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Ambulatory Care – Emergency Department Visits Initiative:* Care Managers educating and reminding members about the availability of 24 hr. nurse line services and ED utilization during every contact.	**Metric:** 3.1.1.3 Frequency of Potentially Preventable Emergency Department Visits
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies members for referral to Care	**Metric:**3.1.1.3 Frequency of Potentially Preventable Readmissions

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Management to engage at the intensive level of care for 30-days post discharge.	
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Value Based Agreements:* Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home. *Provider Collaborated Outreach and Onsite Clinic Days:* 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.	**Metric:** 3.1.1.4 Ambulatory Care
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *AMB PIP Intervention:* Care manager educate members on availability of 24-hour Nurse Line services and ED/ER utilization during every contact.	**Metric:** 3.1.1.5 Ambulatory Care: Emergency Department (ED) Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *Value Based Agreements:* Plan contracts with high-volume providers that include performance metrics to increase members engaged with a primary care provider/patient centered medical home.	**Metric:** 4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services
Goal 4: Strengthen the Health of Families and Communities	**Description of Quality Initiative:**	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	*EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* 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. *Targeted Member Outreach:* 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. *Provider Collaborated Outreach and Onsite Clinic Days:* 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.	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* 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. *CIS SMS Text Campaign:* Vendor initiated SMS text messaging to members identified as not having completed all age-appropriate recommended immunizations reminding them of importance of completing them.	**Metric:** 4.1.1.3 Child Immunization Status
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.	**Metric:** 4.1.1.4 Immunizations for Adolescents

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	EPSDT Birthday Mailers: 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. *Ted E. Bear M.D. Wellness Club:* 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). *HPV Vaccine Adherence Program:* Conducted live outreach calls to 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *CVS Health Tags:* CVS Pharmacies attach messages to prescription bags that educates members about the importance of flu vaccination	**Metric:** 4.1.1.5 Flu Vaccinations for Adults 18-64

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	MS Hold Line Flu Shot Message: When members call into plan, they will hear a recorded message reminding them to get their free flu shot.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable.	**Metric:** 4.1.1.6 Topical Fluoride for Children
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* 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.	**Metric:** 4.1.1.7 Oral Evaluation, Dental Services
Goal 4: Strengthen the Health of Families and Communities	**Description of Quality Initiative:**	**Metric:** 4.1.1.8 Sealant Receipt of Permanent First Molars

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	*EPSDT Preventive Screening Brochure:* A comprehensive but easy to read brochure that educates members about important and recommended child preventive screenings and services with icons and timetable. *EPSDT Birthday Mailers:* 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* 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. *Ted E. Bear M.D. Wellness Club:* Kids program encompassing children ages	**Metric:** 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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).	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *Well Woman Exam Incentive:* Eligible members can earn gift card for completing Pap Smear, Mammogram, Chlamydia Screening, Colorectal Cancer Screening, and Flu Vaccine. *Moving On: Transitioning from Pediatrics to Primary Care:* 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.	**Metric:** 4.1.1.10 Chlamydia Screening in Women Ages 16 to 20
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* 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.	**Metric:**4.1.1.11 Lead Screening in Children

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Ted E. Bear M.D. Wellness Club: 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).	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *New Moms Box*: 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. *Postpartum Depression (PPD) Initiative:* 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	**Metric:** 4.2.1.1 Prenatal and Postpartum Care: Postpartum Care

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	appointment adherence during virtual baby showers. *Postpartum Text Campaign:* 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *New Moms Box*: 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. *Virtual Baby Showers*: 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. *Timeliness of Prenatal Care PIP Intervention:* Care	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *Benefits of Quitting: Tobacco Use Cessation in Pregnant Women:* 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. *Timeliness of Prenatal Care PIP Intervention:* 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. *Progeny:* 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	**Metric:** 4.2.1.3 Live Births Weighing Less than 2,500 Grams

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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. *Preeclampsia Prevention*: 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *EPSDT Birthday Mailers:* 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. *Ted E. Bear M.D. Wellness Club:* 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	**Metric:** 4.2.1.4 Well-Child Visits in the Frist 30 Months of Life

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	upon completion of well-child visits (gift cards vary based on age group). *IWC Outreach:* Dedicated team outreaches parents/guardians of members aged 15 months identified as being past due for well-child visit and assists with scheduling appointments. *National NBA:* Direct mail, SMS, emails, and live calls to members (0-30 months) identified as not having completed well-child visit.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** *Maternity Incentive:* Pregnant members can earn rewards for attending all recommended prenatal and postpartum appointments. *Timeliness of Prenatal Care PIP Intervention:* 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. *High Risk Pregnancy NBA:* 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.	**Metric:** 4.2.1.5 Low-Risk Cesarean Delivery

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.3:** Improve Home and Community-Based Services	**Description of Quality Initiative:** *Non-Traditional Provider Education:* Quality Management staff educate providers about how to write 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.	**Metric:** 4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* 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. *Chronic Conditions Education Series:* 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.	**Metric:** 5.1.1.1 Heart Failure Admission Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* Identifies high-risk members for inpatient readmission utilizing inpatient RAP score and identifies	**Metric:** 5.1.1.2 Asthma Admission Rate

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	members for referral to Care Management to engage at the intensive level of care for 30-days post discharge. *Chronic Conditions Education Series:* 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. *Asthma/COPD Inhaler NBA:* Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Readmission Avoidance Program (RAP):* 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. *Chronic Conditions Education Series:* 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	**Metric:** 5.1.1.3 COPD and Asthma in Older Adults' Admission Rate

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	better manage chronic conditions. *Asthma/COPD Inhaler NBA:* Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *Diabetes Incentive:* Members can earn a reward for completing their A1c blood test, blood pressure check, and dilated retinal exam. *Diabetes Text Campaign:* Health education texts to members with diabetes encouraging them to complete their annual wellness exams and diabetes screening tests. *Diabetes and Cholesterol Mailers:* Health Plan postcards mailed to members educating them on diabetes and cholesterol medication management. *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking. *Primary Health Care Model for Adults:* Gender specific educational brochures educating members about the importance of completing recommended health screenings with PCP/Specialist. *Moving On: Transitioning from Pediatrics to Primary Care:* Members between the ages of	**Metric:**.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	18-20 years can earn a reward for completing preventive care services, adult medical screenings, weight management, and recommended vaccines. *Chronic Conditions Education Series:* 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. *CPT II Code Incentive:* 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking. *Chronic Conditions Education Series:* 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.	**Metric:** 5.1.1.5 Controlling High Blood Pressure

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Wellness Incentive: Members can earn rewards for completing recommended screenings and annual wellness exams. *CPT II Code Incentive:* 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. *Outreach Call Campaign:* 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking.	**Metric:** 5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** *My ActiveHealth:* Free app that features diabetes management, appointment and medication reminders, and exercise/weight goals setting and tracking. *Chronic Conditions Education Series:* 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	**Metric:** 5.1.1.7 Asthma Medication Ratio: Ages 5 to 18 Years

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	better manage chronic conditions. *Asthma/COPD Inhaler NBA:* Multiple channels educating members identified as having a diagnosis of asthma about how to use prescribed inhalers and spacers and common asthma triggers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Residential Substance Use Disorder (SUD) Discharge Program:* 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. *National Opioid Use Disorder (OUD) Program:* 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. *Harm Reduction Coalitions:* Aetna donation to purchase supplies and educate communities around opioid use disorder and prevention.	**Metric:** 5.3.1.1 Monitor Identification of Alcohol and Other Drug Services
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:**	**Metric:** 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 5.3: Improve Outcomes for Members with Substance Use Disorders	*Community Health Workers Initiative:* 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 *Find Help Initiative*: Site used to provide resources and services for social determinants of health	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Annual DUR Program Initiative:* 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.	**Metric:** 5.3.1.3 Use of Opioids at High Dosage in Persons Without Cancer
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *Residential Substance Use Disorder (SUD) Discharge Program:* 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.	**Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	Justice Integrated Care Pilot Program: 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: 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	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	overall cost of care for and among participants. *Development of Behavioral Health Toolkits:* 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: 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.	**Metric:** 5.4.1.2 Follow-Up After Emergency Department for Mental Illness
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *2023 Interactive Voice Response (IVR) Message Outreach Initiative*: IVR campaign educating members about the importance of follow up care for children prescribed	**Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	ADHD/ADD Medications, within 30 days and throughout treatment is ongoing. *ADHD Initiative*: 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. *Member Educational Brochure:* Educational publication that includes behavioral therapies and how to access MyActive Health via the member portal.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Transition Age Youth (TAY):* 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-based approach. Members who meet admissions thresholds benefit from focused care coordination, advanced engagement, connection with appropriate formal and informal	**Metric:** 5.4.1.4 Monitor Mental Health Utilization

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	services and natural and community support, as well as flexible individualized plans for treatment. *Postpartum Depression (PPD) Initiative:* 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. *Richmond Behavioral Health Authority (RBHA) Enhanced Care Coordination (ECC) Initiative:* 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *The High Utilizers of Virginia (HUV) Program*: Program emphasizing in-person engagement with individuals at time of program enrollment, engagement, and coordination	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Flourish Health Partnership Initiative*: 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. *Prior Authorization Criteria Utilized:* Clinical Criteria for Antipsychotics in children less than 18 years of age	**Metric:** 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: 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	**Metric:** 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	address transportation, childcare, and other social determinants of health (SDOH) challenges/issues. *DUR program Initiative*: Reviews and monitors children on concomitant antipsychotics and antidepressants *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening. *High ED Utilizer Monitoring Initiative*: 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. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st 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. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	antidepressants for members under 17 years old.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Chronic Conditions Education Series:* 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.	**Metric:** 5.4.1.7 Medial Assistance with Smoking and Tobacco Use Cessation
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Member Outreach Letters:* Outreach letters sent to members identified as having been prescribed antidepressant medications to inform them of 90-day medication supply.	**Metric:** 5.4.1.8 Antidepressant Medication Management
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *EPSDT Periodicity Schedule:* Provider education about the EPSDT requirement to screen all children ages 12-20 years for depression, utilizing a validated, standardized screening tool. *Postpartum Depression (PPD) Initiative:* 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	**Metric:** 5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	and encourage postpartum appointment adherence during virtual baby showers. *Postpartum Text Campaign:* 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. *Provider Manual and Education/Training:* 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: 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. *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible	**Metric:** 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	members that are due or overdue for care and screening. *HEDIS Toolkit:* 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. *High ED Utilizers Initiative:* 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. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st 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. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA	

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	antidepressants for members under 17 years old *Medication Therapy Management Initiative*: Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** *Behavioral Health Case Management Member Engagement Initiative*: 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. *Gaps in Care Reporting:* Plan generated gap in care reports with information on eligible members that are due or overdue for care and screening. *HEDIS Toolkit:* 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.	**Metric:** 5.4.1.11 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
	High ED Utilizers Initiative: 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. *Pharmacy DUR Program: 1st Fill Antipsychotic Initiative:* Geared to increase provider awareness of metabolic monitoring, engagement of members in supportive/non-pharm services. Includes sending letters to providers of members filling 1st 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. *CVS Pharmacy Advisor Program Initiative*: Geared to increase awareness of risks associated with co-prescribing of antipsychotics and SSRI/SNRI/TCA antidepressants for members under 17 years old *Medication Therapy Management Initiative*: Pharmacists conduct telephonic outreach targeting members who would most benefit from interaction based on chronic conditions, maintenance medications and drug spend	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** *NBA Adherence Program Initiative:* Provides members	**Metric:** 5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Virginia QS Goals and Objectives	Aetna's Quality Initiative	Performance Metric
Objective 5.4: Improve Behavioral Health and Developmental Services for 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.	

HealthKeepers

Table D-2—HealthKeepers' QS Quality Initiatives

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Goal 2: Promote Access to Safe, Gold-Standard Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.	**Metric:** 2.1.1.6 Cervical Cancer Screening *Note: Not a DMAS QS Metric.*
Goal 2: Promote Access to Safe, Gold-Standard Care **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for	**Metric:** 2.1.1.9 Breast Cancer Screening *Note: Not a DMAS QS Metric.*

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	provider education and is distributed by the health plan	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: 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 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** 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 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.	**Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: 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 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed. Age Out Immunization Outreach: Targets members who need immunizations who have aged out AND members who are about	**Metric:** 4.1.1.3 Childhood Immunization Status

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	to age out to get immunized in a timely manner	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** 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	**Metric:** 4.1.1.4 Immunizations for Adolescents
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. 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.	**Metric:** 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	Description of Quality Initiative: HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.	**Metric:** 4.1.1.10 Chlamydia Screening in Women Ages 16 to 20
Goal 4: Strengthen the Health of Families and Communities	**Description of Quality Initiative:** HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for	**Metric:** 4.1.1.11 Lead Screening in Children

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Objective 4.1: Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	provider education and is distributed by the health plan	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** 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. 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.	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Postpartum Care

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	When an OB provider checks eligibility and the member is an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered. 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. 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. 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** 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	**Metric:** 4.2.1.2 Prenatal and Postpartum Care: Timeliness of Prenatal Care

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	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. 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 an Anthem Medicaid member, they will automatically be enrolled in MyAdvocate via the eligibility questions answered. 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.	

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	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. 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.	
Goal 4: Strengthen the Health of Families and Communities **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** Visit Compliance Report: Monthly report that identifies the number of visits needed for compliancy. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed to healthcare providers. 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.	**Metric:** 4.2.1.4 Well-Child Visits in the First 30 Months of Life

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	This is faxed/distributed to health care providers.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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	**Metric:** 5.1.1.1 PQI 08: Heart Failure Admission Rate
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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 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	**Metric:** 5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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	**Metric:** 5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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 CVS Health Tags Program: CVS provides written health messages and assistance from a Tech. 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, by the health plan. 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.	**Metric:** 5.1.1.4 Diabetes Care for Patients with Diabetes: Hemoglobin A1c (HbA1c) Control (<8.0%)
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	Description of Quality Initiative: HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan.	**Metric:** 5.1.1.5 Controlling High Blood Pressure

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	CVS Health Tags Program: CVS provides written health messages and assistance from a Tech. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes.	**Metric:** 5.1.1.6 Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** 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	**Metric:** 5.3.1.2 Follow-Up After Emergency Department Visit for Substance Use Disorders

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	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. 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. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource	**Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
Objective 5.3: Improve Outcomes for Members with Substance Use Disorders	for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** 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.	**Metric:** 5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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 responsive to	**Metric:** 5.4.1.1 Follow-Up After Hospitalization for Mental Illness

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	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. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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 responsive to assisting with emergent member	**Metric:** 5.4.1.2 Follow-Up After Emergency Department Visit for Mental Illness

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	needs. Data is reviewed quarterly to determine a provider's continued participation and support the ongoing development of an optimized network. 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. 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	

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	engaged members will be supported and therefore better equipped to lead a quality life in the community with a decrease in IP BH admission and ED utilization. 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. HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Desktop Reference Guide: This is a quick HEDIS reference guide that is used for provider education and is distributed by the health plan. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** HEDIS Coding Booklet: This booklet is distributed to providers by the health plan as a resource for specific HEDIS Measures and Codes. HEDIS Telehealth Coding Bulletin: This is a bulletin intended to provide coding	**Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	guidelines to health care providers for Telehealth visits. This is faxed/distributed to health care providers, by the health plan.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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.	**Metric:** 5.4.1.5 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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.	**Metric:** 5.4.1.6 Metabolic Monitoring for Children and Adolescents on Antipsychotics
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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. 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	**Metric:** 5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	modalities for cessation, including support groups. 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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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. 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.	**Metric:** 5.4.1.8 Antidepressant Medication Management
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** 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	**Metric:** 5.4.1.10 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Virginia QS Goal and Objective	HealthKeepers' Quality Initiative	Performance Metric
	member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	**Description of Quality Initiative:** Antipsychotic Medication Adherence Standalone Provider Fax: Targets members who are nonadherent to antipsychotic or bipolar medications; less than 80% PDC. 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. Member Outreach: Member Gap in Care outreach to refill medication, attend follow-up appointments and lab testing through Member email, telephone calls, and letters.	**Metric:** 5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Molina

Table D-3—Molina's Quality Strategy Quality Initiatives

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness,	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups by conducting monthly meetings, sharing of comprehensive gap reports, tactical strategies, provide	**Metric:** 4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
Immunization, and Prevention Services for Members	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.	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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.	**Metric:** 5.1.1.7 Asthma Medication Ratio
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** 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	**Metric:** 4.1.1.3 Childhood Immunization Status
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** 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	**Metric:** Breast Cancer Screening **Metric:** Cervical Cancer Screening **Metric:** Colorectal Cancer Screening *Note: Not DMAS QS metrics.*

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
	materials to ensure accuracy and up to date information is shared	
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** 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	**Metric:** 5.1.1.4 Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Control (<8.0%)
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** MHI is working with individual provider/ provider groups, conduct monthly meetings, send them gaps in care report, provide them support for member outreach. Partner with network providers, VDH and schools to participate in immunization campaign, provide education and materials, incentives and school supplies.	**Metric:** 4.1.1.3 Childhood Immunization Status **Metric:** 4.1.1.4 Immunization for Adolescents **Metric:** 4.1.1.11 Lead Screening in Children
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Description of Quality Initiative:** MHI is working with BH provider groups to share data and identify opportunities for improvement such as	**Metric:** 5.3.1.2 – Follow up after Emergency Department visit for Alcohol and other drug

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
★ **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders ★ **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members	coding to ensure services are captured appropriately and timely to improve outcomes and reduce readmission. 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 Target Pay for performance in progress to target BH providers for timely addressing BH quality measures in progress	Dependence Treatment – 7 and 30 days total **Metric:** 5.4.1.2 - Follow up after Emergency Department visit for Mental Illness – 7- and 30-days total **Metric:** 5.3.1.4 Initiation and Engagement for Alcohol and other drug Dependence Treatment
Goal 4: Strengthen the Health of Families and Communities ★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** 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. Compliant members receive incentives for timely completion of their prenatal and postpartum visits. High Risk members are referred to the High Risk OB team to provide timely support, education and resources to ensure a healthy pregnancy. Molina uses Lucina Analytics a data tool in conjunction with the pregnancy dashboard, which identifies of pregnancy early,	**Metric:** 4.2.1.1 Prenatal and Postpartum Care

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
	which helps with getting members access to care more timely.	
Goal 4: Strengthen the Health of Families and Communities ★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Description of Quality Initiative:** 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. Target clinic day to outreach and tie to back-to-school events Member outreach to help with scheduling needs, provider education and share pertinent information about services and rewards that are available.	**Metric:** 4.2.1.4 – Well child visits in the first 30 months after birth **Metric:** Well child visit - Total *Note: Not a Quality Strategy metric.*
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done. Champions Program: to target members who have A1c 8 and above to enroll in the program for management, resources, education and support. Members will receive a certificate based on their A1c outcomes. Vision Centers are incentivized to reach out to members, schedule them and complete the Dilated retinal eye exam. Blood Pressure cuffs sent to targeted members and telehealth visits are facilitated to capture required information. Members are sent home a HgA1c kit to complete.	**Metric:** 5.1.1.4 Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) Control (<8.0%)

Virginia QS Goals and Objectives	Molina's Quality Initiative	Performance Metric
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** Hosting Clinic days in provider's offices to have an open day for appointments for members to get their services done.	**Metric:** 4.1.1.3 Childhood Immunization Status **Metric:** 4.1.1.4 Immunization for Adolescents **Metric:** 4.2.1.4 – Well child visits in the first 30 months after birth **Metric:** Well child visit – Total *Note: Not a quality strategy metric.*
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** MHI has partnered with CVS to conduct timely outreach calls and identify barriers preventing members from being adherent to medication.	**Metric:** 5.1.1.7 Asthma Medication Ratio **Metric:** 5.4.1.12 Adherence to Antipsychotic medications for individuals with Schizophrenia **Metric:** 5.4.1.8 Antidepressant Medication Management
Goal 4: Strengthen the Health of Families and Communities **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** Member outreach targeting kids before they turn two years old and helping them to schedule appointments to close the CIS measure gaps Molina leverages the postpartum care outreach activities to also provide education on immunizations and well child checkups.	**Metric:** 4.1.1.3 Childhood Immunization Status
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members with Chronic Conditions	**Description of Quality Initiative:** MHI has partnered with MRx vendor partner to do outreach calls and identify barriers preventing members to be medication adherent.	**Metric:** 5.1.1.7 Asthma Medication Ratio **Metric:** 5.4.1.12 Adherence to Antipsychotic medications for individuals with Schizophrenia **Metric:** 5.4.1.8 Antidepressant Medication Management

Optima

Table D-4—Optima's QS Quality Initiatives

Virginia QS Goals and Objectives	Optima's Quality Initiative	Performance Metric
Goal 1: **Objective 1.1**: Increase Member Engagement and Outreach	**Description of Quality Initiative:** 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.	**Metric: 1.1.1.3** Monitor Member Language Counts
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective:2.2:** Promote Patient Safety	**Description of Quality Initiative:** Optima Health identifies, reviews, documents, tracks, analyzes, and reports critical incidents to identify and address actual or alleged events or situations that create a significant risk of substantial or serious harm to the physical or mental health, safety, or the well-being of its members.	**Metric: 2.2.1.2** Monitor the Frequency of Reported Critical Incidents by Member Classification
Goal 3: Support Efficient and Value-Driven Care **Objective 3.1:** Focus on Paying for Value	**Description of Quality Initiative:** *Reducing Emergency Department Utilization*: PIP intervention involving providing education to members with the most Low-Acuity-Non-Emergency (LANE) visit; identifying providers with the most LANE member visits and reminding them of members' needs for primary care; and identifying problems with transportation and mitigating barriers.	**Metric: 3.1.1.5** Ambulatory Care: Emergency Department (ED) Visits
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Member with chronic Conditions	**Description of Quality Initiative:** *Follow Up After Hospital Discharge:* PIP intervention involving educating members about the importance of engaging in a 30-day post-discharge follow-up visit with a	**Metric:** Transitions of Care (TRC) - Patient engagement After Inpatient Discharge - documentation of patient engagement provided within 30 days after discharge.

Virginia QS Goals and Objectives	Optima's Quality Initiative	Performance Metric
	PCP or specialist. Optima staff assist with scheduling appointment as needed.	*Note: Not a Quality Strategy metric.*

United

Table D-5—United's QS Quality Initiatives

Virginia QS Goals and Objectives	United's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care **Objective 1.2:** Improve Member Satisfaction **Objective 2.1:** Ensure Access to Care	**Description of Quality Initiative:** • *Dr. Chat*: 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. • *Addition of major health system*: 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. • *Member/Provider Satisfaction*: UHC monitors provider and member	**Metric 1.2.1.1:** Enrollees' Rating Q8-Rating of All Health Care **Metric 2.1.1.1:** Getting Care Quickly Q6 **Metric 2.1.1.3:** Getting Needed Care

Virginia QS Goals and Objectives	United's Quality Initiative	Performance Metric
	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.	
Goal 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1:** Ensure Access to Care **Objective 2.3:** Promote Effective Communication and Care Coordination	**Description of Quality Initiative:** • *Community Partnerships*: Collaboration and partnership with Federally Qualified Health Centers (FQHCs), health systems and other community entities to promote member self-care and facilitate support and assistance in scheduling preventative care.	**Metric:** 2.1.1.2 Respondent Got Non-Urgent Appointment as Soon as Needed **Metric:** :2.1.1.3 Getting Needed Care
Goal 3: Support Efficient and Value-Driven Care **Goal 4:** Strengthen the Health of Families and Communities **Objective 3.1:** Focus on Paying for Value **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Description of Quality Initiative:** *Community Plan Primary Care Provider Incentive Program*: • With the goal of achieving quality member outcomes, UHC educates providers in HEDIS specifications, provides up-to-date detailed data of members experiencing gaps in care, and assists providers with identification and outreach of members to close gaps in care. UHC additionally collaborates with providers and community entities to promote health fairs, clinic days, and other preventative care events.	**Metric:** 3.1.1.4 Ambulatory Care **Metric:** 4.1.1.1 Adults' Access to Preventive/Ambulatory Health Services **Metric:** 4.1.1.2 Child and Adolescent Well-Care Visits **Metric:** 4.1.1.3 Childhood Immunization Status **Metric:** 4.1.1.4 Immunizations for Adolescents **Metric:** 4.1.1.9 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

VA Premier

Table D-6—VA Premier's QS Quality Initiatives

Virginia QS Goal and Objective	VA Premier's Quality Initiative	Performance Metric
Goal 1: Enhance the Member Care Experience **Objective 1.2**: Improve Member Satisfaction	**Description of Quality Initiative:** 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.	**Metric:** 1.2.1.1 Enrollees' Ratings Q8-Rating of all Health Care
Goal: 2: Promote Access to Safe, Gold-Standard Patient Care **Objective 2.1**: Ensures Access to Care **Objective 2.2:** Promote Patient Safety **Objective 2.3:** Promote Effective Communication and Care Coordination	**Description of Quality Initiative:** 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	**Metric:** 2.1.1.3 Getting Needed Care

Virginia QS Goal and Objective	VA Premier's Quality Initiative	Performance Metric
	taking responsibility for wellness and their recovery.	
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	**Description of Quality Initiative:** Community Stabilization Team 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.	**Metric:** 3.2.1.1 Monitor Medical Loss Ratio
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:** Improve Outcomes for Members with Substance Use Disorders	**Description of Quality Initiative:** Case Conferencing with Homeless Shelters 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	**Metric:** 5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) Metric: 5.2.1.1 Use of High-Risk Medications in Older Adults (Elderly **Metric:** 5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment **Metric:** 5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Virginia QS Goal and Objective	VA Premier's Quality Initiative	Performance Metric
Objective 5.4: Improve Behavior Health and Development Services of Members		

Appendix E. Assessment of Follow-Up on Prior Recommendations

DMAS Follow-Up on Prior Year Recommendations for the CCC Plus (MLTSS) Program

Introduction

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that DMAS and the MCOs reported completing in response to HSAG's SFY 2022–2023 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—CCC Plus (MLTSS) Program Overall

Recommendation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders **Objective: 5.4:** Improve Behavioral Health and Developmental Services of Members	**Metric 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Metric 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness
HSAG Recommendation: To improve program-wide performance in support of Objective 5.3 and Objective 5.4 and improve outcomes for members with SUD, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.		
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):		

Recommendation
• DMAS included the measure Follow-Up After Emergency Department Visit for Substance Use 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 Visit for Substance Use **MY 2021:** 7-Day: 11.44% 30-Day: 19.98% **MY 2022:** 7-Day: 14.55% 30-Day: 22.57%
Identify any barriers to implementing initiatives: The ramifications of the COVID-19 PHE continued to be a barrier to improving performance to address the HSAG recommendation.
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 **Objective 4.2:** Improve Outcomes for Maternal and Infant Members	**Metric 4.1.1.4:** Immunizations for Adolescents **Metric 4.2.1.4:** Well-Child Visits in the First 30 Months of Life
HSAG Recommendation: To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.		
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):		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** Immunizations for Adolescents **MY 2021:** 70.70%; 30.52% **MY 2022:** 79.96%; 30.96%		

Recommendation
Measure: Well-Child Visits in the First 30 Months of Life **MY 2021:** 26.28%; 65.74% **MY 2022:** 18.66%; 63.11%
Identify any barriers to implementing initiatives: No barriers to implementation were identified.
HSAG Assessment: 

Recommendation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for Members With Chronic Conditions	**Metric 5.1.1.4:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
HSAG Recommendation: To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended 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): • DMAS included a Comprehensive Diabetes Care measure that includes HbA1c Poor Control (>9.0) 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:** Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) MY 2021: 51.42% MY 2022: 47.39%		
Identify any barriers to implementing initiatives: DMAS did not identify any barriers to implementing initiatives.		
HSAG Assessment: 		

MCOs' Follow-Up on Prior Year Recommendations

From the findings of each MCO's performance for the CY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the CCC Plus (MLTSS) program. The narrative within the MCO's response section was provided by the MCO and has not been altered by HSAG except for minor formatting.

Aetna

Table E-2—Prior Year Recommendations and Responses—Aetna

Recommendation—Performance Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits
Weakness: For the *Ambulatory Care—Emergency Department Visits* PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. **Recommendation:** HSAG recommends that Aetna: • Should seek technical assistance after receiving initial validation feedback to ensure that all necessary revisions are made correctly. The MCO should ensure it accurately documents any specifications followed for the PIP.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Per HSAG's recommendation and feedback, Aetna Better Health of Virginia revised its AMB PIP AIM Statement to follow HEDIS Ambulatory Care (AMB) measure for emergency department (ED) visits. Additionally, the Plan will not include a narrowed focus and will ensure the intervention applies to the entire eligible population. Specifically, the Plan revised its performance indicator to measure the entire population and align with the HEDIS AMB measure by removing all numerator subpopulation content and revising to represent the entire population.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure** *Ambulatory Care—ED Visits* MY2021: 89.52* MY2022: 1,083.05 **No performance improvement was noted as a result of revising the PIP AIM Statement and performance indicator to include and measure the entire population.*		
Identify any barriers to implementing initiatives: • Aetna Better Health of Virginia did not identify any barriers related to revising the PIP performance indicator and content to include the entire population.		

Recommendation—Performance Improvement Projects		
HSAG Assessment: 		
Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care **Goal 5**: Providing Whole-Person Care for Vulnerable Populations **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care **Goal 4:** Strengthen the Health of Families and Communities	**Objective 3.1** Focus on Paying for Value **Objective 5.1** Improve Outcomes for Members with Chronic Conditions **Objective 2.1** Ensure Access to Care **Objective 4.1** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members	**Metric 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits **Metric 5.1.1.6:** Avoidance of Antibiotic Treatment for Acute Bronchitis: Ages 3 Months to 17 Years **Metric 5.1.1.5:** Controlling High Blood Pressure **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 18 and Older **Metric 2.1.1.9:** Breast Cancer Screening **Metric 2.1.1.6:** Cervical Cancer Screening **Metric 4.1.1.3:** Childhood Immunization Status **Metric 4.1.1.4:** Immunizations for Adolescents **Metric 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
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: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Breast Cancer Screening* • *Cervical Cancer Screening* • *Use of Imaging Studies for Low Back Pain* • *Childhood Immunization Status—Combination 3* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* • *Controlling High Blood Pressure*		

Recommendation—Performance Measure Validation
• *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)* • *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* **Recommendation:** HSAG recommends that Aetna: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Taking Care of Children, Use of Opioids, and Utilization 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.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure** *Ambulatory Care ED Visits—Total* 2021: 89.52 2022: 1083.05 **Measure:** *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* 2021: 39.24% 2022: 39.18% **Measure:** *Breast Cancer Screening* 2021: 46.10% 2022: 48.43% **Measure:** *Cervical Cancer Screening* 2021: 41.12% 2022: 47.93% **Measure:** *Use of Imaging Studies for Low Back Pain* 2021: 66.95%

Recommendation—Performance Measure Validation
2022: 64.80% **Measure:** *Childhood Immunization Status—Combination 3* 2021: 37.50% 2022: 56.00% **Measure:** *Comprehensive Diabetes Care-Blood Pressure Control (<140/90 mm Hg)* 2021: 47.45% 2022: 58.88% **Measure:** *Controlling High Blood Pressure* 2021: 49.39% 2022: 54.99% **Measure:** *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* Combination 1 2021: 67.95% 2022: 81.71% **Measure:** *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* 2021: 28.85% 2022: 32.93% **Measure:** *Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies (lower percentage desired)* 2021: 3.34% 2022: 2.81% **Measure:** *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* 2021: 54.74% 2022: 59.61%
Identify any barriers to implementing initiatives: Aetna Better Health of Virginia did not identify any barriers with implementing initiatives.
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Improve Member Satisfaction	**Metric 1.2.1.1:** Enrollees' Ratings Q8 – Rating of all Health Care
Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. **Recommendation:** HSAG recommends that Aetna:		

Recommendation—Member Experience of Care Survey—Child Medicaid
Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.
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 corrective action plans (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 member advisory committee (MAC) meetings to educate members about CAHPS and discuss additional resources, including the 24-hour Nurse Line and telehealth.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** *Rating of All Health Plan—CCC Plus* Adult MY2021: 63.2% Adult MY2022: 67.8% Child MY2021: 66.1% Child MY2022: 63.9% **Measure:** *Rating of All Health Care—CCC Plus* Adult MY2021: 53.6% Adult MY2022: 51.5% Child MY2021: 62.5% Child MY2022: 62.3% **Measure:** *Rating of Specialist—CCC Plus* Adult MY2021: 73.4%

Recommendation—Member Experience of Care Survey—Child Medicaid
Adult MY2022: 71.1% Child MY2021: 64.5% Child MY2022: 60.0%
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: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Ensure Access to Care	**Metrics 2.1.1.1:** Getting Care Quickly Q6 **Metric 2.1.1.3** Getting Needed Care

Weakness: Aetna's 2022 top-box scores were statistically significantly lower than the 2021 top-box scores for three measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*.

Recommendation: HSAG recommends that Aetna:

Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Aetna focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.

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

Recommendation—Member Experience of Care Survey—Child Medicaid
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.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** *Rating of All Specialist Seen Most Often—CCC Plus* Adult MY2021: 73.4% Adult MY2022: 71.1% Child MY2021: 64.5% Child MY2022: 60.0% **Measure:** *Getting Needed Care—CCC Plus* Adult MY2021: 82.6% Adult MY2022: 80.5% Child MY2021: 81.8% Child MY2022: 81.7% **Measure:** *Getting Care Quickly—CCC Plus* Adult MY2021: 82.4% Adult MY2022: 83.0% Child MY2021: 82.9% Child MY2022: 85.6%
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

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric 3.1.1.4:** Ambulatory Care **Metric 5.1.1.6:** Avoidance of Antibiotic Treatment for Acute

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care **Goal 4:** Strengthen the Health of Families and Communities	**Objective 5.1:** Improve Outcomes for Members with Chronic Conditions **Objective 2.1:** Ensure Access to Care **Objective 4.1:** Improve the Utilization of Wellness, Immunization, and Prevention Services for Members **Objective 5.4:** Improve Behavioral Health and Developmental Services for Members	Bronchitis: Ages 3 Months to 17 Years **Metric 2.1.1.6:** Cervical Cancer Screening **Metric 4.1.1.3:** Childhood Immunization Status **Metric 4.1.1.4:** Immunizations for Adolescents **Metric 5.4.1.5**: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics **Metric 3.1.1.3:** Frequency of Potentially Preventable Readmissions

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:

- *Ambulatory Care—ED Visits—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Use of Imaging Studies for Low Back Pain*
- *Plan All-Cause Readmissions—Observed Readmissions—Total*

Recommendation: HSAG recommends that HealthKeepers:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, and Utilization 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 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):

The Anthem Virginia Quality Management department completed the analysis of the HEDIS rates by convening a HEDIS Root Cause Analysis (RCA) Work Group comprised of leaders from the following

Recommendation—Performance Measure Validation
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 Ambulatory Care—ED Visits—Total: • The Utilization Management Team implemented a Case Management Trigger list to identify members to refer for Case Management/CCC Plus Care Coordination • Implemented adding members who identified as outliers on the Inpatient daily census to weekly complex rounds capturing the members "clinical picture". • Established a Clinical Efficiency process that targets members that have been admitted to the hospital. The following initiatives were implemented because of the root cause analysis for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total: • Provider Outreach-targets PCP's with members who have filled an antibiotic prescription > 50% within 3 days of diagnosis of bronchitis/bronchiolitis. The communication addresses coding tips, member antibiotic awareness educational video QR code and continuing education opportunities. The following initiatives were implemented because of the root cause analysis for Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia: • 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. The following initiatives were implemented because of the root cause analysis for Cervical Cancer Screening: • Take Action Initiatives-these are initiatives between Anthem and national organizations to help reduce health disparities in African American and Latino communities. These websites include interactive content, cultural and trusted resources, and specific actions that can be taken to improve a member's health. Take Action for Health | Home • A SMS text message to increase awareness of services available to support their health care needs. Members are encouraged to complete the appropriate screening in a timely manner. The following initiatives were implemented because of the root cause analysis for Childhood Immunization Combo 3: • A SMS text message to increase awareness of services available to support their health care needs. Members are encouraged to complete the appropriate immunizations in a timely manner. • 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

Recommendation—Performance Measure Validation

improve member outcomes. These detailed analyses offer insight into areas of need relative to member demographics, provider groups, or geographic region.

- EPSDT Co-Branding Initiative with High Volume Providers: 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 90days from the member's birthday they have not had their Well Visit, we will send out another reminder to get services completed.
- 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.
- Partnering with Department of Social Services (DSS) offices across the state to ensure new Foster Care members complete a doctor's visit within 60 days of enrollment.

The following initiatives were implemented because of the root cause analysis for Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap):

- 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.
- Partnering with DSS offices across the state to ensure new Foster Care members complete a doctor's visit within 60 days of enrollment.

The following initiatives were implemented because of the root cause analysis for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total:

- 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 decrease in IP BH admission and ED utilization.
- 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.

The following initiatives were implemented because of the root cause analysis for Use of Imaging Studies for Low Back Pain:

- 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.
- Provider education via fax blast based on providers driving non-compliance.

The following initiatives were implemented because of the root cause analysis for Plan All Cause Readmissions:

Recommendation—Performance Measure Validation
• Implementation of Care Transition Intervention (CTI) model that provides outreach from coaches to assist with discharge planning and empower members to manage their own care.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total MY 2021: 38.79% MY 2022: 43.63% **Measure:** Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia MY 2021: 65.06% MY 2022: 67.14% **Measure:** Childhood Immunization Status—Combination 3 MY 2021: 55.08% MY 2022: 68.47% **Measure:** Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) MY 2021: 72.75% MY 2022: 83.94%
Identify any barriers to implementing initiatives: The barriers identified for Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total included: • Members requesting antibiotics. • Member belief that antibiotics will cure viral infections. • Lack of alternatives to antibiotics The barriers identified for Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia included: • Poor adherence/non-compliance w/ meds • Use of oral meds (Less effective than long-term injectables • Member's perception/understanding of disease (improved w/ support from providers, family & caregivers) The barriers identified for Cervical Cancer Screening included: • Fear of cancer diagnosis • Lack of awareness of the purpose of the test • Lack of information about how to get the screening. • Cultural barriers • Lack of awareness of risk factors The barriers identified for Ambulatory Care—ED Visits—Total included: • Members are uninformed of after-hours care offered by the providers. • Underutilization of urgent care facilities by members for non-emergent conditions • Members are uncertain about going to the ER due to COVID-19

Recommendation—Performance Measure Validation

- Contracted providers do not have or provide after-hours or weekend visits.
- Members delay care until the ER is the only option.

The barriers identified for Childhood Immunization Combo 3 included:

- Access to care
- Mistrust is healthcare system.
- Believed to be unnecessary.
- Members are uninformed of the number and type of immunizations required (assuming "vaccinations" are taken care of in one "shot").
- SDOH concerns such as transportation; members unable to get to scheduled appointments.
- Providers not following up with members to remind them of immunization appointments.

The barriers identified for Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) included:

- Access to care
- Mistrust is healthcare system.
- Believed to be unnecessary.
- Members are uninformed of the number and type of immunizations required (assuming "vaccinations" are taken care of in one "shot").
- SDOH concerns such as transportation; members unable to get to scheduled appointments.
- Providers not following up with members to remind them of immunization appointments.

The barriers identified for Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total included:

- Availability of behavioral health services, waitlists, and/or BH staffing shortages (although this is improving).
- Social stigma of participation in mental health services (v. medication management)
- Family engagement
- Poor adherence/non-compliance w/ meds
- Use of oral meds (Less effective than long-term injectables
- Member's perception/understanding of disease (improved w/ support from providers, family & caregivers)
- Poor adherence/non-compliance w/ meds
- Use of oral meds (Less effective than long-term injectables

The barriers identified for Use of Imaging Studies for Low Back Pain included:

- Request from patients to perform x-ray.
- Physicians' belief that an x-ray will reassure patients.

The barriers identified for Plan All-Cause Readmissions—Observed Readmissions—Total included:

- Lack of coordination with primary care providers in scheduling a follow-up visit within 7 days post-discharge.

Recommendation—Performance Measure Validation
• Lack of follow-up to ensure that post-discharge services (e.g., DME, home health) have been fulfilled and any other patient needs. • Members have difficulty in remembering verbal instructions at the time of discharge due to their hospitalization. • Health Plan is not aware of the 'real-time' when a patient is discharged. • Members do not have transportation for a follow up appointment.
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2**: Improve Member Satisfaction	**Metric** 1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care **Metric** 1.2.1.2: Rating of Personal Doctor
Weakness: HealthKeepers' 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national averages for three measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. **Recommendation:** HSAG recommends that HealthKeepers: conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.		
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:		

Recommendation—Member Experience of Care Survey—Child Medicaid
• 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 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** Enrollees' Ratings Q8-Rating of all Health Care 2021: 57.3% 2022: 61.5% **Measure** Rating of Personal Doctor 2021: 69.8% 2022: 69.2%
Identify any barriers to implementing initiatives: The barriers identified during the root cause analysis were: • Physicians and office staff shortages • Limited appointment availability • 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: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Improve Member Satisfaction	**Metric** 1.2.1.2: Rating of Personal Doctor
Weakness: HealthKeepers' 2022 top-box score was statistically significantly lower than the 2021 top-box score for one measure, *Rating of Personal Doctor*. **Recommendation:** HSAG recommends that HealthKeepers:		

Recommendation—Member Experience of Care Survey—Child Medicaid
Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. In addition, HSAG also recommends that HealthKeepers continue to monitor the measures to ensure significant decreases in scores over time do not occur.
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), 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 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** Rating of Personal Doctor 2021: N/A_____% 2022: N/A_____%
Identify any barriers to implementing initiatives: The barriers identified during the root cause analysis were: • Physicians and office staff shortages • Limited appointment availability • 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

Recommendation—Member Experience of Care Survey—Child Medicaid
• 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 Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric** 3.1.1.5: AMB-ED Ambulatory Care: Emergency Department (ED) Visits
Weakness: For the ambulatory care emergency department visits PIP, the MCO received a *Low Confidence* rating related to a *Partially Met* validation score for a critical element for not defining the numerator and denominator correctly for the performance indicator. **Recommendation:** HSAG recommends that Molina: • Ensure it accurately documents any specifications followed for the PIP.		
MCO's Response		
Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • Re-evaluation of PIP designs to create a more integrated approach. • Weekly data review to ensure accuracy and to track and monitor activities to identify effectiveness early		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** HEDIS AMB-ED 2021: 92.26 2022: 1,132.40		
Identify any barriers to implementing initiatives: N/A		
HSAG Assessment:		

Recommendation—Performance Improvement Projects


Recommendation—Performance Improvement Projects		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric** 3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits
Weakness: For the *Follow-Up After Discharge* PIP, the MCO received a *Low Confidence* rating related to *Partially Met* validation scores for a critical element for not defining the numerator and denominator correctly for the performance indicator and not referencing the measure specifications represented when defining the eligible population and performance indicator. **Recommendation:** HSAG recommends that Molina: Ensure it accurately documents any specifications followed for the PIP. The MCO should ensure it addresses all initial validation feedback and makes all revisions.		
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): • Re-evaluation of PIP designs to create a more integrated approach. • Weekly data review to ensure accuracy and to track and monitor activities to identify effectiveness early		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** HEDIS AMB-ED 2021: 92.26 2022: 1,132.40		
Identify any barriers to implementing initiatives: N/A		
HSAG Assessment: 		

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 3.1:** Focus on Paying for Value **Objective 2.**1 Ensure Access to Care **Objective 4.**1 Improve the Utilization of Wellness,	**Metric** 3.1.1.5**:** Ambulatory Care: Emergency Department (ED) Visits-Total **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis **Metric 2.1.1.9** Breast Cancer Screening

Recommendation—Performance Measure Validation		
Goal 4: Strengthen the Health of Families and Communities **Goal 5:** Providing Whole-Person Care for Vulnerable Populations	Immunization, and Prevention Services for Members **Objective 5.**1 Improve Outcomes for Members with Chronic Conditions **Objective 5.4** Improve Behavioral Health and Developmental Services for Members	**Metric 2.1.1.6** Cervical Cancer Screening **Metric 4.1.1.2** Child and Adolescent Well-Care Visits **Metric 5.1.1.4** Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) **Metric 5.1.1.5** Controlling High Blood Pressure **Metric 5.4.1.1** Follow-Up After Hospitalization for Mental Illness **Metric 4.1.1.4**: Immunizations for Adolescents **Metric 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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:

- *Ambulatory Care—ED Visits—Total*
- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Child and Adolescent Well-Care Visits—Total*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg)*
- *Controlling High Blood Pressure*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Combination 2 (Meningococcal, Tdap, HPV)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*

Recommendation: HSAG recommends that Molina:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Molina 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.

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): • Dashboard enhancement, timely refreshing of data, weekly data review to ensure accuracy and/or identification of opportunities. • Development of timely targeted intervention to engage member and improve outcomes • Enhanced member rewards • Enhanced P4Q program • Weekly review of services requiring Prior auth to ensure services was rendered timely • Telephonic outreach to follow up to ensure timely treatment, assist with appointment scheduling, identification of resources • Collaborate with care coordinators to ensure members are receiving services, identification of missed services • Weekly clinical rounds with CMO, BH Medical Director to discuss critical incidents, ED utilization, EPSDT services
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** HEDIS HbA1c <8% 2021: 25.79% 2022: 35.28% **Measure:** Ambulatory Care: Emergency Department (ED) Visits-Total 2021: 92.26 2022: 1,132.40 **Measure:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis 2021: NA 2022: 57.87% **Measure:** Breast Cancer Screening 2021: 38.92% 2022: 43.00% **Measure:** Cervical Cancer Screening 2021: 39.90% 2022: 40.39% **Measure:** Controlling High Blood Pressure 2021: 40.63% 2022: 37.71% **Measure:** Follow-Up After Hospitalization for Mental Illness 2021: 20.80%; 37.78% 2022: 22.14% 43.64% **Measure:** Immunizations for Adolescents 2021: 58.16%; 25.53%

Recommendation—Performance Measure Validation
2022: 73.45%; 30.09% **Measure:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents 2021: 68.61%; 52.07%; 45.74% 2022: 61.56%; 47.45%; 40.15%
Identify any barriers to implementing initiatives: Providers slow to engaged initially but work continually to engage providers by offering support and resources. High volume of unable to reach, however leverage other channels of engagement to validate and connect with members, to Include data sharing through EMR access and/or CVS support.
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience **Goal 2:** Promote Access to Safe, Gold-Standard Patient Care	**Objective 1.2:** Improve Member Satisfaction **Objective 2.1:** Ensure Access to Care	**Metric**1.2.1.1: Enrollees' Ratings Q8-Rating of all Health Care **Metric** 2.1.1.1: Getting Care Quickly Q6 **Metric** 2.1.1.3: Getting Needed Care
Weakness: Molina's 2022 top-box scores were statistically significantly lower than the 2021 NCQA child Medicaid national average for two measures: *Rating of Health Plan* and *Getting Needed Care*. **Recommendation:** HSAG recommends that Molina: Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that Molina focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.		

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): • Identification of key drivers • Member education on tips to prepare for doctor's visit. • Support providers and their members by informing of all up-to-date tools, resources and guides that address clinical needs and self-management topics. Leverage provider and member newsletters. • Build provider partnerships through monthly meetings to facilitate a targeted approach in new visit and f/u appointment scheduling

Recommendation—Member Experience of Care Survey—Child Medicaid
• Support, encourage and assist in provider/staff of the best practices approaches toward open access scheduling. Allow a portion of each day open for urgent care and/or follow-up care. • Educate members on the use of the Nurse hotline/Nurse on Call • Leverage use of Care Connections to help identify and capture clinical assessment • Direct Scheduling with Keona • Increase provider/staff awareness of the benefits/services available to the members; transportation, case management services and benefits • Just in time outreach to members to engagement, identify barriers to care and assist with actionable solutions
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure:** CAHPS Getting Care Quickly 2021: 76.3% 2022: 77.2%
Identify any barriers to implementing initiatives: Slow building of provider engagement, but identify opportunities to leverage provider champions to help support engagement.
HSAG Assessment: 

Optima

Table E-5—Prior Year Recommendations and Responses—Optima

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Measure 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits
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: • ***Ambulatory Care - ED Visits -Total*** **Recommendation:** HSAG recommends that Optima: • Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, Use of Opioids, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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.		

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): Optima Health utilizes the Top 10 diagnoses to identify Low-Acuity Non-Emergent (LANE) members. This enables the health plan to educate members about the importance of other treatment options for non-emergency health situations to help reduce non-emergent ED utilization. The top 10 LANE diagnoses are as follows: • J06.9 Acute Upper Respiratory Infection, unspecified • J10.1 Influenza due to other identified influenza virus with other respiratory manifestations • J02.9 Acute Pharyngitis, unspecified • R11.2 Nausea with vomiting, unspecified • N39.0 Urinary tract infection, site not specified • J20.9 Acute bronchitis, unspecified • M54.5 Low back pain • R10.9 Unspecified abdominal pain • R51 Headache • K52.9 Non-infective gastroenteritis and colitis, unspecified Optima Health's LANE analysis was built to specifically identify and quantify the impact of LANE ED usage. Understanding the cost of care that is paid by the Health plan brings to light the importance of this subject. The health plan incorporates a systemic approach to identifying barriers to LANE and evidence-based interventions to help reduce ED utilization. Interventions include identifying LANE members to provide case management and/or education; identifying providers with the most LANE members, as well as missed trips to routine follow up visits that ultimately results in an ED visit. The providers identified will be given education from our Network Management team. This will be ongoing with a target focus on providers with most LANE visit members seen by the provider/practice. There are also newsletters and email blasts that go to providers for continuous education and/or reminders about other options for members in the health plan as well as seeking care at the provider's office as an option. Educating the provider about other options for the member to seek care will reduce visits, making them aware of the member's activity in seeking care. This enhances provider awareness of the need to address members' care/concerns before LANE visits occur. Identifying members who are high-utilizers of the ED and understanding why the member use the ED is an important step in minimizing unnecessary ED visits. The goal for this process is to assess risk factors that contribute to unnecessary ED visits. Optima Health has a team of Case Managers who provide information and guidance to members who are high ED utilizers. Monitoring and using the data from missed trips will be analyzed and assessed for opportunities that exist for closing the gap on members' missed trips to provider appointments which causes the member to go to the ED for care. This will be addressed by identifying barriers to meeting trips scheduled for members' care. The transportation provider, Verida is collaboratively working with the health plan to identify issues to provide resolution to these gaps.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: **Measure: *Ambulatory Care – ED Visits - Total***

Recommendation—Performance Measure Validation
2021: 83.13 2022: 1063.44
Identify any barriers to implementing initiatives: • Need a more targeted way of highlighting LANE visits with providers • Members continue to need education on when to use the Emergency Department versus going to their Primary Care Provider (PCP)
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	**Metric 4.1.1.3:** 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*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Childhood Immunization Incentive Program • Immunization Health Fairs across the State • HEDIS Blitz • Provider educational Outreach • Data from VIIS and Health Fair Capture is being used to close Gaps. Members are referred to Case Management when appropriate • A dedicated full-time employee to support EPSDT • Partnership with the Virginia Department of Health to increase access to immunizations and provide education • Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.		

Recommendation—Performance Measure Validation
• NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment to include but not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc. A 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: 54.65% 2022: 73.97%
Identify any barriers to implementing initiatives: The MCO did not identify any barriers to implementing initiatives.
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective:** Ensure Access to Care	**Metric 2.1.1.9:** Breast 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: • ***Breast Cancer Screening*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Perform live outreach calls to discuss the importance of breast cancer screening and remind members they are due for a mammogram • Live call outreach to members advising the importance of obtaining mammogram • Pop Care Team sends letters to members with multiple gaps		

Recommendation—Performance Measure Validation
• Incentive provided to member for completing gap in care and obtaining preventative care • Partnership ongoing with Network Education to distribute patient Gap Reports NCQA Population Health Management (PHM) Standards and Audit tools purchased to perform a comprehensive population health assessment to include but not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Breast Cancer Screening*** 2021: 45.23% 2022: 44.76%
Identify any barriers to implementing initiatives: • Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective 2.1:** Ensure Access to Care	**Metric 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*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Collaborate with Health Prevention to send out annual reminders regarding screenings • Incentive provided to member for completing gap in care and obtaining preventative care • Implemented targeted campaigns around cancer screenings • Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.		

Recommendation—Performance Measure Validation
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Cervical Cancer Screening*** 2021: 47.93% 2022: 45.74%
Identify any barriers to implementing initiatives: Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1:** Improve Outcomes for member with Chronic Conditions	**Metric 5.1.1.4:** Comprehensive Diabetes Care Hemoglobin 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)***

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 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 in Symphony/JIVA
- Pop Care Diabetic Eye Exam campaign
- BioIQ at-home A1c program
- Focus Care In-Home A1c testing

Recommendation—Performance Measure Validation
• HEDIS 4th QTR 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 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 to be 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: 61.80% 2022: 52.31%
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Eye Exam (Retinal) Performed*** 2021: 48.18% 2022: 51.58%
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: 44.28% 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 5.1:** Improve Outcomes for Members with Chronic Conditions	**Metric 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***

Recommendation: HSAG recommends that Optima:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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):

- 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 reinforce how to best manage diabetes
- Incentive provided to member for completing gap in care and obtaining preventative care
- Quality Measure Improvement Committee (QMIC) re-established – this committee identifies business owners of measures and documents all interventions.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure: *Controlling High Blood Pressure***

2021: 48.42%

2022: 51.58%

Identify any barriers to implementing initiatives:

- Significant measure improvement and met the benchmark
- No barriers identified at this time. Will continue with the interventions that are in place

HSAG Assessment:

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Development of Services for Members	**Metric 5.4.1.10:** Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

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:

- ***Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***

Recommendation: HSAG recommends that Optima:

- Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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):

- Chronic Care Management conducts assessments for members who have been identified to have a cardiovascular condition such as Hypertension, Coronary Artery Disease, and Heart Failure. For the respective members, a scale and blood pressure cuff are provided, as needed, to enable the member to monitor their progress and notify the PCP if they have abnormal readings.
- Chronic Care Management Team mails hard copy member educational materials that provide guidance on healthy eating, exercise, and symptom awareness to enable members to contact their PCP in a timely manner.
- Chronic Care Management conducts the PHQ-2 screening for all members we engage. Based on a risk stratification scale, members are referred to the Behavioral Health team for further evaluation by a Mental Health provider.

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure: *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications***

2021: 61.90%

2022: 80.20%

Identify any barriers to implementing initiatives:

No barrier identified

HSAG Assessment:

Recommendation—Performance Measure Validation


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	**Metric 4.1.1.4:** Immunizations for Adolescents

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:

- ***Immunizations for Adolescents - Combination 1 (Meningococcal, Tdap)*** **and** ***Combination 2 (Meningococcal, Tdap, HPV)***

Recommendation: HSAG recommends that Optima:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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):

- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well, Child & Immunization Campaigns. Educational Outreach. Data utilized from VIIS and Health Fair Capture to close Gaps and refer to Case Management. FTE for EPSDT
- Immunization program in development to improve member and clinician engagement which includes incentives, targeted outreach, and educational initiatives. Additionally, increased collaboration with the commonwealth's Department of Health regarding vaccination data.
- NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment to include but not limited to SDOH, barriers to care, preferences regarding healthcare, clinical communications, and health disparities to include race/ethnicity, age, zip code, etc.
- Well Child & Immunization Campaigns

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure:** ***Immunizations for Adolescents - Combination 1 (Meningococcal, Tdap)***

2021: 69.19%

2022: 72.04%

- **Measure:** ***Immunizations for Adolescents - Combination 2 (Meningococcal, Tdap, HPV)***

Recommendation—Performance Measure Validation
2021: 30.07% 2022: 27.20%
Identify any barriers to implementing initiatives: • Parents are still hesitant to give their children a vaccine
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Development of Services for Members	**Metric 5.4.1.6:** Metabolic Monitoring for Children and Adolescents on Antipsychotics
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: • ***Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic • Care Coordination letters are sent to the member's 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: *Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing - Total***		

Recommendation—Performance Measure Validation
2021: 39.09% 2022: 46.56%
Identify any barriers to implementing initiatives: An influx of BH patients seeking care through emergency departments (EDs).
HSAG Assessment: 

Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1**: Improve Outcomes for Members with Chronic Conditions	**Metric:** Pharmacotherapy Management of COPD Exacerbation (PCE) *Note: Not a Quality Strategy metric.*

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:

- ***Pharmacotherapy Management of COPD Exacerbation - Bronchodilator* and *Systemic Corticosteroid***

Recommendation: HSAG recommends that Optima:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • 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 • Clinical program to help adherence and therapy completeness • Care Coordinators reach members to educate them on side effects and provide any additional support needed
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Pharmacotherapy Management of COPD Exacerbation - Bronchodilator*** 2021: 58.05% 2022: 67.60%
• **Measure: *Pharmacotherapy Management of COPD Exacerbation - Bronchodilator-Systemic Corticosteroid***

Recommendation—Performance Measure Validation
2021: 46.87% 2022: 56.84%
Identify any barriers to implementing initiatives: Member education on importance of taking prescribed medication
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	**Metric 5.4.1.5:** Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

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:

- ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total***

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 and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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):

- 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
- Clinical program to help adherence and therapy completeness
- Care coordinators reach members to educate them on side effects and provide any additional support needed

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure*: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total***

Recommendation—Performance Measure Validation
2021: 36.62% 2022: 36.25%
Identify any barriers to implementing initiatives: • Member COPD self-management may not follow recommendations, contribute to exacerbations, and avoid seeking medical interventions until in severe clinical distress • Members may not comply with the ongoing prescribed medication regimen, or non-compliance may exist due to economic stress may be affecting members' ability to obtain or refill medications due to financial hardship
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.3:** Improve Outcomes for Members with Substance Use Disorders	**Metric:** Use of Opioids from Multiple Providers (UOP) *Note: Not a Quality Strategy metric.*
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: • ***Use of Opioids From Multiple Providers - Multiple Prescribers*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Ensure appropriate clinical monitoring of the member is completed and reported • Team meetings are held monthly to discuss the program, suggest any improvements, and review data results • Clinical program to help adherence and therapy completeness • Care Coordinators reach members to educate them on side effects and provide any additional support needed
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed:

Recommendation—Performance Measure Validation
• **Measure:** ***Use of Opioids From Multiple Providers - Multiple Prescribers*** 2021: 2.46% 2022: 1.95%
Identify any barriers to implementing initiatives: • Member COPD self-management may not follow recommendations, contribute to exacerbations, and avoid seeking medical interventions until in severe clinical distress • Members may not comply with the ongoing prescribed medication regimen, or non-compliance may exist due to economic stress may be affecting members' ability to obtain or refill medications due to financial hardship
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	**Metric 4.1.1.9:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
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: • ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total*, *Counseling for Nutrition - Total*, and *Counseling for Physical Activity - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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): • Incentive Program, Back to School Fairs across the State • Well Child Campaigns • Educational Outreach. Data utilized from VIS and Health Fair Capture to close Gaps and refer to Case Management. FTE for EPSDT • NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment include but are not limited to SDOH, barriers to care, preferences regarding		

Recommendation—Performance Measure Validation
healthcare, clinical communications, and health disparities including race/ethnicity, age, zip code, etc. • Well Child & Immunization Campaigns
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure:** ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile - Total*** 2021: 63.02% 2022: 63.75%
• **Measure:** ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition - Total*** 2021: 56.93% 2022: 52.55%
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2:** Promote Efficient Use of Program Funds	**Metric 3.2.1.6:** Plan All-Cause Readmission Rate
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: • ***Plan All-Cause Readmission - Observed Readmissions - Total*** **Recommendation:** HSAG recommends that Optima: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that Optima 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 Case Management Team sends a Where to Go Flyer addressing when to visit the Doctor's Office, Urgent Care, and the Emergency Room. This flyer also includes the Free 24-hour Nurse Advice Line education. Case Management outreaches to members to provide education, engage in		

Recommendation—Performance Measure Validation
case management services to include a plan of care, and mail a list of providers in their region for member utilization to address their healthcare needs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: *Plan All-Cause Readmissions - Observed Readmissions - Total*** 2021: NDR% 2022: 11.11% 0.9344
Identify any barriers to implementing initiatives: No barrier Identified.
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 3:** Support Efficient and Value-Driven Care	**Objective 2.1:** Ensure Access to Care **Objective 3.1:** Focus on Paying for Value	**Metric 2.1.1.6:** Cervical Cancer Screening **Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis **Metric 3.1.1.5:** Ambulatory Care: Emergency Department (ED) Visits-Total
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: • *Ambulatory Care—ED Visits—Total* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* • *Cervical Cancer Screening* **Recommendation:** HSAG recommends that United: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that United 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.		

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): 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. • Member outreach to educate, remind and assist members with scheduling an appointment for cervical cancer screenings. Transportation for members was also arranged as needed. • Comprehensive Case management services addressing SDOH, medical, and behavioral needs for member with chronic conditions and high ED utilizers. • 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 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: 45.74% 2022: 45.50% **Measure 2.1.1.12: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis** 2021: 31.37% 2022: 30.42% **Measure 3.1.1.5: Ambulatory Care: Emergency Department (ED) Visits-Total** 2021: 89.84% 2022: 96.04%
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: 

VA Premier

Table E-7—Prior Year Recommendations and Responses—VA Premier

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1:** Focus on Paying for Value	**Metric 3.1.1.5**: Ambulatory Care: Emergency Department (ED) Visits
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: • ***Ambulatory Care—ED Visits—Total*** **Recommendation:** HSAG recommends that VA Premier: • Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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 summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • The Clinical Care Coordinator (CCT) will contact members to help educate them on when to use Urgent Care (UC), Primary Care Provider (PCP), or Emergency Department (ED) and will send a "Where to Go flyer" The Clinical Care Coordinator (CCT) will determine if the member has an assigned PCP and connect them to Member Services if they need to change or select a provider.		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Ambulatory Care—ED Visits—Total** 2021: 81.83% 2022: 62.41		
Identify any barriers to implementing initiatives: Members will need to be educated on when to use the Emergency Department versus going to their PCP.		
HSAG Assessment: 		

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold Standard Patient Care	**Objective 2.1:** Ensure Access to Care	**Metric 2.1.1.12:** Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis *Note: Not a Quality Strategy metric.*

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:

- ***Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- Team meetings are held monthly to discuss the program, suggest any improvements, and review data results
- Clinical program has been established to help adherence and therapy completeness

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total**

2021: 19.92%

2022: 48.75%

Identify any barriers to implementing initiatives:

- No identified barriers

HSAG Assessment:

Recommendation—Performance Measure Validation		
Goal 2: Promote Access to Safe, Gold-Standard Patient Care	**Objective** 2.1: Ensure Access to Care	**Metric** 2.1.1.9: Breast Cancer Screening *Note: Aspirational metric.*

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 VA Premier: • ***Breast Cancer Screening*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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): • Live outreach calls are made to discuss the importance of breast cancer screening and remind members they are due for a mammogram • HEDIS Blitz conducted annually to close care gaps • Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement • Multiple gaps letters mailed to members advising of the need to obtain mammogram • Ongoing partnership with provider practices to review patient gap reports
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Breast Cancer Screening** 2021: 36.71% 2022: 36.91%
Identify any barriers to implementing initiatives: • Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Improved Population Health	**Objective 4.1:** Improve Behavioral Health and Developmental Services of Members	**Metric:** Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia *Note: Not a Quality Strategy metric.*

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 VA Premier: • ***Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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): • Chronic Care Management conducts assessments for members who have been identified to have a cardiovascular condition such as Hypertension, Coronary Artery Disease, and Heart Failure. For respective members, a scale and blood pressure cuff are provided, as needed, to enable the member to monitor their progress and notify the PCP if they have abnormal readings. • Chronic Care Management Team mails hard copy member educational materials that guide healthy eating, exercise, and symptom awareness to enable members to contact their PCP in a timely manner. • Chronic Care Management conducts the PHQ-2 screening for all members we engage. Based on a risk stratification scale, members are referred to the Behavioral Health team for further evaluation by a Mental Health provider.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia** 2021: 61.90% 2022: 63.64%
Identify any barriers to implementing initiatives: • No Barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 4: Improved Population Health	**Objective 4.1:** Improve Outcomes for Maternal and Infant Members	**Metric 4.6.3:** 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***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- 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 (Early and Periodic Screening, Diagnosis and Treatment)
- Data from 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: 61.97%

2022: 62.22%

Identify any barriers to implementing initiatives:

- No Barriers identified

Recommendation—Performance Measure Validation
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	**Metric:** Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) *Note: Not a Quality Strategy metric.*

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:

- ***Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)***

Recommendation: HSAG recommends that VA Premier:

- Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- 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 glucometer, blood pressure cuff, or scale, as needed
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide
- Vendor Dario is used to outreach to members gap-closing efforts
- Members are sent written education materials to reinforce how to best manage diabetes

Identify any noted performance improvement as a result of initiatives implemented (if applicable):
PMV results showed:

- **Measure: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)**

2021: 46.47%
2022: 58.39%

Identify any barriers to implementing initiatives:
No Barriers identified

Recommendation—Performance Measure Validation		
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	**Metric** 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 VA Premier: • ***Controlling High Blood Pressure*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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): • 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 glucometer, blood pressure cuff, or scale, as needed • Members are sent written education materials to give them reinforcement on how to best manage their blood pressure • HEDIS Blitz conducted annually to close care gaps • Provider Education conducted statewide		
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: 58.15%		
Identify any barriers to implementing initiatives: No Barriers identified		

Recommendation—Performance Measure Validation
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective** 5.4, Improve Behavioral Health and Developmental Services of Members	**Metric** 5.4.1.1: Follow-Up After Hospitalization for Mental Illness
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*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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		
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: 19.16% 2022: 21.38%		
• **Measure: Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total** 2021: 37.28% 2022: 41.02%		
Identify any barriers to implementing initiatives: • Numerous unsuccessful outreach attempts to assist member with scheduling follow-up appointment post discharge		
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: 19.16% 2022: 21.38%		

Recommendation—Performance Measure Validation
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	**Metric 4.1.1.4:** Immunizations for Adolescents

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:

- ***Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*** **and** ***Combination 2 (Meningococcal, Tdap, HPV)***

Recommendation: HSAG recommends that VA Premier:

- Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- Childhood Immunization Incentive Program, Back to School Fairs across the State. Well, Child & Immunization Campaigns. Educational Outreach. Data utilized from VIIS to close gaps and referred to case management, when needed.
- 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.
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure: Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)**

2021: 72.99%

2022: 78.47%

- **Measure: Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)**

2021: 30.66%

Recommendation—Performance Measure Validation
2022: 28.47%
Identify any barriers to implementing initiatives: • No Barrier 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	**Metric** Pharmacotherapy Management of COPD Exacerbation (PCE) *Note: Not a Quality Strategy metric.*

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:

- ***Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Systemic Corticosteroid***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- 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
- Clinical program to help adherence and therapy completeness
- Care Coordinators reach members to educate them on side effects and provide any additional support, as needed

Identify any noted performance improvement as a result of initiatives implemented (if applicable):

PMV results showed:

- **Measure: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator**

2021: 59.54%

2022: 61.31%

Recommendation—Performance Measure Validation
• **Measure: Pharmacotherapy Management of COPD Exacerbation—Bronchodilator-Systemic Corticosteroid** 2021: 50.13% 2022: 51.45%
Identify any barriers to implementing initiatives: Member education on importance of taking prescribed medication
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.4:** Improve Behavioral Health and Developmental Services of Members	**Metric** 5.4.1.5: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
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: • ***Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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): • Clinical coordination program for those members aged 6-12 who are taking an atypical antipsychotic • Care coordination letters are sent to the member's PCP and prescriber of atypical antipsychotic • 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:		

Recommendation—Performance Measure Validation
• **Measure: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total** 2021: 50.00% 2022: 41.27%
Identify any barriers to implementing initiatives: No Barriers Identified
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.1** Focus on Paying for Value	**Metric:** Use of Imaging Studies for Low Back Pain *Note: Not a Quality Strategy metric.*
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: • ***Use of Imaging Studies for Low Back Pain*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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): • Clinical Guidelines reviewed and updated • Providers are notified of updated clinical guidelines via newsletter & provider website • Provider newsletter article • Data analysis based on ordering providers to assist in driving interventions • Partner with our Clinically Integrated Networks to develop action items for addressing the use of advanced imaging for initial diagnosis and treatment of low back pain • Adding physical therapy recommendations to the member's newsletter to increase the understanding of low back health and how to prevent injuries		
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Use of Imaging Studies for Low Back Pain**		

Recommendation—Performance Measure Validation
2021: 68.34% 2022: 67.55%
Identify any barriers to implementing initiatives: • No Barriers Identified
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	**Metric** 4.1.1.9: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

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:

- ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total***

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):

- Well Child and Immunization Campaigns created to address gaps in care
- HEDIS Blitz conducted annually to close care gaps
- Provider Education conducted statewide
- Quality Measure Improvement Committee (QMIC) has been reinstated and focuses on measure improvement
- NCQA PHM Standards and Audit tools purchased to perform a comprehensive population health assessment 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.

Recommendation—Performance Measure Validation
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total** 2021: 58.64% 2022: 66.67% • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total** 2021: 48.18% 2022: 60.10% • **Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total** 2021: 40.88% 2022: 52.80%
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	**Metric: 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 VA Premier: • ***Well-Child Visits in the First 30 Months of Life—Age 15 to 30 Months*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living With Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement. In addition, HSAG recommends that VA Premier 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):		

Recommendation—Performance Measure Validation
• Childhood Incentive Program • Health fairs throughout the state of Virginia • HEDIS Blitz • Provider educational outreach • 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) re-established – this committee identifies business owners of measures and documents all interventions. • The Population Health Assessment work group was established on 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.
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: 27.27% 2022: NDR%
• **Measure: Well-Child Visits in the First 30 Months -Age 15 to 30 Months** 2021: 64.00% 2022: 53.57%
Identify any barriers to implementing initiatives: • Timely access to Primary Care Provider (PCP)
HSAG Assessment: 

Recommendation—Performance Measure Validation		
Goal 3: Support Efficient and Value-Driven Care	**Objective 3.2:** Promote Efficient Use of Program Funds	**Metric 3.2.1.6:** Plan All-Cause Readmission Rate *Note: Not a Quality Strategy metric.*
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: • ***Plan All-Cause Readmissions—Observed Readmissions—Total*** **Recommendation:** HSAG recommends that VA Premier: Conduct a root cause analysis or focus study as it relates to these PMs within the Access and Preventive Care, Behavioral Health, Taking Care of Children, Living with Illness, and Utilization domains, and implement appropriate and timely interventions, as applicable, for future improvement.		

Recommendation—Performance Measure Validation
In addition, HSAG recommends that VA Premier 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): • Case Management Team sends a Where to Go Flyer addressing when to visit the Doctor's Office, Urgent Care, and the Emergency Room. This flyer also includes the Free 24-hour Nurse Advice Line education. • Case Management outreaches to members to provide health education, engage in case management services to include a plan of care, and mail a list of providers in their region for member utilization to address their healthcare needs.
Identify any noted performance improvement as a result of initiatives implemented (if applicable): PMV results showed: • **Measure: Plan All-Cause Readmissions—Observed Readmissions—Total** 2021: NDR% 2022: 11.59% 0.9655
Identify any barriers to implementing initiatives: No Barriers Identified
HSAG Assessment: 

Recommendation—Member Experience of Care Survey—Child Medicaid		
Goal 1: Enhance the Member Care Experience	**Objective 1.2:** Improve Member Satisfaction	**Metric 1.2.1.1:** Enrollees' Ratings Q8 – Rating of all Health Care

Weakness: VA Premier's 2022 top-box score was statistically significantly lower than the 2021 NCQA child Medicaid national average for one measure, *Rating of All Health Care*.

Recommendation: HSAG recommends that VA Premier:

Conduct a root cause analysis of the study indicator that has been identified as the area of low performance. This type of analysis is used to investigate process deficiencies and unexplained outcomes to identify causes and potential improvement strategies. HSAG recommends that VA Premier focus initiatives on raising the statistically significantly lower scores and continue to monitor the measures to ensure there are no significant decreases in scores over time.

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—Member Experience of Care Survey—Child Medicaid
• 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 All Health Care** 2021: 83.48% 2022: 88.74%
Identify any barriers to implementing initiatives: No barriers identified
HSAG Assessment: 

Appendix F. 2023–2025 Quality Strategy Status Assessment

Evaluation Methodology Description

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[F-1]

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
Total Served	2,135,985

**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

[F-1] Cardinal Care, Virginia's Medicaid Program, Department of Medical Assistance Services. Medicaid/FAMIS Enrollment. Available at: https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/. Accessed on: Dec 6, 2023.

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.

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. During CY 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. As of January 1, 2024, the MCOs name is Sentara Health Plan.*

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
 **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
	**Objective 4.1:** Improve Utilization of Wellness, Immunization, and Prevention Services for Members
	★ **Objective 4.2:** Improve Outcomes for Maternal and Infant Members ★

Goals	Objectives
Goal 4: Strengthen the Health of Families and Communities	**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:** Improve Outcomes for Members with Substance Use Disorders ★
	★ **Objective 5.4:** 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®)[F-2] quality metrics, CMS Adult and Child Core Set of Health Care Quality Measures for Medicaid, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs), Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[F-3] 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.

[F-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[F-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 *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®, [F-4] 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.

[F-4] Quality Compass® is a registered trademark of NCQA.

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 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)	*Timeliness of Prenatal Care* 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 *Prenatal and Postpartum Care* (PPC) Technical Specifications. (Quality Strategy goal: Strengthen the Health of Families and Communities; objective: ★ Improve Outcomes for Maternal and Infant Members. ★)
Medallion 4.0 (Acute)	*Tobacco Use Cessation in Pregnant Women* 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: ★ Improve Outcomes for Maternal and Infant Members ★; and goal: Providing Whole Person Care for Vulnerable Populations; objective: Improve Behavioral Health and Developmental Services for Members.)
CCC Plus (MLTSS)	*Ambulatory Care—Emergency Department Visits* rates for the percentage of members in the entire eligible population aligned with the HEDIS MY 2022 Technical Specifications *Ambulatory Care* (AMB) measure specifications and who had more than one emergency department visit. (Quality Strategy goal: ★

Program	PIP Topic Area
	Support Efficient and Value-Driven Care ★; objective: Focus on Paying for Value.)
CCC Plus (MLTSS)	*Follow-Up After Discharge* rates for the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge. (Quality Strategy goal: ★ Support Efficient and Value-Driven Care ★; 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; 438l.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-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.

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) PWPs. 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 slogs 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've 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
Goal 5: Providing Whole-Person Care for Vulnerable Populations **Objective 5.3:** Improve Outcomes for Members with Substance Use Disorder **Measure: 5.3.1.4:** Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.3 and improve outcomes for members with SUD, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the behavioral health follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	DMAS included the measure *Follow-Up After Emergency Department Visit for Substance Use* in its PWP which provides an incentive to MCOs to increase performance and close gaps. **Measure:** *Follow-Up After Emergency Department Visit for Substance Use* **MY 2021:** 7-Day: 11.44% 30-Day: 19.98% **MY 2022:** 7-Day: 14.55% 30-Day: 22.57%
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective 5.1:** Improve Outcomes for Members With Chronic Conditions	DMAS included a *Comprehensive Diabetes Care measure that includes HbA1c Poor Control (>9.0)* in its PWP which provides an incentive to MCOs to increase performance and close gaps.

2021–2022 EQRO Recommendations	DMAS Actions
Measure: 5.1.1.4: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) To improve program-wide performance in support of Objective 5.1 and improve outcomes for members with chronic conditions, HSAG recommends DMAS: • Require that the MCOs conduct a root cause analysis to determine why members are not maintaining their diabetes care. • Upon identification of a root cause, require the MCOs to implement appropriate interventions to improve the performance related to proper diabetes management. • Require the MCOs to identify best practices to improve care and services according to chronic care recommended guidelines.	**Measure:** *Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)* **MY 2021:** 51.42% **MY 2022:** 47.39%

Table F-6—Medallion 4.0 (Acute) Prior Year Recommendations and DMAS Responses

2021–2022 EQRO Recommendations	DMAS Actions
Goal: Providing Whole-Person Care for Vulnerable Populations **Objective: 5.4:** Improve Behavioral Health and Developmental Services for Members **Measure 5.4.1.1:** Follow-Up After Hospitalization for Mental Illness To improve program-wide performance in support of Objective 5.4 and improve outcomes for members in need of BH and developmental services, HSAG recommends DMAS: • Require the MCOs to develop processes to ensure providers follow recommended guidelines for	• The DMAS BH team continues to work on the following initiative to improve Medicaid funded behavioral health care across Virginia including the following efforts: – 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. – 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

2021–2022 EQRO Recommendations	DMAS Actions
follow-up and monitoring after hospitalization. • Require the MCOs to identify healthcare disparities (race, ethnicity, age group, geographic location, etc.) with the BH follow-up PM data. • Upon identification of a root cause issue, require the MCOs to implement appropriate QI interventions to improve use of evidence-based practices related to behavioral healthcare and services. • Require the MCOs to identify best practices to conduct follow-up with members discharged from the ED and ensure follow-up visits within seven days and 30 days are completed.	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' 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.

2021–2022 EQRO Recommendations	DMAS Actions
	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%
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 **Objective 4.2: ★ Improve Outcomes for Maternal and Infant Members. ★** **Measure: 4.2.1.4:** Well-Child Visits in the First 20 Months of Life To improve program-wide performance in support of Objective 4.1 and 4.2 and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends DMAS: • Require the MCOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require the MCOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the MCOs to identify best practices to improve care and services according to the Bright Futures guidelines.	DMAS has improved its ability to track MCO required monthly data submissions. **MCH:** • 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: 1. Childhood Immunization rates 2. Well-child rates in all age groups 3. Lead testing rates 4. Increase percentage of lead testing of children aged one (1) to five (5) each contract year 5. Improve the current tracking system for monitoring EPSDT corrective action referrals (referrals based on the correction or amelioration of the diagnosis). • 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. **ICER:** 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. **Measure**: *Child and Adolescent Well-Care Visits* **MY 2021:** 46.57% **MY 2022:** 50.27% **Measure:** *Childhood Immunization Status* **MY 2021:** 65.82% **MY 2022:** 63.22%

2021–2022 EQRO Recommendations	DMAS Actions
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 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.	**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. • 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. **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%

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 [F-5] 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

[F-5] 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.

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.

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
Goal 1: Enhance the Member Care Experience	**Objective 1.1** Increase Member Engagement and Outreach	1.1.1.1. Number of Outreach and Engagement (O&E) Activities Per year	DMAS Cover Virginia	**Cover Virginia 2021:** Spanish Calls Taken by Spanish-Speaking Bilingual Staff: 73,088 **Cover Virginia 2021:** Calls Taken with Language Assistance Services: 50,902 **Medallion 4.0** Call Center Language Calls 2021: 7,551 **CCC Plus** Call Center Language Calls 2021: 545 **2021 DMAS Website** 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	• CCC Plus: • Medallion 4.0:	Increase by X percent the Language and Disability Access report monitoring: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		1.1.1.3 Monitor Member Language Counts	DMAS	• CCC Plus: • Medallion 4.0:	Increase by X percent the Member Language Counts reported • Cardinal Care Program:	
	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: • CCC Plus: 68.5% • Medallion 4.0: 75.7% Adult: • CCC Plus: 58.7% • Medallion 4.0: 55.8%	Increase the Cardinal Care annual CAHPS overall Rating of *all Health Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		1.2.1.2 Rating of Personal Doctor	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	CAHPS 2021 Child: • CCC Plus: 79.5% • Medallion 4.0: 77.7% Adult: • CCC Plus: 72.8% • Medallion 4.0: 68.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Personal Doctor* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
★ **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: • CCC Plus: 89.7% • Medallion 4.0: 86.0% Adult: • CCC Plus: 85.0%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Care Quickly* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: 81.1%		
		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: • CCC Plus: % • Medallion 4.0: % Adult: • CCC Plus: % • Medallion 4.0: %	Increase the Cardinal Care annual CAHPS overall Rating of *Got Non-Urgent Appointment as Soon as Needed* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
		2.1.1.3 Getting Needed Care	CAHPS - AHRQ Child Core Set: CPC-CH Adult Core Set: CPA-AD	AHRQ CAHPS 2021 Child: • CCC Plus: 87.3% • Medallion 4.0: 84.6% Adult: • CCC Plus: 86.1% • Medallion 4.0: 82.9%	Increase the Cardinal Care annual CAHPS overall Rating of *Getting Needed Care* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	
	Objective 2.2 Promote Patient Safety	2.2.1.1 Prevalence of Pressure Ulcers Among LTSS Members	DMAS	Long-Term Nursing Facility: 3.3%[1] Short-Term Nursing Facility: 7.1%[1] CCC Plus Waiver Members: 1.9%[1]	Decrease the prevalence percentage of LTSS members with pressure ulcers by 2025: • Long-Term Nursing Facility: • Short-Term Nursing Facility:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• CCC Plus Waiver Members:	
		2.2.1.2 Monitor the Frequency of Reported Critical Incidents by Member Classification	DMAS	• CCC Plus Waiver w/o PDN: 694 • CCC Plus Waiver: 26 • CCC Plus Waiver W PDN: 30 • DD Waiver: 9 • Emerging Vulnerable: 349 • Minimal Need: 107 • Nursing Facility: 446 • Other: 732 • Total: 2,393[2]	Increase the number and percentage of Cardinal Care program members without PDN critical incidents reported by 2025: • CCC Plus Waiver w/o PDN: • CC Plus Waiver: • DD Waiver: • Emerging Vulnerable: • Minimal Need: • Nursing Facility: • Other: • Total:	
	Goal 2.3 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: • CCC Plus: 93.9% • Medallion 4.0: 93.7% Adult: • CCC Plus: 94.2% • Medallion 4.0: 93.3%	Increase the Cardinal Care annual CAHPS overall Rating of *How Well Doctors Communicate* to perform at or above the CAHPS 50th percentile by 2025: • Adult: • Child:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		2.3.1.2 Service Authorizations	DMAS https://www.dmas.virginia.gov/data/mco-service-authorization-performance/	2022 Fourth Quarter MCO Reporting	Maintain or Increase by X% service authorizations adjudicated timely by 2025: • Cardinal Care Program:	
★ **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: • Cardinal Care Program:	
		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: • Cardinal Care Program:	
		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: • Cardinal Care Program:	
		3.1.1.4 Ambulatory Care	NCQA HEDIS	HEDIS MY 2020 • CCC Plus: 77.45 • Medallion 4.0:	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: • Cardinal Care Program:	
		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 • 2021 CCC Plus: 43.08 HEDIS MY 2020 • CCC Plus: 77.45% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0	Decrease the HEDIS Ambulatory Care: Emergency Department (ED) Visit measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year: • 1-9 Years: • 10-19 Years: • Total: 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: • Cardinal Care Program HEDIS: • Cardinal Care Program Child Core Set: • Less than 1 Year:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 1-9 Years: • 10-19 Years: • Total:	
		3.1.1.6 Days Without Minimum RN Hours	DMAS VBP Reporting Team CMS Payroll Based Journal	NF VBP Program 2019 • CCC Plus:	NF VBP Decrease by X% the number of nursing facility y days without minimum RN hours. • Cardinal Care Program:	
		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 • CCC Plus:	NF VBP Increase by X% the number of days with total nurse staffing hours per resident day meeting minimum requirements. • Cardinal Care Program:	
		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 • CCC Plus:	NF VBP Decrease by X% Long-Stay Residents with a Urinary Tract Infection. • Cardinal Care Program	
		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 • CCC Plus:	NF VBP Decrease by X% the number of unplanned inpatient admissions or outpatient observations stays that occurred among long-stay residents of a nursing home.	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program:	
		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 • CCC Plus:	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 • CCC Plus:	NF VBP Decrease by X% Long-Stay High-Risk Residents with Pressure Ulcers	
	Objective 3.2 Promote Efficient Use of Program Funds	3.2.1.1 Monitor Medical Loss Ratio	DMAS—MCO Financials https://www.dmas.virginia.gov/data/mco-financials/	• CCC Plus: • Medallion 4.0:	Maintain MLR XXXX	
Goal 4: Strengthen the Health of Families and Communities	**Objective 4.1** 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 • CCC Plus: 87.12% • Medallion 4.0: 72.75%	Increase the HEDIS Adults' Access to Preventive/Ambulatory Health Services measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program:	
		4.1.1.2 Child and Adolescent Well-Care Visits	NCQA HEDIS (WCV) Child Core Set: WCV-CH	HEDIS MY 2020 • CCC Plus: 39.86% • Medallion 4.0: 46.57% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Child and Adolescent Well-Care Visits 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
					• Cardinal Care Program: 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: • 3-11 Years: • 12-17 Years: • 18-21 Years: • Total:	
		4.1.1.3 Childhood Immunization Status	NCQA HEDIS (CIS) • Combo 3 Child Core Set: CIS-CH	HEDIS MY 2020 • CCC Plus: 65.58% • Medallion 4.0: 65.82% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Childhood Immunization Status measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program: 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:	
		4.1.1.4 Immunizations for Adolescents	NCQA HEDIS (IMA) • Combo 1 • Combo 2 Child Core Set: IMA-CH	HEDIS MY 2020 Combo 1 • CCC Plus: 64.10%	Increase the HEDIS Immunization for Adolescents measure rate to perform at or	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: % Combo 2 • CCC Plus: 26.02% • Medallion 4.0: % Child Core Set • CCC Plus: • Medallion 4.0:	above the HEDIS 50th percentile by 2025: • Combo 1: • Combo 2: 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: • Combo 1: • Combo 2:	
		4.1.1.5 Flu Vaccinations for Adults 18-64	AHRA CAHPS Adult Core Set: CPA-AD	CAHPS 2021: ND Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the CAHPS Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CAHPS 50th percentile by 2025: • Cardinal Care Program: Increase the CMS Adult Core Set Flu Vaccinations for Adults 18-64 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		4.1.1.6 Topical Fluoride for Children	NCQA HEDIS (TFC) Child Core Set: TFL-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Topical Fluoride for Children measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program – Total: Increase the CMS Child Core Set Topical Fluoride for Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.7 Oral Evaluation, Dental Services	NCQA HEDIS (OED) Child Core Set: OEV-CH CMS 416	HEDIS MY 2020 • CCC Plus: • Medallion 4.0: Child Core Set • CCC Plus: • Medallion 4.0: • CMS 416 2021	Increase the HEDIS Oral Evaluation, Dental Services measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.*	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program Increase the CMS Child Core Set Evaluation, Dental Services measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		4.1.1.8 Sealant Receipt on Permanent First Molars	Child Core Set: SFM-CH CMS 416	Child Core Set • CCC Plus: • Medallion 4.0: CMS 416 2021	Increase the HEDIS Sealant Receipt on Permanent First Molars measure rate to perform at or above the HEDIS 50th percentile by 2025: *Note: MY 2023 Year 1 measure – percentile rankings may not be available.* • Cardinal Care Program Increase the CMS Child Core Set Sealant Receipt of Permanent First Molars 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
					• Cardinal Care Program – Total: *Note: Need to determine target for a CMS 416 measure.*	
		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: •	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: • Cardinal Care Program • BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity Increase the CMS Child Core Set Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• BMI Percentile Documentation • Counseling for Nutrition • Counseling for Physical Activity	
		4.1.1.10 Chlamydia Screening in Women Ages 16 to 20	NCQA HEDIS (CHL) CMS Child Core Set (CHL-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Chlamydia Screening in Women Ages 16-20 measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program *Note: HEDIS measure age is 16-24 Years.* 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: • Cardinal Care Program – Total:	
		4.1.1.11 Lead Screening in Children	NCQA HEDIS (LSC) CMS Child Core Set (LSC-CH)	HEDIS MY 2020 • CCC Plus: NR • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Lead Screening in Children measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Child Core Set Lead Screening in Children measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	★ **Objective 4.2** Improve Outcomes for Maternal and Infant Members	4.2.1.1 Prenatal and Postpartum Care: Postpartum Care	NCQA HEDIS (PPC) Adult Core Set: PPC-AD	HEDIS MY 2020 Postpartum Care • CCC Plus: NR • Medallion 4.0: 66.52% Adult Core Set Postpartum Care • CCC Plus: • Medallion 4.0:	Increase the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 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: • Cardinal Care Program – Total:	
		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 • CCC Plus: NR	Increase the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate to	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Medallion 4.0: 73.00% Adult Core Set Timeliness of Prenatal Care • CCC Plus: • Medallion 4.0:	perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 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: • Cardinal Care Program – Total:	
		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: • Cardinal Care Program – Total:	
		4.2.1.4 Well-Child Visits in the First 30 Months of Life	NCQA HEDIS (W30) Child Core Set: W30-CH	HEDIS MY 2020 • CCC Plus: 71.81% • Medallion 4.0: 72.10% Child Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program • First 15 Months:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 15-30 Months 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: • Cardinal Care Program • First 15 Months: • 15-30 Months	
		4.2.1.5 Low-Risk Cesarean Delivery	Child Core Set: LRCD-CH CDC Wonder State Vital Records	Child Core Set CMS 2021 Reported Rate—CDC Wonder Data:	Decrease the CMS Child Core Set Low-Risk Cesarean Delivery measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
	Objective 4.3 Improve Home and Community-Based Services	4.3.1.1 Number and Percent of Waiver Individuals Who Have Service Plans That are Adequate and Appropriate to Their Needs and Personal Goals	QMR	**FY22** Q1: 86.0% Q2: 50% Q3: 53%	Increase the number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals by 5% by 2025: • Cardinal Care Program – Total:	
		4.3.1.2 Number and Percent of Individuals Who Received	QMR	**FY22** Q1: 97.0%	Increase the number and percent of individuals who	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Services in the Scope Specified in the Service Plan		Q2: 100% Q3: 100%	received services in the scopes specified in their service plan by 5% by 2025: • Cardinal Care Program – Total:	
Goal 5: Providing Whole-Person Care for Vulnerable Populations	**Objective 5.1** 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 • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Heart Failure Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.2 PQI 14: Asthma Admission Rate (Ages 2–17)	Adult Core Set: PQI15-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma Admission measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.3 PQI 05: COPD and Asthma in Older Adults' Admission Rate	Adult Core Set: PQI105-AD	Adult Core Set • CCC Plus: 41.04% • Medallion 4.0:	Decrease the CMS Adult Core Set Asthma in Older Adults' 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
					• Cardinal Care Program – Total: *Note: Lower rate is better.*	
		5.1.1.4 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA HEDIS (HPC) Adult Core Set: HPC-AD	HEDIS MY 2020 • CCC Plus: 51.42% • Medallion 4.0: 41.04% Adult Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program Increase the CMS Adult Core Set Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.1.1.5 Controlling High Blood Pressure	NCQA HEDIS (CBP) Adult Core Set: CBP-AD	HEDIS MY 2020 • CCC Plus: 48.07% • Medallion 4.0: 46.91% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Controlling High Blood Pressure measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Increase the CMS Adult Core Set Controlling High Blood Pressure measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		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	HEDIS MY 2020 • CCC Plus: 47.93% • Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program • *3 Months to 17 Years:* • *18- 64 Years:* • *65 Years and older:* • *Total:* *Note: Recommend dropping the 18-64, 65 years and older, and total.* Increase the CMS Child Core Set Avoidance of Antibiotic Treatment for Acute Bronchitis:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Ages 3 Months to 17 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total: • *3 Months to 17 Years:*	
		5.1.1.7 Asthma Medication Ratio: Age 5 to 18 Years	NCQA HEDIS (AMR) CMS Child Core Set: AMR-CH	HEDIS MY 2020 • CCC Plus: 63.62% • Medallion 4.0: 71.00% Child Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Child Core Set Asthma Medication Ratio: Age 5 to 18 Years measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
	Objective 5.2 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:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• Cardinal Care Program – Total: *Note: Lower rate is better.*	
	★ **Objective 5.3** Improve Outcomes for Members with Substance Use Disorders	5.3.1.1 Monitor Identification of Alcohol and Other Drug Services	DMAS	• CCC Plus: • Medallion 4.0:	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 • 7-Day: 11.44% • 30-Day: 19.98% Medallion 4.0: • 7-Day: 13.92% • 30-Day: 21.88% Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	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: • Cardinal Care Program 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: • Cardinal Care Program – Total:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		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 • CCC Plus: • Medallion 4.0: Adult Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program 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: • Cardinal Care Program – Total:	
		5.3.1.4 Initiation and Engagement of Substance Use Disorder Treatment	NCQA HEDIS (IET) Adult Core Set: IET-AD	HEDIS MY 2020 CCC Plus: • Initiation: 46.41% • Engagement: 12.51% Medallion 4.0: • Initiation: • Engagement: Adult Core Set CCC Plus: • Initiation: • Engagement: • Medallion 4.0: • Initiation:	Increase the HEDIS Initiation and Engagement of Substance Use Disorder Treatment measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program Increase the CMS Adult Core Set Initiation and	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• Engagement:	Engagement of Substance Use Disorder Treatment measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Total:	
		5.3.1.5 Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set: OUD-AD	Adult Core Set • CCC Plus • Medallion 4.0:	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: • Cardinal Care Program – Total:	
	Goal: 5.4 Improve Behavioral Health and Developmental Services for Members	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 • 7-Day: 30.77% • 30-Day: 54.12% Medallion 4.0: • 7-Day: 35.63% • 30-Day: 56.84% Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0:	Increase the HEDIS Follow-Up After Hospitalization for Mental Illness measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days Increase the CMS Adult Core Set Follow-	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				• 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	Up After Hospitalization for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days 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: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		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	HEDIS MY 2020 CCC Plus • 7-Day: 47.03% • 30-Day: 62.83% Medallion 4.0: • 7-Day: 45.34% • 30-Day: 57.38%	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:	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
				Adult Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day: Child Core Set CCC Plus • 7-Day: • 30-Day: Medallion 4.0: • 7-Day: • 30-Day:	• Cardinal Care Program 6 Years and Older • Within 7 Days • Within 30 Days 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: • Cardinal Care Program – 18 and Older: • Within 7 Days • Within 30 Days Increase the CMS Child Core Set Follow-Up After Emergency Department for Mental Illness measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program ages 6-17 Years: • Within 7 Days • Within 30 Days	
		5.4.1.3 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity	NCQA HEDIS (ADD) Child Core Set: ADD-CH	HEDIS MY 2020 CCC Plus • Initiation:	Increase the HEDIS Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Disorder (ADHD) Medication		• Continuation: Medallion 4.0 • Initiation: 45.20% • Continuation: 58.61% Child Core Set CCC Plus: • Initiation: • Continuation: CCC Plus: • Initiation: • Continuation:	Disorder (ADHD) Medication measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase: Increase the CMS Child Core Set Follow-Up for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 6-12 Years • Initiation Phase: • Continuation and Maintenance Phase:	
		5.4.1.4 Monitor Mental Health Utilization	DMAS	DMAS • CCC Plus: • Medallion 4.0:	Increase the percentage of members receiving mental health services by X% by 2025.	
		5.4.1.5 Use of First-Line Psychosocial	NCQA HEDIS (APP)	HEDIS MY 2020	Increase the HEDIS Use of First-Line	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
		Care for Children and Adolescents on Antipsychotics	Child Core Set: APP-CH	• CCC Plus: 43.71% • Medallion 4.0: 69.58% Child Core Set • CCC Plus: • Medallion 4.0:	Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years Increase the CMS Child Core Set Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program – Ages 1-17 Years	
		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: • Blood Glucose Testing—Total: 41.33 • Cholesterol Testing—Total: 28.59% • Blood Glucose and Cholesterol	Increase the HEDIS Metabolic Monitoring for Children and Adolescents on Antipsychotics 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
				Testing—Total: 27.05% Medallion 4.0: NR Child Core Set • CCC Plus: • Medallion 4.0:	• Cardinal Care Program – Ages 1-17 Years 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: • Cardinal Care Program – Ages 1-17 Years	
		5.4.1.7 Medical Assistance with Smoking and Tobacco Use Cessation	CMS Adult Core Set: MSC-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Medical Assistance with Smoking and Tobacco Use Cessation measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 3 Months – 17 Years • 18 – 64 Years • 65 and Older • Total Increase the CMS Adult Core Set Medical Assistance	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					with Smoking and Tobacco Use Cessation measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18-64 Years • 65 and Older	
		5.4.1.8 Antidepressant Medication Management	NCQA HEDIS (AMM) CMS Adult Core Set: AMM-AD	HEDIS MY 2020: CCC Plus: • Effective Acute Phase Treatment: 61.11% • Effective Continuation Phase: 48.29% Medallion 4.0: • Effective Acute Phase Treatment: 57.12% • Effective Continuation Phase: 42.02% Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Antidepressant Medication Management measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 and Older • Effective Acute Phase Treatment • Effective Continuation Phase Treatment Increase the CMS Adult Core Set Antidepressant Medication Management measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					• 65 and Older • Total • Effective Acute Phase Treatment • Effective Continuation Phase Treatment	
		5.4.1.9 Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set: CDF-AD	Adult Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program	
		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	HEDIS MY 2020: • CCC Plus: 77.18% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	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: • Cardinal Care Program • 18 to 64 Years Increase the CMS Adult Core Set Diabetes Screening for People with	

Goal	Objective	Measure Name	Metric specifications	Baseline Performance	Performance Measure Target	MY 2023 Aggregate Rate
					Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure rate to perform at or above the CMCS 50th percentile by 2025: • Cardinal Care Program • 18 – 64 Years	
		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	HEDIS MY 2020 • CCC Plus: • Medallion 4.0 Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 75 Years Increase the CMS Adult Core Set Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 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
					• Cardinal Care Program • 18 – 64 Years • 65 – 75 Years	
		5.4.1.12 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA HEDIS (SAA) CMS Adult Core Set: SAA-AD	HEDIS MY 2020: • CCC Plus: 69.50% • Medallion 4.0: NR Adult Core Set • CCC Plus: • Medallion 4.0:	Increase the HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure rate to perform at or above the HEDIS 50th percentile by 2025: • Cardinal Care Program • 18 to 39 Years 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: • Cardinal Care Program • 18 – 39 Years	

[1] *DMAS Cumulative data from MCO quarterly reports 1/1/2020–3/31/2022.*
[2] *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.*

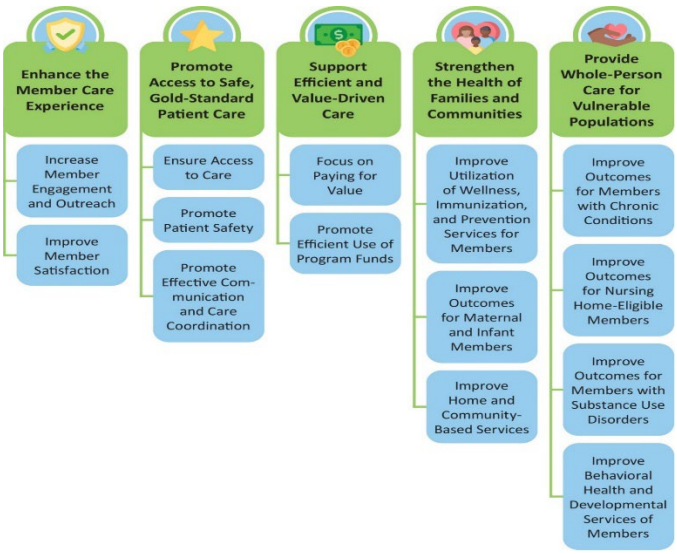
★ *These goals are inclusive of Governor Glenn Youngkin's identified priorities for the Medicaid program that focus on behavioral health enhancement, maternal health outcomes, and access to high quality healthcare services.*

Appendix G. CCC Plus (MLTSS) Program 2023 Snapshot

Virginia Medicaid Background

DMAS administers the CCC Plus (MLTSS) program, which includes the Virginia Medicaid program and FAMIS, the Commonwealth's CHIP program.

Virginia's 2023–2025 Quality Strategy Goals and Objectives



CCC Plus (MLTSS) 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

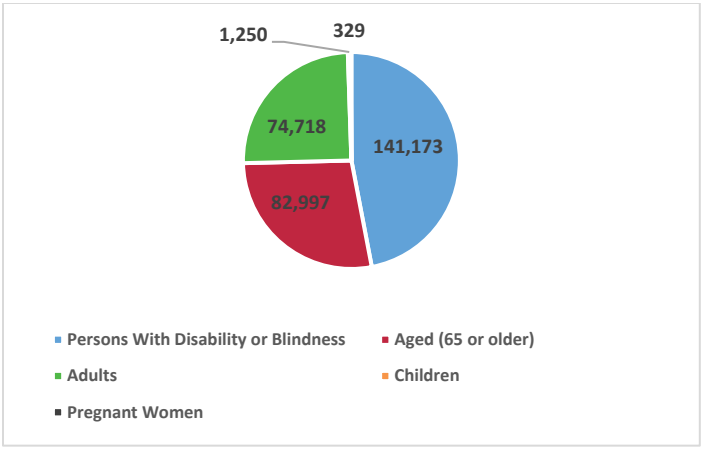
CCC Plus (MLTSS) Program Enrollment

Calendar Year 2023 Average Annual Program Enrollment

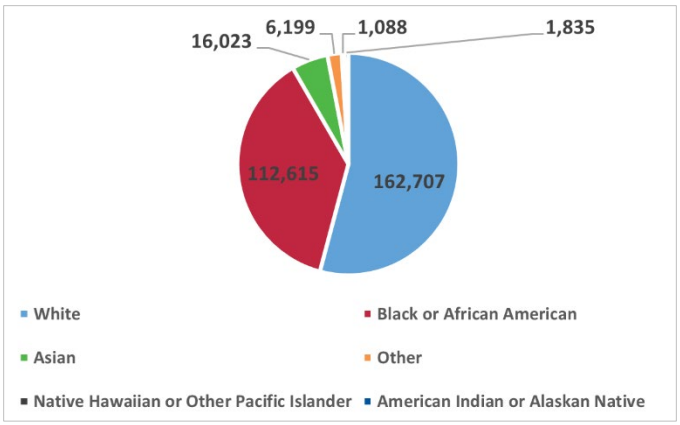
Program	SFY 2023 Enrollment as of 7/1/2023
CCC Plus	307,904

CCC Plus (MLTSS) Program Demographics

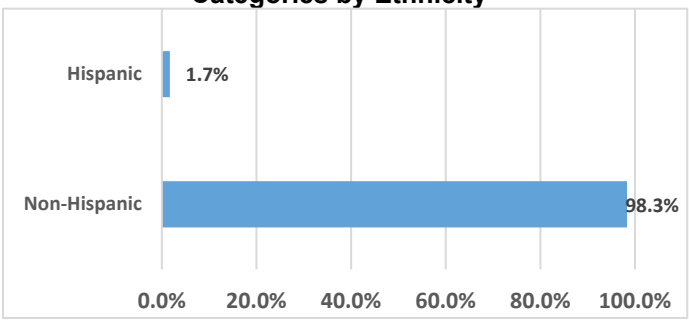
Eligibility Categories



Categories by Race

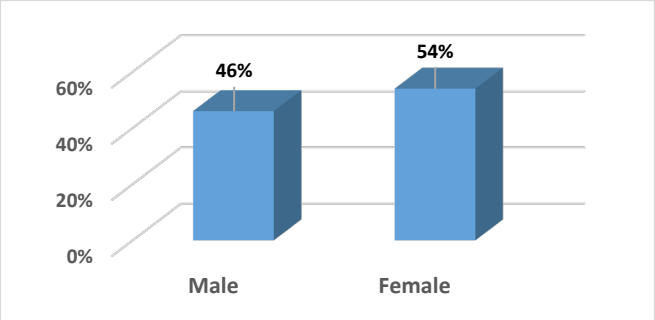


Categories by Ethnicity

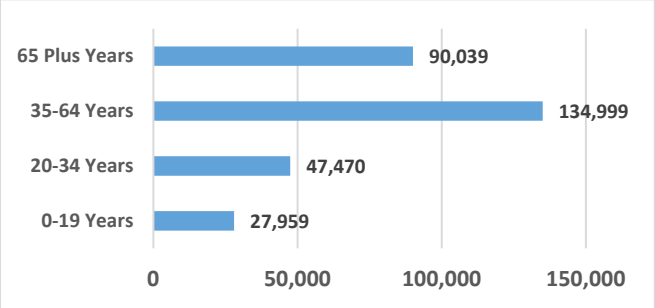


CCC Plus (MLTSS) Program Demographics

Percentage by Gender

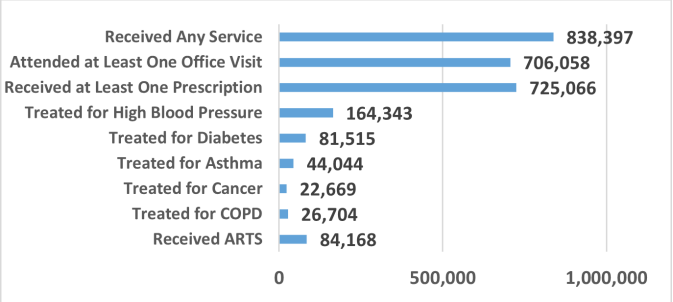


Enrollment by Age Group

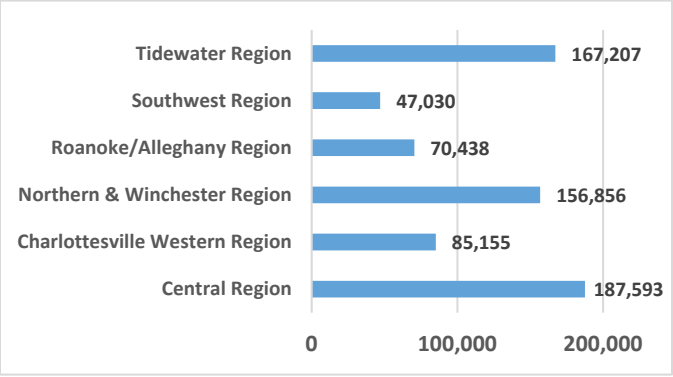


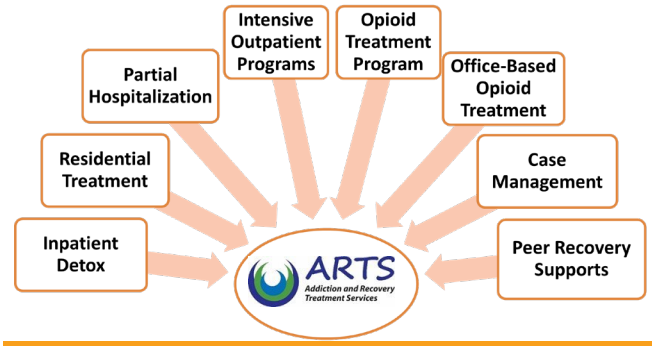
Medicaid Expansion

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 continued to increase with a 24% increase 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.
- Only 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 waivered 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:

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

Strengths	Four of the six MCOs received 100 percent validation scores across all evaluation elements for Steps 1 through 8 and were assigned a *High Confidence* 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.
Weaknesses	Two of the six MCOs have opportunities for improvement related to accurately defining performance indicators, calculating and reporting baseline data correctly, and effectively evaluating the effectiveness of each individual intervention.

Performance Measure Validation Results

Domain	Strengths
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.
Behavioral Health	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.
	Five of the six MCOs' rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Total* measures met or exceeded the 50th percentile.
Taking Care of Children	Five of six MCOs' rates met or exceeded the 50th percentile for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* Fand *Blood Glucose and Cholesterol Testing—Total* PM indicators.
Living With Illness	MCO performance within the Living With Illness domain was the highest for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure, with five of six MCOs' rates meeting or exceeding the 50th percentile for the *Discussing Cessation* PM indicator, and five of six MCOs' rates meeting or exceeding the 50th percentile for the *Advising Smokers and Tobacco Users to Quit* PM indicators.
	Five of six MCOs' rates met or exceeded the 50th percentile for the *Asthma Medication Ratio—Total, Eye Exam for Patients With Diabetes—Total,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure indicators.
Use of Opioids	Four of six MCOs' rates met or exceeded the 50th percentile for *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* PM indicators.

Domain	Opportunities for Improvement
Access and Preventive Care	All reportable MCO rates fell below the 50th percentile for the *Cervical Cancer Screening, Prenatal and Postpartum Care,* and *Use of Imaging Studies for Low Back Pain* measures.
	Four of the six MCOs' rates fell below the 50th percentile for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and five of six MCOs' rates fell below the 50th percentile for the *Breast Cancer Screening* measures.
Behavioral Health	Five of the six MCOs' rates fell below the 50th percentile for the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia—Total* measure. All six MCOs' rates fell below the 50th percentile for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* 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.
Taking Care of Children	All six 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.
Living With Illness	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.

Compliance With Standards Monitoring Results

The MCOs' 2021 compliance scores, for the three-year cycle, ranged from 86.2 percent to 95.2 percent. All six MCOs received a 100 percent 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%.

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%

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 the2022 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

Member Experience of Care Survey Results

	Adult 2022	Adult 2023	Child 2022	Child 2023
Global Top-Box Scores				
Rating of Health Plan	66.6%	65.4%	65.6%	65.5%
Rating of All Health Care	58.8%	58.0%	66.1%	63.9%
Rating of Personal Doctor	70.5%	71.8%	75.6%	75.8%
Rating of Specialist Seen Most Often	72.6%	68.9%	72.3%	72.4%
Composite Tob-Box Scores				
Getting Needed Care	85.7%	83.3%	84.3%	83.3%
Getting Care Quickly	85.8%	82.6%▼	87.6%	85.6%
How Well Doctors Communicate	93.1%	93.4%	93.8%	94.7%
Customer Service	90.4%	91.2%	87.2%	88.5%

▼ *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.

Member Experience of Care Survey Results

Strengths

2023 Medicaid top-box score results:

- Adult—The CCC Plus 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*.

Opportunities for Improvement

2023 Medicaid top-box score result for the CCC Plus (MLTSS) Program:

- Adult—2023 top-box scores were statistically significantly lower than the 2022 top-box scores for *Getting Care Quickly*.
- Child—2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of Health Plan*.
- Child—2023 top-box scores were statistically significantly lower than the 2022 NCQA child Medicaid national average for *Rating of All Health Care*.

Consumer Decision Support Tool

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

MCO	Overall Rating*	Doctors' Communication	Access and Preventive Care
Aetna	★★★	★★★	★★★
HealthKeepers	★★★★	★★★	★★★
Molina	★	—	★★
Optima**	★★★★	★★★	★★★★
United	★★★	—	★★★

MCO	Behavioral Health	Taking Care of Children	Living With Illness
Aetna	★★★★	★★★★	★★★
HealthKeepers	★★★★★	★★★★★	★★★
Molina	★	★★	★★
Optima**	★★★	★	★
United	★★★	★★★	★★★★★

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

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

—Indicates the CCC Plus (MLTSS) MCO did not have enough data to receive a rating.